

ARNE CHIROPRACTIC CLINICS, P.A.

WORK/COMP QUESTIONNAIRE

Name: \_\_\_\_\_ Date of Accident: \_\_\_\_\_

1. Name of employer at time of accident: \_\_\_\_\_

2. Length of time worked there prior to accident: \_\_\_\_\_

3. Type of work being done at time of injury: \_\_\_\_\_

4. In your own words, please describe accident: \_\_\_\_\_  
\_\_\_\_\_

5. Have you been treated by another doctor for this accident?  Yes  No If yes, please list  
doctor's name and address: \_\_\_\_\_

What type of treatment did you receive? \_\_\_\_\_

How long were you treated by this doctor? \_\_\_\_\_

6. Are you:  improved  unchanged  getting worse

7. What types of medicines are you taking? \_\_\_\_\_

8. Have you had physical therapy?  Yes  No If yes, how often? \_\_\_\_\_

Does the physical therapy help?  Yes  No  Don't know

9. Prior to the accident, have you ever had any of the physical complaints similar to what you have now?  
 Yes  No If yes, please describe: \_\_\_\_\_  
\_\_\_\_\_

Were these similar complaints the result(s) of a previous accident(s)?  Yes  No

Please provide details of previous accident(s): \_\_\_\_\_  
\_\_\_\_\_

10. Have you had any other serious accidents which required chiropractic or medical care?  Yes  No  
If yes, please describe: \_\_\_\_\_

11. Have you had any serious injuries or illnesses that required hospitalization?  Yes  No  
If yes, please describe: \_\_\_\_\_  
\_\_\_\_\_

12. Have you had any surgeries?  Yes  No If yes, please list type of surgery and date: \_\_\_\_\_  
\_\_\_\_\_

13. Did you lose time from work due to this accident? ( ) Yes ( ) No If yes, list first date off work \_\_\_\_\_  
 \_\_\_\_\_ Have you returned to work? ( ) Yes ( ) No If yes, list date returned \_\_\_\_\_

**CURRENT COMPLAINTS**

- 1. Currently, I have pain in my: ( ) low back ( ) mid back ( ) upper back ( ) neck
- 2. My pain began: ( ) gradually ( ) suddenly
- 3. I have pain: ( ) sometimes ( ) all the time
- 4. My pain goes into my: ( ) right leg ( ) left leg ( ) right arm ( ) left arm
- 5. I have tingling and/or numbness in my: ( ) right leg ( ) left leg ( ) right arm ( ) left arm
- 6. My pain is worse when I:
  - cough or sneeze ( ) Yes ( ) No
  - sit ( ) Yes ( ) No
  - bend ( ) Yes ( ) No
  - walk ( ) Yes ( ) No
  - lift ( ) Yes ( ) No
  - push ( ) Yes ( ) No
  - pull ( ) Yes ( ) No
- 7. My pain is worse with sexual activity: ( ) Yes ( ) No
- 8. My pain wakes me up during the night: ( ) Yes ( ) No
- 9. Changes in the weather affect my pain: ( ) Yes ( ) No
- 10. I have neck stiffness: ( ) Yes ( ) No
- 11. I have headaches: ( ) Yes ( ) No
- 12. If I do get headaches, they occur: ( ) Daily ( ) 2 X Weekly ( ) 1 X Weekly ( ) Rarely

**OTHER PAIN:**

Please describe any current physical complaint which you are experiencing and were not previously on this questionnaire, or list any additional comments you wish to make regarding your condition:

**JOB DESCRIPTION**

1. In a typical 8-hour workday, I: (Circle # of hours/activity)
- |        |   |   |   |   |   |   |   |   |       |
|--------|---|---|---|---|---|---|---|---|-------|
| Sit:   | 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | hours |
| Stand: | 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | hours |
| Walk:  | 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | hours |

2. On the job, I perform the following activities:

(In terms of an 8-hour workday, "occasionally" means 33%, "frequently" means 34% to 66%, and "continuously" means 67% to 100% of the day).

	NOT AT ALL	OCCASIONALLY	FREQUENTLY	CONTINUOUSLY
Bend/stoop	( )	( )	( )	( )
Squat	( )	( )	( )	( )
Crawl	( )	( )	( )	( )
Climb	( )	( )	( )	( )
Reach above shoulder level	( )	( )	( )	( )
Crouch	( )	( )	( )	( )
Kneel	( )	( )	( )	( )
Balancing	( )	( )	( )	( )
Pushing/Pulling	( )	( )	( )	( )
Lift more than 10 lbs	( )	( )	( )	( )
Lift more than 25 lbs	( )	( )	( )	( )
Lift more than 40 lbs	( )	( )	( )	( )

Signature \_\_\_\_\_

Date \_\_\_\_\_