Work Injury Questionnaire

Name:_____ Date: _____

Date of injury: _____ Location (City,State) _____Time of injury:_____

Did you report this injury to your employer? Yes No Who did you report it to?_____

How did the injury occur?_____
_____
_____
_____
_____

Symptoms immediately following the injury: Please describe in detail _____
_____
_____

Were you taken to the hospital? Y N How did you get to the hospital?_____
What treatment was rendered at the hospital? (Exam, x-rays, medication, instructions)_____
_____

Have you sought any additional treatment, other than the initial treatment since the injury? Y N
If yes, where? _____

Have the symptoms changed since the initial injury? How? _____
_____
Where x-rays or special test performed following the accident? Yes No
If yes, list name or facility where tests were performed:_____.

Did you have any similar symptoms prior to the injury? _____

Have you had a previous injury, fall or other trauma? Y N If yes, please explain: _____
_____

Have you missed work due to this injury? Yes No How many days? _____
Describe your job duties: _____
_____

Are you taking medication due to injuries from this accident? Yes No
If yes, what type of medication?_____
_____.

Is there any additional information you would like us to know?
_____
_____
_____
_____