Patient Name: _____ Date of Birth: _____

Workers Compensation Injuries

Injuries involving Lifting:

From where were you lifting the object?
(i.e. below ground level, ground level, # of feet above ground level)
_____
_____

How many pounds was the object you were lifting?
_____
_____

What position were you in while lifting the object?
(i.e. bent over at waist, upright, twisted to right, twisted to left)
_____

What type of pain did you feel immediately after the injury?
(i.e. gripping pain, sharp pain, dull pain, ache pain, popping feeling)
_____
_____

Injuries involving Falling:

Where at work did you fall?
(from the ground, while running, # of feet above ground)
_____
_____

What part of your body did you land on?
_____
_____

What other areas were injured as a result of your fall?
_____
_____

Other work related injuries:

Other type of accident (if not caused by lifting or a fall)? _____
_____
_____
_____

Job Analysis:
What regular activities to you perform at your job?

_____
_____

How much do you regularly lift at your job?
(# of lbs.)

Are you required to regularly bend over while lifting at your job?

_____
_____

Are your hands subject to repetitive movements? _____ Such as? _____
_____
_____

How many hours are you required to regularly perform each of the following activities at your job?

Sitting _____
Standing _____
Walking_____
Lifting _____

Check below if applicable:

___ Did you report this injury in writing at work?