

Cascade Chiropractic

Woody Bernard D.C.

1420 King Street, Suite D

Bellingham, WA 98229

(360) 671-4242

cascadekey2wellness.com

EMPLOYMENT INJURY QUESTIONNAIRE

Name: _____ Date of accident: _____

- Name of employer at time of accident: _____
- Length of time worked there prior to accident: _____
- Type of work being done at time of injury: _____

4. In your own words please describe the 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? _____

Do these medicines help? Yes No Don't know

8. Have you had physical therapy? Yes No If yes how often:
 Daily Every other day Several times a week Weekly Every other week
 Monthly Other: _____

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

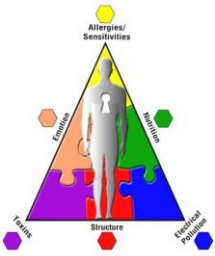
9. Prior to this accident, have you ever had any physical complaints similar to what you have now?
 Yes No Don't know
If yes, please describe: _____

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

Please provide details of the accident(s): _____

10. Have you had any other serious accidents which required medical care? Yes No
Describe: _____

11. Have you had any serious illnesses that required medical care? Yes No
Describe: _____



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12. Have you had any surgeries? Yes No

If yes, list type of surgery and date: _____

13. Have you had any nervous or mental illness? Yes No

Have you had psychiatric care? Yes No

14. Have you received a medical discharge from the Armed Forces? Yes No

15. Have you returned to work since this accident? Yes No

If you have returned to work since this accident, please fill out the information below:

DATE	EMPLOYER	OCCUPATION	LIGHT DUTY REG. DUTY	FULL-TIME PART-TIME

CURRENT MEDICAL COMPLAINTS

BACK PAIN:

1. Currently, I have pain in my: low back mid back upper back

2. My pain began: gradually suddenly

3. I have pain: sometimes all of the time

4. My pain goes into my: right leg left leg both

5. I have tingling or numbness in my: right leg left leg both

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 back 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

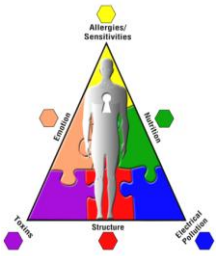
NECK PAIN:

1. My neck pain began: gradually suddenly

2. I have pain: sometimes all of the time

3. My pain goes into my: right arm left arm both

4. I have tingling or numbness in my: right arm left arm both



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NECK PAIN (continued):

5. My neck pain is worse when I:

- | | | |
|-----------------|------------------------------|-----------------------------|
| Cough or sneeze | <input type="checkbox"/> yes | <input type="checkbox"/> no |
| Bend forward | <input type="checkbox"/> yes | <input type="checkbox"/> no |
| Lift | <input type="checkbox"/> yes | <input type="checkbox"/> no |
| Push | <input type="checkbox"/> yes | <input type="checkbox"/> no |
| Pull | <input type="checkbox"/> yes | <input type="checkbox"/> no |
| Turn my head | <input type="checkbox"/> yes | <input type="checkbox"/> no |

6. My pain wakes me up during the night yes no

7. Changes in the weather affect my pain yes no

8. I have neck stiffness yes no

9. I have headaches yes no

10. If I do get headaches, they occur sometimes all of the time

OTHER PAIN:

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

JOB DESCRIPTION:

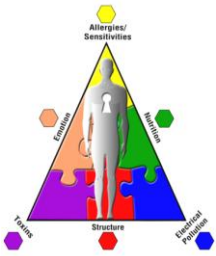
In terms of an 8 hour work day, "occasionally" means 33%, "frequently" means 34% to 66%, and "continuously" means 67% to 100% of the day.

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:

- | | Not at all | Occasionally | Frequently | Continuously |
|----------------------------|--------------------------|--------------------------|--------------------------|--------------------------|
| Bend / stoop | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Squat | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Crawl | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Climb | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Reach above shoulder level | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Crouch | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Kneel | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Balancing | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Pushing / pulling | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Bend / stoop | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |



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3. On the job I lift:

	Not at all	Occasionally	Frequently	Continuously
Up to 10 pounds	[]	[]	[]	[]
11 to 24 pounds	[]	[]	[]	[]
25 to 34 pounds	[]	[]	[]	[]
35 to 50 pounds	[]	[]	[]	[]
51 to 74 pounds	[]	[]	[]	[]
75 to 100 pounds	[]	[]	[]	[]

4. Do you have to bend over while doing any lifting? [] yes [] no

5. Are your feet used for repetitive actions, such as in operating foot controls? [] yes [] no

6. Are your hands used for repetitive actions, such as:

	Simple Grasping	Firm Grasping	Fine Manipulating
Right hand	[] yes [] no	[] yes [] no	[] yes [] no
Left hand	[] yes [] no	[] yes [] no	[] yes [] no

7. Are you required to work on unprotected heights? [] yes [] no

Describe: _____

8. Are you required to be around moving machinery? [] yes [] no

Describe: _____

9. Are you exposed to marked changes in temperature and humidity? [] yes [] no

Describe: _____

10. Are you required to drive automotive equipment? [] yes [] no

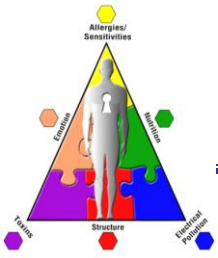
Describe: _____

11. Are you exposed to dust, fumes and/or gases? [] yes [] no

Describe: _____

12. Please list any additional comments: _____

Signature: _____ Date: _____



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