

Name: _____ DOB: _____

-WORK RELATED INJURY QUESTIONNAIRE-

Date of Injury: _____ Time of Injury: _____

Last Date Worked: _____

Did injury happen at work? YES NO UNKNOWN

Was injury witnessed: NO YES by whom? _____

Have you reported injury to your employer? YES NO Date reported: _____

Where is your problem located on your body? _____

How would you characterize your pain (dull, sharp, aching, shooting, etc)? _____

How would you rate your pain on a scale of 1 (mild) to 10 (severe)? _____

Timing (intermittent, constant, etc): _____

Are your symptoms getting: [better] [worse] [the same]

Describe how and where injury occurred: _____

Does anything help your symptom(s) to feel better?

Does anything make your symptom(s) worse?

Have you every had an injury to this body part before? If yes, please explain:

Anything else we should know about your injury?

