PROEX
People Focused Physical Therapy

Workers Compensation Form

Patient Name: _____

Job Title: _____

Employer: _____

What is your current work status?

☐ Working full duty

☐ Off work due to injury, since: ____

☐ Working light or modified duty

☐ Other: _____

Does your job require frequent lifting or carrying? ☐ Yes ☐ No

What is the approximate maximum weight you have to lift? _____ lb.

Is your job physically demanding? ☐ Yes ☐ No

Does your job require constant repetitive activity? ☐ Yes ☐ No

Does your job require strong or repetitive gripping with your hands? ☐ Yes ☐ No

How much of your job do you believe you can perform at this time?

☐ Some ☐ All ☐ None

Date of injury or Onset of Symptoms?

_____

What area of your body did you injure?

_____

How were you injured?_____

Have you had this type of injury before?

☐ Yes ☐ No

How many times? _____

Have you had physical therapy for this problem before? ☐ Yes ☐ No

Have you undergone any diagnostic test for this? (x-rays, MRI, nerve condition test, blood tests)

☐ Yes ☐ No

If yes, please list:_____

Does coughing or sneezing reproduce your pain?

☐ Yes ☐ No

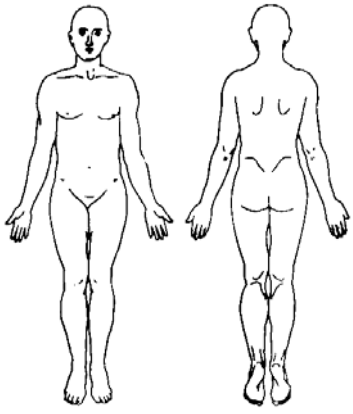
Have you recently had problems with your bladder or bowel?

☐ Yes ☐ No

Please grade the amount of pain you have today (circle one)

0 1 2 3 4 5 6 7 8 9 10

Please indicate on the diagram below where your pain or symptoms are:



What makes your pain or symptoms feel better?

_____

What make your pain or symptoms worse?

_____

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Medical History (Please circle one)

Do you have high blood pressure?	Yes	No
Do you have heart disease?	Yes	No
Do you experience angina (chest pain)?	Yes	No
Do you experience shortness of breath?	Yes	No
Do you have lung disease?	Yes	No
Do you have a history of cancer?	Yes	No
Do you experience heartburn or stomach upset?	Yes	No
Do you have a thyroid condition?	Yes	No
Have you experienced recent weight loss/gain?	Yes	No
Do you have diabetes?	Yes	No
Do you have low blood sugar?	Yes	No
Have you experienced an increase in frequency or intensity of headache?	Yes	No
Do you have unusual joint pain and/or swelling?	Yes	No
Do you have a history of fractures?	Yes	No
Do you have osteoporosis?	Yes	No
Do you have impaired hearing?	Yes	No
Do you have impaired vision?	Yes	No

OB/GYN (circle one)

Are you now, or do you have any reason to believe you may be pregnant?	Yes	No
Have you had any complicated pregnancies?	Yes	No
Have you had pelvic inflammatory disease?	Yes	No
Do you have dysmenorrhea (abnormal menstrual cycle)?	Yes	No

Please list ALL medications, dosage and purpose: _____

_____

Please list all surgeries and dates: _____

_____

Have you seen anyone else for your current problems? If so please explain: _____

_____

This questionnaire is used to assist us in having a better understanding of your overall health status and is part of your confidential medical record. Please discuss any concerns regarding the questionnaire with the therapist.

Signature: _____ Date: _____

People Focused Physical Therapy

Physical Job Demand

1. Are you currently working? ☐ Yes ☐ No

2. How many hours a week are you currently working? _____

3. Is this your normal amount of work hours? ☐ Yes ☐ No

4. How many hours a week do you normally work? _____

5. Are you currently performing your full duties as work? ☐ Yes ☐ No

6. Are you on modified duty? ☐ Yes ☐ No
   If yes, what are your restrictions? _____

   _____

7. Does your company offer modified duty? ☐ Yes ☐ No

8. How would you rate the overall demand of your work? (Check one)
   - ☐ Sedentary
   - ☐ Light
   - ☐ Medium
   - ☐ Heavy
   - ☐ Very Heavy

9. How often do you lift weight from the floor during your workday? (Check one)
   - ☐ Never (0%)
   - ☐ Rarely (0-5 %)
   - ☐ Occasionally (6-33%)
   - ☐ Frequently (34-66%)
   - ☐ Continuously (67-100%)

   9a. What is the average weight you lift from the floor? _____
   9b. What is the maximum weight you lift from the floor? _____

10. How often do you lift overhead during your work day? (Check one)
   - ☐ Never (0%)
   - ☐ Rarely (0-5 %)
   - ☐ Occasionally (6-33%)
   - ☐ Frequently (34-66%)
   - ☐ Continuously (67-100%)

   10a. What is the average weight you lift overhead? _____
   10b. What is the maximum weight you lift overhead? _____

11. How often do you push/pull objects during your work day? (Check one)
   - ☐ Never (0%)
   - ☐ Rarely (0-5 %)
   - ☐ Occasionally (6-33%)
   - ☐ Frequently (34-66%)
   - ☐ Continuously (67-100%)

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11a. What is the average weight you push/pull? _____
11b. What is the maximum weight you push/pull? _____
11c. What do you have to push/pull? _____

12. How often do you carry weight during your work day? (Check one)

☐ Never (0%)
☐ Rarely (0-5 %)
☐ Occasionally (6-33%)
☐ Frequently (34-66%)
☐ Continuously (67-100%)

12a. What is the average weight you carry? _____
12b. What is the maximum weight you carry? _____
12c. On average, how far do you carry objects? _____

13. How often do you reach overhead for prolonged periods during your work day?

☐ Never (0%)
☐ Rarely (0-5 %)
☐ Occasionally (6-33%)
☐ Frequently (34-66%)
☐ Continuously (67-100%)

13a. Please explain these activities: _____

14. How often are you sitting during your work day? (Check one)

☐ Never (0%)
☐ Rarely (0-5 %)
☐ Occasionally (6-33%)
☐ Frequently (34-66%)
☐ Continuously (67-100%)

15. How often are you standing during your work day? (Check one)

☐ Never (0%)
☐ Rarely (0-5 %)
☐ Occasionally (6-33%)
☐ Frequently (34-66%)
☐ Continuously (67-100%)

16. How often are you walking during your work day? (Check one)

☐ Never (0%)
☐ Rarely (0-5 %)
☐ Occasionally (6-33%)
☐ Frequently (34-66%)
☐ Continuously (67-100%)

17. How often do you climb stairs during your work day? (Check one)

☐ Never (0%)
☐ Rarely (0-5 %)
☐ Occasionally (6-33%)
☐ Frequently (34-66%)
☐ Continuously (67-100%)

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18. How often are you at a computer during your work day? (Check one)
    - ☐ Never (0%)
    - ☐ Rarely (0-5 %)
    - ☐ Occasionally (6-33%)
    - ☐ Frequently (34-66%)
    - ☐ Continuously (67-100%)
19. How would you describe the pace of your work? (Check one)
    - ☐ Slow
    - ☐ Steady
    - ☐ Fast
20. Do you do repetitive tasks with your arms/hand during your work day? ☐ Yes ☐ No
    If yes, please explain: _____
    _____
21. Do you have to squat/crouch repetitively during your work day? ☐ Yes ☐ No
    If yes, please explain: _____
    _____
22. Do you have to be in a bent forward position for prolonged periods? ☐ Yes ☐ No
    If yes, please explain: _____
    _____
23. Does your job require you to twist often? ☐ Yes ☐ No
    If yes, please explain: _____
    _____
24. How much of your job do you believe you can perform at this time?
    - ☐ None of the duties
    - ☐ Some of the duties
    - ☐ All of the duties
25. What is your major concern, if any, with performing your job at this time? _____
    _____
    _____

The information provided is an estimate of my performance at work, however to the best of my ability, the information is accurate.

Signature _____ Date _____