

WORKER'S COMP QUESTIONNAIRE – page 2

BEFORE YOUR ACCIDENT, estimate your total lifting effort ability:

- 1. How much weight? Maximum Average
- 2. How far could you carry this weight? _____ For how long a period of time? _____
- 3. Was this lifting done at work? Yes No Or at home or elsewhere? Yes No
- 4. How often did you carry this amount of weight? _____

AFTER YOUR ACCIDENT, describe your total lifting ability:

- 1. How much weight can you now lift without experiencing pain, discomfort, or restriction of motion? _____
- 2. Did you experience this pain, discomfort, or restriction of motion before your accident? Yes No
- 3. How far can you carry this weight now? _____ And, for how long a period of time? _____
- 4. How often can you carry this weight? _____
- 5. Are you now limited in your lifting ability in some body position that you were previously not? Yes No
- 6. What symptoms does lifting produce? _____
- 7. How long do these symptoms last? _____

Are you presently able to:

LIFT Very Heavy _____ lbs. Heavy _____ lbs. Light _____ lbs. Sitting _____ lbs.
WORK Very Heavy _____ lbs. Heavy _____ lbs. Light _____ lbs. Sitting _____ lbs.

What positions can you work with a MINIMUM DEMAND of physical effort?

With Minimum Demand of physical effort, what positions can you work in PART-TIME and for how long?

- Standing Walking Sitting

With Minimum Demand of physical effort, can you work in a SITTING POSITION with some degree of walking or standing activity?

- Yes No

Do you feel that you cannot perform any physical work activity? Yes No

Do you feel that you cannot perform any mental work? Yes No

Relate your BEFORE injury capacity (mark 'B') and your AFTER injury capacity (mark 'A') for performing activities:

- 1. Walking Normal _____ Limited _____ Difficult _____ Pain _____
- 2. Standing Normal _____ Limited _____ Difficult _____ Pain _____
- 3. Sitting Normal _____ Limited _____ Difficult _____ Pain _____
- 4. Bending Normal _____ Limited _____ Difficult _____ Pain _____
- 5. Stooping Normal _____ Limited _____ Difficult _____ Pain _____
- 6. Lifting Normal _____ Limited _____ Difficult _____ Pain _____
- 7. Pushing Normal _____ Limited _____ Difficult _____ Pain _____
- 8. Pulling Normal _____ Limited _____ Difficult _____ Pain _____
- 9. Climbing Normal _____ Limited _____ Difficult _____ Pain _____
- 10. Reaching Normal _____ Limited _____ Difficult _____ Pain _____
- 11. Gripping Normal _____ Limited _____ Difficult _____ Pain _____
- 12. Kneeling Normal _____ Limited _____ Difficult _____ Pain _____
- 13. Balance Normal _____ Limited _____ Difficult _____ Pain _____
- 14. Fatigue Normal _____ Limited _____ Difficult _____ Pain _____

Generally speaking, is your inability to perform these functions due to Pain Weakness Structural limitations Nerves

Do you have normal sexual function? Yes No

Are you able to take care of your personal self, such as dressing, bathing, etc.? Yes No Or, do you require assistance? Yes No

Do you feel your present condition is temporary? Yes No Or, permanent? Yes No

PATIENT SIGNATURE

DATE