WORK / COMP HISTORY

9. Have you been treated by another doctor for this accident? () Yes () No If yes, please list doctor's name and address:		Phone ()	~ <u></u>	• • • • • • • • • • • • • • • • • • • •		· · · · · · · · · · · · · · · · · · ·	int • == - •••••	Patie
Address of Carrier: City State Zip Employer's Name: Employer's Address: City State Zip Phone () 1. Type of Business 2. Date Injured Hour AM / PM Last Date Worked an away of Are your off-work? (*) Yes 3. Previous Workers' Compensation Injury? () Yes () No. 4. Accident reported to employer? 4. Accident reported to employer? 5. Injured at: City State Zip	_ Zip	State ZI	• • •	City	<u> </u>	maganici in in the second	ess	Addre
Name of Compensation Carrier: Employer's Name: Employer's Name: Employer's Address: 1. Type of Business Your Occupation 2. Date Injured. Hour AM / PM. Last Date Worked Are your off work? Yes 1. Type of Business Your Occupation Are your off work? Yes 3. Previous Workers' Compensation Injury? 4. Accident reported to employer? 4. Yes 5. Injured at: City State Zip Are your off work? Yes 5. Injured at: City State Zip State Zip Are your off work? Yes 5. Injured at: 7. Type of work being done at time of injury: 8. In your own words, please describe accident: What type of treatment did your receive? How long were you treated by this doctor? 10. Are you: () Improved 11. What types of medicines are you taking? Do these medicines help? () Yes () No () Don't know: 12. Have you had physical therapy? () Yes () No () Don't know 13. Prior to this accident, have you ever had any of the physical complaints similar to what you have now? () Yes () No If yes, describe:	No contract	and the second section of the second section of	S/S#	Sex		rthdate	Birt	Age_
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() Yes () No () Don't know If yes, describe: The control of	? :7%	o what you have now?	ints similar to v	physical complai	u ever had any of the	accident, have you ev	Prior to this a	13.
If yes, describe:	AMAGE TO	and the state of the same of t	Appears or o	ROX ()	t know			
es and s a linear year kommentarian has a linear li						be:	If yes, describ	
Were these similar complaints the results of a previous accident(s)? () Yes () No	4. A)40 CO	a维性3-78日第1-27 (142-1-15)	their year fast	100/1/2	. 43			6
Were these similar complaints the results of a previous accident(s)? () Yes () No							**	
	•1) No	()Yes (ious accident(s)?	the results of a prev	similar complaints the	Were these s	
Please provide details of accident(s):					•	1 100	40	

		u had any other serious accidents			1.0			()	No .	•
		e;						N.a		
	1050	ou had any serious illnesses that r e:			0.7			NO		
De	186110									
16. Ha	ave yo	ou had any surgeries? () Yes			R				8 * 3	
	**	st type of surgery and date:	200						850	
									•	
		T.								
17. Ha	ave vo	ou had any nervous or mental illne								
		ou had psychiatric care? () Yes			,	` '				
		ou received a medical discharge fr			med For	, , ,	2 () Vas () N	lo.		
								10		
		ou returned to work since this acc			3/6	80 8			2	
IT	you r	ave returned to work since your a	CCIC	ient, p	lease III	ou	t the information b	elow:		
DA	DATE EMPLOYER					OCCUPATION			LIGHT DUTY REG. DUTY	FULL-TIME PART-TIME
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BACI	K DA		KKE	:NI I	MEDICA	AL	COMPLAINTS	ar E		
		tly, I have pain in my:	,	Now	hack	,) mid back ()	unnar	hack	
		n began:	() grad) suddenly	uppei	back	
	have	No.	(netimes	() all of the time			
4. N	1y pai	n goes into my:	() righ		(both		
5. I	have	tingling and/or numbness in my:	() righ	t leg	() left leg ()	both		
6. N		n is worse when I:								
		ough or sneeze	() Yes		() No			n
	si be	t end	() Yes) Yes		() No) No	1		
		alk	() Yes		ì) No	·	e .	
	lif		ì) Yes		ì) No	1		
		ush	() Yes		() No	ľ		
	рι	ıll	() Yes		() No	()		
7. N	ly bac	ck is worse with sexual activity	() Yes		() No	<		
8. N	1y pai	n wakes me up during the night	() Yes		. () No			

() No

()Yes

9. Changes in the weather affect my pain

NECK PAIN: YARRANA AND AND AND AND AND AND AND AND AND	a GNA Sa Bash on the law addition 1
	1.3
1. My neck pain began: () gradually () suddenly	
2: I have pain: () sometimes () all of the	The second second
3. My pain goes into my: () right arm () left arm	() both () wooded CA of
4. I have tingling and/or numbness in my: () right arm () left arm	() both
5. My pain is worse when it	eng panede gagne near ter plant e a cara e a cara
bend forward () Yes () No	remarks a capitalism on each field or a poly
	Complete Sanda San
push Grand Company (17) Yes (1864) (2) No	demonstrative services or and a get
pull. (*) Yes (*) No	The second of th
turn my hood () tes () NU	material of the control of the transfer stone bright
6. My pain wakes me up during the night (1) Yes (1) No (1)	grant and a second seco
7. Changes in the weather affect my pain () Yes () No	
8. Lhave neck stiffness () Yes () No	in a company of the c
9. I have headaches () Yes () No	ه بعد ساله شاست بالاداد با بارها المراها
10. If I do get headaches, they occur: () sometimes () all of the	time
	am wile constructional of the content and other
OTHER PAIN:	在特別都們
Please describe any current medical complaints which you are experien	icing and were not previously covered on this
questionnaire, or list any additional comments you wish to make regarding	g your condition:
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The state of the s	25 (3882)
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and the second section of the section of the second section of the second section of the second section of the section of the second section of the	As a second seco
JOB DESCRIPTION:	and the second s
(In terms of an 8-hour workday, "occasionally!"means 33%; "frequently!")	means 34% to 66% and "continuously" means
67% to 100% of the day).	· continues at ").
the second secon	
1. In a typical 8-hour workday, I: (Circle # of hours / activity)	
Sit: 8 hours	
Stand: 1 2 3 4 5 6 7 8 hours	a remarkable de la company
Walk: 1 2 3 4 5 6 7 8 hours'	
2. On the job, I perform the following activities:	
NOT AT ALL OCCASIONALLY FREQUEN	TLY CONTINUOUSLY
Bend / stoop () ()	()
Squat () () ()	()
Crawl () () () Climb () ()	()
Reach above	
shoulder level ()	·····································
Crouch () () () () Kneel () () ()	. ()
Anger II II II II	(Y
Balancing () ()	()

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	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 movements, such as in operating foot controls? () Yes () No		
6.	Do you use your hands 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		
7.	Are you required to work on unprotected heights? () Yes () No		
	Describe:		_
		· · · · · · · · · · · · · · · · · · ·	_
			-
8.	Are you required to be around moving machinery? () Yes () No		
	Describe:		_
			_
		8	_
9.	Are you exposed to marked changes in temperature and humidity? () Yes () No Describe:		
	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:		_
	<u> </u>		_
			_
		f i	
	Signature: Date:		
	Signature: Date:		