Hayes Sports Chiropractic

WORK / COMP QUESTIONNAIRE

Name _____ Approved by (office use only) _____

Date of Accident _____ Time of Accident _____ ☐am ☐pm

Name of Employer at Time of Accident _____

Employer Address _____

City_____ State_____ Zip _____ Phone Number_____

Occupation_____

In terms of an 8 hour workday I: (choose number of hours for each 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

On the job, I perform the following activities: (check as many as apply)

☐Bend/Stoop ☐Squat ☐Crawl ☐Reach above shoulders ☐Crouch ☐Kneel ☐Push/Pull ☐Maintain awkward posture

On the job, I regularly lift between:

☐1-10 lbs ☐11-24 lbs ☐25-34 lbs ☐35-50 lbs ☐51-74 lbs ☐75-100 lbs

Are you required to bend over while lifting? ☐yes ☐no

Do you use your hands for repetitive movements such as: (check as many as apply)

☐ Simple grasping (left hand) ☐ Firm grasping (left hand) ☐ Fine manipulating (left hand)

☐ Simple grasping (right hand) ☐ Firm grasping (right hand) ☐ Fine manipulating (right hand)

Prior to this accident were you experiencing any similar physical complaints? ☐ yes ☐ no if yes please explain:

In your own words please describe the accident:

Important: This form may be used in the determination of your Workers Compensation eligibility and the amount of compensation you are entitled. To protect your rights please fill out this form correctly and completely.