New Patient Packet

Patient Name:_____

COLORADO PAIN & REHABILITATION

# Workers Compensation Supplemental Questionnaire

Date of injury:_____ Claim #:_____

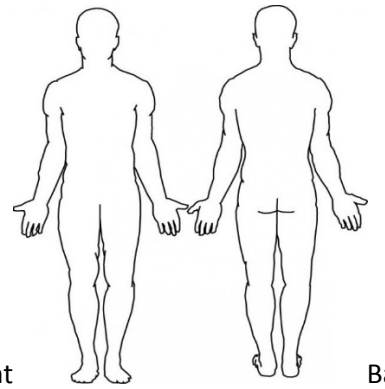
Workers Compensation Insurance (if known):_____

Adjuster on your claim (if known):_____

Workers Compensation Primary Care Physicain:_____

Where did the injury occur: _____

Please circle the diagram below of the body part that was injured:



Front Back

Describe in detail how the injury occured:

_____

_____

_____

_____

_____

Have you previously injured the same area/body part in the past? Y / N If yes, please describe the injury, including any treatments or surgeries. _____

_____

_____

Have you had any of the following treatments/procedures:

☐ MRI ☐ Injections ☐ Therapy

☐ X-ray ☐ Medications ☐ Other _____

Patient Name:_____

Current Work Status: Working Working with Restrictions Not Working

If currently working with restrictions please complete all that apply:

| | | | |
|---|---|---|---|
| ☐ Lifting (maximum weight in pounds) | _____lbs. | ☐ Walking | _____hours per day |
| ☐ Repetitive lifting | _____lbs. | ☐ Standing | _____hours per day |
| ☐ Carrying | _____lbs. | ☐ Sitting | _____hours per day |
| ☐ Pushing/Pulling | _____lbs. | ☐ Crawling | _____hours per day |
| ☐ Reaching over head | | ☐ Kneeling | _____hours per day |
| ☐ Reaching away from body | | ☐ Squatting | _____hours per day |
| ☐ Repetitive motion restrictions_____ | | ☐ Climbing | _____hours per day |

_____

☐ Other_____

_____

Patient Name: _____
Print Name Signature Date

- OR -

Patient Representative: _____
Print Name & Relationship to Patient Signature Date