Name: _____ DOB: _____

-WORK RELATED INJURY QUESTIONS-

Date of Injury: _____

Time of Injury: _____

Was injury witnessed: NO YES by whom? _____

Where is your problem located on your body? _____

How would you characterize your pain (dull, sharp, aching, shooting, etc)? _____

How would you rate your pain on a scale of 1 (mild) to 10 (severe)? _____

Timing (intermittent, constant, etc): _____

Are your symptoms getting: [better] [worse] [the same]

Does anything help your symptom(s) to feel better?

_____
_____
_____

Does anything make your symptom(s) worse?

_____
_____
_____

Have you every had an injury to this body part before? If yes, please explain:

_____
_____
_____

Anything else we should know about your injury?

_____
_____
_____