NECK PAIN:

1. My neck pain began:	( ) gradually	( ) suddenly	
2. I have pain:	( ) sometimes	( ) all of the time	
3. My pain goes into my:	( ) right arm	( ) left arm	( ) both
4. I have tingling and/or numbness in my:	( ) right arm	( ) left arm	( ) both
5. My pain is worse when I:			
cough or sneeze	( ) Yes	( ) No	
bend forward	( ) Yes	( ) No	
lift	( ) Yes	( ) No	
push	( ) Yes	( ) No	
pull	( ) Yes	( ) No	
turn my head	( ) Yes	( ) No	
6. My pain wakes me up during the night	( ) Yes	( ) No	
7. Changes in the weather affect my pain	( ) Yes	( ) No	
8. I have neck stiffness	( ) Yes	( ) No	
9. I have headaches	( ) Yes	( ) No	
10. If I do get headaches, they occur:	( ) sometimes	( ) all of the time	

OTHER PAIN:

Please describe any current medical complaints which you are experiencing and were not previously covered on this questionnaire, or list any additional comments you wish to make regarding your condition:

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JOB DESCRIPTION:

(In terms of an 8-hour workday, "occasionally" means 33%, "frequently" means 34% to 66%, and "continuously" means 67% to 100% of the day).

1. In a typical 8-hour workday, I: (Circle # of hours / 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

2. On the job, I perform the following activities:

	NOT AT ALL	OCCASIONALLY	FREQUENTLY	CONTINUOUSLY
Bend / stoop	( )	( )	( )	( )
Squat	( )	( )	( )	( )
Crawl	( )	( )	( )	( )
Climb	( )	( )	( )	( )
Reach above shoulder level	( )	( )	( )	( )
Crouch	( )	( )	( )	( )
Kneel	( )	( )	( )	( )
Balancing	( )	( )	( )	( )
Pushing / Pulling	( )	( )	( )	( )

3. 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	( ) Yes	( ) No

7. Are you required to work on unprotected heights? ( ) Yes ( ) No

Describe: ______________________________

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8. Are you required to be around moving machinery? ( ) Yes ( ) No

Describe: ______________________________

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9. Are you exposed to marked changes in temperature and humidity? ( ) Yes ( ) No

Describe: ______________________________

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10. Are you required to drive automotive equipment? ( ) Yes ( ) No

Describe: ______________________________

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11. Are you exposed to dust, fumes and/or gases? ( ) Yes ( ) No

Describe: ______________________________

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12. Please list any additional comments: ______________________________

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Signature: ______________________________ Date: ______________

14. Have you had any other serious accidents which required medical care? ( ) Yes ( ) No

Describe: ____________________

15. Have you had any serious illnesses that required hospitalization? ( ) Yes ( ) No

Describe: ____________________

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16. Have you had any surgeries? ( ) Yes ( ) No

If yes, list type of surgery and date: ____________________

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17. Have you had any nervous or mental illnesses? ( ) Yes ( ) No

Have you had psychiatric care? ( ) Yes ( ) No

18. Have you received a medical discharge from the Armed Forces? ( ) Yes ( ) No

19. Have you returned to work since this accident? ( ) Yes ( ) No

If you have returned to work since your accident, please fill out the information below:

DATE	EMPLOYER	OCCUPATION	LIGHT DUTY REG. DUTY	FULL-TIME PART-TIME

CURRENT MEDICAL COMPLAINTS

BACK PAIN:

1. Currently, I have pain in my: ( ) low back ( ) mid back ( ) upper back
2. My pain began: ( ) gradually ( ) suddenly
3. I have pain: ( ) sometimes ( ) all of the time
4. My pain goes into my: ( ) right leg ( ) left leg ( ) both
5. I have tingling and/or numbness in my: ( ) right leg ( ) left leg ( ) both
6. My pain is worse when I:
   - cough or sneeze ( ) Yes ( ) No
   - sit ( ) Yes ( ) No
   - bend ( ) Yes ( ) No
   - walk ( ) Yes ( ) No
   - lift ( ) Yes ( ) No
   - push ( ) Yes ( ) No
   - pull ( ) Yes ( ) No
7. My back is worse with sexual activity ( ) Yes ( ) No
8. My pain wakes me up during the night ( ) Yes ( ) No
9. Changes in the weather affect my pain ( ) Yes ( ) No