

INSURANCE QUESTIONNAIRE

NAME: \_\_\_\_\_ AGE : \_\_\_\_\_ SEX: \_\_\_\_\_

ADDRESS: \_\_\_\_\_

DATE OF ACCIDENT: \_\_\_\_\_

TYPE OF ACCIDENT: ( ) AUTOMOBILE ( ) INDUSTRIAL ( ) FALL ( ) OTHER

WHERE AND WHEN DID THE ACCIDENT TAKE PLACE? \_\_\_\_\_

AREA OF BODY INJURED? ( ) NECK ( ) UPPER BACK ( ) MID-BACK ( ) LOW BACK

HAVE YOU EVER INJURED THIS AREA BEFORE? ( ) YES ( ) NO

STATE IN YOUR OWN WORDS HOW ACCIDENT HAPPENED AND DESCRIBE INJURIES RECEIVED:

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

OCCUPATION: \_\_\_\_\_

EMPLOYED BY: \_\_\_\_\_

DID YOU NOTIFY YOUR EMPLOYER: \_\_\_\_\_

DOES YOUR PRESENT JOB AGGRAVATE YOUR CONDITION? ( ) YES ( ) NO

HAVE YOU MISSED WORK SINCE THE ACCIDENT? \_\_\_\_\_ DAYS \_\_\_\_\_ WEEKS \_\_\_\_\_ MONTHS

DATES OF TOTAL DISABILITY FROM \_\_\_\_\_ TO \_\_\_\_\_

DATES OF PARTIAL DISABILITY FROM \_\_\_\_\_ TO \_\_\_\_\_

HAVE YOU BEEN SEEN BY ANY OTHER DOCTOR FOR THIS INJURY? ( ) YES ( ) NO

NAME OF DOCTOR: \_\_\_\_\_

WHAT WAS HIS DIAGNOSIS? \_\_\_\_\_

WERE YOU HOSPITALIZED? ( ) YES ( ) NO

IF SO, NAME HOSPITAL \_\_\_\_\_ DATE OF : \_\_\_\_\_

SINCE THE ACCIDENT HAS YOUR CONDITION: ( ) IMPROVED ( ) STAYED SAME ( ) WORSENERD

DATE \_\_\_\_\_ SIGNATURE \_\_\_\_\_

JOB DESCRIPTION

( ) CURRENT ( ) PAST

NAME \_\_\_\_\_  
 DATE OF INJURY EMPLOYER \_\_\_\_\_  
 ADDRESS \_\_\_\_\_

Note: In terms of an 8 hour workday, "Occasionally" equals 33%, "Frequently" equals 34% to 66%, and "Continuously" equals 67% to 1000.

In an 8 hour workday I: (Circle full capacity for activity)

Sit - Number of hours: 1 2 3 4 5 6 7 8  
 Stand - Number of hours: 1 2 3 4 5 6 7 8  
 Walk - Number of hours: 1 2 3 4 5 6 7 8

On the job I:

	Not at all	Occasionally	Frequently	Continuously
Bend/ stoop	( )	( )	( )	( )
Squat	( )	( )	( )	( )
Crawl	( )	( )	( )	( )
Climb	( )	( )	( )	( )
Reach above shoulder level	( )	( )	( )	( )
Crouch	( )	( )	( )	( )
Kneel	( )	( )	( )	( )
Balancing	( )	( )	( )	( )
Pushing/Pulling	( )	( )	( )	( )

On the job I lift:

	Not at all	Occasionally	Frequently	Continuously
Up to 10 lbs.	( )	( )	( )	( )
11 to 24 lbs.	( )	( )	( )	( )
25 to 34 lbs.	( )	( )	( )	( )
35 to 50 lbs.	( )	( )	( )	( )
51 to 74 lbs.	( )	( )	( )	( )
75 to 100 lbs.	( )	( )	( )	( )

Must you bend over while doing any lifting? ( ) Yes ( ) No

On the job, are the feet used for repetitive movements as in operating foot controls?

Right: ( ) Yes ( ) No Left: ( ) Yes ( ) No  
 Both: ( ) Yes ( ) No

Hand use for repetitive action such as:

	Simple Grasping	Firm Grasping	Fine Manipulating
Right	( ) Yes ( ) No	( ) Yes ( ) No	( ) Yes ( ) No
Left	( ) Yes ( ) No	( ) Yes ( ) No	( ) Yes ( ) No

Signature: \_\_\_\_\_

Name \_\_\_\_\_

Does the job require:

A. Working on unprotected heights?             Yes             No

Comments \_\_\_\_\_

\_\_\_\_\_

B. Being around moving machinery?             Yes             No

Comments \_\_\_\_\_

\_\_\_\_\_

C. Exposure to marked changes in temperature and humidity?  Yes  No

Comments \_\_\_\_\_

\_\_\_\_\_

D. Driving automotive equipment?             Yes             No

Comments \_\_\_\_\_

\_\_\_\_\_

E. Exposure to dust, fumes, gases?  Yes             No

Comments \_\_\_\_\_

\_\_\_\_\_

ADDITIONAL COMMENTS: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Signature: \_\_\_\_\_