HealthPartners

Initial Injury Questionnaire

Date of Injury: _____ **Employer at time of injury**: _____ **Job title at time of injury**: _____

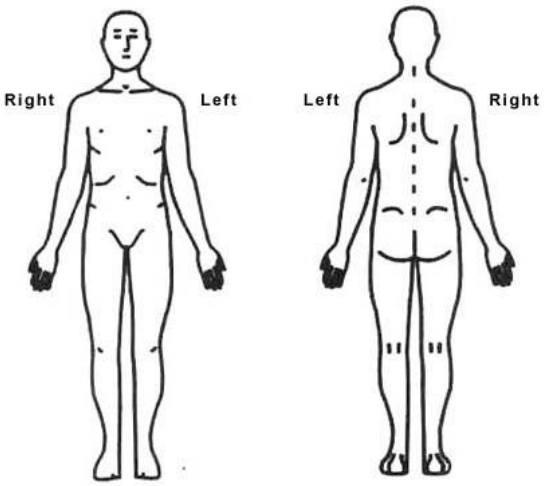
How long have you worked for this employer? _____ How long have you worked in this job before the injury? _____

Please describe how your injury occurred:

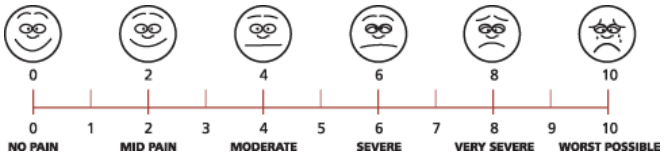
_____

_____

Please circle the areas where you have pain, aching, numbness, tingling, or burning.



On the scale below, circle your current pain level.



Since the injury occurred, is your pain?
☐ Better ☐ Same ☐ Worse

What makes the pain better?

_____

What makes the pain worse?

_____

Do you feel you need work restrictions? Yes ☐ No ☐
If yes, which activities?

_____

If 100% is normal, what is your current function? ____%

Have you received any care for this injury? Yes ☐ No ☐
If yes, when and where?

_____

Have you had a similar injury in the past? Yes ☐ No ☐
If yes, please describe:

_____

Do you have any other jobs? Yes ☐ No ☐
If yes, please describe:

_____

List all hobbies:

_____

List all medical conditions (high blood pressure, diabetes):

_____

_____

List all medications that you take regularly:

_____

_____

List all allergies including allergies to medications:

_____

List all surgeries or overnight stays in the hospital:

_____

Have you used tobacco? ☐ Current ☐ Former ☐ Never

Do you drink alcohol? ☐ Current ☐ Former ☐ Never