

# ORTHOPAEDICS



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## Patient Information

\*\* = Required Information

Date of Injury\*\*: \_\_\_\_\_

Job Title\*\*: \_\_\_\_\_

Date of next doctor's appointment\*\*: \_\_\_\_\_

Do you have a doctor's referral or approval for physical therapy\*\*:  Yes  No

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## Employer

\*\* = Required Information

Name\*\*: \_\_\_\_\_

Address\*\*: \_\_\_\_\_

Zip\*\*: \_\_\_\_\_

City\*\*: \_\_\_\_\_

State: \_\_\_\_\_

Employer Contact (Supervisor or Safety Manager)\*\*: \_\_\_\_\_

Current work status\*\*:  Full duty  Light/Modified Duty  Off duty due to injury (As of what date: \_\_\_\_\_)

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## Insurance

\*\* = Required Information

Adjustor\*\*: \_\_\_\_\_

Adjustor Phone Number\*\*: \_\_\_\_\_

Claim Number: \_\_\_\_\_

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## Legal (if applicable) \*\* = Required

Legal Representative name\*\*: \_\_\_\_\_

Legal Rep. address\*\*: \_\_\_\_\_

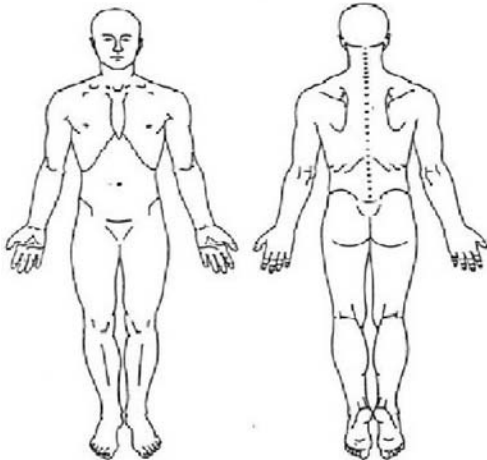
Legal Rep. phone number\*\*: \_\_\_\_\_

Has this case been settled\*\*:  Yes  No

If yes, when\*\*: \_\_\_\_\_

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**On the diagram below, please mark where you are experiencing your symptoms:**



On a scale of 1 to 10 (10 being emergency room pain) how painful is it (circle):

Today?      0 1 2 3 4 5 6 7 8 9 10

At its best?    0 1 2 3 4 5 6 7 8 9 10

At its worst?   0 1 2 3 4 5 6 7 8 9 10

Describe your symptoms (ie: achy, sharp, numbness, tingling...): \_\_\_\_\_

What activities or positions do you have difficulty with, avoid, or are unable to do? \_\_\_\_\_

What eases your symptoms? \_\_\_\_\_

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### Physical Job Demand Questionnaire

1. How many hours a week do you normally work? \_\_\_\_\_
2. Are you working your normal amount of hours? Yes No
3. Does your company offer light/modified duty? Yes No
4. If you are on modified duty, what are your restrictions: N/A \_\_\_\_\_
5. If you were to rate the overall strength demand of your work, would you describe it as:  
Sedentary Light Medium Heavy Very Heavy
6. How often do you lift weight from the floor during your workday?  
Never (0% of day) Rarely (0-5%) Occasionally (6-33%) Frequently (35-66%) Continuously (67-100%)  
What is the average weight you lift from the floor? \_\_\_\_\_  
What is the maximum weight you lift from the floor? \_\_\_\_\_
7. How often do you lift overhead during your workday?  
Never (0% of day) Rarely (0-5%) Occasionally (6-33%) Frequently (35-66%) Continuously (67-100%)  
What is the average weight you lift overhead? \_\_\_\_\_  
What is the maximum weight you lift overhead? \_\_\_\_\_
8. How often do you carry weight during your work day?  
Never (0% of day) Rarely (0-5%) Occasionally (6-33%) Frequently (35-66%) Continuously (67-100%)  
How far do you usually carry objects (feet)? \_\_\_\_\_  
What is the average weight you carry? \_\_\_\_\_  
What is the maximum weight you carry? \_\_\_\_\_
9. How often do you push/pull objects during your workday?  
Never (0% of day) Rarely (0-5%) Occasionally (6-33%) Frequently (35-66%) Continuously (67-100%)  
What is the average weight you push/pull? \_\_\_\_\_  
What is the maximum weight you push/pull? \_\_\_\_\_
10. How often are you standing during your workday?  
Never (0% of day) Rarely (0-5%) Occasionally (6-33%) Frequently (35-66%) Continuously (67-100%)
11. How often are you sitting during your workday?  
Never (0% of day) Rarely (0-5%) Occasionally (6-33%) Frequently (35-66%) Continuously (67-100%)
12. How often are you walking during your workday?  
Never (0% of day) Rarely (0-5%) Occasionally (6-33%) Frequently (35-66%) Continuously (67-100%)
13. How often do you climb stairs during your workday?  
Never (0% of day) Rarely (0-5%) Occasionally (6-33%) Frequently (35-66%) Continuously (67-100%)
14. How often do you have to reach over your head from prolonged periods during your workday?  
Never (0% of day) Rarely (0-5%) Occasionally (6-33%) Frequently (35-66%) Continuously (67-100%)  
Please describe: \_\_\_\_\_
15. How often are you at a computer during your workday?  
Never (0% of day) Rarely (0-5%) Occasionally (6-33%) Frequently (35-66%) Continuously (67-100%)
16. How would you describe the pace of your work? Slow Steady Fast
17. Do you have to squat/crouch repetitively during your workday? Yes No  
Please describe: \_\_\_\_\_
18. Does your job required you to twist often? Yes No  
Please describe: \_\_\_\_\_
19. Does your job require you to be in a bent forward position for prolonged periods? Yes No  
Please describe: \_\_\_\_\_
20. Does your job require constant repetitive activities? Yes No  
Please describe: \_\_\_\_\_
21. How much of your job do you believe you can perform at this time? Some All None
22. What is your major concern, if any, with performing your job at this point in time?

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