|  |  |
| --- | --- |
| **A: Personal Details** | |
| **Staff Name:** | **Employee Number:** |
| **Age:** | **Position:** |
| **Department**: | **Contract**: |

**OCCUPATIONAL INJURY QUESTIONNAIRE**

**Nature of the Incident**

1. Date of Incident: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Incident time \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_am / pm

2. Was this a(n): Please tick the box.

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
|  | Ambulance/ Workplace Accident |  | Needle- prick/ Contaminated Sharps Injury |  | Slip/Fall Accident |
|  | Lifting- related injury |  | Workplace violence |  | Specify: |

3. Please describe the incident in your own words: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

4. Did you have any physical complaints BEFORE THE INCIDENT? **O** Yes **O** No If yes, describe: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_5. Please describe how you felt:

a. DURING the incident: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

b. IMMEDIATELY AFTER the incident: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

c. LATER THAT day: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

d. The NEXT day: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_6. What are your PRESENT complaints and symptoms? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

7. Did you receive emergency care at the scene of the incident? **O** Yes **O** No If yes, describe (e.g., neck brace, back board, etc.): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

8. Did you seek medical consultation/ treatment after the incident? **O** Yes **O** No If yes, please write hospital name, treatment received, and how you were transported to hospital (e.g., friend, ambulance, self, etc.): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

9. Were x-rays/ CT/MRI scans/ imaging tests taken? **O** Yes **O** No If so, what test was performed and on what body part(s) (e.g., neck, upper back, etc.)? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

10. Were you given a diagnosis at the hospital? **O** Yes **O** No If yes, describe in detail: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

11. Have you received any treatment by another doctor since the incident or are you currently under care for your injuries? **O** Yes **O** No If yes, please list doctor name and facility: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

12. What type of treatment did you receive (e.g., prescriptions, other medications, etc.)\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

13. Since this injury occurred, are your symptoms:

**O** Improving **O** Getting worse **O** Remain the same

14. Check the symptoms you’ve noticed since the accident:

|  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
|  | Headache |  | Chest Pain |  | Back Pain |  | Stiff Back |  | Neck Pain |
|  | Stiff Neck |  | Irritability |  | Numbness in Toes |  | Face Flushed |  | Hands Cold |
|  | Feet Cold |  | **Shortness of Breath** |  | Loss of Balance |  | Fatigue |  | Stomach Upset |
|  | Sleeping Problems |  | Depression |  | Fainting |  | Loss of Smell |  | Fever |
|  | **Pins & Needle (Arms)** |  | **Pins & Needles (Legs)** |  | Ringing in Ears |  | Dizziness |  | Anxiety |
|  | Tension |  | Memory Loss |  | Other: | | | | |

15. Have you missed work due to this accident/injury? **O** Yes **O** No If yes, please complete this question:

a) Last day worked: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Restrictions in Activities of Daily Living**

In this section please tick if you are experiencing Difficulty/Pain or Unable to perform any applicable activities of Daily Living in the corresponding column.

|  |  |  |  |
| --- | --- | --- | --- |
| **Health Care** | **Difficult/Painful** | **Unable to Perform** | **Not Applicable** |
| Bathing | O | O | O |
| Getting into/out of bathtub | O | O | O |
| Getting on/off toilet | O | O | O |
| Washing/Grooming hair | O | O | O |
| Taking shoes on/off | O | O | O |
| Applying lotion | O | O | O |
| Brushing Teeth | O | O | O |

|  |  |  |  |
| --- | --- | --- | --- |
| **Activities Involving Posture** | **Difficult/Painful** | **Unable to Perform** | **Not Applicable** |
| Unable to Perform Prolonged standing | O | O | O |
| Prolonged sitting | O | O | O |
| Prolonged walking | O | O | O |
| Climbing stairs | O | O | O |
| Bending | O | O | O |
| Laying on stomach | O | O | O |
| Laying on back | O | O | O |
| Kneeling/Squatting | O | O | O |

|  |  |  |  |
| --- | --- | --- | --- |
| **Travel/Driving** | **Difficult/Painful** | **Unable to Perform** | **Not Applicable** |
| Unable to Perform Turning head while reversing | O | O | O |
| Rotating body while reversing | O | O | O |
| Prolonged sitting as driver/passenger | O | O | O |
| Driving on bumpy road | O | O | O |

|  |  |  |  |
| --- | --- | --- | --- |
| **Social & Recreational Activities** | **Difficult/Painful** | **Unable to Perform** | **Not Applicable** |
| Dancing | O | O | O |
| Playing sports | O | O | O |
| Participating in aerobic activities | O | O | O |
| Weight lifting/body building | O | O | O |
| Running/jogging | O | O | O |

|  |  |  |  |
| --- | --- | --- | --- |
| **Household Responsibilities** | **Difficult/Painful** | **Unable to Perform** | **Not Applicable** |
| Scrubbing tub/floors | O | O | O |
| Vacuuming/mopping | O | O | O |
| Taking out trash | O | O | O |
| Washing dishes | O | O | O |
| Doing laundry | O | O | O |
| Caring for children | O | O | O |

|  |  |  |  |
| --- | --- | --- | --- |
| **Sleeping Habits** | **YES** | **NO** | **Not Applicable** |
| Do you have trouble falling asleep? | O | O | O |
| Is your sleep interrupted due to pain? | O | O | O |
| Are you awakened early due to pain? | O | O | O |
| Do you have trouble sleeping without medication? | O | O | O |

Staff Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date/ Time: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_