

PATIENT QUESTIONNAIRE

PLEASE PRINT

Name _____ Age _____ Social Sec. # _____
Date of Birth _____

Address _____
Street City State Zip

Home Phone _____ Work Phone _____

Do You Live Alone: Yes _____ No _____

Present Occupation _____

Current Work Status: Full Time _____ Part Time _____ Light Duty _____
Retired _____ Sick Leave _____ Other - explain: _____

Last day of full work (if not presently working) _____

Employer's Name and Address _____

Street City State Zip

PERSONAL AND FAMILY HISTORY

Place of Birth _____

Where were you raised and by whom? _____

Were your parents ever divorced? _____ If yes, how old were you at the time?

Father: Age _____ If deceased, age of death _____ Cause of death _____

General health, if living _____

Mother: Age _____ If deceased, age of death _____ Cause of death _____

General health, if living? _____

Brothers and Sisters: Ages: _____

General health? _____

Is there any family history of nervous or mental illness? Yes _____ No _____

If yes, please explain: _____

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questionnaire

B. On the job do you experience:

	Always	Frequently	Infrequently	Never
Time of schedule pressures	_____	_____	_____	_____
Long Hours	_____	_____	_____	_____
Overtime	_____	_____	_____	_____
Work Pressure	_____	_____	_____	_____
Responsibilities	_____	_____	_____	_____
Anxiety or fear on the job	_____	_____	_____	_____
Problems with supervisor or other people at work	_____	_____	_____	_____
Frustrations	_____	_____	_____	_____
Concern for safety of self or others	_____	_____	_____	_____

C. Has your work caused or made worse, any type of physical or medical problem: Yes _____ No _____ If yes, please explain _____

D. Has your work caused or contributed to any of the following emotional changes or nervous system changes?

- Depression _____ Sadness _____ Inability to concentrate _____ Anger _____
- Irritability _____ Tiredness _____ Forgetfulness _____ Sleep disturbance _____
- Anxiety or Nervousness _____ Feelings of guilt or failure _____
- Nervous exhaustion _____ loss of sexual interest _____ withdrawal (avoiding others) _____
- Loss of confidence _____ Trouble controlling impulses _____
- Loss of self-esteem or self-respect _____ Lack of trust _____ Fears _____
- Feelings of insecurity _____ Feelings of inadequacy _____ Brooding _____
- Loss of interest of previously enjoyed activities _____ Headaches _____
- Fainting spells or light-headedness _____ Crying spells _____ suicidal thoughts _____

How do you feel about the future? _____

Questionnaire

USE OF MEDICATION

Medications: List all medications you are currently taking and who prescribes them:

MEDICAL HISTORY

A. List any hospitalizations, surgeries, serious medical problems, or serious accidents with dates:

- 1. _____
- 2. _____
- 3. _____
- 4. _____

B. The following questions are to be answered by women only:

Age of onset of Menstrual Period _____

Menopause - Yes _____ No _____ If yes, year _____

C. List names of Doctors and/or Health Practitioners you have seen in connection with your current medical or stress problems, and why you saw them.

- 1. _____
- 2. _____
- 3. _____

D. Have you been examined, counselled or treated by anyone in the mental health field? Yes _____ No _____

If yes, please explain: _____

The following questions refer to that job or employment which is involved in the Workers Compensation Claim:

A. Describe all of your job duties in your own words:

- 1. _____
- 2. _____
- 3. _____
- 4. _____
- 5. _____
- 6. _____

Questionnaire

MILITARY SERVICE

Dates _____ Type of Discharge _____

Branch of Service _____

Highest Rank _____

Primary Job in Service _____

EDUCATION

Highest grade completed _____ Date of completion _____

Where did you attend high school? _____

Name any colleges attended and degrees awarded _____

Describe any special achievements, interests, hobbies _____

MARITAL HISTORY

Current Marital Status: Single _____ Married _____ Divorced _____ Widowed _____

Dates of Prior Marriages _____

Age and Sex of Children _____

WORK HISTORY

Briefly list jobs since leaving high school and include dates:

1. _____ 5. _____

2. _____ 6. _____

3. _____ 7. _____

4. _____ 8. _____

PERSONAL HABITS

Smoking: Cigarettes _____ Packs per day _____ Cigar _____ Pipe _____

Alcohol: Mild _____ Heavy _____ Oz. per week _____

Height _____ Best Weight _____ Weight Now _____

Loss of weight _____ Gain _____

How much coffee do you drink per day? _____

Questionnaire

Please list any other major stresses or worries which might be influencing your physical or mental health (examples are Marriage or Family problems, Financial pressures, Death of loved ones, etc.

Please add any other information which you believe is pertinent to your Workers Compensation Claim: