

CLEARBROOK

CHIROPRACTIC AND MASSAGE

Workers' Compensation Questionnaire

Full Name: _____ Male Female

Date of Birth (D/M/Y): ____/____/____/ Age: _____

Home Address: _____ City: _____ Province: _____

Postal Code: _____ Care-Card number: _____

Telephone: (Home): _____ (Cell): _____

(E-mail): _____ (Work): _____

Work Place Accident Info

Occupation: _____ Business Name: _____ Full time or part time? _____

Date of accident: _____ Time of accident: _____ Claim #: _____

Have you reported the accident to your employer: Yes / No Supervisor's name: _____

Employment address: _____

Describe **how** the accident happened. What were you doing at work at the time of the accident?

Have you been able to work after the accident? Yes / No

If you have been **unable to work**, please list your last workday: _____

If you are **able to work** but have missed workdays, list any dates missed: _____

If you are able to work, are you working **normal duties** (full capacity) or **modified duties**? _____

If on modified duties, what are the modifications? _____

Check the box that applies:

I went to the hospital after the accident: Yes / No

Name of hospital: _____

I saw a medical doctor after the accident: Yes / No

List the names of MDs: _____

I saw a chiropractor or therapist after the accident: Yes / No

List the names of chiropractors or therapists: _____

After the accident did you have any imaging taken? X-ray / CT / MRI / No Imaging

Did they find anything? _____

List any conditions you had **prior to the accident**:

Neck pain / Mid-back pain / Low-back pain / Headaches / Arm pain / Leg pain

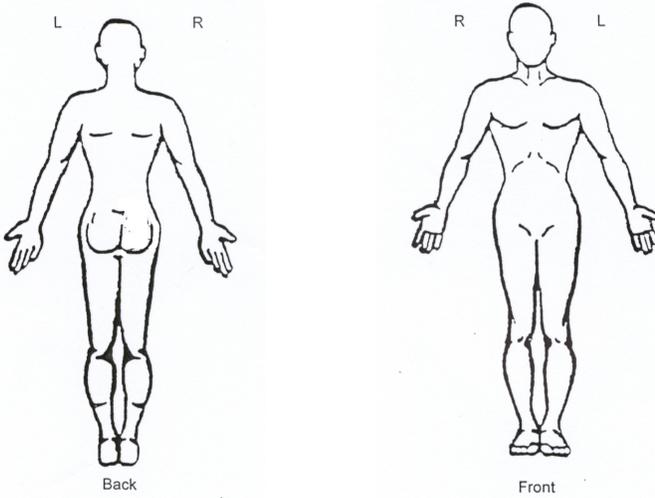
List any **ongoing** conditions you have:

| | | |
|--|---|---|
| Diabetes <input type="checkbox"/> | Heart Disease / Stroke <input type="checkbox"/> | Osteoporosis <input type="checkbox"/> |
| Arthritis <input type="checkbox"/> | Spinal Fusions <input type="checkbox"/> | Double Jointed / Ligament laxity <input type="checkbox"/> |
| Cancer <input type="checkbox"/> | Sciatica/Disc Herniation <input type="checkbox"/> | Current or Recent Pregnancy <input type="checkbox"/> |
| Anemia/Blood Disorder <input type="checkbox"/> | Psychological Disorder <input type="checkbox"/> | Other: _____ |

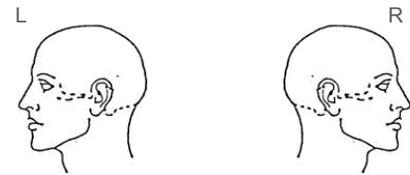
Check all injuries that are a **direct result** of your work accident:

Neck pain / Mid-back pain / Low-back pain / Headaches / Arm pain / Leg pain / Other: _____

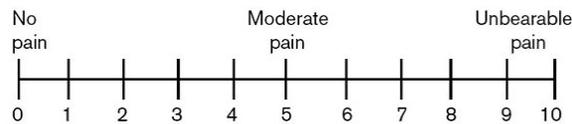
Mark the diagram below to represent **where you feel your symptoms now**:



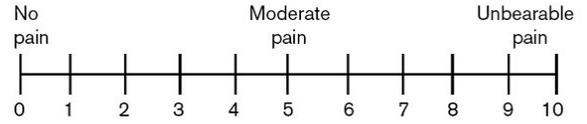
| Please use the following symbols: | |
|-----------------------------------|-----|
| Numb | === |
| Pin/Needle | ooo |
| Stabbing/sharp | ~~~ |
| Stiff/tight | 222 |
| Dull/ache | ΔΔΔ |
| Burning | XXX |



Rate your symptoms immediately **after the accident**:



Rate your symptoms **now**:



My complaint is progressively: Getting better / Staying the same / Getting worse

This complaint is: Constant / Comes and goes

Symptoms are worse in: Morning / Daytime / Evening

Since the accident what **new** medications have you been taking? _____

Check any other symptoms you have:

- | | | |
|---|---|--|
| Anxiety/ Stress <input type="checkbox"/> | Loss of Balance <input type="checkbox"/> | Difficulty swallowing <input type="checkbox"/> |
| Depression <input type="checkbox"/> | Body or legs want to give out <input type="checkbox"/> | Difficulty speaking or slurring <input type="checkbox"/> |
| Sleep Loss <input type="checkbox"/> | Clumsiness <input type="checkbox"/> | Confusion <input type="checkbox"/> |
| Bruising <input type="checkbox"/> | Weight gain <input type="checkbox"/> | Fainting/Blackouts <input type="checkbox"/> |
| Swelling <input type="checkbox"/> | Weight loss (unexplained) <input type="checkbox"/> | Concussion <input type="checkbox"/> |
| Muscle spasms <input type="checkbox"/> | Night sweats <input type="checkbox"/> | Chest pain <input type="checkbox"/> |
| Pain with taking a deep breath <input type="checkbox"/> | Nausea <input type="checkbox"/> | Stomach pain <input type="checkbox"/> |
| Tingling in arms <input type="checkbox"/> | Fatigue <input type="checkbox"/> | Unusual stool (i.e. blood) <input type="checkbox"/> |
| Tingling in legs <input type="checkbox"/> | Double or blurred vision <input type="checkbox"/> | Unusual cough or breathing <input type="checkbox"/> |
| Headache <input type="checkbox"/> | Ear issues (ringing or hearing loss) <input type="checkbox"/> | Poor circulation <input type="checkbox"/> |
| Memory Loss <input type="checkbox"/> | Bowel or bladder control issues- can't start or don't make it to toilet <input type="checkbox"/> | Other: _____ |
| Dizziness <input type="checkbox"/> | | |

Which of the following makes your symptoms worse:

- Lifting / Bending forward / Bending backward / Twisting
 Sneezing / Straining / Coughing / Exercising / Walking
 Sleeping / Working / Driving / Reading / Concentrating
 Dressing / Homecare / Playing sports / Social Activities Other: _____

Which of the following make your symptoms better:

- Ice / Heat / Stretching / Showering or bathing / Exercising / Rest
 Taking medications / Bending a particular way Other: _____

Have you ever had a previous work injury accident? Yes / No When? _____ What was injured? _____

Important: These question ONLY apply to NECK pain.
For example, reading and its effect on neck pain. Lifting and its effect on neck pain only.

NECK DISABILITY INDEX

This questionnaire has been designed to give the doctor information as to how your neck pain has affected your ability to manage in everyday life. **Please answer every section and mark in each section only ONE box** which applies to you. We realize you may consider that two of the statements in any one section relate to you, but **please just mark the box which MOST CLOSELY describes your problem.**

Section 1 - Pain Intensity

- I have no pain at the moment.
- The pain is very mild at the moment.
- The pain is moderate at the moment.
- The pain is fairly severe at the moment.
- The pain is very severe at the moment.
- The pain is the worst imaginable at the moment.

Section 2 -- Personal Care (Washing, Dressing, etc.)

- I can look after myself normally without causing extra pain.
- I can look after myself normally but it causes extra pain.
- It is painful to look after myself and I am slow and careful.
- I need some help but manage most of my personal care.
- I need help every day in most aspects of self care.
- I do not get dressed, I wash with difficulty and stay in bed.

Section 3 – Lifting

- I can lift heavy weights without extra pain.
- I can lift heavy weights but it gives extra pain.
- Pain prevents me from lifting heavy weights off the floor, but I can manage if they are conveniently positioned, for example on a table.
- Pain prevents me from lifting heavy weights, but I can manage light to medium weights if they are conveniently positioned.
- I can lift very light weights.
- I cannot lift or carry anything at all.

Section 4 – Reading

- I can read as much as I want to with no pain in my neck.
- I can read as much as I want to with slight pain in my neck.
- I can read as much as I want with moderate pain.
- I can't read as much as I want because of moderate pain in my neck.
- I can hardly read at all because of severe pain in my neck.
- I cannot read at all.

Section 5-Headaches

- I have no headaches at all.
- I have slight headaches which come infrequently.
- I have slight headaches which come frequently.
- I have moderate headaches which come infrequently.
- I have severe headaches which come frequently.
- I have headaches almost all the time.

Scoring: Questions are scored on a vertical scale of 0-5. Total scores and multiply by 2. Divide by number of sections answered multiplied by 10. A score of 22% or more is considered a significant activities of daily living disability.
(Score x 2) / (Sections x 10) = %ADL

Section 6 – Concentration

- I can concentrate fully when I want to with no difficulty.
- I can concentrate fully when I want to with slight difficulty.
- I have a fair degree of difficulty in concentrating when I want to.
- I have a lot of difficulty in concentrating when I want to.
- I have a great deal of difficulty in concentrating when I want to.
- I cannot concentrate at all.

Section 7—Work

- I can do as much work as I want to.
- I can only do my usual work, but no more.
- I can do most of my usual work, but no more.
- I cannot do my usual work.
- I can hardly do any work at all.
- I can't do any work at all.

Section 8 – Driving

- I drive my car without any neck pain.
- I can drive my car as long as I want with slight pain in my neck.
- I can drive my car as long as I want with moderate pain in my neck.
- I can't drive my car as long as I want because of moderate pain in my neck.
- I can hardly drive my car at all because of severe pain in my neck.
- I can't drive my car at all.

Section 9 – Sleeping

- I have no trouble sleeping.
- My sleep is slightly disturbed (less than 1 hr. sleepless).
- My sleep is moderately disturbed (1-2 hrs. sleepless).
- My sleep is moderately disturbed (2-3 hrs. sleepless).
- My sleep is greatly disturbed (3-4 hrs. sleepless).
- My sleep is completely disturbed (5-7 hrs. sleepless).

Section 10 – Recreation

- I am able to engage in all my recreation activities with no neck pain at all.
- I am able to engage in all my recreation activities, with some pain in my neck.
- I am able to engage in most, but not all of my usual recreation activities because of pain in my neck.
- I am able to engage in a few of my usual recreation activities because of pain in my neck.
- I can hardly do any recreation activities because of pain in my neck.
- I can't do any recreation activities at all.

Comments _____

%ADL

Important: These questions only apply to your back pain or leg pain.
For example, lifting and its effect on back pain.

Oswestry Disability Questionnaire

This questionnaire has been designed to give us information as to how your back or leg pain is affecting your ability to manage in everyday life. Please answer by checking **one box in each section** for the statement which best applies to you. We realise you may consider that two or more statements in any one section apply but please just shade out the spot that indicates the statement **which most clearly describes your problem**.

Section 1: Pain Intensity

- I have no pain at the moment
- The pain is very mild at the moment
- The pain is moderate at the moment
- The pain is fairly severe at the moment
- The pain is very severe at the moment
- The pain is the worst imaginable at the moment

Section 2: Personal Care (eg. washing, dressing)

- I can look after myself normally without causing extra pain
- I can look after myself normally but it causes extra pain
- It is painful to look after myself and I am slow and careful
- I need some help but can manage most of my personal care
- I need help every day in most aspects of self-care
- I do not get dressed, wash with difficulty and stay in bed

Section 3: Lifting

- I can lift heavy weights without extra pain
- I can lift heavy weights but it gives me extra pain
- Pain prevents me lifting heavy weights off the floor but I can manage if they are conveniently placed eg. on a table
- Pain prevents me lifting heavy weights but I can manage light to medium weights if they are conveniently positioned
- I can only lift very light weights
- I cannot lift or carry anything

Section 4: Walking*

- Pain does not prevent me walking any distance
- Pain prevents me from walking more than 2 kilometres
- Pain prevents me from walking more than 1 kilometre
- Pain prevents me from walking more than 500 metres
- I can only walk using a stick or crutches
- I am in bed most of the time

Section 5: Sitting

- I can sit in any chair as long as I like
- I can only sit in my favourite chair as long as I like
- Pain prevents me sitting more than one hour
- Pain prevents me from sitting more than 30 minutes
- Pain prevents me from sitting more than 10 minutes
- Pain prevents me from sitting at all

Section 6: Standing

- I can stand as long as I want without extra pain
- I can stand as long as I want but it gives me extra pain
- Pain prevents me from standing for more than 1 hour
- Pain prevents me from standing for more than 30 minutes
- Pain prevents me from standing for more than 10 minutes
- Pain prevents me from standing at all

Section 7: Sleeping

- My sleep is never disturbed by pain
- My sleep is occasionally disturbed by pain
- Because of pain I have less than 6 hours sleep
- Because of pain I have less than 4 hours sleep
- Because of pain I have less than 2 hours sleep
- Pain prevents me from sleeping at all

Section 8: Sex Life (if applicable)

- My sex life is normal and causes no extra pain
- My sex life is normal but causes some extra pain
- My sex life is nearly normal but is very painful
- My sex life is severely restricted by pain
- My sex life is nearly absent because of pain
- Pain prevents any sex life at all

Section 9: Social Life

- My social life is normal and gives me no extra pain
- My social life is normal but increases the degree of pain
- Pain has no significant effect on my social life apart from limiting my more energetic interests e.g. sport
- Pain has restricted my social life and I do not go out as often
- Pain has restricted my social life to my home
- I have no social life because of pain

Section 10: Travelling

- I can travel anywhere without pain
- I can travel anywhere but it gives me extra pain
- Pain is bad but I manage journeys over two hours
- Pain restricts me to journeys of less than one hour
- Pain restricts me to short necessary journeys under 30 minutes
- Pain prevents me from travelling except to receive treatment

Oswestry Score: _____

Source: Fairbank JCT & Pynsent, PB (2000) The Oswestry Disability Index. Spine 25(22):2940-2953. Davidson M & Keating J (2001) A comparison of five low back disability questionnaires: reliability and responsiveness. Physical Therapy 2002;82:824.

*Note: Distances of 1 mile, ½ mile and 100 yards have been replaced by metric distances in the Walking section. 0-20% (mild), 21-40% (moderate), 41-60% (severe), 61-80% (crippled), 81-100% (bed bound or exaggerating)