## Denver Integrated Spine Center Workman's Compensation Questionnaire 7535 E. Hampden Ave., Suite 405 Denver, CO 80231

	Date:							
	Name:							
	Address: Phone Number:							
1.	Employer at time of accident							
	Employer's address							
	Date of accident							
4. In your own words, please describe accident in as much detail as you can recall:								
5.	What part of your body did you injure?							
б.	Were you able to continue work following the accident? <b>Yes No</b>							
7.	What type of work was being done at the time of injury?							
8.	Were you capable of working on an equal basis with others your age and physical stature							
	prior to the accident? $\square$ Yes $\square$ No							
9.	Prior to this accident, have you ever had any physical complaints similar to what you							
	now have? Yes No							
	Explain if answer is yes:							
ıo.	Dates you have been absent from work due to this injury:							
	Dates absent:							
	Date returned to work:							
11.	Have you been treated elsewhere for this accident?   Yes   No							
	If yes, by whom?							
	AddressPhone number							

. Name of that person	Title
Date reported	Time reported
previously covered on the healt to make regarding your conditi	edical complaints which you are experiencing and were not the questionnaire or list any additional comments you wition.
Signature:	Date:



how you feel.

	ζ	D	_
<b>-</b> 1	N	0	ſ

Print with capital letters within the boxes												
A	В	C	٥	E	F	6	H	I	J	K		A
N	0	P	Q	R	5	T	V	٧	W	X	y	Z

PLEASE darken the circle next to THE ONE CHOICE which most closely describes yo
---

1 DE INC. THE CITE OF THE CITE OF THE CITE OF THE COURSE OF THE CITE OF THE CI								
1. Does your pain interfere with your nor	mal work inside and outside the home?	Work norms 01 O O	-23	ó	δĈ	7_	8	work at all
2. Does your pain interfere with persona	ıl care (such as washing, dressing, etc.)?			0		•		ersonal care
3. Does your pain interfere with your trav	oes your pain interfere with your traveling?							see doctors
4. Does your pain affect your ability to s	sit or stand?	No problems	_	0	0 0	_	_	t/stand at all
5. Does your pain affect your ability to li reach for things?	ift overhead, grasp objects, or	No problema		0	0 0	0		not do at al
6. Does your pain affect your ability to I squat?	ift objects off the floor, bend, stoop, or	No problem:		0	0 0	0		not do at al
7. Does your pain affect your ability to v	walk or run?	No problem:		0	0 0			alk/run at all
8. Has your income declined since your	pain began?	No decline	00	0	0 0	) 0		st all income
9. Do you have to take pain medication	every day to control your pain?	No medicatio						oughout day
10. Does your pain force your to see do your pain began?	ctors much more often than before	Never see do		0	0 0			ctors weekly
11. Does your pain interfere with your a you as much as you would like?	ibility to see the people who are important	to <sub>No problem</sub>		0	0 0	0		rer see them
12. Does your pain interfere with recreat important to you?	tional activities and hobbies that are	No interfere		0	0 0	) 0		interference
13. Do you need the help of your family (including both work outside the homean		Never need	help O O	0	0 0			all the time
14. Do you now feel more depressed, te pain began?	ense, or anxious than before your	No depressi	ion/tension	0		_	-	eion/tension
15. Are there emotional problems cause family, social and or work activities?	d by your pain that interfere with your	No problem		0	O C	) O	_	ere problems
F Name initial L Name Initial Last 4 digits of SSN	St	aff use only						
							Discharoe	Discharge
This questionnaire is designed to enable the doctor to understand how much your neck and/or back pain	Doctor Name Doctor ID	DC Designation	60		90	15	0	0
has affected your ability to manage your everyday activities.								
		/				<u>_</u>	raft	نسيسي
Examiner S	ignature	Date	L	i		3		