Coastal
NEUROPHYSIOLOGY

WORKCOVER / INSURANCE / SOLICITOR CLAIM
CONFIDENTIAL PATIENT QUESTIONNAIRE

Patient Name: _____ Date of Birth: _____

To best assist us with the details for your medical report, please provide as much detail as possible when answering the following questions. This information must be as accurate as possible, as it may be included in our report to your insurer.

What was your occupation at the time of your injury: _____

What is your occupation now? _____

What is the name of your current employer? _____

What is the nature of your employer's business? _____

How long did you work for the employer where you had your injury? _____

How long have you been working in your current position? _____

Please provide details of all types of employment you have performed in the past: _____

_____

_____

_____

Please provide details of your occupational duties: _____

_____

_____

_____

Are you required to perform any heavy lifting, strenuous or repetitive tasks? Please explain and provide examples: _____

_____

_____

Did your injury happen as a single event, or over a period of time:

_____

_____

If yes, when did you first experience symptoms? (provide approx. date): _____

When did you first see a doctor about your current work-related problems? _____

Which doctor(s) did you see? _____

What diagnosis/treatment did you receive from this doctor? _____

_____

_____

_____

When did you report your injury to your employer? _____

Who did you inform? _____

How did the injury happen? Please provide details of the date, time, location and exact details of the activities you were performing at the time: _____

_____

_____

_____

_____

_____

_____

_____

Where were you when your injury happened (please specify an address if possible)? _____

_____

_____

What is the nature of your injury, and what part of your body did you injure? _____

_____

_____

Did you experience any of the following? If yes, please explain which part of your body is affected:

Numbness/tingling: _____

Pain: _____

Weakness: _____

Muscle wasting: _____

Altered function: _____

Problems with co-ordination: _____

Problems with memory/concentration: _____

Broken bones or broken skin: _____

Other: _____

_____

Did you lose consciousness with your injury? _____

Was an ambulance required for your injury? (circle YES or NO)

If YES, to which hospital where you taken? _____

Have any of your symptoms changed, improved or worsened since your injury occurred? (Please indicate how much they have changed) _____

_____

_____

_____

What other investigations have you had related to your injury? (eg: X-Ray, Ultrasound, CT, MRI):

_____

_____

Please summarise the results of the above investigations if you know them:

_____

_____

_____

What treatment(s) have you had for your injury? Who provided the treatment? How often/how many times?

_____

_____

_____

Did any of these treatments improve or worsen the severity of your symptoms? _____

_____

_____

_____

When do you experience your symptoms? (eg: at work, at home, with physical activity, at night):_____

_____

_____

Have you been required to perform “light duties” or “suitable duties” at work since your injury (if yes, please provide approximate dates and details of the duties you have been performing)? _____

_____

_____

_____

_____

Have you had any time off work because of your injury? If YES, please provide details: _____

_____

_____

_____

Has your injury resulted in any of the following? (if YES, please provide details)

Sleep disturbance: _____

Depression/anxiety: _____

Other emotional problems(s): _____

Inability to care for yourself or family: _____

Inability to perform hobbies/interests: _____ Have you had any previous injuries or illnesses affecting the part(s) of your body currently injured?

(if yes, give details): _____

_____

_____

Have you had any previous worker's compensation or insurance claims in the past? YES/NO. If YES please provide details: _____

_____

_____

Do you take any medications? YES/NO If YES please provide details: _____

_____

_____

Do you have any hobbies or non-work-related activities which may have precipitated or contributed to or maintained your symptoms? _____

_____

_____

Were you suffering from any medical conditions *prior* to your injury? Please provide details: _____

_____

_____

_____

Please provide other information you feel may be relevant: _____

_____

_____

_____ _____

Signed by (print name): Date: