

California Sports and Cartilage Institute

Workman's Compensation Patient Questionnaire

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Please answer the following questions to the best of your ability. These questions will be reviewed with you by the doctor, however, your input at this time will greatly assist this evaluation.

Occupational History – Please list the companies in order (most recent first) that you have been employed by over the past 15 years. If employed by two companies at the same time, please make note of this. Any period of time (greater than 1 month) that you have been unemployed should also be noted (i.e. between jobs, in school, raising children, etc.)

1. Company name: _____
Number of years employed here: _____
Job title (i.e. mechanic): _____
Physical job description (i.e. lift, bend, climb, type, etc.): _____

2. Company name: _____
Number of years employed here: _____
Job title (i.e. mechanic): _____
Physical job description (i.e. lift, bend, climb, type, etc.) _____

3. Company name: _____
Number of years employed here: _____
Job title (i.e. mechanic): _____
Physical job description (i.e. lift, bend, climb, type, etc.) _____

4. Company name: _____
Number of years employed here: _____
Job title (i.e. mechanic): _____
Physical job description (i.e. lift, bend, climb, type, etc.): _____

Please ask for additional sheets if needed.

Previous Work Related Injuries:

Previous Motor Vehicle or Significant accidents (fall, etc.)

Please be prepared "step-wise" to report your history of injury, treatment, and current symptoms so that they can be most accurately relayed (this will be discussed with the doctor at length).

Thank you for taking the time to fill this out. It will greatly facilitate your time spent here.

Patient signature

Date
