wcb Saskatchewan Workers' Compensation Board

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Date: _____

Patient name: _____ **Claim no:** _____

Client health questionnaire

In order for the assessment team to get a complete picture of your health, please answer the following questions. All information is confidential.

Pain assessment form

Occupation: _____ Injured at work: ■ Yes ☐ No

Presently working: ☐ Yes ☐ No Date of injury/incident: _____

Onset of pain: ☐ Gradual ☐ Sudden

Description of incident: _____

_____

_____

_____

Family history

Some diseases tend to occur in families. Please complete the chart:

Family member	Age	Health problems	Cause of death (if deceased)
Father			
Mother			
Brothers/sisters			
Children			

Personal habits

Alcohol	☐ Heavy	☐ Moderate	☐ Light	☐ None
Coffee/Tea/Cola	☐ Heavy	☐ Moderate	☐ Light	☐ None
Tobacco	☐ Heavy	☐ Moderate	☐ Light	☐ None
Drugs (non-prescription)	☐ Heavy	☐ Moderate	☐ Light	☐ None

Do you participate in an exercise program?	☐ Yes	☐ No
Have you ever had any x-rays taken of your spine?	☐ Yes	☐ No
Have you ever had any broken bones?	☐ Yes	☐ No

If yes, which bones? _____

_____

Have you ever had a serious incident? _____

_____

Have you been in any incident(s) in the last 2 years? _____

_____

Home and employment issues

Since your injury, are you having difficulties performing tasks in the following areas? If yes, please specify.

Personal care (e.g., dressing, bathing, etc.): _____

_____

Household activities (e.g., cooking, cleaning, yard work, etc.): _____

_____

Community activities (e.g., driving, buying groceries, etc.): _____

_____

Child care (e.g., lifting, carrying, etc.): _____

_____

Leisure activities (e.g., sports, crafts, etc.): _____

_____

Are you receiving any assistance with any of these areas that you did not need before your injury (e.g., home care, increased family support, etc.)? _____

_____

_____

Work

Do you have work to return to? ☐ Yes ☐ No

Since your injury, you have been: ☐ Off work ☐ At work with lighter/restricted duties ☐ At work with full duties

If you are working, are you having any difficulties? ☐ Yes ☐ No

If yes, please specify: _____

_____

Occupational injury

Describe in detail, the incident, including the specific job duty you were performing at the time of the injury:

What were your symptoms? _____

When did your symptoms first occur? _____

Have you ever had these symptoms before? ☐ Yes ☐ No

If so, when? _____

Check the appropriate categories:

Were you lifting? ☐ Yes ☐ No

What did it weigh (approximately)? Please check one.

☐ 30 lbs or less
☐ 30 to 50 lbs
☐ 50 to 75 lbs
☐ 75 to 100 lbs
☐ Over 100 lbs

Height of lift?

From floor to waist	☐ Yes	☐ No
From waist to shoulders	☐ Yes	☐ No
Above shoulder level	☐ Yes	☐ No

Motions involved:

Twisting from waist	☐ Yes	☐ No	Stretching	☐ Yes ☐ No
Bending from waist	☐ Yes	☐ No	Pulling	☐ Yes ☐ No
Bending from knees	☐ Yes	☐ No	Pushing	☐ Yes ☐ No
Kneeling	☐ Yes	☐ No		

Hand/Wrist/Arm motion

Wrist position

Bent up	☐ Yes	☐ No
Bent down	☐ Yes	☐ No
Bent sideways	☐ Yes	☐ No

Elbow position

Extended	☐ Yes	☐ No
Bent	☐ Yes	☐ No

Arm/Shoulder motion

Reaching	☐ Yes	☐ No
Rubbing	☐ Yes	☐ No
Pulling	☐ Yes	☐ No
Pushing	☐ Yes	☐ No

Hand motion

Pinching	☐ Yes	☐ No
Twisting/rotating	☐ Yes	☐ No
Grasping	☐ Yes	☐ No
Squeezing	☐ Yes	☐ No

Other motion (describe): _____

Have you ever done this task before? ☐ Yes ☐ No

How often to you perform this task?

_____ times per hour
_____ times per day
_____ times per week
_____ times per month
_____ hours per day

Other (please indicate times and repetition): _____

How long have you been doing this task? _____

Was there anything unusual about your performance or the task? ☐ Yes ☐ No

If so, what? _____

Did you report to incident? ☐ Yes ☐ No

If yes, to whom and when? _____

If no, why not? _____

Why do you think the injury occurred? _____

_____

Who was the first health care provider you consulted following the injury? _____

_____

Prior workers' compensation claims (area, duration, management): _____

_____

Was there time loss involved? ☐ Yes ☐ No

If yes, how long? _____

Were you referred to a rehabilitation program? ☐ Yes ☐ No

Where? _____

Is there a graduated return-to-work program where you are employed? ☐ Yes ☐ No

Psychosocial assessment

At this time, do you believe that your life is stressful because of relationship or family problems, financial concerns, work-related difficulties, too much to do, too many responsibilities, etc.? ☐ Yes ☐ No

Explain:

Do you feel burned out (i.e., mental, emotional, physical exhaustion)? ☐ Yes ☐ No

Explain:

Do you have an alcohol, drug, prescription or non-prescription medication, or gambling addiction or abuse problem?

☐ Yes ☐ No

Explain:

Do you have an eating disorder (e.g., bulimia, anorexia nervosa or obesity)? ☐ Yes ☐ No

Explain:

Do you have insomnia or a sleep disorder (i.e., can't get to sleep or you wake up too early?

☐ Yes ☐ No

Explain:

Do you have a mental illness (e.g., bipolar disorder, manic depression, schizophrenia, etc.)?

☐ Yes ☐ No

Explain:

Do you consider yourself to be depressed? ☐ Yes ☐ No

Are you experiencing any of the following conditions?

Anxiety disorder (fear, panic)	☐ Yes	☐ No	Obsessive-compulsive disorder	☐ Yes	☐ No
Phobias (e.g., fear of crowds)	☐ Yes	☐ No	Suicidal thoughts or actions	☐ Yes	☐ No

Other (please explain):

Do you have aspects of your personality or behaviour that you or others concern?

Anger outbursts	☐ Yes	☐ No
Isolation and withdrawal from people	☐ Yes	☐ No
Timid/non-assertive	☐ Yes	☐ No

Other (please explain):

Have you experienced emotional, physical or sexual abuse in your life? ☐ Yes ☐ No

Have you sought the help of a psychiatrist or mental health professional? ☐ Yes ☐ No

Medical review

Do you have any diagnosed medical condition (e.g., diabetes, high blood pressure, arthritis, cancer, polio, etc.)? If so, please list.

Have you ever been treated by: ☐ Chiropractor ☐ Physiotherapist ☐ Massage therapist

Please check any of the conditions listed below that are causing you a problem or have caused you a problem in the past.

General symptoms

- ☐ Headache
- ☐ Fever
- ☐ Chills
- ☐ Sweat
- ☐ Headaches
- ☐ Nervousness
- ☐ Weight loss
- ☐ Numbness or pain in arms, hands or legs
- ☐ Allergy
- ☐ Wheezing
- ☐ Nerve pain

EENT

- ☐ Failing vision
- ☐ Need glasses to see distances or to read
- ☐ Crossed eyes
- ☐ Eye pain
- ☐ Deafness
- ☐ Tooth decay
- ☐ Gum trouble
- ☐ Frequent colds
- ☐ Sinus infection
- ☐ Enlarged glands
- ☐ Cold sores
- ☐ Loss of hearing

Skin

- ☐ Rashes, hives
- ☐ Itching/dryness
- ☐ Bruise easily

Respiratory

- ☐ Chronic cough
- ☐ Spitting up phlegm
- ☐ Spitting up blood
- ☐ Chest pain
- ☐ Difficult breathing
- ☐ Asthma

Cardiovascular

- ☐ Rapid heart beat
- ☐ High blood pressure
- ☐ Pain over heart
- ☐ Stroke
- ☐ Varicose veins
- ☐ Swelling ankles
- ☐ Poor circulation
- ☐ Angina

Muscles/Joints

- ☐ Stiff neck
- ☐ Back ache
- ☐ Swollen joints
- ☐ Painful tail bone
- ☐ Foot trouble
- ☐ Elbow pain
- ☐ Wrist pain
- ☐ Hand pain
- ☐ Hip pain
- ☐ Knee pain
- ☐ Arthritis

Other

- ☐ Hair loss

Genitourinary (GU)

- ☐ Trouble urinating
- ☐ Blood in urine
- ☐ Pus in urine
- ☐ Kidney infection
- ☐ Bed wetting
- ☐ Prostate trouble (men)

GU for women

- ☐ Painful menstruation
- ☐ Excessive flow
- ☐ Hot flashes
- ☐ Irregular cycle
- ☐ Back cramps
- ☐ Vaginal discharge
- ☐ Swollen breasts
- ☐ Lumps in breasts

Gastrointestinal

- ☐ Poor appetite
- ☐ Indigestion
- ☐ Excessive hunger
- ☐ Belching/gas
- ☐ Nausea
- ☐ Vomiting (blood)
- ☐ Pain over stomach
- ☐ Constipation
- ☐ Diarrhea
- ☐ Hemorrhoids (Piles)
- ☐ Jaundice
- ☐ Gall bladder trouble

Pain description

What does your pain feel like? _____

Is it present constantly or periodically? _____

Is it present at certain time of the day? _____ At night? _____

When does your pain present and for how long does it last? _____

What positions, movements or activities increase or bring on the pain? _____

_____

What positions, movements or activities decrease the pain? _____

_____

Are you able to sleep at night without pain? ☐ Yes ☐ No

Do you have a firm mattress? ☐ Yes ☐ No

Are you awakened by the pain? ☐ Yes ☐ No

Do you sleep well? ☐ Yes ☐ No

What position do you sleep in? ☐ Back ☐ Stomach ☐ Side

Does anything else affect the pain? _____

☐ Food ☐ Menstruation ☐ Coughing or sneezing ☐ Light

☐ Weather changes ☐ Heat ☐ Exertion

☐ Finger pressure ☐ Ice ☐ Noise

Since the onset of the pain, has it been: ☐ Increasing ☐ Decreasing ☐ Remained the same

Pain management

Are you able to sleep at night without pain? ☐ Yes ☐ No

If so, when? _____

What treatment did you receive at that time? _____

Have you already received treatment for your present problem? ☐ Yes ☐ No

If so, where and when? _____

Did it help? _____

Pain location

Where did your pain start? _____

Has it changed location or spread to other areas? _____

_____

Are there any areas where discomfort is most intense (i.e., it hurts more than somewhere else)? Where? _____

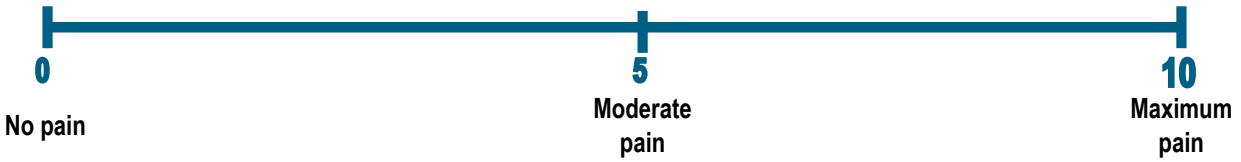
_____

Are there any areas where you do not feel any sensation? Where? _____

_____

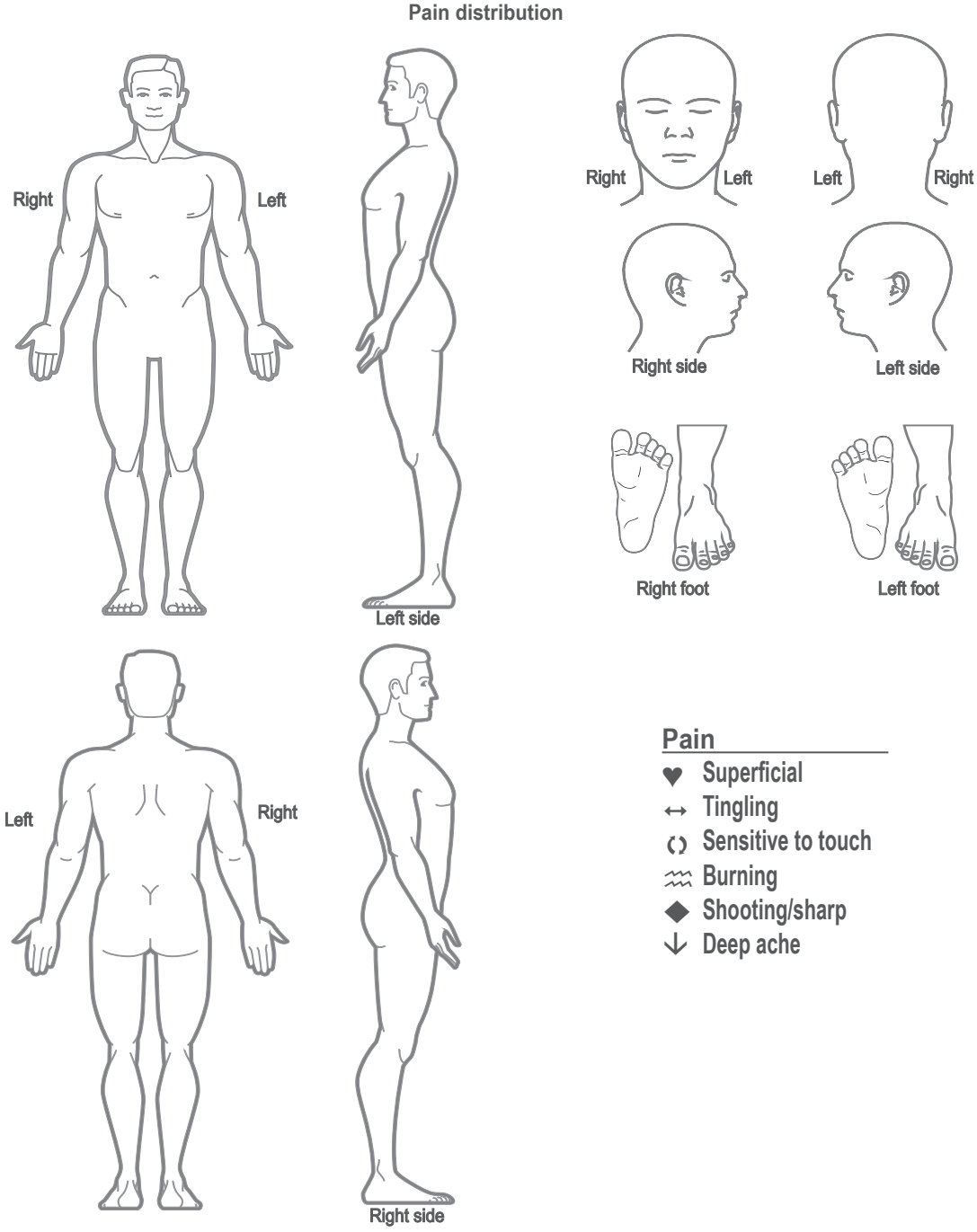
Complete the diagram

Please rate your pain on a scale of 10 for each affected area.



Specify where your pain is located in the diagram below.

First decide which of these words best describes your pain or discomfort — achy, sharp, shooting, burning, tingling (i.e., pins and needles/numbness), sensitive to touch.



Neck pain disability index (Vernon-Mior)

Please read the instructions before answering.

This questionnaire is designed to give the health care provider information as to how your neck pain has affected your ability to manage in your every day life. In each section, mark only the ONE box that applies to you. We realize that you consider that two of the statements in any one section relates to you, but just mark the one that most closely describes your problem today.

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 pain imaginable at the moment

Section 2 - Personal care (e.g., washing, dressing, etc.)

- ☐ I can look after myself normally without causing extra pain
- ☐ I can look after myself, 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 me extra pain
- ☐ Pain prevents me from lifting heavy weights off the floor, but I can manage if they are conveniently positioned (like 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 life very light weights
- ☐ I cannot lift or carry anything at all

Section 4 - Reading

- ☐ I can read as much as I want with no neck pain
- ☐ I can read as much as I want with slight neck pain
- ☐ I can read as much as I want with moderate neck pain
- ☐ I can’t read as much as I want because of moderate neck pain
- ☐ 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 that come infrequently
- ☐ I have moderate headaches that come infrequently
- ☐ I have moderate headaches that come frequently
- ☐ I have severe headaches that come frequently
- ☐ I have headaches almost all of the time

Section 6 - Concentration

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

Section 7 - Work

- ☐ I can do as much work as I want
- ☐ 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 cannot do any work at all

Section 8 - Driving

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

Section 9 - Sleeping

- ☐ I have no trouble sleeping
- ☐ My sleep is slightly disturbed (less than 1 hour sleepless)
- ☐ My sleep is mildly disturbed (1 to 2 hours sleepless)
- ☐ My sleep is moderately disturbed (2 to 3 hours sleepless)
- ☐ My sleep is greatly disturbed (3 to 5 hours sleepless)
- ☐ My sleep is completely disturbed (5 to 7 hours sleepless)

Section 10 - Recreation

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

Pain scale

Rate the severity of your pain by checking one box of the scale

No pain	0	1	2	3	4	5	6	7	8	9	10	Excruciating pain