CORBETT
NEUROPHYSIOLOGY SERVICES
pure 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: ____________________

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Please provide details of your occupational duties: ____________________

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

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

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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? ____

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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: ____

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

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

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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: ______________________________

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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) ______________________________

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

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

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

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

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

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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)? _______________________

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

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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): ____

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

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

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Do you have any hobbies or non-work-related activities which may have precipitated or contributed to or

maintained your symptoms? ____

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

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Please provide other information you feel may be relevant: _______________________________________

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Signed by (print name): Date: