STAR PHYSICAL THERAPY
Sports Therapy & Advanced Rehabilitation

WORKERS COMPENSATION QUESTIONNAIRE

In order to help your therapist better understand the physical demands of your job and set appropriate rehabilitation goals, please complete this questionnaire as completely and accurately as possible.

Patient Name _____ Employer _____

Job Title _____ Supervisor _____

Injury _____ Supervisor's Tel # (____) _____ ext _____

Work Hours _____ am/pm to _____ am/pm Days of week S M T W Th F S

Work Status
- ☐ Modified/alternate duty
- ☐ Full duty
- ☐ Off work

Is modified / alternate duty available?
☐ Yes ☐ No

Have you had previous therapy related to this injury? ☐ Yes ☐ No If yes, where? _____

Have you had an impairment rating for this injury? ☐ Yes ☐ No If yes, where? _____

Doctor's Restrictions: _____

1. **LIFTING REQUIREMENTS:** Does your job require lifting: ☐ Yes ☐ No (If no, skip to question 2.)

   What is the heaviest weight that you lift? _____ pounds floor waist overhead

   How much weight do you lift frequently? _____ pounds floor waist overhead

   How much weight can you lift today? _____ pounds floor waist overhead

   Explain: _____

2. ESSENTIAL JOB ACTIVITIES: A. Place an X in front of the activity if your job involves that activity
   B. Check how much of your workday involves that activity
   C. Mark if you can or cannot do that activity now.

	ACTIVITY	Occasional (0%–33% of day)	Frequent (34% - 66%	Constant (over 66%)	Can you do this activity now?	
X					YES	NO
	Trunk twisting					
	Reaching overhead					
	Reaching below waist					
	Forward bending / stooping					
	Squatting					
	Grasping					
	Pinching					
	Keyboarding					
	Climbing (specify stairs, ladder, etc)					
	Crouching (sustained squat)					
	Kneeling					
	Sustained forward bend					
	Drive (forklift, vehicle, etc)					
	Sitting					
	Standing					
	Walking					

What type of equipment do you use in your job? _____

Injured Worker's Signature: _____ Therapist's initials: _____