

1. How long have you worked for your current employer? \_\_\_\_\_ Years (If less than 1 year \_\_\_\_\_ months)

2. Are You:  Off Work Since: \_\_\_\_ / \_\_\_\_ / \_\_\_\_  Modified Duty Since: \_\_\_\_ / \_\_\_\_ / \_\_\_\_  
 Full Duty

3. When you work, what type of limitations do you experience?

None  Mild  Moderate  Severe  Not Working

4. Select the best description of any change you have had in work activities since your injury/surgery. You work activities have:

<input type="checkbox"/> <b>Not Changed</b> If yes, check one below:	<input type="checkbox"/> <b>Decreased</b> If yes, check one below:	<input type="checkbox"/> <b>Unable to Work</b> If yes, check one below:
<input type="checkbox"/> I have no/slight problems	<input type="checkbox"/> I have no/slight problems	<input type="checkbox"/> I have moderate/significant problems
<input type="checkbox"/> I have moderate/significant problems	<input type="checkbox"/> I have moderate/significant problems	<input type="checkbox"/> For reasons not related to my injury
	<input type="checkbox"/> For reasons not related to my injury	

5. Are you planning to apply to any of the following programs?

	Already On It	Applied For It	Planning To Apply For It
Social Security	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
Disability	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
Worker's Compensation	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No

6. If your problem is work related, check the response that best describes what you actually do at work when working full duty. Check only **ONE** response in each column.

	<b>Sitting</b>	<b>Standing/ Walking</b>	<b>Walking on Uneven Ground</b>	<b>Squatting</b>	<b>Climbing</b>	<b>Lifting/ Carrying</b>	<b>Pounds Carried</b>
hr/day	0 hr./day	0 hr./day	0 hr./day	0 times/day	0 times/day	0 times/day	0-5 lbs.
1 hr/day	1 hr/day	1 hr/day	1 hr/day	1-5 times/day	1 flight, 2 times/day	1-5 times/day	6-10 lbs.
2-3 hrs/day	2-3 hrs/day	2-3 hrs/day	2-3 hrs/day	6-10 times/day	3 flight, 2 times/day	6-10 times/day	11-20 lbs.
4-5 hrs/day	4-5 hrs/day	4-5 hrs/day	4-5 hrs/day	11-15 times/day	10 flights/ladders	11-15 times/day	21-25 lbs.
6-7 hrs/day	6-7 hrs/day	6-7 hrs/day	6-7 hrs/day	16-20 times/day	Ladders with weight 2-3 days/week	16-20 times/day	26-30 lbs.
8-10 hrs/day	8-10 hrs/day	8-10 hrs/day	8-10 hrs/day	More than 20 times/day	Ladders daily with weight	More then 20 times/day	More than 30 lbs.