JOB DEMANDS QUESTIONNAIRE

Name: DOB:	Job Title:	Company Contact & Title	Company Name & Address
Injury:	Shifts per week: Hours per shift:	Telephone #: Fax #:	Claim #:

DESCRIBE THE TASK YOU WERE PERFORMING WHEN INJURED:
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LIST 3 TO 5 PHYSICAL TASKS YOU PERFORM AT WORK THAT WOULD BE DIFFICULT TO PERFORM WITH YOUR CURRENT INJURY.

ACTIVITY/TASK	Max time or weight	How often do you perform the activity per shift?				EXERCISE TESTED	Test Rep, Time or Weight	Pain: Before	Pain: After
Fill in white areas only.		Rare 1-5	Occasional 12-25	Frequent 26-70	Constant 71+				
1.									
2.									
3.									
4.									
5.									

(Staff)Report Completed By: ____________________________________
COMMENTS:____
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