Prof John L Corbett & Associates
M.B., B.S. (Hons), F.R.C.P (U.K.), F.R.A.C.P.,
M.A. (Oxford), D.PHIL. (Oxford), M.A.C.L.M.
Professor of Medicine (Griffith)
Consultant Neurologist
Credentialled Sleep Physician
Provider No. 0035713Y ABN No. 89 372 257 238

159 Nerang Street,
Southport, Queensland. 4215
Tel: (07) 5503 2400
Fax: (07) 5531 1277
Email: bookings@corbett.com.au

WORKCOVER / INSURANCE 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 the 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: _____

  _____

  _____

  _____
- Please provide details of your occupational duties: _____

  _____

  _____

  _____

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

  _____

  _____
- Did your injury happen as a single event, or over a period of time? _____

  _____
  - If yes, when did you first experience symptoms (provide approx. date) _____
- When did you first see a doctor? _____
- Which doctor did you see? _____

- What diagnosis / treatment(s) did you receive from this doctor? _____
  _____
  _____
- When did you report the 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: _____
  _____
  _____
  _____
  _____
  _____
  _____
  _____
  _____
- Where were you when the injury happened (please specify an address if possible)? _____
  _____
  _____
- What is the nature of your illness? What part of your body did you injure? _____
  _____
  _____
  _____
  _____
- Did you experience any of the following? If yes, please explain in which part of your body:
  - Numbness / tingling: _____
  - Pain: _____
  - Weakness: _____
  - Muscle wasting: _____
  - Altered function: _____
  - Problems with co-ordination: _____
  - Problems with memory/concentration: _____
  - Broken bons or broken skin: _____
  - Other:_____
    _____
    _____
- Did you lose consciousness with your injury? _____

- Was an ambulance required for your injury? YES/NO If yes, were you taken to hospital? _____
  If yes, which hospital? _____
- Have any of your symptoms changed / improved since your injury first occurred? Please describe the progression of your symptoms: _____
  _____
  _____
  _____
  _____
- What other investigations have you had related to your injury?
  (e.g. X-Ray, Ultrasound, CT, MRI) _____
  _____
  _____
  _____
- What were the results of these investigations? _____
  _____
  _____
  _____
- What treatment(s) have you had for your injury? Who provided the treatment? How often/how many times? _____
  _____
  _____
  _____
- Did any of these treatments improve or worsen the severity of your symptoms? _____
  _____
  _____
  _____
- When do you experience your symptoms? (for example, at work, at home, with physical activity): _____
  _____
  _____
  _____
- 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)? _____
  _____
  _____
  _____
  _____

- Have you had any time off work relating to your injury? If yes, please provide details: _____

  _____

  _____

  _____

- Has your injury resulted in any of the following? (if yes, give details)
  - Sleep disturbance: _____
  - Depression / anxiety: _____
  - Other emotional problem(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) _____

  _____

  _____

  _____

- Have you had any previous worker's compensation or insurance claims in the past? YES/NO
  If yes, give details: _____

  _____

  _____

- Do you take any medications? YES/NO If Yes: _____

  _____

  _____

- Do you have any hobbies or non-work-related activities which may have precipitated or contributed to or maintained your symptoms? _____

  _____

  _____

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

  _____

  _____

  _____

  Please provide other information you feel may be relevant _____

  _____

  _____

  _____

  _____

Signed by: _____ Date: _____