HealthPartners

Fitness for Duty/Return to Work Questionnaire

Date of Injury/Illness: _____ Employer Requesting Exam: _____ Job Title: _____

1. **Please describe your injury/illness:** _____

   _____

   _____

2. **Have you received any health care for this injury/illness?** ☐ Yes ☐ No
   If yes, when and where?

   Primary Provider's Office: _____

   Emergency Department: _____

   Specialty Care: _____

   Chiropractic Care: _____

   Physical or Hand Therapy: _____

   Imaging (X-Ray, CT, MRI, EMG): _____

   Surgery: _____

   Other: _____

3. **Is the injury/illness related to work?** ☐ Yes ☐ No ☐ To be determined

4. **Have you been <u>off work</u> for this injury/illness?** ☐ Yes ☐ No If yes, for how long? _____

5. **Has a health care provider cleared you to return to work?**

   ☐ Yes, with no restrictions

   ☐ Yes, with the following restrictions: _____

   ☐ No, unable to work due to: _____

6. **Do you feel you are ready to return to work?**

   ☐ Yes, with no restrictions

   ☐ Yes, with the following restrictions: _____

   ☐ No, unable to work due to: _____

7. **List all current or past medical conditions:** _____

   _____

8. **List all surgeries:** _____