

Workers' Compensation Form

Name: _____ Date of Birth: _____ Today's Date: _____
Occupation: _____ Employer: _____
Work Phone Number: _____ Supervisor's Name and Position: _____
Work Insurance Company: _____ Claim No.: _____

Accident History

Date of Injury: _____

Please describe how the accident happened in your own words: _____

Were you taken anywhere after the accident? _____ If yes,
where? _____

Were you hospitalized? _____ If yes, for how long? _____

Did you receive care from any other doctor or health care specialist? _____

If yes, what is the doctor or specialist's name, address, and phone number? _____

What type of care were you given and for how long? _____

Where did you feel the pain? _____

What are your current symptoms? _____

Please rate your current pain: *lowest* 1 2 3 4 5 6 7 8 9 10 *highest*

Has your pain increased, decreased or stayed the same since your injury? _____

Have you ever been injured in a similar manner? _____ If yes, when and how? _____

Medical History

Please list any personal or family medical history:

Cancer: _____

Diabetes: _____

Strokes: _____

Epilepsy: _____

Heart Disease: _____

If female, are you pregnant or is there a chance you could be pregnant? _____

What medications are you currently on? _____

What medical conditions or surgeries have you had in the past or currently have now? _____

Have you ever been hospitalized? _____ Explain: _____

