WORK INJURY INFORMATION

Patient's Name _____ Today's Date _____

Employer Name _____ Employer Phone Number _____

Person to whom the injury was reported _____ Phone Number (if different) _____

Was a First Report of Injury done? [ ] yes [ ] no If yes, please provide a copy Has a claim been filed? [ ] yes [ ] no If yes, pleas provide information

Worker's Comp Insurance Carrier _____ Phone Number _____

Claim Number _____ Adjuster's Name_____

Do you have an Attorney? [ ] yes [ ] no If yes, please provide information

Attorney's Name _____ Phone Number _____

DESCRIPTION OF INJURY

Date of Injury _____ Time of Injury _____ [ ] a.m. [ ] p.m.

Detailed Description of the Incident: _____

_____

_____

Were you unconscious immediately after the Incident? [ ] yes [ ] no If yes, for how long? _____

What best describes how you felt immediately after the Incident? [ ] In shock [ ] Dazed, circumstances vague [ ] Other _____

What type of pain did you feel immediately after the Incident? _____ Is the condition getting worse? [ ] yes [ ] no

Check any symptoms that you have had since the Incident:

[ ] arm/shoulder pain [ ] feet/toe numbness [ ] neck pain [ ] back pain [ ] hand/finger numbness [ ] neck stiffness [ ] back stiffness [ ] headaches
[ ] shortness of breath [ ] chest pain [ ] irritability [ ] dizziness [ ] sleeping difficulty [ ] jaw problems [ ] stomach upset [ ] ear buzzing
[ ] leg pain [ ] tension [ ] ear ringing [ ] fatigue [ ] memory loss [ ] vision blurred [ ] nausea [ ] other_____

What type of pain are you experiencing? [ ] sharp [ ] dull [ ] throbbing [ ] numbness [ ] aching [ ] shooting [ ] burning [ ] tingling [ ] stiffness [ ] other_____

Which (if any) activities does the pain interfere with? _____

Which activities or movements are painful? [ ] sitting [ ] standing [ ] walking [ ] bending [ ] lying down [ ] Other _____

Have you been able to work since the injury? [ ] yes [ ] no If no, how many days of work have you missed? _____

TREATMENT

Did you go to the hospital? [ ] yes [ ] no If yes, when?

[ ] immediately after the collision [ ] later that day [ ] the day after the collision [ ] two or more days after

How did you get to the hospital? [ ] ambulance [ ] private transportation

Hospital _____ Doctor _____

Diagnosis _____

Were x-rays taken? [ ] yes [ ] no If yes, of what area(s)? _____

What treatment did you receive? _____

_____

Were you give any home instructions? [ ] yes [ ] no If yes, what were they? _____

_____

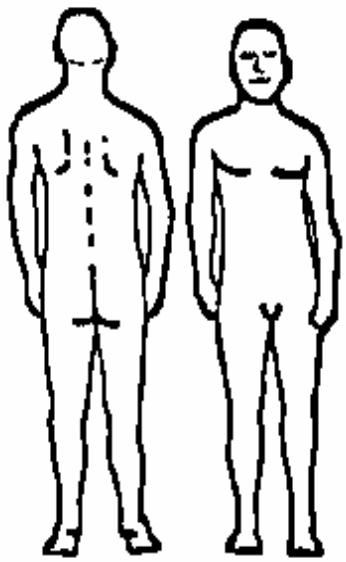
Were you given any medication for this condition? [ ] yes [ ] no If yes, What? _____

Besides the hospital, have you seen another physician or therapist for this condition? [ ] yes [ ] no If yes, please

provide physician/therapist's name _____

What treatment did you receive? _____

PLEASE MARK AREAS OF PAIN ON THE PICTURE BELOW



I certify that the above information is correct to the best of my knowledge.

Patient's Signature _____ Date _____