WORKER COMPENSATION INFORMATION

Date: ______________________

PATIENT INFORMATION

Name: ____ **Birth Date:** ________________

Address: ____

Telephone: ________________________________ **Occupation:**____________________________________

EMPLOYER INFORMATION

Employer Name:____

Employer Address:____

Employer Telephone:_______________________________ **Contact Person:**__________________________

Claim Number:____________________________________

INJURY INFORMATION

Date of Injury:_________________________ Time:__________________ [ ] AM [ ] PM

Place of Injury:__________________________________ Reported to employer? [ ] Yes [ ] No
Name reported to:_____________________________

Give full description of how the injury happened; ____
____
____
____

Have you lost time from work? [ ] Yes [ ] No How much ______________________________________

Other doctors seen for this condition:
____

Were X-rays taken? [ ] Yes [ ] No Other tests? [ ] Yes [ ] No _____________________________

Any previous Workers Compensation injuries? [ ] Yes [ ] No
Dates:__________________________________
Describe previous injuries:
____
____
____

Please check the following area that you are experiencing pain:
[ ] Neck [ ] Mid back [ ] Low back [ ] Arm [ ] Hands [ ] Shoulders
[ ] Hips [ ] leg [ ] Head [ ] Feet [ ] Buttocks

Is the pain on the: [ ] Right [ ] Left [ ] Midline [ ] Bilateral

Please describe your pain: [ ] Stiffness [ ] Muscle Spasm [ ] Numbness [ ] Pins & Needles
[ ] Deep ache [ ] Burning [ ] Sharp [ ] Other___________________________________

Does the pain Radiate? If yes please describe where; ______________________________________

If your injury involved <u>LIFTING</u>, Please complete:

<u>From where were you lifting an object?</u>
[ ] Ground level [ ] A surface below ground level [ ] A surface 1-3 feet high
[ ] A surface 3-5 feet high [ ] a surface above 5 feet high [ ] Above your head

<u>How many pounds was the object you were lifting?</u>
[ ] 1-5 pounds [ ] 5 -10 pounds [ ] 10-20 pounds
[ ] 20-40 pounds [ ] 40-60 pounds [ ] over 60 pounds

<u>What position were you in when the injury happened?</u>
[ ] Back was straight and upright [ ] Bent over at the waist/ head down / up
[ ] Twisting to the right [ ] Twisting to the left

<u>What type of pain did you feel immediately after the injury?</u>
[ ] Dull ache [ ] Sharp pain [ ] Popping feeling
[ ] Numbness/tingling [ ] Paralysis [ ] Stabbing pain

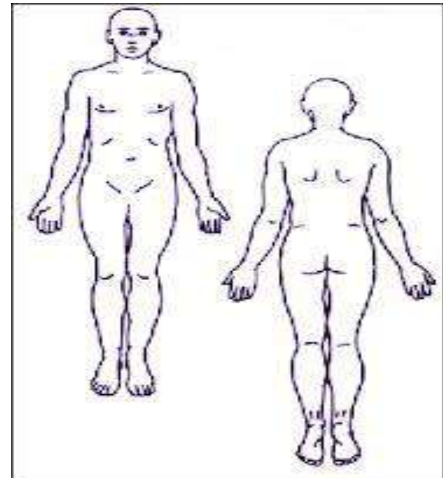
If your injury was from <u>FALLING</u>, Please complete:

<u>How far did you fall?</u>
[ ] On the ground from walking [ ] On the ground from running [ ] From 1-3 feet high
[ ] On the ground from fighting [ ] From 3-5 feet high [ ] From 5-10 feet high
[ ] Over 10 feet high

What part of your body did you land on? ____

What other areas are you experiencing pain with? ______________________________________

Please circle the areas of complaints



Please list anything that aggravates your symptoms at this time?

____

Please list anything that relieves your symptoms at this time?

____

Please rate your symptoms on the pain scale:

Worst:	1	2	3	4	5	6	7	8	9	10
Best:	1	2	3	4	5	6	7	8	9	10

<u>I clearly understand that all services rendered to me are charged directly to me and that I am personally responsible for Payment in the event that my claim for Workers Compensation benefits be denied.</u>

Patient Signature; ____ Date: ______________________