Workers' Compensation History Form

Your Name: ______________________________ Today's Date: _________________________

Date of Accident:__________________________ Location of Accident:___________________

Please describe, to the best of your knowledge, what happened during this accident:

____

____

____

____

Did you go to a hospital? YES NO

If yes, what is the name and city of the hospital? _________________________________

What was the Drs. Name?____

What did the hospital do for your injuries? _____________________________________

Any other Drs. seen?____

What are your major complaints?____

Immediate symptoms:____

Symptoms now: ____

On a scale of 1-10 (**10** being the worst) how strong is the pain that you are having?________

Any complaints in this area before? YES NO; If yes, please explain: __________________

____

Employment History

Employer Name:____

Employer Address: ____

Employer Phone # and Contact Person:____

Position with Company:_______________________ How long employed: __________________

Have you had any previous workers' compensation injuries? YES NO If yes explain:

____

____

Have you been able to work since the accident? YES NO If no please give dates:

____