WORKERS' COMPENSATION HISTORY

Name_____ Age_____ Date of Birth_____/_____/_____ ڤ Male ڤ Female

Address_____ City_____ State_____ Zip_____

SS#_____ Driver's License # _____

Employer's Name _____ Telephone_____

Address_____ City_____ State_____ Zip_____

Carrier's Name_____ Telephone _____

Address_____ City_____ State_____ Zip_____

Have you retained legal counsel for this injury? ڤ Yes ڤ No If yes, give name and address:_____

_____

INJURY DESCRIPTION

Date present injury was received:_____ Time of injury_____ ڤ AM ڤ PM Overtime? ڤ Yes ڤ No

Who saw the accident? _____ Title_____

Who reported the accident? _____ Title_____

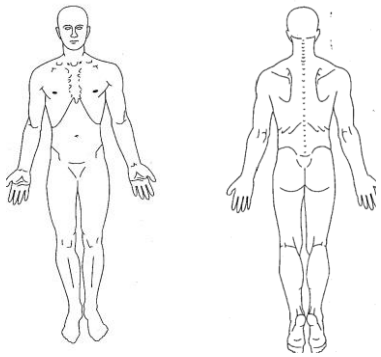
What medical attention was rendered:_____

By whom: ڤ Nurse ڤ M.D . ڤ D.O. ڤ D.C. ڤ Other employee ڤ Other _____

Chief Complaint _____

How did the injury occur:_____

_____ Mark



an x on the picture where you continue to have pain, numbness or tingling.

Type of pain: ڤSharp ڤDull ڤThrobbing ڤNumbness ڤAching ڤShooting ڤBurning ڤTingling ڤCramps ڤStiffness ڤSwelling ڤOther

Symptoms_____

How often do you have this pain?_____

Since the injury, are your symptoms ڤ Improving ڤ The Same ڤ Getting Worse

PRESENT WORK HISTORY

What is the job classification of your normal job?_____

Were you performing your normal job at the time of the accident? ڤ Yes ڤ No What shift were you working?

_____

How long have you been at your present job? _____ Has there been any time loss or absenteeism

caused by the job injury? ڤ Yes ڤ No If yes, explain:_____

Average work week_____Hours _____Days

PREVIOUS WORK HISTORY

Give job description for each job for the preceding 5 years.

1._____ 3._____

2._____ 4._____

Have you ever applied for workers' compensation benefits before? ڤ Yes ڤ No If yes, explain: _____

_____

Was there a time loss from work? ڤ Yes ڤ No From _____ to_____ Year_____

Degree recovered now? _____

Legal counsel? ف Yes ف No If yes, name and address? _____ **JOB**

CONDITION

Type of building _____

Type of floor: ف Rough ف Smooth ف Wood ف Concrete ف Steel ف Other_____

Type of windows: ف Open ف Closed ف No windows

Type of ventilation: ف Blower ف A/C ف Heat ف Exhaust ف None ف Other _____

Type of lighting: ف Fluorescent ف Overhead ف On machine ف Other _____

Are you tired when you go home at night? ف Yes ف No

Do you have any outside jobs? ف Yes ف No If yes, what?_____

Do you participate in any company-sponsored programs such as exercise, sports ect.? ف Yes ف No

If yes, describe:_____

If working on a machine, give description_____

Do you use foot or hand levers? ف Yes ف No Do you work overhead? ف Yes ف No

Do you have to reach? ف Yes ف No Where?_____

Movements on the job: do you move to your ف Right ف Left ف Up ف Down ف Under ف Over

Do you pick up or lift? ف Yes ف No If yes, how much? _____ how often? _____

From where to where? _____

Do you lift from: ف Ground ف Bench ف Platform ف Box ف Pallet ف Other _____

Do you lift in or out of a machine? ف Yes ف No If working on a machine do you: ف Sit ف Stand ف Kneel

Is your work area cluttered? ف Yes ف No If yes, with what? _____

Is your work area: ف Oily ف Dirty ف Slippery ف Other _____

In your job you push or pull? ف Yes ف No If yes, give specifics_____

Do you use a cart? ف Yes ف No Is the cart in good condition? ف Yes ف No

Total amount of weight being pushed or pulled on a daily basis: _____

OFFICE WORK

If your injury occurred from office work only, please fill out the following:

ف sit at desk ف walk ف stand ف stoop ف hold ف carry ف other_____

Give percentage if applicable_____ Do you operate office machinery? ف Yes ف No

If yes, what type? _____

If your work is at a desk, give specifics of job, computer, typewriter, business machines, phone, ect. :_____

_____

If walking, where to and job classification: _____

Do you carry anything or pick anything up? ف Yes ف No If yes, what? _____

_____ _____ _____ _____

Patient Signature Date Office Manager Date