Workers' Compensation History

Patient:

First Name________________ MI________ Last Name________________

Sex________________Date of Birth________________SSN#________________

Address________________________________

City________________ State________________ Zip________________

Phone (H)________________ (C)________________ (W)________________

Insurance:

Name of Compensation Carrier:________________________________

Address of Carrier:________________City________________State________Zip________

Claim#________________ Policy #________________Carrier's Phone________________

Employer:

Employer's Name________________________________

Employer's Address________________City________________State________Zip________

City________________ State________________Zip________________ Phone________________

Type of Business:________________Your Occupation:________________

Date Injured________Hour________AM / PM Last Date Worked:________________Are you off work?___Yes___No

Previous Workers' Compensation Injury? ____Yes____No

Accident reported to employer? ____Yes ____No Name of person reported accident to ________________

Injured at: ________________City:________________State:________________Zip:________________

Length of time worked there prior to accident:________________________________

Type of work being done at time of injury:________________________________

____

In your own words, please describe the accident:________________________________

____

____

Have you been treated by another doctor for this accident? ____Yes ____No

If yes, please list doctor's name and address:________________________________

What type of treatment did you receive?________________________________

How long were you treated by this doctor?________________________________

Are you ___________improved_________unchanged_________getting worse

What types of medicines are you taking?________________________________

Have you had physical therapy? ________Yes ________No If yes, how often? _______Daily _______Every other day _______Several times a week

______Weekly ______Every other week ______Monthly ______Other (describe)________________

Does the physical therapy help? _______Yes ______No ______Don't know

Prior to this accident, have you ever had any of the physical complaints similar to what you have now? _____Yes _______No_____Don't know

If yes, describe:________________________________

____

____

Were these similar complaints the results of a previous accident(s)? ______Yes _____No Please provide details of accident(s):________________

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