Worker's Compensation Accident History

Name ____ Today's Date ___/___/___ Date of Birth ___/___/___

Sex: M F Marital Status: S M D W Occupation ________________ Employer _____________

Address ____ City __________________ State ____ Zip ________

Cell Phone (____) ______________ Work Phone (____) ______________ Home Phone (____) ______________

Email Address __________________________________ may we send you newsletters or office information by email? Y N

May we text you appointment reminders? Y N

Emergency Contact ____________________________________ Phone (____) ______________

Primary Care Doctor ______________________________ Phone (____) ______________ may we contact them? Y N

Your employer's Name ____ Phone (____) ______________

Worker's Comp Insurance Company ______________________________________ Phone (____) ______________

Name of Agent and/or Adjustor __________________________________ Claim #___________________________

Do you have an Attorney? Y N Name __________________________________ Phone (____) ______________

Internal Office Use

Claim # verified Y N

Adjustor Name:

Adjustor Phone:

Claims Mailing Address:

List all drugs (prescription and over the counter) and nutritional supplements you are taking:

Name	Purpose	Dosage
___________________________	_________________________________	____________________________
___________________________	_________________________________	____________________________
___________________________	_________________________________	____________________________

List any known allergies ____

ACCIDENT INFORMATION:

Date of Accident ___/___/___ Time of Accident ________ am/pm

Please explain in detail how your accident happened: ____

____

____

____

Where did you feel immediate pain after the accident? ____

Did you report the accident to your supervisor? Yes No When? ___________ Name: ____________________

Has your employer acknowledged your accident? Yes No

Have you missed any work? Yes No When? ____

Have you returned to work? Yes No If so, date returned to work: _________________________________

Are your work activities restricted as a result of this accident? Yes No If so, explain: _____________________

____

Before this injury, were you capable of working on an equal basis with others your age? Yes No

List any other comments relative to this accident: ____

____

Have you seen any other health care providers for this injury? Yes No (If yes, complete this section)

Doctor's names and addresses: ____

____

What examinations/treatments did you receive? ____

____

Doctor's diagnosis (if known): ____

Doctor's recommendations: ____

List any other comments relative to this injury: ____

____

SYMPTOMS

BELOW: list your symptoms, from most severe to mildest, and include ANY and ALL areas that bother you including knees, shoulders, hands, feet, ear infections, headaches, jaw, etc.

Worst symptom:________________________________ What happened?________________________________

Severity of pain: 0 1 2 3 4 5 6 7 8 9 10 When did the pain start? ____________________________

Quality of pain (circle all that apply): sharp shooting dull ache burning stabbing stiff throbbing numbness

Does your pain radiate into arms? Y N Legs? Y N

Worse with (circle all that apply): sitting standing walking bending lifting other:_________________________

Better with (circle all that apply): rest ice heat stretching exercise pain relievers topical creams other:______________

Worse during (circle): morning afternoon evening during sleep

What treatment have you received for this condition (circle): medication physical therapy surgery other:______________

List any area of your life affected by this complaint (ex: work, home, kids, hobbies, etc) 1. ____________________

2. ____________________

3. ____________________

Symptom 2:____ What happened?____

Severity of pain: 0 1 2 3 4 5 6 7 8 9 10 When did the pain start? ________________________________

Quality of pain (circle all that apply): sharp shooting dull ache burning stabbing stiff throbbing numbness

Does your pain radiate into arms? Y N Legs? Y N

Worse with (circle all that apply): sitting standing walking bending lifting other:____

Better with (circle all that apply): rest ice heat stretching exercise pain relievers topical creams other:___________________________

Worse during (circle): morning afternoon evening during sleep

What treatment have you received for this condition (circle): medication physical therapy surgery other:__________________________

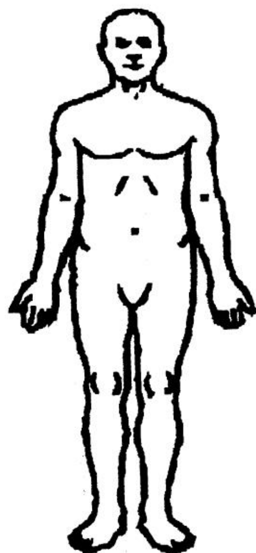
List any area of your life affected by this complaint (ex: work, home, kids, hobbies, etc)

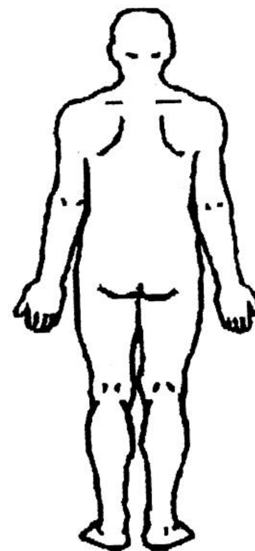
1. ____
2. ____
3. ____

INJURY DETAIL

Please circle area(s) of injury and describe your symptoms using the codes listed below.

N - Numbness P - Pain T – Tingling A – Ache S – Soreness ST – Stiffness MSP – Muscle Spasm





I attest that the above given information is complete and accurate to the best of my knowledge.

Signature ____ Date ___________________