

PATIENT INFORMATION FORM - WORK COMP

Name: _____ Today's Date: ____/____/____

Name of Employer: _____ Position: _____

Supervisor Name: _____ Phone: (____)_____

Address: _____

City: _____ State: _____ Zip: _____

Name of Compensation Carrier _____

Claim #: _____

Adjustor: _____ Phone: (____)_____

Address: _____

City: _____ State: _____ Zip: _____

Date of Injury: _____ Time: _____

Where is pain located: _____

Have you made a report of your accident to your employer? Yes No

Are you off work: Yes No Last Date Worked: ____/____/____

Have you returned to work: Yes No Return Date: ____/____/____

Any prior work compensation injuries: Yes No Date of Injury: ____/____/____

Length of time worked prior to injury: _____

Explain the details of the accident: _____

Have you been treated by another physician for this injury: Yes No

If Yes: Doctor Name: _____ Phone: (____)_____

Treatment: _____

Results: _____

Prior to the accident, have you ever had complaints similar to the ones you are experiencing now: Yes No

If yes, please describe: _____

Has the condition: Got Worse Stayed Constant Comes and Goes

Does the condition interfere with: Sleep Work Daily Routine Other Activities

Please explain: _____

Patient Name (please print): _____

Signature: _____ Date: ____/____/____