

# Worker's Compensation History

Patient Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

Name of Employer: \_\_\_\_\_ Position: \_\_\_\_\_

Supervisor Name: \_\_\_\_\_ Ph: \_\_\_\_\_

Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Name of Compensation Carrier \_\_\_\_\_

Claim #: \_\_\_\_\_

Adjustor: \_\_\_\_\_ Ph: \_\_\_\_\_

Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Date of Injury: \_\_\_\_\_ Time: \_\_\_\_\_

Where is pain located: \_\_\_\_\_

Are you off work:  Yes  No Last Date Worked: \_\_\_\_\_

Have you returned to work:  Yes  No Return Date: \_\_\_\_\_

Any previous 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: \_\_\_\_\_ Ph. # \_\_\_\_\_

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: \_\_\_\_\_

Patient Signature: \_\_\_\_\_ Date: \_\_\_\_\_