WORKER COMPENSATION INFORMATION

Date: _____ Birthdate: _____

Name: _____ Email: _____

Address: _____

Home Phone: _____ Cell Phone: _____

EMPLOYER

Occupation: _____ Employer: _____

Employer Address: _____

Employer Phone: _____ Injury verified by: (For Office Use) _____

Contact Person: _____ Email: _____

WORKER COMPENSATION CARRIER (FOR OFFICE USE)

Worker compensation carrier: _____

Carrier address: _____

Carrier phone: _____ Coverage verified by: _____

Adjuster's name: _____ Claim number: _____

INJURY INFORMATION

Date of injury: _____ Time: _____ AM/PM _____

Location of injury: _____

Please describe in your own words how the accident happened:

Accident reported to employer: (Yes) / (No) (Circle One)

Name of person you reported accident to: _____

Have you been able to work since this injury: (Yes) / (No) (Circle One)

How many days of work have you missed? _____

Prior to the injury were you able to work on an equal basis with others your age? (Yes) / (No) (Circle One)

Place an X next to any of the following symptoms you are experiencing:

Arm/Shoulder Pain: ☐	Feet/Toe Numbness: ☐	Nausea: ☐
Neck Pain: ☐	Back Pain: ☐	Fatigue: ☐
Hand/Finger Numbness: ☐	Neck Stiff: ☐	Vision Blurred: ☐
Back Stiffness: ☐	Headaches: ☐	Memory Loss: ☐
Shortness of Breath: ☐	Chest Pain: ☐	Hearing Issues: ☐
Irritability: ☐	Jaw Problems: ☐	Tension: ☐
Dizziness: ☐	Leg Pain/Numbness: ☐	Upset Stomach: ☐

Is this condition getting progressively worse: Yes No

Rate the severity of your pain on a scale from 1 (no pain) to 10 (severe pain): ____

Type of Pain: (Place an X next to each type)

Sharp: ____ Dull: ____ Throbbing: ____ Numbness: ____ Aching: ____ Shooting: ____

Burning: ____ Tingling: ____ Cramps: ____ Stiffness: ____ Swelling: ____

Please describe other if not listed above: ____

How often do you have this pain? ____

Is the pain constant or does it come and go: ____

Does it interfere with your: Work ____ Sleep ____ Daily Routine ____ Recreation ____

Are the following movements painful to perform: Sitting ____ Bending ____ Standing ____

Walking ____ Lying Down ____ Other ____

Other doctors seen for this condition: Doctor's Name: ____

X-Rays taken? ____ Where: ____ Other Tests: ____

If Yes, by whom? Please list test(s) and result(s): ____

Any previous worker compensation injuries: ____ Date of previous injuries: ____

Describe previous worker compensation injuries: ____

AUTHORIZATION

I clearly understand and agree that all services rendered to me are charged directly to me or my health insurance and that I am personally responsible for payment in the event that my claim for worker compensation benefits is denied. I understand that filing for worker compensation benefits does not relieve me from my responsibility for the payment of all charges.

_____

Signature of Patient, Parent, Guarding or Personal Representative

_____

Date

_____

Please print name of Patient, Parent, Guardian or Personal Representative.