

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.