WORKERS COMPENSATION HISTORY

PATIENT_____ MALE / FEMALE DATE_____

ADDRESS_____CITY_____STATE_____ZIP_____

HOME PHONE_____WORK PHONE_____ AGE_____D.O.B._____

NAME OF COMPENSATION CARRIER_____

PHONE_____ SUPERVISOR NAME_____

ADDRESS OF COMPENSATION CARRIER_____

_____CLAIM #_____

EMPLOYERS NAME_____PHONE_____

ADDRESS_____

OCCUPATION_____

DATE OF INJURY_____TIME_____ A.M. / P.M.

WHAT IS YOUR HEALTH CONCERN?_____

ARE YOU OFF WORK? YES NO LAST DATE WORKED?_____

HAVE YOU RETURNED TO WORK SINCE THE ACCIDENT? YES NO DATE_____

ANY PREVIOUS WORKERS COMPENSATION INJURIES? YES NO DATE_____

LENGTH OF TIME WORKED PREVIOUS TO INJURY_____

EXPLAIN DETAILS OF THE ACCIDENT_____

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HAVE YOU BEEN TREATED BY ANOTHER DOCTOR FOR THIS CONDITION? YES NO

IF YES, LIST DR.'S NAMES AND NUMBERS_____

PRIOR TO THE ACCIDENT, HAVE YOU EVER HAD COMPLAINTS SIMILAR TO THE ONES YOU ARE EXPERIENCING NOW? YES NO

DESCRIBE_____

PATIENT'S SIGNATURE_____DATE_____