WORKERS COMPENSATION HISTORY

PATIENT NAME:			DATE:
ADDRESS:		CITY:	STATE/ZIP CODE:
HOME PHONE NUMBER:		CELL PHONE NUMBER:	
SOCIAL SECURITY NUMBER:	DATE OF BIRTH:	AGE:	GENDER:
EMERGENCY CONTACT NAME:		EMERGENCY CONTACT PHONE NUMBER:	

EMPLOYER INFORMATION

EMPLOYER NAME:	SUPERVISOR'S NAME:	
EMPLOYER ADDRESS:	CITY:	STATE/ZIP CODE:
WORK PHONE:	OCCUPATION:	

ACCIDENT/INJURY DETAILS

DATE OF INJURY:	TIME OF INJURY (A.M. OR P.M.)
EXPLAIN THE DETAILS OF THE ACCIDENT:	
ARE YOU OFF OF WORK? ☐ YES ☐ NO	IF YES, DATE YOU LEFT WORK:
HAVE YOU RETURNED TO WORK SINCE THE ACCIDENT? ☐ YES ☐ NO	IF YES, DATE YOU RETURNED TO WORK:
HAVE YOU BEEN TREATED BY ANY OTHER DOCTORS FOR THIS CONDITION? ☐ YES ☐ NO	IF YES, PLEASE LIST THE NAME(S) OF THE DOCTOR(S):
HAVE YOU HAD ANY PREVIOUS WORKERS COMPENSATION INJURIES? ☐ YES ☐ NO	DATE(S) OF PREVIOUS WORKERS COMPENSATION INJURIES:
PRIOR TO THE ACCIDENT, HAD YOU HAD SIMILAR COMPLAINTS TO THE ONES YOU ARE EXPERINCING NOW? ☐ YES ☐ NO	
IF YES, PLEASE DESCRIBE:	

INSURANCE INFORMATION

COMPENSATION CARRIER NAME:	COMPENSATION CARRIER PHONE:	
COMPENSATION CARRIER ADDRESS:	CITY:	STATE/ZIP:
CLAIM NUMBER:		

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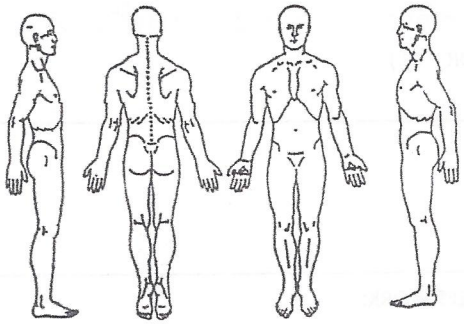
SYMPTOMS

INSTRUCTIONS: Check any/all symptoms noted <u>after</u> the accident.

☐ HEADACHE	☐ DIZZINESS	☐ LIGHT BOTHERS EYES
☐ NECK PAIN	☐ HEAD SEEMS HEAVY	☐ LOSS OF MEMORY
☐ NECK STIFFNESS	☐ PINS & NEEDLES IN ARMS	☐ EARS RING
☐ SLEEPING PROBLEMS	☐ PINS & NEEDLES IN LEGS	☐ FACE FLUSHED
☐ BACK PAIN	☐ NUMBNESS IN FINGERS	☐ BUZZING IN EARS
☐ NERVOUSNESS	☐ NUMBNESS IN TOES	☐ LOSS OF BALANCE
☐ TENSION	☐ SHORTNESS OF BREATH	☐ FAINTING
☐ IRRITABILITY	☐ FATIGUE	☐ LOSS OF SMELL
☐ CHEST PAIN	☐ DEPRESSION	☐ LOSS OF TASTE
☐ DIARRHEA	☐ FEET FEEL COLD	☐ UPSET STOMACH
☐ CONSTIPATION	☐ HANDS FEEL COLD	☐ OTHER:_____
☐ FEVER	☐ COLD SWEATS	☐ OTHER:_____

INSTRUCTIONS: *Please mark the area and type of pain on the drawings using the codes listed below:*

N=Numbness P=Pain A=Ache T=Tingling S=Stiffness/Soreness



COMMENTS:

PLEASE PROVIDE ANY OTHER INFORMATION YOU THINK WE SHOULD KNOW, (i.e. what makes it better/worse? Is your physical or mental function at home or work limited in anyway?

INSTRUCTIONS: Relate your BEFORE injury capacity (mark "B") and your AFTER injury capacity (mark "A") for performing activities:

1.	WALKING	NORMAL____	LIMITED____	DIFFICULT____	PAIN____
2.	STANDING	NORMAL____	LIMITED____	DIFFICULT____	PAIN____
3.	SITTING	NORMAL____	LIMITED____	DIFFICULT____	PAIN____
4.	BENDING	NORMAL____	LIMITED____	DIFFICULT____	PAIN____
5.	STOOPING	NORMAL____	LIMITED____	DIFFICULT____	PAIN____
6.	LIFTING	NORMAL____	LIMITED____	DIFFICULT____	PAIN____
7.	PUSHING	NORMAL____	LIMITED____	DIFFICULT____	PAIN____
8.	PULLING	NORMAL____	LIMITED____	DIFFICULT____	PAIN____
9.	CLIMBING	NORMAL____	LIMITED____	DIFFICULT____	PAIN____
10.	REACHING	NORMAL____	LIMITED____	DIFFICULT____	PAIN____
11.	GRIPPING	NORMAL____	LIMITED____	DIFFICULT____	PAIN____
12.	KNEELING	NORMAL____	LIMITED____	DIFFICULT____	PAIN____
13.	BALANCE	NORMAL____	LIMITED____	DIFFICULT____	PAIN____
14.	FATIGUE	NORMAL____	LIMITED____	DIFFICULT____	PAIN____

SIGNATURE

PATIENT SIGNATURE:	DATE: