WORKERS' COMPENSATION HISTORY

Name______________________________ Age____ Date of Birth____________ ❑ Male ❑ Female
Address______________________________ City________________ State________ Zip________
SS#______________________________ Driver's Lic. #______________________________
Employer's Name______________________________ Tel. #______________________
Address______________________________ City________________ State________ Zip________
Carrier's Name______________________________ Tel. #______________________
Address______________________________ City________________ State________ Zip________
Have you retained legal counsel for this injury? ❑ Yes ❑ No If "Yes," give name and address:____________
____

INJURY DESCRIPTION

Date present injury was received____________ Time of injury________ ❑ AM ❑ PM Overtime? ❑ Yes ❑ No
Who saw the accident? Name______________________________ Title________________
Who reported the accident? Name______________________________ Title________________
What medical attention was rendered?______________________________
By whom? ❑ Nurse ❑ M.D. ❑ D.O. ❑ D.C. ❑ Other employee ❑ Other____________________
How did the injury occur?______________________________
Chief complaint______________________________
Symptoms______________________________
Since the injury, are your symptoms ❑ Improving ❑ The same ❑ Getting worse
If working on a machine, give description______________________________
Do you use foot or hand levers? ❑ Yes ❑ No Do you work overhead? ❑ Yes ❑ No
Do you have to reach? ❑ Yes ❑ No Where?______________________________
Movements on the job: Do you move to your ❑ Right ❑ Left ❑ Up ❑ Down ❑ Under ❑ Over
Do you pick up or lift? ❑ Yes ❑ No If "Yes," how much?____________ How often?____________
From where to where?______________________ Do you lift from ❑ Ground ❑ Bench ❑ Platform
❑ Box ❑ Pallet ❑ Other (Please describe)______________________________
Do you lift in or out of a machine? ❑ Yes ❑ No If working at a machine, do you ❑ Sit ❑ Stand ❑ Kneel
Is your work area cluttered? ❑ Yes ❑ No If "Yes," with what?______________________
Is your work area ❑ Oily ❑ Dirty ❑ Slippery ❑ Other______________________
In your job do you push or pull? ❑ Yes ❑ No If "Yes," give specifics______________________
Do you use a cart? ❑ Yes ❑ No ❑ Two-wheel ❑ Four-wheel Type of wheels ❑ Rubber ❑ Steel ❑ Plastic
Condition of cart ❑ Good ❑ Bad ❑ Other____________ Number of carts being pushed or pulled at once____
Total amount of weight being pushed or pulled on a daily basis______________________

OFFICE WORK

If your injury has occurred from office work only, please fill out the following:
❑ Sit at desk ❑ Walk ❑ Stand ❑ Stoop ❑ Hold ❑ Carry ❑ Other______________________
Give percentage if applicable____________________ Do you operate office machinery? ❑ Yes ❑ No
If "Yes," what type?______________________________
If your work is at a desk, give specifics of job, computer, typewriter, business machines, phone, etc.____________
____
If walking, where to and job classification______________________________
Do you carry anything or pick anything up? ❑ Yes ❑ No If "Yes," what?______________________

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(over)

PREVIOUS WORK HISTORY

Give a job description of services or work performed for each job classification or source of employment for the preceding ten (10) years.

1.____

2.____

3.____

4.____

5.____

Was a pre-employment exam performed or required? ❑ Yes ❑ No

Date____________ Doctor____________ Place____________

Have you ever applied for Workers' Compensation benefits before? ❑ Yes ❑ No Date____________

Reason____

Was there a time loss from work? ❑ Yes ❑ No From____________ To____________ Year______

State the degree of recovery____

Did you retain legal counsel for these injuries? ❑ Yes ❑ No If "Yes," give name and address____________

____

PRESENT WORK HISTORY

What is the job classification of your normal job?________________________

Were you performing your normal job? ❑ Yes ❑ No What shift were you working?____________

How long have you been at your present job?____________ Has there been a time loss or absenteeism caused from job injury? ❑ Yes ❑ No If "Yes," explain____________

Average work week____________Hours ____________Days

JOB CONDITIONS

Type of building____

Type of floor ❑ Rough ❑ Smooth ❑ Wood ❑ Concrete ❑ Steel ❑ Other____________

Type of windows ❑ Open ❑ Closed ❑ No windows

Type of ventilation in the building ❑ Blower ❑ A/C ❑ Heat ❑ Exhaust ❑ None ❑ Other____________

Type of lighting in the building ❑ Fluorescent ❑ Overhead ❑ On machine ❑ Other____________

Are you tired when you go home at night? ❑ Yes ❑ No

Do you have any outside jobs? ❑ Yes ❑ No If "Yes," what type?____________

Do you participate in any company-sponsored programs such as exercise, sports, etc.? ❑ Yes ❑ No

If "Yes," describe____

Type of shop ❑ Union ❑ Non-union

Has outside help been hired? ❑ Yes ❑ No If "Yes," why?____________

How many employees are in the plant?________ How many employees per shift?________

How many employees do your job?________ What is the current injury ratio for that job?________

How many employees have been injured doing your job?________ Do you like your job? ❑ Yes ❑ No

If off work, do you want to return to your job? ❑ Yes ❑ No

What changes would you make in your job?________________________

____

________________________ ____________
Patient Signature Date

________________________ ____________
Staff Signature Date

MARK PAIN AREA	
+++	Burning
000	Stabbing
- - -	Sharp
I I I	Constant