



Worker's Compensation Form

Patient's Name _____ Date _____

Social Security Number: _____ Date of Injury _____ Hour _____ AM/PM

Was injury reported to employer? No Yes Name of person reported injury to: _____

Have you lost time from work? No Yes If Yes, how much time lost? _____

Have you returned to work since this injury? No Yes If Yes, Date _____

Check appropriate box

FULL TIME REGULAR DUTY <input type="checkbox"/>	FULL TIME LIGHT DUTY <input type="checkbox"/>
PART TIME REGULAR DUTY <input type="checkbox"/>	PART TIME LIGHT DUTY <input type="checkbox"/>

Length of time worked there prior to accident? _____

Have you been treated by another doctor for this accident? No Yes, Name of Doctor _____

In your own words, please describe how the accident happened: _____

Since the injury, are you: Improved Unchanged Getting Worse

Have you had Physical Therapy: No Yes If Yes, how often _____

Does Physical Therapy help? No Yes

Prior to this injury, have you ever had any of the physical complaints similar to what you have now?

No Don't Know Yes, describe: _____

Were these similar complaints the result of a previous injury? No Yes If Yes, please provide details of previous injuries: _____

Have you had a previous Worker's Compensation Injury? No Yes If Yes, Date(s) of previous injuries: _____