



# Worker's Compensation Form

**Patient's Name** \_\_\_\_\_ **Date** \_\_\_\_\_

**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: \_\_\_\_\_