

WORKERS COMPENSATION PATIENT HISTORY

Name _____ Date _____ File # _____

History of Occurrences

Employer's business name (at the time of incident) _____

Employer's phone _____ Employer's Address _____

City _____ State _____ Zip _____

Occupation _____ Describe your job _____

Date of Injury _____ Time of Injury _____ AM PM Date Last Worked _____

What were you doing at the time you were injured? How did the accident/injury happen
(lifting/bending, walking, carrying, standing, etc.)? _____

When did your pain begin? **Where** in your body did you first feel it? Was pain intense at first, or did you
feel pain that gradually worsened? (**Be Specific**) _____

Describe the environmental condition which may have contributed to your present injury: Darkness,
faulty equipment, slippery floor, limited space. (Distinguish natural hazards from hazards by other
employees) _____

First Doctor/Hospital/Clinic Seen

Were you hospitalized as a result of this accident? No Yes

What doctor/hospital/clinic did you go to? _____ Date of first visit? _____

DOCTOR 1: Name _____ Date of First Visit _____

Were you examined? Yes No Were x-rays taken? Yes No Did you receive treatment? Yes No

If yes, what kind of treatment did you receive? _____

What benefits did you receive from the treatment? _____

Date of Last Treatment? _____

DOCTOR 2: Name _____ Date of First Visit _____

Were you examined? Yes No Were x-rays taken? Yes No Did you receive treatment? Yes No

If yes, what kind of treatment did you receive? _____

What benefits did you receive from the treatment? _____

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Date of Last Treatment? _____

DOCTOR 3: Name _____ Date of First Visit _____

Were you examined? Yes No Were x-rays taken? Yes No Did you receive treatment? Yes No

If yes, what kind of treatment did you receive? _____

What benefits did you receive from the treatment? _____

Date of Last Treatment? _____

REPORT ACCIDENT TO/ACCIDENT WITNESS

What date did you report this injury? _____

Whom did you report this to? _____ What is their position? _____

Was there a witness to your injury? Yes No

If yes, what was the witness' name? _____ What is their position? _____

Other witness' name? _____ What is their position? _____

PRIOR SIMILAR SYMPTOMS

Did you have any physical complaints **just before the accident?** Yes No

If yes, please describe any physical complaints **just before the accident?** _____

Have you **EVER** had any **PRIOR** injuries, accidents, diseases, or treatment to the area of your body affected? Yes No If yes, state what part of your body was **previously** injured: _____

Describe the injury: _____

Were you treated? Yes No If yes, who treated you? _____

What date did the treatment begin? _____ When did the treatment end? _____

WORK STATUS HISTORY

Have you lost any time from work as a result of this injury? Yes No

If yes, give dates of time loss: _____

If you are currently on **disability (time loss)** do you want to go back to work doing your **regular** work duties? Yes No If no, state why you don't want to go back to your regular work duties: _____

Have you gone back to work? Yes No If yes, what status of work? Modified Regular

When (Date): _____ Please list what restrictions you have been placed on? _____

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If you have gone back to work, please list the activities as:

Those that are painful: _____

Those that are difficult: _____

Are there any problems you have with a fellow employee, supervisor, or management that need to be discussed? Yes No If yes, please discuss: _____

ACTIVITIES OF DAILY LIVING

Do you find any activities that you perform at **home painful** or **difficult**? Yes No

If yes, those **home** activities that you are **unable** to do (be specific): _____

Those **home** activities that are **painful** are (be specific): _____

Those **home** activities that are **difficult** are (be specific): _____

Are you performing exercises at home at this time? Yes No If yes, what are they? _____

How frequently do you perform them? _____

Who prescribed these exercises to you? _____

What exercises or activities could you do before the work-related injury that you no longer do because of pain or loss of function? _____

DO YOU HAVE AN ATTORNEY ON THIS CASE? YES NO

If yes, who? Name _____ Phone _____

Address _____ City _____ State _____ Zip _____