Worker's Compensation History

Patient_____

Address_____

Age_____ Birthdate_____ Sex_____ Social Security#_____

Name of Compensation Carrier_____ Phone#_____

Address of Carrier_____

Employer's Name_____ Phone # _____

1. Type of Business_____ Occupation_____

2. Date injured_____ Last Date Worked_____ Are you off work now? Yes / No

3. Previous Worker's Compensation injury? Yes / No

4. Accident reported to employer? Yes / No

5. Injured at:_____ City_____ State_____ Zip_____

6. Length of time worked there prior to accident_____

7. Type of work being done at time of injury_____

8. In your own words, please describe the accident_____

_____

_____

9. Have you been treated by another doctor for this accident? Yes / No
If yes, please list doctor's name and address_____

_____

What type of treatment did you receive?_____

How long were you treated by this doctor?_____

10. Are you: ____ improving ____ unchanged ____ getting worse

11. Are taking any medications? Yes / No If so please list_____

_____

Do these medicines help? Yes / No

12. Have you had physical therapy? Yes / No

__Daily __Every other day __Several times a week __Weekly
__Every other week __Monthly __Other_____

13. Prior to this accident, have you ever had any of the physical complaints similar to what you have now? Yes / No If so, describe_____

_____

Were these similar complaints the results of a previous accident (s)? Yes / No

Please provide details of accident (s)_____

_____

14. Since this injury occurred, are your symptoms __Improving __Getting worse __Same

15. Check symptoms you have noticed since accident:

__Headache	__Irritability	__Numbness in toes	__Face flushed	__Feet cold
__Neck pain	__Chest pain	__Shortness of breath	__Buzzing in ears	__Hands cold
__Neck stiff	__Nervousness	__Sleeping problems	__Depression	__Loss of taste
__Dizziness	__Ears ringing	__Head seems too heavy	__Lights bother eyes	__Stomach upset
__Fatigue	__Diarrhea	__Pins & needles in arms	__Loss of balance	__Constipation
__Back pain	__Fever	__Pins & needles in legs	__Fainting	__Loss of memory
__Tension	__Cold sweats	__Numbness in fingers	__Loss of smell	

Symptoms other than above_____

16. Do you notice any activity restrictions as a result of this injury? Yes / No If so please describe in detail: _____

_____

_____

17. Other pertinent information we may need to know:_____

_____

Patient Signature:_____ Date:_____