Worker's Compensation Form

Date: _____/20____ Referred by:_____

Full Name: _____ S.S. #:_____-_____-_____

Age: _____ Date of Birth: _____ Gender: _____ Marital Status:_____

Address:_____ City: _____ State: _____ Zip Code: _____

Home Phone: (____)____-_____ Cell Phone: (____)____-_____ Email: _____

Occupation: _____ Employer: _____ Work Phone: (___)_____

Emergency Contact: _____ Phone: _____

Relationship to you: _____ May we contact them: YES / NO

Primary Care Physician: _____

Address: _____Phone #_____

WORK RELATED INJURY

Date of accident: _____ Type of accident: _____
Was This a motor vehicle accident? YES/NO
if yes, What City and State did accident occur? _____
if yes, Was police report filed? YES/NO
Auto Insurance Company Name/policy information_____
What state do you work in? _____
Are your symptoms solely the result of a work related injury? YES/ NO
Please describe how the accident occurred:

_____

_____

_____

Did you experience immediate pain following the accident? YES/ NO
Are you symptoms getting worse? YES / NO Are they: CONSTANT / COMES & GOES
What were your symptoms at that time:

_____

Did you seek treatment at the Hospital or Medical Center? YES / NO
Where_____ When? Same Day /Next Day/ Date:_____
Were you transported by ambulance? YES / NO
Were any test performed at the medical facility?

- XRAYS/ MRI/ CT SCAN Which body part:_____
- BLOODWORK: YES / NO

SOCIAL HISTORY:

Are you a smoker? YES / NO If yes, how much? _____
Do you drink any alcohol? YES / NO How often: Socially/ Occasionally/ Weekly/ Daily

INSURANCE & ATTORNEY INFORMATION:

Do you have an Attorney? If yes, what is his/her name? _____

What is the name of the Worker's Compensation insurance? _____

Do you have a claim number? (Please provide)_____

Did you file an injury report with your employer following the accident? YES / NO

What **symptoms/injuries** did you report initially?_____

Do you have health insurance? If yes, which? _____ **Please give your card to the front desk.**

SYMPTOMS/ INJURIES:

What are your symptoms: **Please circle**

Headaches Neck pain Neck stiffness □ Jaw problems

left/right Arm pain left/right Shoulder pain

left/right Hand/finger pain/numbness Mid-back pain □ Back stiffness

Chest pain Low back pain left/right Leg pain left/right Hip pain

left/right Knee/Ankle pain left/right Foot/Toe pain/numbness

□ Dizziness □ Nausea □ Fatigue □ Sleep difficulty Abdominal pain

□ Difficulty turning head to the right/left □ Vision blurred □ Hearing loss / Balance

On a pain scale of 1 thru 10, 1 being almost no pain and 10 being the greatest, what would you rate your pain level today? _____

Type of pain: Sharp □ Cramping □ Dull □ Throbbing □ Burning □ Stabbing □ Grabbing

To the best of my knowledge, the above information is complete and correct. I understand that it is my responsibility to inform my doctor If I, ever have a change in health.

_____ _____

Signature of patient or Personal Representative Date

_____ _____

Please print name of patient or Personal Representative Date