WORKERS COMPENSATION HISTORY

Name_____ Age_____ Date of Birth_____ ☐ Male ☐ Female
Address_____ City_____ State_____ Zip_____
SS#_____ Driver's Lic. #_____
Employer's Name_____ Tel. #_____
Address_____ City_____ State_____ Zip_____
Carrier's Name_____ Tel. #_____
Address_____ City_____ State_____ Zip_____
Have you retained legal counsel for this injury? Yes No If "Yes", give name and address: _____
_____

INJURY DESCRIPTION

Date present injury was received_____ Time of injury_____ ☐ AM ☐ PM Overtime? ☐ Yes ☐ No
Who saw the accident? Name_____ Title_____
Who reported the accident? Name_____ Title_____
What medical attention was rendered? _____
By whom? ☐ Nurse ☐ M.D. ☐ D.C. ☐ Other employee ☐ Other_____
How did the injury occur? _____
Chief complaint _____
Symptoms _____
Since the injury, are the symptoms ☐ Improving ☐ The same ☐ Getting worse
If working on a machine, give description_____
Do you use foot or hand levelers? ☐ Yes ☐ No Do you work overhead? ☐ Yes ☐ No
Do you have to reach? ☐ Yes ☐ No Where? _____
Movements on the job: Do you move to your ☐ Right ☐ Left ☐ Up ☐ Down ☐ Under ☐ Over
Do you pick up or lift? ☐ Yes ☐ No If "Yes", how much? _____ How often? _____
From where to where? _____ Do you lift from ☐ Ground ☐ Bench ☐ Platform
☐ Box ☐ Pallet ☐ Other (Please describe) _____
Do you lift in or out of a machine? ☐ Yes ☐ No If working at a machine, do you ☐ Sit ☐ Stand ☐ Kneel
Is your work area cluttered? ☐ Yes ☐ No If "Yes", with what? _____
Is your work area ☐ Oily ☐ Dirty ☐ Slippery ☐ Other_____
In your job do you push or pull? ☐ Yes ☐ No If "Yes", give specifics_____
Do you use a cart? ☐ Yes ☐ No ☐ Two-wheel ☐ Four-wheel Type of wheels ☐ Rubber ☐ Steel ☐ Plastic
Condition of cart ☐ Good ☐ Bad ☐ Other_____ Number of carts being pushed at once_____
Total amount of weight being pushed or pulled on a daily basis _____

OFFICE WORK

If your injury has occurred from office work only, please fill out the following:
☐ Sit at desk ☐ Walk ☐ Stand ☐ Stoop ☐ Hold ☐ Carry ☐ Other_____
Give percentage if applicable_____ Do you operate office machinery? ☐ Yes ☐ No
If "Yes", what type? _____
If your work is at a desk, give specifics of job, computer, typewriter, business machines, phone, etc._____
_____
If walking, where to and job classification_____
Do you carry anything or pick anything up? ☐ Yes ☐ No If "Yes", what? _____

PREVIOUS WORK HISTORY

Give a job description of services or work performed for each job classification or source of employment for the preceding ten (10) years.

1. _____
2. _____
3. _____
4. _____
5. _____

Was a pre-employment exam performed or required? ☐ Yes ☐ No
Date_____ Doctor_____ Place_____
Have you ever applied for Worker's Compensation benefits before? ☐ Yes ☐ No Date_____
Reason_____
Was there a time loss for work? ☐ Yes ☐ No From_____ To_____ Year_____
State the degree of recovery_____
Did you retain legal counsel for these injuries? ☐ Yes ☐ No If "Yes", give name and address_____
_____

PRESENT WORK HISTORY

What is the job classification of your normal job? _____
Were you performing your normal job? ☐ Yes ☐ No What shift were you working? _____
How long have you been at your present job? _____ Has there been a time loss or absentee-ism caused from job injury? ☐ Yes ☐ No If "Yes", explain? _____
Average work week _____Hours _____Days

JOB CONDITIONS

Type of building_____
Type of floor ☐ Rough ☐ Smooth ☐ Concrete ☐ Steel ☐ Other_____
Type of windows ☐ Open ☐Closed ☐No windows
Type of ventilation in the building ☐Blower ☐A/C ☐Heat ☐Exhaust ☐None ☐Other_____
Type of lighting in the building ☐ Fluorescent ☐ Overhead ☐On machine ☐Other_____
Are you tired when you go home at night? ☐Yes ☐No
Do you have any outside jobs? ☐Yes ☐No If "Yes", what type? _____
Do you participate in any company-sponsored programs such as exercise, sports, etc.? ☐Yes ☐ No
If "Yes", describe_____
Type of shop ☐ Union ☐ Non-union
Has outside help been hired? ☐ Yes ☐ No If "Yes", why? _____
How many employees are in the plant? _____ How many employees per shift? _____
How many employees do your job? _____ What is the current injury ratio for that job? _____
How many employees have been injured doing your job? _____ Do you like your job? ☐ Yes ☐ No
If off work, do you want to return to your job? ☐ Yes ☐ No
What changes would you make in your job? _____
_____

_____ _____
Patient Signature Date

_____ _____
Staff Signature Date

MARK PAIN AREA

+++	Burning
000	Stabbing
- - -	Sharp
|||	Constant