WORKERS' COMPENSATION HISTORY

Name:_____ Age:_____ DOB___-___-____ Male___ Female___
Address _____ City _____ State_____ Zip _____
S.S.# _____ Driver's License # _____
Employer's Name_____ Telephone _____
Address _____ City _____ State _____ Zip _____
Have you retained legal counsel for this injury? Yes _____ No _____
If marked Yes, Provide Attorney Name, Address & Phone Number:

_____

_____

INJURY DESCRIPTION

Date present injury was received _____ Time of injury_____AM/PM
Overtime _____ Yes _____ No
Witness to the accident? Name _____ Title _____
Who reported accident? Name _____ Title _____
What medical attention was rendered? _____

_____

Whom by? Nurse _____ M.D. _____ D.O. _____ D.C. _____ Other employee _____ Other _____
How did this injury occur? _____

_____

Chief Complaint _____
Symptoms _____
Since the injury, are your symptoms: improving _____ the same _____ getting worse _____
If working on a machine, give description _____
Do you use foot or hand levers? Yes _____ No _____ Do you work overhead? Yes _____ No _____
Do you have to reach? Yes _____ No _____ If Yes, Where? _____
Movements on the job: do you move to your? Right ___ Left ___ Up ___ Down ___ Under ___ Over ___
From where to where? _____ Do you left 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", give specifics _____
Do you use a cart? Yes ____ No ____
If "Yes", Two-wheeled ____ Four-wheeled ____ Type of wheels: Rubber ____ Steel ____ Plastic ____
Condition of cart: Good ____ Bad ____ Other ____ # of carts being pushed or pulled 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 of applicable _____% did you operate office machinery? Yes _____ No _____
If "Yes", what type? _____
If you work 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? _____

I certify that the above information is correct to the best of my knowledge.

Signed _____ Date _____