

WORKERS' COMPENSATION HISTORY

Name: _____ Age: _____ Date of birth: ____/____/____ Male Female
Address: _____ City: _____ State: _____ Zip: _____
Social Security #: _____ Driver's License #: _____ State: _____
Employer's Name: _____ Telephone #: _____
Address: _____ City: _____ State: _____ Zip: _____
Carrier's Name: _____ Telephone #: _____
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 MD DO DC Other employee Other _____
How did the 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 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 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 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 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 Workers' Compensation benefits before? Yes No Date: ___/___/___

Reason: _____

Was there a time loss from work? Yes No From: ___/___/___ to ___/___/___

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? _____ Average workweek _____ hours _____ days

Has there been a time loss or absenteeism caused from job injury? Yes No If yes, explain: _____

JOB CONDITIONS

Type of building: _____

Type of floor: Rough Smooth Wood 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 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? Yes No 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 |



