WORKERS' COMPENSATION PATIENT HISTORY

Name: ______________________________ Date: ______________

HISTORY OF OCCURRENCE

Employer's business name (at time of accident): ______________________________

Employer's Phone: ______________ Employer's Address: ______________________

City: ______________ State: ______________ Zip: ______________

Occupation ______________ Describe your job: ______________

Date of Injury: __________ Time of Injury: __________ AM PM Last date worked: __________

What were you doing at the time you were injured? How did the accident/injury happen (*lifting, bending, walking, carrying, standing, etc.*)? ______________________________

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When did pain begin? Where in your body did you first feel it? Was pain intense at first, or did you feel pain that gradually worsened? *PLEASE BE SPECIFIC:* ______________________________

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Describe the environmental conditions which may have contributed to your present injury: Darkness, faulty equipment, slippery floor, limited space. (*Distinguish natural hazards from hazards created by other employees)*:

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FIRST, SECOND AND THIRD DOCTOR(S)/HOSPITAL(S) SEEN

Were you hospitalized as a result of this accident? ☐ No

If yes, what hospital did you go to? ______________________________

DOCTOR 1: Name ______________________ Date of first visit: ______________

Were you examined? ☐ Yes ☐ No Were X-Rays taken? ☐ Yes ☐ No

Did you receive treatment? ☐ No

If yes, what kind of treatment did you receive? ______________________________

What benefits did you receive from the treatment? ______________________________

Date of last Treatment ______________________

DOCTOR 2: Name ______________________ Date of first visit: ______________

Were you examined? ☐ Yes ☐ No Were X-Rays taken? ☐ Yes ☐ No

Did you receive treatment? ☐ No

If yes, what kind of treatment did you receive? ______________________________

What benefits did you receive from the treatment? ______________________________

Date of last treatment: ______________________________

DOCTOR 3: Name ________________________________ Date of first visit: __________________________

Were you examined? ☐ Yes ☐ No Were X-Rays taken? ☐ Yes ☐ No

Did you receive treatment? ☐ No

If yes, what kind of treatment did you receive? ____

What benefits did you receive from the treatment? ____

Date of last treatment: ______________________________

Report Accident To/Accident Witness

What date did you report this injury? __________________________

Whom did you report this to? ____

What is their position? ____

Was there a witness to your injury? ☐ Yes ☐ No

If yes, what was the witness' name? ____

What is their position? ____

Prior Similar Symptoms

Did you have any physical complaints just before this accident? ☐ No

If yes, please describe any physical complaints just before this accident___________________________

Have you ever had any prior injuries, accidents, diseases, or treatment to the area of you body now affected? ☐ No

If yes, state which part of your body was previously injured: ___________________________________

Date hurt: ___________________________ Describe the injury: ___________________________________

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Were you treated? ☐ No

If yes, who treated you? ____

What date did you begin treatment? ______________________ When did treatment end? _______________

When was the last time (date) you felt pain or problems from that injury? ___________________________

Work Status History

Have you lost any time from work as a result of this new injury? ☐ No

If yes give dates of time loss: ____

If you are currently on disability (time loss) do you want to go back to work doing your regular work duties? ☐ Yes

If no, state why you don't want to go back to your regular work duties: _____________________________

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Have you gone back to work? ☐ No

If yes, what status of work? ☐ Modified ☐ Regular When: ____

Please list what restrictions you have been placed on: ______________________________________

If you have gone back to work, please list the activities as:

Those that are painful: ____________________

Those that are difficult: ____________________

Are there any problems you have with a fellow employee, supervisor, or management that need to be discussed? ☐ No

If yes, please discuss: ____________________

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ACTIVITIES OF DAILY LIVING

Do you find any activities that you perform at home painful or difficult? ☐ No

If yes, list those home activities that you are unable to do *be specify*: ____________________

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Those home activities that are painful are *(be specific)*: ____________________

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Those home activities that are difficult are *(be specific)*: ____________________

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Are you performing exercises at home at this time? ☐ No

If yes, what exercises are they? ____________________

How frequently do you perform them? ____________________

Who prescribed these exercises to you? ____________________

What exercises or activities could you do before this work related injury that you no longer do because of pain or loss of function? ____________________

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LEGAL REPRESENTATION

Do you have an attorney on this case? ☐ No

If yes, who? Name: ____________________

Address: ____________________ City/State/Zip: ____________________