WORKERS' COMPENSATION HISTORY

Name_________________________________ Age____ Date of Birth____________________ ❑Male ❑Female

Address_____________________________________ City______________________ State_____ Zip___________

SS #____ Drivers 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. O. ❑D.C. ❑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 levels? ❑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 are 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 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 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:____

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______________ 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 absenteeism caused from job injury? ❑Yes ❑No If yes, explain____

Average work week __________________Hours ____________________ Days_______________________

JOB CONDITIONS

Type of building____

Type of floor ❑Rough ❑Smooth ❑Wood ❑Concrete ❑Steel ❑Tile ❑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 you job? ❑Yes ❑No

What changes would you make in your job?______________________

____

_________________________ _____________

Patient Signature Date

MARK PAIN AREA	
+++	Burning
000	Stabbing