WORK / COMP HISTORY

Patient _____ Phone ( ) _____

Address _____ City _____ State _____ Zip _____

Age _____ Birthdate _____ Sex _____ S/S # _____

Name of Compensation Carrier: _____ Phone ( ) _____

Address of Carrier: _____ City _____ State _____ Zip _____

Employer's Name: _____ Phone ( ) _____

Employer's Address: _____ City _____ State _____ Zip _____

1. Type of Business _____ Your Occupation _____
2. Date Injured _____ Hour _____ AM / PM Last Date Worked _____ Are you off work? ( ) Yes ( ) No
3. Previous Workers' Compensation Injury? ( ) Yes ( ) No
4. Accident reported to employer? ( ) Yes ( ) No Name of person reported accident to _____
5. Injured at: _____ City _____ State _____ Zip _____
6. Length of time worked there prior to accident: _____
7. Type of work being done at time of injury: _____

   _____
8. In your own words, please describe accident: _____

   _____

   _____

   _____
9. Have you been treated by another doctor for this accident? ( ) Yes ( ) No

   If yes, please list doctor's name and address: _____

   _____

   What type of treatment did you receive? _____

   How long were you treated by this doctor? _____
10. Are you: ( ) improved ( ) unchanged ( ) getting worse
11. What types of medicines are you taking? _____

    _____

    Do these medicines help? ( ) Yes ( ) No ( ) Don't know
12. Have you had physical therapy? ( ) Yes ( ) No If yes, how often?

    ( ) Daily ( ) Every other day ( ) Several times a week ( ) Weekly ( ) Every other week

    ( ) Monthly ( ) Other _____

    Does the physical therapy help? ( ) Yes ( ) No ( ) Don't know
13. Prior to this accident, have you ever had any of the physical complaints similar to what you have now?

    ( ) Yes ( ) No ( ) Don't know

    If yes, describe: _____

    _____

    _____

    Were these similar complaints the results of a previous accident(s)? ( ) Yes ( ) No

    Please provide details of accident(s): _____

    _____

    _____