WORKERS COMPENSATION INJURY INFORMATION

PATIENT:_____ EMPLOYER:_____

DESCRIBE ACCIDENT: Date of Injury:_____ Time:_____

Was injury reported to your employer?_____ When:_____

To whom:_____ When:_____

Where did it occur?_____

What were you doing?_____

How did accident happen (please be specific, i.e., how heavy, how big, etc.)?

_____

_____

_____

_____

Did you continue to work?_____ How long?_____

Hospitalized?_____ Date:_____ X-rays?_____ Date:_____

Unconscious?_____ Fractures?_____ Cuts?_____ Abrasions?_____

Other doctors seen for this injury:_____

Immediate symptoms:_____

Current symptoms:_____

Have you had pain in the same area before?_____

When?_____

History of industrial accident, auto accident, fall, surgery, etc.

_____

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