



WORKER COMPENSATION HISTORY

Last Name _____ First Name _____ Phone (____) _____

Address _____ City _____ State _____ Zip _____

Age ____ DOB ____/____/____ Sex ____ Social Security # ____/____/____

Name of Compensation Carrier _____ Phone # (____) _____ Ext _____

Adjuster Name _____ Claim # _____ Fax (____) _____

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 Accident reported to employer? Yes No Name of person accident reported to _____

4 Injured at _____ City _____ State _____ Zip _____

5 Length of time worked there prior to accident _____

6 Type of work being done at time of injury _____

7 In your own words, please describe the accident _____

8 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? _____

9 Are you: Improved Unchanged Getting Worse

10 What types of medicine are you taking? _____

Do these medicines help? Yes No Don't know



11 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

12 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

13. Were these similar complaints the result of a previous accident? Yes No

Please provide details of accidents

14. Have you had any other serious accidents which required medical care? Yes No

Please describe

15. Have you had any surgeries? Yes No - If yes, list types of surgery and date below

16. Have you had any nervous or mental illnesses? Yes No

Have you had psychiatric care? Yes No

17. Have you received a medical discharge from the Armed Forces? Yes No

18. Have you returned to work since these accidents? Yes No

If you have returned to work since your accident, please fill out the information below:

Date	Employer	Occupation	Light Duty or Regular Duty	Full Time or Part Time
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