WRITE LEGIBLY

WORKERS' COMPENSATION PATIENT HISTORY

WRITE LEGIBLY

NAME_____DATE_____FILE#_____

30 HISTORY OF OCCURRENCE

10 Employer's business name (at the time of accident) _____
Employer's phone _____ Employer's address _____
City _____ State _____ Zip _____
Occupation: _____ Describe your job: _____
What were you doing at the time you were injured? How did the accident/injury happen (lifting/bending, walking, carrying, standing, etc.)? _____
_____
_____
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? *(Be specific):* _____
_____
_____

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

40 FIRST DOCTOR/HOSPITAL/CLINIC SEEN

10 Were you hospitalized as a result of this accident? ☐No
20 What doctor/hospital/clinic did you go to? _____
DOCTOR 1: Name _____ Date of first visit: _____
Were you examined? ☐Yes ☐No Were X-rays taken? ☐Yes ☐No
30 Did you receive treatment? ☐No
40 If yes, what kind of treatment did you receive? _____
What benefits did you receive from the treatment? _____
50 Date of last treatment? _____

50 SECOND DOCTOR/CLINIC SEEN

10 DOCTOR 2: Name _____ Date of first visit: _____
Were you examined? ☐Yes ☐No Were X-rays taken? ☐Yes ☐No
20 Did you receive treatment? ☐No
30 If yes, what kind of treatment did you receive? _____
What benefits did you receive from the treatment? _____
40 Date of last treatment? _____

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60 THIRD DOCTOR/CLINIC SEEN

10 DOCTOR 3: Name _____ Date of first visit: _____
Were you examined? ☐Yes ☐No Were X-rays taken? ☐Yes ☐No

20 Did you receive treatment? ☐No

30 If yes, what kind of treatment did you receive? _____
What benefits did you receive from the treatment? _____

40 Date of last treatment? _____

70 REPORT ACCIDENT TO/ACCIDENT WITNESS

10 What date did you report this injury? _____
Whom did you report this to? _____ What is their position? _____

20 Was there a witness to your injury? ☐No

30 If yes, what was the witness' name? _____ What is their position? _____
Other witness' name? _____ What is their position? _____

80 PRIOR SIMILAR SYMPTOMS

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

20 If yes, please describe any physical complaints **just before this accident?** _____
_____

30 Have you **EVER** had any **PRIOR** injuries, accidents, diseases, or treatment to the are of your body now affected? ☐No

40 If yes, state what part of your body was previously injured: _____
Describe the injury: _____
_____ Date injured: _____

50 Were you treated? ☐No

90 WORK STATUS HISTORY

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

20 If yes, gives dates of times loss: _____

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

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

50 Have you gone back to work? ☐No

51 If yes, what status or work? ☐Modified ☐Regular When (Date): _____

60 Please list what restrictions you have been placed on: _____
_____

70 If you have gone back to work, please list the activities as:
Those that are painful: _____

80 Those that are difficult: _____

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

100 If yes, please discuss: _____
_____
_____

100 ACTIVITES OF DAILY LIVING

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

20 If yes, those **home** activities that you are **unable** to do (be specific): _____

_____

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

_____

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

_____

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

60 If yes, what exercises are they? _____

How frequently do you perform them? _____

Who prescribed these exercises to you? _____

70 What exercises or activities could you do before he work-related injury that you no longer do because of pain or loss of function? _____

_____

_____

ATTORNEY ON CASE

DO YOU HAVE AN ATTORNEY ON THIS CASE? ☐No

If yes, who? Name: _____ Phone: _____

Address: _____ City: _____ State: ____ Zip: _____

Patient Signature: _____ Date: _____

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