Work/Comp History

Patient: ____ Phone: _____________________

Address:________________________________ City:_________________ State:____ Zip:______

Age:_____ Birthdate: ___/___/____ Sex: M___ F___ SS#________________________________

Name of Compensation Carrier:___________________________ Phone:____________________

Address of Carrier:________________________City:_________________ State:____ Zip:______

Employer's Name:______________________________________ Phone:____________________

Address of Employer:________________________City:_______________ State:____ Zip:______

1. Type of Business:____________________________ Occupation:_____________________
2. Date Injured:_________ Hour:____ AM/PM Last Date Worked:_______ Off Work? Y_ N_
3. Previous Workers' Compensation injury? Yes___ No___
4. Accident reported to employer? Y__ N__ Name of person reported 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: Y___ N___
   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 medications help? Yes__ No__ Don't Know__
12. Have you had physical therapy help? Y___ N___
    If yes, How often? Daily___ Every other Day___ Several times/Week___ Weekly___
    Every other week___ Monthly___ Other_______________________________________
13. Prior to this accident, have you ever had any of the physical complaints similar to what you have now? Yes___ No___
    If yes, describe:____
    ____

Were these similar complaints the results of a previous accident(s)?: Y___ N___
Please provide details of accident(s):____
____
____

14. Have you had any other serious accidents which required medical care? Y__N__
____
____
15. Have you had any serious illnesses that required hospitalization? Y__N__
Describe:____
____
____
16. Have you had any surgeries? Y__N__
If yes, list type of surgery and date: ____
____
____
17. Have you had any nervous or mental illnesses? Y__N__
Have you had psychiatric care? Y__N__
18. Have you received a medical discharge from the Armed Forces? Y___N___
19. Have you returned to work since this accident? Y___N___
If you have returned to work since your accident, please fill out the information below:

Date	**Employer**	**Occupation**	**Light Duty or Reg. Duty**	**Full-Time or Part-Time**