

WORKERS' COMPENSATION HISTORY

Name _____ Age _____ Date of Birth _____ Male Female
Address _____ City _____ State _____ Zip _____
SS# _____ Driver's Lic. # _____
Employer's Name _____ Tel. # _____
Address _____ City _____ State _____ Zip _____
Carrier's Name _____ Tel. # _____
Address _____ City _____ State _____ Zip _____
Have you retained legal counsel for this injury? Yes No If "Yes," give name and address: _____

INJURY DESCRIPTION

Date present injury was received _____ Time of injury _____ AM PM Overtime? Yes No
Who saw the accident? Name _____ Title _____
Who reported the accident? Name _____ Title _____
What medical attention was rendered? _____
By whom? Nurse M.D. D.O. D.C. Other employee Other _____
How did the injury occur? _____
Chief complaint _____
Symptoms _____
Since the injury, are your symptoms Improving The same Getting worse
If working on a machine, give description _____
Do you use foot or hand levers? Yes No Do you work overhead? Yes No
Do you have to reach? Yes No Where? _____
Movements on the job: Do you move to your Right Left Up Down Under Over
Do you pick up or lift? Yes No If "Yes," how much? _____ How often? _____
From where to where? _____ Do you lift from Ground Bench Platform
 Box Pallet Other (Please describe) _____
Do you lift in or out of a machine? Yes No If working at a machine, do you Sit Stand Kneel
Is your work area cluttered? Yes No If "Yes," with what? _____
Is your work area Oily Dirty Slippery Other _____
In your job do you push or pull? Yes No If "Yes," give specifics _____
Do you use a cart? Yes No Two-wheel Four-wheel Type of wheels Rubber Steel Plastic
Condition of cart Good Bad Other _____ Number of carts being pushed or pulled at once _____
Total amount of weight being pushed or pulled on a daily basis _____

OFFICE WORK

If your injury has occurred from office work only, please fill out the following:

Sit at desk Walk Stand Stoop Hold Carry Other _____
Give percentage if applicable _____ Do you operate office machinery? Yes No
If "Yes," what type? _____
If your work is at a desk, give specifics of job, computer, typewriter, business machines, phone, etc. _____

If walking, where to and job classification _____
Do you carry anything or pick anything up? Yes No If "Yes," what? _____

PREVIOUS WORK HISTORY

Give a job description of services or work performed for each job classification or source of employment for the preceding ten (10) years.

- 1. _____
- 2. _____
- 3. _____
- 4. _____
- 5. _____

Was a pre-employment exam performed or required? Yes No

Date _____ Doctor _____ Place _____

Have you ever applied for Workers' Compensation benefits before? Yes No Date _____

Reason _____

Was there a time loss from work? Yes No From _____ To _____ Year _____

State the degree of recovery _____

Did you retain legal counsel for these injuries? Yes No If "Yes," give name and address _____

PRESENT WORK HISTORY

What is the job classification of your normal job? _____

Were you performing your normal job? Yes No What shift were you working? _____

How long have you been at your present job? _____ Has there been a time loss or absenteeism caused from job injury? Yes No If "Yes," explain _____

Average work week _____ Hours _____ Days _____

JOB CONDITIONS

Type of building _____

Type of floor Rough Smooth Wood Concrete Steel Other _____

Type of windows Open Closed No windows

Type of ventilation in the building Blower A/C Heat Exhaust None Other _____

Type of lighting in the building Fluorescent Overhead On machine Other _____

Are you tired when you go home at night? Yes No

Do you have any outside jobs? Yes No If "Yes," what type? _____

Do you participate in any company-sponsored programs such as exercise, sports, etc.? Yes No

If "Yes," describe _____

Type of shop Union Non-union

Has outside help been hired? Yes No If "Yes," why? _____

How many employees are in the plant? _____ How many employees per shift? _____

How many employees do your job? _____ What is the current injury ratio for that job? _____

How many employees have been injured doing your job? _____ Do you like your job? Yes No

If off work, do you want to return to your job? Yes No

What changes would you make in your job? _____

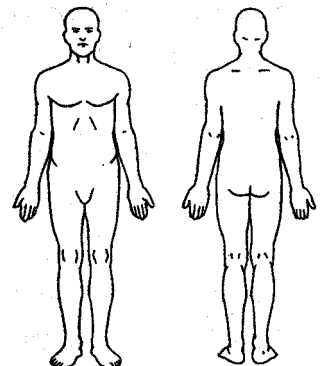
Patient Signature

Date

Staff Signature

Date

MARK PAIN AREA	
+++	Burning
000	Stabbing
---	Sharp
	Constant



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