

# 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

