WORK-RELATED ACCIDENT/INJURY HISTORY

Date ______________

Name ____ Date of Birth ______________ Age _______________

Please read each question carefully and answer all that apply to your most recent work-related accident.

EMPLOYER/OCCUPATION

Date of Accident / Injury _________________________ Time of Accident ________________ AM / PM

Type of Business _______________________________ Your Occupation ______________________________

Accident reported to employer? ☐ Yes ☐ No Accident claim filed? (Form 801) ☐ Yes ☐ No

Name of person reported accident to ______________________Witness of Accident ______________________

Injured at ______________________________ City ____________________ State _______ Zip ________

Length of time worked there prior to accident ____

Previous Workers' Compensation injury? ☐ Yes ☐ No If Yes, When? __________________________

DESCRIPTION OF THE ACCIDENT

Please describe how you were injured ____

____

____

If lifting, how much weight was involved? ___________ What position were you in? ______________________

Was the accident caused by someone besides you? ☐ Yes ☐ No If yes, who? ______________________

What, if any, kind of equipment was involved? ____

What is the function of this equipment? ____

Was the accident caused by failure of equipment or a product? ☐ Yes ☐ No If yes, what was it? ___________

If struck by an object, what was it? _______________________ Where were you struck? __________________

If you fell, how far did you fall? _________________________________ ☐ Inside ☐ Outdoors

What body parts were impacted? ☐ Chest ☐ Knee ☐ Shoulder ☐ Hand ☐ Foot
☐ Hip ☐ Back ☐ Other ________________________

What physical conditions may have contributed to the present injury? (icy, slippery floor; object in the way, etc.)

____

____

CURRENT DISABILITY / WORK STATUS

Last Date Worked ______________________________ Are you off work now? ☐ Yes ☐ No

If yes, name of person authorizing this ____

Have you lost time from work as a result of this accident? ☐ Yes ☐ No

If yes, are you being compensated for time lost from work? ☐ Yes ☐ No

Has modified work or a reduced work load been offered to you as the result of your injuries? ☐ Yes ☐ No

Patient Name ______________________________ Date ____________

PAST MEDICAL TREATMENT

Have you been treated by another doctor for this accident? ☐ Yes ☐ No

If yes, please list the doctor's name and address ______________________________

____

What type of treatment did you receive? ______________________________

How long were you treated by this doctor? ______________________________

Were X-rays taken? ☐ Yes ☐ No Date of X-rays ____________

Where were X-rays taken? ______________________________

Since your accident, are you: ☐ Improved ☐ Unchanged ☐ Getting Worse

What types of medications are you taking? ______________________________

Do these medications help? ☐ Yes ☐ No ☐ Unknown

Have you had any physical therapy or chiropractic care? ☐ Yes ☐ No

If yes, how often? ☐ Daily ☐ Every other day ☐ Several times a week ☐ Weekly
☐ Every other week ☐ Monthly ☐ Other ____________

Does/did physical therapy/chiropractic care help? ☐ Yes ☐ No ☐ Don't know

Prior to this accident, have you ever had any of the physical complaints similar to what you have now?

☐ Yes ☐ No If yes, please describe ______________________________

____

Were these similar complaints the result of a previous accident(s)? ☐ Yes ☐ No

If yes, please provide details of that/those accident(s) ______________________________

____

By my signature below, I am verifying that the above information is true to the best of my knowledge.

______________________________ ____________

Patient Signature Date

DOCTOR'S NOTES