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?_____

(over)

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?_____

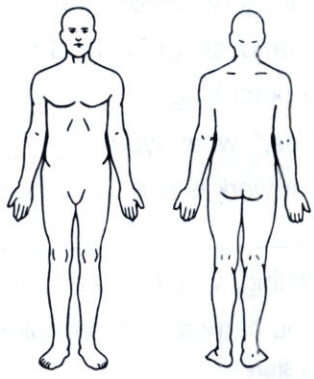
How many employees do your job?_____ What is the current injury ratio for that job?_____

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?_____

_____



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

_____ _____

Patient Signature Date

_____ _____

Staff Signature Date