WORKER'S COMPENSATION HISTORY

PATIENT____ MALE / FEMALE DATE_____________

ADDRESS____________________________________CITY________________STATE________ZIP_______________

HOME PHONE__________________WORK PHONE_________________ AGE________D.O.B._______________

NAME OF COMPENSATION CARRIER____

PHONE______________________________ SUPERVISOR'S NAME_____________________________________

ADDRESS OF COMPENSATION CARRIER____

____CLAIM #_____________________________________

EMPLOYERS NAME____PHONE_________________________

ADDRESS____

OCCUPATION____

DATE OF INJURY_____________________________________TIME____________________ A.M. / P.M.

WHAT IS YOUR HEALTH CONCERN?____

ARE YOU OFF WORK? YES NO LAST DATE WORKED?___________________________

HAVE YOU RETURNED TO WORK SINCE THE ACCIDENT? YES NO DATE_____________________

ANY PREVIOUS WORKERS COMPENSATION INJURIES? YES NO DATE_____________________

LENGTH OF TIME WORKED PREVIOUS TO INJURY____

EXPLAIN DETAILS OF THE ACCIDENT____

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HAVE YOU BEEN TREATED BY ANOTHER DOCTOR FOR THIS CONDITION? YES NO

IF YES, LIST DR.'S NAMES AND NUMBERS____

PRIOR TO THE ACCIDENT, HAVE YOU EVER HAD COMPLAINTS SIMILAR TO THE ONES YOU ARE EXPERIENCING NOW? YES NO

DESCRIBE____

PATIENT'S SIGNATURE____DATE______________________

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