

WORKERS' COMPENSATION QUESTIONNAIRE

In cases where injury is sustained at your workplace we must make sure we have all the information needed to convey an accurate story to your Workers Compensation Carrier. Please answer all questions in as much detail as possible.

Patient Name: _____ Date: _____

INSURANCE INFORMATION

Your employer's name: _____ Phone #: _____

Your employer's workers' comp. insurance co.: _____ Phone #: _____

Address: _____

Claim#: _____ Service Representative: _____

Your health insurance co. _____ Phone #: _____

Address: _____

ID#: _____ Group #: _____

If you have retained an attorney:

Name: _____ Phone#: _____

Address: _____

ACCIDENT INFORMATION

Please explain in detail how your accident happened: _____

Give time and date present injury occurred: _____ am/pm _____/____/____

Was a witness present at the time of the incident: Yes No

Did you feel immediate pain after the accident: Yes No Where? _____

If not then when did you experience the pain? _____

Did you lose consciousness during the accident? Yes No If yes, how long? _____

Where did you go after the accident?

Home Back to Work Hospital Private Doctor

Did you report the accident to your supervisor? Yes No

When? _____ Name: _____

Has your employer acknowledged your accident? Yes No

Have you missed any work? Yes No When? _____

If yes, have you returned to work? Yes No If so, date returned to work: _____

Are your work activities restricted as a result of this accident? Yes No

If so, explain: _____

Before this injury, were you capable of working on an equal basis with others your age? Yes No

List any other comments relative to this accident: _____

List any other complaints/health concerns not directly related to this accident: _____

INFORMATION REGARDING YOUR INJURY

Have you tried any home remedies for your injury (aspirin, heating pad, ice pack, etc)?

What aggravates your injury (i.e.; sitting, walking, bending, etc.)?

What makes your injury better? _____

Since the injury, are your symptoms: Getting better/ Worse / About the Same

Have you seen any other health care providers for this injury? Yes No (If yes, complete this section)

Doctor's names and addresses: _____

What examinations/treatments did you receive?

Doctor's diagnosis (if known): _____

Doctor's recommendations: _____

Currently being treated? Yes No

List any other comments relative to this injury:

INJURY DETAIL

Please circle area(s) of injury and describe your symptoms using the codes listed below.

N - Numbness

P - Pain

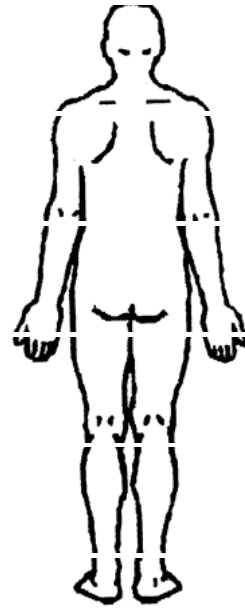
T - Tingling

A - Ache

ST - Stiffness

MSP - Muscle Spasm

S - Soreness



I attest that the above given information is complete and accurate to the best of my knowledge.

Signature: _____ Date: _____