

Name _____ File # _____ Date _____

WORKERS' COMPENSATION - PATIENT DATA FORM - WC/PDF

Worker's Legal Name _____ Time of Injury _____ AM/PM
Worker's Street Address _____ Date of Injury _____
City _____ State _____ Zip _____ Worker's Phone _____
Date of Birth _____ Female _____ Male _____ Last Date Worked _____
Social Security Number _____

1 Employer's Business Name (at time of accident) _____
Employer's Phone _____ Employer's Address _____
City _____ State _____ Zip _____

2 Occupation _____ Describe your job. _____

3 What were you doing at the time you were injured? How did the accident/injury happen (lifting, bending, walking, carrying, standing, etc.)?

4 When did pain begin? Where did you first feel it? Was pain intense at first, or did you feel pain that gradually worsened? Please be specific.

5 Describe the physical conditions which may have contributed to your present injury: Darkness, faulty equipment, slippery floor, limited space. (Distinguish natural hazards from hazards created by other employees such as housekeepers.)

6 Were you hospitalized as a result of this accident? No/Yes
If yes, where _____
How many doctors have you seen for this injury? _____ Please detail whom and what treatment you received (drugs, adjustments, physiotherapy, exercises, braces).

7 Doctor 1. Name _____ Date of first visit _____

8 Were you examined? No/Yes. Were X-rays taken? No/Yes. What body parts? _____

9 What kind of treatment did you receive? _____

10 What benefits did you receive from the treatment? _____
_____ Date of last treatment _____

11 Doctor 2. Name _____ Date of first visit _____
12 Were you examined? No/Yes. Were X-rays taken? No/Yes.
13 What kind of treatment did you receive? _____
14 What benefits did you receive from the treatment? _____
_____ Date of last treatment _____

15 Doctor 3. Name _____ Date of first visit _____
16 Were you examined? No/Yes. Were X-rays taken? No/Yes.
17 What kind of treatment did you receive? _____
18 What benefits did you receive from the treatment? _____
_____ Date of last treatment _____

19 What date did you report this accident? _____ Whom did you report this
to: _____
What is their position? _____
20 Was there a witness to your accident/injury? No/Yes.
21 If yes, what was their name? _____. What is their
position? _____.
22 Have you ever had any PRIOR injuries, accidents, diseases, or treatment to the
area of your body now affected? No/Yes. If yes, answer specific dates and
treatment (from when to when).
23 If yes, state what part of your body was PREVIOUSLY injured: _____
Date hurt: _____ Describe the accident: _____
24 Who treated you? _____
25 What date did treatment begin _____ and end _____
26 When was the last time you felt pain or problems from that injury? _____

27 Have you lost any time from work as a result of this new injury? No/Yes
28 If yes, give dates: _____
29 If you are currently on disability (time loss) do you want to go back to work
doing your regular work duties? No/Yes.
30 If no, state why: _____
31 Have you gone back to work? No/Yes.
32 If yes, when _____. What status of work? Modified _____ Regular _____
33 If modified, please list what restrictions you have been placed on: