WORKER COMPENSATION INFORMATION

Date_____

PATIENT INFORMATION

Name_____ Birthdate_____ Soc. Sec. #_____

Address_____

_____

Telephone_____ Occupation_____

EMPLOYER

Employer Name_____

Employer Address_____

_____

Employer Telephone_____ Injury Verified By (For Office Use)_____

Contact Person_____

WORKER COMPENSATION CARRIER (FOR OFFICE USE)

Worker Compensation Carrier_____

Carrier Address_____

_____

Carrier Phone Number_____ Coverage Verified by_____

Adjuster's Name_____ Claim Number_____

INJURY INFORMATION

Date of Injury_____ Time_____ ☐ AM ☐ PM

Place of Injury_____

Accident reported to employer? ☐ Yes ☐ No Name of person you reported accident to_____

Give full description of how accident happened_____

_____

_____

_____

_____

Have you lost time from work? ☐ Yes ☐ No How much?_____

Other doctors seen for this condition:

Doctor's Name_____ Diagnosis_____

Were X-Rays taken? ☐ Yes ☐ No Other Tests? ☐ Yes ☐ No

If yes, by whom? Please list test(s) and result(s)_____

_____

_____

_____

Any previous Worker Compensation injuries? ☐ Yes ☐ No Date(s) of previous injuries_____

Describe previous Worker Compensation injuries_____

AUTHORIZATION

I clearly understand and agree that all services rendered to me are charged directly to me and that I am personally responsible for payment in the event that my claim for Workers Compensation benefits is denied.

Patient's Signature_____ Date_____

ABOUT YOUR CONDITION

I am here for wellness.	[]N/A	
Do you experience pain every day?	[]No	[]Yes
Do your symptoms interfere with daily life?	[]No	[]Yes
Does the pain interfere with your sleep?	[]No	[]Yes
Do changes in the weather affect your symptoms?	[]No	[]Yes
Do your symptoms cause you to lose your temper?	[]No	[]Yes
Do you wear orthotics or a lift?	[]No	[]Yes
Are your symptoms worse during certain times of the day? If yes, indicate time of day.	[]No	[]Yes []Morning []Noon []Night

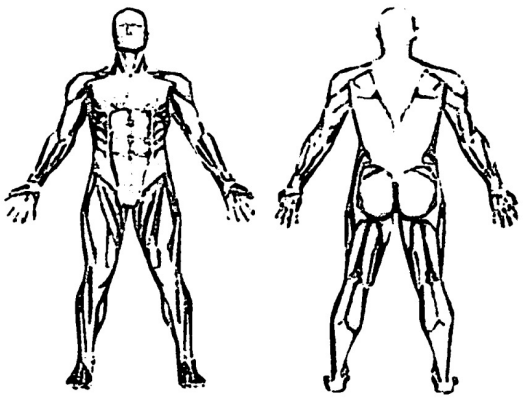
What activities aggravate your symptoms?_____

Is there anything that you can no longer do because of the pain? If yes please explain

[]No []Yes_____

What have you done to alleviate your pain?_____

Please use the following letters to indicate TYPE and LOCATION of the symptoms you currently are experiencing. A=Ache B=Burning N=Numbness P=Pins & Needles S=Stabbing O=Other



REASON FOR VISIT

Nature of visit: ☐ Wellness ☐ Recent Pain ☐ Long Term Pain ☐ Auto ☐ Work

Describe your symptoms (prioritize by severity) _____

_____

When did your symptoms start? _____

How did your symptoms begin? _____

How often do you experience your symptoms?

☐ Constantly (76-100% of the day) ☐ Frequently (51-75% of the day) ☐ Occasionally (26-50% of the day) ☐ Intermittently (0-25% of the day)

How are your symptoms changing? ☐ Getting ☐ Not Changing ☐ Getting Worse

Using a 0-10 Pai n Scale (0=No pain, 10=Most intense pain imaginable)

Rate your **current** level of pain ____ Rate your **average** pain level ____ Rate the **worst** your pain gets ____ Rate the **lowest** your pain gets ____

Has this condition occured before? ☐ Yes ☐ No

Have you seen other doctor's for this condition? ☐ Yes ☐ No

Doctor's names and specialties _____

Types of treatment _____

Results _____