WORKERS' COMP QUESTIONNAIRE Today's Date_____

Patient_____Date of injury_____

Mailing Address_____

City_____State_____Zip_____

Employer:_____

Occupation / Job title:_____

WC Insurance Company:_____Claim#_____

SSN_____ Date of Birth_____

Description of accident: _____

_____

_____

_____

What part(s) of body were affected due to this accident?_____

Did employer send you to any medical facility? □ No □ Yes, where_____

Did you consult any other doctor? □ No □ Yes, where_____

Doctor's diagnosis:_____

Did you lose any time from work? □ No □ Yes, when _____

Do any other diseases or accidents affect your employment? □ No □ Yes, explain:_____

_____

In your work, do you have to favor any part of your body? □ No □ Yes , explain:_____

_____

Have you ever had a Worker's Compensation claim before? □ No □ Yes, area of body_____

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

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

Since this injury, your symptoms have: □ Improved □ Gotten Worse □ Remained the Same

Have you retained an attorney? □ No □ Yes, _____

Patient Signature_____Date_____

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