

WORKER'S COMPENSATIONDate: / / ID #
(for office use only)

First Name: Last Name: MI:

Date of Accident: / / Claim #: Cause of Trauma:
Time of Accident: : am pm Accident Gradual Onset

Employer Name at time of Accident: Occupation:

Employer Address: City: State: Zip:

Employer Contact: Contact Phone #: ()

Adjuster: Adjustor Phone #: ()

Nurse Case Manager: Nurse Case Manager Phone #: ()

Attorney Name: Attorney Phone #:()

Attorney Address: City: State: Zip:

Are you presently working? NO YES If yes: part time full time
Last day worked: / /
Date you returned to modified work : / /
Did you receive Temp. Total Disability? NO YES State Disability? NO YESLocation of accident: Did you receive medical attention at the scene of the accident? Were you rendered unconscious? Were you: Shaken Disoriented
On the job at the address above YES NO YES NO
On the job at another location
On the job in a vehicleWhere did you go immediately following the accident? Hospital Home Personal Doctor To this office Resumed Activity Did your symptoms develop: Immediately Hours later Next Day Few days During 1st week Few wks. Few monthsHave you had any of the following: (check all that apply)
X-Ray Facility: Date: / /
MRI Facility: Date: / /
CT Scan Facility: Date: / /
Other, Explain: Facility: Date: / /Have you received any treatment for this injury? YES NO / If yes, please explain:
Where: By whom:
Prescription received: How many treatments did you receive?
Date of first appointment: / / Date of last appointment: / /

Have you had any prior surgeries? YES NO / If yes, please explain:

Prior to this accident were you experiencing any similar physical complaints? YES NO
If yes, please explain:In your own words please describe the accident and how you immediately felt afterwards?
(please describe on the back of this form)In terms of an 8 hour workday: (Circle the # of hours for each activity)
Sit 1 2 3 4 5 6 7 8 Stand 1 2 3 4 5 6 7 8 Walk 1 2 3 4 5 6 7 8 Bend/Squat 1 2 3 4 5 6 7 8On the job I perform the following activities: (Check as many as apply)
Bend/Stoop Squat Crawl Climb Reach above shoulders Crouch Kneel Push/Pull
Maintain awkward postureOn the job, I regularly lift between:
I do not lift 1-10 lbs. 11-24 lbs. 25-34 lbs. 35-50 lbs. 51-74 lbs. 75-100 lbs.

This form may be used in the determination of insurance benefits and/or litigation for compensation. It is imperative that this form be filled out completely to protect your rights of compensation.

Signature _____ Date / /

