

Name _____ Date _____ File # _____

30 HISTORY OF OCCURENCE

10 Employer's business name (at time of accident) _____

Employer's phone _____ Employer's address _____

City _____ State _____ Zip _____

Occupation _____ Describe your job: _____

Date of injury: _____ Time of injury: _____ AM PM Last date worked: _____

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

When did pain begin? Where in your body did you first feel it? Was pain intense at first, or did you feel pain that gradually worsened?

PLEASE BE SPECIFIC _____

20 Describe the environmental 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):

40 FIRST DOCTOR/HOSPITAL SEEN

10 Were you hospitalized as a result of this accident? No

20 If yes, what hospital did you go to? _____

DOCTOR 1: Name _____ Date of first visit: _____

Were you examined? Yes No Were X-rays taken? Yes No

30 Did you receive treatment? No

40 If yes, what kind of treatment did you receive? _____

What benefits did you receive from the treatment? _____

50 Date of last treatment: _____

50 SECOND DOCTOR/CLINIC SEEN

10 DOCTOR 2: Name _____ Date of first visit: _____

Were you examined? Yes No Were X-rays taken? Yes No

20 Did you receive treatment? No

30 If yes, what kind of treatment did you receive? _____

What benefits did you receive from the treatment? _____

40 Date of last treatment: _____

60 THIRD DOCTOR/CLINIC SEEN

10 DOCTOR 3: Name _____ Date of first visit: _____

Were you examined? Yes No Were X-rays taken? Yes No

20 Did you receive treatment? No

30 If yes, what kind of treatment did you receive? _____

What benefits did you receive from the treatment? _____

40 Date of last treatment: _____

70 REPORT ACCIDENT TO/ACCIDENT WITNESS

10 What date did you report this injury? _____

Whom did you report this to? _____

What is their position? _____

20 Was there a witness to your injury? No

30 If yes, what was the witness' name? _____

What is their position? _____

80 PRIOR SIMILAR SYMPTOMS

10 Did you have any physical complaints just before this accident? No

20 If yes, please describe any physical complaints just before this accident: _____

30 Have you ever had any prior injuries, accidents, diseases, or treatment to the area of your body now affected? No

40 If yes, state what part of your body was previously injured: _____

Date hurt: _____ Describe the injury: _____

50 Were you treated? No

60 If yes, who treated you? _____

What date did treatment begin? _____ When did treatment end: _____

70 When was the last time (date) you felt pain or problems from that injury? _____

90 WORK STATUS HISTORY

10 Have you lost any time from work as a result of this new injury? No

20 If yes give dates of time loss: _____

30 If you are currently on disability (time loss) do you want to go back to work doing your regular work duties? Yes

40 If no, state why you don't want to go back to your regular work duties: _____

50 Have you gone back to work? No

51 If yes, what status of work? Modified Regular When: _____

60 Please list what restrictions you have been placed on: _____

70 If you have gone back to work, please list the activities as:

Those that are painful: _____

80 Those that are difficult: _____

90 Are there any problems you have with a fellow employee, supervisor, or management that need to be discussed? No

100 If yes, please discuss: _____

100 ACTIVITIES OF DAILY LIVING

10 Do you find any activities that you perform at home painful or difficult? No

20 If yes, those home activities that you are unable to do (*be specific*): _____

30 Those home activities that are painful are (*be specific*): _____

40 Those home activities that are difficult are (*be specific*): _____

50 Are you performing exercises at home at this time? No

60 If yes, what exercises are they? _____

How frequently do you perform them? _____

Who prescribed these exercises to you? _____

70 What exercises or activities could you do before the work-related injury that you no longer do because of pain or loss of function?

Do you have an attorney on this case? No

If yes, who? Name _____

Address _____ City _____ State _____ Zip _____