

# WORKERS' COMPENSATION HISTORY

Name \_\_\_\_\_ Age \_\_\_\_\_ Date of Birth \_\_\_\_\_  Male  Female  
Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_  
SS# \_\_\_\_\_ Driver's Lic. # \_\_\_\_\_  
Employer's Name \_\_\_\_\_ Tel. # \_\_\_\_\_  
Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_  
Carrier's Name \_\_\_\_\_ Tel. # \_\_\_\_\_  
Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_  
Have you retained legal counsel for this injury?  Yes  No If "Yes," give name and address: \_\_\_\_\_

## INJURY DESCRIPTION

Date present injury was received \_\_\_\_\_ Time of injury \_\_\_\_\_  AM  PM Overtime?  Yes  No  
Who saw the accident? Name \_\_\_\_\_ Title \_\_\_\_\_  
Who reported the accident? Name \_\_\_\_\_ Title \_\_\_\_\_  
What medical attention was rendered? \_\_\_\_\_  
By whom?  Nurse  M.D.  D.O.  D.C.  Other employee  Other \_\_\_\_\_  
How did the injury occur? \_\_\_\_\_  
Chief complaint \_\_\_\_\_  
Symptoms \_\_\_\_\_  
Since the injury, are your symptoms  Improving  The same  Getting worse  
If working on a machine, give description \_\_\_\_\_  
Do you use foot or hand levers?  Yes  No Do you work overhead?  Yes  No  
Do you have to reach?  Yes  No Where? \_\_\_\_\_  
Movements on the job: Do you move to your  Right  Left  Up  Down  Under  Over  
Do you pick up or lift?  Yes  No If "Yes," how much? \_\_\_\_\_ How often? \_\_\_\_\_  
From where to where? \_\_\_\_\_ Do you lift from  Ground  Bench  Platform  
 Box  Pallet  Other (Please describe) \_\_\_\_\_  
Do you lift in or out of a machine?  Yes  No If working at a machine, do you  Sit  Stand  Kneel  
Is your work area cluttered?  Yes  No If "Yes," with what? \_\_\_\_\_  
Is your work area  Oily  Dirty  Slippery  Other \_\_\_\_\_  
In your job do you push or pull?  Yes  No If "Yes," give specifics \_\_\_\_\_  
Do you use a cart?  Yes  No  Two-wheel  Four-wheel Type of wheels  Rubber  Steel  Plastic  
Condition of cart  Good  Bad  Other \_\_\_\_\_ Number of carts being pushed or pulled at once \_\_\_\_\_  
Total amount of weight being pushed or pulled on a daily basis \_\_\_\_\_

## OFFICE WORK

If your injury has occurred from office work only, please fill out the following:  
 Sit at desk  Walk  Stand  Stoop  Hold  Carry  Other \_\_\_\_\_  
Give percentage if applicable \_\_\_\_\_ Do you operate office machinery?  Yes  No  
If "Yes," what type? \_\_\_\_\_  
If your work is at a desk, give specifics of job, computer, typewriter, business machines, phone, etc. \_\_\_\_\_

If walking, where to and job classification \_\_\_\_\_  
Do you carry anything or pick anything up?  Yes  No If "Yes," what? \_\_\_\_\_