

Worker's Compensation Case History

Name _____ Date _____

Address _____

H. Phone (_____) _____ W. Phone(_____) _____

Date of Birth _____ Occupation _____

Employer _____

Employer address _____

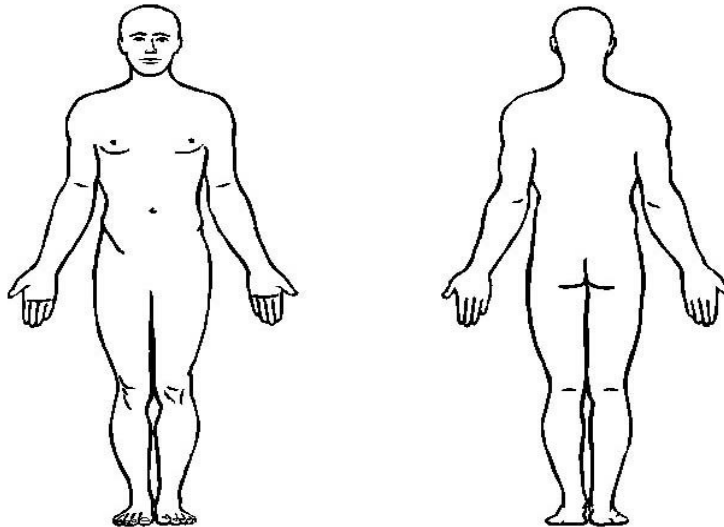
Worker's Compensation cases can be denied due to incomplete and/or unspecified details. Please take your time and do not rush your answers to the following questions. Even details you feel are minor or unimportant may jeopardize your case. It is your responsibility to follow recommendations. In the event your case is denied due to a lack of cooperation or lack of information on this form, you will be responsible for payment in full.

Date of Injury _____

Did you report your injury? YES NO To Whom? _____

SPECIFIC DETAILS OF HOW THE INJURY OCCURRED _____

Using the drawings below, locate areas of pain. BE SPECIFIC AND DETAILED!!!
Grade each affected area on a scale of 1 to 10 with 10 being the most intense.



Please circle the symptoms you have noticed due to this condition.

- | | | |
|---------------|----------------|--------------------------------|
| Headache | Numbness | Sleeping problems |
| Irritability | Chest pain | Hip pain |
| Ears Ringing | Stiffness | Radiating pain |
| Tension | Pins & Needles | Fever |
| Cold Sweats | Fatigue | Dizziness |
| Neck Pain | Soreness | Depression |
| Nervousness | Stabbing pain | Pain with coughing or sneezing |
| Upset stomach | Back pain | Mid back pain |
| Fainting | Burning | Nausea |

Other: (please explain) _____

Have you lost any days from work? _____

Have you been treated for this condition by any other Doctor? Yes No

Where did you receive treatment _____
 When did you receive treatment? _____
 What tests were performed for your symptoms? X-rays MRI CT Scan Medication given
 Other (please explain) _____
 Height _____ Weight _____

Please mark an "X" under the category that best describes your capabilities:

OK = have not noticed symptoms with this task.
DISCOMFORT = can do it but bothers or irritates you then or later on.
PAINFUL = you may still be able to do it but causes pain every time you do.
UNABLE = the pain is so bad that you cannot do it all.

	OK	DISCOMFORT	PAINFUL	UNABLE TO DO
Driving				
Housework				
Sleeping				
Computer work				
Showering				
Washing dishes				
Lawn work				
Child Care				
Cooking				
Bathroom habits				
Sitting				
Bending				
Twisting				
Kneeling				
Sex				
Squatting				
Standing				

Recreational Activities You Participate In

	OK	DISCOMFORT	PAINFUL	UNABLE TO DO
Walking				
Biking				
Golf				
Tennis				
Running				
Horseback riding				
Baseball				
Fishing				
Dancing				
Skiing				
Boating				
Volleyball				
Swimming				
Treadmill				
Weight lifting				

I have read and understand the rules and expectations of a worker's compensation case.

Patient Signature: _____

Date: _____