Workers Compensation Form

Patients Name:_____ **Date: ____ / ____ /____**

1) What was the date of the work injury? _____ / _____ /_____

2) What time did the incident occur? _____:_____ am / pm

3) What is the employer's name? _____

4) What is the employers address? _____

City / State / Zip _____

5) What is your attorney's name? _____

6) What is the attorney's address? _____

City / State / Zip _____

7) Please describe the incident in a few sentences:

_____

_____

_____

_____

_____

8) After the incident, did you report the incident to your supervisor?

Yes	No, I was not sent to a doctor after the incident

9) What is your supervisor's name?_____

10) After the incident, did your employer sent you to a doctor?

Yes	No, I was not sent to a doctor after the incident

11) What did the doctor say was wrong? _____

12) Did you go to a doctor on your own?

Yes	No

13) What was the name of the doctor? _____

14) Are there any other problems that affect your employment?

Yes	No

If yes, what is the problem _____

15) In your work, do you favor one side of your body?

Yes	No

16) If yes, what do you favor at work? _____

17) Before the injury, were you capable of equal work with others your age?

Yes	No, I was not sent to a doctor after the incident

18) Have you injured this area before?

Yes	No