Work Comp Form

Employee Information: **TODAY'S DATE: _____**

Name: _____ Male/Female:_____
Address: (complete mailing address) _____
Cell No.: (____)_____ __Cell Carrier:(ex:AT&T, Verizon, Etc.):_____
Email Address:_____
Date of Birth: _____/____/_____ Marital Status:_____ SS#:_____
Right Handed: __ Left Handed: __ Both:__ Height: _____Weight: _____
Language Preference: _____Interpreter Needed: Y or N If yes, please specify:_____
Doctor's Info:Name:_____Phone #:_____
Emergency Contact Name: _____ Phone #:_____

Employer Information (AT THE TIME OF YOUR INJURY):

Name of Business: _____ Phone #: (____)_____
Address: _____

Attorney Information: ☐ Check here if you do not have an attorney.
Name: _____ Phone #: (____) _____
Address: _____

Information About Your Work Injury:
Date Of Injury: _____ Time the injury occurred: _____ A.M./ P.M.
Date you reported your injury to your employer/supervisor:_____
Name of person to whom you reported your injury: _____
Address or description of location where your injury occurred: _____
_____

HISTORY OF THE INJURY:

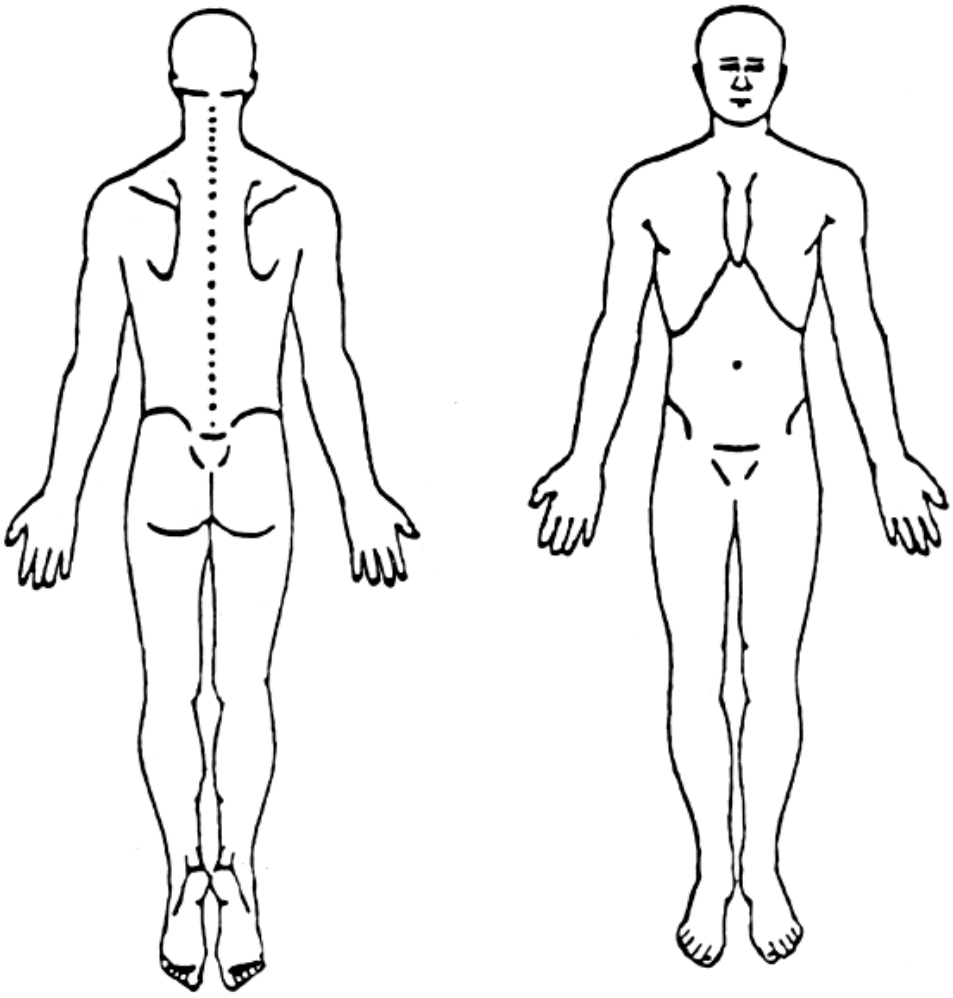
Please describe, in your own words, how your work injury occurred: _____
_____
_____
_____
_____
_____
_____***If needed, continue on the back of this page***

How did your symptoms start? Suddenly:___ Gradually:__
If Gradually, over what period of time? _____
_____
_____

CURRENT SYMPTOMS:

Mark the areas on your body where you are having **symptoms from your work injury/injuries**, Use the letter guide under this paragraph to indicate the type of symptoms in each area. Also, review the PAIN SCALE on the bottom of this page so that you are prepared to answer the doctor's questions.

P = Pain **N** = Numbness/Tingling **T** = Tenderness **B** = Burning **R** = Radiating



PAIN SCALE:

0-1	=	**Minimal**	=	The pain is an annoyance but does not stop me from working.
2-3	=	**Slight**	=	I can tolerate the pain but it causes some difficulty in doing my work. However, it does not stop me from working.
5	=	**Moderate**	=	The pain causes a marked handicap in my ability to work, but I can continue.
7-8	=	**Moderate To Severe**	=	The pain is approaching the worst I have ever experienced or could imagine. It causes a significant problem with working and most of the time I can't.
10	=	**Severe**	=	The pain is the worst I have ever experienced or could imagine and causes me to stop all work and activity.

Please LIST YOUR CURRENT SYMPTOMS/COMPLAINTS resulting from your work injury:

Complaint #1: _____

What percentage of the time do you experience/feel this symptom? _____%

What activities make this symptom worse? _____

_____

What makes this symptom better? _____

_____

PAIN SCALE _____ *0 - 10. The doctor will discuss this with you.*

Complaint #2: _____

What percentage of the time do you experience/feel this symptom? _____%

What activities make this symptom worse? _____

_____

What makes this symptom better? _____

_____

PAIN SCALE _____ *0 - 10. The doctor will discuss this with you.*

Complaint #3: _____

What percentage of the time do you experience/feel this symptom? _____%

What activities make this symptom worse? _____

_____

What makes this symptom better? _____

_____

PAIN SCALE _____ *0 - 10. The doctor will discuss this with you.*

Complaint #4: _____

What percentage of the time do you experience/feel this symptom? _____%

What activities make this symptom worse? _____

_____

What makes this symptom better? _____

_____

PAIN SCALE _____ *0 - 10. The doctor will discuss this with you.*

If needed, list additional symptoms or complaints on the back of this page