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WORKERS COMPENSATION QUESTIONAIRE

1. **Patient's Name:____**
2. **Date of Injury:___________________**
3. **Time of Injury:___________________AM_____PM____**
4. **Did you report injury:__________________**
5. **Employer Name:____**
6. **Address:____**
   ____
7. **Phone :_________________ Contact Person:___________________**
8. **On the date of the injury/illness what was your job title/description:____**
9. **On the date of this injury/illness what were the patients usual work activities:(Describe in detail)____**
   ____
10. **Briefly describe the details of this accident:________________**
    ____
11. **Where you hospitalized? ________________________________**
12. **Name of Hospital:_______________________________**
13. **Did you lose time from work:___________________**
14. **Dates you lost time from work:_______________________**
15. **Are you currently working:__________________________**
16. **Have you had any previous workers compensation injuries?**
    No______ Yes________
    Briefly describe: ________________________________
____
17. **Exactly where did you feel pain immediately after the accident:____**
18. **What type of problem are you presently having?**
    ____
19. **Have you received treatment by any other health professionals including X-rays, lab etc.?_________If so please list:____**
    ____
20. **Workers Compensation Carrier:_________________________**
    Address: ____
    ____
21. **Claim#____**
22. **Please describe in detail what your symptoms are today.____**

Patient's Signature: ____