

NAME \_\_\_\_\_ DATE \_\_\_\_\_

**WORKER'S COMPENSATION INFORMATION:**

**Worker's Compensation Case #:**

Date of injury: \_\_\_\_\_ Time: \_\_\_\_\_ Location: \_\_\_\_\_  
Employer: \_\_\_\_\_ Supervisor's Telephone: \_\_\_\_\_

Address: \_\_\_\_\_

**Insurance Company Case #:**

Worker's Compensation Carrier/Insurance Company: \_\_\_\_\_

Address: \_\_\_\_\_

Coverage verified by: \_\_\_\_\_ Date: \_\_\_\_\_ Phone: \_\_\_\_\_

Accident reported to: \_\_\_\_\_ Date: \_\_\_\_\_ Time: \_\_\_\_\_

Injury verified by: \_\_\_\_\_ Title: \_\_\_\_\_ Phone: \_\_\_\_\_

Length of time employed prior to accident: \_\_\_\_\_

Previous Worker's Compensation Injury:  Yes  No Same Employer:  Yes  No Similar Symptoms:  Yes  No

**Attorney:** \_\_\_\_\_ **Telephone:** \_\_\_\_\_

Address: \_\_\_\_\_

**Describe accident/injury in your own words:**

Last Day Worked: \_\_\_\_\_

Prior Care:  Hospitalized  Physical Therapy  Chiropractic  Other Length of Care: \_\_\_\_\_

Current Care:  Physical Therapy  Chiropractic  Other Begin Date: \_\_\_\_\_

Name of Facility/Physician(s) with addresses and phone numbers: \_\_\_\_\_

Are your conditions improving:  Yes  No If not, what areas are still affected: \_\_\_\_\_

Current restrictions by other physicians: \_\_\_\_\_

**Job Description:**

Sit/Stand/Walk: \_\_\_\_\_

Bend/Lift/Push: \_\_\_\_\_

Repetitive Movements: \_\_\_\_\_

Temperature or Respiratory Exposure: \_\_\_\_\_