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: