**Worker’s Compensation Questionnaire**

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| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| Patient Name: |  | | | | | SS#: | | | |  | | | | | | | | DOB: |  | | |
| What part(s) of your body did you injure at work? | | | | | | | |  | | | | | | | | | | | | | |
| What **date** did your injury occur? (Be as specific as possible) | | | | | | | | | | | |  | | | | | | | | | |
| **How** did your injury occur? | | \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | | | | | | | | | | | | | | | | | | |
| \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | | | | | | | | | | | | | | | | | | | | |
| Did anyone witness your injury? | | | Yes | | No | | | | If **yes**, who? | | | | | |  | | | | | | |
| What **date** did you report the incident to your employer? | | | | | | | | | | |  | | | | | | | | | | |
| What **date** were you first evaluated and/or treated for this medical condition? | | | | | | | | | | | | | | | | |  | | | | |
| Have you stopped working as a result of this injury? | | | | | | | | | Yes | | | | No | | | | | | | | |
| If **yes**, date you stopped working? | | | |  | | | Are you still off work due to this injury? | | | | | | | | | | | | Yes | | No |
| Have you ever had a similar medical problem or injury? | | | | | | | | | | | Yes | | | | No | If **yes**, when? | | | |  | |
| If **yes**, please describe the similar medical problem or injury: | | | | | | | | | | | |  | | | | | | | | | |
| \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | | | | | | | | | | | | | | | | | | | | |
| Have you received previous treatment for your injury? | | | | | | | | | | Yes | | | | No | | | | | | | |
| If **yes**, please list ANY and ALL sources and dates of treatment below: | | | | | | | | | | | | | | | | | | | | | |
| **Who treated you?** | | | | | | | | | **Date?** | | | | | | | | | | | | |
|  | | | | | | | | |  | | | | | | | | | | | | |
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| --- | --- | --- | --- | --- |
| **Please provide us with the following information:**  (You can obtain this information from your employer) | | | | |
| Workers’ Compensation Insurer: | |  | | |
| Address: | |  | | |
|  | |  | | |
| Telephone #: | |  | | |
| Contact Name: | |  | | |
| Claim #: | |  | | |
| Have you retained an attorney? | Yes | | No | |
| If **yes**, please provide us with the following information: | | | | |
| Attorney’s Name: | |  | | |
| Address: | |  | | |
|  | |  | | |
| Telephone #: | |  | | |
|  | | | | |
| Patient Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | | | Date:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |