**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:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |