

Workers Compensation Form



Patients Name: \_\_\_\_\_

Date: \_\_\_\_ / \_\_\_\_ / \_\_\_\_

1) What was the date of the work injury? \_\_\_\_ / \_\_\_\_ / \_\_\_\_

2) What time did the incident occur? \_\_\_\_ : \_\_\_\_ am / pm

3) What is the employer's name? \_\_\_\_\_

4) What is the employers address? \_\_\_\_\_

City / State / Zip \_\_\_\_\_

5) What is your attorney's name? \_\_\_\_\_

6) What is the attorney's address? \_\_\_\_\_

City / State / Zip \_\_\_\_\_

7) Please describe the incident in a few sentences:

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

8) After the incident, did you report the incident to your supervisor?

Yes	No, I was not sent to a doctor after the incident
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9) What is your supervisor's name? \_\_\_\_\_

10) After the incident, did your employer sent you to a doctor?

Yes	No, I was not sent to a doctor after the incident
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11) What did the doctor say was wrong? \_\_\_\_\_

12) Did you go to a doctor on your own?

Yes	No
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13) What was the name of the doctor? \_\_\_\_\_

14) Are there any other problems that affect your employment?

Yes	No
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If yes, what is the problem \_\_\_\_\_

15) In your work, do you favor one side of your body?

Yes	No
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16) If yes, what do you favor at work? \_\_\_\_\_

17) Before the injury, were you capable of equal work with others your age?

Yes	No, I was not sent to a doctor after the incident
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18) Have you injured this area before?

Yes	No
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