WORK INJURY INFORMATION

Date:________________________
Name: ______________________________ Date of Accident: _____/_____/_____
Employer: ___________________________Employer Phone: _________________
Employer Address: ____________________ Employer Fax: ___________________
Your Occupation: ____
Date Injured: _____/_____/______ Time: _______AM/PM
Last Date Worked: _____/_____/______ Are you presently off Work? Yes No
Has the injury been reported to your Employer? Yes No
Name of person injury was reported to:___________________________________
Claim #:____
Insurance Company: ____
Claim Adjuster: _________________________Phone #:_______________________
Where Injured: __________________City: _________State: _____Zip:_________
Length of Time you worked there prior to the injury: ________________________
Type of work being done at time of injury: _________________________________
Describe the injury: ____
____
Been evaluated or treated by another doctor in relation to this injury? Yes No
If yes, please list doctor s name and address:
____
What type of treatment did you receive?
____
What medications are you taking?
____
Have you had physical therapy? If yes, please state type of treatment you received?
____
Prior to this accident, have you ever had any physical complaints similar to what you have now? If yes, please describe: ___________________________________
____
Were any of these complaints the result of a previous accident or injury?
If yes, please describe: ____
____
Have you contacted an Attorney? Yes No
Attorney’s name?____
Address: ____
Phone #____