WORK INJURY QUESTIONNAIRE

Patient's Name: ______________________________ **Date:** ________________________

Date of the accident: __________________________________ **Time:** ___________ **AM PM**

Name of your employer: ____

Address of your employer: ____

Location where accident occurred: ____

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Describe how the accident happened: ____

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Was this accident reported to your supervisor? _____ **If Yes, when?** ________________________

What is the name of your supervisor? ____

Have you lost any time from work due to this injury? _____ **If YES, from** ________ **to** ________

If you are not able to work due to this injury, what job duties must you be able to perform before your employer will allow you to return to work? ____________________________________

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If you are still able to work, are there any of your regular job duties that you are unable to perform? _____ **If YES, please describe:** ____

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Have you been treated by any other healthcare providers for the injuries you received in this accident? _______ **If YES, please describe:** ____

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What symptoms did you feel immediately following this accident? _________________________

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What symptoms are you feeling at the present time? _________________________________

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Name of your Workers Compensation insurance carrier: ______________________________

Phone number of insurance carrier: ____________________ **Claim Number:** __________________

Patient's (or legal guardian's) Signature: ____________________________ **Date:** _____________

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