

WORK INJURY QUESTIONNAIRE

Has injury been reported to immediate supervisor/foreman? Yes _____ No _____

If yes, give his/her name: _____

May I call your employer for authorization to treat you? Yes _____ No _____

Have you retained a Workers' Compensation Attorney for this case? Yes _____ No _____

If yes, name and phone: _____ ph# _____

Date and time this injury occurred: Date: _____ Time: _____ am /pm

Area that you felt pain immediately after the accident? _____

Did you return to work? Yes _____ No _____

For the same company? Yes _____ No _____

Are you currently working? Yes _____ No _____

If no, last date of employment? _____

If working for a different company, name of company: _____

Have you ever injured this area before? Yes _____ No _____

If yes, when? _____ Did you lose time from work? Yes _____ No _____

Do any other medical problems affect your employment? Yes _____ No _____

During daily work or activities, do you have to favor any part of your body? Yes _____ No _____

If yes, explain: _____

Have you ever had a Workers' Compensation claim before? Yes _____ No _____

Since the injury, symptoms are: Improving _____ Worse _____ Unchanged _____

Explain in detail how your accident happened. (Use other side if necessary.)