WORKERS COMPENSATION QUESTIONAIRE

Date ____

Patients Name ____

Employers Name ____

Address: ____

Phone: ____

Accident Date ____________ Time ____________ Place (town) ______________________________

Person reported to/or Supervisor ____

Is case already on record? ( ) Yes ( ) No If Yes Case # ____________________________________

Workers Comp Insurance Company (NOT Personal Insurance Company)

Company Name ____

Address ____

Describe in your own words how accident occurred. (Include part of body that was injured and symptoms)

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Have you ben seen by any other Doctors? ____________

Name of treating Doctor ____

Have you had x-rays or an MRI done for this injury? ____________

Is a lawyer involved in this case? ____________

Name/address/phone ____

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Are you working? ____________ Regular or Limited? ____________

Work? ________________________________ Dates for lost time _________________________________

Person to contact at work for information? ____

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