

Worker's Compensation Case History

Date: _____

Patient Name

Last Name: _____ First Name: _____ Middle: _____

Date of Birth ____/____/____ Home Phone: _____ Cell Phone: _____

Permanent Address: _____ City: _____ State: _____ Zip: _____

Occupation: _____ Employer: _____

Employer's

Address: _____

Worker's Compensation cases can be denied due to incomplete and/or unspecified details. Please take your time and do not rush your answers to the following questions. Even details you feel are minor or unimportant may jeopardize your case. It is your responsibility to follow recommendations. In the event your case is denied due to a lack of cooperation or lack of information on this form, you will be responsible for payment in full.

Date of Injury: _____ Did you report your injury? Yes No To Whom? _____

Have you lost any days from work? Yes No If yes, write dates _____

Have you been treated for this condition by any other doctor? Yes No

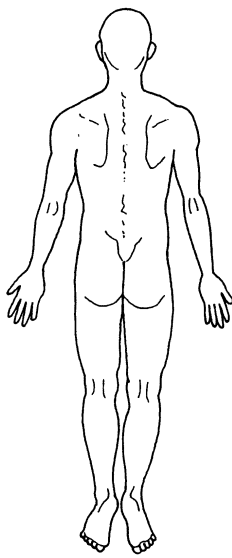
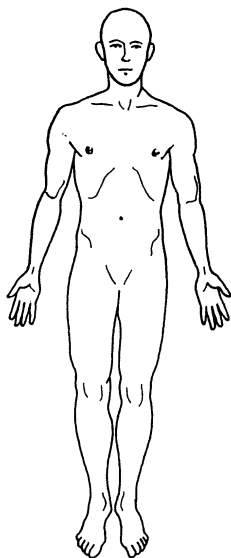
Where did you receive treatment: _____

When did you receive treatment: _____

What tests were performed for your symptoms? X-rays MRI CT Scan Medication Other _____

Height: _____ Weight: _____

Specific details of how the injury occurred: _____



TELL US WHERE YOU HURT.

**Using the drawings, locate areas of pain.
Be specific and detailed.**

**Grade each affected area on a scale of 0 to 10,
with 10 being the most intense.**

Please check off the symptoms you have noticed due to this condition:

- | | | |
|--|--|---|
| <input type="checkbox"/> Dizziness | <input type="checkbox"/> Irritability | <input type="checkbox"/> Pins and needles |
| <input type="checkbox"/> Shoulder pain | <input type="checkbox"/> Low back pain | <input type="checkbox"/> Fatigue |
| <input type="checkbox"/> Headaches | <input type="checkbox"/> Mid back pain | <input type="checkbox"/> Numbness |
| <input type="checkbox"/> Cold sweats | <input type="checkbox"/> Nausea | <input type="checkbox"/> Kidney problems |
| <input type="checkbox"/> Memory Loss | <input type="checkbox"/> Chest pain | <input type="checkbox"/> Neck pain |
| <input type="checkbox"/> Difficulty sleeping | <input type="checkbox"/> Tension | <input type="checkbox"/> Extremity pain, please explain _____ |
| <input type="checkbox"/> Ears ringing | <input type="checkbox"/> Nervousness | <input type="checkbox"/> Fainting |
| <input type="checkbox"/> Stiffness | <input type="checkbox"/> Soreness | <input type="checkbox"/> Stabbing pain |
| <input type="checkbox"/> Burning | <input type="checkbox"/> Hip pain | <input type="checkbox"/> Radiating pain |
| <input type="checkbox"/> Fever | <input type="checkbox"/> Depression | <input type="checkbox"/> Pain with coughing or sneezing |
| <input type="checkbox"/> Other, please explain _____ | | |

Please check off on the category that best describes your capabilities:

OK: Have not noticed symptoms with this task

DISCOMFORT: Can do it but bothers or irritates you then or later on

PAINFUL: You may still be able to do it but causes pain every time you do

UNABLE: The pain is so bad you cannot do it at all

- | | | | | |
|------------------------|-----------------------------|-------------------------------------|----------------------------------|---------------------------------------|
| Driving | <input type="checkbox"/> OK | <input type="checkbox"/> DISCOMFORT | <input type="checkbox"/> PAINFUL | <input type="checkbox"/> UNABLE TO DO |
| Housework | <input type="checkbox"/> OK | <input type="checkbox"/> DISCOMFORT | <input type="checkbox"/> PAINFUL | <input type="checkbox"/> UNABLE TO DO |
| Sleeping | <input type="checkbox"/> OK | <input type="checkbox"/> DISCOMFORT | <input type="checkbox"/> PAINFUL | <input type="checkbox"/> UNABLE TO DO |
| Computer work | <input type="checkbox"/> OK | <input type="checkbox"/> DISCOMFORT | <input type="checkbox"/> PAINFUL | <input type="checkbox"/> UNABLE TO DO |
| Showering | <input type="checkbox"/> OK | <input type="checkbox"/> DISCOMFORT | <input type="checkbox"/> PAINFUL | <input type="checkbox"/> UNABLE TO DO |
| Washing Dishes | <input type="checkbox"/> OK | <input type="checkbox"/> DISCOMFORT | <input type="checkbox"/> PAINFUL | <input type="checkbox"/> UNABLE TO DO |
| Lawn work | <input type="checkbox"/> OK | <input type="checkbox"/> DISCOMFORT | <input type="checkbox"/> PAINFUL | <input type="checkbox"/> UNABLE TO DO |
| Child Care | <input type="checkbox"/> OK | <input type="checkbox"/> DISCOMFORT | <input type="checkbox"/> PAINFUL | <input type="checkbox"/> UNABLE TO DO |
| Cooking | <input type="checkbox"/> OK | <input type="checkbox"/> DISCOMFORT | <input type="checkbox"/> PAINFUL | <input type="checkbox"/> UNABLE TO DO |
| Bathroom habits | <input type="checkbox"/> OK | <input type="checkbox"/> DISCOMFORT | <input type="checkbox"/> PAINFUL | <input type="checkbox"/> UNABLE TO DO |
| Sitting | <input type="checkbox"/> OK | <input type="checkbox"/> DISCOMFORT | <input type="checkbox"/> PAINFUL | <input type="checkbox"/> UNABLE TO DO |
| Bending | <input type="checkbox"/> OK | <input type="checkbox"/> DISCOMFORT | <input type="checkbox"/> PAINFUL | <input type="checkbox"/> UNABLE TO DO |
| Twisting | <input type="checkbox"/> OK | <input type="checkbox"/> DISCOMFORT | <input type="checkbox"/> PAINFUL | <input type="checkbox"/> UNABLE TO DO |
| Kneeling | <input type="checkbox"/> OK | <input type="checkbox"/> DISCOMFORT | <input type="checkbox"/> PAINFUL | <input type="checkbox"/> UNABLE TO DO |
| Sex | <input type="checkbox"/> OK | <input type="checkbox"/> DISCOMFORT | <input type="checkbox"/> PAINFUL | <input type="checkbox"/> UNABLE TO DO |
| Squatting | <input type="checkbox"/> OK | <input type="checkbox"/> DISCOMFORT | <input type="checkbox"/> PAINFUL | <input type="checkbox"/> UNABLE TO DO |
| Standing | <input type="checkbox"/> OK | <input type="checkbox"/> DISCOMFORT | <input type="checkbox"/> PAINFUL | <input type="checkbox"/> UNABLE TO DO |

Recreational Activities You Participate In

- | | | | | |
|-------------------------|-----------------------------|-------------------------------------|----------------------------------|---------------------------------------|
| Walking | <input type="checkbox"/> OK | <input type="checkbox"/> DISCOMFORT | <input type="checkbox"/> PAINFUL | <input type="checkbox"/> UNABLE TO DO |
| Biking | <input type="checkbox"/> OK | <input type="checkbox"/> DISCOMFORT | <input type="checkbox"/> PAINFUL | <input type="checkbox"/> UNABLE TO DO |
| Golf | <input type="checkbox"/> OK | <input type="checkbox"/> DISCOMFORT | <input type="checkbox"/> PAINFUL | <input type="checkbox"/> UNABLE TO DO |
| Tennis | <input type="checkbox"/> OK | <input type="checkbox"/> DISCOMFORT | <input type="checkbox"/> PAINFUL | <input type="checkbox"/> UNABLE TO DO |
| Running | <input type="checkbox"/> OK | <input type="checkbox"/> DISCOMFORT | <input type="checkbox"/> PAINFUL | <input type="checkbox"/> UNABLE TO DO |
| Horseback riding | <input type="checkbox"/> OK | <input type="checkbox"/> DISCOMFORT | <input type="checkbox"/> PAINFUL | <input type="checkbox"/> UNABLE TO DO |
| Baseball | <input type="checkbox"/> OK | <input type="checkbox"/> DISCOMFORT | <input type="checkbox"/> PAINFUL | <input type="checkbox"/> UNABLE TO DO |
| Fishing | <input type="checkbox"/> OK | <input type="checkbox"/> DISCOMFORT | <input type="checkbox"/> PAINFUL | <input type="checkbox"/> UNABLE TO DO |
| Dancing | <input type="checkbox"/> OK | <input type="checkbox"/> DISCOMFORT | <input type="checkbox"/> PAINFUL | <input type="checkbox"/> UNABLE TO DO |
| Skiing | <input type="checkbox"/> OK | <input type="checkbox"/> DISCOMFORT | <input type="checkbox"/> PAINFUL | <input type="checkbox"/> UNABLE TO DO |
| Boating | <input type="checkbox"/> OK | <input type="checkbox"/> DISCOMFORT | <input type="checkbox"/> PAINFUL | <input type="checkbox"/> UNABLE TO DO |
| Volleyball | <input type="checkbox"/> OK | <input type="checkbox"/> DISCOMFORT | <input type="checkbox"/> PAINFUL | <input type="checkbox"/> UNABLE TO DO |
| Swimming | <input type="checkbox"/> OK | <input type="checkbox"/> DISCOMFORT | <input type="checkbox"/> PAINFUL | <input type="checkbox"/> UNABLE TO DO |
| Treadmill | <input type="checkbox"/> OK | <input type="checkbox"/> DISCOMFORT | <input type="checkbox"/> PAINFUL | <input type="checkbox"/> UNABLE TO DO |
| Weightlifting | <input type="checkbox"/> OK | <input type="checkbox"/> DISCOMFORT | <input type="checkbox"/> PAINFUL | <input type="checkbox"/> UNABLE TO DO |
| Other _____ | <input type="checkbox"/> OK | <input type="checkbox"/> DISCOMFORT | <input type="checkbox"/> PAINFUL | <input type="checkbox"/> UNABLE TO DO |

I have read and understand the rules and expectations of a worker's compensation case.

Signature of patient or person acting on patient's behalf

Date: _____