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:_____

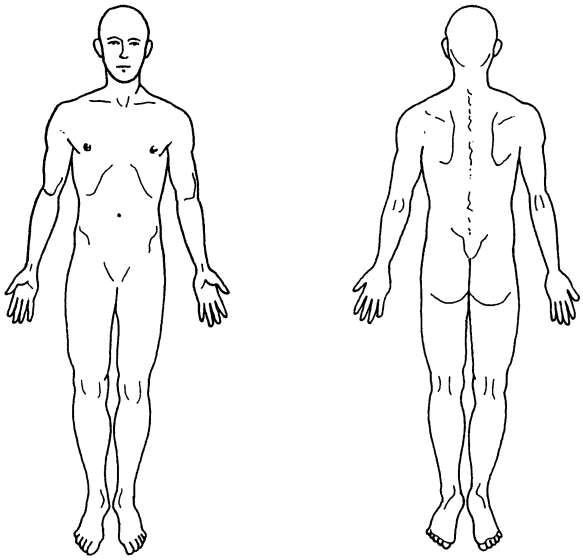
Specific details of how the injury occurred: _____

_____

_____

_____

_____



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:

- ☐ Dizziness
- ☐ Shoulder pain
- ☐ Headaches
- ☐ Cold sweats
- ☐ Memory Loss
- ☐ Difficulty sleeping
- ☐ Ears ringing
- ☐ Stiffness
- ☐ Burning
- ☐ Fever
- ☐ Irritability
- ☐ Low back pain
- ☐ Mid back pain
- ☐ Nausea
- ☐ Chest pain
- ☐ Tension
- ☐ Nervousness
- ☐ Soreness
- ☐ Hip pain
- ☐ Depression
- ☐ Pins and needles
- ☐ Fatigue
- ☐ Numbness
- ☐ Kidney problems
- ☐ Neck pain
- ☐ Extremity pain, please explain_____
- ☐ Fainting
- ☐ Stabbing pain
- ☐ Radiating pain
- ☐ Pain with coughing or sneezing
- ☐ 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	☐ OK	☐ DISCOMFORT	☐ PAINFUL	☐ UNABLE TO DO
Housework	☐ OK	☐ DISCOMFORT	☐ PAINFUL	☐ UNABLE TO DO
Sleeping	☐ OK	☐ DISCOMFORT	☐ PAINFUL	☐ UNABLE TO DO
Computer work	☐ OK	☐ DISCOMFORT	☐ PAINFUL	☐ UNABLE TO DO
Showering	☐ OK	☐ DISCOMFORT	☐ PAINFUL	☐ UNABLE TO DO
Washing Dishes	☐ OK	☐ DISCOMFORT	☐ PAINFUL	☐ UNABLE TO DO
Lawn work	☐ OK	☐ DISCOMFORT	☐ PAINFUL	☐ UNABLE TO DO
Child Care	☐ OK	☐ DISCOMFORT	☐ PAINFUL	☐ UNABLE TO DO
Cooking	☐ OK	☐ DISCOMFORT	☐ PAINFUL	☐ UNABLE TO DO
Bathroom habits	☐ OK	☐ DISCOMFORT	☐ PAINFUL	☐ UNABLE TO DO
Sitting	☐ OK	☐ DISCOMFORT	☐ PAINFUL	☐ UNABLE TO DO
Bending	☐ OK	☐ DISCOMFORT	☐ PAINFUL	☐ UNABLE TO DO
Twisting	☐ OK	☐ DISCOMFORT	☐ PAINFUL	☐ UNABLE TO DO
Kneeling	☐ OK	☐ DISCOMFORT	☐ PAINFUL	☐ UNABLE TO DO
Sex	☐ OK	☐ DISCOMFORT	☐ PAINFUL	☐ UNABLE TO DO
Squatting	☐ OK	☐ DISCOMFORT	☐ PAINFUL	☐ UNABLE TO DO
Standing	☐ OK	☐ DISCOMFORT	☐ PAINFUL	☐ UNABLE TO DO

Recreational Activities You Participate In

Walking	☐ OK	☐ DISCOMFORT	☐ PAINFUL	☐ UNABLE TO DO
Biking	☐ OK	☐ DISCOMFORT	☐ PAINFUL	☐ UNABLE TO DO
Golf	☐ OK	☐ DISCOMFORT	☐ PAINFUL	☐ UNABLE TO DO
Tennis	☐ OK	☐ DISCOMFORT	☐ PAINFUL	☐ UNABLE TO DO
Running	☐ OK	☐ DISCOMFORT	☐ PAINFUL	☐ UNABLE TO DO
Horseback riding	☐ OK	☐ DISCOMFORT	☐ PAINFUL	☐ UNABLE TO DO
Baseball	☐ OK	☐ DISCOMFORT	☐ PAINFUL	☐ UNABLE TO DO
Fishing	☐ OK	☐ DISCOMFORT	☐ PAINFUL	☐ UNABLE TO DO
Dancing	☐ OK	☐ DISCOMFORT	☐ PAINFUL	☐ UNABLE TO DO
Skiing	☐ OK	☐ DISCOMFORT	☐ PAINFUL	☐ UNABLE TO DO
Boating	☐ OK	☐ DISCOMFORT	☐ PAINFUL	☐ UNABLE TO DO
Volleyball	☐ OK	☐ DISCOMFORT	☐ PAINFUL	☐ UNABLE TO DO
Swimming	☐ OK	☐ DISCOMFORT	☐ PAINFUL	☐ UNABLE TO DO
Treadmill	☐ OK	☐ DISCOMFORT	☐ PAINFUL	☐ UNABLE TO DO
Weightlifting	☐ OK	☐ DISCOMFORT	☐ PAINFUL	☐ UNABLE TO DO
Other_____	☐ OK	☐ DISCOMFORT	☐ PAINFUL	☐ UNABLE TO DO

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

_____ Date:_____
Signature of patient or person acting on patient's behalf