Work Related Injury Questionnaire

Patient Name:_____

Name of Employer: _____

Address of Employer: _____

Workers Compensation Case Number: _____

Insurance company covering medical treatment: _____

Contact name & number for claim: _____

Detailed description of how the work related injury occurred:

_____
_____
_____
_____

Date of injury: _____/_____/_____ Time of injury: _____:_____am or pm

Where were you when the injury occurred?: _____

What symptoms did you feel immediately following the injury?:

_____
_____
_____

What symptoms are you currently experiencing?:

_____
_____
_____

What other health care providers have you seen for these injuries?:

Provider Name	Specialty	Recommendation/Treatment	Imaging Performed

Are you currently working?: Yes or No
Did you lose any time from work as a result of these injuries? Yes or No

Patient Signature: _____ Date: _____