Work Injury Report Form

Name: _____ Date: _____

1. Date of accident: ____/____/____ 2. Time: _____ AM PM

3. Where did the accident occur? _____

4. Briefly describe how the accident happened: _____

_____

_____

5. Employers name: _____ 6. Employer's address: _____

7. Employer phone # _____ 8. Date reported: _____

9. Who did you report to? _____ 10. Where were you taken after the accident? _____

11. What was done for you? _____ 12. Have you seen other doctor's for this accident? ◯ No ◯ Yes

13. Have you missed any work due to this accident? ◯ No ◯ Yes If yes, list dates: _____

14. Have you returned to work? ◯ No ◯ Yes ☐ Part time ☐ Full time
If yes, has work aggravated your condition? ◯ No ◯ Yes

15. Have you had similar problems in the past? ◯ No ◯ Yes If yes, describe: _____

_____

16. Occupation: _____ 17. Did you have a pre-employment physical? ◯ No ◯ Yes

18. Please describe your daily job requirements (i.e., how much standing, sitting, lifting, number of pounds, repetitive motions, twisting, bending, stooping, etc.) _____

_____

_____

19. Are you presently unable to do/ perform any social or recreational activities? (describe) _____

_____

_____

_____

20. Check the symptoms apparent since the accident:

☐ Headache	☐ Eyes light sensitive	☐ Fainting	☐ Numbness in toes
☐ Low back pain	☐ Irritability	☐ Loss of balance	☐ Cold feet
☐ Pain down the leg	☐ Chest pain	☐ Neck pain/ Stiffness	☐ Pain behind eyes
☐ Sleeping problems	☐ Loss of smell	☐ Fatigue	☐ Depression
☐ Tension	☐ Diarrhea	☐ Nervousness	☐ Facial Pain
☐ Mid back pain	☐ Dizziness	☐ Numbness in fingers	☐ Loss of taste
☐ Shortness of breath	☐ Ringing/ buzzing	☐ Cold hands	☐ Constipation
☐ Cold sweats	☐ Clicking/ popping jaw	☐ Sore jaw	☐ Hand grip weakness

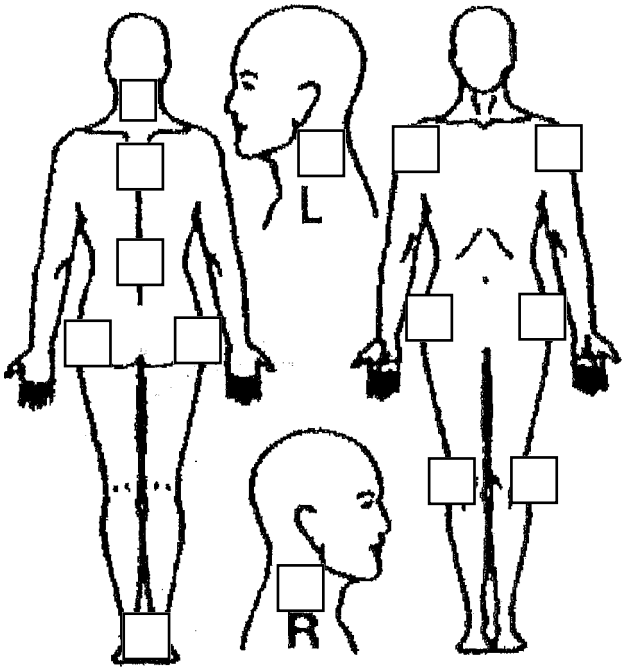
List any others: _____

20. Have you retained an attorney? ◯ No ◯ Yes (who?) _____ Phone #: _____

22. Subjective Pain Drawing

Mark the areas on your body where you feel the described sensations. Use the appropriate symbol. Mark stress points of pain that travels. Include all affected areas.

☐ NUMBNESS ☐ BURNING ☐ PINS & NEEDLES ☐ STABBING ☐ ACHE



I certify that I have read and understand the above information. To the best of my knowledge the above questions have been accurately answered.

Patients Signature _____ Date _____

33. Additional Physicians Notes