WORKER'S COMPENSATION INJURY REPORT

NAME_____ **AGE**_____ **DATE OF BIRTH**_____

DATE OF ACCIDENT/INJURY_____ **TIME**_____ **LOCATION**_____

Employer at time of injury:_____ Injury reported to employer: □No □Yes, When?_____

Please describe how accident/injury happened:_____

Please describe in detail your present symptoms:_____

Please describe symptoms immediately following accident/injury:_____

EMPLOYMENT	**Yes**	**No**	**Describe (if any)**
Have you lost any days of work? Please list dates.	☐	☐	_____
Date of return to work fully.	☐	☐	_____
Prior to the accident were you able to work on an equal basis with others your age?	☐	☐	_____
Are any of your activities restricted? Please explain.	☐	☐	_____

CHECK SYMPTOMS YOU HAVE NOTICED SINCE INJURY ACCIDENT:

☐ Headache	☐ Constipation	☐ Fainting	☐ Chest Pain
☐ Neck Pain	☐ Diarrhea	☐ Loss of Balance	☐ Depression
☐ Neck Stiffness	☐ Dizziness	☐ Loss of Taste	☐ Loss of Strength
☐ Sleeplessness	☐ Nausea	☐ Loss of Smell	☐ Ringing in Ears
☐ Mid Back Pain	☐ Head Feels Heavy	☐ Cold Hands	☐ Light Sensitivity
☐ Low Back Pain	☐ Numbness in Legs	☐ Cold Feet	☐ Clumsiness
☐ Arm Pain	☐ Numbness in Arms	☐ Loss of Memory	☐ Face Flushed
☐ Leg pain	☐ Numbness in Toes	☐ Disorientation	☐ Cold Sweats
☐ Nervousness	☐ Numbness in Fingers	☐ Unclear Thinking	☐ Upset Stomach
☐ Tense Muscles	☐ Difficulty Breathing	☐ Visual Disturbances	☐ Fever
☐ Irritability	☐ Fatigue	☐ Difficulty Swallowing	☐ _____

Your Health Insurance:
Company Name:_____
Address:_____
City, State, Zip:_____
Company Phone Number:_____
Policy Number:_____

Doctors or Hospitals Consulted:
Name:_____
Address:_____
City, State, Zip:_____
Dates of Treatment:_____

JOB DESCRIPTION:

Please describe your job duties in your own words:_____

_____

_____

_____

[In terms of an 8 hour work day, "occasionally" means 33%, "frequently" means 34-66%, and "continuously" means 67-100%]

1. In a typical 8 hour workday, I: (Circle # of hours per activity)

Sit:	1	2	3	4	5	6	7	8	Hours
Stand:	1	2	3	4	5	6	7	8	Hours
Walk:	1	2	3	4	5	6	7	8	Hours

2. On the job, I perform the following activities:

	NOT AT ALL	OCCASIONALLY	FREQUENTLY	CONTINUOUSLY
Bend/Stoop	☐	☐	☐	☐
Squat	☐	☐	☐	☐
Crawl	☐	☐	☐	☐
Climb	☐	☐	☐	☐
Reach above shoulder level	☐	☐	☐	☐
Crouch	☐	☐	☐	☐
Kneel	☐	☐	☐	☐
Balancing	☐	☐	☐	☐
Pushing/Pulling	☐	☐	☐	☐

3. On the job I lift:

	NOT AT ALL	OCCASIONALLY	FREQUENTLY	CONTINUOUSLY
Up to 10 pounds	☐	☐	☐	☐
11 to 24 pounds	☐	☐	☐	☐
25 to 34 pounds	☐	☐	☐	☐
35 to 50 pounds	☐	☐	☐	☐
51 to 74 pounds	☐	☐	☐	☐
75 to 100 pounds	☐	☐	☐	☐

4. Do you have to bend over while doing any lifting? ☐YES ☐NO
5. Are your feet used for repetitive movements, such as operating foot controls? ☐YES ☐NO
6. Do you use your hands for repetitive

	SIMPLE GRASPING	FIRM GRASPING	FINE MANIPULATION
RIGHT HAND	☐YES ☐NO	☐YES ☐NO	☐YES ☐NO
LEFT HAND	☐YES ☐NO	☐YES ☐NO	☐YES ☐NO

7. Are you required to work on unprotected heights? ☐YES ☐NO
8. Are you required to be around moving machinery? ☐YES ☐NO
9. Are you exposed to marked changes in temperature and humidity? ☐YES ☐NO
10. Are you required to drive automotive equipment? ☐YES ☐NO
11. Are you exposed to dust, fumes and/or gases? ☐YES ☐NO
12. Please list any additional comments:_____

_____

Signature:_____ **Date:**_____