WORKERS COMPENSATION QUESTIONAIRE

Patient Name: ____

Date of Injury: ____

How did injury occur?

____

____

On the date of injury, what was your job description/usual work duties?

____

____

Did you miss work? Yes _____ No_____
Exact dates: ____

Are you currently working? Yes ______ No ______

Do you have any current work restrictions?
Yes _____ No_____

If yes, please describe:

____

____

Name of Employer: ____

Employers Address: ____

Employers Phone Number: ____

Name of Employers Insurance: ____

Insurance Phone Number and Address: _____________________________________

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