**Workman’s Comp Patient Data Form**

Date \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Name \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date of Birth \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Address \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Phone # \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date of Injury \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Time \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Location \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Reported injury to \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Position \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Date reported injury \_\_\_\_\_\_\_\_\_\_\_\_\_ Witness? Yes \_\_\_\_ No \_\_\_\_

Describe in detail what happened and what you were doing at the time \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

When did pain begin \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Where did you first feel pain \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Was pain intense at first, or did you feel pain that gradually worsened \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Describe the physical conditions which may have contributed to your present injury: (Darkness, faulty equipment, slippery floor, etc…) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Were you hospitalized as a result of this accident? Yes \_\_\_\_ No \_\_\_\_ If yes, where \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

How long \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Doctor’s name \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Date of 1st visit \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Examined? Yes \_\_\_\_\_ No \_\_\_\_\_ X-rays? Yes \_\_\_\_\_ No\_\_\_\_\_\_\_\_

What kind of treatment \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Benefits from treatment? Better / Same / Worse

Date of last visit \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Appox. No. of visits \_\_\_\_\_\_ Did you see any other doctors? Specify

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Have you ever had any PRIOR injuries, accidents, diseases, or treatment to the area of your body now affected? Yes \_\_\_\_ No \_\_\_\_ If yes, give specific dates, area of body injured, treatment given, and if you continue to have pain or problems \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

If employed, are you able to continue to perform regular occupation? Yes \_\_\_\_\_ No \_\_\_\_\_ If no, indicate

Dates disabled: Full time \_\_\_\_\_\_\_\_\_\_\_\_ to \_\_\_\_\_\_\_\_\_\_\_\_\_\_; Part-time \_\_\_\_\_\_\_\_\_\_\_\_ to \_\_\_\_\_\_\_\_\_\_\_\_

If NOT employed, indicate estimated (or actual) number:

 Total disability \_\_\_\_\_\_\_\_\_\_\_\_ weeks Ended \_\_\_\_\_\_\_\_\_\_\_\_\_\_ 20 \_\_\_\_\_\_

 Partial disability \_\_\_\_\_\_\_\_\_\_\_\_ weeks Ended \_\_\_\_\_\_\_\_\_\_\_\_\_\_ 20 \_\_\_\_\_\_\_

Do you have a lawyer representing you? Yes \_\_\_\_\_ No \_\_\_\_ Name \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Address \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Phone # \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_