WORKER'S COMPENSATION HISTORY INFORMATION

(Please fill out all information completely, indicate N/A if not applicable)

2105 E. Clairemont Avenue, Eau Claire, WI 54703 715-835-9514 Fax 715-835-2602

Patient's Name _____ **Date of injury** _____ **Time** _____ AM/PM

Name of Employer _____ **Telephone Number** _____

Address of Employer/where injury occurred _____

Was injury reported to management? YES NO If Yes, Whom/ Date _____

Have you lost time from work? YES NO If Yes, What is the last day worked? _____

Have you been treated by another doctor for this accident? YES NO

If YES, Name of Doctor(s) _____

Length of time worked there prior to accident: _____

Did anyone witness the accident? YES NO If YES, who? _____

In your own words, please describe how the accident happened:

_____

_ _____

_____

Since the injury, are you: Improved Unchanged Getting Worse

Have you had Physical Therapy? Yes No

Does Physical Therapy help? Yes No If yes, how often? _____

Prior to this injury, have you ever had any of the physical complaints similar to what you have now? YES NO

If YES, please describe _____

Were these similar complaints the result of a previous injury? YES NO If YES, please describe: _____

_____

Have you had any other serious injuries which required medical care? YES NO If YES, please describe: _____

_____

Have you had a previous Worker's Compensation injury? YES NO

If YES, Date(s) of previous injury _____

CURRENT PHYSICAL COMPLAINTS

BACK PAIN: (Mark this area *only* if pertains to injury)

1. Currently, I have pain in my	□Low Back	□Mid Back	□Upper Back
2. My pain began:	□Gradually	□Suddenly	
3. I have pain:	□Sometime	□All of the time	

BACK PAIN CONTINUED:

4. My pain goes into my:	□Right Leg	□Left Leg	□Both Legs
5. I have tingling/numbness in:	□Right Leg	□Left Leg	□Both Legs
6. My pain is worse when I:			
Cough or sneeze	□Yes	□No	
Sit	□Yes	□No	
Bend	□Yes	□No	
Walk	□Yes	□No	
Lift	□Yes	□No	
Push	□Yes	□No	
Pull	□Yes	□No	
7. My back is worse with sexual activity	□Yes	□No	
8. My pain wakes me up during the night	□Yes	□No	
9. Changes in the weather affect my pain	□Yes	□No	

NECK PAIN: (Mark this area *only* if pertains to injury)

10. My neck pain began	□Gradually	□Suddenly	
11. I have pain:	□Sometimes	□All of the time	
12. My pain goes into my:	□Right Arm	□Left Arm	□Both Arms
13. I have tingling/numbness in:	□Right Arm	□Left Arm	□Both Arms
14. My pain is worse when I:			
Cough or Sneeze	□Yes	□No	
Bend Forward	□Yes	□No	
Lift	□Yes	□No	
Push	□Yes	□No	
Pull	□Yes	□No	
Turn my head	□Yes	□No	
15. My pain wakes me up during the night	□Yes	□No	
16. Changes in the weather affect my pain	□Yes	□No	
17. I have neck stiffness	□Yes	□No	
18. I have headaches	□Yes	□No	
19. If I do get headaches, they occur	□Sometimes	□All of the time	

OTHER PAIN: Please describe any current physical complaints which you are experiencing and were not covered on this questionnaire, or list any additional comments you wish to make regarding your condition:

_____

_____

Patient's Signature: _____ Date: _____

Information Taken By: _____ Date: _____