



# 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: \_\_\_\_\_