WORKER'S COMPENSATION QUESTIONNAIRE

If your injuries are related to an on the job accident, please fill out this form:

Employer Name: _____ Occupation: _____

Business Phone: _____ Company contact name: _____

Please explain how your injury occurred: _____

_____

_____

_____

Give time and date when present injury occurred: _____ ☐ AM ☐ PM on ____/____/_____

Where did you feel pain after the accident: _____

Did you return to work: ☐ Yes ☐ No Did your employer send you to a doctor: ☐ Yes ☐ No

If so, give doctor's name: _____ Doctor's Diagnosis: _____

Did you lose time from work: ☐ Yes ☐ No Are you taking any medication: ☐ Yes ☐ No

If yes, please list them: _____

Do any other diseases or accidents affect your employment: ☐ Yes ☐ No

If yes, please explain: _____

In your work, do you favor any part of your body: ☐ Yes ☐ No

If yes, please explain: _____

Have you ever had a worker's compensation claim before: ☐ Yes ☐ No

Before the injury, were you able to work on a equal basis with others your age: ☐ Yes ☐ No

Are your work activities restricted as a result of this accident: ☐ Yes ☐ No

Since the injury, are you symptoms: ☐ Getting Better ☐ Getting Worse ☐ The Same

Have you retained an attorney: ☐ Yes ☐ No In Litigation: ☐ Yes ☐ No

If so, please give name and phone number: _____

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