

HISTORY OF PRESENT ILLNESS OR INJURY:

DESCRIPTION OF THE INCIDENT: (please use back of page if necessary)

Date: _____

Were you knocked unconscious? YES NO How long? _____

Did you report the accident? YES NO To whom? _____

Were you hospitalized? YES NO How long? _____
Where? _____

Did you go to a doctor? YES NO Same day? _____

If not same day, when? _____

Who? _____

Did you receive treatment? YES NO What kind of treatment? _____

How long? _____

Did you receive medication? YES NO What kind? _____

Are you still using these medications? YES NO

Were you told by the Dr. NOT to return to work? YES NO

How long were you off work after injury? _____

Did you return to your previous employment situation? YES NO

Were you performing your regular job duties? YES NO

If different, what were they? _____

Were you able to perform these duties comfortably? YES NO

Please explain _____

What type of physical exertion was involved in your new job duties? _____

Were you given a different job? YES NO

Please explain _____

Are you still working for the same firm? YES NO

IF YES Upon your return to work, were you treated the same as before?

Or differently?

By your supervisors? SAME DIFFERENT Explain _____

By your co-workers? SAME DIFFERENT Explain _____

IF NO Last day worked at company where injury occurred? _____

If you were laid off, fired, or terminated for any reason, describe what reasons you were given for this action and your feelings about this. What was the person's name who was responsible? Please use the back of page to continue, if necessary..

Name _____

Are you presently working for a different firm: YES NO

Name of Firm _____ Start Date? _____

Job Title _____ Job Duties _____

Do you consider this job equal to the job you held at the time of the incident?

YES NO

Please explain _____

Are you collecting disability?

YES

NO

How are you meeting your financial responsibilities?

What are your sources of income?
