DATE:_____

WORK INJURY HISTORY

Patient Information

Name: _____

Date of birth: _____

About the Accident/Injury:
When did the accident or injury occur? (Please include date and time if able)

_____

Was this a work injury? Yes ☐ No ☐

Have you missed work because of this injury?
Yes ☐ No ☐ How Much? _____

Describe what you were doing just before the accident or injury: _____

_____

_____

_____

Briefly describe your injury and how it happened:

_____

_____

_____

_____

Was anyone else injured? Yes ☐ No ☐

Describe how you felt immediately after the injury:

_____

_____

Did you report the injury to your employer?
Yes ☐ No ☐

Did you go to the hospital for the injury?
Yes ☐ No ☐ Which hospital? _____

What have you done for the injury?

_____

_____

Did it help? _____

Have you had an injury like this in the past?
Yes ☐ No ☐

Case information

L&I workers Comp case number: _____

Adjuster assigned to you: _____

Contact number: _____

Symptoms:
Check any symptoms you have had sense the injury:

- ❑ Headache
- ❑ Neck pain/Stiffness
- ❑ Mid back pain
- ❑ Sensitivity to Light
- ❑ Pain Behind Eyes
- ❑ Dizziness
- ❑ Fainting
- ❑ Sleeping problems
- ❑ Numbness in fingers or toes
- ❑ Loss of memory
- ❑ Fatigue
- ❑ Irritability ❑ Depression
- ❑ Ringing/Buzzing in Ears
- ❑ Loss of balance
- ❑ Tension
- ❑ Cold hands or Feet
- ❑ Chest Pain
- ❑ Clicking or Popping Jaw
- ❑ Low Back Pain
- ❑ Nausea
- ❑ Confusion or Disorientation
- ❑ Feeling Light Headed
- ❑ Blurred Vision
- ❑ Other _____

Rate your pain now on a scale of one to ten:
(Circle one) 1 2 3 4 5 6 7 8 9 10

Rate your pain at the time of injury:
(Circle one) 1 2 3 4 5 6 7 8 9 10