

# WORKER'S COMPENSATION INJURY REPORT

NAME \_\_\_\_\_ AGE \_\_\_\_\_ DATE OF BIRTH \_\_\_\_\_

DATE OF ACCIDENT/INJURY \_\_\_\_\_ TIME \_\_\_\_\_ LOCATION \_\_\_\_\_

Employer at time of injury: \_\_\_\_\_ Injury reported to employer:  No  Yes, When? \_\_\_\_\_

Please describe how accident/injury happened: \_\_\_\_\_

\_\_\_\_\_

Please describe in detail your present symptoms: \_\_\_\_\_

\_\_\_\_\_

Please describe symptoms immediately following accident/injury: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

## EMPLOYMENT

	Yes	No	Describe (if any)
Have you lost any days of work? Please list dates.	<input type="checkbox"/>	<input type="checkbox"/>	_____
Date of return to work fully.	<input type="checkbox"/>	<input type="checkbox"/>	_____
Prior to the accident were you able to work on an equal basis with others your age?	<input type="checkbox"/>	<input type="checkbox"/>	_____
Are any of your activities restricted? Please explain.	<input type="checkbox"/>	<input type="checkbox"/>	_____

## **CHECK SYMPTOMS YOU HAVE NOTICED SINCE INJURY ACCIDENT:**

- |   |   |  |  |
|---|---|--|--|
| <input type="checkbox"/> Headache       | <input type="checkbox"/> Constipation         | <input type="checkbox"/> Fainting              | <input type="checkbox"/> Chest Pain        |
| <input type="checkbox"/> Neck Pain      | <input type="checkbox"/> Diarrhea             | <input type="checkbox"/> Loss of Balance       | <input type="checkbox"/> Depression        |
| <input type="checkbox"/> Neck Stiffness | <input type="checkbox"/> Dizziness            | <input type="checkbox"/> Loss of Taste         | <input type="checkbox"/> Loss of Strength  |
| <input type="checkbox"/> Sleeplessness  | <input type="checkbox"/> Nausea               | <input type="checkbox"/> Loss of Smell         | <input type="checkbox"/> Ringing in Ears   |
| <input type="checkbox"/> Mid Back Pain  | <input type="checkbox"/> Head Feels Heavy     | <input type="checkbox"/> Cold Hands            | <input type="checkbox"/> Light Sensitivity |
| <input type="checkbox"/> Low Back Pain  | <input type="checkbox"/> Numbness in Legs     | <input type="checkbox"/> Cold Feet             | <input type="checkbox"/> Clumsiness        |
| <input type="checkbox"/> Arm Pain       | <input type="checkbox"/> Numbness in Arms     | <input type="checkbox"/> Loss of Memory        | <input type="checkbox"/> Face Flushed      |
| <input type="checkbox"/> Leg pain       | <input type="checkbox"/> Numbness in Toes     | <input type="checkbox"/> Disorientation        | <input type="checkbox"/> Cold Sweats       |
| <input type="checkbox"/> Nervousness    | <input type="checkbox"/> Numbness in Fingers  | <input type="checkbox"/> Unclear Thinking      | <input type="checkbox"/> Upset Stomach     |
| <input type="checkbox"/> Tense Muscles  | <input type="checkbox"/> Difficulty Breathing | <input type="checkbox"/> Visual Disturbances   | <input type="checkbox"/> Fever             |
| <input type="checkbox"/> Irritability   | <input type="checkbox"/> Fatigue              | <input type="checkbox"/> Difficulty Swallowing | <input type="checkbox"/> _____             |

## **Your Health Insurance:**

Company Name: \_\_\_\_\_

Address: \_\_\_\_\_

City, State, Zip: \_\_\_\_\_

Company Phone Number: \_\_\_\_\_

Policy Number: \_\_\_\_\_

## **Doctors or Hospitals Consulted:**

Name: \_\_\_\_\_

Address: \_\_\_\_\_

City, State, Zip: \_\_\_\_\_

Dates of Treatment: \_\_\_\_\_

\_\_\_\_\_

**JOB DESCRIPTION:**

Please describe your job duties in your own words: \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_

[In terms of an 8 hour work day, "occasionally" means 33%, "frequently" means 34-66%, and "continuously" means 67-100%]

1. In a typical 8 hour workday, I: (Circle # of hours per activity)

Sit:	1	2	3	4	5	6	7	8	Hours
Stand:	1	2	3	4	5	6	7	8	Hours
Walk:	1	2	3	4	5	6	7	8	Hours

2. On the job, I perform the following activities:

	<b>NOT AT ALL</b>	<b>OCCASIONALLY</b>	<b>FREQUENTLY</b>	<b>CONTINUOUSLY</b>
Bend/Stoop	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Squat	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Crawl	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Climb	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Reach above shoulder level	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Crouch	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Kneel	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Balancing	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Pushing/Pulling	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

3. On the job I lift:

	<b>NOT AT ALL</b>	<b>OCCASIONALLY</b>	<b>FREQUENTLY</b>	<b>CONTINUOUSLY</b>
Up to 10 pounds	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
11 to 24 pounds	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
25 to 34 pounds	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
35 to 50 pounds	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
51 to 74 pounds	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
75 to 100 pounds	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

4. Do you have to bend over while doing any lifting?  YES  NO

5. Are your feet used for repetitive movements, such as operating foot controls?  YES  NO

6. Do you use your hands for repetitive **SIMPLE GRASPING** **FIRM GRASPING** **FINE MANIPULATION**

RIGHT HAND  YES  NO  YES  NO  YES  NO

LEFT HAND  YES  NO  YES  NO  YES  NO

7. Are you required to work on unprotected heights?  YES  NO

8. Are you required to be around moving machinery?  YES  NO

9. Are you exposed to marked changes in temperature and humidity?  YES  NO

10. Are you required to drive automotive equipment?  YES  NO

11. Are you exposed to dust, fumes and/or gases?  YES  NO

12. Please list any additional comments: \_\_\_\_\_

\_\_\_\_\_

**Signature:** \_\_\_\_\_ **Date:** \_\_\_\_\_