

ADDENDUM for WORKERS COMPENSATION PATIENTS

1. What was the date of the injury? _____

2. What time did the injury occur? _____

3. Explain how your injury occurred? _____

4. Where did you feel pain after the incident? _____

5. Did you return to work? _____

6. What is the name of your employer? _____

What is the street address of your employer? _____

What is the City, State, and Zip of your employer? _____

5. What is the name of your attorney? _____

What is the street address of your attorney? _____

What is the City, State, and Zip of your attorney? _____

6. Did you report the incident to your supervisor? - YES - NO

What is your Supervisor's name? _____

7. Did your employer send you to a doctor? - YES - NO

If yes, please provide the doctor's name _____

8. Did you go to a doctor on your own? - YES - NO

If yes, please provide the doctor's name _____

Did you lose time from work? - YES - NO

9. Are there any other problems that affect your employment?

10. Does your job cause you to favor one side of your body? - YES - NO

If yes, which side and why? _____

11. Before the injury, were you capable of performing equal work with others your age? - YES - NO

If no, why? _____

12. Have you injured this area before? -YES - NO

If yes, please explain: _____

13. Are you taking any medications? - YES -NO

If yes, please list: _____

14. Are your work activities restricted as a result of this accident? - YES - NO

If yes, please explain: _____

15. Since the injury, are your symptoms: (circle one)

Getting better Worse Same