APPLIED HEALTHCARE ASSOCIATES

WORKERS COMPENSATION HISTORY

GENERAL INFORMATION			
PATIENT NAME:			DATE:
ADDRESS:		CITY:	STATE/ZIP CODE:
HOME PHONE NUMBER:		CELL PHONE NUMBER:	
WORK PHONE:		CELL PHONE:	
SOCIAL SECURITY NUMBER:	DATE OF BIRTH:	AGE:	GENDER:

EMPLOYER INFORMATION		
EMPLOYER NAME:	SUPERVISOR NAME:	
EMPLOYER ADDRESS:	CITY:	STATE/ZIP CODE:
WORK PHONE:	OCCUPATION:	

COMPENSATION CARRIER INFORMATION		
COMPENSATION CARRIER NAME:	COMPENSATION CARRIER PHONE:	
COMPENSATION CARRIER ADDRESS:	CITY	STATE/ZIP
CLAIM NUMBER:		

ACCIDENT/INJURY DETAILS	
DATE OF INJURY:	TIME OF INJURY (A.M. OR P.M.):
EXPLAIN THE DETAILS OF THE ACCIDENT:	
ARE YOU OFF WORK? ❑ YES ❑ NO	IF YES, DATE YOU LEFT WORK:
HAVE YOU RETURNED TO WORK SINCE THE ACCIDENT? ❑ YES ❑ NO	IF YES, DATE YOU RETURNED TO WORK:
HAVE YOU BEEN TREATED BY ANY OTHER DOCTORS FOR THIS CONDITION? ❑ YES ❑ NO	IF YES, LIST THE DOCTOR(S) NAMES & PHONE NUMBERS:
HAVE YOU HAD ANY PREVIOUS WORKERS COMPENSTATION INJURIES? ❑ YES ❑ NO	DATE(S) OF PREVIOUS WORKERS COMPENSATION INJURIES:
PRIOR TO THE ACCIDENT, HAD YOU HAD SIMILAR COMPLAINTS TO THE ONES YOU ARE EXPERINCING NOW? ❑ YES ❑ NO	
IF YES, PLEASE DESCRIBE:	

SIGNATURE	
PATIENT SIGNATURE:	DATE:

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