

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?

\_\_\_\_\_