

# Workers Comp Questionnaire

Patient \_\_\_\_\_ Date: \_\_\_/\_\_\_/\_\_\_

What was the date of injury? \_\_\_/\_\_\_/\_\_\_

What time did the injury occur? \_\_\_:\_\_\_ AM/PM

What is the name of your employer? \_\_\_\_\_

What is your employer's address? \_\_\_\_\_

Street

City

State

Zip

What is the name of your attorney? \_\_\_\_\_

What is your attorney's address? \_\_\_\_\_

Street

City

State

Zip

Please briefly describe the incident: \_\_\_\_\_

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Did you report the incident to your supervisor? Yes/No

Name of your supervisor? \_\_\_\_\_

Last

First

Did your employer send you to a doctor? Yes/No If yes, please provide the doctor's name

\_\_\_\_\_  
Last, First

**Was this your primary care doctor? Yes/No if no, please provide the name of your primary care doctor:**

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**Last**

**First**

**Are you experiencing any symptoms that affect your employment?**

**Yes/No**

**If yes, please explain:**

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**Does your job cause you to favor one side of your body? Yes/No If yes, which side? \_\_\_\_\_**

**Before your injury, were you capable of performing equal work with others your age? Yes/No**

**Have you injured this area before? Yes/No**