Health Enhancement Therapies, Saint Michael, MN

WORK INJURY QUESTIONNAIRE

Date and time injury occurred: Date: _______________ Time: ____________am /pm

Has injury been reported to your employer? Yes ______No _____

If yes, give his/her name: ____

May I call your employer for authorization to treat you? Yes _____No____

Have you retained a Workers' Compensation Attorney for this case? Yes _____ No ____

If yes, name and phone: ____ PH#_____________________

Did you return to work? Yes _____No ______ For the same company? Yes _____No ______

Are you currently working? Yes _____No ______ If no, last date of employment? _________________

If working for a different company, name of company: ____

Have you ever injured this area before? Yes _____No ____ If yes, when? _____________

Did you lose time from work? Yes_____No____

Have you ever had a Workers' Compensation claim before? Yes _____No ______

Do any other medical problems affect your employment? Yes _____No ______

If yes, explain: ____

Area that you felt pain immediately after the accident: ____

List all symptoms immediately post injury:____

Since the injury, symptoms are: Improving ____ Worse ____ Unchanged ____

List any other treatment or therapy received for this injury and provider: ________________________________

What physical duties required by your job are affected by this injury? __________________________________

What activities of daily living are affected by this injury? ____

Explain in detail how your accident happened. (Use other side if necessary.)