



Today's Date \_\_\_\_\_

Date of Birth \_\_\_\_\_

Preferred Phone \_\_\_\_\_

### Workers' Compensation Injury – History Form

*Confidential*

Name: \_\_\_\_\_

(LAST NAME)

(FIRST NAME)

(PREFERRED NAME)

(INITIAL)

Age: \_\_\_\_\_ Sex:  Male  Female Fire or Police Department: \_\_\_\_\_

Injury: \_\_\_\_\_

Date of Injury: \_\_\_\_\_

Workers' Comp Injury Report Completed? Circle: Yes No

**Describe details of injury.** (Discuss specifics - including mechanism of injury, equipment involved, potential exposures, location, clinical symptoms and any other relevant information.)

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**Initial assessment and treatment.** (Describe details: where, when, X-ray results, etc.):

1. Medical Evaluation (ER, urgent care, etc.)

\_\_\_\_\_  
\_\_\_\_\_

2. X-rays (describe) \_\_\_\_\_

3. Prescription medications? \_\_\_\_\_

4. OTC medications (i.e. ibuprofen)? \_\_\_\_\_

5. Other treatment modalities? \_\_\_\_\_

**Interval course.** Since time of initial injury, describe the interval change of symptoms (i.e. "50% better, with mild persistent swelling and pain").

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**Current work status** (active-duty, off-duty, light-duty, etc.). Describe details.

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_