WORKER'S COMPENSATION FORM

WORK-RELATED INJURY INFORMATION

Your name: _____ Phone: _____

Date and time injury occurred: Date: _____ Time: _____

Please explain in detail how the accident happened: _____

_____

_____

_____

Has injury been reported to immediate supervisor or foreman? Yes _____ No _____

Supervisor's name: _____

May I contact your employer for authorization to treat you? Yes _____ No _____

Employer's name: _____ Phone: _____

Have you retained a workers comp attorney for this case? Yes _____ No _____

Did you return to work? Yes _____ No _____ For the same company? Yes _____ No _____

Did you lose time from work? Yes _____ No _____

If not currently working, give last date of employment: _____

Where did you immediately feel pain? _____

Have you ever injured this area of your body before? Yes _____ No _____

If yes, describe: _____

Do any other medical problems affect your employment? Yes _____ No _____

If yes, describe: _____

During daily work or activities, do you favor any part of your body? Yes _____ No _____

Explain: _____

Have you ever had a workers comp claim before? Yes _____ No _____

Since the injury, the symptoms are: Improving _____ Staying the Same _____ Worsening _____

Changing _____ [describe: _____]

"I understand that it is my responsibility to keep all my massage therapy appointment. I understand that regularly missing appointments (1) is an indication that I may no longer need treatments, (2) may jeopardize my case, and (3) will obligate my therapist to notify my employer, carrier and physician."

Signed: _____ Date: _____