Worker's Comp Incident Form

Patient Name _____ Today's Date _____

Name of Compensation Carrier: _____.

Name of Employer: _____.

The date of the work related injury was: _____.

The time that the injury occurred was: _____ a.m. / p.m.

The last date worked was: (month)_____/ (day)_____/(year)_____.

Were you hospitalized? □ Yes □ No. If yes, please answer the questions below.

When were you hospitalized? □ immediately □ later same day □ next day □ date _____

How were you transported to the hospital? □ ambulance □ life flight □ private transportation

What did the hospital recommend? □ no instructions □ see this clinic □ see DC
□ see own doctor □ see orthopedist □ see neurologist □ prescription medication
□ other: _____

Did you have any xrays taken? □ Yes □ No
If yes, what areas? _____

My current job status is: (please mark the appropriate response below)

- **□ off work as a result of the injuries sustained in the reported work accident.**
- **□ working full duty.**
- **□ working light duty.**

I □ have □ have not been involved in previous work related accidents/injuries.

If you have been involved in previous work related accidents/injuries, please complete below.

Status of previous injuries:

- **□ treated and resolved**
- **□ treated, unresolved, and located at an unrelated area to this accident**
- **□ treated, unresolved, same area as current injury**
- **□ not treated and a completely different area than current injury**
- **□ not treated and still have residual symptoms**
- **□ not treated and do not have any residual symptoms**

This accident was: □ not reported to the employer. □ reported to the employer.

The name of the employee it was reported to was: _____.

Employee's Job Title _____ Phone # _(_____)_____-_____.

The injury occurred at (location): _____.

How many hours did you work that same day prior to the accident: _____.

What type of work were you performing at time of injury: _____
_____.

Describe the accident: _____
_____
_____
_____.

I have:

- **been treated by another doctor for the injuries sustained in this accident.**
- **not been treated by another doctor for the injuries sustained in this accident.**

If you have been treated by another doctor, please continue with the following questions.
List the doctor's name and current/past treatment: _____
_____
_____.

As a result of the treatment received thus far:

- **My condition has improved**
- **My condition has not improved**
- **My condition has worsened since the injury despite treatment received thus far.**