University Orthopaedic Clinic and Spine Center

PATIENT'S NAME _____ DATE OF BIRTH _____

MEDICAL RECORD # _____

FOR OUR WORKER'S COMPENSATION PATIENTS:

When did you injure yourself? _____

Who were you working for, and where? _____

_____

How did the injury happen? _____

_____

_____

Is this your first work injury? _____

If not, please list previous occurrences: _____

_____

Are you presently working at the same capacity, light duty, or not at all? _____

_____

What is the first date you were totally disabled from working? _____

Does your employer provide restricted duty for injured employees? _____

Who is your insurance claim agent? _____

Who is your supervisor or Personnel Director at work? _____

Do you have a Rehab Nurse or Case Manager handling your injury? _____

If yes, who is it? _____

If your case is in litigation, who and where is your attorney? _____

_____

Any additional remarks: _____

_____

_____

Date _____ Patient Signature _____