Leisure Yu MD, Ph.D., QME & IME

One Commitment • One Focus • Our Patients

Worker's Compensation History Form

Start Here— Use black pen or pencil and mark the ● circles completely.

1 **Today's date**

2 **Please print your information.**

Last Name

First Name MI

3 **Please sign and date this form.**

Patient Signature Date

Reviewed by:

Physician Signature Date-

4 **What was your date of injury?**

Print numbers in the boxes.

Month Day Year

5 **List name(s) of any witness(es) to your injury below:** ○ No Witnesses

6 **Did you report the injury?** *Mark ● ONE circle*

○ No ○ Yes

If yes, please answer questions 6.a and 6.b

6a **To whom did you report the injury?**

Please list the name of the person(s) and their phone numbers(s).

6b **What was the date(s) that you reported the injury to the above person(s)?**

Month Day Year

7 **After the injury, were you able to continue working?** *Mark ● ONE circle*

○ No ○ Yes

8 **Were you doing your regular work at the time of the injury ?** *Mark ● ONE circle*

○ No ○ Yes

If you answered **no** to question 8 please explain what you were doing?

9 **Were you sent to a doctor immediately?**

Mark ● ONE circle

○ No ○ Yes

9a **If you answered no to question 9, please explain why?**

9b **If you answered yes to question 9, did you drive yourself?** *Mark ● ONE circle*

○ No ○ Yes

If you answered **no**, please list who drove or how you got to the doctor or clinic.

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10 **Name of doctor, clinic or emergency room where you were first treated:**

11 **Date of the first visit if not the same as date of injury:**

Month Day Year

12 **What did the doctor do for you?** *Mark as many ● circles as needed*

- ○ Injection
- ○ X-Ray
- ○ Physical Therapy
- ○ Medication
- ○ MRI
- ○ Surgery

13 **Did your symptoms improve?** *Mark ● ONE circle*

○ No ○ Yes,

If **yes**, indicate which one(s) below.

Symptoms

- ○ Pain
- ○ Numbness
- ○ Tingling
- ○ Weakness
- ○ Instability
- ○ Swelling
- ○ Stiffness

14 **Were you referred to another physician for this injury?** *Mark ● ONE circle*

○ No ○ Yes If yes, please answer questions 14a through 14d below.

14a **By whom were you referred?**

14b **Doctor's Name:**

14c **Location:**

14d **What did this doctor do for you?** *Mark as many ● circles as needed*

- ○ Injection
- ○ X-Ray
- ○ Physical Therapy
- ○ Medication
- ○ MRI
- ○ Surgery

15 **List the date(s) and name(s) of any other physicians seen for this injury:**

○ No other physicians were seen

16 **Who is your current doctor?**

17 **List your current treatment.**

Mark as many ● circles as needed

- ○ Injection
- ○ X-Ray
- ○ Physical Therapy
- ○ Medication
- ○ MRI
- ○ Surgery

18 **List the Date of Hire for the job you had at the time of injury.**

Month Day Year

19 **List the number of years at this type of work**

20 **Describe your job exactly at the time of injury:**

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21 **Indicate your usual work duties at the time of injury?** *Please indicate a selection for each duty listed.*

	Not at all	Occasionally	Frequently	Constantly
Stand	○	○	○	○
Kneel	○	○	○	○
Reach	○	○	○	○
Bend	○	○	○	○
Walk	○	○	○	○
Climb	○	○	○	○
Stoop	○	○	○	○
Twist	○	○	○	○
Push	○	○	○	○
Pull	○	○	○	○
Squat	○	○	○	○
Drive Vehicle	○	○	○	○
Overhead Work	○	○	○	○
Detailed Handwork	○	○	○	○

22 **Does your usual work require you to lift?** *Mark ● ONE circle*

○ No ○ Yes, If **yes**, please answer questions 22a and 22b below:

22a **What is the average weight you lift during your duties?**

in ○ kilograms or ○ pounds

22b **What is the maximum weight you lift during your duties?**

in ○ kilograms or ○ pounds

23 **What was your work schedule?** *Mark ● ONE circle*

○ Full Time ○ Part Time
○ Full Time with Overtime

24 **Were you returned to regular work?** *Mark ● ONE circle*

○ No ○ Yes, If **no**, please answer questions 24a through 24c below.

24a **Were you returned to Modified work?** *Mark ● ONE circle*

○ No ○ Yes

24b **What restrictions were given to you?**
Please list them below.

24c **Please list the time period(s) you missed work:** ○ No missed work time

From			To		
Month	Day	Year	Month	Day	Year

25 **Are you still employed at the job where you were hurt?** *Mark ● ONE circle*

○ No ○ Yes, If **no**, please answer questions 25a.

25a **Where are you currently working?**

26 **Do you have a new job?** *Mark ● ONE circle*

○ No ○ Yes
If **yes**, please answer questions 26a and 26b

26a **What was the start date of the new job?**
Month Day Year

26b **List below the company your new job is with.**

27 **Have you ever had a previous Work Related Injury?** *Mark ● ONE circle*

○ No ○ Yes, If **yes**, please answer questions 27a through 27d

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27a **Describe the previous Work Related Injury below**:

27b **Who was your employer at the time of the injury?**

27c **Did you have surgery?** *Mark ● ONE circle*
○ No ○ Yes
If **yes**, please list all the surgeries.

27d **Did you fully recover?** *Mark ● ONE circle*
○ No ○ Yes, Please give an explanation below.

28 **Have you ever had a previous Non-Work Related Injury?** *Mark ● ONE circle*
○ No ○ Yes, If **yes**, please answer questions 28a through 28c

28a **Describe the previous Non-Work Related Injury below**:

28b **Did you have surgery?** *Mark ● ONE circle*
○ No ○ Yes, If **yes**, please list all the surgeries.

28c **Did you fully recover?** *Mark ● ONE circle*
○ No ○ Yes, Please give and explanation below

29 **Have you ever broken any bones?** *Mark ● ONE circle*
○ No ○ Yes, Please give and explanation below.

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