Name:
DOB:
Chart:
Age:
Date:

HAND TO SHOULDER SPECIALISTS OF WISCONSIN

WORKER'S COMPENSATION CLAIMS

If your visit today with our office is due to an injury sustained at work, or if it is a progression of symptoms that you feel is related to work, please complete the following questions:

DATE OF INJURY (Approximate date of onset of symptoms): _____

PLACE OF EMPLOYMENT: _____

LENGTH OF EMPLOYMENT: _____ (YEARS, MONTHS)

HOURS WORKED PER DAY: _____ DAYS WORKED PER WEEK: _____

WHAT IS YOUR INJURY?: _____

WAS THIS AN ACUTE INJURY? (Fall, traumatic event, power tool accident): YES NO

If you answered NO please describe in as much detail as possible what you do on a daily basis at work. Please include any *repetitive activities and the length of time and/or number of times* you perform these activities throughout the day, also please indicate if you do any lifting how many times and what weight:

_____

_____

_____

_____

HAVE YOU REPORTED THE INJURY TO YOUR SUPERVISOR / EMPLOYER? _____

NAME AND ADDRESS OF WORKER'S COMPENSATION INSURANCE CARRIER? _____

_____

_____

CLAIM NUMBER: _____ TELEPHONE NUMBER: _____

ADJUSTER NAME: _____ EXTENSION: _____

_____ _____

SIGNATURE DATE

_____

NAME (Please Print)

BC17