WORK STATUS HISTORY

Have you lost any time from work as a result of this new injury? ☐ Yes ☐ No

If yes give dates: _____

If you are currently on **disability (time loss)** do you want to go back to work doing your **regular** work duties? ☐ Yes

If no, state why: _____

Have you gone back to work? ☐ Yes ☐ No If yes, when? _____ What status of work? ☐ Modified ☐ R

Please list what restrictions you have been placed on : _____

_____

If you have gone back to **work**, please list the activities as:

Those that are painful : _____

Those that are difficult : _____

Are there any problems you have with a fellow employee, supervisor, or management that need to be discussed? ☐ Yes

If yes, please discuss : _____

_____

_____

FIRST DOCTOR/HOSPITAL/CLINIC SEEN

Did you go to seek medical help immediately/soon after the accident ? ☐ Yes ☐ No

If yes, how did you get there? ☐ Someone else drove me ☐ Drove own car ☐ Ambulance ☐ Police

DOCTOR1/HOSPITAL/CLINIC SEEN : _____ Date of first visit : _____

Were you examined? ☐ Yes ☐ No Were X-rays taken ? ☐ Yes ☐ No

Were you given treatment? ☐ Yes ☐ No

If yes, what treatment was given to you ? _____

What benefits did you receive from the treatment? _____

Date of last treatment ? _____

OTHER DOCTOR/CLINIC/TESTS FOR THIS INJURY

DATE	DOCTOR/CLINIC	TREATMENT/TESTS	RESULTS