Worker's Compensation Injury Form

Name: ___________________________________ Today's Date:_______________

Date of Accident: _______________________________________ Time:____________________

Have you filled out your "First Report of Injury Form" at Work? Yes No

Is your injury affecting your ability to do your job at work? Yes No

Do you need a note for work? Yes No

What were you doing at the time of the accident? ____

Did you trip, slip, or fall? ____________________________ How far was the fall ? _________________

Upon impact after slip, trip, or fall, how did your body land? _____________________________________

Were you lifting an object? __________________________ How heavy was the object? ______________

Were you twisting or bending? Yes No

Did you hit your head on anything? Yes No On What? _________________________________

Did you lose consciousness? Yes No For how long? ____________________________________

When did the pain begin?____

Since accident pain is : Less ______________ Same ____________________ Worse _______________

Were you transported to hospital? Yes No Which hospital? ________________________________

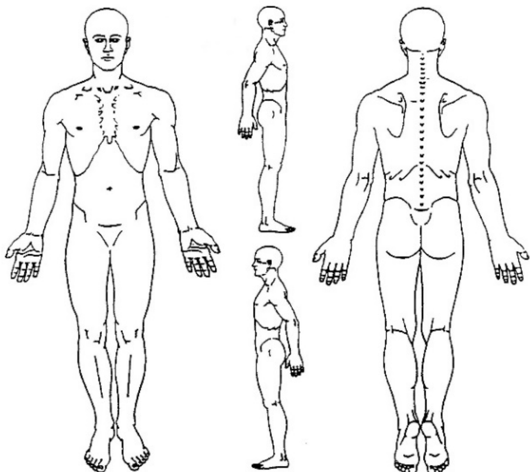
Were x-rays taken ? Yes No What x-rays ? ____

Have you seen another doctor since the accident? Yes No Name of Dr.____

What treatment did you receive?____

Were there any suggested future treatment plans? ____

Please indicate on the body where your pain is



On a scale from 0-10, with 10 being the worst pain, and 0 being no pain, what is your current rating of pain?

0 1 2 3 4 5 6 7 8 9 10