WORK INJURY HISTORY

Date ____________________ W/C Insurance Co. ____________________

Name ____________________ Group Insurance Co. ____________________

Employer ____________________ Claim # ____________________

Type of Business ____________________ Length of Employment ____________________

Name of Employer at Time of Injury ____________________ Occupation ____________________

DESCRIPTION OF ACCIDENT: ____________________

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WITNESS ____________________

DATE REPORTED TO EMPLOYER: ____________________ TO WHOM REPORTED: ____________________

DATE OF INJURY ____________________

JOB DESCRIPTION:

(In terms of an 8-hour workday, "occasionally" means 33%, "frequently" means 34% to 66%, and "continuously" means 67% to 100% of the day).

1. In a typical 8-hour workday, I: (Circle # of hours / activity)

Sit:	1	2	3	4	5	6	7	8	hours
Stand:	1	2	3	4	5	6	7	8	hours
Walk:	1	2	3	4	5	6	7	8	hours

2. On the job, I perform the following activities:

	NOT AT ALL	OCCASIONALLY	FREQUENTLY	CONTINUOUSLY
Bend / stoop	☐	☐	☐	☐
Squat	☐	☐	☐	☐
Crawl	☐	☐	☐	☐
Climb	☐	☐	☐	☐
Reach above shoulder level	☐	☐	☐	☐
Crouch	☐	☐	☐	☐
Kneel	☐	☐	☐	☐
Balancing	☐	☐	☐	☐
Pushing / Pulling	☐	☐	☐	☐

3. On the job, I lift

	NOT AT ALL	OCCASIONALLY	FREQUENTLY	CONTINUOUSLY
Up to 10 pounds	☐	☐	☐	☐
11 to 24 pounds	☐	☐	☐	☐
25 to 34 pounds	☐	☐	☐	☐
35 to 50 pounds	☐	☐	☐	☐
51 to 74 pounds	☐	☐	☐	☐
75 to 100 pounds	☐	☐	☐	☐

4. Do you have to bend over while doing any lifting? ☐ Yes ☐ No
5. Are your feet used for repetitive movements, such as in operating foot controls? ☐ Yes ☐ No
6. Do you use your hands for repetitive actions, such as:

	SIMPLE GRASPING	FIRM GRASPING	FINE MANIPULATING
Right hand	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
Left hand	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No

7. Are you required to work on unprotected heights? ☐ Yes ☐ No
8. Are you required to be around moving machinery? ☐ Yes ☐ No
9. Are you exposed to marked changes in temperature and humidity? ☐ Yes ☐ No

(continued on back)

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10. Are you required to drive automotive equipment? ☐ Yes ☐ No

11. Are you exposed to dust, fumes and/or gases? ☐ Yes ☐ No

If you have returned to work since your accident, please fill out the information below:

DATE	EMPLOYER	OCCUPATION	LIGHT DUTY REG. DUTY	FULL-TIME PART-TIME

Work-related Injuries: Prior Medical History: (Dates, Doctors, Disability, Permanent Disability, Rehabilitation)

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Other Injuries: (Auto, Slips & Falls, Sports)

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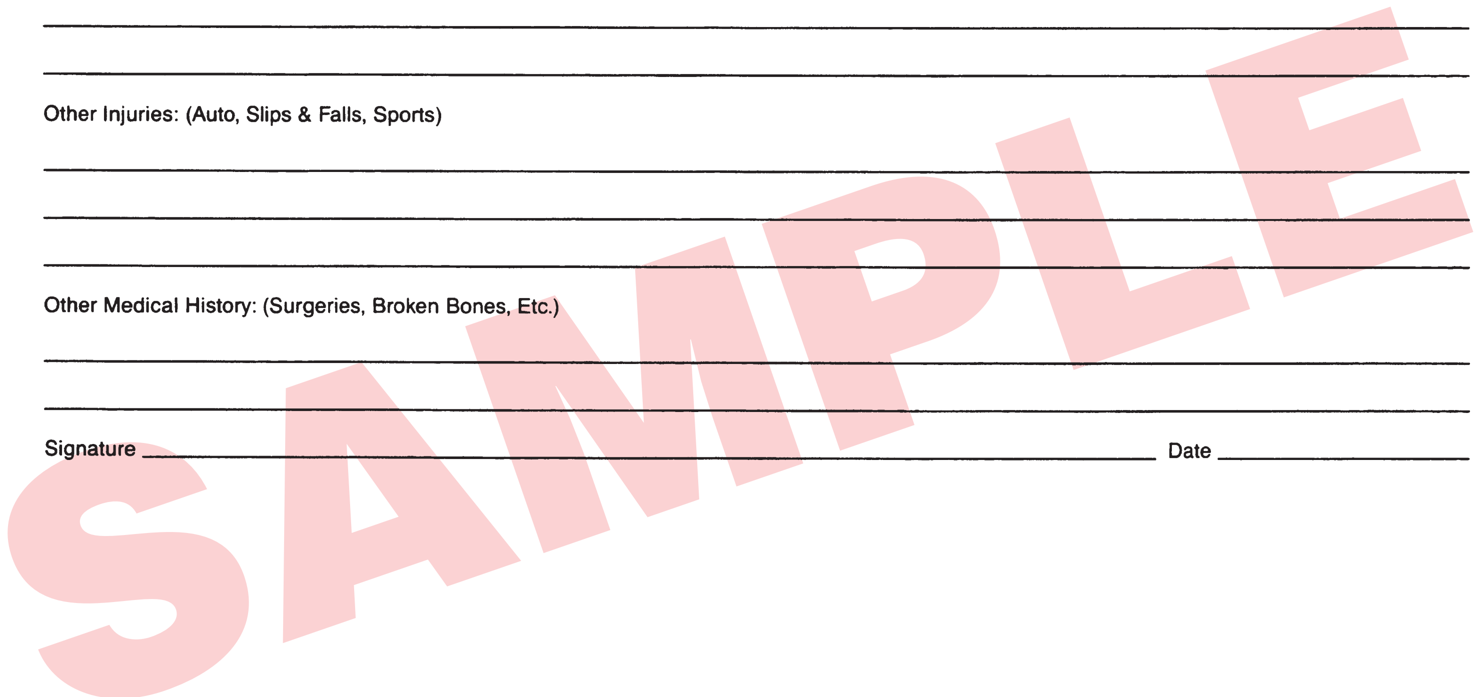

Other Medical History: (Surgeries, Broken Bones, Etc.)

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Signature ______________________ Date ____________