EMERGENCY RESPONDERS HEALTH CENTER

Today's Date _____
Date of birth_____
Preferred Phone _____

Worker's Compensation Injury – History Form

Confidential

Name: _____
(LAST NAME) (FIRST NAME) (PREFERRED NAME) (INITIAL)

Age: _____ Sex: □ Male □ Female Fire or Police Department: _____

Injury: _____

Date of Injury: _____

Worker's Comp Injury Report Completed? Circle: Yes No

Describe details of injury. (Discuss specifics -- including mechanism of injury, equipment involved, potential exposures, location, clinical symptoms and any relevant information).

_____
_____
_____
_____

Initial assessment and treatment (describe details: where, when, X-ray results, etc):

1. Medical Evaluation (ER, urgent care, etc).
   _____
   _____
2. X-rays (describe). _____
3. Prescription medications? _____
4. OTC medications (i.e. ibuprofen)? _____
5. Other treatment modalities? _____

Interval course. Since time of initial injury, describe interval change of symptoms (i.e. "50% better, with mild persistent swelling and pain).

_____
_____
_____

Current work status (active duty, off duty, light duty, etc). Describe.

_____