Patient Questionnaire – Work-Accident

Patient Name: _____ Today's Date: ____/____/____

Basic Information about the Accident:

Date Accident Occurred or Started: ____/____/____
Time of Day when Accident Occurred or Started: ____:____ AM / PM

Describe how the Accident took place:

_____Text_____
_____
_____
_____

Describe the condition or symptoms caused by the Accident:

_____
_____
_____
_____

Work-Accident Specific Information:

Check all that apply:

□ Did the accident occur on the premises of the facility where you normally work (i.e., your local work address)?

□ Did the accident occur during your normal working hours?

□ Did you report the accident to your Employer?

□ Is your Employer covered by Workers' Compensation Insurance under state law?

□ Has your Employer prepared an initial written report?

□ Does the Employer's Report describe the condition or symptoms you are experiencing?

□ Has a claim number been issued for this accident?

□ Have you received any written denial of liability from either your Employer or Worker's Insurance Comp Payer?