Med Exam, Inc.

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WORKER'S COMPENSATION EVALUATION

PATIENT INFORMATION:

Name: _____ Social Security Number: _____

Address_____

City: _____ State: _____ Zip Code: _____

Home Phone: _____ Cell Phone: _____

Birth date _____ Age: _____ Sex: _____

INJURY DATA:

Date of injury(s): _____ _____ _____

Employer at the time of injury(s): _____

Job Title _____

Job duties and description: _____

_____

_____

How long were you employed at the time of the injury(s)? _____

HISTORY OF INJURY:

Briefly describe what happened _____

_____

_____

_____

What problems are you currently experiencing? _____

_____

_____

When did you return to work: Light duty_____ Full duty_____

What are you unable to do as a result of your injury? _____

_____

PAST MEDICAL HISTORY:

What other physical problems or medical conditions do you have? _____

_____

Prior surgeries_____

_____

Prior injuries (please describe): _____

_____

_____

Current medications and dosage_____

_____

Do you take any over the counter medications for your pain? _____

If yes what and how often? _____

CURRENT EMPLOYMENT INFORMATION:

What is your current work status? _____

Are you on any kind of restrictions? _____

If you are not working, are you receiving disability? _____

If you are unemployed or on disability when did you last work? _____

BACKGROUND INFORMATION:

Educational level completed _____

If you attended college what did you study? _____

Certifications or special training: _____

Prior work experience_____

_____

I hereby authorize Med Exam to release any information regarding my worker's compensation claim and/or personal injury to my attorney.

Patient Signature Date