PUTNAM COUNTY

WORKERS COMPENSATION
HEALTH SURVEY

CLAIMANT INFORMATION

DATE:_____

FULL NAME:_____
Last First Middle (initial)

ADDRESS:_____
Street Address Apt. #

_____
City State Zip Code

PHONE: _____ EMAIL: _____

JOB TITLE:_____ DEPARTMENT: _____

DOB:_____ SOCIAL SECURITY # _____ SEX:_____

HEIGHT:_____ WEIGHT: _____ VISION: _____

DATE OF ACCIDENT:_____ LOCATION OF ACCIDENT:_____

HOW DID THE INJURY OCCUR:_____
_____

AREAS OF INJURY: _____

DID YOU LOSE CONSCIOUSNESS: YES ___ NO ___ If yes, when and where: _____

DID YOU GO TO THE EMERGENCY ROOM: YES___ NO ___ If yes, what ER: _____

- WHRE BODY PARTS X-RAYED: YES___ NO ___ If yes, which body part(s):_____
- DID YOU RECEIVE TREATMENT IN THE ER: YES___ NO ___ If yes, please explain:

  _____
  _____

ARE YOU CURRENTLY UNDERGOING TREATMENT FOR AN INJURY THAT WAS SUSTAINED DURING THIS ACCIDENT: YES____ NO____ If yes, please explain:

_____
_____

PAST MEDICAL HISTORY

DO YOU HAVE A SERIOUS ILLNESS OR INJURY: YES___ NO ___ If yes, please explain:_____
_____

HAVE YOU EVER HAD ANY TYPE OF SURGERY: YES___ NO ___ If yes, please explain: _____
_____

DO YOU TAKE ANY TYPE OF MEDICATION CURRENTLY: YES ___ NO ___ If yes, please explain and list the medications:_____
_____

HAVE YOU EVER HAD A SIMILAR CONDITION OR PRIOR ACCIDENT: YES __ NO __ If yes, please explain and give details: _____
_____

CURRENT CONDITION

Approximately how soon after your injury did you start treatment? _____
_____

Are you any better now than when you started treatments? YES ____ NO ___

How many(minutes, hours or days) does relief last after treatment for your injury? _____
_____

Do you have a difficult time walking, bending, lifting or sitting ? YES ___ NO ___ If yes, please explain:
_____
_____

DISCLAIMER AND SIGNATURE

I certify that my answers are true and complete and to the best of my knowledge. If this application leads to employment, I understand that false or misleading information in my application or interview may result in my release.

SIGNATURE: _____ DATE: _____