Med Exam, Inc.

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? _____

_____