ALOHA FOOT AND ANKLE ASSOCIATES, INC

WORKER COMPENSATION HISTORY

Last Name __________________________ First Name ____________________________ Phone (____) ______________

Address _____________________________________ City _______________________ State __________ Zip _________

Age _____ DOB ____/____/_____ Sex _____ Social Security # ____/____/____

Name of Compensation Carrier ___________________________________ Phone # (____) ______________ Ext _______

Adjuster Name __________________________________ Claim # _____________________ Fax (____) ______________

Address of Carrier _____________________________ City _______________________ State __________ Zip ________

Employer's Name ____ Phone (____) ______________

Employer's Address ___________________________ City ________________________ State __________ Zip ________

1 Type of Business ______________________________________ Your Occupation ______________________________

2 Date Injured ____/____/_____ Hour ____ AM/PM Last Date Worked ____/_____/_____ Are you off work? ☐Yes ☐No

3 Accident reported to employer? ☐ Yes ☐ No Name of person accident reported to _____________________________

4 Injured at ___________________________________ City _______________________ State ___________ Zip ________

5 Length of time worked there prior to accident _______________

6 Type of work being done at time of injury ____

7 In your own words, please describe the accident ____

____

____

8 Have you been treated by another doctor for this accident? ☐Yes ☐ No

If yes, please list doctor's name and address ____

____

What type of treatment did you receive? ____

How long were you treated by this doctor? ____

9 Are you: ☐Improved ☐Unchanged ☐Getting Worse

10 What types of medicine are you taking? ____

Do these medicines help? ☐ Yes ☐ No ☐ Don't know

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11 Have you had physical therapy? ☐ Yes ☐ No

If yes, how often? ☐ Daily ☐Every other day ☐ Several times a week ☐Weekly ☐Every other week ☐Monthly Other ____________________

Does the physical therapy help? ☐ Yes ☐ No ☐ Don't know

12 Prior to this accident, have you ever had any of the physical complaints similar to what you have now?
☐ Yes ☐ No ☐ Don't know
If yes, describe
____
____

13. Were these similar complaints the result of a previous accident? ☐ Yes ☐ No
Please provide details of accidents
____
____

14. Have you had any other serious accidents which required medical care? ☐Yes ☐No
Please describe
____
____

15. Have you had any surgeries? ☐ Yes ☐No - If yes, list types of surgery and date below
____
____

16. Have you had any nervous or mental illnesses? ☐ Yes ☐No
Have you had psychiatric care? ☐ Yes ☐ No

17. Have you received a medical discharge from the Armed Forces? ☐ Yes ☐ No

18. Have you returned to work since these accidents? ☐Yes ☐ No
If you have returned to work since your accident, please fill out the information below:

Date	Employer	Occupation	Light Duty or Regular Duty	Full Time or Part Time