Spring Lake Massage Therapy & Wellness Center

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ON-THE-JOB INJURY / WORKMANS COMP / L&I FORM

Today's Date:____

Patient Name:____

Phone:____

Job Title:____

Date of Birth:____

PATIENT'S WORKERS COMPENSATION / L&I INFORMATION

Employer Name, Address, Phone:______________________________
____

Insurance Name & Address:______________________________
____

Insurance Adjustor Name, Phone:______________________________
____

Date & Time of Injury:____________________Claim#: ______________

INJURY INFORMATION

In your own words, please describe the accident/ how your injury occurred?____
____
____

Initial symptoms, if any, related to incident?______________________________
____
____
____

Any Activities of Daily Living (ADL's, i.e. trouble sitting/hard to clean the house) or WORK DUTIES affected since the incident?______________
____
____

What self-care have you done for yourself, if any, since the incident?
____
____
____