Work Comp Injury Report

Midwest Bone and Joint Center, P.C.
1706 Prospect Drive
Macon, MO 63552
660-385-1006
660-385-1028

D. Christopher Main, DO
Nola Moore, FNP-BC, ONP-C

Patient Name:_____ Phone: _____
Employer Name:_____ Employer Contact:_____
Hire Date:_____ # Years Worked: _____Injury Date:_____
Date Injury Reported: _____To Whom: _____
Injury Witnessed? □Yes □No Witnesses: _____

Do you have commercial Insurance that will cover your doctor bills if workers compensation does not cover them? □Yes □No

Insurance Name:_____

I understand that I am responsible for my bill for services rendered to me by D. Christopher Main, DO, or Nola Moore, FNP-BC, ONP-C until the Bureau of Workers Compensation or my self-insured employer covers expenses incurred by my evaluation or treatment.

What is current occupation? _____
Describe your job duty in detail (i.e. the job you were performing when you developed your problem; what you do with your arms and hands at work; how often you perform these activities; how many pounds you lift and how often; whether or not you do data entry; if you do repetitive work. Please be very specific.)_____
_____
_____
_____
_____
_____
_____
_____
_____
_____

Are you currently working you current job? □Yes □No
If no longer working for this company, date of last day worked:_____
Are you on light duty? □Yes □No How long have you been on light duty? _____
Hours per day worked?_____ Hours per week worked?_____
Do you have a second job? □Yes □No Hrs/week_____ Hrs/day_____
If yes please describe your job duties: _____
_____
_____
_____
_____
_____
_____
_____

Past work history dating back 10 years:
Where Describe duties

_____
_____
_____
_____
_____

Recreational activities. Check any of the following you are involved in:
☐Motorcycle/ATV ☐wood cutting ☐automotive repair☐quilting/sewing ☐golf
☐Tennis ☐bowling ☐rodeo ☐MMA ☐running ☐bicycling ☐lawn care ☐other_____

Have you ever had a work comp claim prior to this one?
Company_____ Year_____ ☐Open ☐Closed
Please describe_____
Company_____ Year_____ ☐Open ☐Closed
Please describe_____
Company_____ Year_____ ☐Open ☐Closed
Please describe _____

Relating to this injury:
Please describe how you were injured:_____
_____
_____

Dominant hand: ☐Right ☐Left

Have you been treated by a physician or in the ER?
Who:_____ When:_____ Where:_____
Who:_____ When:_____ Where:_____

Tests performed for this injury:
Xray ☐Yes ☐No Where: _____MRI ☐Yes ☐No Where:_____
CT Scan ☐Yes ☐No Where:_____EMG/NCV ☐Yes ☐No Where:_____
Other: _____

Treatments you have tried so far:
☐Rest/Activity modification ☐Physical Therapy ☐Immobolization/Brace/Orthotic
☐Chiropractic ☐Massage ☐Tylenol ☐Injection
☐Pain Medication _____☐Anti-inflammatory Medication_____
☐Over the counter medications _____

Previous Surgeries for this problem:
Date Physician Where

_____
_____

Medications you are currently taking for this Injury:

_____
_____

Signature:_____ Date: _____