

Sacramento Knee & Sports Medicine Medical Corporation
Workers' Compensation Questionnaire

Name: _____ Birthdate: ____/____/____

Your occupation at the time of your injury: _____

Are you currently working? ____ Yes ____ No If yes, Regular work? ____ Modified work? ____

If no, what was the date you last worked? _____

Are you currently receiving medical treatment for your injury? ____ Yes ____ No

If yes, please list the type treatment and who provided the treatment:

Any prior injuries? ____ Yes ____ No

If yes, please list the body part injured, date of occurrence, type and duration of treatment, and ongoing difficulties:

1. _____
2. _____
3. _____

Have you ever been disabled because of an injury? ____ Yes ____ No

If yes, when were you disabled and for how long? _____

Do you need to use stairs at home? ____ Yes ____ No

Number of persons in your household: _____

Do you have an attorney representing you for this injury? ____ Yes ____ No

If yes, name: _____

Phone: (_____) _____ Fax: (_____) _____

Address: _____

Comments/additional information: _____

Signature: _____ **Date:** ____/____/____