*Waterland Wellness*
22014 7th Ave S, Suite 105
Des Moines, WA 98198
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**ON-THE-JOB INJURY (WORKERS COMP / L&I) QUESTIONNAIRE**

Patient Name: _____ Ph: _____

DOB: _____ Job Title: _____

**PATIENTS WORKERS COMPENSATION / L&I INFORMATION**

Employer Name/Address/Phone: _____

_____

Insurance Name & Address: _____

_____

Insurance Adjustor Name & Phone#: _____

Date & Time of Injury: _____ Claim#: _____

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**INJURY INFORMATION**

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

_____

_____

_____

_____

_____

_____

What was the weather like (if applicable) or work environment like at the time of incident? _____

_____

_____

_____

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? _____

_____

_____