Dr. Lisa Vizzacco
1255 Oaklawn Avenue, 2d
Cranston, RI 02920
401-942-6020

Employee Information

Employer: _____

Address: _____

Telephone: _____

Supervisor _____

Work Comp Insurance Carrier _____

Telephone _____ Claim #_____

Claims Adjuster _____

Accident Information

Date & Time of Accident: _____

Was your accident directly related to work? _____

Briefly describe what happened _____

Was anyone else present during your accident _____

Did you report your accident to employer _____

What recommendations did your employer make to you after your accident _____

_____

Have you injured yourself in the workplace before

Is your job
- Physically stressful …… ____
- .Mentally stressful …… ____
- workplace noisy ……..…… ____
- Have you changed jobs in the last year. ____

Did the accident render you unconscious _____
If yes, for how long _____

Please describe how you felt immediately after the accident.
_____

Have you gone the hospital or seen any other Doctor.

Describe any treatment you received. _____

Xrays taken: _____

Medication prescribed _____

Have you returned to work _____

Actual work days missed _____

Are your work duties limited as a result of injury _____

Have you retained an Attorney. _____

If yes, whom: _____

His/Her Telephone: _____

Symptoms

Describe your current symptoms as related to this accident:
_____

Have you ever had this pain before, if yes please describe
_____

_____

Are your symptoms improving, unchanged or getting worse (circle one).