



Edmondson Park Medical
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PATIENT WORKCOVER QUESTIONNAIRE

Please complete the form below and return to reception to be included with your file – If you are unsure or need assistance, please ask reception or your Doctor

Surname: _____ First Name: _____

Address: _____

Home Tel: _____ Mobile: _____

Occupation: _____ D.O.B. _____

Please advise the date when the injury / Accident Occurred

Day _____ Date _____ Time _____ AM/PM

Is your injury related to :

WORK MOTOR VEHICLE ACCIDENT

PUBLIC LIABILITY VICTIMS COMPENSATION

OTHER _____

If WORK Related, please advise the following details:

(Also note that you must complete a work injury claim form with your employer)

Name of your employer: _____

Employers Address _____

Employers Phone Number _____

Have you reported your injury to your employer: YES NO

If yes, Who did you report the incident to ? : _____

Claim No / Insurance company (If Known): _____

When did you commence work with your employer? : _____

Please describe your duties of employment:

How long have you been doing this type of duty?: _____

Please describe what you were doing when the injury occurred or the accident happened

Have you had any of the previous injuries of a similar nature ?(Please list these and advise month and year of injury)

Please list your pain and problems in order of severity

Patient Signature_____Date_____