Workers’ Compensation Impairment Report

Insurance Name and Address:

Claim Number:

Employer Name:

Employer Address:

Nature of Business:

Patient Name:

Sex:

Date of Birth:

Patient Address:

Patient Telephone number:

Occupation:

Social Security Number:

Injured at:

Date of current exam:

Date and Hour of Injury or Onset of Illness:

Date Last Worked:

Date and Hour of First Examination or Treatment:

# History of Injury/Illness

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# Subjective Complaints

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## Body Part 1

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## Body Part 2

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# Activities of Daily Living

We went over each of the 34 activities of daily living, self-care, personal hygiene, communication, physical activity, sensory function, non-specialized hand activities, travel, sexual functioning, and sleep.

# Relevant Medical History

## Med Trials to Date

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## Therapy/Ancillary Treatments to Date

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## Prior Care Facility/Case Consult Providers

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## General Health Conditions/Past Medical History

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## General Review of Systems

Constitutional:

Eyes/vision:

Ears/Nose/Throat:

Cardiovascular/Heart/Circulation:

Respiratory/Breathing:

Gastrointestinal/Digestive:

Genitourinary/Urinary or Reproductive:

Musculoskeletal/Joints:

Skin:

Neurological/Dizziness/Weakness/Sensory:

Psychiatric/Depression/Anxiety/History of Suicidal Thoughts/Addictions:

Endocrine/Diabetes or Thyroid:

Hematological/Lymphatic/Bruising/Bleeding or Swollen Areas:

Allergic/Immunologic/Drug Intolerance etc:

# Social History

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# Objective Findings

(Include significant physical examination, laboratory, imaging, or other diagnostic findings.)

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# X-ray and Laboratory Results

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# Diagnoses

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# Whole Person Impairment (WPI) rating using State Specific Impairment Rule Set

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# Apportionment

Only if required by jurisdiction.

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# Maximal Medical Improvement (MMI)

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# Future Medical Treatment

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# Functional Limitations

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# Ability to Resume Usual and Customary Occupation

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# Documentation

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# Time Disclaimer

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# Signature

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