

**Orthopedic Sports Medicine & Spine Care Inst.**

**W. Chris Kostman, MD**

**Workers' compensation patients please complete this page**

Are you currently employed? \_\_\_\_\_ yes, \_\_\_\_\_ no, if yes, regular or limited duty? \_\_\_\_\_

If limited duties, describe  
limitation: \_\_\_\_\_

Last date of employment \_\_\_\_\_

Description of regular job activities \_\_\_\_\_

Regular job duties include:

	Continuous	Frequent	Occasional	Never
Lifting (wt range)	_____	_____	_____	_____
Bending/squatting	_____	_____	_____	_____
Sitting	_____	_____	_____	_____
Driving	_____	_____	_____	_____

Please list prior physicians that have evaluated/treated you for this  
injury \_\_\_\_\_

Please describe any treatment you have had for this  
injury \_\_\_\_\_

Have you had any surgery for this injury? \_\_\_\_\_ if yes, list type, date and  
surgeon \_\_\_\_\_

Have you ever injured or had significant pain in this part of body before that injury at  
work? \_\_\_\_\_

If so, please describe the previous injury or symptoms, and indicate when it happened.

Have you ever reported a work comp injury before? \_\_\_\_\_ If so, have you been treated? \_\_\_\_\_

Describe injuries, treatments, results, etc. in detail (include dates)