Disability Form Completion Worksheet

Name: _____

Date Of Birth: ___ / _____ / _____

Date of 1st visit for disabling condition: __ / ____ / _____

Date 1st out of work: ___ / ____ / _____

Duration of expected absence, frequency of abscences per month: _____

Condition(s) Causing Disability:

_____
_____
_____
_____

Symptoms from the conditions (what patient is experiencing, such as: neck pain, low back pain, headaches, etc):

_____
_____
_____
_____
_____

Current treatments (medications, surgery, therapy, etc):

_____
_____
_____
_____

Is the patient seeing another medical provider (including therapists, surgeons, pain doctors, etc) for this problem as well?

No Yes _____