Workers Compensation Intake Form

- **Please fill out this form as completely as possible. ***
- **Skip any section that does not apply to you. ***

Name: _____ Date: _____

Age: _____ DOB: _____

Sex: __ M __ F __ R Handed __ L Handed

Employer (at time of injury): _____

Job Title (at time of injury): _____

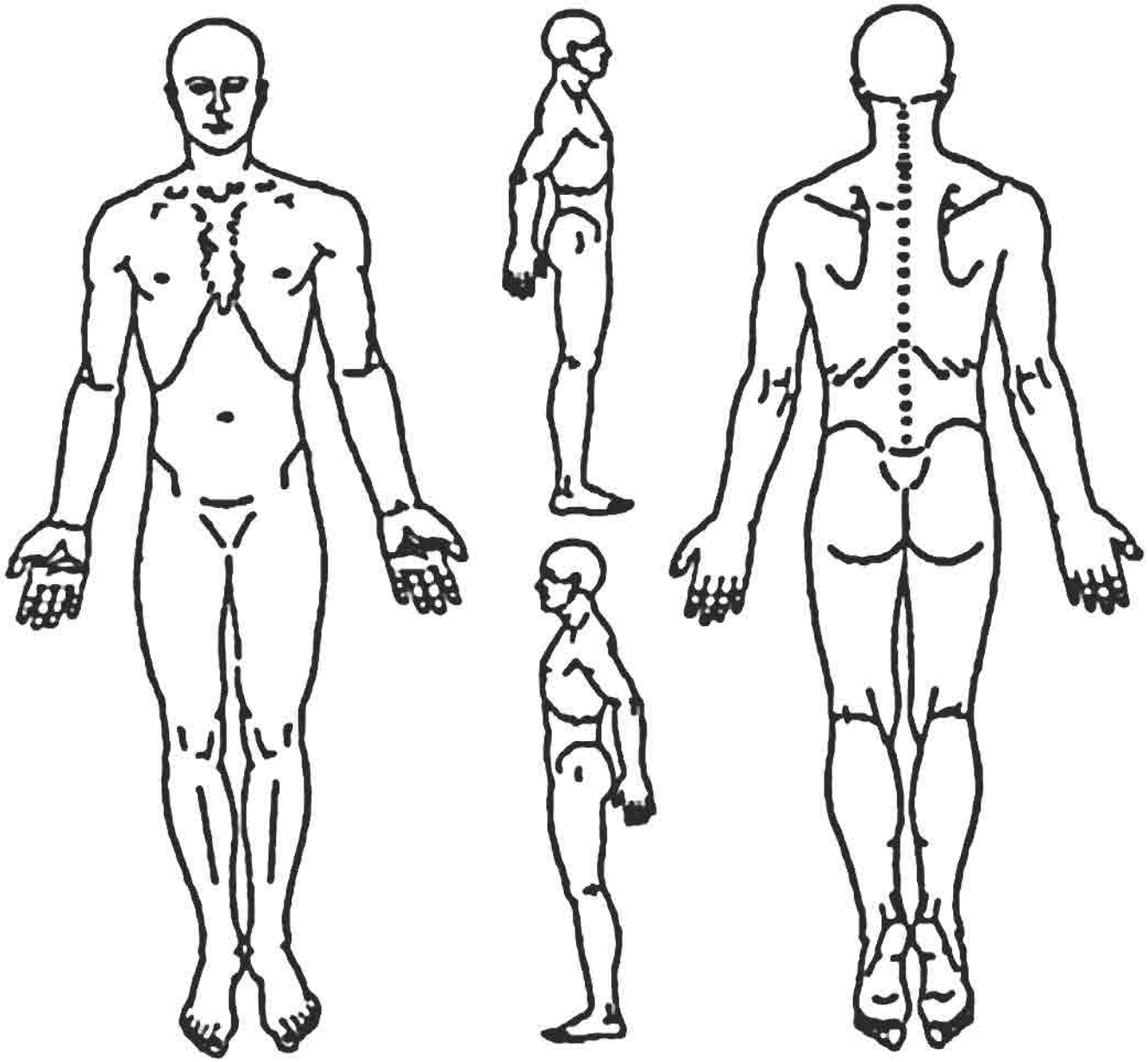
Please describe your injury and how you injured yourself: _____

_____

_____

_____

Symptom Diagram: Please mark diagram in area where you experience symptoms >



Name: _____

Approximate date of onset of injury/illness: _____
Type of injury: __ Acute Injury __ Multiple injuries __ Overuse injury __ other

Is this injury/illness work related? __ No __ Yes
Describe you symptoms, check all that apply:
__ *Pain*
__ Sharp __ Dull __ Aching __ Throbbing __ Stabbing __ Shooting __ Burning
__ Numbness or tingling: Location _____
__ Radiating symptoms: Location _____
__ *Other symptoms* _____
Pain scale:

0	1	2	3	4	5	6	7	8	9	10
No Pain										Worst pain

What is the frequency of your symptoms? __ constant __ intermittent __ hourly
__ daily __ weekly
What time of day is worse? __ no difference __ morning __ afternoon __ evening
__ night
Do your symptoms wake you from sleep? __ no __ yes: __ sometimes __ often
What makes your symptoms better? __ medications __ heat __ cold __ rest
__ chiropractor __ physical therapy __ other _____
What makes your symptoms worse? __ working __ sitting __ standing __ bending
__ *lifting* __ *typing* __ other _____
Overall, since the injury are you: __ better __ worse __ no change
Have you had this problem before? __ No __ Yes - When? _____
Have you had a prior work related injury? __ No __ Yes – What? _____
Are you on disability? __ *No* __ *Yes – for What?* _____
Are you represented by a lawyer for this injury? __ No __ Yes
What treatments have you had for your injury? _____

_____

_____

What tests have you had? __ X-ray __ CT scan __ MRI __ EMG __ other

Supplies: __ Braces __ Walking Aids __ TENS

Medications (all):_____

Therapy (what and how many visits):_____

Interventions: __ Injections __ Surgery __ other

Complimentary: __ Chiropractic __ Acupuncture __ other

Name: _____

Work History (most recent)
Employer: _____
Job Title: _____
Check any of the following that you do frequently at work:
Lifting __ how much weight __ Bending/Twisting __ climbing stairs __
Typing __ Gripping/grasping __ sitting __ standing __ Walking __
How long have/had you worked at this job? Years __ Months __
How many hours per day do/did you work? __
How many days per week do/did you work? __
Current work Status:
__ Full time without restrictions
__ working with restrictions – List: _____
__ not working _ last day worked: _____

Medical History:
Please list any medical problems you are currently or have ever been treated for by a doctor:
__ High blood pressure __ Diabetes __ Heart problems __ Lung problems
__ Kidney problems __ other _____
Please list any surgeries you have ever had including the dates: _____
_____
Please list any other medications that you are taking, including over the counter medicines and supplements: _____
_____
Please list any allergy to medicines that you have:
_____
Family History: please list any medical problems that your family members have: _____
_____
Social History
Marital status: __ single __ married __ divorced __ other
Children (list ages): _____
Do you smoke? __ No __ Yes How many packs per day _____
Do you drink alcohol? __ No __ Yes __ How much _____
Do you exercise? __ No __ Yes How much _____

Do you have any of the following medical conditions?

__ heart attack/ stroke	__ heart surgery/pacemaker	__ heart murmur
__ congenital heart defect	__ mitral valve prolapse	__ artificial heart valves
__ alcohol/ drug abuse	__ veneral disease	__ hepatitis
__ anemia	__ diabetes	__ shingles
__ cancer	__ glaucoma	__ kidney problems
__ high blood pressure	__ psychiatric problems	__ rheumatic fever
__ headaches/ migraines	__ tuberculosis	__ ulcers/ colitis
__ seizures/ epilepsy	__ sinus problems	__ asthma/ emphysema
__ arthiritis	__ difficulty breathing	__ chemotherapy
__ low back problems	__ frequent neck pain	__ artificial joints