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NEW PATIENT INTAKE FORM – Worker's Compensation

Today's Date_____/_____/____

PATIENT INFORMATION **CONFIDENTIAL**

Thank you for the opportunity to serve you. If you have any questions, do not hesitate to ask. We will be happy to help.

Name____ DOB_____/_____/_____ S/S______-______-_______

First MI Last

Address____City________________State______Zip__________

Please check your preferred method of contact

❒Home Phone: _________________________ ❒Work Phone: _________________________

❒Cell Phone: _____________________ ❒e-mail address*:______________________________

* Your e-mail will not be shared with any 3rd parties and is used for occasional office announcements and promotions.

Height________Weight________Last known Blood Pressure:________________

Do you smoke: ❒ No❒ Yes (If yes how often________________) If you quit: Start date:___________End Date: ___________

Sex: ❒ Female ❒ Male Status: ❒ Minor ❒Married ❒Single ❒ Other:________

Ethnicity/Race:___________________________________Employed: ❒Full-Time ❒Part-Time

Your Employer____ Phone________________

Business Address____City_________________ State_____Zip__________

Your Occupation_______________________________________Length of time worked at employer____________________

Name of Compensation Carrier____Phone__________________

Address____

Who may we thank for referring you to us?____

Person to contact in case of an emergency____Phone__________________

HEALTH HISTORY

Please check the following symptoms you have noticed **SINCE THE ACCIDENT** (❍) or **BEFORE THE ACCIDENT**(❒):

❍ ❒ Headaches
❍ ❒ Neck Pain
❍ ❒ Neck Stiffness
❍ ❒ Mid Back Pain
❍ ❒ Low Back Pain
❍ ❒ Arm Pain
❍ ❒ Leg Pain
❍ ❒ Pins and Needles in Arms
❍ ❒ Pins and Needles in Legs
❍ ❒ Numbness in Fingers
❍ ❒ Numbness in Toes
❍ ❒ Cold Hands
❍ ❒ Cold Feet
❍ ❒ Nervousness
❍ ❒ Tension
❍ ❒ Irritability
❍ ❒ Mood Swings
❍ ❒ Sleeping Problems
❍ ❒ Fatigue
❍ ❒ Depression
❍ ❒ Chest Pain
❍ ❒ Shortness of Breath
❍ ❒ Cold Sweats
❍ ❒ Fever
❍ ❒ Fainting
❍ ❒ Dizziness
❍ ❒ Loss of Balance
❍ ❒ Light Sensitivity with Eyes
❍ ❒ Ringing/ Buzzing in Ears
❍ ❒ Loss of Memory
❍ ❒ Loss of Smell
❍ ❒ Loss of Taste
❍ ❒ Upset Stomach
❍ ❒ Constipation
❍ ❒ Diarrhea
❍ ❒ Urinary Problems
❍ ❒ Heartburn
❍ ❒ Ulcers
❍ ❒ Allergies
❍ ❒ Menstrual Pain
❍ ❒ Menstrual Irregularity
❍ ❒ Hot flashes
❍ ❒ Other ______________
❍ ❒ Other ____________

Have **YOU** (❍) or **A FAMILY MEMBER** (❒) ever been diagnosed with any of the following conditions:

❍ ❒ AIDS/HIV
❍ ❒ Cancer
❍ ❒ High Blood Pressure
❍ ❒ Heart Disease
❍ ❒ Diabetes
❍ ❒ Stroke
❍ ❒ None
❍ ❒ Unknown
❍ ❒ Other _____________

ACCIDENT INFORMATION:

Date of accident______/_____/______ Time of Day_____________Location of accident __________________________________

Was the accident reported to your employer? ❒No ❒Yes, name of person reported accident to ___________________________

What type of work were you doing at the time of the accident? ____

Please describe the accident in your own words: ____

____

____

Did you lose consciousness? ❒ No ❒ Yes, for how long? ____

What was your mental and emotional state immediately following the accident? ____

Where did you go immediately following the accident? ____

Have you been treated by another doctor since the accident? ❒ No ❒ Yes , If yes…

Please list the name of the doctor and address: ____

Please explain what type of treatment you received: ____

What type of X-rays were taken if any? ____

Was there any other imaging done? (i.e., MRI, CT, etc.) ____

Do you have any congenital (from birth) factors that may relate to this problem? ❒ No ❒ Yes, ________________________

Do you have any previous illnesses which relate to this case ❒ No ❒ Yes, ____

Have you ever been involved in a work comp accident before? ❒ No ❒ Yes, ____

Have you lost time from work as a result of this accident? ❒ No ❒ Yes, If yes Last day worked:______/_____/______

JOB DESCRIPTION:

In a typical 8-hour work day, I: (circle the number of hours/ activity)

Sit:	1	2	3	4	5	6	7	8	hours
Stand:	1	2	3	4	5	6	7	8	hours
Walk:	1	2	3	4	5	6	7	8	hours

On the job, I perform the following activities:

	NOT AT ALL	OCCASIONALLY	FREQUENTLY	CONTINUOUSLY
Bend/stoop	❒	❒	❒	❒
Squat	❒	❒	❒	❒
Crawl	❒	❒	❒	❒
Climb	❒	❒	❒	❒
Reach above head	❒	❒	❒	❒
Kneel	❒	❒	❒	❒
Balancing	❒	❒	❒	❒
Pushing/pulling	❒	❒	❒	❒
Lifting, how much?_________	❒	❒	❒	❒
Typing	❒	❒	❒	❒

Please add any other information that you feel is pertinent: ____

____

____

PLEASE LIST YOUR CURRENT AREAS OF COMPLAINT:
(chief complaint)

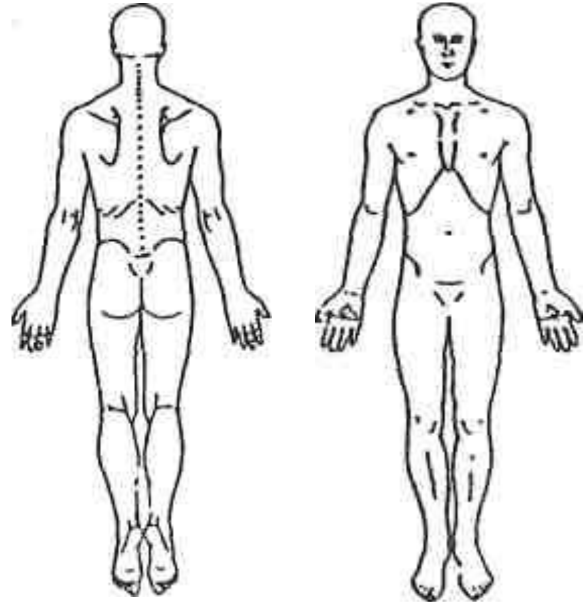
1)______________________ 2)______________________ 3)______________________ 4) ______________________

0 1 2 3 4 5 6 7 8 9 10   0 1 2 3 4 5 6 7 8 9 10   0 1 2 3 4 5 6 7 8 9 10   0 1 2 3 4 5 6 7 8 9 10

CIRCLE THE NUMBER THAT BEST DESCRIBES THE INTENSITY OF YOUR PAIN: 0 = None, 10 =Severe

PLEASE MARK YOUR AREAS OF COMPLAINT ON THE BODY DIAGRAM USING THE FOLLOWING KEY:

Dull	= D
Aching	= A
Stiffness	= S
Burning	= B
Tingling	= T
Numbness	= N
Sharp	= !!!
Shooting	= XXX



How often do you notice your symptoms? ❒ Constantly ❒ Frequently ❒ Occasionally

Does anything relieve your pain?

What activities make pain increase? ❒Sitting ❒Standing ❒Walking ❒Bending ❒Lying down on_______

❒Cough/sneeze ❒Push ❒Pull ❒Sleeping ❒Lifting

Please describe any other activities that are restricted due to this injury?________________________________

____

Is the condition getting worse? ❒ No ❒ Yes ❒ Same

Have you had this problem before? ❒ No ❒ Yes, When?________________________________

Have you had x-rays before? ❒ No ❒ Yes, When?___________________What areas? ______________________

I am currently taking the following medications for the following reasons: ❒ None Do these medicines help?❒ Yes ❒ No

____

____

List Allergies: ____

Surgical History: ____

For Women Only: Is there a possibility that you may be pregnant? ❒ No ❒ Yes

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Which best describes your health goals: ❒pain relief only ❒correct entire problem ❒ wellness/ preventative care

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I certify that the above information is true and accurate to the best of my knowledge

DATE:____/____/____ **SIGNATURE:** ______________________________________

PARENT/GUARDIAN: ______________________________________