



NEW PATIENT INTAKE FORM – Worker’s Compensation

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, Date, S/S, Address, City, State, Zip, Home Phone, Work Phone, Cell Phone, Birth Date, Height, Weight, e-mail address, Sex, Status, Spouse/ Parent’s Name, Phone, Who may we thank for referring you to us?, Person to contact in case of an emergency, Your Employer, Business Address, City, State, Zip, Type of Business, Your Occupation, Name of Compensation Carrier, Phone, Address

HEALTH HISTORY

Please check the following symptoms you have noticed SINCE THE ACCIDENT (O) 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

Have YOU (O) 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 you 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	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Squat	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Crawl	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Climb	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Reach above head	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Kneel	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Balancing	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Pushing/pulling	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Lifting	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Typing	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

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

PLEASE LIST YOUR CURRENT AREAS OF COMPLAINT:

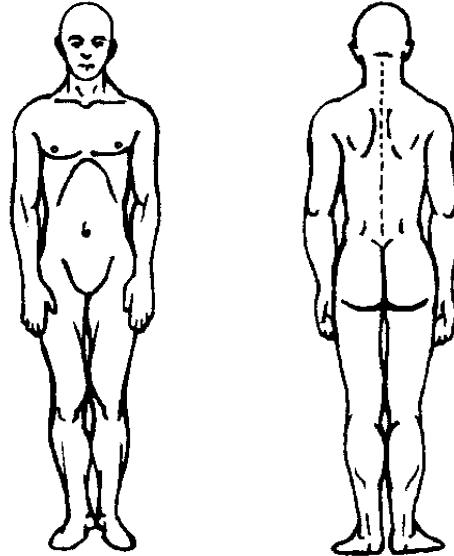
(chief complaint)

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: 1 = Mild, 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
- Other _____ = ***



How often do you notice your symptoms? Constantly Frequently Occasionally

Does anything relieve your pain? _____

What activities are difficult to perform? Sitting Standing Walking Bending Lying Down

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

Is the condition getting worse? No Yes

Have you had this problem before? No Yes, When? _____

Have you ever been diagnosed with a Subluxation? 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

Surgical History: _____ None

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

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

DATE: ___/___/___

SIGNATURE: _____

PARENT/GUARDIAN: _____