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Worker's Comp Intake Form

Name_____ Date of Birth _____

Date of Injury _____ Have you reported your Injury? Yes / No

Name of Employer _____

Describe the accident _____

_____

Contributing factors to your injury (i.e.: wet floor, faulty equipment, etc.) _____

Have you lost days from work _____ Dates _____

Have You Missed Work as a Result? _____ Dates Missed _____

Are You Taking Anything for Pain _____

Have You Ever Experienced Similar Symptoms to What You are Experiencing Now?

Please Describe _____

Have You Seen Other Doctors For This Injury?

Doctor #1 _____ X-Rays Taken? _____

Doctor #2 _____ X-Ray Taken? _____

Have you had similar symptoms prior to this injury? _____ Date _____

Any history of ankle, knee, hip, wrist, elbow or shoulder injuries _____

_____

Have you had a spinal x-ray taken within past 7 years _____ Date & Facility _____

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Chief Complaint #1

PROVOKING (what activities aggravate your injury) -Circle-
Sitting / Standing / Lying / Walking / Reaching / Bending / Other

PALLIATIVE (what makes it feel better) -Circle-
Ice / Heat / Lying / Pain Med. / Stretching / Other

QUALITY (describe the pain) -Circle-
Sharp / Electric / Burning / Stabbing / Aching / Deep / Other

Any sensations **radiating** into the following? -Circle-
Arms / Legs / Forearm / Hands / Buttock / Thighs / Foot / Shoulder / Shoulder Blades

Describe the radiating -Circle-
Sharp / Dull / Tingling / Numbness / Prickling / Other

Please rate your pain:
On a scale of 0 - 10 with 0 being no pain and 10 pain that prevents ALL activities _____

PATTERN (time of day most aggravated) -Circle-
Early Morning / Mid-Day / Late Eve / After Work / After Exercise / Other

Chief Complaint #2

PROVOKING (what activities aggravate your injury) -Circle-
Sitting / Standing / Lying / Walking / Reaching / Bending / Other

PALLIATIVE (what makes it feel better) -Circle-
Ice / Heat / Lying / Pain Med. / Stretching / Other

QUALITY (describe the pain) -Circle-
Sharp / Electric / Burning / Stabbing / Aching / Deep / Other

Any sensations **radiating** into the following? -Circle-
Arms / Legs / Forearm / Hands / Buttock / Thighs / Foot / Shoulder / Shoulder Blades

Describe the radiating -Circle-
Sharp / Dull / Tingling / Numbness / Prickling / Other

Please rate your pain:
On a scale of 0 - 10 with 0 being no pain and 10 pain that prevents ALL activities _____

PATTERN (time of day most aggravated) -Circle-
Early Morning / Mid-Day / Late Eve / After Work / After Exercise / Other

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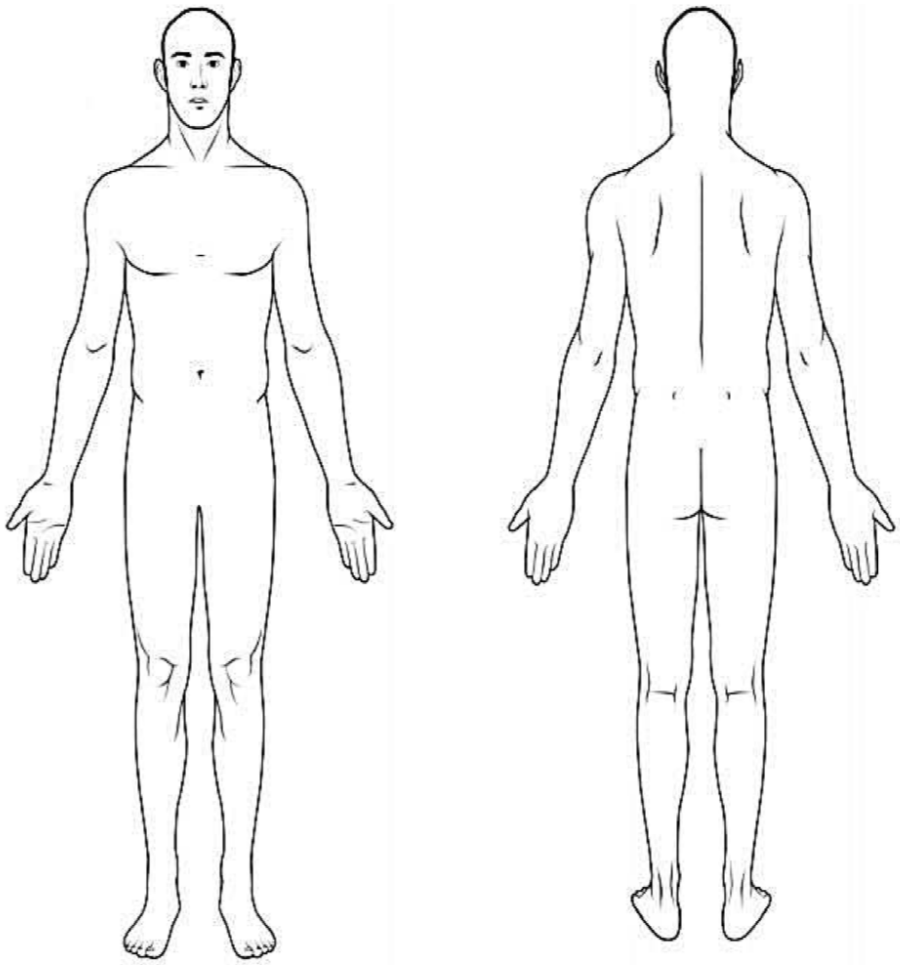
Please mark where you pain is located. Use the following key:

B = Burning
S = Stabbing
A = Aching

N = Numbness
P = Pins and Needles
O = Other



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