# *Work Comp Injury/Accident Intake Form*

**Today's Date:** _____ **Name:** _____ **Date of Injury:** _____

## Insurance Information

Work Comp Insurance Company: _____ Address: _____
Claims Adjuster's Name: _____ Claim #: _____
Adjuster's Phone #: _____ Adjuster's Fax #: _____
Have you retained an attorney: ☐N ☐Y
Attorney's Name: _____ Attorney's Phone#: _____

## Incident Details and Body Pain/Injury

How were you injured/how did injury occur:*(Please give as much detail as possible)* _____
_____
_____
When did the pain begin: _____ Other body parts affected: _____
Did you sustain bruises: ☐N ☐Y*(Where)* _____ Any bleeding cuts: ☐N ☐Y*(Where)* _____
Any broken bones: ☐N ☐Y*(If yes please explain)* _____
Please describe how you felt immediately after the injury/accident: _____
How did you feel later that day/night:_____Feel the next day: _____
Was an ambulance called: ☐N ☐Y Did you go to ER: ☐N ☐Y*(If yes where did you go)* _____
See your PCP or other Specialist: ☐N ☐Y*(If yes, who did you see and when)* _____
Have you had any Xrays/MRI's: ☐N ☐Y Prescribed any Medications: ☐N ☐Y Had any Treatments: ☐N ☐Y
*(If yes, where did you go/who did you see)* _____
Did your injury require surgery: ☐N ☐Y*(If yes, please give details)* _____
_____
Have you been given a diagnosis: ☐N ☐Y*(If yes, what is the diagnosis)* _____

## General Symptoms (Since Injury/Accident Occurred)

| ✓ | ✓ | ✓ | ✓ | ✓ |
|---|---|---|---|---|
| ☐Neck Pain/Stiffness | ☐Pins&Needles Legs | ☐Numbness Toes | ☐Constipation | ☐Blurred Vision |
| ☐Upper Back Pain | ☐Pins&Needles Feet | ☐Numbness Fingers | ☐Diarrhea | ☐Double Vision |
| ☐Mid Back Pain | ☐Dizziness | ☐Cold Sweats | ☐Bowel Changes | ☐Other Vision Problems |
| ☐Lower Back Pain | ☐Headaches | ☐Hot Sweats | ☐Bladder Changes | |
| ☐Loss of Balance | ☐Light Sensitivity | ☐Fever | ☐Fainting | ☐Confused |
| ☐Loss of Memory | ☐Pain behind eyes | ☐Fatigue | ☐Seizures | ☐Disoriented |
| ☐Pins&Needles Arms | ☐Irritability | ☐Sleep Difficulties | ☐Forgetfulness | |
| ☐Pins&Needles Hands | ☐Depression | ☐Nervousness/Anxiety | ☐Ringing/buzzing/ears | |
| ☐Heavy Head | ☐Shortness of Breath | | | |

## Additional Questions

What is your best time of day/why: _____

What is your worst time of day/why: _____

What gives you the most relief:_____

Are you able to find a comfortable sleeping position: ☐N ☐Y*(Explain if no)* _____

Are you sleeping through the night: ☐N ☐Y Do you wake up in pain: ☐N ☐Y

How many hours sleep a night are you averaging: _____

Has this changed since the injury/accident: ☐N ☐Y*(If yes, how)* _____

Did you have a regular exercise routine before the injury: ☐N ☐Y Are you able to exercise now: ☐N ☐Y

Has your exercise routine changed because of the injury: ☐N ☐Y*(If yes, how)*_____

Have you missed any work because of the injury: ☐N ☐Y*(If Yes, how much time missed)*_____

Does your job involve any of these:

*Twisting*☐ *Bending*☐ *Lifting*☐ *Climbing stairs/ladder etc.*☐ *Sitting long periods*☐ *Standing long periods*☐ *Computer Work*☐ *Phones*☐ *Any type of Repetitive Work*☐ *Assembly Line/Factory Work*☐ *Neck/Eye Strain*☐

Other: _____Has the injury impacted your ability to do household chores: ☐N ☐Y *(If yes, how)*_____ Take care of yourself personally: ☐N ☐Y _____

Have you had other treatments prior to coming here: ☐N ☐Y*(If yes, what treatments have you had)*_____ _____ How many treatments have you had:_____

Have these treatments given you relief: ☐N ☐Y How long does relief last: _____

On a scale of 1-10 **(With 1 being No Pain and 10 being Extreme Pain)** how would you rate your current level of pain *(Please Circle)*

No Pain ←1 2 3 4 5 6 7 8 9 10→ Extreme Pain

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Provider Initials: _____