Name:

DOB:

New Worker's Compensation/ Personal Injury Intake Form

Date & time of Injury:___/___/___ ____am | pm **City in which you were injured:**_____

Area(s) of Body Injured: (e.g. right wrist, left index finger)_____

Briefly Describe How You Were Injured:_____

_____

_____

Where Were You Treated?: (e.g. U.S. Healthworks, HMH Emergency room)_____

_____

Treatment History:

Have you had Physical or Occupational Therapy for this injury? _____ If Yes, answer the following:

How many sessions have you completed?_____ When?_____

Was the therapy helpful? (mark one)

My symptoms are ☐ improved ☐ unchanged ☐ worse

Have you been provided with any durable medical equipment? (e.g. wrist brace, tennis elbow strap, etc.)

Please describe:_____

Were you prescribed medications for your injury? If Yes, please list medications:

_____

_____

Name:

DOB:

Have you had any corticosteroid injections? If Yes, answer the following:

Body part(s):_____

Date(s) of injection(s):_____ Did they help? For how long?_____

Have you had surgery for this injury? If Yes, answer the following:

Date of surgery:_____

Type of surgery:_____

Name of surgeon/location:_____

Have you had other studies performed?(e.g. MRI, CT scan, Nerve Conduction Study) If Yes, answer the following:

Date of study:_____

Type of study:_____

Location of study:_____

Results:_____

Employer Information

Name of Employer:_____

Job Title:_____

Briefly describe your work duties:_____

_____

_____

How long have you been employed at this job:_____

List any prior Worker's Compensation Claim: (Date of Injury, Type of Injury):

_____

_____

Are you currently working?_____ If Yes, do you have any work restrictions? (list restrictions)

_____

Date that you last worked:_____