WORKMAN'S COMP ACCIDENT INTAKE

Today's Date: ________

Patient Name: ______________________________ Age: _______ Occupation: ______________________

Place of work: ______________________________

Date of Accident: __________ Time of Accident: ______ ☐AM ☐PM

Please describe the accident in your own words:

____

____

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AT THE SCENE

Did medical personnel (ambulance, fire) come to the scene? ☐ yes ☐ no
If yes, were you treated at the scene? ☐ yes ☐ no
If yes, what treatment did you receive? ____

____

HOSPITAL/EMERGENCY DEPARTMENT

Did you go to the Emergency Room? ☐ yes ☐ no If no, skip to next section
If yes, what was the name of the hospital? ______________________________________

What was the doctor's name (if known)? ______________________________________
Did you go by: ☐ ambulance ☐ someone drove me ☐ I drove myself
When did you go to the Emergency Room? ☐ Immediately after the accident ☐ the next day
☐ two or more days later ☐ _______ # of hours after the accident

Were x-rays taken? ☐ yes ☐ no
If yes, what x-rays were taken? (check all that apply): ☐ neck ☐ upper back ☐ mid back ☐ low back
Left: ☐ shoulder ☐upper arm ☐ elbow ☐ forearm ☐ wrist ☐ hand ☐ fingers ☐ hip
☐thigh ☐knee ☐ calf ☐ ankle ☐ foot ☐ toes
Right: ☐ shoulder ☐upper arm ☐ elbow ☐ forearm ☐ wrist ☐ hand ☐ fingers ☐ hip
☐thigh ☐knee ☐ calf ☐ ankle ☐ foot ☐ toes
☐ I had x-rays, but I am not sure what was x-rayed.
☐ Additional x-rays not marked above: ____
Do you know the results of your x-rays? ☐ yes ☐ no
If yes, please explain: ____

Were any additional tests performed? ☐ unsure ☐ yes ☐ no
If yes, do you know what tests were performed? ☐ yes ☐ no
If yes, please check all that apply: ☐ blood ☐ CAT/CT scan ☐ MRI ☐ other ____________________
Do you know the results of any of these tests? ☐ yes ☐ no
If yes, please explain: ______________________________
Did you receive a diagnosis? ☐ yes ☐ no If yes, please explain: ______________________________

Please explain any treatment given in the Emergency Room: ______________________________
☐ I was not given any treatment.
Upon leaving, what treatment plan were you given? ______________________________
☐ I was not given a treatment plan.
What prescriptions (and dosing), if any, were you given?______________________________
☐ I was not given any prescriptions.

NAME:___________________________________ DOB:___________ DATE:______________

AFTER THE ACCIDENT

Have you seen your primary care physician or any other doctor since the accident? ☐ yes ☐ no
If no, skip to next section
If yes, what was the name of the physician? ____
Was this doctor your primary care physician? ☐ yes ☐ no
What date(s) did you see this doctor? ____

Were x-rays taken? ☐ yes ☐ no
If yes, what x-rays were taken? (check all that apply): ☐ neck ☐ upper back ☐ mid back ☐ low back
Left: ☐ shoulder ☐upper arm ☐ elbow ☐ forearm ☐ wrist ☐ hand ☐ fingers ☐ hip
☐thigh ☐knee ☐ calf ☐ ankle ☐ foot ☐ toes
Right: ☐ shoulder ☐upper arm ☐ elbow ☐ forearm ☐ wrist ☐ hand ☐ fingers ☐ hip
☐thigh ☐knee ☐ calf ☐ ankle ☐ foot ☐ toes
☐ I had x-rays, but I am not sure what was x-rayed.
☐ Additional x-rays not marked above: ____
Do you know the results of your x-rays? ☐ yes ☐ no
If yes, please explain: ____

Were any additional tests performed? ☐ unsure ☐ yes ☐ no
If yes, do you know what tests were performed? ☐ yes ☐ no
If yes, please check all that apply: ☐ blood ☐ CAT/CT scan ☐ MRI ☐ other _______________________
Do you know the results of any of these tests? ☐ yes ☐ no
If yes, please explain: _________________________________
Did you receive a diagnosis? ☐ yes ☐ no If yes, please explain: ____________________________________

Please explain any treatment given at the doctor's office : ____
☐ I was not given any treatment.
Upon leaving, what treatment plan were you given? ____
☐ I was not given a treatment plan.
What prescriptions (and dosing), if any, were you given?____
☐ I was not given any prescriptions.

Have you received any additional treatment other than what you listed above? ☐ yes ☐ no
If yes, please fill in the information: (use the back side if more space is needed)

Date (s)	Name of Practitioner	Type of Practitioner	Treatment
		☐ MD ☐ ND ☐LAc ☐LMT ☐ PT ☐ DC ☐ DO ☐ other ____________	
		☐ MD ☐ ND ☐Lac ☐LMT ☐ PT ☐ DC ☐ DO ☐ other ____________	

To the best of my knowledge, the above information is complete and correct. I understand it is my responsibility to inform my doctor if I or my minor child have any changes to my health.

____ __________
Signature of patient (or parent/guardian or personal representative of patient) Date:
Relationship to patient: ☐ self ☐ parent ☐ guardian ☐ representative

Your insurance company: ______________________	Your Claim Number: ______________________	Your Agent's Name: ______________________ Agent's Phone: ______________________

For office use only: N ________ B ________