Work Injury Intake Form

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Name: _____ ☐ Male ☐ Female Date:_____

Address: _____ City:_____ Zip:_____

Home/Cell Phone: _____ Work Phone: _____

Date of Birth: _____ Age: ____ E-Mail (Confidential):_____

Social Security #: _____ Primary Doctor: _____

Employer Name:_____ Employer Address:_____

Employer Phone:_____ Did you report the injury to your employer? ☐No ☐Yes

Comp Insurance Company:_____ Claim number:_____

Have you hired an attorney? ☐No ☐Yes Name: _____

Who introduced you to our office? _____

Date of Injury:_____

How did it happen? ☐Lifting ☐Bending ☐Twisting ☐Falling ☐Other _____

Your job title and description of duties:_____

Have you missed work due to this injury? ☐No ☐Yes If yes, first date missed: _____

Are your currently working? ☐No ☐Yes ☐ Regular Duty ☐ Light Duty

List the injured body part(s):

1. _____
2. _____
3. _____

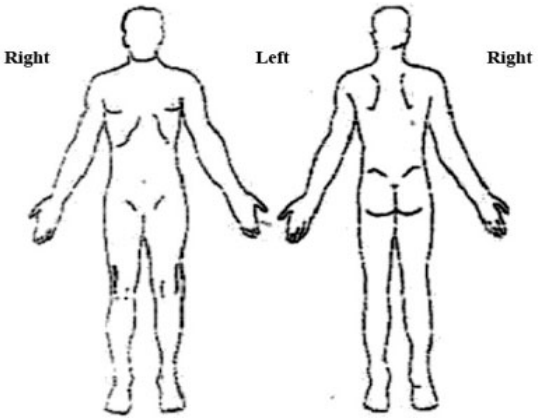
Circle the number that best represents your pain:

0 . 1 . 2 . 3 . 4 . 5 . 6 . 7 . 8 . 9 . 10
(no pain) (pain) (worst)

0 . 1 . 2 . 3 . 4 . 5 . 6 . 7 . 8 . 9 . 10
(no pain) (pain) (worst)

0 . 1 . 2 . 3 . 4 . 5 . 6 . 7 . 8 . 9 . 10
(no pain) (pain) (worst)

Mark below the areas you feel: **P** = Pain, **N**= Numbness



Check the box of your problem's location:

☐ Head				☐ Arm	L	R	B
☐ Neck				☐ Pelvis/Hip	L	R	B
☐ Upper Back				☐ Thigh	L	R	B
☐ Mid Back				☐ Knee	L	R	B
☐ Low Back				☐ Lower Leg	L	R	B
☐ Shoulder	L	R	B	☐ Ankle	L	R	B
☐ Chest	L	R	B	☐ Foot	L	R	B

Circle **L** = Left **R** = Right **B** = Both

How much of the day do you have symptoms?
☐100% ☐75% ☐50% ☐25% ☐0%

Was the onset of main problem: ☐Sudden ☐Gradual ☐Unknown ☐Other:_____

Have you ever had this before? ☐No ☐Yes How many times? _____

What activities has this problem affected? ☐Sitting ☐Standing ☐Walking ☐Lying Down ☐Sleeping ☐Driving ☐Work Duties ☐Exercising ☐
Other:_____

What percent of your work activities are you able to perform?
0% . 10 . 20 . 30 . 40 . 50 . 60 . 70 . 80 . 90 . 100%

What percent of your home activities are you able to perform?
0% . 10 . 20 . 30 . 40 . 50 . 60 . 70 . 80 . 90 . 100%

What percent of your recreational activities are you able to perform?
0% . 10 . 20 . 30 . 40 . 50 . 60 . 70 . 80 . 90 . 100% *(over)*

What relieves this problem? ☐Sitting ☐Standing ☐Walking ☐Lying Down ☐Other:_____

Have you had any tests for this? ☐No ☐X-Ray ☐MRI ☐CT
Which facility?_____ When?_____ Do you have them? ☐No ☐Yes

Have you had physical Therapy for this problem? ☐No ☐Yes How many visits? _____

Have you had chiropractic care for this problem? ☐No ☐Yes How many visits? _____

Have you seen other providers for this condition? ☐No ☐Yes If so, please list their:

Name:_____ Diagnosis: _____ Treatment:_____
Name:_____ Diagnosis: _____ Treatment:_____

Please Complete Your Health History: Circle **L** = Left **R** = Right **B** = Both

Chronic pain or problem: ☐Neck ☐Mid Back ☐Low Back
☐ Shoulder: L R B ☐Hip: L R B ☐Knee: L R B ☐Ankle: L R B ☐Foot: L R B

Ever diagnosed with the following conditions? ☐Whiplash ☐Disc Bulge or Herniation ☐Disc Degeneration
☐Arthritis of Neck or Back ☐Stenosis ☐Osteopenia ☐Osteoporosis

List any other Spine, Joint, or Health Conditions: _____

List any Surgery (date): _____

Cancer? ☐No ☐Yes Type:_____ Heart Condition? ☐No ☐Yes Type:_____

Occupation:_____ Hobbies/Interests:_____

Do you exercise regularly? ☐No ☐Yes What is it? _____

Do you feel you are having anxiety or stress that is affecting your health? ☐No ☐Yes

Authorization and Release:

I authorize my insurance benefits to be paid to Balanced Body PT & Chiro.

I consent to release related diagnostic reports to Balanced Body PT & Chiro.

I have been provided an opportunity to review the Notice of Privacy Practices.

I acknowledge that I am financially responsible for all fees not covered by insurance.

_____

Patient Signature