



Milton Chiropractic & Rehabilitation, Inc.



BAY STATE PHYSICAL THERAPY

Workers Compensations Intake Form

File Number (Office Use) _____

Patient Information:

Today's Date _____

Name _____

I prefer to be called _____

Address _____

Sex Male Female

Occupation _____

Employer _____

Address _____

If minor, name of parent or guardian _____

Who should we contact in case of an emergency? _____

Relation _____

Address _____

Attorney _____

Primary Care Physician _____

Home Phone _____

Work Phone _____

Email _____

Social Security No. _____

Date of Birth _____

Height ____' ____" Weight ____ lbs

Marital Status _____

No of Children _____

Phone _____

Phone _____

Phone _____

» Is He/She within Harvard Vanguard Medical Group YES NO

How did you hear about our office? _____

Have you ever been to a chiropractor before? YES NO If so, whom? _____

Insurance Information:

Insurance Company _____

Policy Holder's Name _____

Address _____

Policy number _____

Social Security # _____

Phone _____

Accident Information:

Date _____ Time _____ AM PM

Please describe the pain and its location _____

Was your accident directly related to your work? YES NO

Were there witnesses? YES NO

Did you report the accident to your employer? YES NO

What recommendations did your employer make just after your accident? _____

Please give the address where the accident occurred (if other than employer's address) _____

Briefly describe the events that happened just before and during your accident _____

Has this type of accident happened to you before? YES NO

To the best of your knowledge, has this accident happened in your workplace before? YES NO



Milton Chiropractic & Rehabilitation, Inc.



BAY STATE PHYSICAL THERAPY

In general:

- Is your job physically stressful? YES NO
- Is your job mentally stressful? YES NO
- Is your workplace noisy? YES NO
- Have you changes jobs in the last year? YES NO

Post-Injury Information:

Have you seen any other doctor(s) since the accident? YES NO Name _____

When did you go? IMMEDIATELY NEXT DAY 2 DAYS PLUS

How did you get there? AMBULANCE PRIVATE TRANSPORTATION

Name of hospital and/or attending doctor: _____

Was he/she a: D.C. M.D. D.O. D.D.S.

Please describe any treatment you received _____

Were X-Rays done? YES NO An MRI? YES NO CAT scan? YES NO

Was medication prescribed? YES NO If yes, what? _____

Have you missed any work since the accident? YES NO Date(s) _____

Are your work activities restricted as a result of your injury? YES NO

Indicate the symptoms that are a result of this accident:

- | | | | |
|---|--|--|---|
| <input type="checkbox"/> DIZZINESS | <input type="checkbox"/> DIFFICULTY SLEEPING | <input type="checkbox"/> JAW PROBLEMS | <input type="checkbox"/> NAUSEA |
| <input type="checkbox"/> MEMORY LOSS | <input type="checkbox"/> ARM/SHOULDER PAIN | <input type="checkbox"/> IRRITABILITY | <input type="checkbox"/> BACK PAIN |
| <input type="checkbox"/> HEADACHE(S) | <input type="checkbox"/> NUMB HANDS/FINGERS | <input type="checkbox"/> FATIGUE | <input type="checkbox"/> LOW BACK PAIN |
| <input type="checkbox"/> BLURRED VISION | <input type="checkbox"/> TENSION | <input type="checkbox"/> CHEST PAIN | <input type="checkbox"/> BACK STIFFNESS |
| <input type="checkbox"/> BUZZING IN EAR | <input type="checkbox"/> NECK PAIN | <input type="checkbox"/> SHORT BREATH | <input type="checkbox"/> LEG PAIN |
| <input type="checkbox"/> EARS RINGING | <input type="checkbox"/> NECK STIFF | <input type="checkbox"/> STOMACH UPSET | <input type="checkbox"/> NUMB FEET/TOES |
| <input type="checkbox"/> OTHER _____ | | | |

Did you ever experience similar symptoms prior to the accident? YES NO

Has your condition IMPROVED WORSENER or STAYED SAME since the accident?

Is your condition affecting your WORK SLEEP or DAILY ROUTINE? Please explain _____

Please indicate your degree of difficulty (on a scale of 1-5, with 1 being comfortable, 3 being uncomfortable, and 5 being painful) in performing the following activities:

- | | | | |
|-------------------|-------------------|----------------------|--------------|
| ___ Lying on Back | ___ Lying on Side | ___ Lying on stomach | ___ Sitting |
| ___ Standing | ___ Stretching | ___ Lovemaking | ___ Walking |
| ___ Running | ___ Sports | ___ Working | ___ Lifting |
| ___ Bending | ___ Kneeling | ___ Pulling | ___ Reaching |

Patient Signature _____

Date _____