Performance
HEALTH GROUP
Correct • Prevent • Excel

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Work Related Injury Intake

Name: _____ Occupation: _____

Adjustor's Name and Phone #: _____ Claim #: _____

Date and Time of Injury: _____

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1) Was the injury reported to your employer? Yes_____ No_____ (if no, please report it immediately)
2) a) Name of Employer: _____
   b) Address of Employer: _____
   c) Phone # of Employer: _____
3) Describe how the injury occurred.

   _____

   _____
4) Describe all the symptoms you experienced immediately after the injury (Please be specific).

   _____

   _____
5) Did you miss work for any period of time? Yes _____ No _____

   If yes, please give dates_____
6) Are you presently at work full time, full duties? Yes _____ No _____

   If no, please give the last date of work or the current restrictions_____
7) Who rendered treatment first (i.e. First-aid, medical doctor, chiropractor, etc) and when?

   _____
8) Did you attend your doctor's office? Yes _____ No _____

   Please indicate your doctor's name _____

   Did you receive any: Imaging (x-rays, MRI, CT)? _____ Area _____

   Medication? _____ Name of Medication _____

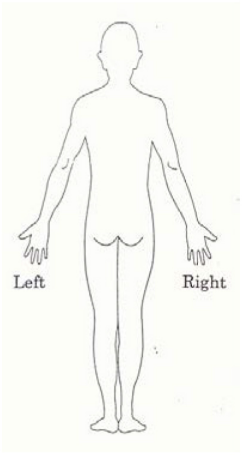
   Other types of treatment _____

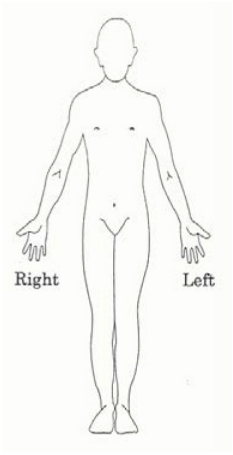
9) a) Describe all symptoms you are experiencing presently?

_____

_____

b) Please mark the area on the diagram where you were injured





c) Did you have any problems in any of the areas indicated before the injury? If so, where and for how long?

_____

_____

Signature: _____ Date: _____