

## Worker Compensation Injury Intake Form

NAME: \_\_\_\_\_ HOME PHONE: \_\_\_\_\_ CELL PHONE: \_\_\_\_\_

ADDRESS: \_\_\_\_\_ CITY: \_\_\_\_\_ STATE: \_\_\_\_\_ ZIP: \_\_\_\_\_

SEX: M/F RIGHT HANDED  LEFT HANDED

WAS YOUR INJURY WORK RELATED? YES  NO

ATTENDING PHYSICIAN: \_\_\_\_\_

EMPLOYER AT THE TIME OF INJURY: \_\_\_\_\_

JOB TITLE AT THE TIME OF INJURY: \_\_\_\_\_

TIME WITH EMPLOYER BEFORE INJURY: \_\_\_\_\_

CURRENT EMPLOYER: \_\_\_\_\_

BRIEFLY DESCRIBE YOUR CHIEF COMPLAINT: \_\_\_\_\_

DESCRIBE INJURY (BRIEFLY, HOW, WHEN AND WHERE DID IT HAPPEN?) \_\_\_\_\_

### MEDICAL HISTORY

1. PLEASE BRIEFLY DESCRIBE, WITH APPROXIMATE DATES, ALL PREVIOUS MAJOR INJURIES: \_\_\_\_\_

2. PLEASE BRIEFLY DESCRIBE, WITH APPROXIMATE DATES, ALL PREVIOUS MAJOR ILLNESSES: \_\_\_\_\_

3. PLEASE LIST ANY MEDICATION ALLERGIES: \_\_\_\_\_

### PERSONAL & SOCIOECONOMIC INFORMATION

1. MARITAL STATUS: SINGLE  MARRIED  DIVORCED  WIDOWED  LIVING W/ SIGNIFICANT OTHER

2. NUMBER OF CURRENT DEPENDENTS: \_\_\_\_\_

3. HIGHEST EDUCATION LEVEL ATTAINED: \_\_\_\_\_

4. HAVE YOU SERVED IN THE ARMED FORCES? YES  NO

5. HOW MANY HOURS ARE YOU WORKING PER WEEK? \_\_\_\_\_

6. ARE YOU RECEIVING:

TIME LOSS COMPENSATION  SOCIAL SECURITY  UNEMPLOYMENT  GENERAL ASSISTANCE (DSHS)

7. DO YOU SMOKE? YES  NO  IF YES, HOW MUCH? \_\_\_\_\_ HAVE YOU QUIT? YES  NO

8. DO YOU DRINK ALCOHOL? YES  NO  IF YES, HOW MUCH? \_\_\_\_\_ HAVE YOU QUIT? YES  NO

9. How many times a week do you engage in physical activity? \_\_\_\_\_

## Visual Pain Rating Scale

How bad is your pain? (Circle the number.)

0 1 2 3 4 5 6 7 8 9 10  
No Pain Unbearable Pain

## Pain Diagram

On the following diagrams, indicate all areas of:

Pain — xxxx  
Stiffness — ////  
Numbness — oooo  
Other (specify) — \_\_\_\_\_

