Pt. Name: _____

WORK COMP - INTAKE QUESTIONNAIRE

Date of accident: _____ Name of employer at time of accident: _____
_____

Length of time worked there prior to accident: _____

Type of work being done at time of injury: _____

In your own words, please describe accident: _____
_____
_____

Have you been treated by another doctor for this accident: ❑ Yes ❑ No
If Yes, please list name and address: _____
_____
_____

What type of treatments did you receive? _____
_____

How long were you treated by this doctor? _____

Are you: ❑ better ❑ worse ❑ staying same

What medicines are you taking FOR THIS PROBLEM: _____
_____

Does the medication help: ❑ Yes ❑ No

Have you had physical therapy: ❑ Yes ❑ No If yes, how often (per week)? _____
How many weeks? _____
Does the PT help: ❑ Yes ❑ No

Prior to this accident, have you ever had any of the physical complaints similar to what you have now: ❑ Yes ❑ No
Describe: _____
_____
_____

Were these similar complaints the results of a previous accident(s)? ❑ Yes ❑ No
Provide details of the accident(s): _____
_____

Have you returned to work since your accident? ❑ Yes ❑ No
If yes, detail in what capacity: _____
_____

Have you had any other serious accidents which required medical care? ❑ Yes ❑ No
Describe: _____
_____
_____

Patient's Signature: _____ Date: _____