

Occupational Injury Intake Form

Tigges Chiropractic and Wellness

Name _____ Date _____

Date present injury occurred: ___/___/___/ Time: _____ AM / PM

What address were you at when injured? _____

INJURY INFORMATION

Please explain in detail how accident happened: _____

What injuries did you suffer? _____

Since the injury, are your symptoms: Improving? Getting worse? Same?

Are your work activities restricted as a result of this accident? Yes No

Did you notify your employer of this injury? Yes No

With whom did you speak? _____

Did you return to work? Yes No

If yes, date returned: ___/___/___ If no, date last worked: ___/___/___

Did you consult any other doctor? Yes No If so, date consulted: ___/___/___

If so, doctor's name: _____ DC MD DO DDS

Diagnosis or treatment: _____

Have you ever injured this area before? Yes No If yes, when: _____

If injured before, did you lose time from work? Yes No

If you lost time from work with injuries prior to this injury, give names of doctors consulted.

Are there other disease or accidents that affect your employment? Yes No If so, explain.

In your work, do you have to favor any part of your body? Yes No If so, explain.

Any history of absenteeism caused from accidents on the job? Yes No

Ever had a worker's compensation claim before? Yes No

Before the injury, were you capable of working on an equal basis with others your age? Yes No

Have you retained an attorney? Yes No Litigation? Yes No Maybe

If yes, please give name and address: _____

Patient Signature _____ Date ___/___/___

Did anyone witness your injury? Yes No

Who? _____

Did you report the injury to anyone? Yes No Who? _____

Was the report: Written Verbal

Did you go to the hospital? Yes No If yes: Right after the injury Next day

Other _____

If yes, how did you get there? Ambulance Other _____

If by ambulance, did the ambulance attendants place you in a: Neck Brace Back Brace

Other _____

List any medication or medical supplies given? _____

Did you have X-rays taken at the hospital? Yes No

If you went to the hospital or saw another doctor, please answer the following:

Hospital Name _____ Doctor Name _____

Diagnosis _____ Treatment received _____

What type of work do you do? _____

Requirements? _____

Have you lost any days of work because of this injury? Yes No

If yes, date(s) _____

Have you retained an attorney? Yes No Litigation? Yes No Maybe

If yes, please give name and address: _____

Patients Signature _____ Date ___ / ___ / ___ /
