CAPITAL PHYSICAL THERAPY

Worker's Compensation Intake Form

Patient Information:

Name _____ Home Phone _____
Address _____ Work Phone _____
_____ Social Security No. _____
_____ Date of Birth _____
Sex ☐ **Male** ☐ **Female** Height ____' ____" Weight _____ lbs
Occupation _____ Marital Status _____
Employer _____ No of Children _____
EMAIL ADDRESS_____
If minor, name of parent or guardian _____
Nearest relative not living with you _____
Relation _____ Phone _____
Address _____
Attorney _____ Phone _____
How did you hear about Bay State Physical Therapy? ☐ Friend/Former patient_____ ☐ Website
☐ Gym member ☐ Drive by ☐ Walk in ☐ Yellow pages ☐ Moneysaver ☐ Doctor_____

Accident Information:

Date _____ Time _____ AM PM Was it reported? ☐ **YES** ☐ **NO**
Town accident occurred in _____ Street _____
Please explain in detail how the accident occurred _____
_____
Please list symptoms felt immediately after the accident _____
_____
Where were you taken after the accident? _____
If hospital, how were you taken? ☐ **AMBULANCE** ☐ **PRIVATE VEHICLE** ☐ **OTHER**
Were X-Rays done? ☐ **YES** ☐ **NO** An MRI? ☐ **YES** ☐ **NO** CAT scan? ☐ **YES** ☐ **NO**
Have you seen any other doctor(s) since the accident? ☐ **YES** ☐ **NO** Name _____
Have you missed any work since the accident? ☐ **YES** ☐ **NO** Date(s) _____
Did you ever experience similar symptoms prior to the accident? ☐ **YES** ☐ **NO**
Has your condition ☐ **IMPROVED** ☐ **WORSENED** or ☐ **STAYED SAME** since the accident?
Please share any other information that might be important to your diagnosis and treatment _____
_____

Insurance Information:

Insurance Company _____
Address _____ Phone _____
_____ Adjustor's Name _____
_____ Claim # _____
Utilization Company _____ Phone _____
Nurse _____ Fax _____

Patient Signature _____ **Date** _____