CLIENT INTAKE FORM

1. **Client(s)**:

Background:
Name: _____
Address: _____
Date of birth: _____
Social Security Number: _____
Marital Status: _____
Name of Spouse (if applicable): _____
Name(s) of Child(ren): _____
Telephone Number (home): _____
Telephone Number (work): _____
Telephone Number (cell): _____
Email address: _____
Employer: _____
Employer's Address: _____
Position: _____
Duties: _____
Salary (present): _____
Salary (last five years): _____
_____

2. **Incident/Accident**:

Date: _____
Time: _____
Place: _____
Circumstances/How did the injury occur: _____
_____
_____
Witnesses: _____
Work Related? (yes/no) Explain why or why not: _____
_____
Was the injury reported to your employer: (yes/no): _____
Specifically, who did you report the injury to, date and time: _____
_____
Describe details of the manner in which you reported the injury: _____
_____
_____
_____

3. **Injuries:**

Describe each body part that was injured and in what way: ____________________________

____

____

Describe how each injury manifested itself. What did it initially feel like? Was it made worse by time or better with the passing of time? In what way?: ______________________

____

Diagnosis: ____

Prognosis: ____

Describe all prior Medical History/Problems/Pre-existing Injuries to the same areas as injured: ____

____

____

4. **List all physicians you have seen thus far**:

Name: ____

Address: ____

Was this physician authorized by your employer's workers' compensation insurance carrier? In other words, did the work comp carrier arrange for this treatment or did you make arrangements for this treatment on your own?______________________________________

____

Name: ____

Address: ____

Was this physician authorized by your employer's workers' compensation insurance carrier? In other words, did the work comp carrier arrange for this treatment or did you make arrangements for this treatment on your own?______________________________________

____

Name: ____

Address: ____

Was this physician authorized by your employer's workers' compensation insurance carrier? In other words, did the work comp carrier arrange for this treatment or did you make arrangements for this treatment on your own?______________________________________

____

Name: ____

Address: ____

Was this physician authorized by your employer's workers' compensation insurance carrier? In other words, did the work comp carrier arrange for this treatment or did you make arrangements for this treatment on your own?______________________________________

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5. **List as much information as you know about the employer's work comp insurance carrier:**

Insurance carrier's name:_____
Insurance carrier's address: _____
_____
Insurance carrier's phone: _____
Insurance carrier's fax:_____
Name of adjustor assigned:_____
Address of adjustor assigned:_____
Phone of adjustor assigned:_____
Fax of adjustor assigned: _____
Email of adjustor assigned: _____
Assigned claim number:_____
Date of injury as used by the carrier (if different than the date of injury stated above):_____
_____