

Date: _____

Who referred you to us?: _____

2441 State Street New Albany, Indiana 47150 (812) 945-4500

Name (first, middle initial, last): _____

Address: _____

City: _____ State: _____ Zip: _____

Date of Birth: _____ Age: _____ Gender: Male Female Height: _____ Weight: _____

Social Security number: ____/____/____ Home phone: () _____ Cell phone: () _____

Email: _____ What is the best way to reach you?: Home Cell Work E-mail

Compensation carrier: _____

Compensation carrier address: _____

City: _____ State: _____ Zip: _____

Employer: _____ Job title: _____ Work phone: () _____ Ext _____

Employer's Address: _____

City: _____ State: _____ Zip: _____

• ***Claim information - (Please also bring your insurance card(s) so we can put a copy in your file. Thanks!)***

1. Type of business: _____ Your occupation: _____

2. Date and time of accident: _____ a.m. p.m. Last date worked: _____ Are you off work?: Yes No3. Previous Worker's Compensation Injury?: Yes No4. Accident reported to employer?: Yes No name of person accident reported to: _____

5. Injured at: _____ City: _____ State: _____ Zip: _____

6. Length of time worked there before accident: _____

7. Type of work being done at time of injury: _____

8. In your own words, describe the events that occurred just before and during your accident: _____

_____9. Have you been treated by another doctor for this accident?: Yes No If yes, please list Doctor's name and address: _____

What type of treatment did you receive?: _____

How long were you treated by this Doctor?: _____

10. Are you: Improved Unchanged Getting worse

11. What types of medicines are you taking?: _____

Do these medicines help?: Yes No12. Have you had physical therapy?: Yes NoIf yes, how often?: Daily Every other day Several times a week Weekly Every other weekDoes the physical therapy help?: Yes No Don't know

13. Prior to this accident, have you ever had any physical complaints similar to what you have now?: Yes No Don't know

If yes, describe: _____

Were these complaints the results of a previous accident?: Yes No

Please describe the details of accidents: _____

14. Since this injury occurred, are your symptoms: Improving Unchanged Getting worse

15. Check the symptoms you have noticed since the accident:

- | | | | | |
|--|---|--|--|--|
| <input type="checkbox"/> Headache | <input type="checkbox"/> Irritability | <input type="checkbox"/> Numbness in toes | <input type="checkbox"/> Face flushed | <input type="checkbox"/> Feet cold |
| <input type="checkbox"/> Neck Pain | <input type="checkbox"/> Chest pain | <input type="checkbox"/> Shortness of breath | <input type="checkbox"/> Buzzing in ears | <input type="checkbox"/> Hands cold |
| <input type="checkbox"/> Neck Still | <input type="checkbox"/> Dizziness | <input type="checkbox"/> Fatigue | <input type="checkbox"/> Loss of balance | <input type="checkbox"/> Stomach upset |
| <input type="checkbox"/> Sleeping problems | <input type="checkbox"/> Head seems too heavy | <input type="checkbox"/> Depression | <input type="checkbox"/> Fainting | <input type="checkbox"/> Constipation |
| <input type="checkbox"/> Back pain | <input type="checkbox"/> Pins/needles in arms | <input type="checkbox"/> Lights bother eyes | <input type="checkbox"/> Loss of smell | <input type="checkbox"/> Cold sweats |
| <input type="checkbox"/> Nervousness | <input type="checkbox"/> Pins/needles in legs | <input type="checkbox"/> Loss of Memory | <input type="checkbox"/> Loss of taste | <input type="checkbox"/> Fever |
| <input type="checkbox"/> Tension | <input type="checkbox"/> Numbness in fingers | <input type="checkbox"/> Ears ring | <input type="checkbox"/> Diarrhea | <input type="checkbox"/> _____ |

Symptoms other than above: _____

16. Have you lost time from work as a result of this injury?: Yes No If yes, please complete:

Last day worked?: _____ Type of employment?: _____

17. Do you notice any activity restrictions as a result of this injury?: Yes No If yes, please describe in detail: _____

18. Please list any other information you feel we should know: _____

Patient's signature

Date

Spouse's or Guardian's signature

Date