Injury Form

Company: ___________________________ Date: ________________

Employee Name: ___________________________ DOB: ________________

Date of injury: ________________ Claim #: _____________________________
(if not available, must provide claim # prior to any f/u visits)

Date injury was reported: ________________

Name of W/C insurance carrier: _____________________________

Employee needs post-accident: _____________________________

________ drug screen (within 48 hours of injury)

________ BAT (within 8 hours of injury)

Length of employment for current employer: ________________

Any other current employment? __________ If so, explain: _____________________________

Brief description of injury:

____________________________________________________________________________

____________________________________________________________________________

____________________________________________________________________________

Current pain rating (0-10) from least to worst: _____________________________

Current pain is (please circle):

ACHING DULL SHARP BURNING SHOCK-LIKE THROBBING STABBING

CONSTANT COMES AND GOES NUMBNESS PINS AND NEEDLES WEAKNESS LIMITED RANGE OF MOTION

Associated symptoms: (please circle all that apply): Location: ________________

____________________________________________________________________________

____________________________________________________________________________

What makes pain worse? _____________________________________________

What makes pain better? _____________________________________________

Medications taken for this injury: _______________________________________

History of similar pain or injury (if so, when): _____________________________

Any other prior injuries? (if so, what type and when): _____________________________

____________________________________________________________________________

____________________________________________________________________________

____________________________________________________________________________

____________________________________________________________________________

EMPLOYEE MUST BRING INSURANCE CARD AND PHOTO ID TO APPOINTMENT. Signature implies that employee is attesting to the information reported as being true to the best of his/her knowledge.

Created on Tuesday, March 29, 2016

___________________________ signature of employee

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