Quad City & Clinton Occupational Health

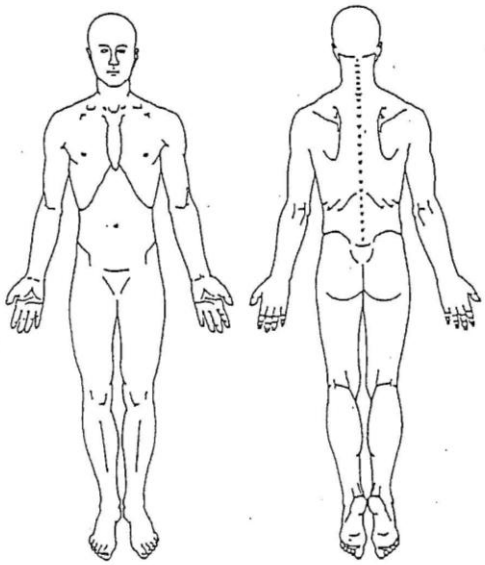
(a division of Braaten Health, LLC)
www.OccHealth.biz

New injury or incident intake sheet

NAME:_____ Date of injury:_____
SSN:_____ Time of injury:_____
DOB:_____ Date injury reported: _____
Employer:_____ Supervisor:_____
# of years on the job:_____
Job Title:_____

Describe injury/incident:_____
Describe **ALL** of your current symptoms related to the injury/incident:_____

Instructions:
On the body diagram below, please indicate where your pain is located at the present time. Please do not indicate areas of pain that are not related to your present injury or condition, Use the following symbols ////=pain, XXX=numbness/tingling



-Were you seen in the ER/Urgent care/ primary physician for this problem YES NO
-Have you ever been treated by a physician, PA, NP, DO, or chiro for this problem or a similar problem in the past YES NO
-Have you ever had x-rays, CT scan, MRI,or NCV/EMG of this area YES NO
-Are you currently taking any medications for this problem YES NO
-Have you had any procedures or therapy for this problem YES NO

Please describe all Yes answers from above:_____

Quad City Occupational Health	Clinton Occupational Health	Administration and Billing Office
1820 W 3rd St	1647 Lincoln Way	5403 Victoria Ave, Suite 20
Davenport, IA 52802	Clinton, IA 52732	Davenport, IA 52807
563.322.2103 phone	563.242.2900 phone	563.327.0132 Office
563.322.2117 fax	563.242.2903 fax	563.359.5642 Fax
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Have you recently had any of the following:			Do you have any of the following :		
- Fever, chills, or sweats	YES	NO	-Diabetes	YES	NO
- Weight loss	YES	NO	-Heart Disease	YES	NO
- Infections	YES	NO	-Asthma	YES	NO
- Taken prednisone	YES	NO	-Emphysema	YES	NO
- Multiple joint pain	YES	NO	-Anemia	YES	NO
- Hospitalization	YES	NO	-High blood pressure	YES	NO
- Fatigue	YES	NO	-Cancer	YES	NO
			-Psychiatric Illness	YES	NO

Please describe all above YES answers:_____
_____

Please provide us with:
-Current medications: _____
-Allergies: _____
-Previous Surgeries:_____

Immunizations please provide dates:
Tetanus:
Hepatitis B:
Last TB test:

SOCIAL HISTORY

Are you a smoker:	YES	NO	ppd:	how many years:
Are you married:	YES	NO		
Do you have children	YES	NO	how many:	
Do you drink alcohol	YES	NO	how much:	
Do you do any drugs	YES	NO		
Do you have a history of drug or alcohol abuse	YES	NO		

Are you right or left handed:_____

Please list all hobbies/projects: _____

Please list all projects you've done in the year prior to the injury:_____

Do you currently have another job/business:_____

Do you participate in regular exercise/sports:_____

Please list all previous employers most recent first: _____

Now or in the last month have you felt physically or emotionally threatened by anyone	YES	NO
Do you need a referral for help with this situation	YES	NO

Signature _____ Date:_____

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