AEIOU
occupational + urgent healthcare

Hours
- Monday to Friday 8:00am - 8:00pm
- Saturday & Sunday 11:00am - 5:00pm

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): CONSTANT COMES AND GOES
ACHING DULL SHARP BURNING SHOCK-LIKE THROBBING STABBING

Associated symptoms: (please circle all that apply): Location: _____
NUMBNESS PINS AND NEEDLES WEAKNESS LIMITED RANGE OF MOTION

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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