Evolution Health Center
"Evolutionary Chiropractic Care & Weight Loss"
By Main Street Chiropractic
T: (302) 390-2402 E: contact@evolvechirocare.com

New Patient Intake Form – Work Injury

Patient Information: Full Name: _____

Date of Birth: _____Gender: _____

Address: _____

Phone Number: _____

Email: _____

Emergency Contact Name and Phone Number: _____

Injury Information:

Date of Injury: _____ Time of Injury: _____

Location of Injury: _____

Describe how the injury occurred: _____

_____

Did the injury occur at your current job? Yes / No

If no, please provide the name and address of your employer at the time of the injury:
_____

Injuries:

Which body parts are hurting as a result of the injury? (Check all that apply)

[ ] Neck [ ] Back [ ] Shoulder [ ] Arm [ ] Hand [ ] Leg [ ] Foot [ ] Other:
_____

_____

Medical Information:

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Do you have any pre-existing medical conditions? Yes / No

If yes, please list: _____

Do you have any allergies? Yes / No

If yes, please list: _____

Are you currently taking any medications or supplements? Yes / No

If yes, please list: _____

Have you ever received chiropractic care before? Yes / No

If yes, please provide the name and location of the chiropractic office: _____

Insurance Information: Do you have worker's compensation insurance? Yes / No

If yes, please provide the name of the insurance company: _____

Claim Number: _____

Do you have health insurance? Yes / No

If yes, please provide the name of the insurance company: _____

Do you have an attorney representing you for this injury? Yes / No

If yes, please provide the name and contact information of your attorney: _____

_____

Signature: _____ Date: _____

Thank you for completing this form. We look forward to helping you on your path to recovery.