# Workers Compensation Intake Form

Name: _____ Male _____ Female _____

Address: _____ Telephone Number: (_____)_____

_____ Work Telephone Number: (_____)_____

_____ Mobile Telephone Number (_____)_____

Emergency Contact: _____ Telephone Number: (_____)_____

Family Physician: _____ Telephone Number: (_____)_____

How were you referred to us? _____

**EMPLOYER INFORMATION:**

Employer: _____ Occupation: _____

Employers Address:_____ Telephone Number: (_____)_____

_____

**WORKERS COMPENSATION INFORMATION:**

Date of Injury: _____ Claim Number:_____

Claim Adjustor: _____ Telephone Number:_____

Do you have legal representation for this work-related injury? Yes No

Are you currently working? Yes No Last Date Worked:_____

Name of Attorney: _____ Telephone Number:_____

**RELEASE OF INFORMATION:**

I hereby authorize Paramount Physical Therapy to release any information regarding this injury, illness or condition which is required to process my claim to my insurance/attorney.

_____ _____

Signature Date