CLIENT INTAKE AND OFFICE POLICIES FOR INJURED WORKERS

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Providing Support for Life's Transitions

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PATIENT IDENTIFYING INFORMATION:

Patient Name	Date of Birth	Social Security Number
Patient's Street Address	City/State	Zip Code
Home Phone	Cell Phone	Email Address
Emergency Contact	Relationship	Phone Number

WORKERS' COMPENSATION INSURANCE INFORMATION:

Insurance Company	Billing Address		
Claims Examiner	Phone	Fax	Email
Claim Number	Date of Injury		

ATTORNEY INFORMATION (if applicable):

Attorney for Industrial Injury	Phone	Fax	Email

For Office Use:

INFORMATION ABOUT YOUR INJURY:
Please describe how you were injured at work:

_____
_____
_____
_____

Please list the physical and psychological complaints which resulted from your injury:

_____
_____
_____
_____

Please list diagnostic procedures, treatment and surgeries related to your industrial injury:

_____
_____
_____
_____

Other Medical Issues:

_____

Please list your current medications, supplements, remedies:

Medication Name	Dosage/Frequency	Purpose	Start Date

EMPLOYMENT INFORMATION:

Employer	Job Title	Job Duties	Dates of Employment	Supervisor

What is your current work status?

_____

Do you hope to return to work in your same profession and if so, what would be needed for you to do so?

_____
_____
_____
_____

EDUCATION:

Please check educational milestones that apply to you:

___ completed grade school ___ AA degree (junior college)
___ completed high school ___ BA or BS degree (college)
___ earned GED ___Masters level or doctorate degree
___ trade school or special training. Subject: _____

PSYCHOSOCIAL INFORMATION:

Please list the names and ages of the members of your family (parents, siblings, children):

_____
_____
_____
_____

Please identify the marital status that applies to you:

___ married (for ___ years)
___ divorced (number of times ___)
___ co-habitating with partner
___ widowed
___ single

Describe your activities on a typical day at present (including exercise):

_____
_____
_____
_____

Describe a typical night of sleep/rest:

_____
_____
_____

Please describe your use of the following substances:

Substance	**Amount**	**Frequency**	**Benefits**
Caffeine			
Cigarettes			
Alcohol			
Marijuana			

PSYCHOLOGICAL BACKGROUND:

Please check all of the following issues that are part of your history:

___ Physical, verbal and/or sexual abuse
___ Other childhood or adult trauma
___ Serious illness or injuries
___ Substance abuse
___ Arrests/imprisonment
___ Other work-related injuries
___ Mental Illness
___ Suicide attempts
___ Military service

What are three of your strategies for coping with emotional pain?

1_____
2_____
3_____

Who are the people and/or organizations from whom you receive social support?

_____
_____
_____

Experience with psychotherapy and/or substance abuse treatment (include dates):

_____
_____
_____

What are the major stressors in your life at this time:

1_____
2_____
3_____

PAIN EXPERIENCE (if applicable):

Body Part Quality of Pain Intensity of Pain today (0-10 scale)

1_____
2_____
3_____

What are three mostly useful things you do to cope with or reduce your pain?

1_____
2_____
3_____

OFFICE POLICIES:

Payment: Your workers' compensation carrier is responsible for payment for authorized treatment. I will bill them directly for my services.

Confidentiality: Not all information disclosed during sessions is confidential when receiving treatment within the workers' compensation system. As treating physician for a psychological injury I am required to provide the insurer with an initial evaluation, periodic progress reports, and other reports as requested. Additionally, I may also discuss treatment with your other treatment providers as needed. If you are involved in litigation, your attorney may receive copies of reports. Efforts will be made to share only information that is relevant to treatment for your industrial injury. You have a right to review your medical records.

Immediate disclosure of information outside of your insurer, your treatment providers, and your attorney may be required in the following circumstances for safety purposes:

- When there is reasonable suspicion of abuse to a child, dependent or elder adult.
- When the client communicates a serious threat of bodily injury to others.
- When the therapist has a reasonable belief that the client may be a danger to themselves, others, or property of others.
- When law otherwise requires disclosure.

I also receive regular professional consultation. In such cases, neither your name nor any identifying information about you is revealed.

I use a professional version of Zoom for Telehealth if appropriate. I make efforts to secure our conversations, but there exists the possibility for hackers to breech security.

Canceled/Missed Appointments: If an appointment is missed or canceled with less than 24 hours of notice, you will be charged $50. Insurance companies will not pay for missed appointments. Exceptions will be made for illness or family emergencies.

Emergency Treatment: I usually return calls within 24 hours. If there is a life-threatening emergency, please call 911. When I am out of town or otherwise unavailable, a qualified professional will cover for me by checking my calls.

I have completed this intake form as accurately and honestly as possible. I have read and understand the office policies noted above.

_____

Client Name **Client Signature** **Today's Date**