No Fault / Workers Comp Intake Worksheet

Insurance Company: _____ **Adjuster:** _____ **Policy Number:** _____

Main Number: _____-_____-_____ **Direct Phone:** _____-_____-_____ **Claim Number:** _____

Fax Number: _____-_____-_____ **Extension:** _____ **Email:** _____

****

Patient Name: _____ **Date of Injury:** **Date of Birth:** ___ / ___ / ___

Address: _____ **City:** _____ **State:** _____ **ZIP** _____

Phone Number: _____-_____-_____ **Cell Phone:** _____ - _____ - _____

Email Address: _____

Employer Information: _____ **Company Address:** _____

City: _____ **State:** _____ **Zip:** _____

HR Department Representative: _____ **Phone Number:** _____ - _____ - _____

FAX Number: _____ - _____ - _____

History of Present Illness: Patient was injured in a No-Fault / Worker's Comp Accident on_____**Report number:** _____

Referring Physician Data

_____, **MD** **Phone Number:** _____ -_____ -_____ **Number of Visits:** _____

Fax Number: _____ - _____ -_____ **Date of RX:** _____

Physician's Diagnostic Assessment: (Description and ICD-9 / ICD-10 Codes)

Assessment	Code	Assessment	Code
1.		4.	
2.		5.	
3.		6.	

RX: MEDICAL THERAPEUTIC MASSAGE for 1 HOUR (60 minute session) to Increase Circulation, Reduce Pain and Increase R.O.M.)

Note: Medical Therapeutic Massage includes but is not limited to: Effleuarage, Pettrissage, Trigger Point therapy (per Simons and Travell), Deep Tissue, Myofacial Release, Therapeutic Stretching and other appropriate treatments within the scope of practice.

Patient Signature: _____ **Date:** _____
(Additional treatments may be prescribed by the referring Physician after further evaluation)

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