BRICKEN AND ASSOCIATES, P.C.
25810 Oak Ridge Drive
The Woodlands, Texas 77380
(281) 364-0067 – Fax (281) 364-0712

New Patient Workers Compensation Intake form

These questions will help me get to know you and to insure that I provide you with the appropriate care. Feel free to leave any questions blank that you are uncomfortable with until you talk to me. Thank you.

Patient Name: ____ Date of Birth: __________ Age:________
Sex: Male / Female Home Phone: __________________ Cell Phone: ____________________
Date of Injury or Onset of Illness: ____/____/______
Treating Physician: ____________________________ Phone:_________________________
Type of Injury / Diagnosis / Description: ____
____
____
Previous Psychological services for this injury: Yes / No
If Yes, Who: ________________________________ Phone: ____________________ When: ___/___/_____
Have you ever seen a Psychologist or Psychiatrist: Yes / No If Yes, Reason: ___________________________
____
If Yes, Who:________________________________ Phone:____________________ When: ___/___/______
Education Level: ____________________ GED / H. S. Diploma: Yes / No Graduation / GED Date: ________
Martial Status (Circle One): Single Married Divorced Widow/Widower Separated
Number of Marriages: _____ Years Married: _____ Number of Children:____ Ages:___ ___ ___ ___ ___
Are your Parents living: Father: Yes / No Mother: Yes / No
Are they still married: Yes / No If no, how old were you when they divorced:_______
Do you have any Brothers: Yes / No If yes, how many: ______ Good Childhood? Yes / No
Do you have any Sisters: Yes / No If yes, how many: ______
Have you had Physical Therapy? Yes / No If so, How long?______________
Have you had any surgeries to repair injury: Yes / No Are you scheduled for more surgeries: Yes / No
What type of procedures/therapies have you had: ____
____
Medications and how many per day: _________________________ _________________________
________________ __________________________ ____________________________ ________________
Opiods/Narcotics and how many per day: _________________________ _________________________
__________ ____________________________ __________________________
_______________________ ____________________
Do you smoke cigarettes: Yes / No If yes, how much: ______________________________________
Do you drink alcohol: Yes / No If yes, how much in the past week: __________________________________
Do you have a plan to harm yourself or anyone else: Yes / No
Have you ever had a history of drug addiction: Yes / No If yes, what drugs and when did you quit: ______
____
Do you have any other Medical Issues: Yes / No If yes, what: ______________________________________
____

<u>WORK RELATED INJURY</u> please complete the following:
Do you have an attorney for your injury: Yes / No Do you have a Third Party Lawsuit: Yes / No
Rate your pain: ______ (1 – 10) 10 = Worst pain ever experienced, 1 = Almost no pain
Where is the pain? ____
Radiates to arms and legs? _______________ Numbness? ______________ Tingling? _________________
Employer at time of Injury: ____________________________________ Phone: ____________________
Position: ________________________________ Length of Employment: ____years ____months
Did you return to work? _______Was it light duty? _________ Were you fired? __________________
Previous jobs & how long in each____
____
Have you ever had any previous worker's compensation injuries: Yes / No
Work Hardening? Yes / No If so, How long? _____________

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Patient Name: ____________________

Symptom Checklist

Height: __'___" Weight: ____lbs Weight Gain: ___lbs Weight Loss:____lbs

Number of Hours of Sleep: ______hrs

Please check all that apply

- ____ Difficulty Sleeping
- ____ Crying Spells
- ____ Loss of Sex Drive
- ____ Memory Loss
- ____ Temper Outbursts
- ____ Frustration
- ____ Rapid Heart Beat
- ____ Difficulty in Catching Your Breath
- ____ Light Headed
- ____ Sense of Impending Doom
- ____ Nausea
- _____ Loss of Appetite
- _____ Loss of Enjoyment
- _____ Difficulty with Concentration
- _____ Anger
- _____ Panic Attacks
- _____ Stomach Knots
- _____ Tightness in Chest
- _____ Shortness of Breath
- _____ Profuse Sweating
- _____ Nervousness
- _____ Headaches

Additional information you would like to share about yourself and your situation:

____

____

____

____

Have you ever been convicted of a crime ____ Yes ____ No
Are you currently facing charges for any offense, on probation or parole ____ Yes ____ No
Are you currently part of any legal action ____ Yes ____ No
If you answered "Yes" to any of the above, please explain:___________________________________

____

____

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Patient Information Sheet

Date: _______________

Patient Name (First) :___________________ (M.I.):_____ (Last):___________________
DoB: ____/____/______ Sex: Male / Female SSN:___/___/____DL#:_______________
Address:____Apt#:_______
City:_________________________State:____________ Zip Code:_______________
Home Phone:(_____)_____________ Cell Phone:(_____)______________
Employer:___________________________________Work Phone:(____)_____________

Person completing form:_____________________ Relationship w/patient:____________
(If other than Patient) (Mother/Father/Guardian/Spouse)

Workers Compensation Information

Is this a workers compensation case? __Yes __No Date of Injury:___/___/____
Workers Compensation Insurance Carrier:_____________________________________
Phone #:(____)___________ Adjuster Name:___________________________________
Employer at time of Injury:____________________Employer Phone:(____)___________
Employer address: ___________________________State:__________ Zip:_________
Name of Referring Physician/Referral Source:___________________________________
(Dr. Name/Phone Book/Other)

I hereby authorize the release of any medical information necessary to process my insurance claims. I permit a copy of this authorization to be used in place of the original. By signing this form, I am authorizing medical/psychological treatment by Dr. Glenn J. Bricken & Associates. I also authorize payments of medical benefits directly to this doctor for services received in this office, if assigned.

I give my permission for information and a treatment report to be disclosed to the referring doctor.

Signature:X________________________________**Date:**____________________
(This must be signed by the patient, or by their legal guardian if under age, prior to any services being rendered.)

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WEIGHT LIFTING / PHYSICAL RESTRICTIONS

Patient Name: ____________________________________

Treating WC Physician: _____________________________

Do you have a weight restriction (lifting), or other physical restriction, rendered by a medical professional? (Circle one) No Yes

If yes, by whom? ______________________________________. (______)_______________
(Name of medical professional) Phone #

Do you have a script or copy of the restriction document? No / Yes
If yes, can you provide our office a copy? No / Yes

The restriction / limitation denoted above is a weight lifting restriction of ________ lbs.

The restriction / limitation denoted above is for other physical restrictions (please explain):

____

____

____
.

Completed By: ____ Date: _____/_____/_______

STAFF USE ONLY:

The restriction denoted above has been confirmed by: _________________ Date: ___/___/_____

(1.) **A copy of the prescription / report / dictation has been received by our staff:** ☐
(2.) **A confirmation call was made to the medical professional and / or staff:** ☐
(3.) **Other: ____** ☐

[If documentation has been received in regards to this restriction, please forward a copy to CPRC / Dr. Alianell to be included in the Physical Therapy Evaluation.]