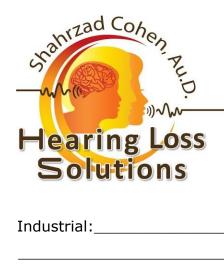


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Workers' Compensation Initial History Intake Form

Name:	Date of Birth:
Employer (at the time of injury):	
Date of Injury:	
Date of Start of Employment (At the place	e that injury has happened):
Duration of Employment:	
Date of The Last Day Attending Work:	
Description of Work Duties:	
History of Injury- How did the injury happ	pen?
Blast Injury or Direct Noise Exposure:	
Body Parts Injured:	
Current Work Status (If retired or not wo	rking how are you spending your time?)
Present Complaints:	



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Noise Exposure History

Industrial:				
Military:				
Recreational:				
Recreational:				
Medical History				
Allergies:				
Tobacco:				
Alcohol:				
Surgeries:				
Ear Infections:				
Hearing Loss:				
Tinnitus:				
Head Trauma:				
Prior Falls:				
Balance Problems:				
Vertigo Attacks:				
Cancer:				
Chemotherapy or Excessive Antibiotic Use:				
Excessive Use of Pain Medications (Prescription or Other such as Aspirin):				
Authorization to Release or Discuss Medical Records:				