Concentra®

Improve the health of America's workforce, one patient at a time.

Employer Services - Injury Care
Patient Information

Last name:_____ First name:_____ M.I.:_____

Date of birth (MM/DD/YYYY):_____

Injury date:_____ Injury time: _____

Where did the injury occur? _____

_____

_____

_____

How did the injury happen? _____

_____

_____

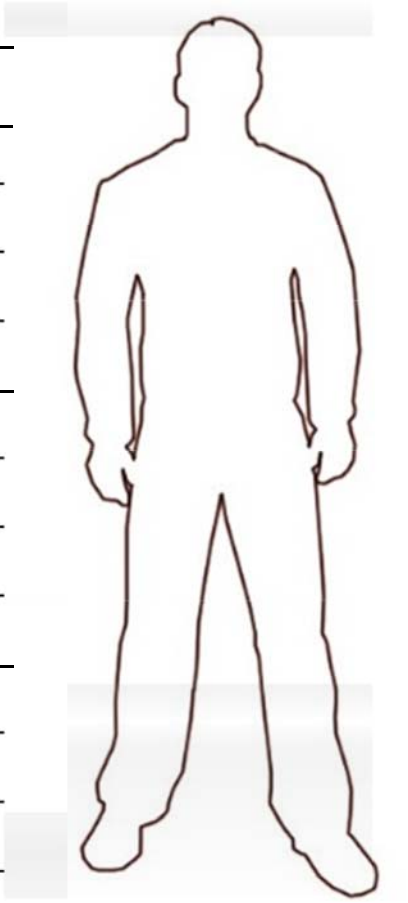
_____

What part of your body is injured? _____

_____

_____

_____



Please check which side of your body is injured. ❒ Right ❒ Left ❒ Both

Using the figure at right, please circle the areas where you are injured.

Were you seen elsewhere for this injury? ❒ Yes ❒ No

If so, where?

Name: _____

Address: _____

City: _____ ST: _____

Phone: _____