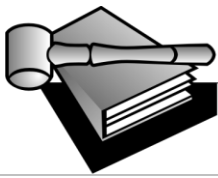


**Client Intake Form****Name:****Appointment Date:****Mr./Mrs./Miss:****Appointment Time:****Phone Number:**

Age:			
Accident Date:			
Areas of Injury:			
Job Title:			
Employer:			
Length of Employment:			
Hourly Rate:			
Weekly Hours:		Full Time, Part Time Seasonal, Casual:	
Current Work Status:			
Attempt to RTW Pre – injury and / or modified:			
FAF form:			
NEL or Pension Award:			
Prior WSIB accidents or claims:			
WSIB Retraining program:			
Any other benefits (CPP) or source of income:			
Any surgeries pertaining to the accident:			
Undergoing any treatment:			
Upcoming tests scheduled:			
Last WSIB correspondence:			
Latest WSIB Decision letter:			
Other Ailments or any MVA:			



Any representatives or Union on file:

Synopsis:

**Hospital or Medical sought:
(When)**

Xray's taken:

Referral Source:

Peters Notes:

Result:

Follow up? _____
(If so please indicate whether meeting or call back date)

No Further Action? _____
(If so, please indicate direction given)