



www.APCenters.com • Telephone: 818.989.9001 • Email: DrShCohen@gmail.com
5900 Sepulveda Boulevard • Suite 335 • Sherman Oaks • California 91411

Shahrzad Cohen, Au.D., M.S.
Doctor of Audiology

Workers' Compensation Initial History Intake Form

Name: _____ Date of Birth: _____

Employer (at the time of injury): _____

Date of Injury: _____ Today's Date: _____

Date of Start of Employment (At the place 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 happen? _____

Blast Injury or Direct Noise Exposure: _____

Body Parts Injured: _____

Current Work Status (If retired or not working how are you spending your time?)

Present Complaints: _____



www.APCenters.com • Telephone: 818.989.9001 • Email: DrShCohen@gmail.com
5900 Sepulveda Boulevard • Suite 335 • Sherman Oaks • California 91411

Shahrzad Cohen, Au.D., M.S.
Doctor of Audiology

Noise Exposure History

Industrial: _____

Military: _____

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: _____

