**History of Injury/Accident/Condition:** (be very specific in details involving injury and treatment)

NAME:___________________________________

Date of Injury: _________________________

Height:_______ Weight________ Dominant Hand: Left Right

Body parts involved at the time of injury:________________________________________________________

________________________________________________________________________________________

________________________________________________________________________________________

How did the injury occur:__________

________________________________________________________________________________________

________________________________________________________________________________________

________________________________________________________________________________________

________________________________________________________________________________________

Immediate symptoms or complaints following the injury (describe each body part involved in detail):

________________________________________________________________________________________

________________________________________________________________________________________

________________________________________________________________________________________

________________________________________________________________________________________

________________________________________________________________________________________

________________________________________________________________________________________

Was the injury witness:  Yes  No  If yes, by who______________________________________

Did you report the injury: Yes  No  If yes, when _________________________________

If yes, To whom________________________________________________________
Name of your employer at the time of injury______________________________________

Did you finish what you were doing following the injury: Yes  No

Did you return to work: Yes  No  If yes, modified duty or full duty

If no, why_______________________________________________________________

Where were you first seen following your injury________________________________

When were you first seen following your injury__________________________________

Were you sent by the employer: Yes  No

Tests performed: Xrays  Nerve Test  MRI  Other________________________________________

Do you know what the tests show?________________________________________________

What type of treatment did you receive immediately following your injury:

Physical Therapy: Yes  No  If yes, # of visits______________________________ Did it help: Yes  No

Chiropractic: Yes  No  If yes, # of visits______________________________ Did it help: Yes  No

Acupuncture: Yes  No  If yes, # of visits______________________________ Did it help: Yes  No

Medications Yes  No  If yes, name__________________________________________ Did it help: Yes  No

Name____________________________________ Did it help: Yes  No

Name____________________________________ Did it help: Yes  No

Name____________________________________ Did it help: Yes  No

Name____________________________________ Did it help: Yes  No

Are you currently working: Yes  No  If yes, modified duty or full duty

If no, last date worked_____________________________________________________

Have you missed work due to your injury: Yes  No If yes, approximate dates________

________________________________________________________________________

OTHER TREATMENT RECEIVED FOLLOWING INJURY AND PRIOR TO THIS VISIT:
(start with most recent treatment/physician)

Name of the Dr. you are currently seeing or was last seen by:_____________________

When was your last visit with this Dr.________________________________________

Did he/she release you from care (P&S): Yes  No  If yes, when:________________________
Were you release to return to work: Yes  No  If yes, when did you return_______________________________

Were you released with restriction: Yes  No  If yes, what restrictions_______________________________

Are you currently working: Yes  No  If no, why__________________________________________

If yes, same employer: Yes  No  If no, who____________________________________________________

If now, type of new job title/position?____________________________________________________________

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**JOB DESCRIPTION**

Job title at the time of the injury:_________________________________________________________________

Hours worked per day_______  Days worked per week___________  Overtime_____________

Number of years, months, or days you have worked for this employer_____________________________________

Number of years, months, or days you have been in this line of work_____________________________________

Work duties (describe what you did on an average work day):____________________________________________

____________________________________________________________________________________________

Mark any activity required in the course of your normal work activity, using these descriptive symbols:  C = continuous     R = repetitive     O = Occasionally     S= Seldom      N = Never

___Gripping  ___Torquing  ___Carry  ___Bend  ___Stoop

___Squat  ___Kneel  ___Climb Stairs  ___Climb Ladder  ___Reach Overhead

___Reach Forward  ___Walk  ___Stand  ___Sit  ___Power Tools

___Hand Tools  ___Computer Use  ___Lift  ___Push  ___Pull

Other:_________________________________________________________________________________________

Weight you had to lift or carry (use symbols as above):

___0-5  ___5-10  ___10-20  ___20-30  ___30-40  ___40-50  ___50-60  ___60-70  ___70+

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**WORK HISTORY**

Describe your past work experience/positions, including type of position and duration:__________

____________________________________________________________________________________________

____________________________________________________________________________________________

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3
MEDICAL HISTORY

Medical Conditions:

___Diabetes  ___Hypertension  ___Stroke (when)___________________________
___Hepatitis  ___Hypothyroid  ___Hyperthyroid
___GERD  ___PUD  ___Heart Attack (when)_____________________
___Tuberculosis
___Depression  ___Anxiety  ___Arthritis(type)___________________________

Other:________________________________________________________

Current Medications:_______________________________________________________________

Allergies:____________________________________________________________

Surgeries: Yes  No  If yes, date and region__________________________________________

    date and region__________________________________________

    date and region__________________________________________

Hospitalized: Yes  No  If yes, date and reason:_________________________________________

    date and reason:_________________________________________

Have you ever had a prior industrial injury or claim involving the body region you are being seen for today:

Yes  No  If yes, Date of injury:_______________________________________________________________

    Did you fully recover:_______________________________________________________________

    Did you receive a settlement:_________________________________________________________

Have you ever had any other industrial injuries: Yes  No  If yes, what body region(s) and date:

                                                                                     

Have you ever had any other injuries or accidents: Yes  No  If yes, what body region(s) and date:

                                                                                     

If yes, what type of treatment did you receive and for how long:____________________________
If yes, did you fully recover: Yes  No  If no, what residual symptoms do you have:_________________

Do you routinely receive any type of medical treatment (physical therapy, chiropractic, acupuncture): Yes  No  If yes, how often and for what:________________________

SOCIAL HISTORY

Marital Status: Single  Married  Divorced  Widowed

Children: Yes  No  If yes, how many:_________________

Where were you born:______________________________

Highest level of education:__________________________

Trade School___________________________________________

Hobbies_____________________________________________________

Recreational Activity_____________________________________________________

Smoke: Yes  No  If yes, how many a day_________ for how long________________________________

Drink: Yes  No  If yes, how many a day_____ week_______ or month_________

Do you use recreational drugs: Yes  No  If yes, what type________________________________________

Have you ever attended a detoxification or drug/alcohol rehabilitation program: Yes  No
PATIENT PAIN ASSESSMENT
(CIRCLE ONE)

Answer all of the following questions:

1. How is your pain right now, at this moment: none slight mild moderate severe
2. How is your pain at its worst: none slight mild moderate severe
3. How is your pain on the average: none slight mild moderate severe
4. How much is your pain aggravated with activity: never sometimes frequently always
5. How frequently do you experience pain: never sometimes frequently always
6. Does your pain interfere with your ability to walk: never
   a. If yes how long or far can you walk: _______distance _______time
7. Does your pain interfere with your ability to stand: never
   a. If yes how long can you stand: _______minutes _______hours
8. Does your pain interfere with your ability to sit: never
   a. If yes how long can you sit: _______minutes _______hours
9. Does your pain interfere with your ability to lift: never
   a. If yes how much and how far can you lift: _______pounds _______duration
10. Are you concerned about performing activities which might make your pain worse: never sometimes frequently always
11. Does your pain interfere with your ability to perform or engage in social activities: never sometimes frequently always
12. Does your pain interfere with your ability to travel: never sometimes frequently always
13. Does your pain interfere with your ability to perform your daily activities: never sometimes frequently always
14. Does your pain interfere with your ability to perform your personal hygiene: never sometimes frequently always
15. Does your pain interfere with your ability to dress: never sometimes frequently always
16. Does your pain interfere with your ability to perform household chores/cleaning: never sometimes frequently always
17. Does your pain interfere with your ability to perform personal or household cooking: never sometimes frequently always
18. Does your pain interfere with your ability to perform home repairs or maintenance: never sometimes frequently always

18. Does your pain interfere with your ability to write or type:
   a. If yes, how long can you type or write: never sometimes frequently always

19. Does your pain interfere with your ability to engage in sexual activities: never sometimes frequently always

20. Does your pain interfere with your ability to concentrate: never sometimes frequently always

21. Does your pain affect your overall mood: never sometimes frequently always

22. Over the past week have you felt depressed: never sometimes frequently always

23. Over the past week have you felt anxious: never sometimes frequently always

24. Over the past week have you felt irritable: never sometimes frequently always

25. Do you have any complaints involving your stomach with taking medications, now or previously: never sometimes frequently always

26. If yes, do you take any medication for this: never sometimes frequently always

27. If yes, have you ever been treated for an ulcer, reflux, or other stomach condition due to your your industrial injury or not: Yes No

28. If yes, what treatment and diagnosis did you have: _______________________

29. Does your pain interfere with your ability to sleep: never sometimes frequently always
   (if yes, answer the following questions)