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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?____

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-+

WORK HISTORY

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

____

____

MEDICAL HISTORY

Medical Conditions:

___Diabetes ___Hypertension ___Stroke (when)______________________________

___Hepatitis ___Hypothyroid ___Hyperthyroid

___GERD ___PUD ___Heart Attack (when)________________________

___Tuberculosis ___Cancer (type)_______________________________

___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

Name:_________________________ Date:____________________

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 sometimes frequently always
   a. If yes how long or far can you walk: ___________distance _________time

7. Does your pain interfere with your ability to stand: never sometimes frequently always
   a. If yes, how long can you stand: _________ minutes ________ hours

8. Does your pain interfere with your ability to sit: never sometimes frequently always
   a. If yes, how long can you sit: _________ minutes ________ hours

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

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)