Today's date: _____

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INITIAL HISTORY OF INJURY

1. When did you first notice this medical problem? Date: _____

2. What do you feel caused this condition? _____

3. Who was your employer at the time you noticed this condition? _____

4. How did the injury/ accident/ condition happen? Please be specific:
_____
_____
_____
_____
_____
_____

5. What were the immediate symptoms? _____

What body parts were injured?_____

6. Where you at work or away from work when you first noticed this condition? Explain:_____
_____

7. Did you finish what you were doing? **Yes** **No**
8. Did you report the injury or problem? **Yes** **No** If yes, when _____
To whom?_____
9. Were you off work due to this condition? **Yes** **No** If yes, how long?_____

HISTORY OF TREATMENT

1. When did you first see a doctor for this problem? _____

2. To which hospital or clinic were you taken? _____

3. Were you sent by your employer? **Yes** **No**

4. Name of the doctor you saw? _____ What type of doctor?_____

5. Were test performed? **Yes** **No**
Xrays EMG Nerve Tests MRI Other_____

6. What did the test show?_____

7. What recommendations were made or what treatment was prescribed?

a. Physical Therapy (give dates, how often?_____

b. Medication (give names)_____

c. Injections (type and location)_____
Did they work?_____

d. Casting **Yes No** Splinting **Yes No**

e. Surgery (what kind, date)_____

WORK REQUIREMENTS

Work duties (describe what you do during an average work day)
_____
_____
_____
_____
Lifting/carrying _____ lbs, bending_____, stooping_____, squatting_____
Use of tools_____ repetitive hand manipulation_____
standing # of hrs _____, walking # of hrs_____

Number of years that you have worked for this employer?_____
Last date of work? _____

CURRENT COMPLAINTS

Body Part #**1**:_____ pain Level (1-10) _____ **intermittent/constant**

What activities do you have difficulty with? walking, standing, sitting, lifting, travel, personal hygiene, ability to dress, household chores, cooking, home repair , writing, typing, sexual activities, sleeping.

What makes it better?_____

Other symptoms: e.g. numbness, tingling, weakness, stiffness, etc.,:
_____

Body Part #**2**:_____ pain Level (1-10) _____ **intermittent/constant**

What activities do you have difficulty with? walking, standing, sitting, lifting, travel, personal hygiene, ability to dress, household chores, cooking, home repair , writing, typing, sexual activities, sleeping.

What makes it better?_____

Other symptoms: e.g. numbness, tingling, weakness, stiffness, etc.:
_____

PRESENT DISABILITY

Are you presently working? **Yes No** Are you on temporarily disability? **Yes No**

What doctor placed you on your current disability status? _____
On What date? _____

Are you currently on modified duty with work restrictions? **Yes No**

If yes, what are your restrictions? _____

PREVIOUS DISABILITY HISTORY

Before this injury, had you ever missed work because of a work related injury? **Yes No**

Have you had prior pain in involved body part **Yes No**

Have you had prior motor vehicle accident? **Yes No**

Prior workers compensation injury? **Yes No** if yes give date_____
Injured body part? _____Employer_____

Did you return to the same duties you had before the injury**? Yes No**

Did you have any work restrictions**? Yes No**
Did you have any permanent Disability? **Yes No**
If yes, what were your restrictions? _____

Military History_____
Any disability from military service? _____

PAST MEDICAL HISTORY

Circle if you have any of the following:

Diabetes
High Blood Pressure
Liver Problems (hepatitis)
Heart Disease/ Attack
Depression
Easy Bleeding
Hypothyroidism
Cholesterol Problems
Kidney Disease
Ulcer/ GERD
Cancer
History of Blood Clots
Stroke
Emphysema
Asthma
Addiction to Alcohol or Drugs
Psychiatric Problems
Irregular Heart beat

List all operations you have had and the approximate date or year you had them:

Surgery:_____ Date:_____

Surgery:_____ Date:_____

Surgery:_____ Date:_____

List any medications that you are currently taking and the dosage:

_____ _____

_____ _____

_____ _____

Please list any allergies or adverse reactions that you have had to medications:

Medication_____ Reaction_____

Other Allergies: ☐ Iodine ☐ Nickel ☐ Environmental ☐ Latex

FAMILY HISTORY

Please circle below if anyone in your immediate family has had any of the following:

Stroke Heart Disease Diabetes Cancer High Blood Pressure

Back Pain Neck Pain Depression Drug/Alcohol Addiction

Suicide Arthritis

ACTIVITIES OF DAILY LIVING

Please check all tasks you are unable to complete:

☐ Dress yourself including shoes
☐ Wash and dry yourself
☐ Take a bath
☐ Get on and off the toilet
☐ Cut your food
☐ Lift a full cup to your mouth
☐ Make a meal
☐ Write a note
☐ Type a message on a computer
☐ Use a telephone
☐ Work outdoors on flat ground
☐ Climb up 1 flight of stairs (10 steps)
☐ Stand
☐ Sit
☐ Recline
☐ Rise from a chair
☐ Run errands
☐ Light housework
☐ Feel what you touch
☐ Open car doors
☐ Turn faucets off and on
☐ Get in and out of a car
☐ Sleep
☐ Engage in sexual activity

REVIEW OF SYSTEMS

Please circle any of the following symptoms that you have had in the last week:

GENERAL
Fever
Weakness
Fatigue
Appetite loss
Nighttime sweats
Shaking / chills

SKIN
Skin disease
Pigmentation changes
tumors/cancers
cysts

HEAD
Headaches
Loss of memory
Problem Concentrating

EYES/VISION
Blurred/double vision
Decreased vision
Itching, burning, tearing
Light sensitivity

CARDIOVASCULAR
Chest pain
Heart palpitations
High blood pressure
Shortness of breath
Feet/ankle swelling
Varicose veins

RESPIRATORY
Chronic cough
Asthma
Emphysema
Chronic bronchitis
Pneumonia
Tuberculosis
Coughing blood
Wheezing

GASTROINTESTINAL
Frequent indigestion
Nausea or vomiting
Abdominal pain
Frequent constipation
Frequent diarrhea
Blood in stools

EARS/NOSE/THROAT
Ear pain
Infection or discharge
Hearing decreased/ loss
Ringing in ears
Recurrent throat issues
Voice Changes
Dental disease
Sinus problems

GENITOURINARY
Painful/difficult urination
Blood in urine
Urine incontinence

MUSCULOSKELETAL
Other non-injury related issues
Multiple joint pains
Pain / cramping in calf

NEUROLOGIC
Convulsions
Loss of consciousness
Other non-injury issues

PSYCHIATRIC
Depression
Nervousness
Sleeping all day
Sleep Disturbance
Spontaneous crying
Emotional outburst
Thoughts of suicide

ENDOCRINE
Increased thirst
Increased appetite
Increased urination
Diabetes
Hair loss

HEMATOLIC
Bleeding gums
Easy bruising/bleeding that's hard to stop

SOCIAL HISTORY

With Whom do you live? **Alone** **Family** **Friends** Other_____

Do you smoke? **Yes** **No** If "yes", how many packs a day and for how many years?____

If you are a former smoker, when did you quit and for how long did you smoke?_____

Do you drink alcoholic beverage? **Yes** **No** If "yes" how much and how often do you drink?_____

Do you exercise on a regular basis? **Yes** **No** What type of exercise do you do?_____

Have you been in an alcohol or drug rehabilitation program? **Yes** **No**

RECREATIONAL ACTIVITIES

What are your hobbies/sports interests (ie. gardening, cooking, crocheting, basketball etc)_____
_____
_____

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