



PATIENT INFORMATION

PATIENT NAME _____

R / L Handed
WT: _____ / HT: _____

Age: _____ Date: _____ Date of injury: _____

Employer at time of injury: _____ Job title: _____

When did you begin working for this employer? _____

How did this injury happen? _____

What body parts were injured? _____

Where did you first go for treatment? _____

What other doctors have you seen for this injury? _____

Who is treating you now? _____ When was your last visit? _____

Are you currently working? Yes ___ No ___

If yes please list your current employer. If no please list your last day of work: _____

What medications are you taking, and how often: _____

What are your complaints and where does it hurt? _____

Which activities aggravate your complaints? (Again, please specify how the activity affects each body part.)

TYPES OF TREATMENT

Acupuncture: Yes ___ No ___ No help ___ Good ___ Great ___
Physical therapy: Yes ___ No ___ No help ___ Good ___ Great ___
Chiropractic: Yes ___ No ___ No help ___ Good ___ Great ___
Injections: Yes ___ No ___ Type: Epidural / Cortisone No help ___ Good ___ Great ___
Surgery: Yes ___ No ___ If yes, please list body parts and dates _____

MRI: Yes ___ No ___ If yes, please list body part and date. _____

EMG: Yes ___ No ___ If yes, please list date. _____

PRIOR MEDICAL HISTORY

Severe accidents: (Motor vehicle) Yes ___ No ___

If yes: Date of accident _____ Was there a lawsuit? Yes ___ No ___

Please list injured body parts _____

Previous worker comp injuries: Yes ___ No ___ If yes please list body part and dates _____

Broken bones: Yes ___ No ___ if yes please list body part and dates.

Operations: Yes ___ No ___ if yes please list type of operation and date.

Hospitalizations: Yes ___ No ___ if yes please list reason and date.

Allergies to medications: Yes ___ No ___ if yes please list name of medication.

Do you have any of the following? (Please circle yes or no)

Tuberculosis Yes No Hepatitis Yes No High Cholesterol Yes No
HIV Yes No Diabetes Yes No
Heart Disease Yes No High Blood Pressure Yes No
Other serious illnesses: _____

Work History

List prior employers and starting date:

Employer name: _____ Date _____
Employer name: _____ Date _____
Employer name: _____ Date _____