

WORKER'S COMPENSATION HISTORY

PATIENT INFORMATION

Patient: _____ Date of Birth: _____ Date: _____
Marital Status: M S W D
Address: _____ City: _____ State: _____ Zip: _____
SS No: _____ Home Phone: _____ Work Phone: _____
(at time of injury)
Occupation: _____ Employer: _____
(at time of injury)
Address: _____ Supervisor: _____
Current Employer: _____ Current Work Phone: _____
Nearest relative not living with you? _____ Phone: _____
Who referred you to our practice? _____

INJURY INFORMATION

Give time and date present injury occurred _____ AM PM ____/____/____
Please explain in detail how your present injury occurred? _____

To whom was injury reported? _____ Phone _____
Where did you feel pain immediately after the injury? _____
Did **you** consult any other doctor? Yes No
If so, give doctor's name _____ D.C., M.D., D.O., D.D.S.
Did **employer** send you to doctor? Yes No
If so, give doctor's name _____ D.C., M.D., D.O., D.D.S.
Doctor's diagnosis _____
Did you return to work? Yes No If so, date returned to work _____
Did you lose time from work? Yes No If so, date off work _____
Did another doctor take you off work? Yes No If yes, from _____ to _____
Were you hospitalized? Yes No
What medications are you presently taking? _____

Do any other diseases or accidents affect your employment? Yes No If so, explain _____

In your work, do you have to favor any part of your body? Yes No If so explain _____

Before the injury, were you capable of working on an equal basis with others your age? Yes No
Are your work activities now restricted as a result of this accident? Yes No
If so, what work activities? _____
Since the injury, are your symptoms Improving? Getting worse? The same?
Have you retained an attorney? Yes No
If so, name, address, & phone # _____

Over Please ➡

HEALTH QUESTIONNAIRE

PLEASE CHECK (✓) CONDITIONS YOU ARE CURRENTLY EXPERIENCING

MUSCULO-SKELETAL SYSTEM

- Low back pain
- Mid back pain
- Pain between shoulders
- Neck pain
- Disc problems
- Arm problems
- Leg problems
- Swollen joints
- Painful joints
- Stiff joints
- Sore muscles
- Weak muscles
- Walking problems
- Muscle spasms
- Broken bones
- Shoulder pain
- Carpal Tunnel

GENITO-URINARY SYSTEM

- Bladder trouble
- Excessive urination
- Scanty urination
- Painful urination
- Discolored urine

FEMALE

- Vaginal discharge
- Vaginal bleeding
- Vaginal pain
- Breast pain
- Lumps on the breast

GASTRO-INTESTINAL SYSTEM

- Poor appetite
- Excessive hunger
- Difficult chewing
- Difficult swallowing
- Excessive thirst
- Nausea
- Vomiting Blood
- Abdominal pain
- Diarrhea
- Constipation
- Black stool
- Bloody stool
- Hemorrhoids
- Liver trouble
- Gall bladder problems
- Weight trouble

NERVOUS SYSTEM

- Numbness
- Loss of feeling
- Paralysis
- Dizziness
- Fainting
- Headaches
- Muscles jerking
- Convulsions
- Forgetfulness
- Confusion
- Depression
- Insomnia

HABITS

- Cigarettes
- Alcohol Abuse
- Coffee or Tea
- Exercise
- Drug Abuse
- _____

CARDIO-VASCULAR RESPIRATORY

- Chest pain
- Pain over heart
- Difficult breathing
- Persistent cough
- Coughing phlegm
- Coughing blood
- Rapid heartbeat
- Blood pressure problems
- Heart problems
- Lung problems
- Varicose veins

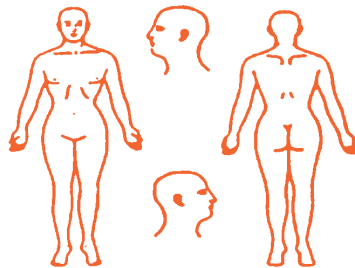
EYE, EAR, NOSE AND THROAT

- Eye strain
- Eye inflammation
- Vision problems
- Ear pain
- Ear noises
- Ear discharge
- Hearing loss
- Nose pain
- Nose bleeding
- Nose discharge
- Difficult breathing through nose
- Sore gums
- Dental problems
- Sore mouth
- Sore throat
- Hoarseness
- Difficult speech
- Sinus
- Allergy
- Jaw pain

ARE YOU PREGNANT?

- YES NO

Please mark your area of pain on the figure below.



P ___ Pain N ___ Numb

S ___ Spasm

Pain Index

Least 1 2 3 4 5 6 7 8 9 10 Most

Patient's Signature: _____