

Patient Registration for Work Related Injury

The information you provide is confidential and will not be reproduced or shared without your permission unless permitted by law.

First name _____ MI _____ Last name _____

Gender _____ Birth date _____ Social security # _____

Drivers license # _____ Issued in which state? _____

Home address _____ City _____ State _____ Zip _____

Home phone # _____ Voice mail/Pager # _____

Name of employer at time of injury _____ Their Phone # _____

Their address _____ City _____ State _____ Zip _____

Occupation at time of injury _____ Length of employment _____

Your present occupation _____ Length of employment _____

Your present employer _____ Work phone # _____

[circle one] Spouse, Partner or Parent name _____ Their phone # _____

Emergency contact person _____ Their phone # _____

Who referred you or how did you hear about this office? _____

Who is filling out this questionnaire? _____ Relationship to patient: _____

Day and date of the accident _____ Time of the accident _____ AM / PM

Location of accident _____ Witness name _____

Name of person the accident was reported to: _____

Did you file Form 801 with your employer after the accident? [circle one] No Yes *Please give us a copy of the report for your file.*

Describe the accident in your own words: _____

Describe how you felt immediately after the accident: _____

On the following pain scale diagram, circle the number from 0 to 10 that best represents the level of pain you felt immediately after the accident:

No pain = 0 1 2 3 4 5 6 7 8 9 10 = Incapacitating pain

List and describe the parts of your body that were injured or cause you pain or discomfort as a result of this accident, including all bumps, bruises, broken bones, cuts, scrapes, scratches, or marks on your body.

Did you receive medical attention at the scene? [circle one] No Yes

Were you taken to a hospital? [circle one] No Yes *Name of hospital* _____

What did you do immediately after the accident or hospital? [circle one] Went home Went back to work Went to a doctor

Has another doctor treated you since the accident or hospital? [circle one] No Yes **Still treating?** [circle one] No Yes

Date of your FIRST treatment _____ Diagnosis _____

Doctor's Name _____ [circle one] MD DO DC ND Phone # _____

Address or location where you were treated _____

Have x-rays or MRI films been taken for your current condition? [circle one] No Yes **When?** _____

What other tests have been done to diagnose or monitor your current condition? _____
When? _____

Are you taking any prescription medications for your work injury? [circle one] No Yes

Please list the names of those prescription medications you are taking for your injury. Be sure to indicate the dosage or how much you take and how often you take it:

1. _____
2. _____
3. _____
4. _____

Please list all OTHER medicines you take for other health conditions even if you take herbs or vitamins.

Name	Why do you take it?	What dosage?	Taken for how long?
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_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

Describe your symptoms from the day after the accident until today: _____

On the following pain scale diagram, circle the number from 0 to 10 that best represents the typical level of pain you have felt from the day after the accident until today.

No pain = 0 1 2 3 4 5 6 7 8 9 10 = Incapacitating pain

Are your work activities restricted as a result of this accident? [circle one] No Yes

If Yes, please describe or give me a copy of your work restriction: _____

What is the LAST date that you worked full or part time after the accident? _____

Before the accident were you capable of working on an equal basis with others your age? [circle one] No Yes

Were you involved in any prior work accidents? [circle one] No Yes **In what month and year?** _____

Were you involved in any prior auto accidents? [circle one] No Yes **In what month and year?** _____

Did you have any physical complaints caused by a prior accident that were bothering you before this accident or that are worse after this accident? [circle one] No Yes

Please describe: _____

Did you have any other physical complaints or problems before this accident? [circle one] No Yes

Please describe: _____

Your Current Job Description

In terms of an 8- hour workday, "occasionally" means 33%, "frequently" means 34%- 66%, and "continuously" means 67%- 100% of the day.

1. **In a typical 8- hour workday, I:** [please circle the number of hours of activity]

Sit	1	2	3	4	5	6	7	8 hours
Stand	1	2	3	4	5	6	7	8 hours
Walk	1	2	3	4	5	6	7	8 hours

2. **On the job, I perform the following activities:** [circle one for each activity]

Bend, Stoop	Not At All	Occasionally	Frequently	Continuously
Squat	Not At All	Occasionally	Frequently	Continuously
Crawl	Not At All	Occasionally	Frequently	Continuously
Climb	Not At All	Occasionally	Frequently	Continuously
Reach over shoulder level	Not At All	Occasionally	Frequently	Continuously
Crouch	Not At All	Occasionally	Frequently	Continuously
Kneel	Not At All	Occasionally	Frequently	Continuously
Balancing	Not At All	Occasionally	Frequently	Continuously
Push, pull	Not At All	Occasionally	Frequently	Continuously

3. **On the job, I lift:** [circle all that apply]

Up to 10 pounds	Not At All	Occasionally	Frequently	Continuously
11 to 24 pounds	Not At All	Occasionally	Frequently	Continuously
25 to 34 pounds	Not At All	Occasionally	Frequently	Continuously
35 to 50 pounds	Not At All	Occasionally	Frequently	Continuously
51 to 74 pounds	Not At All	Occasionally	Frequently	Continuously
75 to 100 pounds	Not At All	Occasionally	Frequently	Continuously

4. Do you have to bend over while doing any lifting? [circle one] No Yes

5. Are your feet used for repetitive movements, such as in operating foot controls? [circle one] No Yes

6. Do you use your hands for repetitive actions, such as: [circle all that apply]

<i>Right hand:</i>	Simple Grasping	Firm Grasping	Fine Manipulating
<i>Left hand:</i>	Simple Grasping	Firm Grasping	Fine Manipulating

7. Are you required to work on unprotected heights? [circle one] No Yes

8. Are you required to be around moving machinery? [circle one] No Yes

9. Are you exposed to marked changes in temperature and humidity? [circle one] No Yes

10. Are you required to drive automotive equipment? [circle one] No Yes

11. Are you exposed to dust, fumes and/ or gases? [circle one] No Yes

Signature _____ Date _____

Health History

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Personal History

Name _____ Date of Birth _____ Age _____

[circle one] Right handed Left handed Ambidextrous Your HEIGHT: _____ feet _____ inches

Your current WEIGHT: _____ pounds Your normal WEIGHT: _____ pounds

Have you recently gained or lost a significant amount of weight? [circle one] Yes No If YES, how much and over what time period? _____

Female patients, please answer the following questions:

Are you pregnant, or do you have any reason to believe that you could be pregnant? [circle one] Yes No

Number of children _____ Number of pregnancies _____ Number of births _____

Social History Please check the appropriate column if any of the following apply to you:

PAST	PRESENT		
<input type="checkbox"/>	<input type="checkbox"/>	Tobacco	Per day _____ or per week _____
<input type="checkbox"/>	<input type="checkbox"/>	Alcohol	Per day _____ or per week _____
<input type="checkbox"/>	<input type="checkbox"/>	Caffeinated drinks	per day _____ or per week _____
<input type="checkbox"/>	<input type="checkbox"/>	Decaffeinated coffee	per day _____ or per week _____
<input type="checkbox"/>	<input type="checkbox"/>	Drugs and related substances	

Past Health History

PRIOR INJURIES

Please list all major past injuries, even if you never received medical care

INJURY DATE OCCURRED WORK RELATED [yes or no] DOES THE CONDITION RECUR [yes or no]

PRIOR ADULT ILLNESSES

Please list all serious illnesses, such as ASTHMA, CANCER, DIABETES, HEART DISEASE, HEPATITIS, HIGH BLOOD PRESSURE, HIV INFECTION, SEIZURES, SICKLE CELL ANEMIA, TUBERCULOSIS.

DATE DIAGNOSIS TREATMENT GIVEN ANY REMAINING PROBLEMS?

PRIOR SURGERIES & HOSPITALIZATIONS

Please list all major surgeries/ operations and times you were hospitalized, even if you never had surgery

DATE TYPE OF SURGERY OR CAUSE OF HOSPITALIZATION ANY COMPLICATIONS? ANY REMAINING PROBLEMS?

Family History Please tell us about your birth parents and blood relatives if this information is available to you

Mother is [circle one] LIVING DECEASED Age _____ Cause of death _____

Father is [circle one] LIVING DECEASED Age _____ Cause of death _____

Please check the appropriate column if any of the following apply now or in the past to your blood relatives

- | | |
|--|---|
| <input type="checkbox"/> Alcoholism | <input type="checkbox"/> Cancer |
| <input type="checkbox"/> Allergies | <input type="checkbox"/> Diabetes mellitus |
| <input type="checkbox"/> Arthritis | <input type="checkbox"/> Heart Disease |
| <input type="checkbox"/> Anemia, blood, bleeding disorders | <input type="checkbox"/> Inherited disorder _____ |

Your Symptoms List Please check the appropriate column for symptoms you have experienced before (PAST) or for symptoms you currently experience (PRESENT)

- | PAST | PRESENT | | PAST | PRESENT | |
|--------------------------|--------------------------|------------------------------|--------------------------|--------------------------|--|
| <input type="checkbox"/> | <input type="checkbox"/> | General fatigue | <input type="checkbox"/> | <input type="checkbox"/> | Skin rash, dermatitis, eczema |
| <input type="checkbox"/> | <input type="checkbox"/> | Headache | <input type="checkbox"/> | <input type="checkbox"/> | Chronic sinus problems |
| <input type="checkbox"/> | <input type="checkbox"/> | Tinnitus, noises in the ear | <input type="checkbox"/> | <input type="checkbox"/> | Excessive thirst |
| <input type="checkbox"/> | <input type="checkbox"/> | Fainting | <input type="checkbox"/> | <input type="checkbox"/> | Chronic cough |
| <input type="checkbox"/> | <input type="checkbox"/> | Vision disturbances | <input type="checkbox"/> | <input type="checkbox"/> | Chest pain |
| <input type="checkbox"/> | <input type="checkbox"/> | Convulsions | <input type="checkbox"/> | <input type="checkbox"/> | Rapid heart beat |
| <input type="checkbox"/> | <input type="checkbox"/> | Dizziness, lightheadedness | <input type="checkbox"/> | <input type="checkbox"/> | Difficulty swallowing |
| <input type="checkbox"/> | <input type="checkbox"/> | Muscular incoordination | <input type="checkbox"/> | <input type="checkbox"/> | Heartburn and/ or indigestion |
| <input type="checkbox"/> | <input type="checkbox"/> | Generalized muscle pain | <input type="checkbox"/> | <input type="checkbox"/> | Loss of appetite |
| <input type="checkbox"/> | <input type="checkbox"/> | TMJ (jaw) pain | <input type="checkbox"/> | <input type="checkbox"/> | Nausea |
| <input type="checkbox"/> | <input type="checkbox"/> | Neck pain | <input type="checkbox"/> | <input type="checkbox"/> | Abdominal pain |
| <input type="checkbox"/> | <input type="checkbox"/> | Back pain | <input type="checkbox"/> | <input type="checkbox"/> | Loss of bladder or bowel control |
| <input type="checkbox"/> | <input type="checkbox"/> | Joint swelling | <input type="checkbox"/> | <input type="checkbox"/> | Painful urination |
| <input type="checkbox"/> | <input type="checkbox"/> | Joint stiffness | <input type="checkbox"/> | <input type="checkbox"/> | Frequent urination |
| <input type="checkbox"/> | <input type="checkbox"/> | Shoulder pain | <input type="checkbox"/> | <input type="checkbox"/> | Difficult urination or changes in stream |
| <input type="checkbox"/> | <input type="checkbox"/> | Arm pain | <input type="checkbox"/> | <input type="checkbox"/> | Constipation |
| <input type="checkbox"/> | <input type="checkbox"/> | Elbow pain | <input type="checkbox"/> | <input type="checkbox"/> | Irregular bowel habits |
| <input type="checkbox"/> | <input type="checkbox"/> | Wrist, Hand pain | <input type="checkbox"/> | <input type="checkbox"/> | Irregular menstrual flow |
| <input type="checkbox"/> | <input type="checkbox"/> | Hip pain | <input type="checkbox"/> | <input type="checkbox"/> | Excessive menstrual flow |
| <input type="checkbox"/> | <input type="checkbox"/> | Leg pain | <input type="checkbox"/> | <input type="checkbox"/> | Breast tenderness and/ or lumps |
| <input type="checkbox"/> | <input type="checkbox"/> | Knee pain | <input type="checkbox"/> | <input type="checkbox"/> | Vaginal discharge |
| <input type="checkbox"/> | <input type="checkbox"/> | Ankle, foot pain | <input type="checkbox"/> | <input type="checkbox"/> | PMS |
| <input type="checkbox"/> | <input type="checkbox"/> | Enlarged lymph nodes, glands | <input type="checkbox"/> | <input type="checkbox"/> | ED |

Signature _____

Date _____