CONFIDENTIAL PATIENT INFORMATION / Worker's Comp

Name _____ **S.S.N.**_____ **Date** _____

Address _____ **City/State** _____ **ZIP** _____

D.O.B _____ **Height/Weight** _____ **Home Phone** _____

Employer _____ **Occupation** _____ **Work Phone** _____

Email _____ **Spouse/Partner Name** _____

Whom may we thank for referring you to us _____

Emergency Contact _____ **ER Contact Phone #** _____

Date of injury _____ **Have you reported your injury Yes / No**

Describe the accident _____

_____

Contributing factors to your injury (ie: wet floor, faulty equipment, etc.) _____

Have you lost days from work _____ **Dates** _____

If you have seen other doctors for this injury, please detail:

Doctor 1 _____ **X-rays taken** _____

Doctor 2 _____ **X-rays taken** _____

Others _____

Have you had similar symptoms prior to this injury? _____ **Date** _____

Do you wear foot supports _____ **Do you exercise regularly** _____

Any history of ankle, knee, hip, wrist, elbow or shoulder injuries _____

Have you had a spinal x-ray taken within past 7 years _____ **Date & Facility** _____

FAMILY HISTORY (list any significant diseases- diabetes, cancer, etc.) Are you adopted? _____

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Mother _____ **Father** _____

Grandparents _____ **Aunt/Uncle/Siblings** _____

Women: Are You Pregnant _____ **How Far Along** _____ **Breast Implants** _____

Do you Exercise Regularly_____ **Types of Exercises** _____

Do you smoke/use tobacco? _____ **If so, how often?** _____
Chief Complaint _____

ONSET (what were you doing when injury occurred) _____

PROVOKING (what activities aggravate your injury) Circle- Sitting / Standing / Lying / Walking / Reaching/ Bending / Other _____

PALLIATIVE (what makes it feel better) Circle- Ice / Heat / Lying / Pain Med. / Stretching / Other ___
_____

QUALITY (describe the pain) Circle- Sharp / Electric / Burning / Stabbing / Aching / Deep / Other __
_____

Any sensations radiating into the following -Circle- Arms / Legs / Forearm / Hands / Buttock / Thighs / Foot / Shoulder / Shoulder Blades / Other _____

Describe the radiating -Circle- Sharp / Dull / Tingling / Numbness / Prickling / Other _____

SEVERITY On a scale of 0 - 10 with 0 being no pain and 10 pain that prevents ALL activities _____

PATTERN (time of day most aggravated) Circle- Early Morning / Mid Day / Late Eve / After Work / After Exercise / Other _____

Complaint #2 _____

PROVOKING (what activities aggravate your injury) Circle- Sitting / Standing / Lying / Walking / Reaching/ Bending / Other _____

PALLIATIVE (what makes it feel better) Circle- Ice / Heat / Lying / Pain Med. / Stretching / Other ___
_____

QUALITY (describe the pain) Circle- Sharp / Electric / Burning / Stabbing / Aching / Deep / Other __
_____

Any sensations radiating into the following -Circle- Arms / Legs / Forearm / Hands / Buttock / Thighs / Foot / Shoulder / Shoulder Blades / Other _____

Describe the radiating -Circle- Sharp / Dull / Tingling / Numbness / Prickling / Other _____

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SEVERITY **On a scale of 0 - 10 with 0 being no pain and 10 pain that prevents ALL activities _____**

PATTERN **(time of day most aggravated)** Circle- **Early Morning / Mid Day / Late Eve / After Work / After Exercise / Other _____**

CHECK ANY OF THE FOLLOWING YOU ARE CURRENTLY EXPERIENCING

HEAD

_____ Headache
_____ Allergies
_____ Dizziness
_____ Deafness
_____ Ringing in Ears
_____ Loss of Balance
_____ Fainting
_____ Eye Pain
_____ Failing Vision
_____ Nosebleeds
_____ Sinus Infection

CHEST

_____ Chest Pain
_____ Difficulty Breathing
_____ Asthma

ABDOMEN

_____ Difficult Digestion
_____ Abdominal Cramps
_____ Diarrhea
_____ Constipation
_____ Nausea
_____ Change in Urinary Function
_____ Change in Bowel Function

OTHER

_____ Loss of Sleep
_____ Nervousness
_____ Depression
_____ Fever
_____ HIV+/Aids
_____ Change in Menstrual Cycle
_____ Pregnant
_____ Hemorrhoids
_____ Other_____

PLEASE CHECK ANY OF THE FOLLOWING YOU'VE HAD

_____ Alcoholism
_____ Appendectomy
_____ Cancer
_____ Diphtheria
_____ Gall Bladder Problems
_____ Heart Disease
_____ Liver Problems
_____ Multiple Sclerosis
_____ Allergies
_____ Arteriosclerosis
_____ Colitis
_____ Eczema
_____ Goiter
_____ Hepatitis
_____ Malaria
_____ Pleurisy
_____ Anemia
_____ Arthritis
_____ Diabetes
_____ Emphysema
_____ Epilepsy
_____ Kidney Stone/ Infection
_____ Ulcers
_____ Migraines

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_____ Polio	**_____ Prostate Problems**	**_____ Pneumonia**
_____ Thyroid Trouble	**_____ Tuberculosis**	**_____ Scarlet Fever**
_____ Venereal Disease	**_____ Whooping Cough**	

Signature _____ Date _____

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