

Medical History / History of Injury

Today's Date: ___/___/___ Date of injury or onset of problem ___/___/___

Patient Name: _____ Home Phone: () _____

Address: _____ City: _____ Zip: _____

Age: _____ Birthdate: ___/___/___ Sex: ^{HAND} R L Social Security No.: _____

Employer's Name _____ Work Phone: () _____

Employer's Address _____ City: _____ Zip: _____

Work Comp. Ins. Carrier _____ Phone: () _____

Adjuster: _____ Claim #: _____ WCAB #: _____

Attorney: _____ Address: _____ City: _____

Occupation at time of injury: _____

Length of employment prior to injury _____ Years _____ Months

Describe accident / injury / exposure. (Please be as detailed as possible: How it happened; etc.)

Primary complaint at time of injury: _____

Current complaints: (Give details: area involved, weakness, loss of motion; pain: severity, frequency, activity)

Things I can't do: _____

Things that aggravate my symptoms: _____

DISABILITY INFORMATION

Did you continue working at the time of the injury? () Yes () No
Are you working now? () Yes () No. If not; last day you worked ___/___/___
Employer: _____

Are you still working for same employer () Yes () No
List dates of disability from this injury: ___/___/___ to ___/___/___

Have you ever been disabled for any other reason? () Yes () No
When? ___/___/___ to ___/___/___ Why? _____
When? ___/___/___ to ___/___/___ Why? _____

Are you doing the same job as when you were hired? () Yes () No
If not what are you doing that's different? _____

OTHER INJURIES

INDUSTRIAL

1. Employer _____ Date ___/___/___ Body part injured _____
2. Employer _____ Date ___/___/___ Body part injured _____
3. Employer _____ Date ___/___/___ Body part injured _____

NON-INDUSTRIAL

4. _____ Date ___/___/___ Body part injured _____
5. _____ Date ___/___/___ Body part injured _____
6. _____ Date ___/___/___ Body part injured _____

LIST ALL DOCTORS WHO YOU HAVE SEEN FOR YOUR CURRENT INJURY

Doctor _____ Speciality _____ City _____
Doctor _____ Speciality _____ City _____
Doctor _____ Speciality _____ City _____

Have you ever had an injury like this before? () Yes () No
Are you or have you taken any medication for this injury? () Yes () No
Medication _____ Medication _____

Have you had any tests for this injury? Blood tests (), Xrays (), CT scan (), MRI scan (), Bone scan (),
EMG/Nerve conduction studies (), Vascular studies ().
Other _____

WORK HISTORY
(latest employer first)

Employer _____ Job _____ Dates ___/___/___ to ___/___/___
Employer _____ Job _____ Dates ___/___/___ to ___/___/___
Employer _____ Job _____ Dates ___/___/___ to ___/___/___

DESCRIBE JOB AT THE TIME OF INJURY

TITLE _____

Years at job _____

Please describe job tasks during a typical workday: Hours spent:

| | | | | | | | | |
|----------|---|---|---|---|---|---|---|---|
| Sitting | 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 |
| Standing | 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 |
| Crawling | 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 |
| Climbing | 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 |

Other Activities:

| | Not at all | Less than 1/3rd of the work day. | 1/3 to 2/3rds of the work day. | Greater than 2/3rds of the work day. |
|-------------------------------|------------|----------------------------------|--------------------------------|--------------------------------------|
| Pushing/Pulling | () | () | () | () |
| Typing | () | () | () | () |
| Reaching above shoulders | () | () | () | () |
| Reaching above head | () | () | () | () |
| Lifting/Gripping 0 to 10 lbs. | () | () | () | () |
| Lifting/Gripping 10 to 25# | () | () | () | () |
| Lifting/Gripping 25 to 50# | () | () | () | () |
| Lifting/Gripping 50 to 100# | () | () | () | () |
| Lifting/Gripping over 100# | () | () | () | () |

Are your hands used for repetitive actions?, such as:

| | Simple Grasping | Firm Grasping | Fine Manipulation | Writing |
|------------|-----------------|---------------|-------------------|---------|
| Right Hand | () | () | () | () |
| Left Hand | () | () | () | () |

Please make any additional comments related to your current problem _____

To the best of my knowledge the above is accurate and complete.

Signed _____ Date ____/____/____