Barcode Label

Interviewer: ___________
Office: ___________

PLEASE USE BLACK INK

Patient Information

Please Print

Name ____ Date_________________________

Date of Birth ___________________ Social Security #:_____________________________________

Street Address____

City ___________________________ State ____________________ Zip _____________________

Home Phone _____________ Cell Phone ____________ E-Mail Address ________________________

Occupation ____ ☐ **Unemployed**

Employer ______________________________ Business Phone ______________________________

Employer Address____ Length of Employment________

Second Employer ____ Phone: ____________________

Second Employer Address ____

Sex: ◻ Male ◻ Female Height________ Weight _____ Dominant Hand: ◻ Left ◻ Right

Race: ◻ African American ◻ Asian ◻ Caucasian ◻ Hispanic ◻ Other

Are you: ◻ Married ◻ Single ◻ Domestic Partnership ◻ Divorced ◻ Separated ◻ Widowed

Spouse's Name: ____

Emergency Contact Name _______________________________________ Relationship_______________

Contact Phone ____

Name of nearest relative not living with you: ____________________________Phone:__________________

Private Health Insurance Information

Health Insurance Carrier ____ Waiver Signed ☐

Health Insurance Address____

Policy Number ______________________________________ Group Number______________________

Policy Holder _______________________________________ DOB of Policy Holder ___________________

Employer of Policy Holder ____________________________________ Relationship __________________

Patient's Signature: _______________________________________ Provider's Initials:_____________

Accident Information

How were you injured? ☐ Auto ☐ W/C ☐ Slip & Fall ☐ Auto/While on Job

☐ Cab ☐ Bus ☐ Motorcycle ☐ Pedestrian ☐ Other________________________________

Date of Injury _______________ What State? ___________

Brief description of how accident happened: ____

____

Did you strike your head or any other part of your body in this accident? ___________________________

____

Have you been able to work since your accident? ☐ Yes ☐ No Last day worked? __________________

Has an out of work slip been issued to you? ☐ Yes ☐ No

Auto Accident:

Were you the driver? ☐ Passenger? ☐ Seat Belted? ☐ Yes ☐ No

Has this accident been reported to the auto insurance company? ☐ Yes ☐ No

Driver's Name _________________________ Policy Holder's Name ________________________________

Policy Holder's car insurance carrier ____

Policy Holder's Phone Number ____

PIP Adjuster: ____________________ Phone #: ____________________ PIP Claim #: _______________

IF YOU DO NOT OWN A MOTOR VEHICLE:

Does anyone else in household own motor vehicles? ☐ Yes ☐ No

Workers Compensation:

Date of Injury ___________ WC Carrier __________________________ Claim# _____________________

Who is/was your employer at the time of injury? ____

Employer Address ____

(City) (State) (Zip)

Employer Phone Number ____________________ Supervisor's Name___________________

Have you filed a "First Report of Injury" with your employer? ☐ Yes ☐ No

Patient's Signature: ____ Provider's Initials:____________

Prior Accidental Injuries

Please enter the information regarding **previous** accidents (**not including the current accident**), listing the most recent first.

WHAT TYPE OF ACCIDENT? (PLEASE PROVIDE DETAILS FOR PREVIOUS ACCIDENTS ONLY)

1st Accident (Previous to this current accident)

☐ Auto ☐ Work Comp ☐ Auto/While on Job ☐ Cab ☐ Bus ☐ Motorcycle ☐ Pedestrian

☐ Sports ☐ Military Duty ☐ Other: ______________________________

When did the injury happen? _________________ Where did the injury happen: _________________________

What was injured: _________________________ Where were you treated? ____________________________

Date of last treatment? _____________________ Recovery: ☐ Full ☐ Partial

2nd Accident

☐ Auto ☐ Work Comp ☐ Auto/While on Job ☐ Cab ☐ Bus ☐ Motorcycle ☐ Pedestrian

☐ Sports ☐ Military Duty ☐ Other: ______________________________

When did the injury happen? _________________ Where did the injury happen: _________________________

What was injured: _________________________ Where were you treated? ____________________________

Date of last treatment? _____________________ Recovery: ☐ Full ☐ Partial

3rd Accident

☐ Auto ☐ Work Comp ☐ Auto/While on Job ☐ Cab ☐ Bus ☐ Motorcycle ☐ Pedestrian

☐ Sports ☐ Military Duty ☐ Other: ______________________________

When did the injury happen? _________________ Where did the injury happen: _________________________

What was injured: _________________________ Where were you treated? ____________________________

Date of last treatment? _____________________ Recovery: ☐ Full ☐ Partial

Patient's Signature: ____ Provider's Initials:____________

Present Health

Why do you need an evaluation today? Check the appropriate area and briefly explain.
(Examples-pain, numbness, tingling, burning, weakness)

□ Neck □ Shoulder □ Elbow □ Wrist □ Low Back □ Hip □ Knee □ Leg □ Ankle □ Foot
□ Other (please specify): ____________________

____

____

When did the symptom(s) begin? ____________________

How did the pain symptom(s) start? Check the appropriate response or explain.

□ Suddenly □ Gradually □ Twisting □ Pulling □ Fall □ Lifting □ Bending □ Hit by Object
□ Sports □ No Apparent Cause ____________________

Did you go to the hospital, E.R., or Urgent Care? ☐ Yes Date(s) ___________ ☐ No

Name of hospital, E.R. or Urgent Care: ____________________

Did you have X-rays, MRI, CT Scan, or other diagnostic testing? ____________________

Have you been treated anywhere else for this accident? ☐ Yes ☐ No

If yes, where? ____________________ Phone Number: ____________________

Have you been injured prior to this accident? ☐ Yes ☐ No

Have you ever had a Disability Rating for a previous accident? ☐ Yes ☐ No

Please list any medications you are currently taking ____________________

____

Please list any supplements you are currently taking____________________

____

Please list any allergies (including drug and **latex allergies**) you may have:

____

____

Who is your Primary Care Provider? ____________________ Phone: ____________________

Primary Care Provider Address____________________

Patient's Signature: ____________________ Provider's Initials:____________

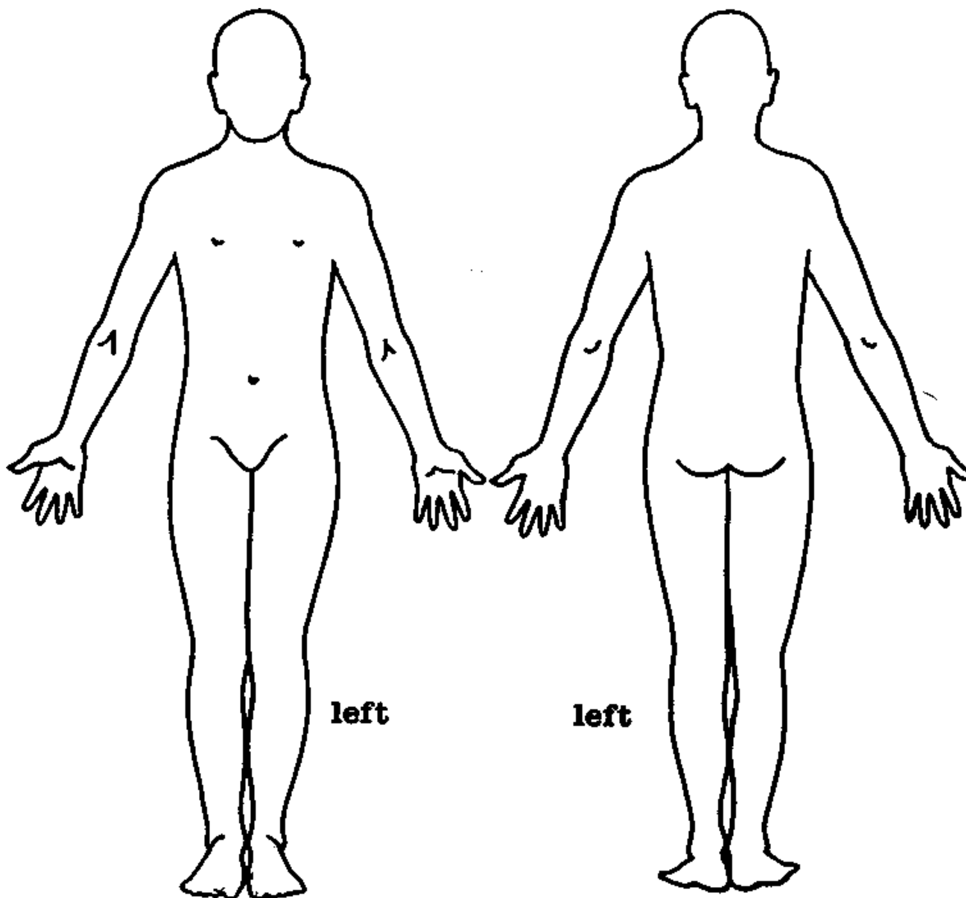
Pain Description

Please rate your pain on a scale of 1-10.
(1= mild pain, 10=the worse pain you've ever felt)

Areas of Injury	Pain Scale	Areas of Injury	Pain Scale	Areas of Injury	Pain Scale
Head		Left Shoulder		Right Shoulder	
Neck		Left Elbow		Right Elbow	
Upper Back		Left Wrist/Hand		Right Wrist/Hand	
Lower Back		Left Knee		Right Knee	
Hips		Left Ankle/Foot		Right Ankle/Foot	

Use the pictures below to indicate your problem areas. Use the appropriate symbol to indicate numbness, pins & needles, burning, stiffness, aching, or stabbing pain.

Numbness: □	Pins & Needles: .-.	Aching pain: ±
Stabbing pain: ↑	Burning: #	Stiffness: u



Patient's Signature: ____ Provider's Initials:_____________

Loss of Enjoyment/Duties Under Duress Summary

Complete the following questionnaire as it relates to how your injury(s) affect your performance of your living and work duties. Place a check in front of the day-to-day **living or work duties that are painful or difficult for you to perform as a result of the injuries** you sustained. Then check mark the appropriate box designating reason for difficulty. Include those duties/responsibilities, which require that you reduce the time you are capable of performing them.

Job description: ____

N/A Work Reason for the Difficulty/Limitation

_____ Lifting ☐ Increased Pain ☐ Restricted Movement ☐ Weakness ☐ Cannot Perform
_____ Bending ☐ Increased Pain ☐ Restricted Movement ☐ Weakness ☐ Cannot Perform
_____ Sitting ☐ Increased Pain ☐ Restricted Movement ☐ Weakness ☐ Cannot Perform
_____ Walking ☐ Increased Pain ☐ Restricted Movement ☐ Weakness ☐ Cannot Perform
_____ Computer Duties ☐ Increased Pain ☐ Restricted Movement ☐ Fatigue ☐ Cannot Perform
_____ Other:________ ☐ Increased Pain ☐ Restricted Movement ☐ Fatigue ☐ Cannot Perform

N/AStudies/School Reason for the Difficulty/Limitation

_____ Lifting ☐ Increased Pain ☐ Restricted Movement ☐ Weakness ☐ Cannot Perform
_____ Bending ☐ Increased Pain ☐ Restricted Movement ☐ Weakness ☐ Cannot Perform
_____ Sitting ☐ Increased Pain ☐ Restricted Movement ☐ Weakness ☐ Cannot Perform
_____ Walking ☐ Increased Pain ☐ Restricted Movement ☐ Weakness ☐ Cannot Perform
_____ Computer Duties ☐ Increased Pain ☐ Restricted Movement ☐ Fatigue ☐ Cannot Perform
_____ Studying ☐ Increased Pain ☐ Restricted Movement ☐ Fatigue ☐ Cannot Perform
_____ Other:________ ☐ Increased Pain ☐ Restricted Movement ☐ Fatigue ☐ Cannot Perform

N/A Domestic Duties Reason for the Difficulty/Limitation

_____ Vacuuming ☐ Increased Pain ☐ Restricted Movement ☐ Fatigue ☐ Cannot Perform
_____ Taking Care of Kids ☐ Increased Pain/Anxiety ☐ Restricted Movement ☐ Fatigue ☐ Cannot Perform
_____ Cleaning ☐ Increased Pain ☐ Restricted Movement ☐ Fatigue ☐ Cannot Perform
_____ Preparing Meals ☐ Increased Pain ☐ Restricted Movement ☐ Fatigue ☐ Cannot Perform
_____ Other: _________ ☐ Increased Pain/Anxiety ☐ Restricted Movement ☐ Fatigue ☐ Cannot Perform

N/A Household Duties Reason for the Difficulty/Limitation

_____ Yardwork ☐ Increased Pain ☐ Restricted Movement ☐ Fatigue ☐ Cannot Perform
_____ Transportation ☐ Increased Pain/Anxiety ☐ Restricted Movement ☐ Fatigue ☐ Cannot Perform
_____ Shopping ☐ Increased Pain/Anxiety ☐ Restricted Movement ☐ Fatigue ☐ Cannot Perform
_____ Taking Out Trash ☐ Increased Pain ☐ Restricted Movement ☐ Weakness ☐ Cannot Perform
_____ Other: _______ ☐ Increased Pain ☐ Restricted Movement ☐ Weakness ☐ Cannot Perform

N/A Sports Reason for the Difficulty/Limitation

Name Sport: ______________ ☐ Increased Pain ☐ Restricted Movement ☐ Weakness ☐ Cannot Perform
Pre-Accident Level of Participation: ☐ Socially ☐ Competitively ☐ Profession

Patient's Signature: ___________________________________ Provider Initials:____________

Review of Systems

Weight ____________ Weight 1 yr. Ago ___________ Max. Weight ______ When ________

Medical History:

Please mark any of the symptoms that **apply to you <u>TODAY</u>:**

SYMPTOM	YES	NO	**SYMPTOM**	YES	NO
Abdominal Pain			Muscle Weakness		
Anxiety			Numbness or Tingling		
Chest Pain			Painful or Urgent Urination		
Cough			Rapid Hearth Beat		
Cuts that won't stop bleeding			Rash		
Depression			Shortness of Breath		
Fever/Chills			Swelling of Legs		
Frequent Urination			Vomiting		
Frequent/Easy Bruising			Discolored Stools		
Irregular Heart Beat			Wound Healing Problems		
Joint Pain or Swelling			**Other:**_______________________ ______________________________		
Muscle Pain or Swelling					

Check if **you have had any of these conditions in the <u>PAST</u> or if there is any family history** of these conditions:

MAJOR ILLNESS	YES	NO	**FAMILY**	**MAJOR ILLNESS**	YES	NO	**FAMILY**
Anemia				Liver Disease			
Arthritis				Kidney Disease			
Heart Arrhythmia/Palpations				Loss of Vision			
Asthma				Neuropathy			
Bleeding Problems				Paralysis			
Blood Clots				Peripheral Vascular Disease			
Cancer:_____________				Pneumonia			
Chest Pain/Angina				Psychiatric Illness			
Diabetes				Pulmonary Embolism			
Gall Bladder Disease				Reflux			
Gastric Ulcers				Skin Ulcer/Breakdown			
Glaucoma				Steroid Use			
Heart Attack				Stroke			
Heart Failure				Thyroid Disease			
Heart Murmur				Tuberculosis-TB			
Hepatitis B				Urinary Infections			
Hepatitis C				Valve Disorders (Heart)			
High Blood Pressure				Wound Healing Problems			
HIV/AIDS				Orthopaedic Conditions: ______________________			
Immune Deficiency				**Other:**_________________ ______________________			

Patient's Signature: ________________________________ Provider Initials:____________

Surgical History

Please list any surgeries and the dates they were performed:

Date:	Surgery:

Social History

Do you have Children?
☐Yes – How many: __________ ☐No

Are you Pregnant? (**Women Only**)
☐Yes☐No

Do you Live Alone?
☐Yes☐No

Drugs/Alcohol:
History of Substance Abuse?
☐Yes☐No

Do you drink Alcoholic Beverages?
☐Yes – How much: ___________ ☐No

Do you smoke Cigarettes?
☐Yes - How much: ___________ ☐No

If you smoked in the past, how long has it been since you stopped?
☐0-3 months ☐3-6 months ☐6-12 months ☐Over a year ago

Exercise:
Do you Exercise?
☐Daily☐Weekly☐Monthly☐Rarely☐Never

What type of Exercise?
☐Walking☐Running☐Swimming ☐Weight Lifting ☐Aerobics
☐Other _______________________

Patient's Signature:____________________________ | Provider Signature:______________________