WORK/COMP HISTORY

Patient_____ S.S.#_____
Address_____ City_____ ST._____ Zip_____
Home #_____ Cell #_____ Drivers License #_____
Sex □ M □ F Age_____ Birth date_____ Marital Status M S W D Spouse's name_____
Name of Compensation Carrier_____ Phone_____
Address of Carrier_____ City_____ St._____ Zip_____
Employer's Name_____ Phone_____
Employer's Address_____ City_____ St._____ Zip_____
Type of Business_____ Your Occupation_____
Date Injured_____ Hour_____ AM/PM Last Date Worked_____ Are you off work? Y/ N
Accident reported to employer? ( ) Yes ( ) No Name of person reported accident to_____
Injured at_____ City_____ St._____ Zip_____
Type of work being done at time of injury_____

_____
Have you been treated by another doctor for this accident? ( ) Yes ( ) No Who?_____
What type of treatment did you receive?_____
How long were you treated by this doctor?_____
Describe the accident_____

_____
Are you ( ) Improved ( ) Unchanged ( ) Getting Worse
What type of medicines are you taking?_____
Do they help?_____
Prior to this accident, have you had any of the physical complaints similar to what you have now?
( ) Yes ( ) No Describe_____
Were these similar complaints the result of a previous accident(s)? ( ) Yes ( ) No
Details of accident_____
Have you had any other serious accidents which required medical care? ( ) Yes ( ) No
Describe_____
Have you had any illnesses that required hospitalization? ( ) Yes ( ) No
Describe_____
Have you had any surgeries? ( ) Yes ( ) No
List types of surgeries and dates_____
Have you had any nervous or mental illnesses? ( ) Yes ( ) No Have you had any psychiatric care?_____

Current Medical Complaints

Back Pain

1. Currently, I have pain in my	( ) low back	( ) mid back	( ) upper back
2. My pain began	( ) gradually	( ) suddenly	
3. I have pain	( ) sometimes	( ) all the time	
4. My pain goes into my	( ) right leg	( ) left leg	( ) both
5. I have tingling and/ or numbness in my	( ) right leg	( ) left leg	( ) both
6. My pain is worse when I			
cough or sneeze	( ) Yes	( ) No	
sit	( ) Yes	( ) No	
bend	( ) Yes	( ) No	
walk	( ) Yes	( ) No	
lift	( ) Yes	( ) No	
push	( ) Yes	( ) No	
pull	( ) Yes	( ) No	
7. My pain wakes me up during the night	( ) Yes	( ) No	
8. Changes in the weather affect my pain	( ) Yes	( ) No	

Neck Pain

1. My neck pain began	( ) gradually	( ) suddenly	
2. I have pain	( ) sometimes	( ) all the time	
3. My pain goes into my	( ) right arm	( ) left arm	( ) both
4. I have tingling and/or numbness in my	( ) right arm	( ) left arm	( ) both

5. Pain is worse when I

cough or sneeze	( ) Yes	( ) No
sit	( ) Yes	( ) No
bend	( ) Yes	( ) No
walk	( ) Yes	( ) No
lift	( ) Yes	( ) No
push	( ) Yes	( ) No
pull	( ) Yes	( ) No
6. My pain wakes me up during the night	( ) Yes	( ) No
7. Changes in the weather affect my pain	( ) Yes	( ) No
8. I have neck stiffness	( ) Yes	( ) No
9. I have headaches	( ) Yes	( ) No
10. If I do get headaches, they occur	( ) sometimes	( ) all the time

Other Pain

Please describe any current complaints which you are experiencing not mentioned_____

_____

_____

Job Description

1. In as typical 8 hour workday, I

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

	Not At All	Occasionally	Frequently	Continuously
Bend/stoop	( )	( )	( )	( )
Squat	( )	( )	( )	( )
Crawl	( )	( )	( )	( )
Climb	( )	( )	( )	( )
Reach above shoulder level	( )	( )	( )	( )
Crouch	( )	( )	( )	( )
Kneel	( )	( )	( )	( )
Balancing	( )	( )	( )	( )
Pushing/Pulling	( )	( )	( )	( )
3. On the job I lift	( )	( )	( )	( )
up to 10 pounds	( )	( )	( )	( )
11-24 pounds	( )	( )	( )	( )
25-34 pounds	( )	( )	( )	( )
35-50 pounds	( )	( )	( )	( )
51-74 pounds	( )	( )	( )	( )
75-100 pounds	( )	( )	( )	( )

4. Do you have to bend over while doing any lifting? ( ) Yes ( ) No
5. Are your feet used for repetitive actions, such as in operating foot controls? ( ) Yes ( ) No
6. Do you use your hands for repetitive actions, such as

	Simple Grasping	Firm Grasping	Fine manipulation
Right hand	( ) Yes ( ) No	( ) Yes ( ) No	( ) Yes ( ) No
Left hand	( ) Yes ( ) No	( ) Yes ( ) No	( ) Yes ( ) No

7. Are you required to work on unprotected heights? ( ) Yes ( ) No
8. Are you required to be around moving machinery? ( ) Yes ( ) No
9. Are you exposed to marked changes in temperature and humidity? ( ) Yes ( ) No
10. Are you required to drive automotive equipment? ( ) Yes ( ) No
11. Are you exposed to dust, fumes and/or gases? ( ) Yes ( ) No
12. Please list all additional comments_____

_____

Signature_____ Date_____