HISTORY FORM

NAME: _____ **AGE:** _____

☐ Right ☐ Left Handed ☐ Male ☐ Female Height: ____ft. ____in. Weight: _____lbs.

Date of Injury _____ Date of this Examination _____

WORK (JOB) HISTORY

Employer at the time of injury _____ City of Employment _____

Date Hired _____ Job Title _____

Job duties at time of injury/illness _____

_____

Did you do any lifting? ☐ No ☐ Yes

Heaviest weight lifted was: _____ pounds _____ times per hour _____hours per day.

Did you do any keyboarding (computer, typing, mouse)? ☐ No ☐ Yes

How many minutes per hour: _____ and how many hours per day: _____

Did you do any task (work) rapidly or repetitively (over and over)? ☐ No ☐ Yes

Explain: _____

_____

How Often: _____ Times per Hour _____ Times per Day _____ Times per Week

Did you do any: ☐ Sitting ☐ Standing ☐ Walking ☐ Lifting ☐ Climbing ☐ Kneeling ☐ Squatting

☐ Bending ☐ Crawling ☐ Pushing ☐ Pulling ☐ Reaching above shoulder level

Work on: ☐ Ladders ☐ Scaffolding ☐ Roofs ☐ Other:_____

Hours worked per day _____ Days worked per week _____ Total hours worked per week _____

When hired did you have any restrictions? ☐ No ☐ Yes If yes, explain _____

_____

_____

PAST WORK HISTORY

Where have you worked prior to the job you were injured on?

Prior Employer	Duties	Date Started	Date Stopped

At the time of your injury, were you working two jobs? ☐ No ☐ Yes If yes, please describe:

Name of Employer	Duties	Date Started	Date Stopped
	Hours per day: Days per week:		

CURRENT WORK STATUS

Are you working now? ☐ No ☐ Yes If yes–working for same employer where injury occurred? ☐ No ☐ Yes

If working for same employer, did you ever stop? ☐ No ☐ Yes If yes, give the date stopped: _____

If yes, give date you started working after the injury: _____

If working for same employer, are you doing the same job you did when you were injured? ☐ No ☐ Yes

Are you working with any restrictions or limitations? ☐ No ☐ Yes Explain _____

_____

Are you working for a different employer? ☐ No ☐ Yes If yes, Name of employer _____

Job/Title and Duties _____ Date started _____

Do you have any job restrictions or limitations? ☐ No ☐ Yes Explain _____

_____

_____

If not working, date stopped working for employer where injured _____ Why did you stop? _____

Have you had employment with other employers since your injury? ☐ No ☐ Yes If yes, please describe:

Employer	Duties	Date Started	Date Stopped	Why did you stop?

Since your injury, were you off work any time? ☐ No ☐ Yes Days _____ Weeks _____ Months _____

Since your injury, have you worked with restrictions or modifications on any job at any time? ☐ No ☐ Yes

Explain: _____ Dates: From _____ to _____

HISTORY OF PRESENT INJURY

Date of Injury _____ Place of Injury _____ Time of Injury _____ am/pm

Shift (working hours) on date of injury: Start: _____ am/pm End: _____ am/pm

Describe the injury: What were you doing? How did it occur? What part or parts of the body were hurt?

_____

_____

Did you stop work or modify your activities immediately after the injury? ☐ No ☐ Yes If yes, explain:

_____

Did you report your injury? ☐ No ☐ Yes If yes, to whom _____

When did you report the injury? Date: _____ Time: _____

Following your injury, did you do any self treatment? ☐ No ☐ Yes Heat, Ice, Rest, Medicine, Other_____

When did you first receive medical treatment? Date: _____ Time: _____ Never: ☐

Following your injury what treatment did you receive? None: ☐

Were you ever denied medical treatment? ☐ No ☐ Yes

If yes, explain why treatment was denied:_____

Medication: ☐ No ☐ Yes What medication? _____

☐ Brace – Neck/Back ☐ Splints – Arm/Wrist ☐ Supports – Elbow/Wrist/Knee/Ankle ☐ Cast ☐ Sling

☐ Cane ☐ Crutches ☐ Walker ☐ Other: _____

Where did you receive treatment? ☐ None ☐ Company Doctor ☐Emergency Room ☐ Chiropractor

☐ Family Doctor ☐ Walk In Clinic ☐ Other – Name: _____ City _____ State ___

I received the following tests after my injury:

☐ X-rays of _____

☐ CT scan of _____

☐ MRI of _____

☐ Nerve Test: EMG/NCS of arms and hands or of legs and feet (please indicate)

☐ Blood/Urine Test

☐ Other: _____

Were you admitted to the hospital? ☐ No ☐Yes If yes, what hospital _____

How long did you stay _____ Did you have surgery? ☐ No ☐ Yes Date of Surgery _____

Explain what was done: _____

FOLLOW-UP CARE

I had follow-up care: ☐ No ☐ Yes Medication: ☐ No ☐ Yes What meds? _____

_____

Physical Therapy ☐ No ☐ Yes Treatment Dates: _____ Times per Week _____ Months _____

Chiropractic Therapy ☐ No ☐ Yes Treatment Dates: _____ Times per Week _____ Months _____

Injections ☐ No ☐ Yes Where: _____ How many _____

Surgery ☐ No ☐ Yes Type and Date of Surgery: _____

☐ Other – Explain: _____

☐ Cane ☐ Crutches ☐ Walker ☐ Braces for Back or Neck ☐ Splints for Arm or Leg

☐ Supports for Elbow, Wrist, Knee or Ankle ☐ Sling ☐ Cast ☐ Other: _____

DIAGNOSTIC STUDIES

		Body Parts	Dates	Findings or Results
1. X-rays	☐ No ☐ Yes			
2. MRI	☐ No ☐ Yes			
3. CAT Scan	☐ No ☐ Yes			
4. Arthrogram	☐ No ☐ Yes			
5. Discogram	☐ No ☐ Yes			
7. Neuro Test EMG/NCS	☐ No ☐ Yes			
8. Psychological Tests	☐No ☐ Yes			
9. Other:	☐ No ☐ Yes			

CURRENT TREATMENT

Are you receiving treatment now? ☐ No ☐ Yes If no, give date of last treatment: _____

With Doctor, Chiropractor, P.T., Other – Name: _____

How often seen _____ Date of last visit _____ Date of next visit _____

Describe treatment: ☐ Physical Therapy ☐ Chiropractic ☐ Brace ☐ Support ☐ Injections
Other: _____

Are you taking medication now? ☐ No ☐ Yes

Name	Purpose of Meds (pain, sleep, etc.)	Strength or dose and times taken daily
1.		
2.		
3.		
4.		

Does your treatment help? ☐ No ☐ Yes ☐ A little ☐ A lot

Does your medication help? ☐ No ☐ Yes ☐ A little ☐ A lot

VOCATIONAL REHABILITATION – JOB RETRAINING

Have you had any job retraining? ☐ No ☐ Yes or contact about retraining? ☐ No ☐ Yes

For what job (occupation) _____

Date started or expected to start _____ Date ended or expected to end _____

PAST HISTORY

Prior to the injury in question, have you ever had similar problems with injuries to the body part or parts involved in this claim? ☐ No ☐ Yes If yes, give details.

Date of Injury	Work-Related	Non-Work Related	Body Parts	Treatment

Did you get completely well? ☐ Yes How long did it take? _____

☐ No Were you having problems at the time of the injury in question? If yes, explain _____

Have you had any other work or non-work injuries since the injury involved in this claim? ☐ No ☐ Yes If yes, explain _____

Date of Injury _____ How did injury occur; work; non-work; body parts; treatment. _____

Did you get completely well? ☐ Yes How long did it take? _____

If no, explain _____

Have you ever had an auto accident/motor vehicle accident? ☐ No ☐ Yes If yes:

Date of Injury	Body Parts	Treatment	Did you get completely well?

Have you had any other **non-work** serious accidents, sports injuries or illnesses? ☐ No ☐ Yes

Explain: _____

Have you had a prior work injury to any part of your body different from the body part involved in this claim?

☐ No ☐ Yes If yes, explain _____

PAST HISTORY (Continued)

Have you ever received a permanent disability settlement? ☐ No ☐ Yes

If yes, give date(s) and settlement: _____ Explain – Percentage/Amount/ Body Parts Involved:

_____

Do you have any adult illnesses?			Current Treatment/Medications
High Blood Pressure	☐ No	☐ Yes	
Diabetes	☐ No	☐ Yes	
Heart Disease	☐No	☐ Yes	
Lung Disease	☐ No	☐ Yes	
Cancer	☐ No	☐ Yes	
Other:			

Have you had any surgery? ☐ No ☐ Yes

Date of Surgery	Type and Body Part of Surgery	Results of Surgery

Have you ever had any non-surgical hospital admission (including childbirth)? ☐ No

☐ Yes Explain: _____

_____

Do you use:			Type	Amount	Past Use
Alcohol	☐ No	☐ Yes			
Circle: Coffee or Tea	☐ No	☐ Yes		__ cups per day / week	
Drugs ("Pot", etc.)	☐ No	☐ Yes			
Tobacco	☐ No	☐ Yes	Cigarettes Cigars Chewing Tobacco		
Other:					

Prior to the injury in question, did you participate in any outdoor or recreational activities? ☐ No ☐ Yes

☐ Gardening ☐ Sewing ☐ Arts/Crafts ☐ Cooking ☐ Computer ☐ Sports ☐ Hiking ☐ Biking ☐ Hunting

☐ Fishing ☐ Golf ☐ Tennis ☐ Softball ☐ Basketball ☐ Soccer ☐Water Sports ☐ Dancing ☐ Skiing

☐ Walking ☐ Other _____

Are you able to participate in any of these activities now? ☐ No ☐ Yes If yes, which activities can you participate in now? _____

_____

PRESENT COMPLAINTS

Are you still having pain? ☐ No ☐ Yes If yes, where?

☐ Neck ☐ Rt ☐ Lt ☐ Shoulder/Scapulae/Arms ☐ Rt ☐ Lt ☐ Elbows/Forearms ☐ Rt ☐ Lt

☐ Wrists/Hands/Fingers ☐ Rt ☐ Lt ☐ Upper Back/Mid Back ☐ Rt ☐ Lt ☐ Lower Back ☐ Rt ☐ Lt

☐ Pelvis/Hips ☐ Rt ☐ Lt ☐ Knees/Legs ☐ Rt ☐ Lt ☐ Ankles/Feet/Toes ☐ Rt ☐ Lt

☐ Headaches ☐ Rt ☐ Lt Other _____

If the pain radiates, where does it travel from (what body part) _____ to (what body part) _____. Right Side: ☐ No ☐ Yes Left Side: ☐ No ☐ Yes

Do you have: Numbness ☐ No ☐ Yes Tingling ☐ No ☐ Yes Burning ☐ No ☐ Yes

If yes, where? What body part? _____ ☐ Right ☐ Left

If the numbness, tingling and burning travels, where does it go from (what body part) _____

to (what body part) _____.

What is the character of the pain: (Circle) Dull Stabbing Cramping Sharp Throbbing Shooting Aching

Burning Other _____

Intensity of the pain with 0 no pain and 10 greatest pain

Mild	Medium	Great
1-3 _____	4-7 _____	8-10 _____

Frequency of the pain: _____ Once in a while _____ Off and on _____ All the time

Do you have:

Stiffness ☐ No ☐ Yes Where? _____ Grating/Grinding ☐ No ☐ Yes Where? _____

Swelling ☐ No ☐ Yes Where? _____ Locking ☐ No ☐ Yes Where? _____

Snapping/Popping ☐ No ☐ Yes Where? _____

Do you have any weakness in any joints or muscles? ☐ No ☐ Yes Where? _____

_____

Do you have any giving way of joints? ☐ No ☐ Yes _____

Falling? ☐ No ☐ Yes How many times in the past six months? _____

PRESENT COMPLAINTS (Continued)

Does the pain and/or numbness, tingling or burning in your hands, fingers, other _____ awaken you from sleep? ☐ No ☐ Yes How many times per night: _____ How many days per week: _____

Do you have full range of motion of your joints? ☐ No ☐ Yes

What joints are limited? ☐ Neck ☐ Shoulders ☐ Elbows ☐ Wrists ☐ Hands ☐ Fingers ☐ Back ☐ Hips ☐ Knees ☐ Ankles ☐ Toes ☐ Other _____

_____

What makes the pain worse? ☐ Sitting ☐ Standing ☐ Walking ☐ Stooping ☐ Twisting ☐ Lifting ☐ Pushing ☐ Pulling ☐ Repetitive Hand Motions ☐ Lifting Arms Overhead ☐ Grasping (holding) Tightly ☐ Stair Climbing ☐ Kneeling ☐ Bending ☐ Other _____

_____

What makes the pain better? ☐ Nothing ☐ Physical Therapy ☐ Chiropractic Treatment ☐ Water Therapy ☐ Acupuncture ☐ Medications ☐ Injections ☐ Surgery ☐ Braces For: Back / Neck ☐ Supports For: Elbows / Wrists / Knees / Ankles ☐ TENS unit ☐ Pain Patches ☐ Changing Positions ☐ Lying Down ☐ Getting off Feet ☐ Gym / Exercise ☐ Resting ☐ Using a Cane ☐ Using Crutches ☐ Avoiding those positions and activities that make the pain worse ☐ Other _____

Do you lose control of bladder (urine) or bowels (stools)? ☐ No ☐ Yes

Other bowel or bladder problems? _____

Epworth Sleepiness Scale

Name: _____

Date: _____

Your age: (Yr) _____ Your sex: ☐ Male ☐ Female

How likely are you to doze off or fall asleep in the situations described below, in contrast to feeling just tired?

This refers to your usual way of life in recent times.

Even if you haven't done some of these things recently try to work out how they would have affected you.

Use the following scale to choose the most appropriate number for each situation:-

0 = would never doze
1 = Slight chance of dozing
2 = Moderate chance of dozing
3 = High chance of dozing

Situation	Chance of dozing
Sitting and reading	
Watching TV	
Sitting, inactive in a public place (e.g. a theatre or a meeting)	
As a passenger in a car for an hour without a break	
Lying down to rest in the afternoon when circumstances permit	
Sitting and talking to someone	
Sitting quietly after a lunch without alcohol	
In a car, while stopped for a few minutes in the traffic	
Total	

Score:

0-10 Normal range
10-12 Borderline
12-24 Abnormal

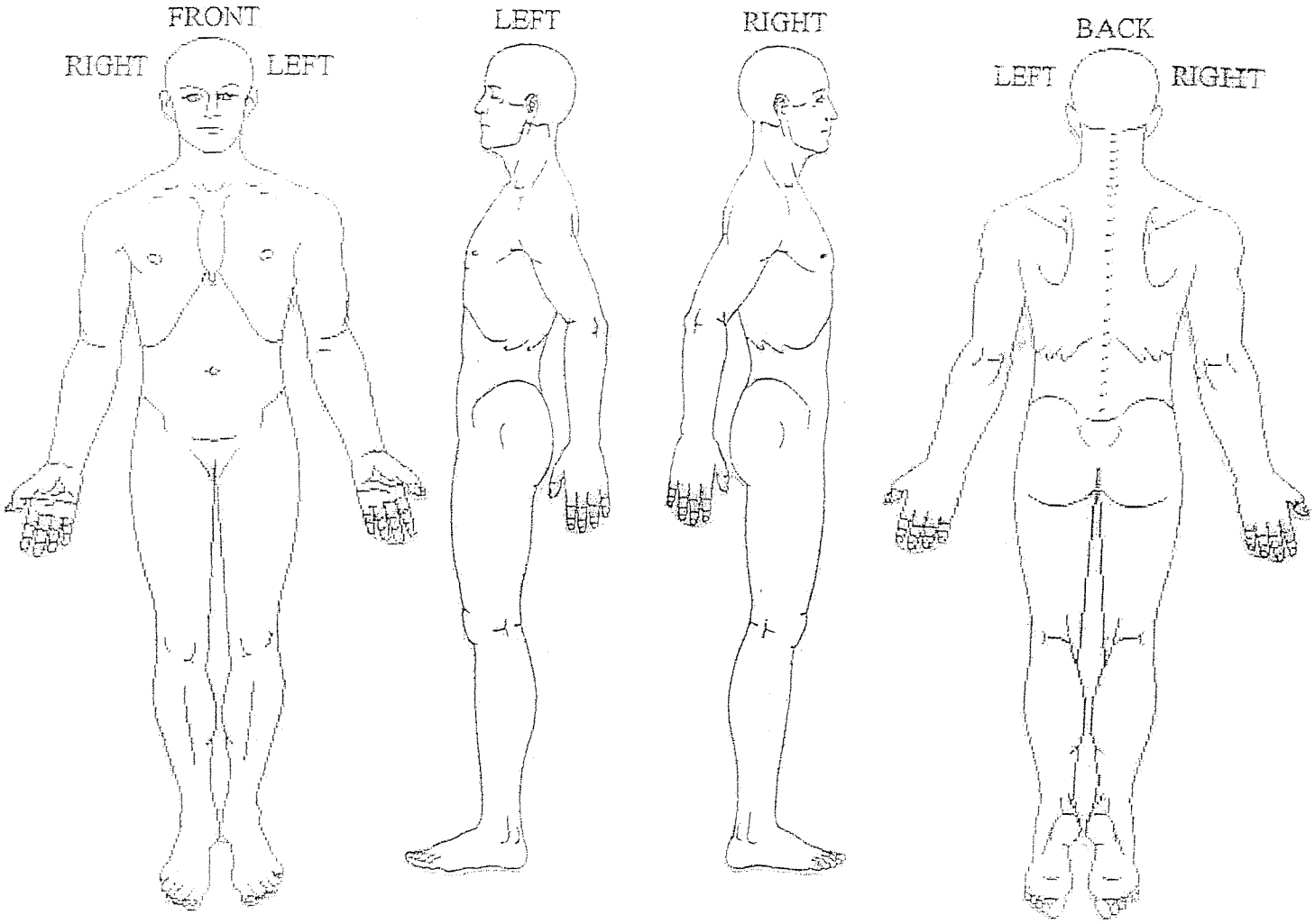
Complete this drawing **for your symptoms at this time** (Do not show where symptoms used to be).

PAIN DRAWING

Using the key, describe your present ailment

KEY

Major Pain:	XXX	Tingling:	YYY
Secondary Pain:	///	Burning:	ZZZ
	Loss of Sensation: OOO		



ACTIVITIES OF DAILY LIVING (ADL'S)

SELF CARE AND HYGIENE

Do you have problems with…

1. Brushing your teeth — No ☐ Yes ☐ Pain (1-10): ___
2. Combing your hair — No ☐ Yes ☐ Pain (1-10): ___
3. Dressing yourself — No ☐ Yes ☐ Pain (1-10): ___
4. Bathing yourself — No ☐ Yes ☐ Pain (1-10): ___
5. Feeding yourself — No ☐ Yes ☐ Pain (1-10): ___
6. Controlling your bladder — No ☐ Yes ☐ Pain (1-10): ___
7. Controlling your bowels — No ☐ Yes ☐ Pain (1-10): ___

COMMUNICATION

Do you have problems with…

1. Writing — No ☐ Yes ☐
2. Typing (computer) — No ☐ Yes ☐
3. Speaking — No ☐ Yes ☐
4. Seeing — No ☐ Yes ☐
   Use corrective lenses — No ☐ Yes ☐
5. Hearing — No ☐ Yes ☐
   Use a hearing aid — No ☐ Yes ☐

PHYSICAL ACTIVITIES

Can you…

1. Stand - ½ hr. — No ☐ Yes ☐ Pain Level (1-10): ___
2. Sit - ½ hr. — No ☐ Yes ☐ Pain Level (1-10): ___
3. Recline (Lay Down) — No ☐ Yes ☐ How long: _____
4. Walk - 1 block — No ☐ Yes ☐ Pain Level (1-10): ___
5. Climb Stairs-1 flight — No ☐ Yes ☐ Pain Level (1-10): ___

TRAVEL

Can you…

1. Drive – Car – 1 hour — No ☐ Yes ☐
   Pain Level 1–10: _____
2. Ride – Car – 1 hour — No ☐ Yes ☐
   Pain Level 1–10: _____
3. Ride – Public Transportation: Bus, Trolley, Train — No ☐ Yes ☐
4. Ride – Airplane — No ☐ Yes ☐

SENSORY FUNCTION

Can you…

1. Feel with your fingers normally (Tactile Feeling) — No ☐ Yes ☐
2. Taste normally — No ☐ Yes ☐
3. Smell normally — No ☐ Yes ☐

NON-SPECIALIZED HAND ACTIVITIES

Can you…

1. Grasp or hold things — No ☐ Yes ☐
   Pain Level 1–10: _____
2. Lift or carry groceries: 10 lbs. — No ☐ Yes ☐
   Pain Level 1–10: _____
3. Feel the difference between a nickel and a dime — No ☐ Yes ☐

SEXUAL DYSFUNCTION

Do you have…

1. Problems having sex — No ☐ Yes ☐
   Pain Level 1–10: _____

SLEEP

Do you have…

1. Restful sleep — No ☐ Yes ☐
2. If no, how long can you sleep before waking up?
   _____