COMPREHENSIVE HISTORY, RECORD REVIEW and EXAM

Name: _____ **Appointment Date: _____**
SS Number: _____-_____-_____ **Birth date: _____**
Interpreter: _____ **Language: _____**
Date of Injury: _____
Age: _____ **Height: _____ in** **Handed: L R**
Sex: _____ **Weight: _____ lbs** **Footed: L R**

Medications:

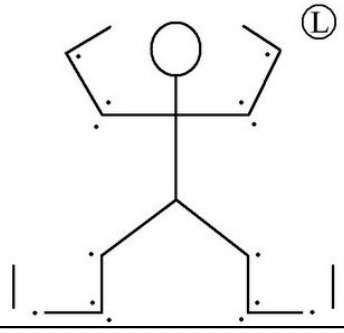
	Name	Dose	How Often	Since when
For **Pain**				
For **Other**				

Do these medications help? ( ) Yes ( ) No ( ) I Don't Know

Section Below For Dr's Use Only – Patients: Continue Writing On Next Page **H&P Notes**

	L	R	PEx:
Grip:	_____	_____	**Spine: _____**
Pinch:	_____	_____	**MSK: _____**
Arm:	_____	_____	**Vasc: _____**
Fore:	_____	_____	
Wrist:	_____	_____	
Thigh:	_____	_____	**Notes:**
Calf:	_____	_____	
Ankle:	_____	_____	

Vision: _____ **_____**
Glasses: Y / N **Norm?**
BP: _____ **Y / N**
Pulse: _____ **Y / N**
Resp: _____ Y / N



Neuro:
MS: _____
CN: _____
Motor: _____
Sens: _____
DTRs: _____
Coord: _____
G&S: _____

Plan:

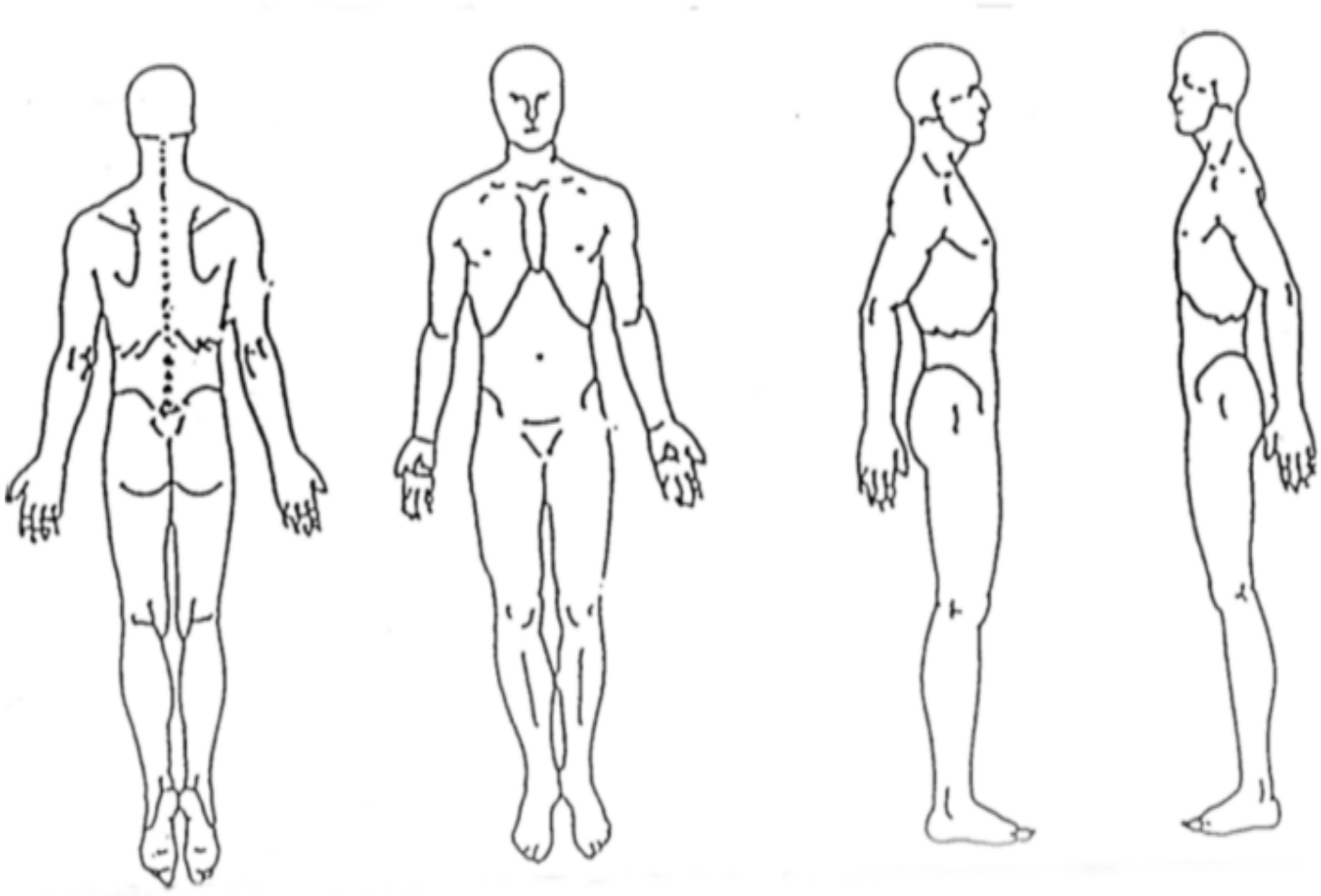
Section I: PAIN
****PLEASE PRINT CLEARLY!!****

1. What is (are) your main complaint(s)?

   _____
   _____
   _____
   _____
   _____

   Has this problem improved? _____ worsened? _____ unchanged? _____

   Does it prevent or impair work? _____ social life? _____



Pain X

Numbness/Tingling Δ

Weakness O

2. **Please shade in or mark the diagram above according to the legend to indicate the area** of your **pain**, or **main complaint**.

3. Briefly describe the **character** of your pain
(*For instance*, mild dull pain becoming sharp and severe with activity or fatigue; burning, pulling, cutting, electrical types of pain):

_____
_____
_____

SECTION I: MUSCULOSKELETAL PAIN

4. My pain began: ( ) gradually ( ) suddenly. I have pain: ( ) sometimes ( ) constantly.

5. Please **rate** the pain now:

1 2 3 4 5 6 7 8 9 10
Slightly painful Moderately Painful Very Painful

6. Please rate your pain **before** the injury:

1 2 3 4 5 6 7 8 9 10
Slightly painful Moderately Painful Very Painful

7. My pain is **worse** when I:

Cough or sneeze	( ) Yes	( ) No	**Sit**	( ) Yes	( ) No
Bend forward	( ) Yes	( ) No	**Walk**	( ) Yes	( ) No
Lifting items	( ) Yes	( ) No	**Push**	( ) Yes	( ) No
Turn my head	( ) Yes	( ) No	**Pull**	( ) Yes	( ) No

8. My pain prevents my sleeping ( ) Yes ( ) No ( ) Sometimes
Wakes me up during the night ( ) Yes ( ) No ( ) Sometimes

9. Changes in position affects my pain: ( ) Yes ( ) No ( ) Sometimes
Best position for sleeping, if any? _____ Worst position? _____
How long can you hold this? _____

10. Changes in the weather affect my pain: ( ) Yes ( ) No ( ) Sometimes
My pain is worse with sexual activity: ( ) Yes ( ) No ( ) Sometimes
I have neck stiffness: ( ) Yes ( ) No ( ) Sometimes
My headaches last: _____ ( ) minutes ( ) hours ( ) days ( ) months

OTHER PAIN

11. Please describe any **current medical complaints** which you are experiencing and were **not previously covered** on this questionnaire, or list any additional comments you wish to make regarding your condition?

_____
_____
_____
_____

SECTION II: CHANGES IN SENSATION OR FEELING

12. Have you lost sensation (**numbness**)? _____ (If NO, skip ahead) If so, **WHERE?** (Please be specific)

_____

_____

Please **rate** your numbness:

1 2 3 4 5 6 7 8 9 10
Normal Moderately Numb Cannot Feel

Is the numbness constant? _____ If not, how long does it last? _____
Does anything make the numbness worse? _____ What? _____
Have you hurt yourself by not feeling the numb part? _____

13. Apart from numbness, does any body part feel unusual or abnormal? _____
Please describe which area(s) of the body are affected: _____
Is this constant? _____ If not, how often does it occur? _____

SECTION III: LOSS OF STRENGTH (WEAKNES)

14. Have you experienced **weakness**? _____ (If NO, skip ahead) If so, **WHERE?** In which muscle, limb or area?

_____

_____

_____

Please **rate** your weakness:

1 2 3 4 5 6 7 8 9 10
Normal Strength Moderately Weak Extremely Weak

Have you fallen, dropped objects or hurt yourself from weakness? _____
If so, please explain: _____
When did these symptoms of weakness begin? _____
Are these symptoms of weakness constant? _____ If not, how often does it occur and when?

_____
Does anything cause weakness? ( ) Yes ( ) No If so, what? _____

SECTION IV: ASSOCIATED QUESTIONS

15. If applicable, do the **pain, numbness, altered sensations** and **weakness** all occur together and at the same time? ___ Where in the body? _____

16. Do you have any problems with your coordination? ____ Please explain:

_____

_____

17. Have you had problems controlling your bladder or bowels? _____ Please explain:

_____
_____
_____

When did these problems begin? _____
Is the problem constant? _____ If not, how often does it occur? _____
Does it wake you? _____ Have you soiled yourself? _____
Does control vary with your spinal symptoms? _____

18. Have you had problems with sexual function? Please explain:

_____
_____

When did this problem begin? _____

(SECTION V: REVIEW OF RECORDS: IMAGING AND LAB REVIEW)

SECTION VI: PAST MEDICAL AND PSYCHIATRIC HISTORY

19. Before your accident your health was: excellent ___ good ___ fair ___ poor ___
How many flights of stairs could you climb without resting? _____
Please list recreational activities you are unable to do since the injury:

_____
_____

20. Do you have **other health problems** or conditions, for instance, high blood pressure, diabetes, heart disease, etc? _____ Please explain fully: _____

_____
_____

21. Check below if you have had **any** of the following diseases/illnesses as a child or as an adult:

Anemia:	_____	Diabetes:	_____	Kidney Disease:	_____
Hernia:	_____	Pneumonia:	_____	Fracture (s):	_____
Cancer:	_____	Chicken Pox:	_____	Tuberculosis:	_____
Polio:	_____	Skin Problems:	_____	Rheumatic Fever:	_____
Ulcer:	_____	Stool Disorder:	_____	Thyroid Disease:	_____
Heart Disease:	_____	Mental Disorder:	___	Arthritis:	_____
Epilepsy:	_____	Hepatitis/Jaundice:	_____		
Gallbladder:	_____	Asthma:	_____		
Bleeding disorder:	_____	High Blood Pressure:	_____		

22. **For Women Only:** # of pregnancies _____ # of live births _____
Is there a possibility that you could be pregnant? _____

23. If you have **psychiatric problems** or conditions, for instance, severe depression, mood swings, etc., Please explain fully:

_____
_____
_____

24. Previous HOSPITALIZATIONS or OPERATIONS:

Hospital	**Reason/Operation**	**Date** ____ ____

_____
_____
_____
_____

25. Do you have **bleeding** problems? _____
Have you ever had a **blood transfusion**? ____ If so, when?_____

26. If you now smoke, how many packs a day? ____ for ____ years/months.
If you did smoke, how many packs a day? ____ for ____ years/months.

27. Do you drink alcohol? ____ If so, how much? _____
Do you use recreational drugs? ____ If so, which? _____
If not, did you in the past? ____ Which? _____

Do you have any **allergies**, including to medications? ( ) Yes ( ) No
If so, to what? _____

SECTION VII: SOCIAL AND PERSONAL HISTORY

28. Place of birth: _____ State: _____
If you were not born in the **USA**, when did you arrive? _____
Highest education level completed? _____

29. Do you/Have you traveled to **foreign places**? ____
Where/When? _____
Do you/Have you serve(d) in the **military**? ____
Which branch, where and when? _____

30. What is your **current occupation**? (job description)?
_____
_____
For how many years? _____ If unemployed, when were you last? _____

31. Do you have any hobbies, special skills or interests? ( ) Yes ( ) No
If yes, please describe: _____
_____
Has the injury in question hindered or stopped you from doing any of your usual activities (including recreation)? ( ) Yes ( ) No If yes, please explain: _____
_____
_____
_____
Do you participate in a fitness program or any sports activities? ( ) Yes ( ) No

SECTION VIII: FAMILY MEDICAL HISTORY

32. **Parents/Spouse:**

	Alive?	**Age**	**Any Medical Problems?**
Mother	_____	_____	_____
Father	_____	_____	_____
Husband/Wife	_____	_____	_____

33. **Siblings:** # of brothers _____ # of sisters _____
Your **oldest** sibling is a boy / girl (circle one) How old? _____
Your **youngest** sibling is a boy / girl (circle one) How old? _____
Have **any** of your siblings died? If so, at what age and from what?

_____

_____

Do **any** of your siblings have any medical problems? Explain?

_____

_____

34. **Children**: # of sons _____ # of daughters _____
Your **oldest** child is a boy / girl (circle one) How old? _____
Your **youngest** child is a boy / girl (circle one) How old? _____
Have **any** of your children died? If so, at what age, and from what? _____

_____

Do **any** of your sons / daughters have any medical problems? ____
Explain: _____

35. Does/did **any** relative have medical problems like yours? _____

37. Do any **other diseases** run in your family? _____ If so, which and in whom?

Disease(s)	**Relative(s)**

SECTION IX: REVIEW OF SYSTEMS

38. Height: _____ Appetite: Good _____ Fair _____ Poor _____
Weight: _____lbs. Gaining: _____ Losing: _____ Same _____

39. If you have any problems with the following body systems, and have not previously explained these problems in this questionnaire, please describe them below:

Skin: _____
Glands (lymph nodes): _____
Head, Eyes, Ears, Nose or Throat: _____
Teeth: _____
Neck: _____
Breasts: _____
Chest and Breathing: _____
Heart: _____
Blood Vessels (arteries and veins): _____
Abdomen (belly) and Digestion: _____
Urination: _____
Genital and Anal area: _____
Limb and Muscle: _____
Bones and Joints: _____
Spine (upper and lower back): _____
Nervous System (brain, spinal cord, nerves): _____

40.

Activities of Daily Living (ADL)

Self Care and Hygiene

Do you have problems with….

1. Brushing your teeth Yes☐ No☐
2. Combing your hair Yes☐ No☐
3. Dressing yourself Yes☐ No☐
4. Bathing yourself Yes☐ No☐
5. Feeding yourself Yes☐ No☐
6. Controlling bladder Yes☐ No☐
7. Controlling bowels Yes☐ No☐

Physical Activities

Can you….

1. Stand ½ hour? Yes☐ No☐
2. Sit ½ hour? Yes☐ No☐
3. Recline (Lay Down)? Yes☐ No☐
4. Walk? Yes☐ No☐
5. Climb? Yes☐ No☐

Sensory Function

Can you….

1. Feel your fingers normally? Yes☐ No☐
2. Taste normally? Yes☐ No☐
3. Smell normally? Yes☐ No☐

Sleep

Do you have….

1. Restful sleep? Yes☐ No☐

Communication

Do you have problems with….

1. Writing Yes☐ No☐
2. Typing Yes☐ No☐
3. Speaking Yes☐ No☐
4. Seeing Yes☐ No☐
5. Use corrective lenses Yes☐ No☐
6. Hearing Yes☐ No☐
7. Use hearing aid

Travel

Can you….

1. Drive a car? Yes☐ No☐
2. Ride in a car? Yes☐ No☐
3. Ride on public transportation? Yes☐ No☐
4. Ride on an airplane? Yes☐ No☐

Non-Specialized Hand Activities

Can you….

1. Grasp or hold things? Yes☐ No☐
2. Lift/Carry groceries? Yes☐ No☐
3. Feel the difference between a nickel and an dime? Yes☐ No☐

41. **Epworth Sleepiness Scale**

Date: _____

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

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 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 car, while stopped for a few minutes in traffic……	☐
Total…….	☐

WORKER'S COMPENSTION INJURIES

CURRENT ACCIDENT

42. Employer's Name: _____ Phone: ( ) _____
Employer's Address: _____ City _____
State: _____ Zip: _____ Typer of Business: _____
Your Job Title: _____

43. Date of Injury: _____ Hour: _____ AM / PM
Injured At: Address: _____ City _____
State: _____ Zip: _____ Type of work being done at the time of injury:
_____

44. In your own words, please briefly describe the accident:
_____
_____
_____

45. Work-related Motor Vehicle Accident (MVA): **See attached form**.

46. Was the accident reported to your employer ( ) Yes ( ) No
Name of Person/Supervisor: _____ Gender: Male / Female

47. Length of time employed there prior to the accident: _____
Are you off work? ( ) Yes ( ) No Last day worked: _____

48. Have you had a previous injury? ( ) Yes ( ) No
Was it work related? ( ) Yes ( ) No

49. Were any of these problems present before the injury in question or related to another injury which occurred between then and now? _____
_____
_____
If you were having these problems with the same body part involved in this claim using the scale below, please circle the number that best estimates the amount of pain you were/are having:

1	2	3	4	5	6	7	8	9	10
Slightly painful			Moderately Painful					Very Painful	

50. Have you ever received a disability/impairment settlement? ( ) Yes ( ) No
If yes, please describe (when; percentage; any restrictions): _____
_____
_____

51. Prior work experience (what type, physical demands, etc.):
_____
_____
_____

52. Have you been recommended for, or have you participated in a vocational rehabilitation program as a result of this injury? ( ) Yes ( ) No

If yes, please describe (date started, present status, occupation to be retrained in, etc.):

_____

_____

_____

53. **Treating Doctors**

Fill in the chart below with the information of doctors who have previously treated you. Please start with your injury, to the present.

a. **Doctor's Name** **Phone Number** **City** **How Long Treated**

_____ _____ _____ _____

Diagnostic Tests: _____ Meds/Treatment: _____

_____ _____

b. **Doctor's Name** **Phone Number** **City** **How Long Treated**

_____ _____ _____ _____

Diagnostic Tests: _____ Meds/Treatment: _____

_____ _____

c. **Doctor's Name** **Phone Number** **City** **How Long Treated**

_____ _____ _____ _____

Diagnostic Tests: _____ Meds/Treatment: _____

_____ _____

d. **Doctor's Name** **Phone Number** **City** **How Long Treated**

_____ _____ _____ _____

Diagnostic Tests: _____ Meds/Treatment: _____

_____ _____

e. **Doctor's Name** **Phone Number** **City** **How Long Treated**

_____ _____ _____ _____

Diagnostic Tests: _____ Meds/Treatment: _____

_____ _____

DICTATION REMINDER: MEDICATIONS

54. Have you had physical therapy? ( ) Yes ( ) No ( ) Don't know
If yes, how often? ( ) Daily ( ) Every other day ( ) _____ times a week
( ) Weekly ( ) Every other week ( ) Monthly ( ) Other
Does physical therapy help? ( ) Yes ( ) No ( ) Don't know

55. Have you returned to work since the accident? ( ) Yes ( ) No
If you have returned to work since your accident, please fill out the information below:

Date:	Employer	Occupation	Duty – Reg/Light	Full/Part
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____

Previous Injuries

56. Prior to this accident, have you ever had any physical complaints similar to what you have now? ( ) Yes ( ) No ( ) Don't know If yes, please describe: _____

_____

_____

Were these similar complaints the result of a previous **accident(s)**?: ( ) Yes ( ) No
Please provide details of the accident(s): _____

_____

_____

Have the symptoms of this previous accident resolved? If so, when? _____

_____

57. Besides the above, have you had **any** serious accidents, which required medical care? ( ) Yes ( ) No If yes, please describe: _____

_____

_____

(In terms of an 8-hour workday "occasionally" means up to 33%, "frequently" means 34% to 66%, and "continuously" means 67% to 100% of the day).

58. In a typical 8-hour workday, I: (Circle # of hours/activity)

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

59. Please mark with an **X** how often you perform the following activities on the job:

	Never	**Occasionally**	**Frequently**	**Continuously**
Bend/Stoop	_____	_____	_____	_____
Squat	_____	_____	_____	_____
Crawl	_____	_____	_____	_____
Climb	_____	_____	_____	_____
Reach above shoulders	_____	_____	_____	_____
Kneel	_____	_____	_____	_____
Balance	_____	_____	_____	_____
Pushing/Pulling	_____	_____	_____	_____
Lifting:				
Up to 10 lbs.	_____	_____	_____	_____
10 to 25 lbs.	_____	_____	_____	_____
25 to 35 lbs.	_____	_____	_____	_____
35 to 45 lbs.	_____	_____	_____	_____
50 to 75 lbs.	_____	_____	_____	_____
75 to 100 lbs.	_____	_____	_____	_____
100 lbs. and up	_____	_____	_____	_____

Do you bend over while **lifting**? ( ) Yes ( ) No

60. Do you use your hands for repetitive actions, such as:

	Simple Grasping	Firm Grasping	Fine Manipulating
Right Hand	_____	_____	_____
Left Hand	_____	_____	_____

61. Are you required to work on **unprotected heights**? ( ) Yes ( ) No
If yes, please describe: _____
Are you required to drive **automotive equipment**? ( ) Yes ( ) No
If yes, please describe: _____
Are you exposed to **dust, fumes, and/or gases**? ( ) Yes ( ) No
If yes, please describe: _____
Are your feet used for repetitive movements, like operating foot controls? ( )Yes ( ) No

WORK-RELATED MOTOR VEHICLE INJURY ONLY

NATURE OF VEHICLE ACCIDENT

45a. Date of Accident: ___ / ____ / ____ Time of Day _____ AM / PM

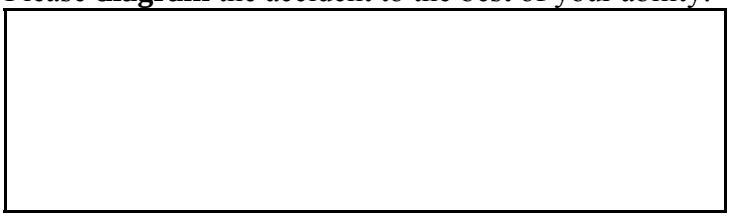
45b. Were you: ( ) Driver ( ) Passenger ( ) Pedestrian ( ) Front Seat ( ) Back Seat
Number of people in your vehicle? _____
Were you wearing seat belts? _____ Did air bag(s) open? _____

45c. What **direction** were **you** headed?
North/East/South/West _____
On (name of street / highway):_____
What **direction** was/were **other** vehicle(s) headed?
North/East/South/West _____
On (name of street / highway):_____

45d. Were you struck from: ( ) Behind ( ) Front ( ) Left side ( ) Right side
Approximate speed cars: **Yours:** _____ mph **Other(s):** _____ mph

45e. In your own words, please **describe accident**:
_____
_____
_____
_____

Please **diagram** the accident to the best of your ability:



45f. Vehicles drivable after the accident? **Yours**: ( ) Yes ( ) No ( ) Unknown
Other(s): ( ) Yes ( ) No ( ) Unknown

45g. Your vehicle make: _____ model _____ year _____
Other vehicle make: _____ model _____ year _____

Approximate damages to your vehicle: $_____.00 Other: $_____.00

NATURE OF NON-VEHICLE ACCIDENT

45h. Date: __ / __ / ____ Time _____ Place_____
In your own words, please **describe accident**: _____
_____
_____

RESULTS OF ACCIDENT

45i. Were the police notified? ( ) Yes ( ) No

45j. Was anyone **killed** or **severely injured** in the accident? ( ) Yes ( ) No
If yes, please describe in detail, including any bone fractures: _____
_____
_____
_____

45k. Were you **knocked unconscious**? ( ) Yes ( ) No ( ) Unknown
For how long? _____

45l. Please describe how you felt: **IMMEDIATELY AFTER** the accident: _____
_____
LATER that day: _____
_____
The **NEXT DAY**: _____
_____

45m. Where were you taken after the accident? _____
45n. Were you seen at a **hospital**? If so, which: _____
X-rays taken? ( ) Yes ( ) No ( ) Don't Know
Of which body parts? _____
Other tests performed? ( ) Yes ( ) No ( ) Don't Know
Which? _____
Given treatment? ( ) Yes ( ) No What? _____
Admitted to the hospital? ( ) Yes ( ) No

45o. Did you have any physical complaints **BEFORE THE ACCIDENT**? ( ) Yes ( ) No
If yes, please describe in detail: _____
_____
_____

45p. Have you ever been involved in an accident before? ( ) Yes ( ) No
If yes, please describe, including date(s) and type(s) of accident(s), as well as injury(ies): _____ _____
_____
_____