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? ____

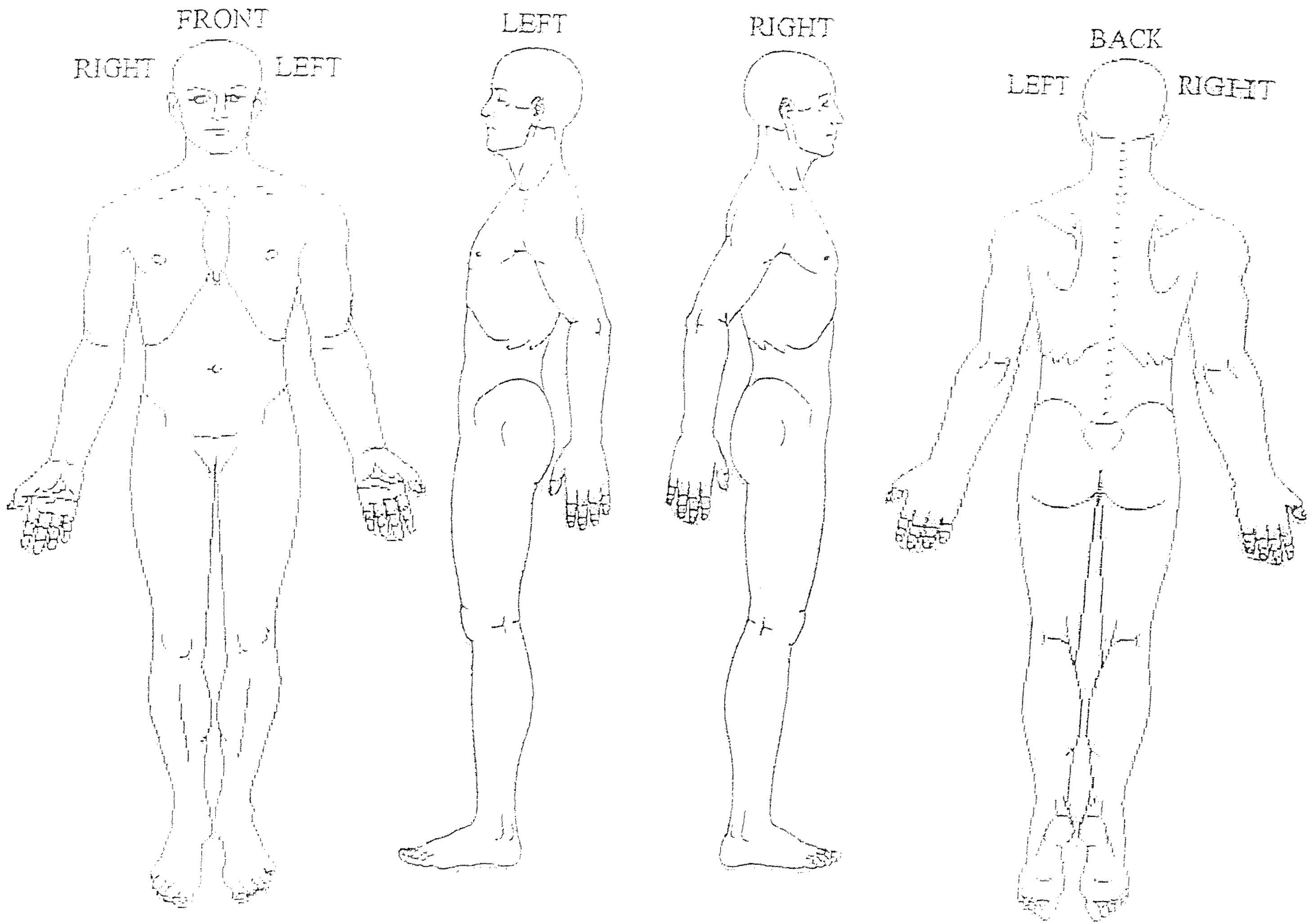
Complete this drawing **for your symptoms at this time** (Do <u>not</u> show where symptoms <u>used to be</u>).

PAIN DRAWING

Using the key, describe your present ailment

KEY

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



Chapter 18

Table 18-4 Ratings Determining Impairment Associated With Pain

Name:________________ Date:________

I. Pain (Self-report of Severity)

A. Rate how severe your pain is **right now, at this moment** (circle a number):

0 1 2 3 4 5 6 7 8 9 10

No pain — Most severe pain can imagine

B. Rate how severe your pain is **at its worst** (circle a number):

0 1 2 3 4 5 6 7 8 9 10

None — Excruciating

C. Rate how severe your pain is **on the average** (circle a number):

0 1 2 3 4 5 6 7 8 9 10

None — Excruciating

D. Rate how much your pain is **aggravated by activity** (circle a number):

0 1 2 3 4 5 6 7 8 9 10

Activity does not aggravate pain — Excruciating following any activity

Sum score of Section I: A–D = Total pain severity/4 = ________

E. Rate how **frequently** you experience pain (circle a number):

0 1 2 3 4 5 6 7 8 9 10

Rarely — All of the time

Add total pain severity score (items A–D/4) to score for item E = ________

Total pain severity score (range from 0 to 20) = ________

II. Activity Limitation or Interference

A. How much does your pain interfere with your ability to **walk 1 block**? (circle a number):

0 1 2 3 4 5 6 7 8 9 10

Does not restrict ability to walk — Pain makes it impossible for me to walk

B. How much does your pain prevent you from **lifting 10 pounds** (a bag of groceries)? (circle a number):

0 1 2 3 4 5 6 7 8 9 10

Does not prevent from lifting 10 pounds — Impossible to lift 10 pounds

C. How much does your pain interfere with your ability to **sit for 1/2 hour**? (circle a number):

0 1 2 3 4 5 6 7 8 9 10

Does not restrict ability to sit for 1/2 hour — Impossible to sit for 1/2 hour

D. How much does your pain interfere with your ability to **stand for 1/2 hour**? (circle a number):

0 1 2 3 4 5 6 7 8 9 10

Pain does not interfere with ability to stand at all — Unable to stand at all

E. How much does your pain interfere with your ability to **get enough sleep**? (circle a number):

0 1 2 3 4 5 6 7 8 9 10

Does not prevent me from sleeping — Impossible to sleep

F. How much does your pain interfere with your ability to **participate in social activities**? (circle a number):

0 1 2 3 4 5 6 7 8 9 10

Does not interfere with social activities — Completely interferes with social activities

G. How much does your pain interfere with your ability to **travel up to 1 hour by car**? (circle a number):

0 1 2 3 4 5 6 7 8 9 10

Does not interfere with ability to travel 1 hour by car — Completely unable to travel 1 hour by car

H. In general, how much does your pain interfere with your **daily activities**? (circle a number):

0 1 2 3 4 5 6 7 8 9 10

Does not interfere with my daily activities — Completely interferes with my daily activities

I. How much do you **limit your activities to prevent your pain from getting worse?** (circle a number):

0 1 2 3 4 5 6 7 8 9 10

Does not limit activities — Completely limits activities

J. How much does your pain interfere with your **relationship with your family/partner/significant others?** (circle a number):

0 1 2 3 4 5 6 7 8 9 10

Does not interfere with relationships — Completely interferes with relationships

K. How much does your pain interfere with your ability to do **jobs around your home?** (circle a number):

0 1 2 3 4 5 6 7 8 9 10

Does not interfere — Completely unable to do any job around home

L. How much does your pain interfere with your ability to **shower or bathe without help from someone else?** (circle a number):

0 1 2 3 4 5 6 7 8 9 10

Does not interfere at all — My pain makes it impossible to shower or bathe without help

M. How much does your pain interfere with your ability to **write or type?** (circle a number):

0 1 2 3 4 5 6 7 8 9 10

Does not interfere at all — My pain makes it impossible to write or type

N. How much does your pain interfere with your ability to **dress yourself**? (circle a number):

0 1 2 3 4 5 6 7 8 9 10

Does not interfere at all — My pain makes it impossible to dress myself

O. How much does your pain interfere with your ability to **engage in sexual activities**? (circle a number):

0 1 2 3 4 5 6 7 8 9 10

Does not interfere at all — My pain makes it almost impossible to engage in any sexual activity

P. How much does your pain interfere with your ability to **concentrate**? (circle a number):

0 1 2 3 4 5 6 7 8 9 10

Never — All the time

Sum score of Section II:
A-P = Total score for activity limitation/16 =
Mean activity limitation = ___________

III. Individual's Report of Effect of Pain on Mood

A. Rate your **overall mood** during the past week. (circle a number):

0 1 2 3 4 5 6 7 8 9 10

Extremely high/good — Extremely low/bad

B. During the past week, how **anxious or worried** have you been because of your pain? (circle a number):

0 1 2 3 4 5 6 7 8 9 10

Not at all anxious/worried — Extremely anxious/worried

C. During the past week, how **depressed** have you been because of your pain? (circle a number):

0 1 2 3 4 5 6 7 8 9 10

Not at all depressed — Extremely depressed

D. During the past week, how **irritable** have you been because of your pain? (circle a number):

0 1 2 3 4 5 6 7 8 9 10

Not at all irritable — Extremely irritable

E. In general, how anxious/worried are you about performing activities because they **might make your pain/symptoms worse**?

0 1 2 3 4 5 6 7 8 9 10

Not at all anxious/worried — Extremely anxious/worried

Sum score of Section III:
A-E = Total pain impairment attributed to mood state/5 =
Mean score = ___________

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

ACTIVITIES OF DAILY LIVING

Please indicate your difficulty level at this time:	Without Difficulty	With Some Difficulty	With Much difficulty	Unable to do
A. Self-care – Are you able to:				
Dress yourself including shoes				
Comb your hair				
Wash and dry yourself				
Take a bath				
Get on and off the toilet				
Brush your teeth				
Cut your own food				
Lift a full glass to your mouth				
Open a new milk carton				
Make a meal				
B. Communication – are you able to:				
Write a note				
Type a message on a computer				
See a television screen				
Use a telephone (hearing)				
Speak clearly				
D. Hand activities – are you able to:				
Open car doors				
Open previously opened jars				
Turn faucets on or off				
E. Physical Activity – are you able to:				
Work outside on flat ground				
Work outside on uneven ground				
Climb five flights of stairs				
Stand for 30 minutes				
Walk for 30 minutes				
Sit for 30 minutes				
Recline				
Rise from a chair				
Run errands				
Perform light chores at home				

Please indicate your difficulty level at this time: (Continued)	Without Difficulty	With Some Difficulty	With Much difficulty	Unable to do
F. Travel – are you able to:				
Ride in a car or bus				
Drive a vehicle				
Fly as a commercial passenger				
Shop				
Get in and out of a car				
G. Sleep/personal – are you able to:				
Sleep - restful				
Sleep - pattern				
H. Sexual – are you able to:				
Adequate lubrication				
Erection				
Orgasm				
Ejaculation				
I. Continence – are you able to:				
Maintain bladder control				
Maintain bowel control				
J. Medications – are you able to:				
Remember to take medications				
Take medications without a reminder or assistance				
K. Money management – are you able to:				
Make money decisions				
Pay bills timely				
Pay bills properly				
L. Social interaction – are you able to:				
Interact with family members				
Interact with friends				
Interact with strangers				

Completed by: ______________________________ Date: ______________

Signature: ____