HISTORY FORM

Date:_____

Please answer the questions below. Use a separate page if needed. The information is very important and should be filled out completely before coming to your appointment. (PLEASE FILL OUT IN PEN)

Name: _____ Address: _____ City _____ State _____

Phone: Home _____ Cell _____ SSN: _____

Sex: M F Age: _____ Birth Date: _____ Ht: _____ Wt: _____ Major Hand: Right Left

Date(s) of injury: (1)_____ (2)_____ (3)_____ (4)_____

Body-part(s) injured: (1)_____ (2)_____ (3)_____ (4)_____

Employer at time of injury: _____ How long? _____

How long did you do this type of work? _____ What was your last day worked? _____

At the time of the injury, were you working for more than one employer? Yes ☐ No ☐ If yes, please list:
Employer's name: Dates of Employment Job Title
_____
_____

Since the injury, have you worked/are you currently working for a different employer Yes ☐ No ☐ If yes, please list:
Employer's name: Dates of Employment Job Title
_____
_____

CURRENT COMPLAINTS

Complaint #1: _____
What percentage of the time do you experience/feel this symptom? _____%
What activities make this symptom worse? _____
_____
In the last few months have these symptoms? ☐ stayed the same ☐ improved ☐ worsened
☐ fluctuated but overall has stayed about the same
What makes this symptom better? _____
_____
Can/do you have this symptom without activity? _____

Complaint #2: _____
What percentage of the time do you experience/feel this symptom? _____%
What activities make this symptom worse? _____
_____
In the last few months have these symptoms? ☐ stayed the same ☐ improved ☐ worsened
☐ fluctuated but overall has stayed about the same
What makes this symptom better? _____
_____
Can/do you have this symptom without activity? _____

Complaint #3: _____
What percentage of the time do you experience/feel this symptom? _____%
What activities make this symptom worse? _____
_____

In the last few months have these symptoms? ☐ stayed the same ☐ improved ☐ worsened
☐ fluctuated but overall has stayed about the same

What makes this symptom better? _____

_____

Can/do you have this symptom without activity? _____

Additional complaints, list: _____

What percentage of the time do you experience/feel these symptoms? _____%

What activities makes them worse? _____

_____

What makes them better? _____

_____

In the last few months have these symptoms? ☐ stayed the same ☐ improved ☐ worsened
☐ fluctuated but overall has stayed about the same

If your condition has **worsened,** please explain: _____

_____

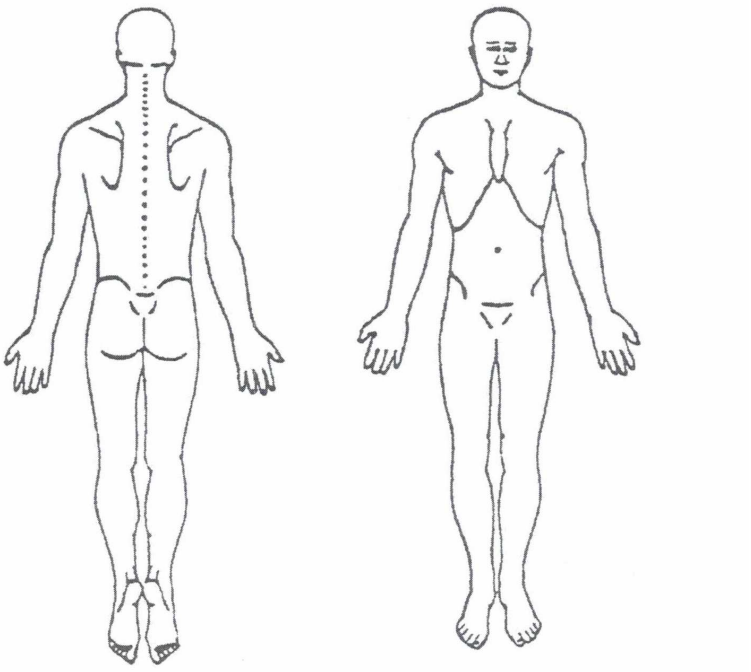
If your condition is the same, how long has it been that way? _____

Use this space for any additional information / details in response to questions above:

PAIN DRAWING

Mark the areas on the body chart that show where you are having pain from your work injury(ies).

ACHING	BURNING	STABBING	PINS & NEEDLES	NUMBNESS
XXXXXX	^^^^^^	//////////	oooooooooooo	- - - - - - -
XXXX	^^^^	//////	oooooo	- - - - -



Discomfort Levels for Different Activities: Please indicate the level of discomfort (on a scale of 1-10) caused by performing the activities listed below, both **AT WORK AND IN DAILY LIFE**, as a result of your injury(s).

Activity	**On a scale of 1-10 (10=worst) CIRCLE the discomfort level you experience with these activities.**		
Lifting	1 2 3 4 5 6 7 8 9 10	Standing	1 2 3 4 5 6 7 8 9 10
Carrying	1 2 3 4 5 6 7 8 9 10	Kneeling	1 2 3 4 5 6 7 8 9 10
Overhead use of arms	1 2 3 4 5 6 7 8 9 10	Squatting	1 2 3 4 5 6 7 8 9 10
Pushing	1 2 3 4 5 6 7 8 9 10	Walking on uneven terrain	1 2 3 4 5 6 7 8 9 10
Pulling	1 2 3 4 5 6 7 8 9 10	Walking on flat surface	1 2 3 4 5 6 7 8 9 10
Grasping	1 2 3 4 5 6 7 8 9 10	Running	1 2 3 4 5 6 7 8 9 10
Fine Manipulation - hands	1 2 3 4 5 6 7 8 9 10	Stooping	1 2 3 4 5 6 7 8 9 10
Repetitive hand use	1 2 3 4 5 6 7 8 9 10	Twisting - neck	1 2 3 4 5 6 7 8 9 10
Reaching - arms	1 2 3 4 5 6 7 8 9 10	Twisting - waist	1 2 3 4 5 6 7 8 9 10
Crawling	1 2 3 4 5 6 7 8 9 10	Driving	1 2 3 4 5 6 7 8 9 10
Jumping	1 2 3 4 5 6 7 8 9 10	Climbing	1 2 3 4 5 6 7 8 9 10
Bending - neck	1 2 3 4 5 6 7 8 9 10	Downward gazing	1 2 3 4 5 6 7 8 9 10
Bending - waist	1 2 3 4 5 6 7 8 9 10	Upward gazing	1 2 3 4 5 6 7 8 9 10
Sitting	1 2 3 4 5 6 7 8 9 10		

ACTIVITIES OF DAILY LIVING QUESTIONNAIRE

For each question below, please check "Yes" or "No." If you answer "Yes," please explain in the space below the question.

Do you experience any difficulties or limitations feeding yourself? No ☐ Yes ☐

Do you experience any difficulties or limitations bathing yourself? No ☐ Yes ☐

Do you experience any difficulties or limitations grooming yourself? No ☐ Yes ☐

Do you experience any difficulties or limitations dressing yourself? No ☐ Yes ☐

Do you experience any difficulties with bowel or bladder function (urgency, control, telling when you need to "go")? No ☐ Yes ☐

Do you experience any difficulties or limitations with sexual function? No ☐ Yes ☐

Do you experience any difficulties or limitations with sitting? No ☐ Yes ☐

Do you experience any difficulties or limitations with transferring positions (from bed to chair, sitting to standing, etc.)? No ☐ Yes ☐

Do you experience any difficulties or limitations with standing? No ☐ Yes ☐

Do you experience any difficulties or limitations with walking? No ☐ Yes ☐

Do you require the use of any assistive devices (cane ☐, crutch ☐, walker ☐, etc.)? No ☐ Yes ☐

Do you experience any difficulties or limitations negotiating stairs? No ☐ Yes ☐

Do you require the use of a handrail? No ☐ Yes ☐

Do you experience any difficulties or limitations with communication (writing, typing, speaking, listening)? No ☐ Yes ☐

Do you experience any difficulties or limitations with sensory function (hearing, seeing, feeling, tasting, or smelling)? No ☐ Yes ☐

Do you experience any difficulties or limitations with hand activities (gripping, grasping, twisting, sensation, use of fingers, etc.)? No ☐ Yes ☐

Do you experience any difficulties or limitations with sleep (change in your pattern of sleep or your ability to sleep)? No ☐ Yes ☐

Do you experience any difficulties or limitations with travel (driving or riding in a car☐, plane☐, etc.)? No ☐ Yes ☐

Do you experience any difficulties or limitations performing housework? No ☐ Yes ☐

Do you experience any difficulties or limitations performing yard work? No ☐ Yes ☐

Do you experience any difficulties or limitations with cooking? No ☐ Yes ☐

Do you experience any difficulties or limitations with recreational activities? No ☐ Yes ☐

Pre/Post Injury Capacity

How much could you lift (in pounds) before this injury? _____

How much could you lift (in pounds) right after the injury? _____

How much can you lift (in pounds) now? _____

Before this injury(s), did you have any work limitations or restrictions in the use of the injured body part or parts?

_____

_____

DESCRIPTION OF INJURY FOR THE DATE(S) OF INJURY(S) LISTED ABOVE

Please describe in detail how the injury(s) occurred. (use additional sheet if more room needed)

Do you recall what happened? No ☐ Yes ☐ Give description of what happened: (give specific details):

_____

_____

_____

What body parts were injured? _____

Did you feel pain in each body part …immediately or …later on

Body part:_____ ☐ Immediately, ☐ later on Body part: _____ ☐ Immediately, ☐ later on

Body part:_____ ☐ Immediately, ☐ later on Body part: _____ ☐ Immediately, ☐ later on

Did you complete your work shift? Yes ☐ No ☐

Did you report your injury to your employer Yes ☐ No ☐. That same day? If "no", why not? _____

Were you transported to the hospital? Yes ☐ No ☐. If yes, via: ☐ ambulance, ☐ private car, ☐ employers car

Were you hospitalized? Yes ☐ No ☐ If yes: how long? What procedures, tests, and treatments were done? ☐ X-rays, ☐ ultrasound, ☐ CT scan, ☐ MRI, ☐ Physical therapy, ☐ IV, ☐ pain shots, ☐ pain pills; ☐ surgery-procedure.

What symptoms did you have immediately after the injury(s)? ☐ pain, ☐ aching, ☐ stabbing, ☐ burning, ☐ pins and needles, ☐ numbness?

After the immediate time of the injury, ___1 ___2 ___3 ___ 4 days; ___weeks; ____ months did you notice any change in the pain? ☐ Same pain

☐ Different type of pain, ☐ same pain, ☐ increasing pain, ☐ radiating, ☐ throbbing, ☐ aching, ☐ stabbing, ☐ burning, ☐ pins and needles, ☐ numbness

If pain radiates; to where? _____

☐ New location of pain, where? _____

TREATMENTS PERFORMED AS AN OUTPATIENT

Describe the medical attention you received after the injury(s).

****Please do not put "see medical records"- this information is to be filled out by you!**

NAME OF DOCTOR THAT CARED FOR YOU	DATE OF FIRST VISIT	AMOUNT OF TIME IN WEEKS/MONTHS/YEARS OF CARE

OUTPATIENT TREATMENT	TIME PERIODS OR DATES	RELIEF: Temporary	Partial	Total
Physical Therapy				
Occupational Therapy				
Oral Medications				
Pain Med Injections				
Corticosteroid Injections				

OUTPATIENT DIAGNOSTIC TESTS	AREAOF BODY	DATES	RESULTS IF KNOWN
MRI			
ULTRASOUND			
CT SCAN			
PLAIN XRAYS			
ARTHROSCOPY			
TRIGGER POINT INJECTIONS			
EPIDURAL INJECTIONS			

Any other injuries from the accident not already mentioned? ☐ yes ☐ no

Ifyes:what?_____

Date last seen by Physician: _____ Physician's name: _____

WORK STATUS: Dates off work due to the injury:_____

Dates of modified duty _____

Current Work Restrictions:_____

Are you still working for the same employer as you were at the time of the injury? Yes ☐ No ☐

If No, what is last date of actual work at employer where you had your most recent work injury: _____

If Yes, are you doing the exact same job? Yes ☐ No ☐ If No, please describe the differences:

_____

Are you currently on medical leave? Yes ☐ No ☐ Do you receive State Disability payments? Yes ☐ No ☐

Workers' Compensation temporary disability payments? Yes ☐ No ☐ Other? _____

Do you feel physically able to return to your regular duties? Yes ☐ No ☐ If No, what job duties did you perform that you can no longer do? _____

Do you wish to return to lighter duty for the same employer? Yes ____ No ____

JOB DUTIES AT THE TIME OF INJURY
Employer Name:
Job Title at time of Injury:
Hours worked per Day: Hours worked per week:
Description of Job Responsibilities: (Describe all activities you did on the job - what you did at work.) **Be specific**:

ACTIVITY LEVELS: Please indicate the activities you performed at work. Base this information on your job description and what duties you were required to do at the time of your injury. ***PLEASE DESCRIBE YOUR HEAVIEST/HARDEST DAY AT WORK.**

Activity	**Frequency performed - Total Per Work Day**			
	Never 0 hours	Occasional up to 3 hours	Frequent 3-6 hours	Constant 6-8+ hours
Lifting				
Carrying				
Overhead use of arms				
Pushing				
Pulling				
Grasping				
Fine Manipulation - hands				
Repetitive hand use				
Reaching - arms				
Crawling				
Jumping				
Bending - neck				
Bending - waist				
Sitting				
Standing				
Kneeling				
Squatting				
Walking - uneven terrain				
Walking on flat surface				
Running				
Stooping				
Twisting - neck				
Twisting - waist				
Driving				
Climbing				
Downward gazing				
Upward gazing				

Please indicate the daily lifting and carrying requirements of the job: Indicate the height the object is lifted from the floor, table or overhead location and the distance the object is carried.

Lifting

Weight (pounds)	Never 0 hours	Up to 3 hours	Frequently 3-6 hours	Constantly 6-8+ hours	Height from Floor	Height from Table	Overhead
0-10							
11-25							
26-50							
51-75							
76-100							
100 +							

Carrying

Weight (pounds)	Never 0 hours	Up to 3 hours	Frequently 3-6 hours	Constantly 6-8+ hours	Distance Carried
0-10					
11-25					
26-50					
51-75					
76-100					
100 +					

Describe the heaviest item(s) you were required to carry and the distance carried:

PRIOR EMPLOYMENT: List **all jobs** you have had, from the most recent to the oldest. Use back of form if necessary.

Employer	Job Title/Duties	From - To

PAST MEDICAL HISTORY:

Please list the information about your medical history in the sections below. If a section does not apply to you, mark an ☒ in the 'denied' box:

Childhood illnesses and injuries: ☐ Denied

_____

Medication allergies: ☐ Denied

_____

Present medications taken not previously listed, do not include vitamins): ☐ Denied _____

_____

Surgeries include dates: ☐ Denied _____

_____

Hospitalizations include dates: ☐ Denied _____

_____

Adult illnesses: ☐ Denied _____

_____

Who is your primary care provider (family doctor or general medical provider) name & location/city: _____

_____

Previous Injuries / Injury History: Please list below all injuries you have had prior to this injury. Include dates and list time off work, if any. When all these items are not listed, it may appear that YOU concealed the information intentionally. You should include:

*childhood injuries/diseases *injuries you later recovered from *injuries resulting in broken bones
*injuries requiring stitches *injuries with treatment by a chiropractor *any chiropractic visits (for any reason)
*sports injuries *injuries that did not occur at work *any injury resulting in lost work time *slip and fall" accidents
*prior work injuries

DATE	DESCRIBE THE INJURY/ACCIDENT AND BODY PART(S) AFFECTED	WORK RELATED? (YES OR NO)	TIME OFF WORK? (How long? Dates?)

Have you had any automobile accidents?

Date: _____ Description of injury (s)_____

Body parts injured: _____

Date: _____ Description of injury (s)_____

Body parts injured: _____

_____

Have you received any past settlement awards?

If yes, for which body part(s) and date(s) of injury? _____

Date Received: _____ Amount: _____ Was this Workers' Compensation or Personal Injury? _____

Vocational Rehabilitation/retraining to a different job?

Have you been contacted by a Vocational Rehabilitation Agency? ☐ Yes ☐ No
If yes, is rehabilitation/retraining underway? ☐ Yes ☐ No

FAMILY HISTORY

	Age	Alive?		Diabetes?		Heart Disease?		Cancer? If yes, what type?		
		Yes	No	Yes	No	Yes	No	Yes	No	Type
Father										
Mother										
Brother(s)										
Sister(s)										

REVIEW OF SYSTEMS

Please List Any Problems That You **Now Have** With The Following Body Systems:
Ears/Nose/Throat: ☐ Denied _____
Eyes: ☐ Denied _____
Lungs: ☐ Denied _____
Liver: ☐ Denied _____
G-I Tract (Stomach, Intestines, Bowels, Etc.): ☐ Denied _____
Kidney/Bladder: ☐ Denied _____
[Women] Reproductive System: ☐ Denied _____
Skin: ☐ Denied _____
Neurological: ☐ Denied _____
Heart/Circulation: ☐ Denied _____
Psychological: ☐ Denied _____

SOCIAL HISTORY

Are You? ☐ Married ☐ Single ☐ Separated ☐ Divorced ☐ Widowed
How many children or family members do you have at home (other than your spouse)? _____
Education: highest level attained? ☐ High School, ☐ Junior College, ☐ 4 year University, ☐ Tech School
List Degrees, Diplomas, Licenses, Certifications You Hold: ☐ MS, ☐ MA, ☐ Ph.D., ☐ MD Other: _____
Do you use alcohol? ☐ yes ☐ no if 'yes', how many drinks per week? _____
Do you smoke tobacco? ☐ yes ☐ no if 'yes', how many packs per day or week? _____
Use recreational drugs? ☐ yes ☐ no if 'yes', what & how often? _____
Do you exercise? ☐ yes ☐ no describe type & frequency. If 'no', explain why not: _____
_____
If you participate in sports activities, describe type & frequency: _____
_____
What are your hobbies or leisure activities (what do you do to relax or have fun?) Describe:
_____

List any other ways that your injury affects your life not yet addressed:
_____ (Rev. 7/21)