# 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 <u>before</u> 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: ____________________________ Type of business: _____________________ How long? ______

How long did you do this type of work? _______________________ Last day worked? _____________________________

Periods of modified duty ___________________________________________________________________________

Dates off work due to the injury: _____________________________________________________________________

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 ____

Have you been contacted by a Vocational Rehabilitation Agency? Yes ____ No ____ Is Rehab underway? Yes ____ No ____

**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 | Reason Job Ended |
|---|---|---|---|
| | | | |
| | | | |

**At the time of the injury, were you working for more than one employer?** Yes ____ No ____
If yes, please list employer(s) and type of work performed.

___________________________________________________________________________________________________

___________________________________________________________________________________________________

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

**Please describe in detail how the injury(s) occurred.**

If there was more than one injury, please number them. Use separate page if needed. Do not write on back of page.

**What symptoms did you have immediately after the injury(s)?**

## MEDICAL TREATMENT:

Describe the medical attention you received after the injury(s). Please include the following: names of all physicians, the dates you saw them, medications & treatments they prescribed, what x-rays were taken, physical therapy, surgeries, hospitalizations etc. (Dates of treatment can be listed as a "from - to" period, i.e. 3/4/09 – 4/6/10).

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

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**PRESENT COMPLAINTS: PLEASE BASE THIS ON WHEN YOUR PAIN IS AT ITS WORST.**

Describe: type of pain, severity, duration, what causes the pain, and what relieves the pain **<u>per body part</u>** claimed or injured.

______________________________________________________________________________

______________________________________________________________________________

______________________________________________________________________________

______________________________________________________________________________

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______________________________________________________________________________

______________________________________________________________________________

______________________________________________________________________________

**Current Medications**: Please list **all** medications you take, including those for medical conditions not related to this injury. Bring medications to the appointment with you.

Describe complaints that were caused by the injury(s), but have now gone away.

Do you feel your symptoms have improved, stayed the same, or worsened since the injury (please explain per body part claimed):

| Body Part | Symptoms are better, worse, or the same |
| --- | --- |
| | |
| | |
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| | |

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

At the time of this injury, please list all recreational and non-work activities you participated in: (hobbies, sports, etc.)

Which of these activities can you no longer participate? ______

**On the body chart below, mark the painful areas with the appropriate symbols:**

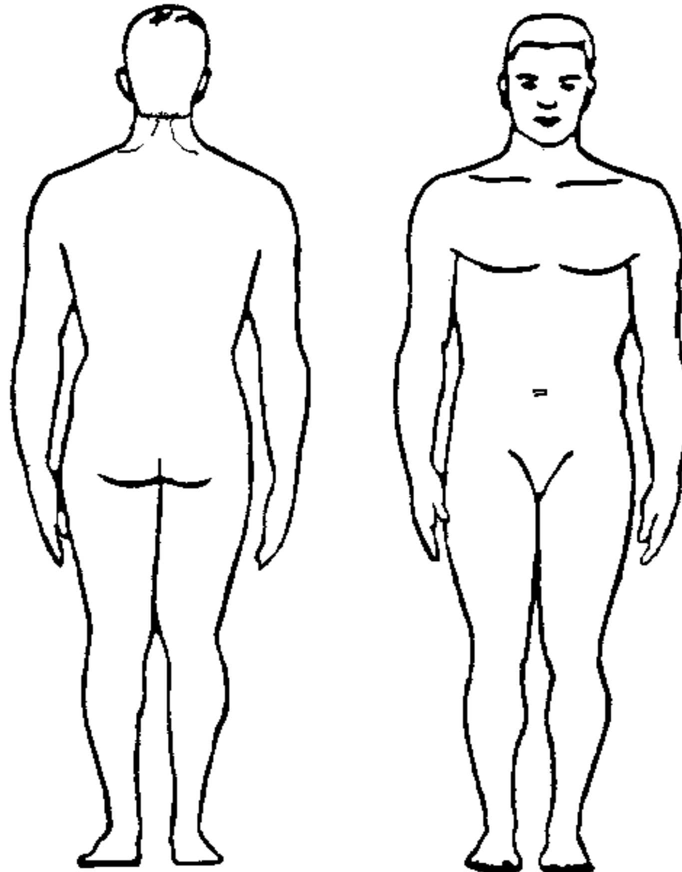
| | | | |
|---|---|---|---|
| **Numbness** | = = = = | **Burning** | x x x x |
| **Stabbing** | / / / / | **Aching** | o o o o |
| **Pins & Needles** | - - - - - - | | |

**Also, next to each painful area, write the two words, one word from each column below, which best describes the intensity and frequency of your pain:**

| Intensity | Frequency |
|---|---|
| Minimal | Occasional |
| Slight | Intermittent |
| Moderate | Constant |
| Severe | |

**PLEASE DESCRIBE HOW YOUR PAIN FEELS AT IT'S WORST**

__



**Person filling out this page: Applicant ____ Interpreter ____ Other:** ______________________________________

**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) list the discomfort level you experience with these activities.** | | |
|---|---|---|---|
| Lifting | | Standing | |
| Carrying | | Kneeling | |
| Overhead use of arms | | Squatting | |
| Pushing | | Walking on uneven terrain | |
| Pulling | | Walking on flat surface | |
| Grasping | | Running | |
| Fine Manipulation - hands | | Stooping | |
| Repetitive hand use | | Twisting - neck | |
| Reaching - arms | | Twisting - waist | |
| Crawling | | Driving | |
| Jumping | | Climbing | |
| Bending - neck | | Downward gazing | |
| Bending - waist | | Upward gazing | |
| Sitting | | | |

**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:

*automobile accidents *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?) |
|---|---|---|---|
| | | | |
| | | | |
| | | | |
| | | | |
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| | | | |
| | | | |

**List all prior hospitalizations, surgeries, or incidents that required hospital care:**

___________________________________________________________________________

___________________________________________________________________________

___________________________________________________________________________

___________________________________________________________________________

___________________________________________________________________________

**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? ______________

**SOCIAL HABITS:**
Do you smoke? No ____ Yes ____ If Yes, how much / how often? ____________________________________
Do you drink? No ____ Yes ____ If Yes, how much / how often? ____________________________________
Do you use drugs? No ____ Yes ____ If Yes, how much / how often? ____________________________________

**Employment History**: 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 |
|---|---|---|
| | | |
| | | |
| | | |
| | | |
| | | |
| | | |
| | | |
| | | |

**Other Medical History:**

Do you have diabetes? No Yes Other family members with diabetes? No Yes Who? ___________________________

Have you or your blood relatives inherited any disease from your/their blood relatives? No Yes

If Yes, who and what? ___________________________________________________________________________

Do you have gout? No Yes Do you have arthritis? No Yes Previous back/neck pain? No Yes

**Family Health History:**

| | Age | Health | List Health Problems | Age at death | Cause of death |
|---|---|---|---|---|---|
| Father | | | | | |
| Mother | | | | | |
| Brother(s) | | | | | |
| | | | | | |
| Sister(s) | | | | | |
| | | | | | |
| Son(s) | | | | | |
| | | | | | |
| Daughter(s | | | | | |
| | | | | | |

**Marriage History:**

| Spouse's Name | Date Married | Date Divorced | Children? |
|---|---|---|---|
| | | | |
| | | | |
| | | | |

**Education History:**

High School: ______________________________ Location: ________________________ years attended _______

College: __________________________________ Location: ________________________ years attended _______

Degrees/Concentrations: ______________________________________________ year of graduation ___

College: __________________________________ Location: ________________________ years attended _______

Degrees/Concentrations: ______________________________________________ year of graduation ___

Vocational Education: __________________________________________________ years attended _______

Other Post High School Education:

# 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.)

**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<br>0 hours | Occasional<br>up to 3 hours | Frequent<br>3-6 hours | Constant<br>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 | Floor | 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: | | | | | | | |

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? __________________

Have you been seen by a prior QME for this injury? _________________________________

Have you been made Permanent and Stationary? Yes No

If Yes, by which doctor? _________________________________

Employee Signature: Date:

December 2020 version

Email address: _________________________________________________

**Applicants Name:** ___________________________________ **Date:**________________________-

# Activities of Daily Living Questionnaire

**For each question below, please check "Yes" or "No."**
**If you answer "Yes," please write specific explanations 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

**Activities of Daily Living Questionnaire, continued**

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, etc.)? ☐ 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

# Epworth Sleepiness Scale

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 |