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: _____ 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 Preclusions: _____

_____

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 <u>in detail</u> how the injury(s) occurred.
If there was more than one injury, please number them. Use the back of page if needed.

What symptoms did you have <u>immediately after</u> 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>!**

PRESENT COMPLAINTS:

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

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

_____

_____

_____

_____

_____

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

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:

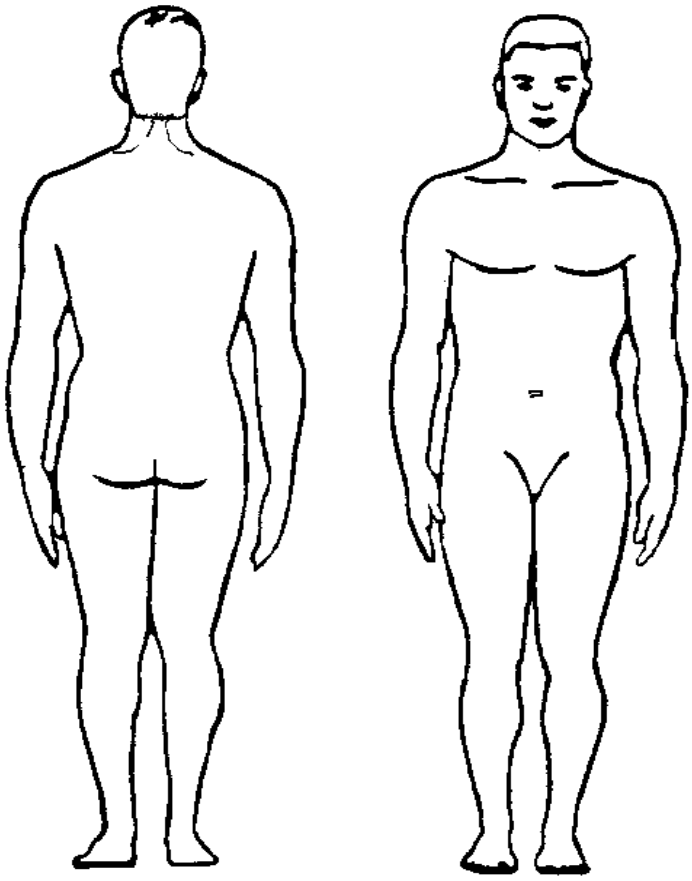
Numbness	= = = =	**Burning**	**x x x x**
Stabbing	/ / /	**Aching**	**o o o o**
Pins & Needles	- - - - - -		

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

<u>Intensity</u>	**<u>Frequency</u>**
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?)

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 (good, fair, poor)	Health problems	Age at death	Cause of death
Father					
Mother					
Brother(s)					
Sister(s)					
Children					

EDUCATION:

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 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	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:

EMAIL ADDRESS: _____

1.30.2020 version

Applicant Name: _____ **Date:_____**

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

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

Oswestry Disability Questionnaire

This questionnaire has been designed to give us information as to how your back or leg pain is affecting your ability to manage in everyday life. Please answer by checking **one box in each section** for the statement which best applies to you. We realise you may consider that two or more statements in any one section apply but please just shade out the spot that indicates the statement **which most clearly describes your problem.**

Section 1: Pain Intensity

- ☐ I have no pain at the moment
- ☐ The pain is very mild at the moment
- ☐ The pain is moderate at the moment
- ☐ The pain is fairly severe at the moment
- ☐ The pain is very severe at the moment
- ☐ The pain is the worst imaginable at the moment

Section 2: Personal Care (eg. washing, dressing)

- ☐ I can look after myself normally without causing extra pain
- ☐ I can look after myself normally but it causes extra pain
- ☐ It is painful to look after myself and I am slow and careful
- ☐ I need some help but can manage most of my personal care
- ☐ I need help every day in most aspects of self-care
- ☐ I do not get dressed, wash with difficulty and stay in bed

Section 3: Lifting

- ☐ I can lift heavy weights without extra pain
- ☐ I can lift heavy weights but it gives me extra pain
- ☐ Pain prevents me lifting heavy weights off the floor but I can manage if they are conveniently placed eg. on a table
- ☐ Pain prevents me lifting heavy weights but I can manage light to medium weights if they are conveniently positioned
- ☐ I can only lift very light weights
- ☐ I cannot lift or carry anything

Section 4: Walking*

- ☐ Pain does not prevent me walking any distance
- ☐ Pain prevents me from walking more than 2 kilometres
- ☐ Pain prevents me from walking more than 1 kilometre
- ☐ Pain prevents me from walking more than 500 metres
- ☐ I can only walk using a stick or crutches
- ☐ I am in bed most of the time

Section 5: Sitting

- ☐ I can sit in any chair as long as I like
- ☐ I can only sit in my favourite chair as long as I like
- ☐ Pain prevents me sitting more than one hour
- ☐ Pain prevents me from sitting more than 30 minutes
- ☐ Pain prevents me from sitting more than 10 minutes
- ☐ Pain prevents me from sitting at all

Section 6: Standing

- ☐ I can stand as long as I want without extra pain
- ☐ I can stand as long as I want but it gives me extra pain
- ☐ Pain prevents me from standing for more than 1 hour
- ☐ Pain prevents me from standing for more than 30 minutes
- ☐ Pain prevents me from standing for more than 10 minutes
- ☐ Pain prevents me from standing at all

Section 7: Sleeping

- ☐ My sleep is never disturbed by pain
- ☐ My sleep is occasionally disturbed by pain
- ☐ Because of pain I have less than 6 hours sleep
- ☐ Because of pain I have less than 4 hours sleep
- ☐ Because of pain I have less than 2 hours sleep
- ☐ Pain prevents me from sleeping at all

Section 8: Sex Life (if applicable)

- ☐ My sex life is normal and causes no extra pain
- ☐ My sex life is normal but causes some extra pain
- ☐ My sex life is nearly normal but is very painful
- ☐ My sex life is severely restricted by pain
- ☐ My sex life is nearly absent because of pain
- ☐ Pain prevents any sex life at all

Section 9: Social Life

- ☐ My social life is normal and gives me no extra pain
- ☐ My social life is normal but increases the degree of pain
- ☐ Pain has no significant effect on my social life apart from limiting my more energetic interests e.g. sport
- ☐ Pain has restricted my social life and I do not go out as often
- ☐ Pain has restricted my social life to my home
- ☐ I have no social life because of pain

Section 10: Travelling

- ☐ I can travel anywhere without pain
- ☐ I can travel anywhere but it gives me extra pain
- ☐ Pain is bad but I manage journeys over two hours
- ☐ Pain restricts me to journeys of less than one hour
- ☐ Pain restricts me to short necessary journeys under 30 minutes
- ☐ Pain prevents me from travelling except to receive treatment