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? _____ 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 a separate page if needed. (DO NOT WRITE ON THE BACK)

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? _____

_____

_____

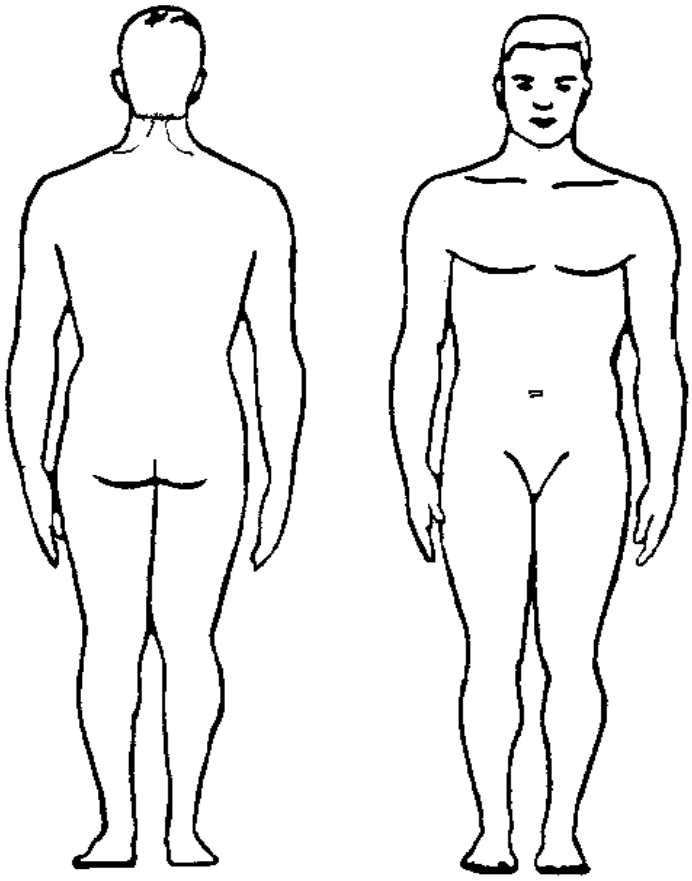
On the body chart below, mark the painful areas with the appropriate symbols:

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:

1.30.20 version

EMAIL ADDRESS: _____

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