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MEDICAL GROUP

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WORKER'S COMPENSATION HISTORY FORM

NAME (Last, First, Middle Initial)		Height	Weight
Exam Date	Date of Injury	☐ Right-handed	☐ Left-handed
Age	Birth date	Sex ☐ Male ☐ Female	
Job Title		Current Employer	

CHIEF COMPLAINT

Briefly describe what body part was injured:

JOB HISTORY (Last 5 years)

COMPANY	POSITION	DATES OF EMPLOYMENT

HISTORY OF INJURY

Please describe how you were injured in detail.

Name of any witnesses

To whom did you report the injury?

What specific body part(s) was/were injured?

Describe your symptoms

Were you able to continue working? ☐ Yes ☐ No

Were you doing your regular work at the time of injury? ☐ Yes ☐ No

If not, what were you doing?

Were you sent to a doctor immediately? ☐ Yes ☐ No

If not, please explain:

If yes, did you drive or did someone take you?

INITIAL TREATMENT PROGRAM

Name of doctor of clinic where you were first seen

Date of first visit if not the same as the date of injury

Were x-rays taken ☐ Yes ☐ No What body parts?

Were you given medication? ☐ Yes ☐ No Name of medication(s):

Did you receive physical therapy? ☐ Yes ☐ No How often?

Did the symptoms clear up? ☐ Yes ☐ No Which ones?	
Were you referred to another doctor? ☐ Yes ☐ No By whom?	
Doctor's Name	Location
What did they do for you?	
Please list names and dates of all other physicians seen for this injury: _____ _____ _____	
Dates and results of any special tests (EMG, MRI, CT, etc.) _____ _____	

PRESENT TREATMENT

Who is your current doctor?	
Date last seen:	What are you being treated for?
Have you had any reinjuries? ☐ Yes ☐ No What and when?	

PRESENT COMPLAINTS

List all parts of your body where you have symptoms:	
Do you have pain? ☐ Yes ☐ No Where?	
Is your pain? ☐ Sharp ☐ Dull ☐ Aching	
Is your pain? ☐ Occasional ☐ Frequent ☐ Constant ☐ Mild ☐ Slight ☐ Moderate ☐ Severe	
On a scale of 1-10 (10 being the worst pain imaginable) please rate your pain at its worst: ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ 7 ☐ 8 ☐ 9 ☐ 10	
Do you have any of the following?	
Numbness? ☐ Yes ☐ No Where?	
Tingling? ☐ Yes ☐ No Where?	
Stiffness? ☐ Yes ☐ No Where?	
Weakness? ☐ Yes ☐ No Where?	
Swelling? ☐ Yes ☐ No Where?	
Popping? ☐ Yes ☐ No Where?	
Grinding? ☐ Yes ☐ No Where?	
Locking? ☐ Yes ☐ No Where?	
Giving Way? ☐ Yes ☐ No Where?	
Deformity? ☐ Yes ☐ No Where?	
Radiation of pain? ☐ Yes ☐ No Where?	
Bowel or bladder problems? ☐ Yes ☐ No	
What makes the pain worse?	
What makes the pain better?	
Since the injury, has the problem gotten: ☐ Worse ☐ Better ☐ Same	

Have you had a previous **WORK-RELATED** INJURY? ☐ Yes ☐ No When?

If yes, please describe:

Who was your employer at the time of the injury?

Did you fully recover? ☐ Yes ☐ No

Did you have surgery? ☐ Yes ☐ No If yes, please explain:

Did you receive a permanent disability settlement? ☐ Yes ☐ No

Have you had a previous **NON-WORK** RELATED INJURY? ☐ Yes ☐ No When?

If yes, please describe:

Did you fully recover? ☐ Yes ☐ No

Have you had ever injured the same body part that you are being seen for today? ☐ Yes ☐ No

If yes, please explain:

Did you fully recover? ☐ Yes ☐ No

Have you ever had any of the following medical conditions? If so, please check:

☐ Arthritis ☐ Gout ☐ Emotional Problems ☐ Bleeding Disorders ☐ Liver Disease ☐ Glaucoma ☐ Cancer ☐ High Blood Pressure
☐ Diabetes ☐ Ulcers ☐ Kidney Disease ☐ Heart Disease ☐ Tuberculosis ☐ Pneumonia ☐ Thyroid Disease

List all other medical conditions: _____

Have you had any surgeries? ☐ Yes ☐ No If yes, please list including dates: _____

List current medications:

Any allergies to medication: ☐ Yes ☐ No If yes, please list including dates: _____

Have you ever been hospitalized? ☐ Yes ☐ No If yes, please explain:

FAMILY HISTORY

Does your mother, father, brothers or sisters have any of the following? If so, please check:

☐ Arthritis ☐ Gout ☐ Diabetes ☐ Rheumatism ☐ Thyroid Problems ☐ Heart Disease

SOCIAL HISTORY

MARITAL STATUS ☐ Married ☐ Single ☐ Divorced ☐ Widowed ☐ Other:

Do you have children? ☐ Yes ☐ No If yes, please list ages:

Do you smoke? ☐ Yes ☐ No If yes, how much? How long?

Do you drink alcohol? ☐ Yes ☐ No If yes, how much?

Hobbies / Interests / Sports:

Level of education (highest grade completed):

WORK STATUS

Do you have a concurrent job? ☐ Yes ☐ No

Are you currently working? ☐ Yes ☐ No If yes, regular or modified work? ☐ Regular ☐ Modified

If modified, what restrictions were given?

Please list dates you missed work From: To:

Are you still employed? ☐ Yes ☐ No

If not, where are you working?

New job? ☐ Yes ☐ No If so, start date?

JOB DESCRIPTION

Describe daily job duties at the time of injury:

Mark your usual work duties prior to your injury with the following letters:
N - Not at all **O** - Occasionally (25%) **F** - Frequently (30-75%) **C** - Constantly (80% or more)

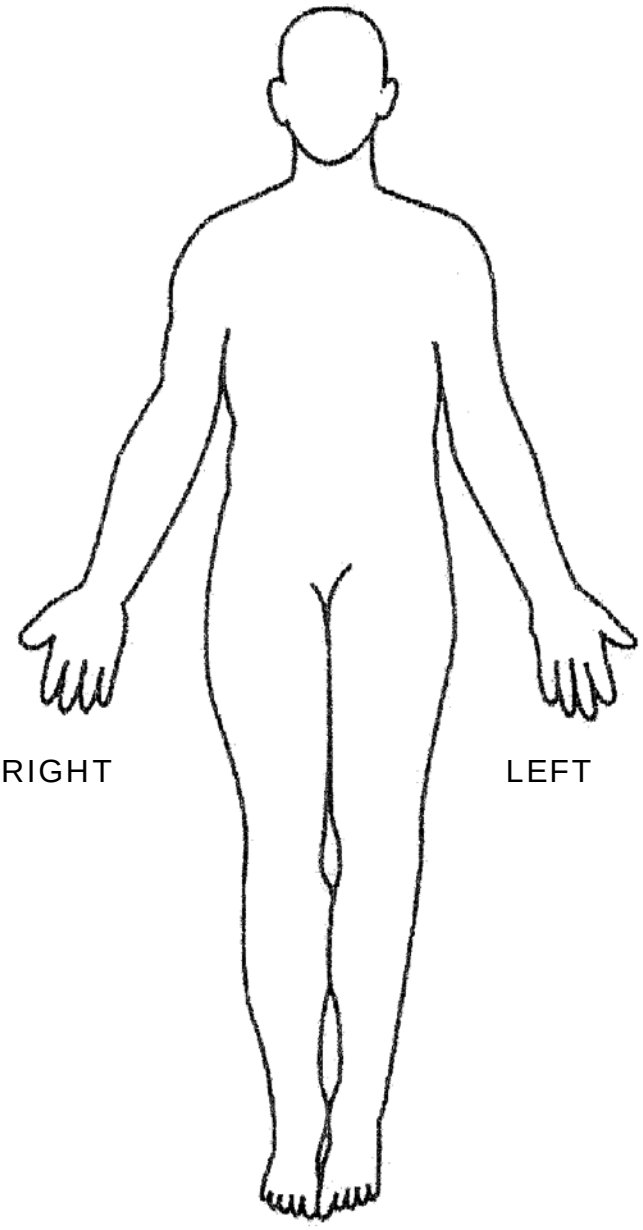
Stand	Kneel	Reach	Bend	Walk	Climb
Stoop	Twist	Push	Pull	Squat	Drive vehicle
Overhead work	Detailed handwork		Exposure to dust		
Computer/keyboarding _____ How many hours per day?			Exposure to noise		
Lift an average weight of _____ lbs			Exposure to gas		
Maximum weight of _____ lbs			Exposure to fumes		
Prior to your injury, what was your work schedule?			Hours worked per day:		
Days per week?			Overtime?		

PAIN DRAWING GRID ASSESSMENT

Please mark the areas where you experience the following sensations:

ACHE	BURNING	NUMBNESS	PINS & NEEDLES	STABBING
^^^^	XXXX	OOOO	= = = =	/ / / /

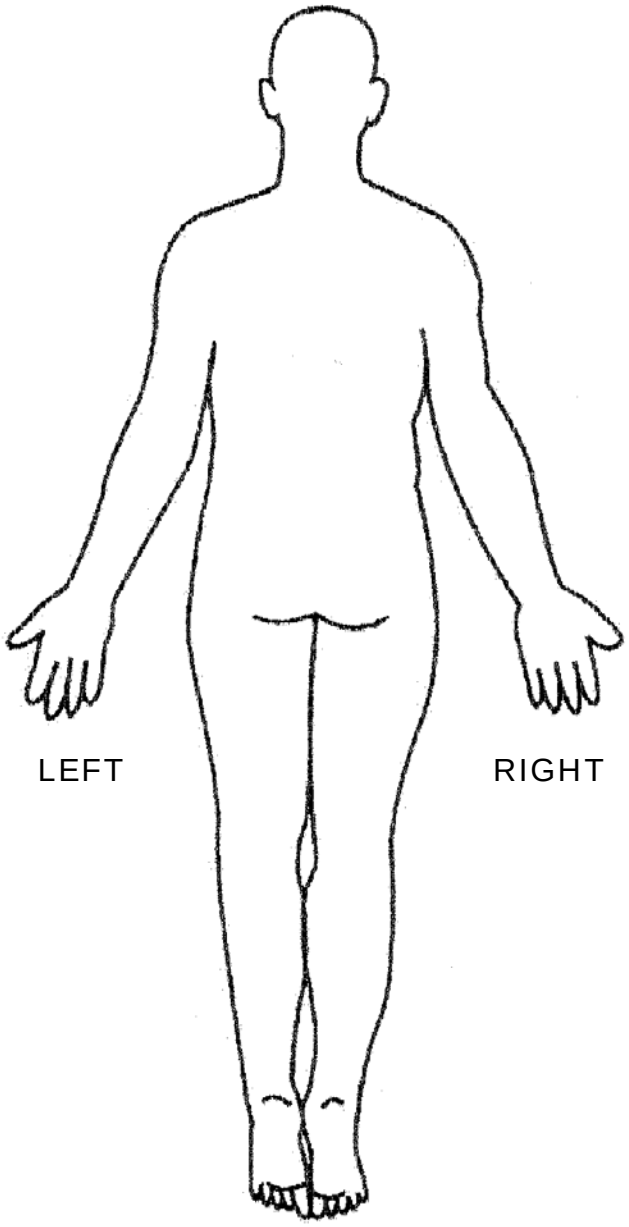
FRONT



RIGHT LEFT

FRONT

BACK



LEFT RIGHT

BACK