WORKERS' COMPENSATION HISTORY

THE FOLLOWING INFORMATION CONCERNS YOUR GENERAL HEALTH AND BACKGROUND. ALTHOUGH SOME OF THE QUESTIONS MAY NOT APPEAR TO APPLY TO YUR PRESENT INJURY, THE INFORMATION MAY HELP THE DOCTOR DIAGNOSE YOUR CONDITION.

PLEASE FILL IN THE FORM AS COMPLETELY AS POSSIBLE.
NOTIFY OUR STAFF IF YOU HAVE ANY QUESTIONS; THEY WILL BE GLAD TO HELP YOU.
PHONE: (714) 841-5333

Patient's Last Name: _____ First Name: _____ Date: _____

Street Address: _____ City: _____

Zip: _____ Home Phone: (_____)_____ Work Phone: (_____)_____

Social Security# _____ Driver Lic#: _____

Date of Birth: _____ Age: _____ Sex: M F

Smoker: YES NO Married: YES NO

Height: _____ Weight: _____ RIGHT / LEFT Handed

Nearest Relative _____ Relative's Phone#: _____

INJURY INFORMATION

Date of Injury: _____ Time of Injury: _____

Employer at time of injury: _____

When were you hired:_____ How many years/months worked: _____

Date Claim filed: _____ Last date of employment: _____

Please list all parts of the body injured: _____

Prior to the date(s) above have you ever injured the same area(s) of your body? _____
S

_____

Did you have a pre-employment physical examination? **YES NO**

Any work restrictions based on that exam? **YES NO** Explain: _____

Describe how the injury happened: (Did you fall, were your struck by something, were you in an auto accident, were you using special equipment, etc…) **(Develop history from injury date to present date including care and treatment of the injured, dates of work & doctor's visits)**

_____

_____

_____

_____

_____ (OVER) →

Describe what part of your body was injured in the accident:

_____

What kind of pain or discomfort did you experience at the time of injury?

_____

Did you report the accident at the time of injury? **YES NO** to Whom?: _____

Were there any witnesses to the accident, if so, who? _____

Activities of Daily Living

Has this injury or condition affected your activities of **Daily Living**? **YES** or **NO**

Do you have difficulty or need help with any of the following daily activities? (Circle affected activity):
Bathing, Grooming, Dressing, Eating, Defecating, Urinating, Combing/Brushing Hair

Explain: _____

Can you? (circle all applicable):
Stand, Sit, Recline, Walk, Stoop, Kneel, Reach, Bend, Twist, Lean

Have Trouble? (circle all applicable):
Seeing, Tactile Feelings, Tasting, Smelling

Explain:_____

Do you have difficulties? (Circle all applicable):
Grasping, Holding, Pinching, Percussive Movements, Sensory Discrimination

Explain:_____

Do you have difficulties? (Circle all applicable):
Riding a Bicycle, Driving a vehicle, Traveling by plane, Train, Car

Do you have difficulty participating in desired sexual activity
(Orgasm, Ejaculation, Lubrication, Erection)? YES or NO

Explain: _____

Can you participate in? (Circle all applicable)
Individual, Group Activities, Sports, Any other Hobbies: _____

Are you under the care of a psychologist or psychiatrist for any reason? ☐No ☐Yes Explain:

_____

Sleep History

The following questionnaire will help you measure your general level of daytime sleepiness. You are to rate the chance that you would doze off or fall asleep during different routine daytime situations. Each item is rated from 0 to 3, with 0 meaning you would never doze off or fall asleep in a given situation, and 3 meaning that there is a verynhigh chance that you would doze or fall asleep in that situation.

1. Sitting and resting 0__ 1__ 2__ 3__

GAF	WPI
1	90
2	89
3	89
4	88
5	87
6	87
7	86
8	85
9	84
10	84
11	83
12	82
13	82
14	81
15	80
16	80
17	79
18	78
19	78
20	77
21	76
22	76
23	75
24	74
25	73
26	73
27	72
28	71
29	71
30	70
31	69
32	67
33	65

GAF	WPI
34	63
35	61
36	59
37	57
38	55
39	53
40	51
41	48
42	46
43	44
44	42
45	40
46	38
47	36
48	34
49	32
50	30
51	29
52	27
53	26
54	24
55	23
56	21
57	20
58	18
59	17
60	15
61	14
62	12
63	11
64	9
65	8
66	6

GAF	WPI
34	63
35	61
36	59
37	57
38	55
39	53
40	51
41	48
42	46
43	44
44	42
45	40
46	38
47	36
48	34
49	32
50	30
51	29
52	27
53	26
54	24
55	23
56	21
57	20
58	18
59	17
60	15
61	14
62	12
63	11
64	9
65	8
66	6

2. Watching television 0__ 1__ 2__ 3__
3. As a passenger in a car for an hour without a break 0__ 1__ 2__ 3__
4. Lying down to rest in the afternoon 0__ 1__ 2__ 3__
5. Sitting and talking to someone 0__ 1__ 2__ 3__
6. Sitting quietly after lunch (when you've had no alcohol) 0__ 1__ 2__ 3__
7. In a car while stopped in traffic 0__ 1__ 2__ 3__

PAST MEDICAL TREATMENT

What occurred immediately after the incident? (Were you provided with medical treatment, etc…):

_____

_____

Did you go to a hospital/Clinic? **YES** **NO** When? _____

If you did not seek or receive medical treatment immediately following the incident, when and for what reason, did you first seed or receive medical care?

_____

_____

Name of Doctor/Specialist: _____ (D.O., M.D., or Chiropractor?)

Treatment: _____

Frequency and duration of the treatment: _____

Who Referred you to the Doctor/or Chiropractor? _____

Did you see any other doctor/chiropractors prior to presenting to our office? **YES** **NO**

Name of Physician: _____ Date Seen: _____

Type of Treatment rendered: _____

CURRENT TREATMENT

Name of Doctor: _____ Treatment rendered: _____

Diagnosis: _____

Chiropractor's Name: _____ Location: _____

Diagnosis: _____ Treatment: _____

Who referred you to Chiropractor:

_____

How long is each treatment _____ How often: _____

Does it help? **YES NO** How long have you been treating?: _____

Physical Therapy: What does the therapist do for treatment?: _____

How long is the treatment _____ How often: _____ Does it help? **YES NO**

Following your first medical care, did you see any other doctors or undergo any special tests? MRI, CT SCAN, X-RAY, If so, please list the doctor or facility visited and briefly state why you saw them. (referred by someone else or due to pain and discomfort, etc.)

_____

_____

What were the findings on the tests? _____

_____

Current Complaints?

_____

_____

What did the doctor tell you was wrong with you? _____

What makes the pain better?_____

What makes the pain worse? _____

When or how often do you experience pain: _____

PAST MEDICAL HISTORY

Personal doctor/Chiropractor _____

City _____ Phone: (_____) _____

Your personal doctor has treated you for the following: Please list:

_____

Do you have, or have you ever had any of the following (Please Circle)

Alcoholism	Y	N	Gout	Y	N
Anemia	Y	N	Heart trouble	Y	N
Arthritis	Y	N	High Blood pressure	Y	N
Edema(Swelling)	Y	N	Kidney disease	Y	N
Bleeding Disorder	Y	N	Liver Disease	Y	N
Cancer	Y	N	Mental illness	Y	N
Diabetes	Y	N	Migraine headaches	Y	N
Emphysema	Y	N	Stomach ulcers	Y	N

Epilepsy	Y	N	Stroke			Y	N
Glaucoma	Y	N	Tuberculosis	Y	N		
Drug Abuse	Y	N	HIV – Aids virus	Y	N		

Other serious diseases: _____

Previous motor vehicle accidents _____ Date: _____

Previous Work Comp. accidents _____ Date: _____

Previous wounds/burns _____

Orthopedic problems (describe) _____

Operations/Surgeries (please circle)

Appendix	Y	N	when_____
Gallbladder	Y	N	when_____
Hernia	Y	N	when_____
Hysterectomy	Y	N	when_____
Stomach	Y	N	when_____
Tonsils	Y	N	when_____

Other operations or surgeries: _____

Have you been hospitalized for any other problems? Please describe:

_____

Do you have any other claims or suits pending? **YES** **NO** Explain: _____

Are you currently taking ANY medication, if so, please list: _____

Are you allergic to any medications? Please List: _____

How and when did you discover you had allergic problems? _____

FAMILY HISTORY

Father: Alive / Deceased AGE_____ HEALTH _____
Mother: Alive / Deceased AGE_____ HEALTH _____

Do you have brothers? **Y** **N** How many? _____ Health _____

Do you have sister? **Y** **N** How Many? _____ Health _____

PERSONAL & SOCIAL HISTORY

Do you smoke? **Y** **N** If so, How much? _____ Since: _____

Do you drink? **Y** **N** If so, How Much? _____ Since: _____

Do you drink: Wine:_____ Beer: _____ Hard Liquor: _____

Marriage Status (Circle) **SINGLE MARRIED DIVORCED WIDOWED SEPERATED**

Children? **Y** **N** How Many?_____

Country of Birth _____ How long in U.S. _____

Highest level of education completed _____ Grade: _____ Year_____

Military history: Branch: _____ Date entered: _____ Date discharged: _____

Type of discharge: _____

OCCUPATIONAL HISTORY

Employer at time of injury: _____

When did you begin working there? _____ Job Title: _____

Work hours: From: _____ To: _____ Days: **M T W TH F S SUN**

Work restrictions when hired? **YES NO** if so, please list: _____

Are you presently working for the same company where you were injured? **YES NO**

If not, when did you leave your employer? _____ Why: _____

Do you have any concurrent jobs when _____? **Y** **N** Where: _____

If you have a new employer, what is your current job description? _____

Employers Name: _____ Location:_____

When did you start the new Job? _____

What are your physical duties at the new job? _____

Are you Full Time? **Y** **N** Part Time? **Y** **N**

Any restrictions? _____

If you are not presently working at all, are you seeking a new job? _____

How long have you been off work? _____

Who advised you to be off work? _____

If you are on medical leave, when are you expected to return to work? _____

List employer and dates of employment BETWEEN the job in which you injured yourself and your current employer:

_____

Do you feel you are able to return to work? **YES** **NO** in what capacity? _____

PAST EMPLOYERS – PLEASE FILL OUT COMPLETELY

Employer: Dates Worked (From/To) Job Title All dates injured:

1) _____

2) _____

3) _____

PLEASE NOTE THE FOLLOWING INFORMATION PERTAINING TO THE SPECIFIC JOB REQUIREMENTS AT THE TIME OF INJURY:

General job description at time of injury: _____

Divide you typical 8 hour day into SITTING, STANDING AND WALKING:

SITTING	1	2	3	4	5	6	7	8	HOURS
STANDING	1	2	3	4	5	6	7	8	HOURS
WALKING	1	2	3	4	5	6	7	8	HOURS

NOTE:	**Occasional**	**=**	**33% of the time**
	Frequently	**=**	**33-66% of the time**
	Continuous	**=**	**66-100% of the time**

Check the frequency of activity required to perform your job.

ACTIVITY (Hours per day)	**NEVER** 0 hours	**OCCASIONALLY** Up to 3 hours	**FREQUENTLY** 3 -6 hours	**CONSTANTLY** 6 – 8 + hours
Sitting				
Walking				
Standing				
Bending (Neck)				
Bending (Waist)				
Squatting				
Climbing				
Kneeling				
Crawling				
Twisting (Neck)				
Twisting (Waist)				
Hand use: Dominant hand Right__ Left__				
Is repetitive use of hand required?				
Simple Grasping (right hand)				
Simple Grasping (left hand)				
Power Grasping (right hand)				
Power Grasping (left hand)				
Fine Manipulation (right hand)				
Fine Manipulation (left hand)				
Pushing & Pulling (left hand)				
Pushing & Pulling (right hand)				

Reaching (above shoulder level)				
Reaching (below shoulder level)				

	LIFTING					Carrying				
	Never 0 hrs	Occasionally Up to 3 hours	Frequently Up to 3hrs.	Constantly 6-8 + hrs.	Height	Never	Occasionally	Frequently	Constantly 6-8 hrs.	Distance
0-10 lbs.										
11-25 lbs.										
26-50 lbs.										
51-75 lbs.										
76-100 lbs.										
100+ lbs.										

Please describe the heaviest item required to carry and the distance to be carried:

_____

_____

Please indicate if your job requires:	YES	NO	(IF YES, PLEASE BRIEFLY DESCRIBE)
a. Driving cars, trucks, forklifts and other equipment?	☐	☐	_____
b. Working around equipment and machinery?	☐	☐	_____
c. Walking on uneven ground?	☐	☐	_____
d. Exposure to excessive noise?	☐	☐	_____
e. Exposure to extremes in temperature, humidity?	☐	☐	_____
f. Exposure to dust, gas, fumes, or chemicals?	☐	☐	_____
g. Working at heights?	☐	☐	_____
h. Operation of foot controls or repetitive protective gear?	☐	☐	_____
i. Use of special visual or auditory protective equipment?	☐	☐	_____
j. Working bio-hazards such as: blood borne pathogens, sewage, hospital waste, etc.	☐	☐	_____

Were you required to use your feet in repetitive movements? (as in operating foot controls):

RIGHT FOOT: YES NO
LEFT FOOT: YES NO

Please list types of machines, tools, or other equipment used in your job: (At Time Of Injury):

_____

(Over ⟶)

PACIFICA ORTHOPEDICS
Sports Medicine & Rehabilitation Center

DISCLOSURE STATEMENT

THIS INFORMATION IS TRUE AND CORRECT TO THE BEST OF MY KNOWLEDGE:

PATIENT SIGNATURE: _____ DATE: _____

Interpreter Name: _____Certification Number:_____

Agency Name:_____ PHONE#: (_____)_____

_____
Interpreter Signature

PACIFICA ORTHOPEDIC & SPORTS MEDICINE CENTER
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HUNTINGTON BEACH, CA. 92648
(714) 841-5333 / FAX: (714) 841-5303

CONSENT FOR MEDICAL TREATMENT

I HEREBY CONSENT TO AND AUTHORIZE THE ADMINISTRATION OF ALL TREATMENTS THAT MAY BE CONSIDERED ADVISABLE OR NECESSARY IN THE JUDGMENT OF THE PHYSICIAN, AND I AUTHORIZE THIS MEDICAL CLINIC AND THE PHYSICIAN TO FURNISH INFORMATION TO INSURANCE CARRIERS OF THEIR TREATMENT.

PATIENT: _____ DATE: _____

OTHER PERSON RESPONSIBLE: _____

WITNESS: _____