WORKERS COMPENSATION QUESTIONNAIRE

Today's Date: _____ /_____/_____

WELCOME: The doctor and staff welcome you and want you to provide you with the best possible care. We will conduct a thorough history and physical examination to decide if we can assist you. If we do not believe that your condition will respond to our care, we will refer you to the appropriate healthcare provider. If you are a candidate for care in this office, then a treatment plan will be recommended to fit your individual needs.

INSTRUCTIONS: Please complete the following information in its entirety. The information submitted on this form is strictly confidential. If you have difficulty understanding any portion of this for, please ask for assistance. If the question does not pertain to you, simply write in N/A for non-applicable.

PERSONAL INFORMATION:

Name: (*First*)_____ (*Middle*)_____(*Last*)_____
Address: _____ City: _____ State: _____
Zip: _____ Birth Date: _____ /_____/_____ Age: ___
Marital Status (*Circle*): Divorced Married Single Separated Widowed
Cell Phone: (_____)_____-_____Cell Phone Carrier_____
Email Address: _____@_____

Emergency Contact Information
Name: (*First*)_____ (*Last*)_____
Relationship: _____ Home Phone: (_____) _____-_____ Cell Phone: (_____) _____-_____

PAYMENT/INSURANCE INFORMATION:

Is the condition(s) that brought you here today due to an on-the-job injury?
□ Yes □ No
Who besides yourself is responsible for your bill? □Self-Pay Health Insurance
Medicare Medicaid □ Worker's Comp
Auto Insurance □ Other (*Be Specific*): _____
Please give a copy of all present health insurance cards.

WORKERS COMPENSATION QUESTIONS

Date of Injury: _____Time: _____AM/PM
Location (city and state where injury occurred): _____
Did patient go to the hospital? ___Yes ___No Via: Ambulance_____Other Indicate:
_____
Did the patient suffer and cuts or contusions? ____Yes ____No Describe: _____
Is the patient working at the present time? ____Yes ____No Date last worked: _____
Has the patient missed any time from work? ___Yes ____No Dates: _____
At work patient is required to (in hours): Stand_____ Drive_____ Walk_____ Lift_____
Sit_____ Type _____ Other (Describe):_____
What limitations does patient experience as a result of the injury: (circle the affected area(s) below):
Standing Driving Walking Lifting Sitting Typing
Other(describe):_____
Further describe limitations:_____

DR INITIALS_____

PRIMARY COMPLAINT:

_____

When did it start? _____

Describe the condition: _____

What do you think caused the problem? _____

Rate the pain from 1-10: At its worst ____ At the present time ___ At least severe ___

Does the pain travel? □ Yes □ No If yes, from where to where? _____

Is condition getting worse? □ Yes □ No

List the activities that this condition prevents you from doing? _____

SECOND COMPLAINT:

_____

When did it start? _____

Describe the condition: _____

What do you think caused the problem? _____

Rate the pain from 1-10: At it's worst ____ At the present time ___ At least severe ___

Does the pain travel? □ Yes □ No If yes, from where to where? _____

Is condition getting worse? □ Yes □ No

List the activities that this condition prevents you from doing? _____

_____

THIRD COMPLAINT:

_____

When did it start? _____

Describe the condition: _____

What do you think caused the problem? _____

Rate the pain from 1-10: At it is worst ____ At the present time ___ At least severe ___

Does the pain travel? □ Yes □ No If yes, from where to where? _____

Is condition getting worse? □ Yes □ No

List the activities that this condition prevents you from doing? _____

_____

LIST MEDICATIONS, VITAMINS, SUPPLEMENTS:

_____

_____

_____

_____

_____

LIST PAST TRAUMA, ACCIDENTS, INJURIES, HOSPITALIZATIONS, SURGERIES:

_____

_____

_____

_____

_____

DR INITIALS_____

LIST FAMILY HISTORY, SOCIAL HISTORY, EXERCISE LEVEL, SMOKING, STRESS LEVEL:

_____

_____

_____

_____

_____

Primary Care or Treating Facility:
NAME_____
ADDRESS_____
PHONE_____FAX_____

AUTHORIZATION FOR RELEASE OF INFORMATION:

I authorize the release of any medical information necessary to process my insurance claims.

AUTHORIZATION OF ASSIGNMENT:

I authorize payment of medical benefits to _____ for services rendered to me.

ACCEPTANCE AS A PATIENT:

I understand and agree that this office has the right to refuse to accept me as a patient at any time before treatment begins, or terminate my care as a patient if in the course of treatment if I am not following the treatment plan for my condition, or be referred out to another health provider as the doctor deems medically necessary. I understand that the taking of a history and the conducting of a physical examination are not considered treatment, but are part of the process of information
gathering so that the doctor can determine whether to accept me as a patient.

_____
PATIENT PRINTED NAME

_____
PATIENT SIGNATURE

_____
DATE

DR INITIALS _____

REVIEW OF SYSTEMS

Patient Name: _____ Patient File #: _____ Today's Date: _____ /_____/_____

INSTRUCTIONS: Please fill out all of the sections. If none of the conditions apply, select "None."

Constitutional:
- ☐ **None**
- ☐ Chills
- ☐ Daytime Drowsiness
- ☐ Fatigue
- ☐ Fever
- ☐ Night Sweats
- ☐ Weight Gain
- ☐ Weight Loss

Eyes/Vision:
- ☐ **None**
- ☐ Blindness
- ☐ Blurred Vision
- ☐ Cataracts
- ☐ Change in Vision
- ☐ Double Vision
- ☐ Eye Pain
- ☐ Field Cuts
- ☐ Glaucoma
- ☐ Itching *(around the eyes)*
- ☐ Photophobia
- ☐ Tearing
- ☐ Wears Glasses or Contacts

Ears, Nose and Throat:
- ☐ **None**
- ☐ Bleeding
- ☐ Dental Implants
- ☐ Dentures
- ☐ Difficulty Swallowing
- ☐ Discharge
- ☐ Dizziness
- ☐ Ear Drainage
- ☐ Ear Infection*(s)*
- ☐ Ear Pain
- ☐ Fainting
- ☐ Headaches
- ☐ Head Injury *(history of)*
- ☐ Hearing Loss
- ☐ Hoarseness
- ☐ Loss of Smell
- ☐ Nasal Congestion
- ☐ Nose Bleeds
- ☐ Post Nasal Drip
- ☐ Rhinorrhea *(runny nose)*
- ☐ Sinus Infections
- ☐ Snoring
- ☐ Sore Throats
- ☐ Tinnitus *(ringing in the ears)*
- ☐ TMJ Disorder

Cardiovascular:
- ☐ **None**
- ☐ Angina *(chest pain or discomfort)*
- ☐ Chest Pain
- ☐ Claudication *(leg pain or achiness)*
- ☐ Heart Murmur
- ☐ Heart Problems
- ☐ Orthopnea *(difficulty breathing while lying)*
- ☐ Palpitations *(irregular or forceful heart beat)*
- ☐ Paroxysmal Nocturnal Dyspnea *(shortness of breath at night)*
- ☐ Shortness of Breath
- ☐ Swelling of Leg*(s)*
- ☐ Ulcers
- ☐ Varicose Veins

Gastrointestinal:
- ☐ **None**
- ☐ Abdominal Pain
- ☐ Belching
- ☐ Black, Tarry Stools
- ☐ Constipation
- ☐ Diarrhea
- ☐ Difficulty Swallowing
- ☐ Heartburn
- ☐ Hemorrhoids
- ☐ Indigestion
- ☐ Jaundice *(yellowing of the skin)*
- ☐ Nausea
- ☐ Rectal Bleeding
- ☐ Abnormal Stool Caliber *(quality)*
- ☐ Abnormal Stool Color
- ☐ Abnormal Stool Consistency
- ☐ Vomiting
- ☐ Vomiting Blood

Respiration:
- ☐ **None**
- ☐ Asthma
- ☐ Coughing up blood
- ☐ Shortness of Breath
- ☐ Sputum Production
- ☐ Wheezing

Endocrine:
- ☐ **None**
- ☐ Cold Intolerance
- ☐ Diabetes
- ☐ Excessive Appetite
- ☐ Excessive Hunger
- ☐ Excessive Thirst
- ☐ Frequent Urination
- ☐ Goiter
- ☐ Hair Loss
- ☐ Heat Intolerance
- ☐ Unusual Hair Growth
- ☐ Voice Changes

Skin:
- ☐ **None**
- ☐ Changes in Nail Texture
- ☐ Changes in Skin Color
- ☐ Hair Growth
- ☐ Hair Loss
- ☐ Hives
- ☐ Itching
- ☐ Paresthesia (numbness, prickling, or tingling)
- ☐ Rash
- ☐ History of Skin Disorders
- ☐ Skin Lesions or Ulcers
- ☐ Varicosities

Nervous System:
- ☐ **None**
- ☐ Dizziness
- ☐ Facial Weakness
- ☐ Headaches
- ☐ Limb Weakness
- ☐ Loss of Consciousness
- ☐ Loss of Memory
- ☐ Numbness
- ☐ Seizures
- ☐ Sleep Disturbance
- ☐ Slurred Speech
- ☐ Stress
- ☐ Strokes
- ☐ Tremors
- ☐ Unsteadiness of Gait

Allergy:
- ☐ **None**
- ☐ Anaphylaxis *(history of)*
- ☐ Food Intolerance
- ☐ Itching
- ☐ Nasal Congestion
- ☐ Sneezing

Hematology:
- ☐ **None**
- ☐ Anemia
- ☐ Bleeding
- ☐ Blood Clotting
- ☐ Blood Transfusion*(s)*
- ☐ Bruises easily
- ☐ Fatigue
- ☐ Lymph Node Swelling

Psychological:
- ☐ **None**
- ☐ Anhedonia *(inability to experience joy or enjoy life)*
- ☐ Anxiety
- ☐ Appetite Changes
- ☐ Behavioral Change*(s)*
- ☐ Bipolar Disorder
- ☐ Confusion
- ☐ Convulsions
- ☐ Depression
- ☐ Insomnia
- ☐ Memory Loss
- ☐ Mood Change*(s)*

Female:
- ☐ **None**
- ☐ Birth Control Therapy
- ☐ Breast Lumps / Pain
- ☐ Burning Urination
- ☐ Cramps
- ☐ Frequent Urination
- ☐ Hormone Therapy
- ☐ Irregular Menstruation
- ☐ Urine Retention
- ☐ Vaginal Bleeding
- ☐ Vaginal Discharge

Male:
- ☐ **None**
- ☐ Burning Urination
- ☐ Erectile Dysfunction
- ☐ Frequent Urination
- ☐ Hesitancy or Dribbling
- ☐ Prostate Problems
- ☐ Urine Retention

Patient Signature: _____

FOR OFFICE USE ONLY:

I have reviewed the above ROS with the above-named patient: _____ Doctor Signature _____ Date