WRITE LEGIBLY

WORKERS' COMPENSATION PATIENT HISTORY

WRITE LEGIBLY

Name ______ Date ______ File # ______

30 HISTORY OF OCCURENCE

10 Employer's business name (at time of accident) ______

Employer's phone ______ Employer's address ______

City ______ State ______ Zip ______

Occupation ______ Describe your job: ______

Date of injury: ______ Time of injury: ______ AM PM Last date worked: ______

What were you doing at the time you were injured? How did the accident/injury happen (lifting, bending, walking, carrying, standing, etc.)?

______

______

When did pain begin? Where in your body did you first feel it? Was pain intense at first, or did you feel pain that gradually worsened?

PLEASE BE SPECIFIC ______

______

______

20 Describe the environmental conditions which may have contributed to your present injury: Darkness, faulty equipment, slippery floor, limited space. *(Distinguish natural hazards from hazards created by other employees such as housekeepers)*:

______

______

40 FIRST DOCTOR/HOSPITAL SEEN

10 Were you hospitalized as a result of this accident? ☐ No

20 If yes, what hospital did you go to? ______

DOCTOR 1: Name ______ Date of first visit: ______

Were you examined? ☐ Yes ☐ No Were X-rays taken? ☐ Yes ☐ No

30 Did you receive treatment? ☐ No

40 If yes, what kind of treatment did you receive? ______

What benefits did you receive from the treatment? ______

50 Date of last treatment: ______

50 SECOND DOCTOR/CLINIC SEEN

10 DOCTOR 2: Name ______ Date of first visit: ______

Were you examined? ☐ Yes ☐ No Were X-rays taken? ☐ Yes ☐ No

20 Did you receive treatment? ☐ No

30 If yes, what kind of treatment did you receive? ______

What benefits did you receive from the treatment? ______

40 Date of last treatment: ______

©Copyright 1991 Michael E. Whitton, D.C., P.C.

60 THIRD DOCTOR/CLINIC SEEN

10 DOCTOR 3: Name ____________ Date of first visit: ____________

Were you examined? ☐ Yes ☐ No Were X-rays taken? ☐ Yes ☐ No

20 Did you receive treatment? ☐ No

30 If yes, what kind of treatment did you receive? ____________

What benefits did you receive from the treatment? ____________

40 Date of last treatment: ____________

70 REPORT ACCIDENT TO/ACCIDENT WITNESS

10 What date did you report this injury? ____________

Whom did you report this to? ____________

What is their position? ____________

20 Was there a witness to your injury? ☐ No

30 If yes, what was the witness' name? ____________

What is their position? ____________

80 PRIOR SIMILAR SYMPTOMS

10 Did you have any physical complaints **just before this accident?** ☐ No

20 If yes, please describe any physical complaints **just before this accident:** ____________

30 Have you ever had any **prior** injuries, accidents, diseases, or treatment to the area of your body now affected? ☐ No

40 If yes, state what part of your body was **previously** injured: ____________

Date hurt: ____________ Describe the injury: ____________

____

____

50 Were you treated? ☐ No

60 If yes, who treated you? ____________

What date did treatment begin? ____________ When did treatment end: ____________

70 When was the last time (date) you felt pain or problems from that injury? ____________

90 WORK STATUS HISTORY

10 Have you lost any time from work as a result of this new injury? ☐ No

20 If yes give dates of time loss: ____________

30 If you are currently on **disability (time loss)** do you want to go back to work doing your **regular** work duties? ☐ Yes

40 If no, state why you don't want to go back to your regular work duties: ____________

____

50 Have you gone back to work? ☐ No

51 If yes, what status of work? ☐ Modified ☐ Regular When: ____________

60 Please list what restrictions you have been placed on: ____________

____

70 If you have gone back to **work,** please list the activities as:

Those that are painful: ____________

80 Those that are difficult: ____________

©Copyright 1991 Michael E. Whitton, D.C., P.C.

90 Are there any problems you have with a fellow employee, supervisor, or management that need to be discussed? ☐ No

100 If yes, please discuss: ______________________________

____

____

100 ACTIVITIES OF DAILY LIVING

10 Do you find any activities that you perform at **home painful** or **difficult?** ☐ No

20 If yes, those **home** activities that you are **unable** to do *(be specific)*: ______________________________

____

30 Those **home** activities that are **painful** are *(be specific)*: ______________________________

____

40 Those **home** activities that are **difficult** are *(be specific)*: ______________________________

____

50 Are you performing exercises at **home** at this time? ☐ No

60 If yes, what exercises are they? ______________________________

How frequently do you perform them? ______________________________

Who prescribed these exercises to you? ______________________________

70 What exercises or activities could you do before the work-related injury that you no longer do because of pain or loss of function?

____

____

____

Do you have an attorney on this case? ☐ No

If yes, who? Name ______________________________

Address ______________________ City ______________________ State ____________ Zip ____________

©Copyright 1991 Michael E. Whitton, D.C., P.C.