Date: ____________

PATIENT INFORMATION

(Please Print)

LAST NAME: ____________________ **FIRST:** _______________ **MI:** _____ **SSN#:** _____________

Gender: Male Female **Date of Birth:** Month: _____ Day: ______ Year: __________

INJURY DETAIL

Was this an L&I or Motor Vehicle Accident? Yes No

If YES, provide the following:

LABOR & INDUSTRIES

Claim #: ______________________________________	**Date Filed:** Month: _____ Day: ______ Year: ________ **Date of Injury:** Month: _____ Day: ______ Year: ________

Insurance Carrier Name:	**Claim Manager Name:**	**Claim Manager #:**

Employer at the time of injury?

MOTOR VEHICLE ACCIDENT *(*We do not bill third party auto claims)*

Claim #: ______________________________________	**Date of Accident:** Month: _____ Day: ______ Year: ________

Personal Injury Protection (PIP) Ins. Company:	**Claim Adjustor Name:**	**Claim Adjustor #:**	
Address:	**City:**	**State:**	**Zip:**

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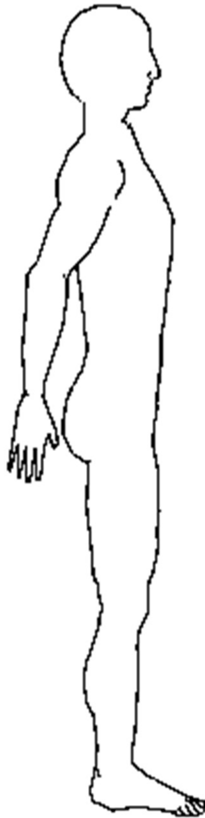
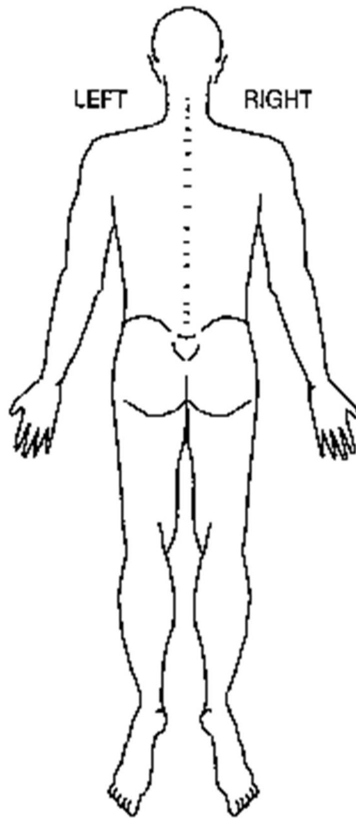
CHIEF COMPLAINT

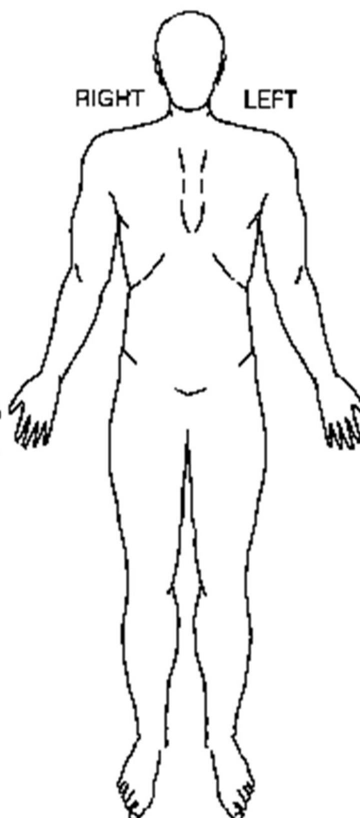
Chief Complaint: ________________________________ ____ ____ ____	**Date of Injury:** Month: _____ Day: _____ Year: _____

Please mark the areas on injury or discomfort on the chart below. Include all affected areas. Use the appropriate symbols indicated below. Darken symbol if more severe.

Numbness	Pins & Needles	Burning	Aching	Stabbing
- - - - - - - -	O O O O O O O	^ ^ ^ ^ ^ ^ ^	X X X X X X	+ + + + + +







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If required, use the space below to describe your condition further: ____________________________

____

____

____

If required, use the space below to describe your condition further: ____________________________

____

____

____

Have you had a previous injury to this area? ____

____

____

What makes it worse? ____

____

____

What makes it better? ____

____

____

What have you tried in the past to help with this (e.g. ice, heat, massage, rest, etc.)? ______________

____

____

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Which word best describes the **LEVEL** of pain/discomfort you are having today?			
None	*0*	*1*	*2*
	3	*4*	*5*
	6	*7*	*8*
	9	*10*	***Worse Pain Ever!***

Which word best describes the **TYPE** of pain/discomfort you are having today?		
Dull	*Achy*	*Burning*
Stabbing	*Numbness*	*Tingling*
Pulling	*Cramping*	*Tightness*

Which word best describes the **TIMING** of your pain/discomfort?
Constant
Comes & Goes
Getting Worse
Getting Better
Wakes Me at Night

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MEDICAL HISTORY - Has the patient had any of the following:

☐	Abdominal Aortic Aneurysm	☐	Crohn's Disease	☐	Hypothyroidism
☐	Angina	☐	Depression	☐	Irritable Bowel Syndrome
☐	Anxiety	☐	Diabetes Mellitus	☐	Kidney Disease
☐	Arrhythmia	☐	Emphysema	☐	Pituitary Tumor
☐	Asthma	☐	Gastric Reflux (GERD)	☐	Seizure Disorder
☐	Blood Disorder	☐	Heart Disease	☐	Stroke
☐	Cancer/Type:	☐	Heart Murmur	☐	Tuberculosis (TB)
☐	Cirrhosis	☐	Hepatitis	☐	Ulcerative Colitis
☐	Clotting Disorder	☐	Hyperlipidemia	☐	Ulcers
☐	COPD	☐	Hypertension	☐	Other:_

SURGICAL HISTORY - Has the patient had any of the following surgeries:

☐	Appendectomy	☐	Cosmetic Surgery	☐	Prostate Surgery
☐	Brain Surgery	☐	C-Section	☐	Small Intestine Surgery
☐	Breast Surgery	☐	Eye Surgery	☐	Spine Surgery
☐	Coronary Artery Angioplasty	☐	Fracture Surgery	☐	Tubal Ligation
☐	Coronary Artery Bypass Graft	☐	Hernia Repair	☐	Valve Replacement
☐	Cholecystectomy	☐	Hysterectomy	☐	Vasectomy
☐	Colon Surgery	☐	Joint Replacement	☐	Other:____________________

** If yes to any of the above, please provide additional details including dates:________________________

MEDICATIONS: List any medication(s) the patient is taking, including any over the counter medications, vitamins and supplements. Please also include the dosage and frequency of each medication:

____

____

____

____

____

ALLERGIES: List any allergies and the type of reaction the patient has to medications and/or foods:

____

____

REVIEW OF SYSTEMS: Are you experiencing any of the following symptoms? (check "X" all that apply)

☐	Fever/chills	☐	Abdominal pain	☐	Weakness
☐	Fatigue	☐	Loss of appetite	☐	Numbness or tingling
☐	Weight loss/gain	☐	Nausea/vomiting	☐	Dizziness
☐	Cough	☐	Heartburn	☐	Headaches
☐	Shortness of breath	☐	Constipation	☐	Easy bruising
☐	Chest pain	☐	Diarrhea	☐	Skin rash
☐	Trouble swallowing	☐	Blood in your stool	☐	Other:_________________

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FAMILY HISTORY: Place an "X" in the box that relates to the patient's family medical history

Relationship to Patient	Aneurysm	Breast Cancer	Cancer	Clotting Disorder	Colon Cancer	COPD/Emphysema	Diabetes	Gallbladder disease	Heart Attack	Heart Disease	Hyperlipidemia	Hypertension	Kidney Disease	Prostate Cancer	Stroke
Mother															
Father															
Sister															
Brother															
Maternal Grandmother															
Maternal Grandfather															
Paternal Grandmother															
Paternal Grandfather															
Other:_______________															
Other:_______________															

☐ Family History Unknown ☐ Adopted

SOCIAL HISTORY:

Tobacco Use (Please check one)

☐ Never Smoker

☐ Former Smoker - quit date: ____________________

☐ Current Smoker - # of packs per day: ____________________

Alcohol Use (Please check one)

☐ No

☐ Yes - # of drinks per day/week:____________________

Drug Use (Please check one)

☐ No

☐ Yes - Type:____________________ Frequency:____________________

Do you work? YES / NO

If yes, what do you do? ____________________

Who else lives in your household with you? ____________________

____

OTHER / ADDITIONAL NOTES:

____

____

____

____

____

____

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