INITIAL EVALUATION – Work Related Accident

LAST NAME: _____ FIRST NAME: _____ MI: ____ Date: _____

What brings you into our office? ☒ **Work Related Accident**

When did this accident happened? _____

Immediately after the accident, did you feel dazed? ☐ Yes ☐ No

Did you lose consciousness? ☐ Yes ☐ No

Was your head injured? ☐ Yes ☐ No

Immediately after the accident, did you experience: ☐ Headache ☐ Neck Paid ☐ Low Back Pain

Did you see another doctor before coming here? ☐ Yes ☐ No

Did you go to a hospital after the accident? ☐ Yes ☐ No If yes, which hospital? _____

How did you get to the hospital? ☐ Ambulance ☐ Drove self ☐ Somebody else ☐ Police

Were any of the following tests performed at the hospital?
☐ X-Rays ☐ MRI ☐ CT Scan ☐ Lab Work

Do you feel your condition is:☐ Improving ☐ Staying the same ☐ Getting Worse

Have you lost time from work? ☐ Yes ☐ No

Can you perform physical work activities: ☐ Yes ☐ No
If no, because of: ☐ Pain ☐ Weakness ☐ Stress

Can you go to sleep without problems? ☐ Yes ☐ No

Do you awaken because of pain? ☐ Yes ☐ No

Did you have sleep problems before? ☐ Yes ☐ No

Activities of Daily Living *Please select all activities which you are currently experiencing problems:*

☐ Seeing	☐ Tasting	☐ Smelling	☐ Eating	☐ Hearing	☐ Insomnia
☐Dressing	☐Reading	☐Typing	☐Writing	☐Grasping	☐ Using the toilet
☐ Standing	☐ Leaning	☐ Walking	☐ Stooping	☐ Squatting	☐ Loss of Sexual Drive
☐ Bending	☐ Twisting	☐ Carrying	☐ Lifting	☐ Pushing	☐ Restful sleeping
☐ Sitting	☐ Driving	☐ Sports	☐ Exercising	☐ Reclining	☐ Loss of concentration
☐ Irritable	☐ Riding in car	☐ Air Travel	☐ Climbing	☐ Pulling	☐ Changes in personality
☐ Grooming	☐ Pinching	☐ Kneeling	☐ Reaching	☐ Nervous	☐ Tactile feeling
☐ Bathing	☐ Holding				

Past Medical History *Please select all conditions that you have had or are currently having:*

□None	□Other	□Abdominal pain	□Abnormal Weight gain/loss	□Angina
□Anorexia	□Anxiety	□Aortic aneurysm	□Arthritis	□Asthma
□Bladder infection	□Blood disorder	□Brest lumps	□Breast Soreness	□Bronchitis
□Cancer	□Cardiovascular disease/heart attack	□Chest pain	□Chronic cough	□Chronic sinusitis
□Colitis	□Constipation	□Convulsions	□COPD	□Depression
□Dermatitis	□Diabetes	□Difficulty swallowing	□Dizziness	□Emphysema
□Endometriosis	□Epilepsy	□Excessive thirst	□Fainting	□Frequent urination
□General fatigue	□Gout	□Hand pain	□Headache	□Heart attack
□Heart disease	□Heartburn/Indigestion	□Hepatitis	□High Blood Pressure	□High cholesterol
□High PSA	□High triglycerides	□Hypertension	□Irregular menstrual	□Irritable colon
□Jaw pain	□Kidney disorders	□Kidney stones	□Liver problems	□Loss of appetite
□Loss of bladder control	□Low back pain	□Lung Disease	□Mental Disease	□Mid back pain
□Muscular in coordination	□Neck pain	□Osteoarthritis	□Pain in ankle or foot	□Pain in lower leg or knew
□Pain in upper arm or elbow	□Pain in upper leg and hip	□Painful urination	□PMS	□Pneumonia
□Profuse menstrual flow	□Prostate problems	□Rapid heart beat	□Renal Disease	□Theumatiod arthritis
□Scoliosis	□Shoulder pain	□Stroke	□Swelling/stiffness of joints	□Thyroid disease
□Tinnitus (ear noices)	□Tuberculosis	□Tumor	□Ulcer	□Visual disturbances
□Wrist pain	□**Gallbladder Problems**			

Family History *Please select all conditions that run in your family:*

□None	□Other	□Abdominal pain	□Abnormal Weight gain/loss	□Angina
□Anorexia	□Anxiety	□Aortic aneurysm	□Arthritis	□Asthma
□Bladder infection	□Blood disorder	□Brest lumps	□Breast Soreness	□Bronchitis
□Cancer	□Cardiovascular disease/heart attack	□Chest pain	□Chronic cough	□Chronic sinusitis
□Colitis	□Constipation	□Convulsions	□COPD	□Depression
□Dermatitis	□Diabetes	□Difficulty swallowing	□Dizziness	□Emphysema
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□Scoliosis	□Shoulder pain	□Stroke	□Swelling/stiffness of joints	□Thyroid disease
□Tinnitus (ear noices)	□Tuberculosis	□Tumor	□Ulcer	□Visual disturbances
□Wrist pain	Gallbladder problems			

Surgical History *Please select all surgeries that you have had in the past.*

□ None	□ Other	□ Abdominal Exploration	□ Abdominoplasty	□ Abortion
□ ACL Reconstruction	□ Adenoid Removal	□ Angioplasty	□ Appendectomy	□ Bone Fracture Repair
□ Breast Lump Removal	□ Bunion Remova	□ Carotid Artery Surgery	□ Cataract Surgery	□ Cervical spine Surgery
□Cholecystectomy	□ Cosmetic Breast Burgery	□ C-Section	□ Facelit	□ Gallbladder Removal
□ Gastric Bypass	□ Heart Bypass Surgery	□ Heart Surgery	□ Hemorrhoid Surgery	□ Hernia Repair
□ Hip Joint Replacement	□ Hysterectomy	□ Kidney Transplant	□ Knee Arthroscopy	□ Knee Joint Replacement
□ Knee surgery	□ LASIK Eye Surgery	□ Liposuction	□ Lumbar spine surgery	□ Mastectomy
□ Prostate Removal	□ Rotator Cuff Surgery	□ TMJ Surgery	□ Tonsillectomy	□ Vasectomy
	□ Surgical History was rev'd not contributory			

Medications *Please select all medications that you are currently taking:*

□ None	□ Other	□ Advil
□ Ambien	□ Analgesics	□ Anti-inflammatories
□ Aspirin	□ Atenolol	□ Blood Pressure Medication
□ Daily Vitamins	□ Diabetes Medication	□ Flexeril
□ Isorsubrine	□ Monopril	□ Motrin
□ Muscle relaxers	□ Pin Medication	□ Skelaxin
□ Synthroid	□ Tylenol	□ Vicodin

Allergies *Please select all items that you are allergic to:*

□ None	□ Other	□ Adhesive tape	□ Animal dande	□ Anticonvulsants
□ Barbiturates	□ Bee stings	□ Dirt	□ Dust mites	□ Eggs
□ Feathers	□ Felt tip pens	□ Fire ant stings	□ Fish	□ Gasoline fumes
□ Hair Spray	□ Histamine	□ Hornet stings	□ Insecticides	□ Insulin
□ Iodine	□ Latex	□ Milk	□ Mold	□Nail polish remover
□ New Carpet	□ Newspaper ink	□ Paint or paint thinner	□ Peanuts	□ Penicillin
□ Perfume	□ Pets	□ Pollen	□ Pool Chlorine	□ Seafood
□ Shampoo	□ Shellfish	□ Smoke	□ Soy	□ Sulfa Drugs
□ Tobacco smoke	□ Tree nuts	□ Wasp Stings	□ Wheat	□Yellow jacket stings

Social History *Please answer the following questions:*

□ Married □ Single □ Widowed □ Divorced □ Separated

Do you have any children? If yes, how many? _____

Do you use: □ Tobacco □ Alcohol □ Coffee