

Name: _____ Age: _____ Date: _____

JOB DESCRIPTION

Occupation: _____ Number of years at this job: _____

Are you currently working? YES NO If so... Part-time Full-time

Regular Duty Modified Duty Working: _____ Hrs/Wk

What are your restrictions, if any? _____

Does your job require you to: (please check all that apply)

Lift or carry greater than 15 lbs. Bend or twist repetitively.

Work overhead. Repetitive motion of the arms or legs.

HISTORY OF PROBLEM FOR WHICH YOU ARE SEEING US

Date Problem/Symptoms Started: _____

Location of symptoms/pain when the problem started: _____

HOW DID THE PROBLEM START?

Home/Leisure At Work Motor Vehicle Accident Fall Other: _____

Please briefly describe: _____

Location of symptoms/pain now: _____

Frequency of symptoms/pain: (please check one)

CONSTANT INTERMITTENT RARE

Since the onset of symptoms, has the problem: (please check one)

IMPROVED WORSENER STAYED THE SAME

Does coughing or sneezing cause any pain? YES NO

If so, where? _____

Do any of the following activities make your symptoms worse? (please check all that apply)

WALKING LYING BENDING/TWISTING WORKING OVERHEAD

SITTING KNEELING LIFTING/CARRYING OTHER: _____

STANDING TYPING PUSHING/PULLING

List anything (i.e. activities, positions, or treatments) that makes the pain better:

Do you have any weakness, if so, which arm, leg or muscle? _____

Have you had any new or recurrent problems with: Control of urination? YES NO

Bowel movements? YES NO

Have you experienced recent weight loss or fevers? YES NO

Please continue on the other side ➤

HISTORY OF TREATMENT OF THIS PROBLEM

DIAGNOSTIC HISTORY

<u>TEST</u>	<u>RECEIVED</u>	<u>DATE OF TEST/LOCATION</u>
X-ray	<input type="checkbox"/> YES <input type="checkbox"/> NO	_____
MRI Scan	<input type="checkbox"/> YES <input type="checkbox"/> NO	_____
CT Scan	<input type="checkbox"/> YES <input type="checkbox"/> NO	_____
Bone Scan	<input type="checkbox"/> YES <input type="checkbox"/> NO	_____
EMG	<input type="checkbox"/> YES <input type="checkbox"/> NO	_____
Other: _____	<input type="checkbox"/> YES <input type="checkbox"/> NO	_____

MEDICATIONS

EXAMPLES

RECEIVED

DID THIS HELP?

(If yes, please circle the medication below.)

<u>Anti-Inflammatories/ Cox-2 Inhibitors</u>	Naprosyn, Ibuprofen, Vioxx Voltaren, Celebrex, Bextra	<input type="checkbox"/> YES <input type="checkbox"/> NO	<input type="checkbox"/> YES <input type="checkbox"/> NO
<u>Muscle Relaxers</u>	Soma, Flexeril, Skelaxin, Zanaflex	<input type="checkbox"/> YES <input type="checkbox"/> NO	<input type="checkbox"/> YES <input type="checkbox"/> NO
<u>Pain Medication</u>	Tylenol w/ Codeine, Vicodin, Darvocet, Percocet	<input type="checkbox"/> YES <input type="checkbox"/> NO	<input type="checkbox"/> YES <input type="checkbox"/> NO
<u>Oral Steroid</u>	Prednisone, Medrol Dose Pak	<input type="checkbox"/> YES <input type="checkbox"/> NO	<input type="checkbox"/> YES <input type="checkbox"/> NO
Neurontin, Zonegram, Paxil, Amitriptyline, Nortriptyline, Pamelor, Elavil, Prozac		<input type="checkbox"/> YES <input type="checkbox"/> NO	<input type="checkbox"/> YES <input type="checkbox"/> NO
<u>Other</u> <i>Please list:</i> _____		<input type="checkbox"/> YES <input type="checkbox"/> NO	<input type="checkbox"/> YES <input type="checkbox"/> NO

TREATMENTS

RECEIVED

DID THIS HELP?

Physical Therapy/ Exercise	<input type="checkbox"/> YES <input type="checkbox"/> NO	<input type="checkbox"/> YES <input type="checkbox"/> NO
Chiropractic Care	<input type="checkbox"/> YES <input type="checkbox"/> NO	<input type="checkbox"/> YES <input type="checkbox"/> NO
Injections in Muscle or other injections in office	<input type="checkbox"/> YES <input type="checkbox"/> NO	<input type="checkbox"/> YES <input type="checkbox"/> NO
Epidural Steroid Injections	<input type="checkbox"/> YES <input type="checkbox"/> NO	<input type="checkbox"/> YES <input type="checkbox"/> NO
Facet Blocks	<input type="checkbox"/> YES <input type="checkbox"/> NO	<input type="checkbox"/> YES <input type="checkbox"/> NO
Braces/Corsets	<input type="checkbox"/> YES <input type="checkbox"/> NO	<input type="checkbox"/> YES <input type="checkbox"/> NO

Back Surgery: Cervical Thoracic Lumbar When: _____

Prior to the onset of your current problem, did you ever visit a health care provider for problems with your spine? YES NO If yes, please list...

PHYSICIAN NAME

MONTH/YEAR OF TREATMENT

LEGAL ADVICE

Do you have an attorney regarding this injury/problem? YES NO

If yes, please list your attorney's name: _____