Patient Registration/Information

Name:	Date of Birth:
Phone Number:	Address:
Sex Assigned at Birth: Current Gender Identity:	City/State/Zip:
Email:	❑ ***I would like email reminders for future appointments***
Company Name: Company Address:	Company Contact: Phone Number:

Injury Care:	**Post-Accident Services:**
☐ First Report of Injury ☐ Report of Aggravation ☐ Changing of Attending Physician ☐ Emergency/Urgent Care Follow Up	☐ Need Post Accident BAT/Drug Screen ☐ Breath Alcohol Test Already Done at ER ☐ Saliva Alcohol Test Already Done at ER ☐ Drug Screen Already Done At ER
Date and Time injury occurred:	
Describe what your injury is and how your injury occurred in detail (PLEASE BE SPECIFIC):	

Interpreter Services:

☐ I do need a Medical Interpreter for the ________________ language.

☐ I do not need an Medical Interpreter for my appointment

WC Initial Patient Medical History

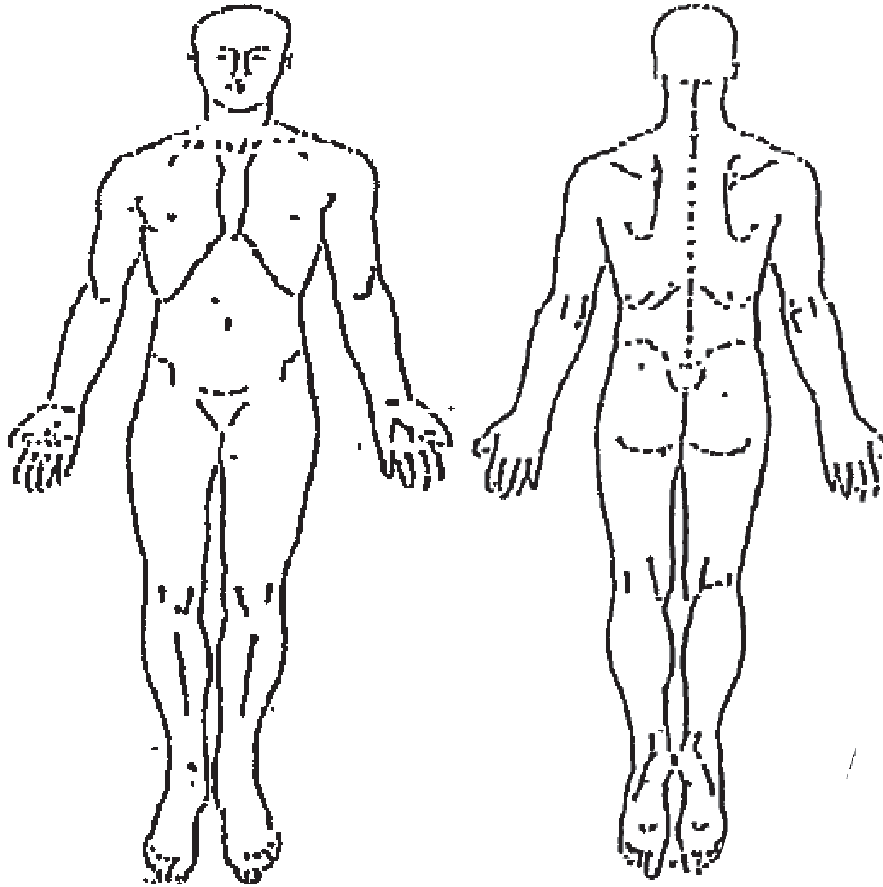
Name:

DOB: **Today's Date:**

I. CURRENT MEDICAL INFORMATION

1. Do you currently have pain as a result of the injury/illness you are here for? Yes No (skip to #2)
If yes, please mark the areas where you currently have pain using the sensations/symbols below:

Aching	Numbness	Pins and Needles	Burning	Stabbing
▲▲▲	= = =	●●●	X X X	/ / /



Pain Scale

0	Pain Free
1	Very Mild Annoyance Mild aches, no medication needed
2	Minor Annoyance Dull aches, no medication needed
3	Annoying enough to be a distraction Non-prescription medication needed
4	Can be ignored if you are really involved, but still distracting, often talked about. Non-prescription medication removes pain for 3-4 hours
5	Can't be ignored for more than 30 minutes High doses of non-prescription medications may help minimally
6	Can't be ignored for any amount of time, you can still go to work and participate in social activities. Non-prescription medications only mildly effective in large doses
7	Makes it difficult to concentrate, disrupts or interferes with sleep. You can function only with effort. Non-prescription medication not effective at all
8	Physical activity severely limited. You can read and converse with effort
9	Nonfunctional for all practical purposes. Cannot concentrate, physical activity halted. Panic depression and related emotional and social issues set in notwithstanding treatment.
10	Totally nonfunctional. Unable to speak. Crying out or moaning uncontrollably.

2. Do you take any medications (prescription, non prescription) supplements or vitamins? Yes, please list: No

3. Are you allergic to any medicine, food, clothing, bee stings or other substances? Yes, please list: No

4. When was your last tetanus shot? What is your weight? Height?

II. PAST MEDICAL HISTORY (***please list pertinent information from the last five years***)

1. Have you had any surgeries? Yes No
   Please list: ______________________________
2. Have you had any injuries? Yes No
   Please list:
3. Please list any present or past illnesses (include approximate year/date):

III. WORK HISTORY

1. How long have you worked at your current job?______________________
2. Have you had any recent changes in duties/responsibilities? Yes No
   Please list:
3. What kind of exposures do you have?
4. Current Employment Status: Full Time Part Time Seasonal Self-employed Unemployed

IV. SOCIAL HISTORY

1. Do you smoke? Yes No How many packs per day?______________
2. Do you drink alcohol? Yes No How much? ______________
3. Do you drink caffeinated beverages? Yes No How many per day? __________
4. Do you use recreational drugs? Yes No Please list: ______________
5. Do you have any children? Yes No Ages: ______________
6. What are your hobbies? ______________________________
7. Do You: Live Alone? Yes No Have stairs? Yes No Have help at home? Yes No

V. FAMILY HISTORY

1. Do you or your immediate family members have:

Cancer	Yes	No	Heart Disease	Yes	No
Diabetes	Yes	No	High Blood Pressure	Yes	No
Stroke	Yes	No	Arthritis	Yes	No
Other Diseases	Yes	No			
If yes, please list:					

VI. REVIEW OF SYMPTOMS

1. Do you currently experience:

Night Sweats	Yes	No	Weakness	Yes	No
Rashes	Yes	No	Weight Gain	Yes	No
Stiffness	Yes	No	Weight Loss	Yes	No
Numbness	Yes	No	Chest Pain	Yes	No
Blood in Stool	Yes	No	Fainting Spells	Yes	No
Muscle Pain	Yes	No	Ringing in Ears	Yes	No
Irregular Heart Rate	Yes	No	Stomach Pain	Yes	No
Fever then Chills	Yes	No	Excessive Thirst	Yes	No
Shortness of Breath	Yes	No	Excessive Hunger	Yes	No

Physician Comments/Notes: