Worker's Comp Intake Form

Date: _____ Case #_____ Patient ID#:_____

Name:_____ Social Security #_____

Address _____ City/State_____ Zip Code_____

Home phone_____ Cell phone _____ Email address_____

Insurance Co._____ Ins phone #_____

Sex ___ M ___ F Age _____ Date of Birth _____ Marital Status _____

Occupation _____ Shift 1 2 3 Description _____

Employer _____ Work phone # _____

Work Address _____ Years worked _____

Spouse _____ List children _____

Spouse's Social Security _____ Spouse's Occupation _____

Spouse's Employer _____ Spouse's Work #_____

Spouse's Insurance _____ Spouse's Ins. Phone # _____

Last Doctor's Name_____ Care received _____

List Medications _____

Worker's Comp Carrier_____ Address _____

Contact Person _____ Claim #_____

Are your present problems due to an injury? Yes No On the Job Auto Collision Personal Injury Other

Have you made a report of your accident? Yes No To Employer Auto Carrier Other _____

Are you now or have you ever been disabled/impaired? (Service or Work) Yes No When _____

Have you retained an attorney? Yes No Name & Address _____

Did you return to work? Yes No

Did you consult with any other doctor? Yes No

If so, give Dr.'s name and address _____

City _____ State_____ Zip code _____ Phone # _____

Dr.'s Diagnosis? _____

What care/treatments have you received? _____

Have you injured this area before? Yes No If yes, did you lose any time from work? Yes No

If you injured this area before and was under a Dr.'s care give the Dr.'s name and address_____

_____ Date of original injury_____

Do any other diseases or accidents affect your ability to work? Yes No If so, please explain_____

Before the injury were you capable of working on an equal basis with others your age? Yes No

Are your work activities restricted as a result of this accident? Yes No If yes, how so? _____

_____

Since the injury have your symptoms been _____ improving _____ getting worse _____ the same

TURN OVER

Describe how the injury occurred: _____

Describe where and when the injury occurred: _____

CHIEF COMPLAINT / REGIONS OF PAIN

1) _____ What makes your pain//problem better? _____

2) _____ What makes your pain/problem worse? _____

HAVE YOU HAD ANY OF THE FOLLOWING DISEASES?

___ 303.9 Alcoholism	___ 345. Epilepsy	___ 072. Mumps
___ 280. Anemia	___ 240. Goiter	___ 511. Pleurisy
___ 541. Appendicitis	___ 429.9 Heart Disease	___ 480. Pneumonia
___ 716. Arthritis	___ 042. HIV Positive	___ 045. Polio
___ 239. Cancer	___ 487. Influenza	___ 390. Rheumatic Fever
___ 052. Chicken Pox	___ 724.2 Low Back Pain	___ 737.30 Scoliosis
___ 250. Diabetes	___ 055. Measles	___ 846. Sprain/Strain Sacroiliac
___ 690. Eczema	___ 319 Mental Disorder	___ 847.0 Whiplash

HABITS

___ Smoking	Packs/Day	___
___ Alcohol	Cups/Day	___
___ Coffee	Cups/Day	___
___ Soda Pop	Cups/Day	___

EXERCISE

___ None
___ Moderate
___ Daily
Type: _____

FAMILY HISTORY

		Diabetes	Heart	Kidney	Cancer	Back
Mother - Living	___ Yes ___ No	___	___	___	___	___
Father – Living	___ Yes ___ No	___	___	___	___	___
Brother(s), # of ___		___	___	___	___	___
Sister(s), # of ___		___	___	___	___	___
Adoption History		___	___	___	___	___

SEVERITY OF PAIN

List region of pain and circle severity number. (1 = least, 10 = greatest)

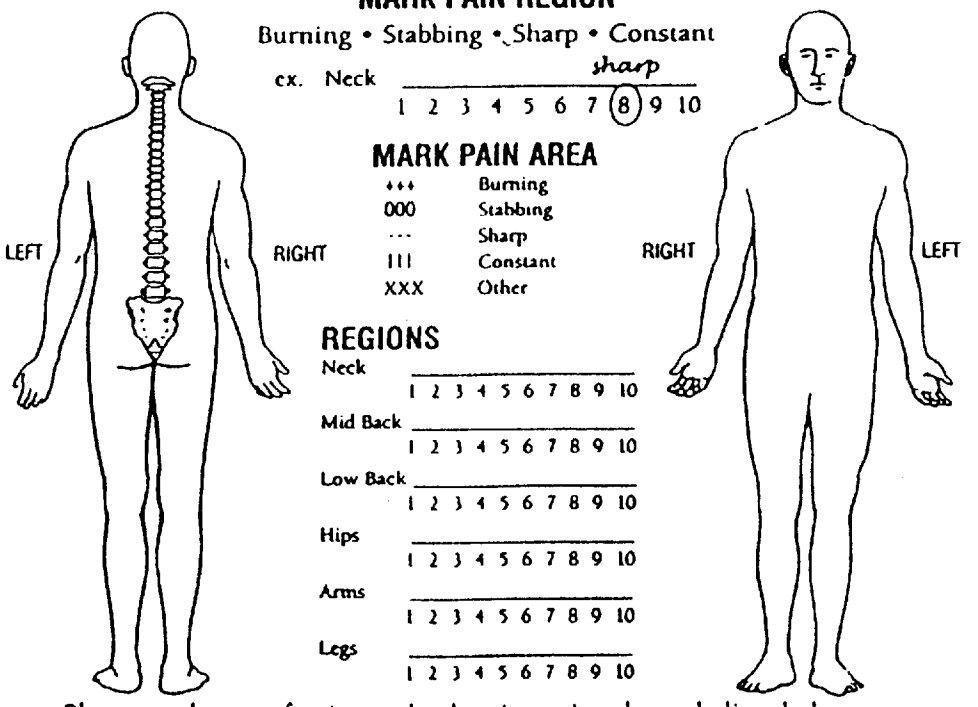
MARK PAIN REGION

Burning • Stabbing • Sharp • Constant

ex. Neck sharp
1 2 3 4 5 6 7 (8) 9 10

MARK PAIN AREA

↓↓↓	Burning
000	Stabbing
^^^	Sharp
III	Constant
XXX	Other



REGIONS

Neck _____
1 2 3 4 5 6 7 8 9 10

Mid Back _____
1 2 3 4 5 6 7 8 9 10

Low Back _____
1 2 3 4 5 6 7 8 9 10

Hips _____
1 2 3 4 5 6 7 8 9 10

Arms _____
1 2 3 4 5 6 7 8 9 10

Legs _____
1 2 3 4 5 6 7 8 9 10

Please mark area of pain on the drawing using the code listed above.

MODIFIED **NECK** PAIN & DISABILITY QUESTIONNAIRE

NAME: _____ DATE: _____ FILE: _____

The purpose of this questionnaire is to measure your perceived disability from your condition. The selections you choose will give your doctor information about how your pain has affected your ability to manage in everyday life.

Instructions: In each section, mark with an "X" only one which most closely applies to you. Please answer every section.

PAIN INTENSITY
___0 I have no pain at the moment
___1 My pain is very mild at the moment
___2 My pain is moderate at the moment
___3 My pain is fairly severe at the moment
___4 My pain is very severe at the moment
___5 My pain is the worst imaginable at the moment

PERSONAL CARE (WASHING, DRESSING, ETC)
___0 I can look after myself normally without causing extra pain
___1 I can look after myself normally but it causes extra pain
___2 It's painful to look after myself, and I am slow and careful
___3 I need some help but manage most of my personal care
___4 I need help every day in most aspects of self care
___5 I don't get dressed, wash with difficulty, and stay in bed

HEADACHES
___0 I have no headaches at all
___1 I have mild headaches which come infrequently
___2 I have mild headaches most of the time
___3 I have moderate headaches which come frequently
___4 I have severe headaches which come infrequently
___5 I have headaches nearly all the time

WORK
___0 I can do as much work as I want to
___1 I can only do my usual work, but not more
___2 I can do most of my usual work, but no more
___3 I cannot do my usual work
___4 I am very limited in what work I can do
___5 I cannot do any work at all

READING
___0 I can read as much as I want with no neck pain
___1 I can read as much as I want with only mild neck pain
___2 I can read as much as I want with moderate neck pain
___3 I can't read as much as I want due to moderate neck pain
___4 I can hardly read at all because of severe neck pain
___5 I cannot read at all due to severe neck pain

CONCENTRATION
___0 I can concentrate fully when I want to with no difficulty
___1 I can concentrate fully when I want to with mild difficulty
___2 I have mild difficulty concentrating when I want to
___3 I have a lot of difficulty in concentrating when I want to
___4 I find it very difficult to concentrate when I want to
___5 I cannot concentrate at all

SLEEPING
___0 I have no trouble sleeping
___1 I can only sleep well by taking medications
___2 I get less than 6 hours sleep before the wakes me up
___3 I get less than 4 hours sleep before the pain wakes me up
___4 I get less than 2 hours sleep before the pain wakes me up
___5 My pain prevents me from sleeping at all

CHANGING DEGREE OF PAIN
___0 My pain is rapidly decreasing and I am getting better
___1 My pain fluctuates but I am gradually getting better
___2 My pain is increasing and my improvement is slow
___3 My pain is not changing. I am not getting better or worse
___4 My pain is increasing and I am gradually getting worse
___5 My pain is rapidly increasing. I am rapidly getting worse

SOCIAL LIFE
___0 My social life is normal and gives me no extra pain
___1 My social life is normal but increases the degree of pain
___2 Pain has no significant effect on my social life, apart from limiting more energetic interests (dancing, etc)
___3 Pain has restricted my social life. I don't go out as often
___4 Pain has restricted my social life to my home
___5 I have no social life because of pain

TRAVELING
___0 I can travel anywhere without extra pain
___1 I can travel anywhere but it gives me extra pain
___2 Pain is bad but I manage journeys over two hours
___3 Pain restricts me to journeys of less than one hour
___4 Pain restricts me to short necessary journeys under ½ hour
___5 Pain prevents me from traveling except to my doctor

MODIFIED **OSWESTRY** DISABILITY QUESTIONNAIRE

NAME: _____ DATE: _____ FILE#: _____

The purpose of this questionnaire is to measure your perceived disability from your condition. The selections you choose will give your doctor information about how your pain has affected your ability to manage in everyday life.

INSTRUCTIONS: In each section, mark with an "X" only one which most closely applies you. Please answer every section:

PAIN INTENSITY
___0 I have no pain
___1 Pain comes and goes and is very mild
___2 Pain is constant and is very mild
___3 Pain comes and goes and is moderate
___4 Pain is constant and is moderate
___5 Pain is constant and is severe

PERSONAL CARE (washing and dressing)
___0 I can look after myself normally without causing extra pain
___1 I can look after myself normally but it causes extra pain
___2 It is painful to look after myself and I am slow and careful
___3 I need some help but manage most of my personal care
___4 I need help every day in most aspects of self care
___5 I do not get dressed, wash with difficulty, and stay in bed

LIFTING
___0 I can lift heavy weights extra pain
___1 I can lift heavy weights but it gives me extra pain
___2 Pain prevents me from lifting heavy weights but I can manage if they are conveniently positioned
___3 Pain prevents me from lifting heavy weights but I can manage light to medium weights if they are conveniently positioned
___4 I can only lift very light objects
___5 I cannot lift or carry anything at all

WALKING
___0 Pain does not prevent me from walking any distance
___1 Pain prevents me from walking more than one mile
___2 Pain prevents me from walking more than ½ mile
___3 Pain prevents me from walking more than ¼ mile
___4 I can only walk using a cane or crutches
___5 I am in bed most of the time and have to crawl to the toilet

SITTING
___0 I can sit in any chair as long as I like
___1 I can only sit in my favorite chair as long as I like
___2 Pain prevents me from sitting for more than 1 hour
___3 Pain prevents me from sitting for more than ½ hour
___4 Pain prevents me from sitting for more than 10 mins
___5 I avoid sitting since it increases my pain straight away

STANDING
___0 I can stand as long as I want without extra pain
___1 I can stand as long as I want but it gives me extra pain
___2 Pain prevents me from standing for more than 1 hour
___3 Pain prevents me from standing for more than ½ hour
___4 Pain prevents me from standing for more than 10 mins
___5 Pain prevents me from standing at all

SLEEPING
___0 I have no trouble sleeping
___1 I can only sleep well by taking medications
___2 I get less than six hours sleep before the pain wakes me up
___3 I get less than four hours sleep before the pain wakes me up
___4 I get less than two hours sleep before the pain wakes me up
___5 Pain prevents me from sleeping at all

CHANGING DEGREE OF PAIN
___0 My pain is rapidly decreasing and I am getting better
___1 My pain fluctuates but I am gradually getting better
___2 My pain is decreasing and my improvement is slow
___3 My pain is not changing—I am not getting better or worse
___4 My pain is increasing and I am gradually getting worse
___5 My pain is rapidly increasing –I am getting worse

SOCIAL LIFE
___0 My social life is normal and gives me no extra pain
___1 My social life is normal but increases the degree of pain
___2 Pain has no significant effect on my social life apart from limiting my more energetic interests (e.g. dancing, etc.)
___3 Pain has restricted my social life, I don't go out as often
___4 Pain has restricted my social life to my home
___5 I have no social life because of pain

TRAVELING
___0 I can travel anywhere without extra pain
___1 I can travel anywhere but it gives me extra pain
___2 Pain is bad but I manage journeys over two hours
___3 Pain restricts me to journeys of less than 1 hour
___4 Pain restricts me to short, necessary journeys under ½ hour
___5 Pain prevents me from traveling except to my doctor