

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 Pain ☐ 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:

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

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

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

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

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

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

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

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

- | | | |
|--|--|--|
| <input type="checkbox"/> None | <input type="checkbox"/> Other | <input type="checkbox"/> Advil |
| <input type="checkbox"/> Ambien | <input type="checkbox"/> Analgesics | <input type="checkbox"/> Anti-inflammatories |
| <input type="checkbox"/> Aspirin | <input type="checkbox"/> Atenolol | <input type="checkbox"/> Blood Pressure Medication |
| <input type="checkbox"/> Daily Vitamins | <input type="checkbox"/> Diabetes Medication | <input type="checkbox"/> Flexeril |
| <input type="checkbox"/> Isorsubrine | <input type="checkbox"/> Monopril | <input type="checkbox"/> Motrin |
| <input type="checkbox"/> Muscle relaxers | <input type="checkbox"/> Pin Medication | <input type="checkbox"/> Skelaxin |
| <input type="checkbox"/> Synthroid | <input type="checkbox"/> Tylenol | <input type="checkbox"/> Vicodin |

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

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