# History of Present Illness for Work Related Injury

Last Name: _____ First Name: _____ Date: _____

Date of Birth: _____ Time of Injury: _____ Date of Injury: _____

Current Height: _____ Have you had a bone density scan (for osteoporosis)? ☐ Yes ☐ No

Current Weight: _____ Where/Year: _____

**Laterality:** ☐ **Right** ☐ **Left** ☐ **Bilateral**

☐ **Fracture**

☐ **Laceration/Wound**

***Primary Affected Area:*** *Choose most significant area for today's visit*

☐ Neck ☐ Mid Back ☐ Low Back ☐ Shoulder ☐ Clavicle ☐ Upper Arm ☐ Elbow ☐ Forearm

☐ Wrist ☐ Hand ☐ Hip ☐ Pelvis ☐ Thigh ☐ Knee ☐ Lower Leg ☐ Ankle ☐ Foot

**On a scale of 0 to 10, 0 being no pain and 10 being the worst, please circle below your current level of pain**

☐ 0 ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ 7 ☐ 8 ☐ 9 ☐ 10

No Pain — Moderate Pain — Worst Possible Pain

**Signs & Symptoms:** ☐ Bruising ☐ Inflammation ☐ Numbness/tingling ☐ Stiffness ☐ Weakness ☐ Swelling

**Aggravated By:** ☐ Daily Activities ☐ Exercise ☐ Lifting ☐ Overhead ☐ Motion ☐ Sports ☐ Throwing ☐ Work

**Relieved By:** ☐ Activity ☐ Compression Wrap ☐ Elevation ☐ Heat ☐ Ice ☐ Injections ☐ NSAIDS ☐ Pain Medication ☐ Physical Therapy ☐ Rest ☐ Tylenol ☐ I do not get relief

**Pain Is:** ☐ Dull ☐ Sharp ☐ Throbbing ☐ Intermittent ☐ Constant ☐ No Pain

Please explain how the accident occured:_____

_____

**Do you have an immediate or previous history of falls?** ☐ Yes ☐ No

**Do you use an assistive device to help you ambulate?** ☐ Yes ☐ No

If yes, please check the most appropriate device: ☐ Cane ☐ Walker ☐ Wheelchair ☐ Rolling Scooter ☐ Other: _____

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**Have you ever been treated in the past by a chiropractor?** ☐ Yes ☐ No

If yes, please provide the name & address of the chiropractor: _____

**Have you filed any workers compensation claim (s) in the past for this medical condition?** ☐ Yes ☐ No

If yes, please provide details: _____

_____

**Have you ever been involved in any motor vehicle collisions?** ☐ Yes ☐ No

If yes, please provide details: _____

_____

**Are you currently engaged in any other employment?** ☐ Yes ☐ No

If yes, please provide names and addresses: _____

_____

**Do you currently (in the past 12 months) participate in any athletic, recreational or sporting activities?** ☐ Yes ☐ No

If yes, please list: _____

**Have you ever received pain management treatment?** ☐ Yes ☐ No

If yes, please provide the name and address of the treating physician(s) for this condition._____

_____

## Patient Attestation:

I certify that the statements provided are true and correct and provided to the best of my ability.

_____ _____

Patient Signature Date

Clinical Staff's Initials _____

# Medications You Are Currently Taking

Today's Date: _____

Patient Name: _____ Date of Birth: _____

List all medications you are taking including non-prescription medications and opioids ☐ I am not taking any medications

| | Medication #1 | Medication #2 | Medication #3 | Medication #4 |
|---|---|---|---|---|
| Name: | | | | |
| Dosage: | | | | |
| Frequency: | | | | |
| Route: | ☐ Oral ☐ Inject ☐ Topical ☐ Nasal ☐ Inhale ☐ Patch ☐ Drops | ☐ Oral ☐ Inject ☐ Topical ☐ Nasal ☐ Inhale ☐ Patch ☐ Drops | ☐ Oral ☐ Inject ☐ Topical ☐ Nasal ☐ Inhale ☐ Patch ☐ Drops | ☐ Oral ☐ Inject ☐ Topical ☐ Nasal ☐ Inhale ☐ Patch ☐ Drops |
| | **Medication #5** | **Medication #6** | **Medication #7** | **Medication #8** |
| Name: | | | | |
| Dosage: | | | | |
| Frequency: | | | | |
| Route: | ☐ Oral ☐ Inject ☐ Topical ☐ Nasal ☐ Inhale ☐ Patch ☐ Drops | ☐ Oral ☐ Inject ☐ Topical ☐ Nasal ☐ Inhale ☐ Patch ☐ Drops | ☐ Oral ☐ Inject ☐ Topical ☐ Nasal ☐ Inhale ☐ Patch ☐ Drops | ☐ Oral ☐ Inject ☐ Topical ☐ Nasal ☐ Inhale ☐ Patch ☐ Drops |
| | **Medication #9** | **Medication #10** | **Medication #11** | **Medication #12** |
| Name: | | | | |
| Dosage: | | | | |
| Frequency: | | | | |
| Route: | ☐ Oral ☐ Inject ☐ Topical ☐ Nasal ☐ Inhale ☐ Patch ☐ Drops | ☐ Oral ☐ Inject ☐ Topical ☐ Nasal ☐ Inhale ☐ Patch ☐ Drops | ☐ Oral ☐ Inject ☐ Topical ☐ Nasal ☐ Inhale ☐ Patch ☐ Drops | ☐ Oral ☐ Inject ☐ Topical ☐ Nasal ☐ Inhale ☐ Patch ☐ Drops |
| Preferred Pharmacy: | Name: _____ | | Address: _____ | |

Clinical Staff's Initials _____