



## INDUSTRIAL CLINIC PATIENT HISTORY

PATIENT NAME: \_\_\_\_\_ TODAY'S DATE: \_\_\_\_\_

EMPLOYER: \_\_\_\_\_ DATE OF BIRTH: \_\_\_\_\_

Date of industrial injury or illness: \_\_\_\_\_

1. Briefly describe what happened: \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_

2. Please list all body parts injured in this accident (please circle left, right or both if applicable):

LEFT/RIGHT/BOTH \_\_\_\_\_ LEFT/RIGHT/BOTH \_\_\_\_\_

LEFT/RIGHT/BOTH \_\_\_\_\_ LEFT/RIGHT/BOTH \_\_\_\_\_

3. What symptoms are you having as a result of this injury: \_\_\_\_\_

\_\_\_\_\_

4. Have you ever had these current symptoms in the same parts of your body that are injured now?

\_\_\_\_\_ NO \_\_\_\_\_ YES (please explain) \_\_\_\_\_

\_\_\_\_\_

5. Are you currently under the care of a physician, chiropractor, physical therapist, or any other medical professional for any condition?

\_\_\_\_\_ NO \_\_\_\_\_ YES (name of physician or other medical professional) \_\_\_\_\_

\_\_\_\_\_

6. Do you have others in you home that you are responsible to provide care for?

\_\_\_\_\_ NO \_\_\_\_\_ YES (please explain) \_\_\_\_\_

\_\_\_\_\_

7. Please describe any home activities, volunteer work, hobbies or sports you participate in:

\_\_\_\_\_

\_\_\_\_\_

Patient Signature \_\_\_\_\_ Date \_\_\_\_\_

Reviewed By: \_\_\_\_\_ MD Date: \_\_\_\_\_

8. Please describe any activities you have stopped or restricted because of this injury or illness:

Stopped: \_\_\_\_\_

Restricted: \_\_\_\_\_

9. Have you had any surgeries: \_\_\_\_\_ NO \_\_\_\_\_ YES

Date: \_\_\_\_\_ Type: \_\_\_\_\_ Reason: \_\_\_\_\_

Date: \_\_\_\_\_ Type: \_\_\_\_\_ Reason: \_\_\_\_\_

10. Do you now or have you had any major illnesses? \_\_\_\_\_ NO \_\_\_\_\_ YES

Please describe: \_\_\_\_\_

11. List any medications you are taking at this time: \_\_\_\_\_

\_\_\_\_\_

12. Do you have any allergies? \_\_\_\_\_ NO \_\_\_\_\_ YES

Please describe: \_\_\_\_\_

13. What is your current Job/Title? \_\_\_\_\_

Current Employer: \_\_\_\_\_ Hours per day: \_\_\_\_\_

Years with this employer: \_\_\_\_\_ Total years in this type of work: \_\_\_\_\_

14. Briefly describe your usual job duties: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

15. Have you ever had a prior injury or medical condition to this/these body part(s)? \_\_\_\_\_ NO \_\_\_\_\_ YES

Please describe: \_\_\_\_\_

16. Do you have any other jobs or are you self-employed? \_\_\_\_\_ NO \_\_\_\_\_ YES

Please describe other work activities, days per week and hours per day performed:

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Patient Signature \_\_\_\_\_ Date \_\_\_\_\_

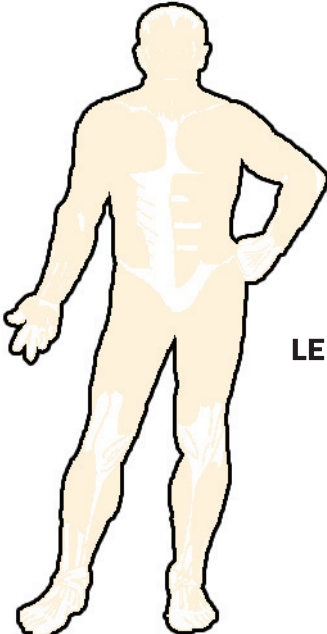
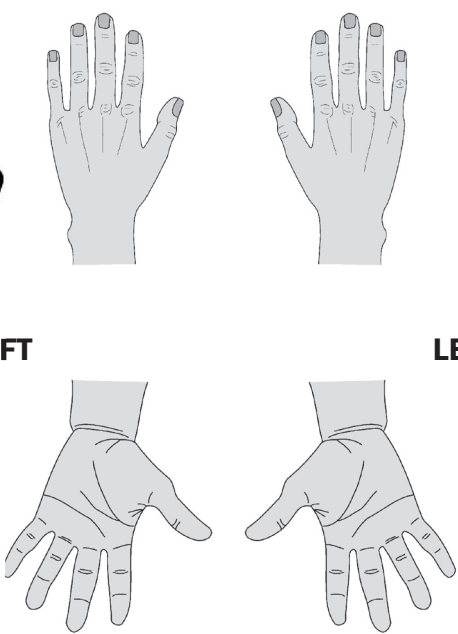

Reviewed By: \_\_\_\_\_ MD Date: \_\_\_\_\_

# PATIENT PAIN DRAWING - TO BE FILLED OUT BY PATIENT ONLY

Name: \_\_\_\_\_ Date: \_\_\_\_\_

**Where is your pain now?**

Mark all areas on your body where you feel any pain or numbness. Include all affected areas even if it was not caused by this injury. To complete the picture please draw in you face.

<b>NUMBNESS</b> ===	<b>PINS &amp; NEEDLES</b> 0 0 0	<b>PAIN</b> X X X
		
<b>RIGHT</b>	<b>LEFT</b>	<b>LEFT</b>
<b>FRONT</b>	<b>LEFT</b>	<b>RIGHT</b>
	<b>LEFT</b>	<b>BACK</b>

**How bad is your pain?**

Please circle the number showing how bad your pain is when it is at its best:

Best: (No Pain) 0 1 2 3 4 5 6 7 8 9 10 (Worst Possible Pain)

Please circle the number showing how bad your pain is when it is at its worst:

Worst: (No Pain) 0 1 2 3 4 5 6 7 8 9 10 (Worst Possible Pain)

Patient Signature \_\_\_\_\_ Date \_\_\_\_\_

Reviewed By: \_\_\_\_\_ MD Date: \_\_\_\_\_