

WORKER'S COMP PATIENT REGISTRATION

Today's Date: _____ Name: _____ DOB: _____ SSN#: _____

Referral Doctor: _____ Family Doctor: _____

Gender: Male Female Marital Status: Married Single Divorced

Current Employment Status: Full time Part time Retired Student Home maker
 Unemployed Disabled Self-employed

Most Recent Occupation: _____ Employer: _____

Street Address: _____ City: _____ State: _____ Zip Code: _____

Home phone: _____ Mobile phone: _____ Alternate phone: _____

Email: _____

Emergency Contact: _____ Relationship: _____ Phone: _____

Date of Injury: _____ Worker's Comp Insurer: _____

Adjuster Name: _____ Phone#: _____ Claim#: _____

If you were off work due to injury, how long? _____ from date? _____ to date? _____

Describe how you get injured: _____

Health Insurance Carrier: _____ Subscriber ID: _____

Height: _____ Weight: _____

Do you smoke? Yes No If Yes, how much? _____

Do you consume alcohol? Yes No If Yes, how often? _____

Do you have any allergies? Yes No If Yes, please list _____

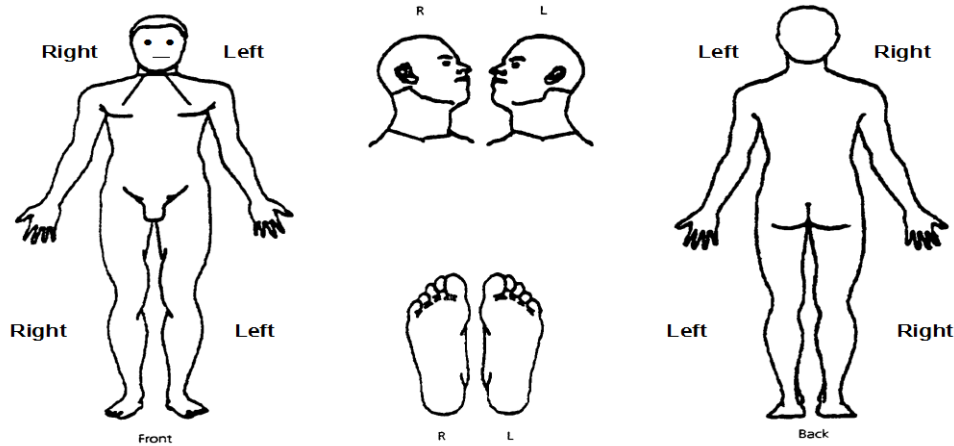
Please list your CUERNT medical conditions (why you visit today):

Please list your PAST medical conditions and medical care provider:

Please list all past surgeries and year:

Please list medications with dosage and frequency you are taking:

Location of Pain: Please shade in the painful areas in the diagram below. Put "x" on areas of tingling, "o" on burning areas, and "*" on areas with no feeling at all.



Least Pain level (0 being the least amount of pain): 0 1 2 3 4 5 6 7 8 9 10

Worst Pain level (0 being the least amount of pain): 0 1 2 3 4 5 6 7 8 9 10

Which of the following treatments have you had for your pain? Check all that apply.

- Over the counter Pain Killer (such as Motrin, Advil, Aspirin, Aleve, Tylenol)
- Surgery Physical Therapy Massage Acupuncture Chiropractic
- Nerve blocks and injections (such as epidurals, facet injections, etc)
- TENS Botulinum Toxin Biofeedback/Relaxation training Counseling/Psychotherapy
- Other: _____

Which of the following make your pain feel worse? Check all that apply.

- Sitting Standing Walking Lying down Bending forward Bending backwards Morning hours
- Evening hours Coughing, Sneezing Damp weather Physical therapy/Massage Getting out of bed Stress
- Other: _____

Which of the following make your pain feel better? Check all that apply.

- Sitting Standing Walking Lying down Bending forward Bending backwards Morning hours
- Evening hours Relaxation Physical therapy Acupuncture Heat Ice pack Alcoholic
- Other: _____

Signature_____ Date_____