# Pacific Medical Group LLC (WC)

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**PATIENT INFORMATION**

Name _____ Date _____
Sex _____ Marital Status _____ Date of Birth: _____ Home Phone _____
Address _____ City _____ State _____ Zip _____
Occupation _____ Who referred you to our office? _____
Social Sec. # _____-_____-_____ Bus. Phone (_____) _____-_____ Employer _____
What is your preferred contact phone number? Home Cellular Work
May the office staff leave a message, for you at this number? Yes No
EMERGENCY CONTACT: Name _____ Phone _____

**INSURANCE INFORMATION**

Insurance Co._____ Phone # _____
Address_____ City _____ State _____ Zip _____
Date of Injury _____ Claim # _____
ADDITIONAL INSURANCE (Secondary Insurance)
*Yes* *No* If Yes Complete the following:
Name of insured _____ Relationship to Patient _____
Insurance Co. Name _____ Phone # _____
Insurance Co. Address_____ City_____ State____ Zip _____
Group # _____ Employer # _____
How much is your deductible?_____ How much have you used?_____ Max. annual benefit?_____

**MECHANISM OF INJURY**

Please explain in detail how your accident happened _____

_____

_____

_____

Did you report this injury in writing at your work? *Yes* *No*

Are your work activities restricted as a result of this accident? *Yes* *No*
Since this injury are your symptoms *improving?* *getting worse?* *the same?*
Have you retained an attorney? *Yes* *No*

If so, name and address _____

Give date and time present injury occurred: **DATE** _____ 20_____ at _____ AM PM

Where did you feel pain immediately after the accident? _____

_____

Did you return to work? *Yes* *No* If so, date returned to work _____

**CHIEF COMPLAINT**

What Areas of your Body are in pain from this injury? Rate worst area, first and so on. (Please include any/all areas of numbness or radiating pain, tingling or other sensations from the injury as well)

1. Area _____ (circle) mild moderate severe
2. Area _____ (circle) mild moderate severe
3. Area _____ (circle) mild moderate severe
4. Area _____ (circle) mild moderate severe
5. Area _____ (circle) mild moderate severe
6. Area _____ (circle) mild moderate severe

Please **Circle** the Quality of the main area of pain: dull aching sharp shooting burning throbbing deep nagging other areas: _____

Does any of the areas of pain radiate or travel (shoot) to any areas of your body? *Yes* *No*

Where?_____

Do you have any numbness or tingling in your body? *Yes* *No*

Where? _____

Grade Intensity/Severity (0 is no pain) 0 1 2 3 4 5 6 7 8 9 10 (10 is worst possible pain)

How frequent is pain present, how long does it last? _____

Does anything aggravate it? _____

Does anything make it better? _____

**LIMITATIONS TO ACTIVITIES OF DAILY LIVING DUE TO THIS INJURY**

Do you have problems with self-care and personal hygiene? Yes No (circle those that apply)
brushing teeth, combing hair, bathing, dressing, eating, laundry, house work, yard work,
Do you have difficulty urinating and having bowel movements? Yes No How so? _____
_____

Do you have difficulty with communication? Yes No (circle those that apply)
writing, typing, seeing, hearing, speaking
Do you have difficulty performing certain physical activities? (circle those that apply) such as, standing, sitting, reclining, walking and climbing stairs
Do you have problems with, (circle those that apply) hearing, seeing, tasting, smelling
Do you have difficulty with such activities as (circle those that apply) grasping, lifting, walking, or weakness
Do you have problems traveling for prolonged periods either driving or flying? Yes No
Do you have difficulty sleeping and awakens with pain and discomfort? Yes No

**TREATMENT**

Who is your current treating Physician for this injury? _____

If so, give the doctor's name _____ *D.C., M.D., D.O., D.D.S.*

Doctor's Diagnosis _____

What treatments did you receive? _____

What Medications were prescribed? _____

Did you receive an X-ray or MRI? *Yes* *No* If yes, please bring the reports if available or what were the results?

_____

**JOB DESCRIPTION**

Date Began Employment: _____

Job description and duties: _____

_____

_____

JOB ANALYSIS:

What regular activities do you perform at your job? **(circle the ones that apply)**

bending, stooping, squatting, pushing, pulling, reaching, twisting, turning, standing, walking, climbing, stretching, grasping, gripping, working in awkward positions

OTHER_____

**How much** do you regularly lift at your job? _____

What is the **Maximum** amount of weight you lift at work? _____

Are you required to regularly bend while lifting at your job? _____

Do you work full time? *Yes* *No* Do you Stand or Sit or both? _____

**INJURY ANALYSIS:**

INURIES INVOLVING LIFTING:

From what level were you lifting the object? _____

How many pounds was the object you were lifting? _____

What position were you in while you were lifting the object? _____

What type of pain did you feel immediately after the injury? _____

INJURIES INVOLVING FALLING:

Where at work did you fall? _____

What part of your body did you land on? _____

What other areas did you injure as a result of your fall? _____

**SOCIAL AND FAMILY HISTORY**

FAMILY HEALTH HISTORY

Associated health problems of relatives: _____

_____

Deaths in immediate family:

| Cause of parents or siblings death | Age at death |
|---|---|
| _____ | _____ |
| _____ | _____ |
| _____ | _____ |
| _____ | _____ |

SOCIAL HISTORY

Do you smoke? *Yes* *No* Drink alcohol? *Yes* *No* (occasional socially daily) Recreational drugs? *Yes* *No*

If you smoke how many cigarettes per day? _____

**RELEVANT MEDICAL HISTORY**

Current illnesses: _____

_____

_____

Previous injury or trauma: _____

_____

_____

Have you ever broken any bones? *Yes* *No* Which? _____

List Allergies or Sensitivity to what medications:

_____

_____

CURRENT MEDICATIONS and DOSAGES

| Medication & Dosage | Reason for taking |
|---|---|
| _____ | _____ |
| _____ | _____ |
| _____ | _____ |
| _____ | _____ |
| _____ | _____ |

SURGURIES

| Date | Type of Surgery |
|---|---|
| _____ | _____ |
| _____ | _____ |
| _____ | _____ |
| _____ | _____ |

I have read the above information and certify it to be true and correct to the best of my knowledge, and hereby authorize this office to provide me with medical and other healthcare, in accordance with this state's statutes.

Signature _____ Date _____

**If the patient is a minor (under I8 yrs. of age), please supply parent/guardian information below:**

Name of Parent or Guardian _____

Home Phone_____ Cellular Phone_____

Address (if different than patient) _____ City_____ State_____ Zip Code_____

Parent/Guardian Signature _____ Date _____