AZ MEDICAL AND SPORTS REHAB

Work Injury

History

Form # ___ Date _____ Patient ID _____

Last Name _____ First Name _____ MI _____

Birthdate _____ Age _____ Email _____

Would you like to receive emails about specials and upcoming events? ☐ Yes ☐ No

Address_____

City _____ State _____ Zip _____

Phone (H)_____(W)_____(C)_____

Occupation _____ Employer _____

Spouse's Name _____ Employer _____

Emergency Contact Name _____ Phone _____

How did you hear about us? ☐ Walk In ☐ Social Media ☐ Event ☐ Yelp ☐ Google

☐ Referred by _____ ☐ Other _____

Primary Care Physician _____ Date of last exam _____

Address_____

City _____ State ____ Zip _____ Phone _____

Date of Accident: _____ Was the accident on the job? ☐ Yes ☐ No

Address of accident: _____

Time of Accident: _____ am / pm ☐ Daylight ☐ Dawn ☐ Dusk ☐ Dark

Briefly describe the accident _____

_____

_____

_____

Was your accident directly related to your work? ☐ Yes ☐ No

Were there witnesses? ☐ Yes ☐ No

Did you report the accident to your employer? ☐ Yes ☐ No

What recommendations did your employer make after the accident? _____

_____

Has this type of accident happened to you before? ☐ Yes ☐ No

AZ MEDICAL AND SPORTS REHAB

Work Injury

History

To the best of your knowledge, has this accident happened in your workplace before? ☐ Yes ☐ No

Were Emergency Medical Services at the scene? ☐ Yes ☐ No

Describe the discomfort felt at time of accident. _____

_____

Where did you feel the symptoms?_____

_____

At the time of the accident, did you become or experience any of the following?

☐ Confused ☐ Disoriented ☐ Light headed ☐ Dizzy ☐ Nauseated ☐ Blurred vision

☐ Ringing/Buzzing in ears ☐ Loss of balance ☐ Other _____

_____

Did you go to the hospital? ☐ Yes ☐ No Which hospital?_____

How did you get there? ☐ Ambulance ☐ Private Transportation

Was an X-ray done? ☐ Yes ☐ No Was an MRI done? ☐ Yes ☐ No

What was your diagnosis? _____

How did the hospital treat your injuries?_____

_____

List medications prescribed _____

Do you still have any of the symptoms you named above? ☐ Yes ☐ No

If yes, which ones? _____

Have you missed any work since the accident? ☐ Yes ☐ No Dates: _____

Has your condition (☐ Improved ☐ Worsened ☐ Stayed) the same since the accident?

Is your condition affecting your ☐ Work ☐ Sleep ☐ Daily Routine? Please explain:

_____

_____

How many hours are in your normal weekday?

Please indicate your daily job duties and any activities that you are asked to perform?

AZ MEDICAL AND SPORTS REHAB

Work Injury

History

☐ Standing (How long? _____) ☐ Twisting ☐ Typing ☐ Operating Equipment ☐ Crawling
☐ Work W/ Arms Above Head ☐ Lifting ☐ Driving ☐ Walking ☐ Bending ☐ Stooping
☐ Sitting (How long? _____) ☐ Other _____

Please check the symptoms you have noticed since the accident below:				
☐ Headache	☐ Neck Pain	☐ Upper Back Pain	☐ Shoulder Pain	☐ Mid-back Pain
☐ Low Back Pain	☐ Depression	☐ Buzzing In Ears	☐ Arm/Leg Pain	☐ Jaw Pain/Clicking
☐ Dizziness	☐ Fatigue	☐ Loss of Memory	☐ Cold Hands/Feet	☐ Numbness/Tingling
☐ Loss of Smell	☐ Irritability	☐ Digestive Problems	☐ Joint/Stiffness	☐ Menstrual Problems
☐ Pinched Nerves	☐ Loss of Sleep	☐ Loss of Balance	☐ Chest Pain	☐ Light Bothers Eyes
☐ Fever	☐ Nervousness	☐ Vision Problems	☐ Urinary Problems	☐ Sleeping Problems
☐ Paralysis	☐ Tension	☐ Fainting	☐ Pins/Needles Feeling	☐ Stomach Upset
☐ Difficulty Swallowing	☐ Sciatica	☐ Sinus Pain	☐ Sore Muscles	☐ Head Feels Too Heavy

Current Complaints

List current symptoms separately in order of severity.

1st Body Part: _____

Date Symptom first appeared: _____

How often do you experience these symptoms?

☐ Constant ☐ 100% ☐ Frequent 75% ☐ Intermittent 50%

☐ Occasional 25% ☐ Rare 10%

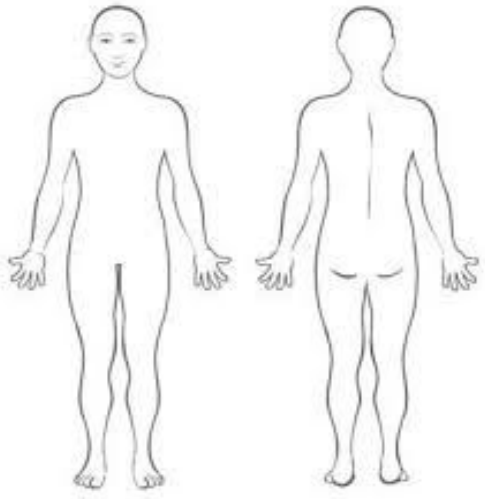
What makes Symptom increase?_____

What makes symptom decrease?_____

Type of pain?

☐ Sharp ☐ Dull ☐ Aching ☐ Burn ☐ Throb ☐ Numb ☐ Other:

_____



AZ MEDICAL AND SPORTS REHAB

Work Injury

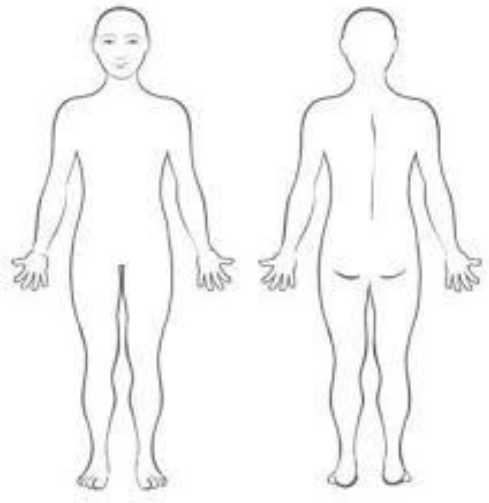
History

Please rate the intensity of your symptoms (0 being no symptoms, 10 being extreme)

☐0 ☐1 ☐2 ☐3 ☐4 ☐5 ☐6 ☐7 ☐8 ☐9 ☐10

Where does the pain radiate to? _____

2nd Body Part:



_____

Date Symptom first appeared: _____

How often do you experience these symptoms?

☐ Constant ☐ 100% ☐ Frequent 75% ☐ Intermittent 50%

☐ Occasional 25% ☐ Rare 10%

What makes Symptom increase?_____

What makes symptom decrease?_____

Type of pain?

☐ Sharp ☐Dull ☐ Aching ☐Burn ☐Throb ☐Numb ☐Other:

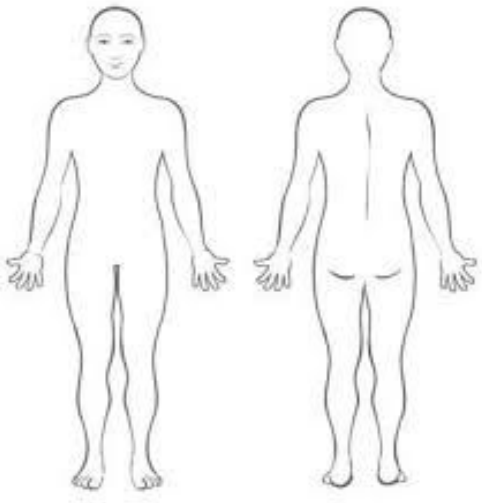
_____

Please rate the intensity of your symptoms (0 being no symptoms, 10 being extreme)

☐0 ☐1 ☐2 ☐3 ☐4 ☐5 ☐6 ☐7 ☐8 ☐9 ☐10

Where does the pain radiate to? _____

3rd Body Part: _____



Date Symptom first appeared: _____

How often do you experience these symptoms?

☐ Constant ☐ 100% ☐ Frequent 75% ☐ Intermittent 50%

☐ Occasional 25% ☐ Rare 10%

What makes Symptom increase?_____

What makes symptom decrease?_____

Type of pain?

AZ MEDICAL AND SPORTS REHAB

Work Injury

History

☐ Sharp ☐ Dull ☐ Aching ☐ Burn ☐ Throb ☐ Numb ☐ Other:

_____

Please rate the intensity of your symptoms (0 being no symptoms, 10 being extreme)

☐0 ☐1 ☐2 ☐3 ☐4 ☐5 ☐6 ☐7 ☐8 ☐ 9 ☐10

Where does the pain radiate to? _____

Please list any medications or vitamins you are currently taking (including dosage)

1_____ Frequency_____ Dosage_____

What is this for? _____

2_____ Frequency_____ Dosage_____

What is this for? _____

3_____ Frequency_____ Dosage_____

What is this for? _____

Are you allergic to any medications? If Yes, please list: _____

X-RAY CONFIRMATION

At this time, to the best of my knowledge, I am not pregnant and I consent to radiographic pictures if necessary.

_____ _____

Patient Signature Date

I understand the information contained within this form and guarantee it was completed correctly and to the best of my knowledge.

_____ _____

Patient Signature Date

AUTHORIZATION FOR CARE OF MINOR CONSENT TO TREAT A MINOR

I hereby authorize the doctor(s) at Arizona Medical and Sports Rehab and whomever they designate as assistants to administer care to a child.

AZ MEDICAL AND SPORTS REHAB

Work Injury

History

Name of Minor Patient _____

Parent name_____

_____ _____

Parent Signature Date