# PATIENT INFORMATION FORM

NAME: _____ D.O.B. ___/___/___ S.S.#: ___/___/___

STREET: _____ TOWN: _____ STATE: _____ ZIP: ___

PHONE #: _____ HEIGHT: _____ WEIGHT: _____ HAIR COLOR: _____

DATE OF INJURY/ACCIDENT: _____ DESCRIPTION: _____

WERE YOU: ( ) at work ( ) auto accident ( ) slip and fall

DID YOU: Go to the hospital? _____ If so, when? ___ where? _____

Have tests performed? _____ If so, what? _____

See a doctor? _____ If so, who is the doctor? _____

How often do you seek treatment in a week? _____ Are you taking any medication? _____

If so, what? _____

Who referred you to your current doctor? _____ Is your current treatment helping your condition? _____

WERE YOU EMPLOYED AT THE TIME OF THE INJURY/ACCIDENT? _____

If so, where? _____ For how long? _____

What type of work do you perform? _____

Does this include:

| | | | | |
|---|---|---|---|---|
| HEAVY LIFTING | Regularly( ) | Occasionally( ) | Seldom( ) | Never( ) |
| LIGHT LIFTING | Regularly( ) | Occasionally( ) | Seldom( ) | Never( ) |
| SITTING | Regularly( ) | Occasionally( ) | Seldom( ) | Never( ) |
| WALKING | Regularly( ) | Occasionally( ) | Seldom( ) | Never( ) |

Did you miss time from work? YES( ) NO( )

Are you working now? YES( ) NO( )

When did you return?: ___/___/___ Are you performing your regular work? YES( ) NO( ) Did you work somewhere else? YES( )NO( )

If yes, where? _____ When did you start? _____

When was the last day you worked? _____

Have you been injured at work before? YES( ) NO( ) If so, when? _____

Who did you treat with? _____

Did you file an insurance claim? _____ If so, with who, and when? _____

Have you ever had surgery? YES( ) NO( )

If so, what type? _____ When? _____ Was this work related? YES( ) NO( )

What are your daily activities? _____

DO YOU PRESENTLY PERFORM:

Housework: YES( ) NO( ) Child Care: YES( ) NO( ) Yard Work: YES( ) NO( ) Shopping: YES( ) NO( )

SPORTING ACTIVITIES:

Golf YES( ) NO( ) Baseball/Softball YES( ) NO( ) Basketball YES( ) NO( ) Bowling YES( ) NO( )

Run: YES( ) NO( ) If yes, how far? _____ If yes, daily( ), weekly( ), seldom( )

Walk: YES( ) NO( ) If yes, how far? _____ If yes, daily( ), weekly( ), seldom( )

Aerobics: YES( ) NO( ) If yes, how far? _____ If yes, daily( ), weekly( ), seldom( )

What are your hobbies? _____

*I understand that I am not a patient of the physician who is to examine me.*

*This examination is being performed for the purpose of evaluating my present medical condition (s) and its not intended to be understood to be for the purpose of any medical treatment. The results of your examination will be forwarded to the person who scheduled this and the results of this examination should be available within two weeks of today's date.* **Thank you for taking the time to fill out this form.**

SIGNED: _____ DATE: ___/___/___