Dr. Jon P. Kelly, M.D

Worker's Compensation Injury History Form

Patient Name:____Date:____________________

Job Description

Age:________ Right / Left Handed (Circle One) Employer at the time of injury:__________________________

Job Title:___________________________________ Number of hourse worked: per day_______ per week_______

Basic work duties at the time of injury:____

____

____

Tools/Machinery routinely used:____

Objects you lifted alone while working:_____________________________Heaviest objects lifted:_______________

Estimate the weight of the heaviest objects lifted:______ Number of times a day this amount was lifted:_______

Objects lifted with co-workers each day:________Weight of objects:_______Number of times lifted:__________

Length of time with this employer at the time of injury:________ Length of time in this line of work:___________

Did you work for any other empluer, for any friends, or have a home-based business on the side while working

for this employer?____

If yes, please complete the following:

Name of employer or type of home-based business:____

Type of work performed for employer, at home, or for friends:____

Time period you worked for other employer, friend, or at home-based business:_____________________________

List places of employment for the last 10 years:

Employer:______________________ Position held:____________________ Length of time:____________________

Duties performed:____

Employer:______________________ Position held:____________________ Length of time:____________________

Duties performed:____

Employer:______________________ Position held:____________________ Length of time:____________________

Duties performed:____

If you have additional employers, please list:____

____

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Date of injury:_______ If there is no specific date of injury, when did you first begin to have problems?_________

What were you doing at the specific time of injury? If there was no specific injury, when did symptoms begin?

____

____

____

____

What parts of your body were injured?____

What symptoms did you have?____

Did you continue to work?______________________ If no, why not?__________________________

When was the injury reported?_________________________To whom?____________________

Place where the treatment was first received?____________________Date of first treatment:______________

Course of Treatment to Date

Treatment Received	Date	Physician	Location	Type	Results of Treatment
X-Rays					
MRI					
Therapy					
CAT Scan					
Myelogram					
Injections / Epideral					
Surgery					
Chiropractic Care					
Acupuncture					
EMG/Nerve Conduction					
Other					

Which treatments helped?____

Which physician(s) is currently treating you?____

What diagnosis have you been given?____

What further treatments have you been told are needed?__________________________________

Have you been released from care by any physician?___ If yes, when and which physician(s)?_______________

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Since the injury, have you returned to any type of work?_______If yes, when did you return to work?__________

Are you working for the same employer?______Are you currently performing the same duties for them?_______

If you have a new employer, who is it?______________________________When did you start?_______________

What are your duties for the new employer?____

If working for the same employer, what duties are you **not** performing?____________________________________

Dates you did not work at all: From___________to____________ From___________to____________

Dates light duty performed: From___________to____________ From___________to____________

Dates full duty performed: From___________to____________ From___________to____________

Since injury, have you had any other injuries that are industrial or non-industrial?__________________________

If yes, date of injury:_______ Was it industrail?_______ What area of the body was injured?__________________

Treatment for above injury (type and where received)?____

Present Complaints

Symptoms	Where	How Often	Worsened By	Received By
Pain				
Numbness				
Tingling				
Swelling / Stiffness				
Weakness				
Difficulty with balance				
Other (i.e. hedaches)				

Have you had loss of bladder or bowel control?_______If yes, please describe in detail:_____________________

____

Back Pain: Increased with: Coughing_____ Sneezing_____ Bending_____ Twisting_____ Lifting_____

Standing_____ Sitting_____ Walking_____ Driving_____ Lying Down_____ Nights_____

Since your initial symptoms, are you: better_____, the same_____, worse_____?

Which is most troublesome? Back pain_____ Leg pain_____ Neck pain_____ Arm pain_____

How frequent is your pain? Comes and goes__________ Constant____________

On a scale from 1-10, with 10 being the worst possible pain, describe your pain:

1	2	3	4	5	6	7	8	9	10

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Past Medical History

Have you had any other **work** related injuries to the areas involved in this claim or other areas?__________ If yes:
Dates of injury:___________________ Areas injured:_________________ Employer at the time:__________________
Treatment received, and by whom:____
When were you released from care for this injury?______________ When was your last treatment?_____________
Do you have future medical care?_________________ If yes, what?____
Did you receive a settlement for this injury?_________ If yes, how much or what percentage rating?_____________
Have you had **non-work** related injuries to the areas involved in this claim or other areas?____________________
Dates of injury:__________ Areas injured:______________ Treatment received, and by whom:___________________
When were you released from care for this injury?_________________When was your last treatment?____________
Did you have back/neck pain or limitations prior to your current injury?_____________________________________
Please check any of the following you currently have or have had in the past:

Condition	Yes	No	Current Treatment
Diabetes			Type:
Heart Disease			
High Blood Pressure			
Lung Problems Asthma/TB			
Stroke/Seizures Psychological			
Stomach/Ulcers/ Bleeding			
Liver Disease			
Thyroid Disease			
Tumors/Cancer			
Kidney Problems			
Arthritis			Where:
Other			

Surgeries:____

Current medications you are taking: Dose: How Often?

1.____ _______________ ____________________________
2.____ _______________ ____________________________
3.____ _______________ ____________________________

Patient Signature____ Date______________________

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