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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