Workers' Comp Injury Health History Questionnaire

If you need help completing this form bring it to the receptionist.

Social Security #: _____Last Name:_____ First:_____

Address: _____ City: _____

State_____ Zip Code_____ Home Phone:_____

Date of Birth: _____Gender: M / F (Circle) Cell Phone:_____

Employer: _____Occupation: _____

Employer Phone #: _____ Contact Person/Supervisor: _____

Supervisor Phone Number: _____ Length of Employment: _____

How would you prefer to be contacted for appointment reminders? (please **circle** preference below)

1.TEXT 2.EMAIL 3.PHONE (HOME or CELL)

Do you now have or have you ever had:

High Blood Pressure	☐ Yes	☐ No	Arthritis	☐ Yes	☐ No
Diabetes	☐ Yes	☐ No	Epilepsy/Seizures	☐ Yes	☐ No
Heart Disease/High Cholesterol	☐ Yes	☐ No	Lung Disease/TB/Asthma	☐ Yes	☐ No
Kidney Disease	☐ Yes	☐ No	Cancer	☐ Yes	☐ No
Carpal Tunnel	☐ Yes	☐ No	Anemia/Bleeding/Bruising	☐ Yes	☐ No
Psychiatric Illness	☐ Yes	☐ No	Hernia	☐ Yes	☐ No
Broken Bones/Back/Neck/ Injury	☐ Yes	☐ No	Joint/Muscle injury	☐ Yes	☐ No
Work Restrictions/ Disability Rating	☐ Yes	☐ No	Drug/Alcohol Addiction	☐ Yes	☐ No
Hospitalizations/Surgeries	☐ Yes	☐ No	Smoke Cigarettes	☐ Yes	☐ No
Ulcer/GERD/Inflammatory Bowel	☐ Yes	☐ No	How many per day? _____		
Skin diseases	☐ Yes	☐ No	Number of years? _____		

Explain any yes answers: _____

_____

_____

Last Tetanus: _____ Last Menstrual Period: _____ *(Females only)*

List **all** the **Medications**, Vitamins or Supplements you are presently taking, **both** prescription and over the counter, indicate dosages: _____

_____

List any **Allergies** to medication, food, latex, chemicals: ☐ None

_____

_____

Patient Name: _____ Date of Birth: _____Date: _____

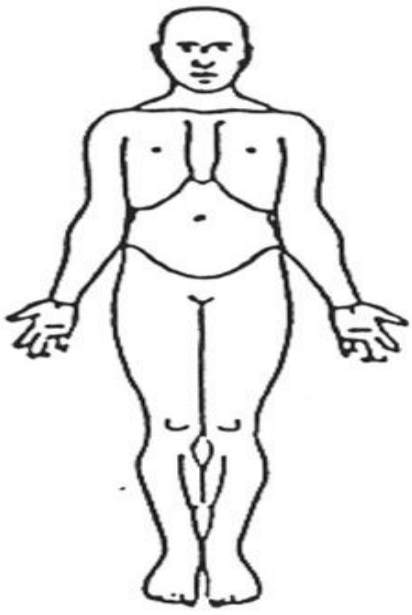
Please answer the following questions about the injury you are here for today:

1. How did this injury occur: _____
   _____
2. Date of Injury: _____ Time of Injury: _____
3. Body part affected: _____
4. When did you first notice the symptoms:_____
5. Describe any remedies you may have used and whether they were effective? _____
   _____
6. Describe any difficulties you are having with activities at home or at work?_____
   _____
7. Have you ever had a similar problem in the past? ☐ Yes ☐ No If yes, please describe:_____
8. Have you seen other health care providers for this problem? ☐ Yes ☐ No If yes, please describe when it occurred and the treatment provided:_____
   _____

Please use the drawing below to indicate the location and description of your symptoms:

Using the symbols given below, mark the areas on your body where you feel the described sensations. Include all affected areas:

Aching	**Numbness**	**Pins & Needles**	**Burning**	**Stabbing**	**Other**
#####	**=======**	**OOOOO**	**XXXXX**	**//////////**	**+++++**



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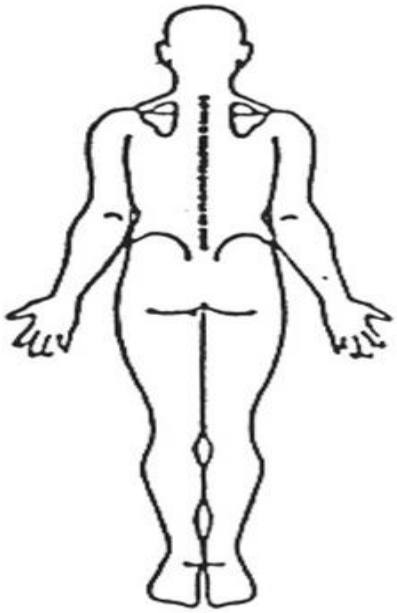

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I authorize this treating facility to perform any and all tests or procedures as deemed necessary by the attending physician and/or employer. I authorize the release of medical information concerning my care to another medical facility or medical provider for the purpose of continuing my care, to my employer and their workers' compensation carrier. I understand that this information may be used for the purpose of informing and communicating to other physicians, organizations and professionals regarding the health/medical services provided to me. I agree to allow COMP, LLC to bill my health insurance if my claim is denied. I understand that I am responsible for any remaining balance/charges incurred at COMP, LLC. I understand that I will be billed on a monthly basis and will be charged 1% interest per month for any balance over thirty days. I further understand that my employer will be notified if I am unable to keep a scheduled appointment. I attest that the information contained on this 2 page form is complete and correct to the best of my knowledge.

Employee/Patient Signature: _____ Date: _____