History of Present Illness for Work Related Injury

UOA
University Orthopaedic Associates
A DIVISION OF ORTHO ALLIANCE NJ

Last Name: _____ First Name: _____ Date: _____

Date of Birth: _____ Time of Injury: _____ Date of Injury: _____

Current Height: _____ Have you had a bone density scan (for osteoporosis)? ☐ Yes ☐ No

Current Weight: _____ Where/Year: _____

Laterality: ☐ **Right** ☐ **Left** ☐ **Bilateral**

☐ **Fracture** ☐ **Laceration/Wound**

Primary Affected Area: *Choose most significant area for today's visit*

☐ Neck ☐ Mid Back ☐ Low Back ☐ Shoulder ☐ Clavicle ☐ Upper Arm ☐ Elbow ☐ Forearm

☐ Wrist ☐ Hand ☐ Hip ☐ Pelvis ☐ Thigh ☐ Knee ☐ Lower Leg ☐ Ankle ☐ Foot

On a scale of 0 to 10, 0 being no pain and 10 being the worst, please circle below your current level of pain

☐ 0 ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ 7 ☐ 8 ☐ 9 ☐ 10

No Pain — Moderate Pain — Worst Possible Pain

Signs & Symptoms: ☐ Bruising ☐ Inflammation ☐ Numbness/tingling ☐ Stiffness ☐ Weakness ☐ Swelling

Aggravated By: ☐ Daily Activities ☐ Exercise ☐ Lifting ☐ Overhead ☐ Motion ☐ Sports ☐ Throwing ☐ Work

Relieved By: ☐ Activity ☐ Compression Wrap ☐ Elevation ☐ Heat ☐ Ice ☐ Injections ☐ NSAIDS ☐ Pain Medication ☐ Physical Therapy ☐ Rest ☐ Tylenol ☐ I do not get relief

Pain Is: ☐ Dull ☐ Sharp ☐ Throbbing ☐ Intermittent ☐ Constant ☐ No Pain

Please explain how the accident occured:_____

_____

Do you have an immediate or previous history of falls? ☐ Yes ☐ No

Do you use an assistive device to help you ambulate? ☐ Yes ☐ No

If yes, please check the most appropriate device: ☐ Cane ☐ Walker ☐ Wheelchair ☐ Rolling Scooter ☐ Other: _____

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Have you ever been treated in the past by a chiropractor? ☐ Yes ☐ No

If yes, please provide the name & address of the chiropractor: _____

Have you filed any workers compensation claim (s) in the past for this medical condition? ☐ Yes ☐ No

If yes, please provide details: _____

_____

Have you ever been involved in any motor vehicle collisions? ☐ Yes ☐ No

If yes, please provide details: _____

_____

Are you currently engaged in any other employment? ☐ Yes ☐ No

If yes, please provide names and addresses: _____

_____

Do you currently (in the past 12 months) participate in any athletic, recreational or sporting activities? ☐ Yes ☐ No

If yes, please list: _____

Have you ever received pain management treatment? ☐ Yes ☐ No

If yes, please provide the name and address of the treating physician(s) for this condition._____

_____

Patient Attestation:

I certify that the statements provided are true and correct and provided to the best of my ability.

_____ _____

Patient Signature Date

Clinical Staff's Initials _____

Medications You Are Currently Taking

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Today's Date: _____

Patient Name: _____ Date of Birth: _____

List all medications you are taking including non-prescription medications and opioids ☐ I am not taking any medications

	Medication #1	Medication #2	Medication #3	Medication #4
Name:				
Dosage:				
Frequency:				
Route:	☐ Oral ☐ Inject ☐ Topical ☐ Nasal ☐ Inhale ☐ Patch ☐ Drops	☐ Oral ☐ Inject ☐ Topical ☐ Nasal ☐ Inhale ☐ Patch ☐ Drops	☐ Oral ☐ Inject ☐ Topical ☐ Nasal ☐ Inhale ☐ Patch ☐ Drops	☐ Oral ☐ Inject ☐ Topical ☐ Nasal ☐ Inhale ☐ Patch ☐ Drops
	Medication #5	**Medication #6**	**Medication #7**	**Medication #8**
Name:				
Dosage:				
Frequency:				
Route:	☐ Oral ☐ Inject ☐ Topical ☐ Nasal ☐ Inhale ☐ Patch ☐ Drops	☐ Oral ☐ Inject ☐ Topical ☐ Nasal ☐ Inhale ☐ Patch ☐ Drops	☐ Oral ☐ Inject ☐ Topical ☐ Nasal ☐ Inhale ☐ Patch ☐ Drops	☐ Oral ☐ Inject ☐ Topical ☐ Nasal ☐ Inhale ☐ Patch ☐ Drops
	Medication #9	**Medication #10**	**Medication #11**	**Medication #12**
Name:				
Dosage:				
Frequency:				
Route:	☐ Oral ☐ Inject ☐ Topical ☐ Nasal ☐ Inhale ☐ Patch ☐ Drops	☐ Oral ☐ Inject ☐ Topical ☐ Nasal ☐ Inhale ☐ Patch ☐ Drops	☐ Oral ☐ Inject ☐ Topical ☐ Nasal ☐ Inhale ☐ Patch ☐ Drops	☐ Oral ☐ Inject ☐ Topical ☐ Nasal ☐ Inhale ☐ Patch ☐ Drops
Preferred Pharmacy:	Name: _____		Address: _____	

Clinical Staff's Initials _____