

# History of Present Illness for Work Related Injury



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

Fracture

Left

Laceration/Wound

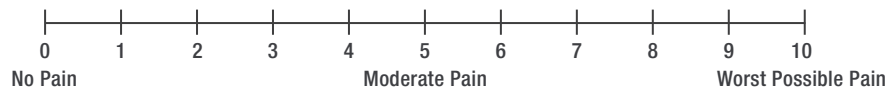
Bilateral

## 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



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 occurred: \_\_\_\_\_

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:	<input type="checkbox"/> Oral <input type="checkbox"/> Inject <input type="checkbox"/> Topical <input type="checkbox"/> Nasal <input type="checkbox"/> Inhale <input type="checkbox"/> Patch <input type="checkbox"/> Drops	<input type="checkbox"/> Oral <input type="checkbox"/> Inject <input type="checkbox"/> Topical <input type="checkbox"/> Nasal <input type="checkbox"/> Inhale <input type="checkbox"/> Patch <input type="checkbox"/> Drops	<input type="checkbox"/> Oral <input type="checkbox"/> Inject <input type="checkbox"/> Topical <input type="checkbox"/> Nasal <input type="checkbox"/> Inhale <input type="checkbox"/> Patch <input type="checkbox"/> Drops	<input type="checkbox"/> Oral <input type="checkbox"/> Inject <input type="checkbox"/> Topical <input type="checkbox"/> Nasal <input type="checkbox"/> Inhale <input type="checkbox"/> Patch <input type="checkbox"/> Drops
	Medication #5	Medication #6	Medication #7	Medication #8
Name:				
Dosage:				
Frequency:				
Route:	<input type="checkbox"/> Oral <input type="checkbox"/> Inject <input type="checkbox"/> Topical <input type="checkbox"/> Nasal <input type="checkbox"/> Inhale <input type="checkbox"/> Patch <input type="checkbox"/> Drops	<input type="checkbox"/> Oral <input type="checkbox"/> Inject <input type="checkbox"/> Topical <input type="checkbox"/> Nasal <input type="checkbox"/> Inhale <input type="checkbox"/> Patch <input type="checkbox"/> Drops	<input type="checkbox"/> Oral <input type="checkbox"/> Inject <input type="checkbox"/> Topical <input type="checkbox"/> Nasal <input type="checkbox"/> Inhale <input type="checkbox"/> Patch <input type="checkbox"/> Drops	<input type="checkbox"/> Oral <input type="checkbox"/> Inject <input type="checkbox"/> Topical <input type="checkbox"/> Nasal <input type="checkbox"/> Inhale <input type="checkbox"/> Patch <input type="checkbox"/> Drops
	Medication #9	Medication #10	Medication #11	Medication #12
Name:				
Dosage:				
Frequency:				
Route:	<input type="checkbox"/> Oral <input type="checkbox"/> Inject <input type="checkbox"/> Topical <input type="checkbox"/> Nasal <input type="checkbox"/> Inhale <input type="checkbox"/> Patch <input type="checkbox"/> Drops	<input type="checkbox"/> Oral <input type="checkbox"/> Inject <input type="checkbox"/> Topical <input type="checkbox"/> Nasal <input type="checkbox"/> Inhale <input type="checkbox"/> Patch <input type="checkbox"/> Drops	<input type="checkbox"/> Oral <input type="checkbox"/> Inject <input type="checkbox"/> Topical <input type="checkbox"/> Nasal <input type="checkbox"/> Inhale <input type="checkbox"/> Patch <input type="checkbox"/> Drops	<input type="checkbox"/> Oral <input type="checkbox"/> Inject <input type="checkbox"/> Topical <input type="checkbox"/> Nasal <input type="checkbox"/> Inhale <input type="checkbox"/> Patch <input type="checkbox"/> Drops
Preferred Pharmacy:	Name: _____		Address: _____	

Clinical Staff's Initials \_\_\_\_\_