Injured Worker History Form

Name: _____ _____ _____

Last **First** **MI** **Age** **Date of Birth**

Today's Date: _____ **Date of Injury**: _____

Describe what happened when the injury occurred or pain started _____

_____

_____

Employer_____ **Date of Hire** _____

Usual Occupation_____

Briefly describe your job _____

_____

How physically demanding is your job?

☐Sedentary (occasionally lifting up to 10 lbs)

☐Light (frequently lifting up to 10 lbs; occasionally 20 lbs)

☐Light-Medium (frequently lifting up to 20 lbs, occasionally 30 lbs)

☐Medium (frequently lifting up to 25 lbs; occasionally 50 lbs)

☐Medium-Heavy (frequently lifting up to 35 lbs; occasionally 75 lbs)

☐Heavy (frequently lifting up to 50 lbs; occasionally 100 lbs)

☐Very Heavy (frequently lifting over 50 lbs; occasionally >100 lbs)

Work status at the time of injury or onset of this episode of pain:

☐Regular (full time) ☐Regular (part time) ☐Temporary light duty ☐Permanent light duty ☐Already on disability

Work status today:

☐Regular Duty ☐Limited/Light Duty-As Of __/__/__ ☐Receiving Disability-As Of __/__/__

☐Other_____

How satisfied are you with your job?

☐Very Satisfied ☐Satisfied ☐Dissatisfied ☐It is the Worst Job I Have Ever Had

When was the last time you worked? _____

How many months have you worked during the last 24 months? _____

If your pain got completely better during the next few weeks, do you think your employer would let you return to the job you had before this episode of pain?

☐Yes ☐Probably ☐Doubtful ☐Definitely Not ☐I Don't Know ☐ Not Applicable

_____

Do you feel this injury was your employer's fault? ☐Yes ☐No

If yes, how so? _____

Has your employer treated you fairly? ☐Yes ☐No ☐ I Don't Know

If no, please explain:

_____

_____

_____

New Patient Pain History Form

Name: _____ Date of Birth: ____/____/_____ Today's Date: ____/____/_____

Date the Pain Began: ____/____/_____ Reason for visit: _____

_____

_____

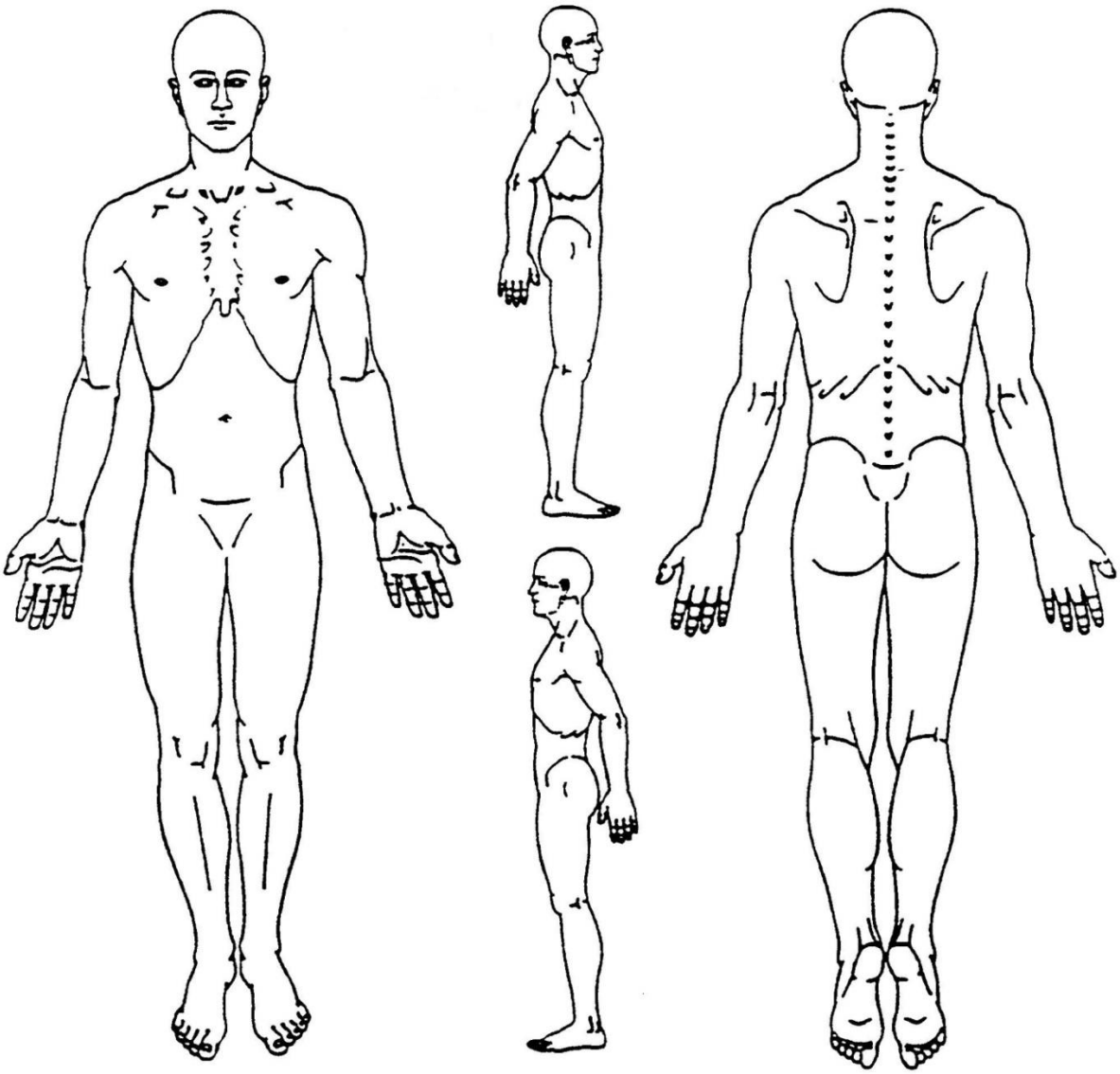
Describe what caused the pain (accident, injury, etc.): _____

_____

_____

Pain

1. Pain/Symptom Description – Mark the affected areas on your body where you feel your typical pain and/or symptom and place a star by where you are most affected.



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2. How would you describe the kind of pain/associated symptoms that you have:
   ☐Sharp ☐Stabbing ☐Aching ☐Dull ☐Burning ☐Cramping ☐Pins and needles ☐Throbbing
   ☐ Numbness – If so, where? _____ ☐ Weakness – If so, where? _____
3. Pain compared to when it first started: ☐Improved by _____% ☐Worsened by _____% ☐No Change
4. Pain Severity: If "0" is no pain and "10" is the worst pain imaginable, please note your pain over the <u>past two weeks</u> by circling the appropriate number:

Pain at its worst:	[0 1 2] Mild	[3 4 5 6 7] Moderate	[8 9 10] Severe
Pain at its least:	[0 1 2] Mild	[3 4 5 6 7] Moderate	[8 9 10] Severe
Pain on average:	[0 1 2] Mild	[3 4 5 6 7] Moderate	[8 9 10] Severe

Pain Frequency: ☐Constant ☐Intermittent, ____# of hours in pain per day
Time of Day Pain is at its Worst: ☐ Morning ☐Afternoon ☐Evening ☐Nighttime
How Often You Stop Activity Due to Pain: ☐Never ☐Rarely ☐Occasionally
☐ Several Times a Day ☐Spend Most of the Day Lying/Sitting

5. Activities which relieve pain: _____
6. Activities which increase pain: _____
7. Medications you take to relieve pain (please list all): _____
   _____
8. Current exercise activities: _____

Diagnostic tests performed for this condition:

<u>Test</u>	<u>Date</u>	<u>Location</u>
☐X-Rays	_____	_____
☐CT Scan	_____	_____
☐MRI	_____	_____
☐Bone Scan	_____	_____
☐EMG (nerve test)	_____	_____
☐Other	_____	_____

List the doctors (Primary Care, MD Specialist, Osteopathic Specialist, Chiropractor, or Therapist) you have seen in the last year for your condition:

<u>Doctor's Name</u>	<u>Type of Doctor</u>	<u>Location</u>	<u>Approximate Date</u>
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

Effect of treatment(s) you have had, or are currently receiving, for your pain:

<u>Treatment</u>	<u>Helped</u>	<u>Made Things Worse</u>	<u>No Difference</u>	<u>Currently Receiving</u>
Heat/Ice/Ultrasound	☐	☐	☐	☐
Massage	☐	☐	☐	☐
TENS Unit	☐	☐	☐	☐
Physical Therapy	☐	☐	☐	☐
Epidural Injections	☐	☐	☐	☐
Back Brace	☐	☐	☐	☐
Acupuncture	☐	☐	☐	☐
Mental Healthcare	☐	☐	☐	☐
Chiropractic Care	☐	☐	☐	☐

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New Patient Health History Form

Name: _____Today's Date:_____/_____/_____

Date of Birth: _____/_____/_____PCP: _____

Allergies and Medications:

Medication allergies:_____

List any other allergies:_____

Current Medications:

Medication	Dose/Frequency	Used to Treat	For How Long?
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

Past Medical History (please check those which apply):

□Hypertension
□Heart Disease
□Hyperlipidemia
□Nerve/Muscle disease
□Stroke
□Seizures
□Migraine
□Fibromyalgia
□Chronic Pain (>3 months)
□Diabetes Mellitus
□GERD/Ulcers/Gastritis
□Depression
□Motor Vehicle Accident
□Thyroid Disease
□Pulmonary
□Kidney Disease
□Anxiety
□Substance Abuse
□Cancer
□Work Related Injury
□Fractures
□DVT
□Prostate Problems

□Nerve/Muscle Disease (please specify):_____

Any other relevant medical history:_____

Family History (please place a check mark indicating relation of relative)

Status:	Alive	Deceased	Unknown	No Known Issues	Arthritis	Cancer	Depression	Diabetes	Early Death (<50yo)	Heart Disease	High Blood Pressure	Lung Disease	Neurological Disorder	Osteoporosis	Stroke	Spine Problems	Drug/Alcohol Abuse	Thyroid Disease
Mother																		
Father																		
Sister																		
Brother																		
Maternal Grandmother																		
Maternal Grandfather																		
Paternal Grandmother																		
Paternal Grandfather																		
Daughter																		
Son																		

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Other relevant family history:_____

Surgical History (please check those which apply and provide approximate year performed):

□Appendectomy_____ □Gall Bladder _____ □Neck Surgery_____
□Back Surgery_____ □Heart Surgery _____ □Orthopedic and/or Joint
□Breast Surgery_____ □Hernia Repair _____ Surgery_____
□C-Section_____ □Hysterectomy_____ □Tonsillectomy _____

Any other relevant surgical history:_____

Social History

1. Marital status: □Married □Domestic Partner □Widowed □Never Married □Divorced/Separated
2. Whom do you live with: □Spouse □Children □Parents □Roommate(s) □Partner □Alone □Other_____
3. Highest grade or level of education completed: _____
4. Tobacco Use: □Never □Current □Former (Quit Date: _____)
   a. Type(s) of tobacco used: □Cigarettes □Cigars □Pipe □Chewing Tobacco
   b. Average number of packs per day: _____ Age when started using tobacco: _____
5. Cups of coffee per day? _____ Cups of other caffeinated beverages per day? _____
6. Do you use alcohol? □Yes □No If so, average number of alcoholic beverages per week:_____
   a. Times in the past year you consumed 4+ drinks in one day: _____
   b. Do you use alcohol to control your pain? □Yes □No
7. Drugs you have used:
   a. at any time: □Stimulants □Hallucinogens □Marijuana □Cocaine □Meth □None of these
   b. in the past 12 months: □Stimulants □Hallucinogens □Marijuana □Cocaine □Meth □None of these
8. Are you currently employed? □Yes □No
   a. If so, how many hours per week do you work? _____
   b. Where do you work?_____
   c. What type of work do you do?_____
9. Are you currently on disability or involved in a disability claim? □Yes □No
10. Are you currently involved in a legal claim? □Yes □No
    a. If so, are you represented by an attorney? □Yes □No If yes, please provide name:_____

Review of Symptoms (Check all those which apply):

☐ Low Back Pain	☐ Dizziness	☐ Fever	☐ Wheezing
☐ Joint Pain	☐ Headaches	☐ Weight Loss	☐ Coughing
☐ Joint Swelling	☐ Urinary Frequency	☐ Night Sweats	☐ New Rash
☐ Muscle Pain	☐ Loss of Control of Urine	☐ Vision Change	☐ Psoriasis
☐ Night Pain	☐ Loss of Control of Bowels	☐ Double Vision	☐ Skin Breakdown
☐ Numbness	☐ Constipation	☐ Difficulty Swallowing	☐ Depressed Mood
☐ Tingling	☐ Nausea	☐ Chest Pain	☐ Sleep Problems
☐ Weakness	☐ Vomiting	☐ Palpitations	☐ Anxiety
☐ Black Stools	☐ Shortness of Breath	☐ 2 or More Falls in the Last Year OR 1 With Injuries	

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Tualatin Map and Directions

From the South

- Travel North on I-5
- Take exit 289, turn right at the light
- Follow the curve to the right, proceed on SW 65th Ave
- Turn left into the entrance to Legacy Meridian Park Medical Center
- Make the second left and park in any designated patient space
- Inside the building, take the elevator to the second floor to reach Suite 250

From the West

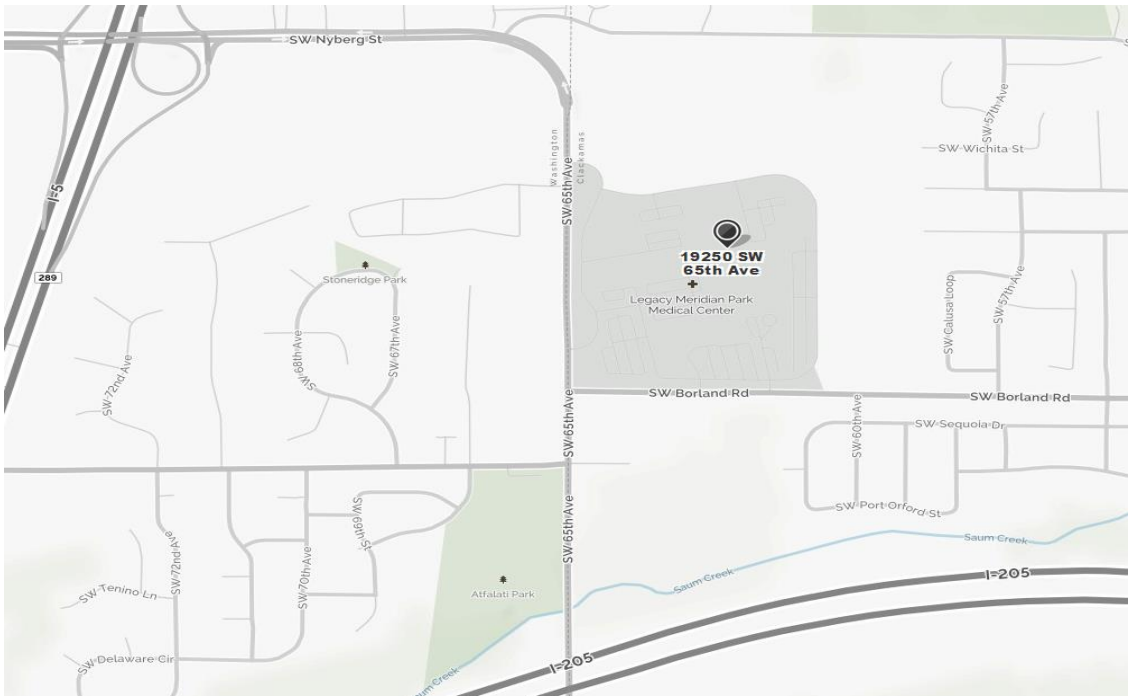
- Travel to I-5
- Follow remaining directions from the South or North (according to your proximity to the Nyberg St exit)

From the East

- Travel West on I-205
- Take exit 3, turn right onto Stafford Road
- Turn left onto Borland Road and proceed to SW 65th Avenue (approximately 4 miles)
- Turn right onto SW 65th Ave
- Make the first right into Legacy Meridian Park Medical Center
- Make the second right and park in any designated patient space
- Inside the building, take the elevator to the second floor to reach Suite 250

From the North

- Travel South on I-5
- Take exit 289, turn left at the light
- Cross the overpass and proceed on Nyberg Road
- Follow the curve to the right, proceed on SW 65th Ave
- Turn left into the entrance to Legacy Meridian Park Medical Center
- Make the second left and park in any designated patient space
- Inside the building, take the elevator to the second floor to reach Suite 250



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Northwest Map and Directions

Address: 1040 NW 22nd Ave., Ste 320 Portland, OR 97210

From the South

- Travel North on I-5
- At the 1-5 split, stay left toward City Center
- Follow signs to I-405/City Center/Beaverton exit (exit 299B)
- Take Exit 2B, Everett Street, onto 14th Street
- Continue on 14th Street. Turn left onto NW Marshall Street

From the West

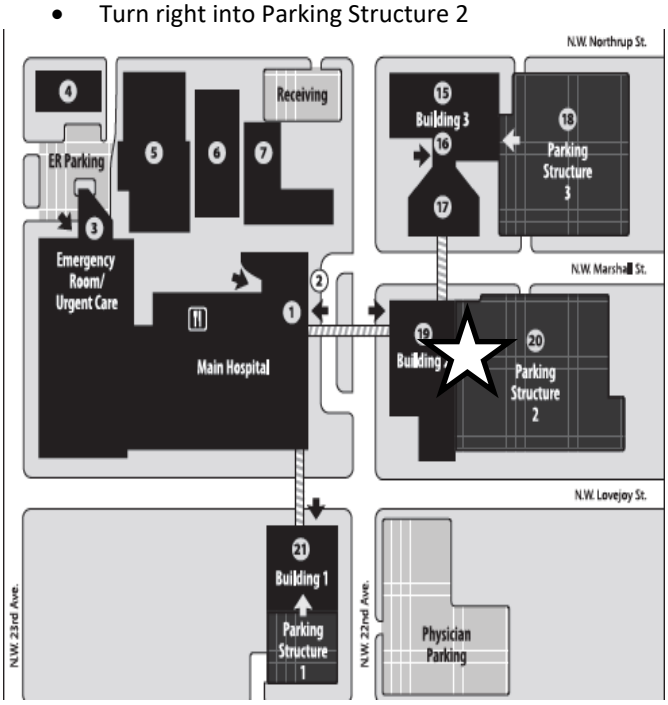
- Travel East on US26/Sunset Highway
- Exit onto I-405 – Seattle/St Helens
- Take exit 2B, Everett Street, onto 14th Street
- Continue on 14th Street. Turn left onto NW Marshall Street
- Turn left into Parking Structure 2 between 21st and 22nd Ave

From the East

- Travel West on I-84
- Follow signs to I-5 North (right lanes)
- Follow I-5 North to Exit 302B
- Take exit 302B across the Fremont Bridge
- Cross the Willamette River on Fremont Bridge, stay to the right
- Take Vaughn Street Exit (Exit 3)
- Turn left onto NW 23rd Ave (first light after Vaughn St exit)
- Turn left onto NW Northrup Street
- Turn right onto NW 22nd Ave
- Turn left onto NW Marshall
- Turn right into Parking Structure 2

From the North

- Travel South on I-5
- Take exit 302B across the Fremont Bridge
- Cross the Willamette River on Fremont Bridge, stay to the right
- Take Vaughn Street Exit (Exit 3)
- Turn left onto NW 23rd Ave (first light after Vaughn St exit)
- Turn left onto NW Northrup Street
- Turn right onto NW 22nd Ave
- Turn left onto NW Marshall
- Turn right into Parking Structure 2



Parking at the Good Samaritan Campus

We have several options for parking:

Use our parking structure. You may park for free in any of the three parking structures, which have gates. Please take a ticket upon entering and, at the conclusion of your appointment, RMA will issue you a parking validation ticket free of charge. If you enter the parking structure and exit within 15 minutes, no validation is required.

Valet parking. You may use Legacy's free valet parking from 7 a.m. to 5 p.m. at the main hospital entrance, N.W. 22nd Avenue and Marshall Street.

Street parking. Street parking may be available. Please observe all posted placards.

Handicapped parking. The easiest accessible handicap parking to RMA is on level H of parking structure 2.