

VIKRAM TALWAR, MD

INCORPORATED

Diplomat American Academy of Orthopedic Surgery

WORKERS COMPENSATION HEALTH QUESTIONNAIRE

Patient Name: _____ Date of Birth: _____ Age: _____

Height: _____ Weight: _____

Who referred you to our office? _____

What is your job? _____

Employer at time of injury: _____ How long did you work there? _____

How did you get hurt at work? _____

Please describe accident/injury:

Pain level today (1-10): _____

Treatment Since Injury

	YES	NO	Number of Visits	Year
Physical Therapy				
Chiropractic				
Acupuncture				
Injections				

-Type(i.e epidural, facet, ablation):

Medications for injury: Please List				
Brace				
Home Exercise Program				
Surgery				

-Type of Surgery:

Who has treated you so far (Provider names)?:

Did you miss work? Yes No Is yes, when and how long?: _____

Are you working now? Yes No If yes, full duty or modified? _____

Prior injuries to the same area? Yes No

If yes, when: _____ Did the symptoms resolve? Yes No

Symptoms now (1-10): _____

Patient Name: _____

Date of Birth: _____

How often does the pain/numbness occur: Rare Intermittent Occasional Persistent N/A

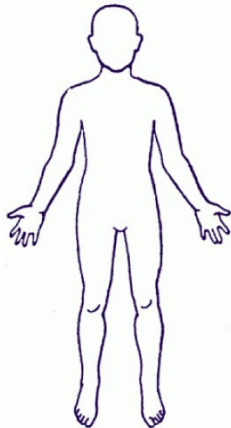
What is the status of your condition since the onset date:
 Unchanged Improving Fluctuating Stable Worse Resolved

Where type of pain/ numbness are you experiencing? Check all that apply No pain/numbness
 Ache Burning Deep Superficial Dull Localized Piercing Sharp Shooting Throbbing Electric Tingling Numb Discomfort

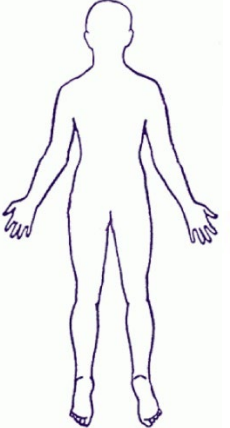
What is the location of your pain/numbness? Check all that apply No pain/numbness
 Neck Upper back Mid back Lower back Gluteal area Flank
 Thighs Legs Shoulder Arm Hand Fingers
 Other: _____ (circle one) (circle one) (circle one) (circle one) (circle one)
RT / LT / Both RT / LT / Both RT / LT / Both RT / LT / Both RT / LT / Both

Below "X" the areas you feel pain


FRONT





BACK





Circle which best describes your pain:



0
No Hurt


2
Hurts Little Bit


4
Hurts Little More


6
Hurts Even More


8
Hurts Whole Lot


10
Hurts Worst

What aggravates your condition? Check all that apply Nothing aggravates my condition
 Daily activity Ascending stairs Descending stairs Coughing Driving
 Flexion Extension Lifting weight Rotating/twisting Bending Standing
 Sitting Walking Exercise Lying down/sleep Other: _____

What relieves your condition? Check all that apply Nothing relieves my condition
 Ice Heat Elevation Mobility Rest Stretching Exercise Brace
 Massage Physical therapy (how many visits completed): _____ Acupuncture Chiropractic
 Injection OTC meds (which med): _____
 Pain medication (which med): _____

Pain level after taking your medication: No Pain - 0 1 2 3 4 5 6 7 8 9 10 - Incapacitating

PLEASE LIST ALL MEDICATIONS YOU ARE TAKING (including OTC/vitamins/herbals/supplements)

No medications to list
 See attached medications list

Are you taking blood thinners? Yes No

Medication	Dosage & Frequency	Purpose & Administered route i.e. oral/IV/topical	Physician

Patient Name: _____

Date of Birth: _____

DRUG & OTHER ALLERGIES (list):

NO KNOWN DRUG ALLERGIES

Have you had a fall in the last 12 months? Yes No More than 2 times? Yes No

SOCIAL HISTORY

Do you smoke tobacco products? Yes No If yes, have you ever tried to quit? Yes No

Type: _____ Packs per day: _____ Years used: _____

Do you drink alcohol? Yes No If yes, how many drinks per week? _____

Do you presently use any recreational drugs? Yes No If so, please list: _____

Have you traveled or lived outside the US or Canada? Yes No If yes, when/where: _____

PAST MEDICAL AND FAMILY HISTORY

Illness/Condition	Self	Relative	Describe
Anesthesia complications	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	_____
Bleeding prob/blood clots	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	_____
Cancer	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	_____
Diabetes	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	_____
Heart disease	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	_____
Hepatitis/HIV	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	_____
High Blood Pressure	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	_____
Liver disease	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	_____
Psychiatric illness	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	_____
Stroke/TIA	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	_____
Tuberculosis	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	_____
Other:	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	_____

Do you have a chronic illness Yes No If yes, what is it: _____

DIAGNOSTIC HISTORY

None

Study	Within 6 months	Within 1 year	Body Part
X-rays	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	_____
MRI/CT	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	_____
EMG/nerve conduction studies	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	_____
Myelogram	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	_____
Bone scan/DEXAscan	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	_____
Other:	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	_____

Patient Name: _____

Date of Birth: _____

PRIOR SURGERY					<input type="checkbox"/> None
Name of Operation	Reason	Date	Facility	Physician	

REVIEW OF SYSTEMS

CHECK IF YOU HAVE ANY OF THE FOLLOWING

Constitutional <input type="checkbox"/> Fever/chills/night sweats <input type="checkbox"/> Weakness/fatigue <input type="checkbox"/> Weight gain <input type="checkbox"/> Weight loss <input type="checkbox"/> Other: _____	Cardiovascular <input type="checkbox"/> Stroke/blood clots <input type="checkbox"/> Chest pain <input type="checkbox"/> Abnormal heart rhythm <input type="checkbox"/> High blood pressure <input type="checkbox"/> Heart problem: _____ <input type="checkbox"/> Other: _____	Integumentary <input type="checkbox"/> Rash <input type="checkbox"/> Skin infections <input type="checkbox"/> Skin lesions <input type="checkbox"/> Other: _____	Ear, Nose, Throat & Eyes <input type="checkbox"/> Eye/vision disorders <input type="checkbox"/> Frequent sore throat <input type="checkbox"/> Vertigo/dizziness <input type="checkbox"/> Voice hoarseness <input type="checkbox"/> Difficulty swallowing <input type="checkbox"/> Other: _____
Gastrointestinal (GI) <input type="checkbox"/> Constipation/diarrhea <input type="checkbox"/> Liver/gallbladder issues <input type="checkbox"/> Nausea/vomiting <input type="checkbox"/> Ulcers <input type="checkbox"/> Heartburn/reflux <input type="checkbox"/> Black or bloody stool <input type="checkbox"/> Other: _____	Neurological <input type="checkbox"/> Diff. walking/balance <input type="checkbox"/> Dizziness <input type="checkbox"/> Seizures <input type="checkbox"/> Headache <input type="checkbox"/> Weakness/numbness <input type="checkbox"/> Neurologic problem <input type="checkbox"/> Other: _____	Respiratory <input type="checkbox"/> Lung issues: _____ <input type="checkbox"/> Recent cold/flu <input type="checkbox"/> Wheezing/asthma <input type="checkbox"/> Coughing blood <input type="checkbox"/> Shortness of breath <input type="checkbox"/> Abnormal chest x-ray <input type="checkbox"/> Other: _____	Genitourinary <input type="checkbox"/> Kidney stones <input type="checkbox"/> Frequent urination <input type="checkbox"/> Blood in urine <input type="checkbox"/> Kidney disease <input type="checkbox"/> Bladder leakage <input type="checkbox"/> Other: _____
Psychiatric <input type="checkbox"/> Anxiety <input type="checkbox"/> Depression <input type="checkbox"/> Insomnia <input type="checkbox"/> Mood disorder <input type="checkbox"/> Other: _____	Allergic/Immunologic <input type="checkbox"/> Rheumatoid arthritis <input type="checkbox"/> Lupus <input type="checkbox"/> Hives/Eczema <input type="checkbox"/> Autoimmune disorder <input type="checkbox"/> Other: _____	Musculoskeletal <input type="checkbox"/> Arthritis/osteoporosis <input type="checkbox"/> Broken bones <input type="checkbox"/> Joint pain/swelling <input type="checkbox"/> Carpal tunnel <input type="checkbox"/> Other: _____	Endocrine <input type="checkbox"/> Diabetes – I or II <input type="checkbox"/> Parathyroid/Paget's <input type="checkbox"/> Heat/cold intolerance <input type="checkbox"/> Thyroid disorder <input type="checkbox"/> <input type="checkbox"/> Other: _____
Hematology/Lymphatic <input type="checkbox"/> Easy bruising/bleeding <input type="checkbox"/> Enlarged glands <input type="checkbox"/> Anemia <input type="checkbox"/> Blood transfusions <input type="checkbox"/> Other: _____	Females Only <input type="checkbox"/> Pregnant <input type="checkbox"/> Last menstrual period: _____	Other: <input type="checkbox"/> ALL NEGATIVE	

Office use:
 Pulse: _____ BP: _____ BMI: _____
 General Appearance: Well nourished Not well nourished Stand Normally Doesn't stand normally
 Oriented x 3: Awake Responsive Oriented of person/place/time
 Mood and Affect: Normal Not Normal

Patient Signature (Date)

Provider Signature (Date)