



### CONFIDENTIAL PATIENT INFORMATION

Patient Name \_\_\_\_\_ Date \_\_\_\_/\_\_\_\_/\_\_\_\_  
(First, Middle, Last)  
Gender M/F Date of Birth \_\_\_\_/\_\_\_\_/\_\_\_\_ Current Age \_\_\_\_\_ SSN# \_\_\_\_\_  
\_\_\_\_\_  
Address City/State/Zip  
Phone (\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_ (\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_ (\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_  
Home Cell Other  
Email \_\_\_\_\_ Best reached by EMAIL/PHONE/TEXT

### WORKERS COMPENSATION INFORMATION

Date and time of accident \_\_\_\_/\_\_\_\_/\_\_\_\_ \_\_\_\_ AM \_\_\_\_ PM  
Was your accident directly related to your work YES/NO  
Briefly describe the events that occurred just before and during your accident  
Give the address where the accident occurred (if other than employer's address)  
Was anyone else present during your accident YES/NO  
Did you report your accident to your employer? YES/NO  
What recommendations did your employer make just after your accident? \_\_\_\_\_

Has this type of accident happened before? YES/NO  
To the best of your knowledge, has this accident occurred in your workplace before? YES/NO  
In general  
Is your job physically stressful? YES/NO  
Is your job mentally stressful? YES/NO  
Is your workplace noisy? YES/NO  
Have you changed jobs in the last year? YES/NO

### AFTER INJURY

Did the accident render you unconscious? YES/NO  
Please describe how you felt immediately after the accident \_\_\_\_\_  
\_\_\_\_\_  
Have you gone to a hospital or seen any other doctor? YES/NO  
Name of doctor \_\_\_\_\_  
When did you go to the hospital? \_\_ Just after the accident \_\_ The next day \_\_ 2+ days \_\_ Other \_\_\_\_\_  
How did you get there? \_\_ Ambulance \_\_ Private transportation  
Name of hospital and/or attending doctor \_\_\_\_\_  
Was he/she a \_\_ MD \_\_ DO \_\_ DC \_\_ DDS  
Describe the type of treatment you received \_\_\_\_\_  
Were X-Rays taken? YES/NO  
Was medication prescribed? YES/NO \_\_\_\_\_  
Have you been able to work since the injury? YES/NO  
Are your work activities restricted as a result of this injury? YES/NO  
Indicate the symptoms that are a result of this accident



Dizziness  Memory loss  Headaches  Blurred vision  Buzzing in ear  Ears ringing  
 Difficulty Sleeping  Irritability  Fatigue  Tension  Neck pain  Neck stiffness  Jaw problems  
 Arm/shoulder pain  Numb hands/fingers  Chest pain  Shortness of breath  Stomach upset  
 Nausea  Back pain  Lower back pain  Back stiffness  Leg pain  Numb feet/toes  
 Is your condition getting worse?  YES  NO  CONSTANT  COMES AND GOES

Level of comfort while performing the following activities			
	Comfortable	Uncomfortable	Painful
Lying on back			
Lying on side			
Lying on stomach			
Sitting			
Standing			
Walking			
Running			
Sports			
Working			
Lifting			
Bending			
Kneeling			
Reaching			
Other _____			

Have you retained an attorney? **YES/NO**  
 If yes, whom? \_\_\_\_\_  
 Attorney phone number \_\_\_\_\_

**RECOVERY**

How many hours are in your normal workday? \_\_\_\_\_  
 Please indicate your daily job duties and any activities which you are occasionally asked to perform  
 Standing  Sitting  Walking  Lifting  Driving  Twisting  Crawling  Bending  
 Operating equipment  Work with arms above head  Typing  Stooping  
 What positions can you work with a minimum physical effort and for how long? \_\_\_\_\_  
 Prior to injury were you capable of working on an equal basis with others your age? **YES/NO N/A**  
 Do you work with others who can help you with any heavy lifting? **YES/NO N/A**  
 Is there any light duty work you could request while in recovery? **YES/NO N/A**

Upland Spine & Rehab invites you to discuss with us any questions regarding our services. The best services are based on a friendly, mutual understanding between provider and patient.  
 Our policy requires payment in full for all services rendered at time of visit, unless arrangements have been made. If accounts are not paid within 90 days of the date of service and no financial arrangements have been made, you will be responsible for legal fees, collection agency fees, interest charges and any other expenses incurred in collecting the account.  
 I authorize the staff at Upland Spine & Rehab to perform any necessary services needed during diagnosis and treatment. I also authorize the provider to release any information required to process insurance claims.  
 I understand it is my responsibility to inform this office of any changes to the information I have provided.

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Patient (Parent/Legal Guardian) Name \_\_\_\_\_ Patient (Parent/Legal Guardian) Signature \_\_\_\_\_ Date \_\_\_\_\_