



Workers' Compensation Demographic Form

Please Print Clearly

Patient Information

Date of Visit		Account Number		Workers' Compensation Coordinator	
Patient Name (Last, First, MI)				Social Security Number	
Street Address				Home Phone Number	
City, State, Zip Code		Country if not US Citizen		Work Phone with Extension	
Date of Birth (mm/dd/yyyy)	Age	Sex M/F	Marital Status		Drivers License #
Primary Doctor		Referred By		Referring Doctor's Phone Number	
Current Employer		Full Time Y/N	Occupation		
Injury Type if Aplicable (Work, Auto, Other)		Injury Date		Military Y/N	Military Branch
Emergency Contact		Relationship		Phone Number	

Insurance Information

Employer at Time of Injury			Phone Number with Extension		
Employer Address			City, State, Zip Code		
Workers' Compensation Insurance Company					
Street Address			City, State, Zip Code		
Claim Number		Date of Injury		Date First Report was Filed	Filed by Whom?
Claim Representative			Phone Number		Fax Number

For Office Use Only

Nurse Case Manager		Phone Number		Fax Number	
Company					
Street Address			City, State, Zip Code		
Utilization Review Department			Phone Number		Fax Number
Street Address			City, State, Zip Code		



Patient's name: _____

Date: _____

Allergies

Do you have any known drug, food, or environmental allergies?	Yes	No
---	-----	----

Please list any allergies below:

Current Medications

List any medications you are taking, including over-the-counter medications and supplements:

Medication	Dose	How Often

Past Medical History

Do you have or have you had any of the following medical conditions?

	Yes	No
Hypertension (high blood pressure)		
Heart disease		
Stroke		
Diabetes		
Asthma		
Emphysema		
Peptic ulcers (stomach or duodenal)		
Kidney disease		
Hepatitis		
Cancer		
Thyroid disease		
Osteoporosis		
Arthritis		

Family History

Have any of your blood relatives (living or deceased) had any of the following conditions?

	Yes	No
Hypertension (high blood pressure)		
Heart disease		
Stroke		
Diabetes		
Asthma		
Emphysema		
Peptic ulcers (stomach or duodenal)		
Kidney disease		
Hepatitis		
Cancer		
Thyroid disease		
Osteoporosis		
Arthritis		

List other medical conditons you have below:

Social History

Which best describes your situation?

I live alone	
I live with family	
I live with friends	
I live in a structured setting with help	

OB GYN for Women

Are you now pregnant?	Yes	No
How many children have you had?		
	0	1
	2	3
	4	5
	6+	

What is your smoking history?

I have never smoked	
I used to smoke	
I currently smoke	
How many packs a day?	

Past Surgical Procedures

List any surgical procedures you may have had in the past and your approximate age at the time:

Procedure	Age

What is your alcohol intake?

I do not drink alcohol	
I drink alcohol every day	
I drink once or more each week	
I drink once or more each month	
I drink rarely	

Continue on the back side

REVIEW OF SYSTEMS
Which of the following do you have?

Skin/Lymphatic

Rash	Yes	No
New skin spots	Yes	No
Skin infections	Yes	No
Change in a mole	Yes	No
Non-healing sores	Yes	No
Swollen lymph nodes	Yes	No

Neurologic

Severe headaches	Yes	No
Fainting spells	Yes	No
Seizures and convulsions	Yes	No
Dizziness	Yes	No
Memory loss	Yes	No

Eyes

Vision problems	Yes	No
Glaucoma	Yes	No

ENT

Hoarseness	Yes	No
Nose bleeds	Yes	No
Hearing loss	Yes	No
Ringing in the ears	Yes	No
Difficulty swallowing	Yes	No
Tooth pain or infection	Yes	No

Endocrine

Diabetes	Yes	No
Thyroid disease	Yes	No

Urologic

Burning with urination	Yes	No
Blood in urine	Yes	No
Frequency of urination	Yes	No

Allergies/Immune Disorders

Hay fever	Yes	No
Anaphylactic reaction	Yes	No
Rheumatoid disease	Yes	No
Other autoimmune disease	Yes	No

Gastrointestinal

Heartburn	Yes	No
Abdominal pain	Yes	No
Nausea	Yes	No
Jaundice	Yes	No
Bloody stool	Yes	No
Black stool	Yes	No

Musculoskeletal

Joint pain	Yes	No
Joint swelling	Yes	No
Back pain	Yes	No
Neck pain	Yes	No
Muscle pain	Yes	No

Hematologic

Easy bruising	Yes	No
Excessive bleeding	Yes	No

Constitutional

Chronic fatigue	Yes	No
Weight loss	Yes	No
Excessive weight gain	Yes	No
Fever	Yes	No
Night sweats	Yes	No

Cardiovascular

Chest pain	Yes	No
Racing heart beat	Yes	No
Poor circulation	Yes	No

Psychological

Depression	Yes	No
Anxiety	Yes	No

Respiratory

Asthma	Yes	No
Wheezing	Yes	No
Shortness of breath	Yes	No
Persistent cough	Yes	No
Cough up blood	Yes	No

For Office Use:

Physician notes:

Patient Update

Date of Visit	Changes (Y/N)	Initials

Physician Review Dates

Date of Visit	Physician Signature



This notice describes how health information about our patients may be used and disclosed, and how you can get access to your health information. This is required by the Privacy Regulations created as a result of the Health Insurance Portability and Accountability Act of 1996 (HIPPA).

Our Commitment to Your Privacy

Our practice is dedicated to maintaining the privacy of your health information. We are required by law to maintain the confidentiality of your health information.

Use And Disclosure Of Your Health Information In Certain Special Circumstances

The following circumstances may require us to use or disclose your health information:

- 1. To public health authorities/health oversight agencies that are authorized by law to collect information.
2. Lawsuits and similar proceedings in response to a court or administrative order.
3. If required to do so by a law enforcement official.
4. When necessary to reduce or prevent a serious threat to your health and safety or the health and safety of another individual or the public. We will only make disclosures to a person or organization able to help prevent the threat.
5. If you are a member of U.S. or foreign military (including veterans) and if required by the appropriate authorities.
6. To federal officials for intelligence and national security activities authorized by law.
7. To correctional institutions or law enforcement officials if you are an inmate or under the custody of a law enforcement official.
8. For Workers' Compensation and similar programs.
9. Data that is collected by CORE Orthopaedic Medical Center, which does not include the identity of the patient, may be utilized for research purposes.

Your Rights Regarding Your Health Information

- 1 You can request that our practice communicate with you about your health and related issues in a particular manner or at a certain location. For instance, you may ask that we contact you at home, rather than work. We will accommodate reasonable requests.
2. You can request a restriction in our use or disclosure of your health information for treatment, payment, or healthcare operations. Additionally, you have the right to request that we restrict our disclosure of your health information to only certain individuals involved in your care or the payment for your care, such as family members and friends. We are not required to agree to your request; however, if we do agree, we are bound by our agreement except when required by law, in emergencies, or when the information is necessary to treat you.
3. You have the right to inspect and obtain a copy of the health information that may be used to make decisions about you, including patient medical records and billing records, but not including psychotherapy notes. You must submit your request in writing to CORE Orthopaedic Medical Center, P.C. at (760) 943-6700 who will have up to 30 days to comply.
4. You may ask us to amend your health information if you believe it is incorrect or incomplete, and as long as the information is kept by or for our practice. To request an amendment, your request must be made in writing and submitted to CORE Orthopaedic Medical Center, P.C. at (760) 943-6700 who will have 60 days to respond. You must provide us with a legitimate reason that supports your request for amendment.
5. You are entitled to receive a copy of this Notice of Privacy Practices. At any time, you may obtain a copy of this notice by contacting our front desk receptionist.
6. If you believe your privacy rights have been violated, you may file a complaint with our practice or with the Secretary of the Department of Health and Human Services. To file a complaint, contact CORE Orthopaedic Medical Center, P.C. at (760) 943-6700. All complaints must be submitted in writing; you will not be penalized for filing a complaint.
7. Our practice will obtain your written authorization for uses and disclosures that are not identified by this notice or permitted by applicable law.

If you have any questions regarding this notice or our health information privacy policies, please contact your physician. I hereby acknowledge that I have been presented with a copy of this office's Notice of Privacy Practices.

Signature: _____ Date: _____

Print Name: _____

General Authorization to Release Health Information

I hereby authorize the release of my personal health information to any health provider approved by my treating physician. I understand that I may cancel this authorization at anytime by notifying my treating physician in writing.

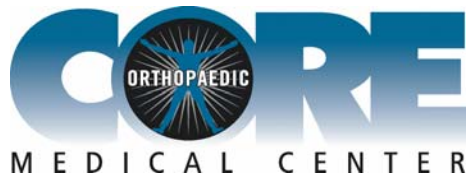
Signature: _____ Date: _____

Print Name: _____

DOCTOR'S FIRST REPORT OF OCCUPATIONAL INJURY OR ILLNESS

Within 5 days of your initial examination, for every occupational injury or illness, send two copies of this report to the employer's workers' compensation insurance carrier or the insured employer. Failure to file a timely doctor's report may result in assessment of a civil penalty. In the case of diagnosed or suspected pesticide poisoning, send a copy of the report to Division of Labor Statistics and Research, P.O. Box 420603, San Francisco, CA 94142-0603, and notify your local health officer by telephone within 24 hours.

1. INSURER NAME AND ADDRESS			PLEASE DO NOT USE THIS COLUMN		
2. EMPLOYER NAME			Case No.		
3. Address	No. and Street	City	Zip	Industry	
4. Nature of business (e.g., food manufacturing, building construction, retailer of women's clothes.)				County	
5. PATIENT NAME (first name, middle initial, last name)		6. Sex <input type="checkbox"/> Male <input type="checkbox"/> Female		7. Date of Birth Mo. Day Yr.	
8. Address: No. and Street City Zip		9. Telephone number ()		Hazard	
10. Occupation (Specific job title)		11. Social Security Number - -		Disease	
12. Injured at: No. and Street City County				Hospitalization	
13. Date and hour of injury or onset of illness Mo. Day Yr. _____ a.m. _____ p.m.		14. Date last worked Mo. Day Yr.		Occupation	
15. Date and hour of first examination or treatment Mo. Day Yr. _____ a.m. _____ p.m.		16. Have you (or your office) previously treated patient? <input type="checkbox"/> Yes <input type="checkbox"/> No		Return Date/Code	
<p>Patient please complete this portion, if able to do so. Otherwise, doctor please complete immediately, inability or failure of a patient to complete this portion shall not affect his/her rights to workers' compensation under the California Labor Code.</p> <p>17. DESCRIBE HOW THE ACCIDENT OR EXPOSURE HAPPENED. (Give specific object, machinery or chemical. Use reverse side if more space is required.)</p>					
18. SUBJECTIVE COMPLAINTS (Describe fully. Use reverse side if more space is required.)					
19. OBJECTIVE FINDINGS (Use reverse side if more space is required.)					
A. Physical examination					
B. X-ray and laboratory results (State if non or pending.)					
20. DIAGNOSIS (if occupational illness specify etiologic agent and duration of exposure.) Chemical or toxic compounds involved? <input type="checkbox"/> Yes <input type="checkbox"/> No ICD-9 Code ____ - ____					
21. Are your findings and diagnosis consistent with patient's account of injury or onset of illness? <input type="checkbox"/> Yes <input type="checkbox"/> No If "no", please explain.					
22. Is there any other current condition that will impede or delay patient's recovery? <input type="checkbox"/> Yes <input type="checkbox"/> No If "yes", please explain.					
23. TREATMENT RENDERED (Use reverse side if more space is required.)					
24. If further treatment required, specify treatment plan/estimated duration.					
25. If hospitalized as inpatient, give hospital name and location		Date admitted Mo. Day Yr.		Estimated stay	
26. WORK STATUS -- Is patient able to perform usual work? <input type="checkbox"/> Yes <input type="checkbox"/> No					
If "no", date when patient can return to:		Regular work ____/____/____		Specify restrictions _____	
Modified work ____/____/____					
Doctor's Signature _____		CA License Number _____			
Doctor Name and Degree (please type) _____		IRS Number _____			
Address _____		Telephone Number (____) _____			



Workers' Compensation Injury History Form

Patient Name: _____ Date: _____

Job Description

Age: _____ Right / Left Handed (Circle one) Employer at the time of injury: _____

Job Title: _____ Number of hours worked: per day _____ per week _____

Basic work duties at the time of injury: _____

Tools/Machinery routinely used: _____

Objects you lifted alone while working: _____ Heaviest objects lifted: _____

Estimate the weight of the heaviest objects lifted: _____ Number of times a day this amount was lifted: _____

Objects lifted with co-workers each day: _____ Weight of objects: _____ Number of times lifted: _____

Length of time with this employer at the time of injury: _____ Length of time in this line of work: _____

Did you work for any other employer, for any friends, or have a home-based business on the side while working for this employer? _____

If yes, please complete the following:

Name of employer or type of home-based business: _____

Type of work performed for employer, at home, or for friends: _____

Time period you worked for other employer, friend, or at home-based business: _____

List places of employment for the last 10 years:

Employer: _____ Position held: _____ Length of time: _____

Duties performed: _____

Employer: _____ Position held: _____ Length of time: _____

Duties performed: _____

Employer: _____ Position held: _____ Length of time: _____

Duties performed: _____

If you have additional employers, please list: _____

Date of Injury: _____ If there is no specific date of injury, when did you first begin to have problems? _____

What were you doing at the specific time of injury? If there was no specific injury, when did symptoms begin?

What parts of your body were injured? _____

What symptoms did you have? _____

Did you continue to work? _____ If no, why not? _____

When was the injury reported? _____ To whom? _____

Place where treatment was **first** received? _____ Date of **first** treatment: _____

Course of Treatment to Date

Treatment received	Date	Physician	Location	Type	Results of Treatment
X-Rays					
MRI					
Therapy					
CAT Scan					
Myelogram					
Injections/Epidural					
Medications					
Surgery					
Chiropractic Care					
Acupuncture					
EMG/Nerve Conduction					
Other					

Which treatments helped? _____

Which physician(s) is currently treating you? _____

What diagnosis have you been given? _____

What further treatments have you been told are needed? _____

Have you been released from care by any physician? _____ If yes, when and which physician(s)? _____

Since the injury, have you returned to any type of work? _____ If yes, when did you return to work? _____

Are you working for the same employer? _____ Are you currently performing the same duties for them? _____

If you have a new employer, who is it? _____ When did you start? _____

What are your duties for the new employer? _____

If working for the same employer, what duties are you **not** performing? _____

Dates you did not work at all: From _____ to _____ From _____ to _____

Dates light duty performed: From _____ to _____ From _____ to _____

Dates full duty performed: From _____ to _____ From _____ to _____

Since the injury, have you had any other injuries that are industrial or non-industrial? _____

If yes, date of injury: _____ Was it industrial? _____ What area of the body was injured? _____

Treatment for above injury (type and where received)? _____

Present Complaints

Symptoms	Where	How Often	Worsened By	Relieved by
Pain				
Numbness				
Tingling				
Swelling/Stiffness				
Weakness				
Difficulty with balance				
Other (i.e. headaches)				

Have you had loss of bladder or bowel control? _____ If yes, please describe in detail: _____

Back Pain: Increased with: Coughing _____ Sneezing _____ Bending _____ Twisting _____ Lifting _____

Standing _____ Sitting _____ Walking _____ Driving _____ Lying down _____ Nights _____

Since your initial symptoms, are you: better _____, the same _____, worse _____?

Which is most troublesome? Back pain _____ Leg pain _____ Neck pain _____ Arm pain _____

How frequent is your pain? Comes and goes _____ Constant _____

On a scale from 1-10, with 10 being the worst possible pain, describe your pain:

1	2	3	4	5	6	7	8	9	10
---	---	---	---	---	---	---	---	---	----

Past Medical History

Have you had any other **work** related injuries to the areas involved in this claim or other areas? _____ If yes:

Dates of injury: _____ Areas injured: _____ Employer at the time: _____

Treatment received, and by whom: _____

When were you released from care for this injury? _____ When was your last treatment? _____

Do you have future medical care? _____ If yes, what? _____

Did you receive a settlement for this injury? _____ If yes, how much or what percentage rating? _____

Have you had **non-work** related injuries to the areas involved in this claim or other areas? _____ If yes:

Dates of injury: _____ Areas injured: _____ Treatment received, and by whom: _____

When were you released from care for this injury? _____ When was your last treatment? _____

Did you have back/neck pain or limitations prior to your current injury? _____

Please check any of the following you currently have or have had in the past:

Condition	Yes	No	Current Treatment
Diabetes			Type:
Heart Disease			
High Blood Pressure			
Lung Problems/Asthma/TB			
Stroke/Seizures/Psychological			
Stomach/Ulcers/Bleeding			
Liver Disease			
Thyroid Disease			
Tumors/Cancer			
Kidney Problems			
Arthritis			Where:
Other			

Hospitalizations: _____

Surgeries: _____

Current medications you are taking:

Dose:

How Often:

- | | | |
|----------|-------|-------|
| 1. _____ | _____ | _____ |
| 2. _____ | _____ | _____ |
| 3. _____ | _____ | _____ |
| 4. _____ | _____ | _____ |
| 5. _____ | _____ | _____ |

Family History

Please list any family members who have in the past, or are currently receiving treatment for:

Condition	Relationship to you	Treatment
Diabetes		
High Blood Pressure		
Heart Disease		
Cancer		
Excessive Bleeding		
Problems with anesthesia		
Stroke		
Other		

Social History

Ethnic Background: _____ Marital Status: _____ Highest level of education completed: _____

Do you exercise regularly? If so, what? _____

Alcohol intake per day: 0 1-2 3-4 5-8 10-15 more Type of alcohol: _____

Smoking: Cigars _____ per day; Cigarettes _____ pack(s) per day for _____ years; Quit _____ years ago.

List all hobbies performed before the injury and the ones you are no longer able to do because of the injury: _____

Women Only

Are you currently pregnant? _____ Are you trying to become pregnant? _____

Is there a possibility you may be pregnant now? _____

When was your last menstrual period? _____

Please describe any "female" problems you are currently experiencing and the treatment you are receiving: _____

Family Doctor Contact Information: _____