Is this a Worker's Comp Injury? Yes or No (Please Circle One)

Claim Number: _____ Adjusters Contact Information: _____ Date of Injury: _____

Patient Name: _____ _____
First MI Last Preferred Name

SS#:_____Birth Date:_____Age:_____Height:_____Weight: _____ Sex: Male ☐ Female ☐

Address:

_____
Street Address Apt. # City State Zip

Patient lives in: ☐ Home ☐ Apartment ☐ Nursing Home ☐ Name of Nursing Home Ph: _____

Cell #: _____Work #:_____Home #: _____

Email Address: _____ Driver's License #: _____

Patient's Employer: _____ Address, City, Zip: _____

Marital Status: ☐ Married ☐ Single ☐ Divorced ☐ Widowed ☐ Other _____ **Work Status:** ☐ Working Full-time ☐ Working Part-time ☐ Retired ☐ Student ☐ Disabled ☐ On

Leave Occupation: _____ Employer: _____

Guardian Information (If patient is a Minor/under the age of 18)

Name: _____Relationship to Patient:_____

SS#:_____Birth Date:_____/_____/_____Age:_____Height: Weight: Sex: Male Female

Address:

_____
Street Address Apt. # City State Zip

Primary Care Physician: Phone: _____

Section I. Primary Insurance (If you do not have insurance, please skip to Section II.) Insurance Plan Name:_____

Policyholder's Name: _____Policy #: _____

oup#:_____Policyholder's Date of Birth: _____

Patient's relationship to Policy holder: ☐ Self ☐ Spouse ☐ Legal Guardian ☐ Dependent ☐ other: Secondary Insurance

Policy holder's Employer:_____Policy holder's Name: _____

Policy #: _____ Group#:_____Policyholder's Date of Birth: _____

Patient's relationship to Policyholder: ☐ Self ☐ Spouse ☐ Legal Guardian ☐ Dependent ☐ other:

Methodist MEDICAL GROUP

Date Of Injury: _____ Referred By: _____

Family Physician: _____ Phone: _____

Details Of Injury: (How? Where? Any Treatment?) _____

_____

Body Part Being Seen For: _____

Side of Body: (Check) ☐ Right ☐ Left ☐ Both Dominant Hand (Check): ☐ Left ☐ Right

Date symptoms began: / / Current Symptoms: _____

If there is pain, where is it located? Pain Level (1-10; 10 being worst): _____

Medical History (High Blood Pressure, Diabetes, Emphysema, Gastric Reflux, etc.) _____

_____

_____

Patient Medications: _____

_____

Pharmacy: _____ Address: _____

HOSPITALIZATIONS/SURGERIES Ortho/Spine	YEAR	Surgeon/Hospital

Patient Drug Allergies: _____

_____

☐ No Known Allergies

FAMILY HISTORY						
Member	Alive/Deceased				Age	Heath Status
Grandmother(mom's)		A		D		
Grandfather (mom's)		A		D		
Grandmother (dad's)		A		D		
Grandfather(dad's)		A		D		
Father		A		D		

FAMILY HISTORY						
Member	Alive/Deceased				Age	Heath Status
Mother		A		D		
Sister/Brother		A		D		
Sister/Brother		A		D		
Sister/Brother		A		D		
Sister/Brother		A		D		

Review of systems (please check if you are currently or have had problems with these and describe)

Fevers ☐ Chills ❒ Night Sweats ❒ Lethargy ❒ Weight gain or loss of 10 pounds in the last 12 months ❒ Depression

❒ Anxiety ❒ Hallucinations ❒ Eye pain ❒ Change in Vision ❒ Earache ❒ Ear drainage ❒ Nasal drainage ❒ Throat Pain

❒ Change in voice❒ Chest Pain ❒ Irregular Heart beat ❒ Stroke ❒ Shortness of breath while lying flat

❒ Shortness of breath ❒ Wheezing❒ Oxygen usage at home ❒ Abdominal pain ❒ Nausea ❒ Jaundice ❒ Ulcers

❒ Constipation ❒ Diarrhea ❒ Vomiting ❒Painful Urination ❒ Blood in urine ❒ Flank pain ❒ Urinary incontinence

❒ Numbness in genital area ❒ Neuropathy ❒ Seizures❒ Focal weakness ❒ Focal numbness ❒ Sciatica

❒ Balance problems ❒ Diabetes ❒ Excessive thirst ❒ Cold intolerance ❒ Heat intolerance ❒ Cancer ❒ Tuberculosis

❒ Blood clot ❒ Arthritis ❒ Hepatitis ❒ High Blood Pressure ❒ Skin issues: _____ ❒ Hay fever/Allergies

Other: _____

Social History

Do you drink alcohol? ☐ No alcohol consumption ☐ Yes, consumes alcohol ☐ Social Drinker ☐ Previous Alcoholism

Do you use tobacco? ☐ Never ☐ currently (everyday) ☐ currently (some days) ☐ Formerly **Do you overuse/abuse?** ☐ Never ☐ Currently ☐ In the past: Exercise regularly? ☐ Yes ☐ No Times per week and type: _____

Do you use an assistive device for ambulation (cane, walker, etc.)? ☐ Yes ☐ No Type: _____ _____