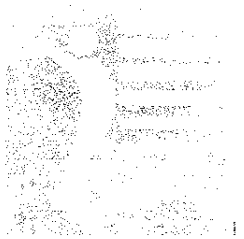
FOUNTAIN VALLEY



PHYSICAL MEDICINE

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FOUNTAIN VALLEY PHYSICAL MEDICINE WORK ACCIDENT HISTORY FORM

YOUR NAME: _____ TODAY'S DATE: _____

DATE OF ACCIDENT: _____ TIME OF ACCIDENT: _____ AM PM

WHERE DID THE ACCIDENT HAPPEN: _____

PLEASE DESCRIBE, TO THE BEST OF YOUR KNOWLEDGE, WHAT HAPPENED DURING THIS ACCIDENT: _____

_____

_____

_____

DID YOU GO TO A HOSPITAL? _____ SAME DAY? _____ NEXT DAY? _____

IF YES, NAME AND CITY OF HOSPITAL? _____

WHAT PARTS OF YOUR BODY WERE X-RAYED AT THE HOSPITAL? _____

WHAT DID THE HOSPITAL DO FOR YOUR INJURIES? _____

_____

HOW LONG DID YOU STAY AT THE HOSPITAL? _____

HAVE YOU SEEN ANY OTHER DOCTOR AS A RESULT OF THIS ACCIDENT? _____

DOCTOR'S NAME _____

WHAT BLEEDING CUTS OR BRUISES DID YOU SUSTAIN DURING THIS ACCIDENT? _____

IF YOU HAVE BEEN IN ANY PREVIOUS WORK ACCIDENTS, PLEASE LIST THE YEAR EACH OF THE ACCIDENTS WAS IN:

1. _____ 4. _____

2. _____ 5. _____

3. _____ 6. _____

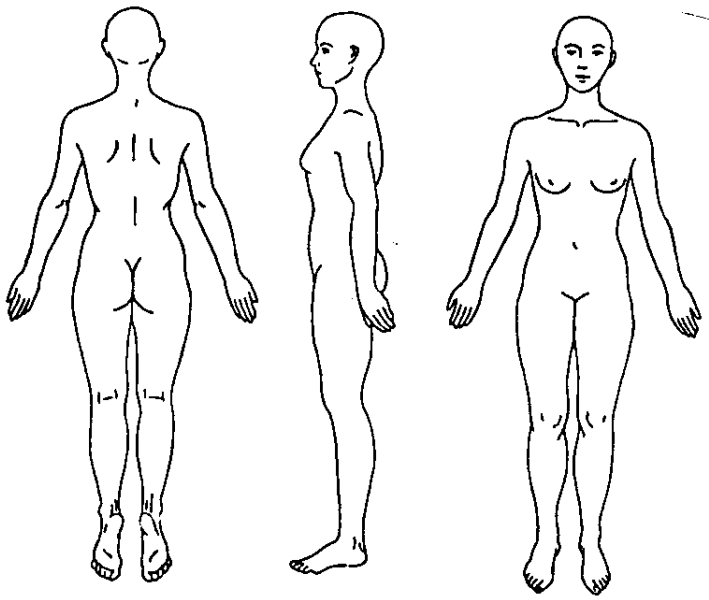
PLEASE CIRCLE THE AREA OF YOUR PAIN OR PAINS AND DRAW A LINE FROM THOSE CIRCLES TO THE DESCRIPTION THAT BEST DESCRIBES THE INTENSITY OF THE PAIN ON THE LEFT AND THE FREQUENCY OF THE PAIN ON THE RIGHT (SEE DEFINITIONS LISTED BELOW):

MILD

SLIGHT

MODERATE

SEVERE



OCCASIONALLY

INTERMITTENT

FREQUENT

CONSTANT

MILD - AN ANNOYANCE WITH NO HANDICAP REGARDING NORMAL FUNCTION.

SLIGHT - TOLERATED PAIN WITH SOME HANDICAP IN THE ACTIVITY THAT PRECEDED THE PAIN.

MODERATE - TOLERATED PAIN, BUT WITH A MARKED HANDICAP IN THE PERFORMANCE OF THE ACTIVITY THAT PRECEDED THE PAIN.

SEVERE - PAIN SO BAD THAT IT WOULD PRECLUDE THE ACTIVITY THAT PRECEDED THE PAIN.

OCCASIONALLY - PAIN PRESENT 25% OF THE TIME.

INTERMITTENT - PAIN PRESENT 50% OF THE TIME.

FREQUENT - PAIN PRESENT 75% OF THE TIME.

CONSTANT - PAIN PRESENT 100% OF THE TIME.

STARTING DATE OF PRESENT SYMPTOMS: _____

HOW LONG HAVE SYMPTOMS BEEN THE SAME? IF THEY ARE CHANGING, DESCRIBE HOW.

_____

DOES REPEATED TWISTING OR TURNING MAKE YOUR PAIN WORSE? _____

IF YES, IN WHAT REGION OF YOUR BODY? _____

IS YOUR PAIN WORSE WHEN ARISING FROM A CHAIR? _____

IS YOUR PAIN WORSE BY STRAINING, COUGHING OR SNEEZING? _____

IS YOUR PAIN SHARP OR DULL? _____

DO YOU HAVE ANY NUMBNESS OR TINGLING IN YOUR ARMS, HANDS OR FINGERS? _____

DO YOU HAVE ANY NUMBNESS OR TINGLING IN YOUR BUTTOCKS, LEGS OR FEET? _____

DOES A BRACE (IF YOU HAVE TRIED ONE) HELP RELIVED THE PAIN? _____

HAVE YOU HAD ANY CHANGE IN YOUR BOWEL HABITS? _____

HAVE YOU LOST ANY TIME FROM WORK BECAUSE OF THIS ACCIDENT? _____

IF YES, PLEASE GIVE DATES AND NUMBER OF HOURS OF TIME LOST: _____

_____

TOTALLY DISABLED FROM _____ TO _____ .

PARTIALLY DISABLED FROM _____ TO _____.

PREVIOUS BACK OR NECK PROBLEMS OR SURGERIES (GIVE DATES):

1. _____ 5. _____

2. _____ 6. _____

3. _____ 7. _____

4. _____ 8. _____