



Your upcoming Neurology visit is for an injury that happened at work or has issues that may be handled by an attorney. Compared to the usual medical evaluation, there are several important differences. First, the usual physician patient confidentiality is limited, as various entities that have an interest in your case have the right to this information, including attorneys, adjusters, and employers. Second, facts that may not seem relevant to the medical facts of the case must be included for a complete report. Please fill these pages as completely as possible, the doctor will review these papers and use the information in his report

Name: _____ Age: _____ Date of Birth: _____

Date of Injury: _____

Employer: _____

Describe injury:

Body Parts affected: neck, back, arms, head, etc.

When was first medical treatment? _____ Where? _____

What tests were performed? _____

What treatment did you receive? _____

Did the symptoms improve, worsen, no change?

Have new symptoms developed? _____

What is your present treatment? (medications, therapies) _____

Present caregivers: (physicians, chiropractor, therapist, etc.)

1. _____ 2. _____

3. _____ 4. _____

What is your job description? _____

How many days have you missed work? _____

Have your work duties changed? _____ How? _____

Have home or leisure activities changed? _____? How? _____



Symptom (such as Back pain)	Intensity 1-mild to 10 unbearable	How often present 10% to 100% of the time	What makes it better such as medicine or change of activity	What makes it worse?



PAST MEDICAL HISTORY

List previous injuries you have had, note if the same parts of the body were affected, and comment on what time the recovery took, and whether you were left with any permanent symptoms or limitations.

Have you had any other job related injuries YES NO
If so give details.

Operations (include dates) 1. _____
2. _____ 3. _____
4. _____ 5. _____

Major Illnesses (diabetes, cancer, heart) 1. _____
2. _____ 3. _____
4. _____ 5. _____

Previous Medical Caregivers that may have important information on your health

1. _____ 2. _____
3. _____ 4. _____
5. _____ 6. _____



SOCIAL HISTORY

SINGLE ___ MARRIED ___ DIVORCED ___ LIVING WITH SIGNIFICANT OTHER ___ WIDOWED ___

No. of children _____ No. living with you _____

RECREATIONAL ACTIVITIES HOBBIES

Activity	Frequency	Affected by injury?

Habits coffee/cola _____ servings per day

Alcohol _____ servings per day/week/mo

Tobacco _____ packs per day _____ no of years

Have you ever had a problem with chemical dependency? _____

EMPLOYMENT HISTORY

Start Date	End Date	Job Title	Employer

CIRCLE IF YOU HAVE

GENERAL	EYE	SKIN	EAR-NOSE-THROAT	GENITO-URINARY
Fever Malaise Weight gain Weight loss	Eye pain Glaucoma Blurred vision Double vision Temp loss of vision	Rash Psoriasis Melanoma Acne	Hearing loss Tinnitus Hoarse voice Vertigo	Hematuria Dysuria Incontinence Kidney stones
CARDIOVASC	RESPIRATORY	GASTROINTEST	MUSCLE SKELETAL	NEUROLOGICAL
Chest pain Palpitation Pacemaker Heart failure Foot edema Valve disease	Asthma Shortness of breath Emphysema Cough Hemoptysis Sleep Apnea	Heartburn Nausea Liver disease Gall bladder Swallowing diff	Neck pain Back pain Joint pain Cramps Carpal tunnel Gait trouble Joint replacement	Stroke Seizures Memory loss Speech trouble Tremors Numbness Headaches Parkinson's