WORKER'S COMP PATIENT REGISTRATION

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Orthopedic Surgery and Joint Replacement

Fellowship Trained, Board Certified in Sports Medicine

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Patient _____ **DOB**_____ **Age** _____

Address _____ **City** _____ **State** _____ **Zip**_____

Home Phone _____ **Cell Phone** _____

Social Security Number _____ **Email Address** _____

Male ( ) Female ( ) **Referred By:** _____

Marital Status: ( ) Single ( ) Married ( ) Widowed ( ) Separated ( ) Divorced

EMERGENCY CONTACT

Name _____ **RELATIONSHIP** _____

Cell Phone _____ **Home Phone** _____

Employer _____ **Business Phone ( )**_____

Employer's Address _____

Type of Injury _____ **Date of Injury**_____ Claim # _____

Adjuster's Name _____ **Adjuster's Phone #** _____

CONSENT FOR TREATMENT/ RELEASE OF INFORMATION

I grant consent to Dr. Winternitz to administer medical treatment and perform medical procedures as deemed necessary. I authorize the release of medical information to my insurer, or the agents to process my payment for services. To the best of my knowledge, all the information above is true and correct. ASSIGNMENT OF BENEFITS: I hereby assign all benefits payable by my insurance company to William W. Winternitz Jr., M.D.

Patient Signature _____ Date _____

WORKER'S COMP
COMPREHENSIVE NEW PATIENT HEALTH INFORMATION

DATE _____

Name: _____Age_____DOB_____Height_____Weight_____

Side of Injury: Right_____ Left_____ Dominant Hand R L BP _____ P _____

Family Physician_____ Referring Physician _____

Reason For Visit/What Bothers You Now? _____

_____

_____

Date of Injury or Duration of Symptoms: _____

How did The Injury Occur? _____

_____

What Makes Your Pain Worse?_____

_____

What Makes Your Pain Better? _____

_____

Pain Scale: 1 2 3 4 5 6 7 8 9 10

Least Moderate Severe

What Treatment Have You Had For Your Injury? _____

_____

Who Were Your Treating Doctors? _____

_____

Any prior history of injury to the affected area? Yes No

Work Related? Yes No

Have you ever received a Settlement? Yes No If so, Date_____ and Amount $_____

Any prior studies performed? X-rays MRI CT scan Bone Scan EMG/NCV testing

Name: _____ **Date:** _____

MEDICAL HISTORY:

___Check here if all negative

___High Blood Pressure
___Diabetes
___Heart Disease
___Heart Attack
___Heart Arrhythmia, chest pain
___Asthma
___Emphysema
___Ulcer Disease, Hiatal Hernia
___Hepatitis
___Fibromyalgia
___Bleeding Disorder
___Seizures
___Thyroid Problems
___Osteoporosis
___Cancer_____
___Phlebitis/blood clots
___Stroke
___Kidney Stones
___Prostate Problems
___Headaches, Migraines
___Sleep Apnea
___Muscular Dystrophy
___HIV

Are you pregnant? Y or N

SURGICAL HISTORY:

___Check here none

YEAR	PROCEDURE	YEAR	PROCEDURE
_____	_____	_____	_____
_____	_____	_____	_____

HOSPITALIZATIONS: _____

CURRENT MEDICATIONS:

____Check here if none

NAME OF DRUG	DOSAGE (mg)	TIMES PER DAY
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

Name: _____ **Date:** _____

ALLERGIES:

___Check here if none

Foods_____ ___Dust ___Pollen ___Cats ___Dogs

___Latex ___Iodine ___Adhesive Tape

Medicines: ___Penicillin ___Sulfa other: _____

SOCIAL HISTORY:

Occupation: _____full time _____ part time ____

Education _____grade_____high school _____college _____post graduate

_____Single _____married ___committed ___divorced other_____

CHILDREN _____none _____number

TOBACCO _____never_____stopped _____year currently smoking_____packs per day times _____years

ALCOHOL ___none _____few per month _____1/week _____few per week _____daily

DRUG USE ___none other_____

EXERCISE ___none ___1/month ___few times per week ___daily

ADAPTIVE DEVICES:

___check here if none

___foot support / orthotic ___ankle brace / AFO ___corset ___spine brace other_____

___crutches ___ walker ___ wheel chair other_____

FAMILY HISTORY:

Mother ___alive ___deceased cause_____

Father ___alive ___deceased cause_____

Number of sibling's _____

Family Medical Problems ___diabetes ___heart disease ___cancer ___spine problems

other_____

Name: _____ **Date:** _____

REVIEW OF SYSTEMS:

How would you rate your health: ___excellent ___good ___ fair ___poor

Do you have any of the following symptoms? Circle If (Yes).

___NONE ***Constitutional:*** fever weight loss tiredness

___NONE ***Eyes:*** glasses blurred vision double vision

___NONE ***ENT:*** deafness sinus infection ringing hoarseness dizziness difficulty swallowing

___NONE ***Heart:*** chest pain irregular heart beat pounding in chest

___NONE ***Lungs:*** shortness of breath wheezing cough cough up blood

___NONE ***Abdomen:*** loss of appetite diarrhea constipation abdominal pain

Blood in stool black bowel movements

___NONE ***Urinary:*** burning loss of urine difficulty voiding infections blood in urine

___NONE ***Musculoskeletal:*** sprains swelling arthritis stiffness

___NONE ***Skin/Breast:*** rash skin ulcers sores lumps birthmarks masses

___NONE ***Neurologic:*** balance problems memory problems

___NONE ***Behavioral:*** depression anxiety sleep disturbance hallucinations claustrophobia

___NONE ***Endocrine:*** hair growth/loss crave fluids/food hyperactive sleep all the time

Work Status:

Are you currently working? (Circle one) **Yes** **No** Are you working Regular duties or Modified duty

Are you working for the same employer or different? _____

Have you missed time from work due to your injury? (Circle) **Yes** **No**

If YES when was your first day off? _____ When did you return to work? _____

When was the last day you worked full duty_____ Modified duty? _____

Are you currently involved in Vocational Rehabilitation? If so where and by whom?

_____

Job Description

Instructions: Please complete this form to the best of your ability at the time of your injury.

Employer _____ New Job _____
Exact Job title _____ _____
Date of Hire _____ _____
Work Hours _____ _____

Number of days per week _____ _____

Did you have any work restrictions when you were hired? _____

If yes, Specify _____

What is your job description:

_____

_____

On and 8 hour workday how many hours a day do you do the following? **(Circle number of hours for each activity)**

A.	Sitting	1	2	3	4	5	6	7	8
B.	Standing	1	2	3	4	5	6	7	8
C.	Walking	1	2	3	4	5	6	7	8

Occasionally- 0%to 33% Frequently- 34% to 66% Continuously- 67% to 100%

You are required to lift and carry:	Never	Occasionally	Frequently	Constantly
A. Up to 10 pounds	_____	_____	_____	_____
B. 11 to 20 pounds	_____	_____	_____	_____
C. 21 to 50 pounds	_____	_____	_____	_____
D. 51 to 100 pounds	_____	_____	_____	_____

What is the heaviest object that you lift on your workday? _____ How much does it weigh? _____lbs.

You are required to use your hands for repetitive motions, such as:

		Fine manipulation	**Simple grasping**	**Pushing/Pulling**
A.	Right Hand	Yes____ No____	Yes ____ No____	Yes____ No ____
B.	Left Hand	Yes____ No____	Yes____ No____	Yes____ No____

You are required to use your feet for repetitive use:

A.	Right foot	Yes____	No____
B.	Left foot	Yes____	No____

You are required to do the following:

	Never	Occasionally	Frequently	Constantly
A. Bending	_____	_____	_____	_____
B. Squatting	_____	_____	_____	_____
C. Crawling	_____	_____	_____	_____
D. Kneeling	_____	_____	_____	_____
E. Climbing	_____	_____	_____	_____
F. Walking on uneven ground	_____	_____	_____	_____
G. Walking above ground	_____	_____	_____	_____
H. Reach above shoulder level	_____	_____	_____	_____
I. Reaching at shoulder level	_____	_____	_____	_____
J. Reach below shoulder level	_____	_____	_____	_____

Please list any types of machinery used on your job or vehicles driven:

_____

_____

Please list the names, locations, and positions of prior employers in last 10 years:

_____

_____

_____

Örebro Musculoskeletal Pain Questionnaire (ÖMPQ)

Linton and Boersma 2003[1]

1. **Name** _____ **Phone** _____ **Date** _____
2. **Date of Injury** _____ **Date of birth** _____
3. **Male** ☐ **Female** ☐

These questions and statements apply if you have aches or pains, such as back, shoulder or neck pain. Please read and answer questions carefully. Do not take long to answer the questions, however it is important that you answer every question. There is **always** a response for your particular situation.

	2x (max 10)
5. Where do you have pain? Place a tick (✓) for all appropriate sites. ☐ Neck ☐ Shoulder ☐ Arm ☐ Upper Back ☐ Lower Back ☐ Leg ☐ Other (state)	
6. How many days of work have you missed because of pain during the past 18 months? Tick (✓) one. ☐ 0 days (1) ☐ 1-2 days (2) ☐ 3-7 days (3) ☐ 8-14 days (4) ☐ 15-30 days (5) ☐ 1 month (6) ☐ 2 months (7) ☐ 3-6 months (8) ☐ 6-12 months (9) ☐ over 1 year (10)	
7. How long have you had your current pain problem? Tick (✓) one. ☐ 0-1 week (1) ☐ 1-2 weeks (2) ☐ 3-4 weeks (3) ☐ 4-5 weeks (4) ☐ 6-8 weeks (5) ☐ 9-11 weeks (6) ☐ 3-6 months (7) ☐ 6-9 months (8) ☐ 9-12 months (9) ☐ over 1 year (10)	
8. Is your work heavy or monotonous? Circle the best alternative. 0 1 2 3 4 5 6 7 8 9 10 Not at all Extremely	
9. How would you rate the pain that you have had during the past week? Circle one. 0 1 2 3 4 5 6 7 8 9 10 No pain Pain as bad as it could be	

* Modified for use by WorkCover NSW (with permission)

1 Linton SJ, Boersma K. Early identification of patients at risk of developing a persistent back problem: the predictive validity of the Örebro Musculoskeletal Pain Questionnaire. Clin J Pain 2003;19: 80-86.

making a difference

10. In the past three months, on average, how bad was your pain on a 0-10 scale? Circle one.

0 1 2 3 4 5 6 7 8 9 10

No pain — Pain as bad as it could be

11. How often would you say that you have experience pain episodes, on average, during the past three months? Circle one.

0 1 2 3 4 5 6 7 8 9 10

Never — Always

12. Based on all things you do to cope, or deal with your pain, on an average day, how much are you able to decrease it? Circle the appropriate number. 10 - x

0 1 2 3 4 5 6 7 8 9 10

Can't decrease it at all — Can decrease it completely

13. How tense or anxious have you felt in the past week? Circle one.

0 1 2 3 4 5 6 7 8 9 10

Absolutely clam and relaxed — As tense and anxious as I've ever felt

14. How much have you been bothered by feeling depressed in the past week? Circle one.

0 1 2 3 4 5 6 7 8 9 10

Not at all — Extremely

15. In your view, how large is the risk that your current pain may become persistent? Circle one.

0 1 2 3 4 5 6 7 8 9 10

No risk — Very large risk

16. In your estimation, what are the chances that you will be able to work in six months? Circle one. 10 - x

0 1 2 3 4 5 6 7 8 9 10

No chance — Very large chance

17. If you take into consideration your work routines, management, salary, promotion possibilities and work mates, how satisfied are you with your job? Circle one. 10 - x

0 1 2 3 4 5 6 7 8 9 10

Not satisfied at all — Completely satisfied

Here are some of the things that other people have told us about their pain. For each statement, circle one number from 0 to 10 to say how much physical activities, such as bending, lifting, walking or driving, would affect your pain.

18. Physical activity makes my pain worse.

0 1 2 3 4 5 6 7 8 9 10

Completely disagree — Completely agree

19. An increase in pain is an indication that I should stop what I'm doing until the pain decreases.

0 1 2 3 4 5 6 7 8 9 10

Completely disagree — Completely agree

20. I should not do my normal work with my present pain.

0 1 2 3 4 5 6 7 8 9 10

Completely disagree — Completely agree

Here is a list of five activities. Circle the one number that best describes your current ability to participate in each of these activities.

21. I can do light work for an hour. 10 - x

0 1 2 3 4 5 6 7 8 9 10

Can't do it because of pain problem — Can do it without pain being a problem

22. I can walk for an hour. 10 - x

0 1 2 3 4 5 6 7 8 9 10

Can't do it because of pain problem — Can do it without pain being a problem

23. I can do ordinary household chores. 10 - x

0 1 2 3 4 5 6 7 8 9 10

Can't do it because of pain problem — Can do it without pain being a problem

24. I can do the weekly shopping. 10 - x

0 1 2 3 4 5 6 7 8 9 10

Can't do it because of pain problem — Can do it without pain being a problem

25. I can sleep at night. 10 - x

0 1 2 3 4 5 6 7 8 9 10

Can't do it because of pain problem — Can do it without pain being a problem

ACTIVITIES OF DAILY LIVING (ADL'S)

(**Patient:** Please answer each question once with an X in the appropriate column. Note that these questions should be answered as they pertain to your activities of daily living based on your current injury. If the activity does not apply to you please answer N/A)

Name: _____ Date: _____

Are you able to:	**Yes**	**No**	**N/A**	**If NO please explain**
1. Dress yourself including shoes				
2. Wash and dry yourself				
3. Take a bath				
4. Get on and off the toilet				
5. Cut your food				
6. Lift a full cup to your mouth				
7. Make a meal				
8. Write a note				
9. Type a message on a computer				
10. Use a telephone				
11. Work outdoors on flat ground				
12. Climb up 1 flight of stairs (10 steps)				
13. Stand				
14. Sit				
15. Recline				
16. Rise from a chair				
17. Run errands				
18. Light housework				
19. Feel what you touch				
20. Open car doors				
21. Turn faucets on and off				
22. Get in and out of a car				
23. Sleep				
24. Engage in sexual activity				

(rev 1-2013)

Patient Signature: _____ Date: _____

Provider Initials _____ Date_____