Laura A. Timmerman, MD

Workers Compensation Information

Date		
Name	Birthdate	
Cell Phone	Home Phone	
Address		
City	State	Zip Code
Employer Name		
Employer Address		
City	State	Zip Code
Phone	Occupation	
List the physical demands of your job,		
Worker compensation carrier		
Carrier Address		
Adjuster's Name	Adjuster's Phone Number	
Claim Number	Date of Injury	

Give a full description of how the accident happened

Last date worked ☐ Full Duty ☐ Modified Duty

Any previous Worker Compensation Injuries? ☐ Yes ☐ No

Describe Previous Worker Compensation Injuries Has this or any other claim settled?

☐ Yes ☐ No

I clearly understand and agree that all services rendered to me are charged directly to me and that I am personally responsible for payments in the event that my claim for Worker Compensation benefit is denied

Signature of Patient/Insured/Guardian

Date

Medical History Form

First Name	Middle Name	Last name
Appointment Date	with Dr.	
Age Sex ☐ Female ☐ Male		
Height	Weight	
Dominant Hand. ☐ Left ☐ Right	Did you bring X-Rays? ☐ Yes ☐ No	
Who is your primary physician? (name)	☐ MD ☐ PA	
Clinic Name		
What is your reason for this visit?		
☐ Pain ☐ Numbness ☐ Weakness ☐ Swelling ☐ Stiffness		
☐ Other	Latex allergy? ☐ Yes ☐ No	
What body part is involved?		
Elbow ☐ Right ☐ Left Wrist ☐ Right ☐ Left Hand ☐ Right ☐ Left Hip ☐ Right ☐ Left Back ☐ Right ☐ Left		
Knee ☐ Right ☐ Left Ankle ☐ Right ☐ Left Foot ☐ Right ☐ Left Neck ☐ Right ☐ Left		
How long ago did it start? ☐ Days ☐ Weeks ☐ Months ☐ Years		
Have you had a problem like this before?	☐ Yes ☐ No	
In this section, check the ONE BOX which best describes how your problem started. Then answer the questions below the box you checked. ☐ NO INJURY (or the onset was: ☐ Gradual ☐ Sudden)		
Please indicate why do you think it started. INJURY (☐ Accident ☐ Sport (NOT Auto or Work)		
Date		
Please specify where and how it happened		
What Sport?	School?	
INJURY AT WORK	Date	
From a: ☐ lift ☐ twist ☐ fall ☐ bend ☐ pull ☐ reach		
☐ WORK RELATED (BUT NOT INJURY)		
Date		
How did your work cause the problem?		

☐ AUTO ACCIDENT Date

How was your car hit?

Comments

On a scale of 0-10 (10 is the worst) how severe is your pain?

○1 ○2 ○3 ○4 ○5 ○6 ○7 ○8 ○9 ○10

What is the quality of the pain?

☐ Sharp ☐ Dull ☐ Stabbing ☐ Throbbing ☐ Aching ☐ Burning

The pain is

☐ Constant ☐ Comes and goes (intermittent)

Does your pain wake you from your sleep?

☐ Yes ☐ No

Do you have

☐ Swelling ☐ Bruises ☐ Numbness ☐ Tingling ☐ Weakness

☐ Loss olcontrol of bowel or bladder ☐ Locking/Catching ☐ Giving way

Since my problem started, it is

☐ Getting better ☐ Getting worse ☐ Unchanged

What makes your symptoms worse?

☐ Standing ☐ Squatting ☐ Walking ☐ Kneeling ☐ Lifting

☐ Stairs ☐ Exercise ☐ Sitting ☐ Twisting ☐ Coughing

☐ Lying in bed ☐ Sneezing ☐ Bending

Which makes your symptoms better?

☐ Rest ☐ Elevation ☐ Ice ☐ Heat ☐ Other

What medications are you taking now?

ALLERGIC TO ANY MEDICATIONS?

☐ Yes ☐ No

If yes please list and describe reaction

Have you had any of these treatments?

Injection ☐ Yes ☐ No

Cane/Crutch ☐ Yes ☐ No

Brace ☐ Yes ☐ No

Physical Therapy ☐ Yes ☐ No

Were you seen in the E.R. for this problem?

☐ Yes ☐ No

Which E.R.?

Date

Are you here today because of a E.R. visit? ☐ Yes ☐ No

Who saw you in the E.R.? ☐ MD ☐ PA

What tests/scans have you had for this problem

☐ X-Rays ☐ MRI ☐ CAT Scan ☐ Bone Scan ☐ Nerve Test (EMG/NCV)

Where?

Have you already had surgery for a problem in this same area either recently or in the past? If yes, please list below ☐ Yes ☐ No

Procedure #1	Surgeon	City	Date
Procedure #1	Surgeon	City	Date

Current work status

☐ Regular ☐ Retired ☐ Disabled ☐ Student ☐ Light Duty

☐ Not working due to this problem

How long? (light Duty)

When is the last date you worked your regular job?

Are you currently receiving or plan to apply for:

Disability	Worker's Comp	Unemployment
☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No

Have you had a prior problem with this same Orthopedic condition in the past?

☐ Yes ☐ No

Explain

Do your other joints have:

☐ morning stiffness lasting over 30 minutes	☐ joint pain or swelling	☐ Back Pain
☐ Gout	☐ Rheumatoid arthritis	☐ Osteoporosis
☐ prior fracture (which bone)	☐ None of these	

Have you had any of these symptoms? If no, mark None.

		Year	Comments
1) GI	☐ Heartburn, ulcers		
	☐ Blood in Stool		
	☐ Hepatitis		
	☐ Nausea, Vomiting		
	☐ Liver disease		
	☐ None		

Have you had any of these symptoms? If no, mark None.

2) ENDO

Year Comments

- ☐ Thyroid Disease
- ☐ Heat orCold
- ☐ Intolerance
- ☐ None

Year Comments

3) CON

- ☐ Weight Loss
- ☐ Loss of Appetite
- ☐ None

Year Comments

4) EYE

- ☐ Blurred Vision
- ☐ Double Vision
- ☐ Vision Loss
- ☐ None

Year Comments

5) ENT

- ☐ Hearing Loss
- ☐ Trouble Swallowing
- ☐ Hoarseness
- ☐ None

6) CV Year Comments

- ☐ Chest Pain
- ☐ Palpitations
- ☐ None

Year Comments

7) RS

- ☐ Chronic Cough
- ☐ Shortness of Breath
- ☐ None

		Year	Comments
8) GU	☐ Painful Urination		
	☐ Kidney Problems		
	☐ Blood in Urine		
	☐ None		

		Year	Comments
9) SK	☐ Frequent Rashes		
	☐ Lumps		
	☐ Skin Ulcers		
	☐ Psoriasis		
	☐ None		

		Year	Comments
10) NEU	☐ Headaches		
	☐ Seizures		
	☐ Dizziness		
	☐ None		

		Year	Comments
11) PSY	☐ Depression		
	☐ Sleep Disorder		
	☐ Drug/Alcohol		
	☐ Addiction		
	☐ None		

		Year	Comments
12) HEM	☐ Easy Bleeding		
	☐ Anemia Easy		
	☐ Bruising		
	☐ None		

13) ARE YOU HIV POSITIVE

☐ Yes ☐ No

PAST MEDICAL HISTORY

Are you Diabetic? ☐ Yes ☐ No

Treatment:
☐ Insulin ☐ Oral Meds ☐ Diet ☐ None

Are you taking, or have you ever taken, blood thinners?
☐ Yes ☐ No

If yes, which one?

Past Surgical History: what operations have you had and when? Please list

Have you or a family member ever had a reaction to anesthesia?
☐ Yes ☐ No

Explain

Past Hospitalizations; (Not for Surgery)

Have you ever had

☐ Blood Clots ☐ AnkleSwelling ☐ High Blood Pressure ☐ Kidney Failure
☐ Heart Attack Year ☐ Stroke ☐ Cancer Location
☐ Stomachache while taking anti-inflammatories (includes Advil/ Aleve) ☐ Heart Failure ☐ I do not have any of the above conditions

Family History

Have any direct relatives had any of the following disorders?
☐ Diabetes ☐ High Blood Pressure ☐ Rheumatoid Arthritis ☐ None

If so, which relative

Do any direct relatives have the same condition you are being seen for today?
☐ Yes ☐ No

SOCIAL HISTORY

Do you use tobacco ☐ Yes. ☐ No — If Yes packs per day

Patient informed of smoking risk? ☐ Yes ☐ No

Alcohol use? ☐ Yes ☐ No — If yes how often ☐ Daily ☐ Other /week

Marital History:
M S D W

How many people live with you?

Occupation

Student ☐

Employer		
Do you plan to be working 6 months from now? ☐ Yes ☐ No		
PLEASE SIGN: The information on these this form is accurate to the best of my knowledge.		
Date		
FOR OFFICE USE ONLY		
Completed	Date	
Review #1 by	Date	
Review #2 by	Date	

Release of Information

Initial if this page is intentionally left blank

Who (if anyone) would like Dr. Timmerman and Staff to be able to speak to regarding your care?

1. Name	Relationship
2. Name	Relationship
3. Name	Relationship
Please list a phone number where messages can be left regarding your care.	
Patient Signature	

IF PATIENT IS A MINOR

I

give permission to Dr. Timmerman to evaluate and treat my child

even though I may not be present at the time of the evaluation/treatment.

Name	Relationship
Patient/Guardian Signature	
Date	