Dr. Mark C. Anken, D.C.

Worker's Compensation Questionnaire for Reoccurrence

Patient's Name: _____ Date: _____
First MI Last

Address: _____ City: _____ State: _____ Zip Code: _____

Phone #: _____ Work #: _____ Cell #:_____

Sex: M F Date of Birth_____ Age_____ Social Security#_____

Primary Care Physician (PCP) _____ Health Ins: _____

Date of Reoccurrence of Injury: _____ Date of Initial Injury: _____

Name of Employer: _____

Cause of Injury: _____

Please list any interventions, injury or trauma, treatments, or care you've sought for your complaint(s):

_____

_____**Any**

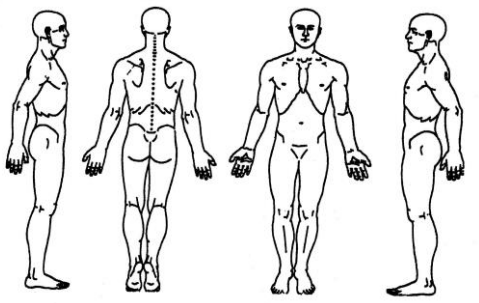
surgeries? Yes / No If yes, type of surgery & when:_____

_____

Have you ever broken any bones? Which? _____

Have you had any x-rays? Where? When? _____

WC Complaints



Please place an "X" on these Figures to show where your Pain is Located. Include symptoms of Tingling/Numbness

Patient Height :_____ **Weight:** _____

Symptom 1 (Please check only one symptom. *Additional symptom sections are available if needed*.**)**

□ Headaches □ Neck Pain □ Jaw Pain □ Upper Back Pain □ Middle Back Pain □ Low Back Pain □ Shoulder Pain
□ Elbow Pain □ Forearm Pain □ Wrist Pain □ Hand Pain □ Thumb Pain □ Hip Pain □ Knee Pain □ Leg Pain
□ Ankle Pain □ Foot Pain □ Chest Pain □ Other _____

Is the symptom located **LEFT, RIGHT, CENTER or BILATERAL?** (Please circle all that apply.)

Intensity of Pain: (No Pain) **0 1 2 3 4 5 6 7 8 9 10** (Very Intense)

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Frequency: _____% of awake time

Did you experience this symptom prior to your injury? Yes No

What aggravates the symptom? (Check all that apply.)

□ Bending Neck Forward □ Bending Neck Backward □ Tilting head to Right □ Tilting Head to Left
□ Turning Head to Right □ Turning Head to Left □ Bending Forward at Waist □ Bending Backward at Waist
□ Tilting Left at Waist □ Tilting Right at Waist □ Twisting Left at Waist □ Twisting Right at Waist □ Sitting □ Standing
□ Getting up from seated position □ Lifting □ Any Movement □ Driving □ Walking □ Running □ Nothing
□ Changing Positions □ Chewing □ Other_____

What relieves the symptoms? (Check all that apply.)
□ Resting □ Ice □ Heat □ Stretching □ Exercise □ Massage □ Walking □ Pain Medication □ Muscle Relaxers
□ Nothing □ Other _____

Type of Pain: (Check all that apply.)
□ Sharp □ Dull □ Achy □ Burning □ Throbbing □ Piercing □ Stabbing □ Deep □ Nagging □ Shooting □ Stinging
□ Numbness/Tingling □ Swelling □ Weakness □ Stiffness □ Other _____

When is pain worse? (Check all that apply.) □ Morning □ Afternoon □ Evening □ Night □ None

Does the pain radiate? Yes No If YES, where does the pain radiate? (Check all that apply.)
□ Jaw □ New □ Low Back □ Shoulder □ Arm □ Elbow □ Forearm □ Wrist □ Hand □ Fingers □ Hip □ Buttock
□ Thigh □ Leg □ Knee □ Ankle □ Foot □ Toes □ Other: _____

Additional Symptoms? (Check any that apply.) □ Dizziness □ Loss of Range of Motion □ Visual Disturbance
□ Anxiety □ Depression

Additional symptom sections are available if needed.

Activities of Daily Living Under Duress

At work: (Check all that apply.) □ Lifting □ Bending □ Sitting □ Walking □ Computer Duties
□ Other: _____

At School: (Check all that apply.) □ Lifting □ Bending □ Sitting □ Walking □ Computer Duties
□ Other: _____

Household/domestic duties: (Check all that apply.) □ Vacuuming □ Taking Care of Children □ Cleaning □ Shopping
□ Preparing Meals □ Yard work □ Transportation □ Taking out the trash □ Other: _____

Sports: (Check all that apply.) □ Social □ Competitive □ Regional □ Other:_____

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Review of Systems Health History:

Have you had any of the following **pulmonary (lung-related)** issues?
□ Asthma/difficulty breathing □ Lung problems □ COPD □ Emphysema □ Other _____ □ None of the above

Have you had any of the following **cardiovascular (heart-related)** issues or procedures?
□ Heart surgeries □ Congestive heart failure □ Murmurs or valvular disease □ Heart attacks/MIs
□ Heart disease/problems □ Hypertension □ Pacemaker □ Angina/chest pain □ Irregular heartbeat
□ High Blood Pressure/Chest pain □ Other _____ □ None of the above

Have you had any of the following **neurological (nerve-related)** issues?
□ Visual changes/loss of vision □ One-sided weakness of face or body □ History of seizures □ One-sided decreased feeling in the face or body □ Headaches □ Memory loss □ Tremors □ Vertigo □ Loss of sense of smell
□ Strokes/TIAs □ Other _____ □ None of the above

Have you had any of the following **endocrine (glandular/hormonal)** related issues or procedures?
□ Thyroid disease □ Hormone replacement therapy □ Injectable steroid replacements □ Diabetes
□ Other _____ □ None of the above

Have you had any of the following **renal (kidney-related)** issues or procedures?
□ Renal calculi/stones □ Hematuria (blood in the urine) □ Incontinence (can't control) □ Bladder Infections
□ Difficulty urinating □ Kidney disease □ Dialysis □ Other _____ □ None of the above

Have you had any of the following **gastroenterological (stomach-related)** issues?
□ Nausea □ Difficulty swallowing □ Ulcerative disease □ Frequent abdominal pain □ Hiatal hernia □ Constipation
□ Pancreatic disease □ Irritable bowel/colitis □ Hepatitis or liver disease □ Bloody or black tarry stools
□ Vomiting blood □ Bowel incontinence □ Gastroesophageal reflux/heartburn □ Other _____ □ None of the above

Have you had any of the following **hematological (blood-related)** issues?
□ Anemia □ Regular anti-inflammatory use (Motrin/Ibuprofen/Naproxen/Naprosyn/Aleve) □ HIV positive
□ Abnormal bleeding/bruising □ Sickle-cell anemia □ Enlarged lymph nodes □ Hemophilia
□ Hypercoagulation or deep venous thrombosis/history of blood clots □ Anticoagulant use/therapy □ Regular aspirin use
□ Other _____ □ None of the above

Have you had any of the following **dermatological (skin-related)** issues?
□ Significant burns □ Significant rashes □ Skin grafts □ Psoriatic disorders □ Other _____□ None of the above

Have you had any of the following **musculoskeletal (bone/muscle-related)** issues?
□ Rheumatoid arthritis □ Gout □ Osteoarthritis □ Broken bones □ Spinal fracture □ Spinal surgery □ Joint surgery
□ Arthritis (unknown type) □ Scoliosis □ Metal implants □ Other _____ □ None of the above

Have you had any of the following **psychological** issues?
□ Psychiatric disorders/diagnosis □ Major depression □ Suicidal ideations □ Bipolar disorder □ Homicidal ideations
□ Schizophrenia □ Psychiatric hospitalizations □ Other _____ □ None of the above

Family Health History:
Do you have a family history of? (Please indicate all that apply)
□ Cancer □ Strokes/TIA's □ Headaches □ Cardiac disease □ Neurological diseases □ Adopted/Unknown
□ Cardiac disease below age 40 □ Psychiatric disease □ Diabetes □ Other _____ □ None of the above

Cause(s) of death in immediate family (parents or siblings) and ages at death: _____
_____

Is there anything else in your past medical history that you feel is important to your care here? _____
_____

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