

Name: _____ Age: _____
 Occupation: _____
 Referred By: _____
 Injured Extremity: _____ Right or Left Handed: _____
 Date of Injury: _____
 Today's Date: _____
 Type of Exam: _____

WORK INFORMATION

Who was the employer **at the time of injury**? _____

What was your job title? _____ What was your date of hire? _____

Are you still working for the employer? If not, when did you last work?
 Y N _____

How many hours a week do you work? _____

Very briefly describe your job duties... _____

	Yes	No		Yes	No
Do you have: Diabetes.....	<input type="checkbox"/>	<input type="checkbox"/>	Thyroid Disease.....	<input type="checkbox"/>	<input type="checkbox"/>
Rheumatoid	<input type="checkbox"/>	<input type="checkbox"/>	Allergies.....	<input type="checkbox"/>	<input type="checkbox"/>
Arthritis..	<input type="checkbox"/>	<input type="checkbox"/>	Do you smoke?.....	<input type="checkbox"/>	<input type="checkbox"/>

Any other illnesses? _____

Have you previously had an injury to your hands or upper extremities? Y N

If yes, please explain: _____

Have you had any previous workers compensation claims? Y N
 If yes, what part of the body _____ year _____

Name: _____
Date: _____

HISTORY

EXAM

ASSESSMENT

DIAGNOSIS

CAUSE

TREATMENT