Health Questionnaire

Name: _____ **Date completed:** _____

Age: _____ ☐ Right Handed

Job title when injured: _____ ☐ Left handed

Date of Injury/ies: _____, _____, _____

HISTORY OF INJURY

Mechanism of injury/ies:
Please describe how you were injured at work for each date of injury, starting with the oldest if more than one:

_____

_____

_____

_____

_____

_____

_____

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PLEASE USE ADDITIONAL SHEETS IF NEEDED

Administrative Services by:

Phone: (408) 445-8400
Fax: (408) 791-2050
Email: support@PeakEvals.com

Mailing Address
13980 Blossom Hill Road, Suite B
Los Gatos, CA 95032

Diagnostic Imaging Studies:

Date completed	Study completed, (X-ray, MRI, myelogram, etc.)	Results if known

Additional Diagnostic Studies:

Date completed	Study completed, (EMG, nerve conduction studies, EEG, etc.)	Results if known.

Clinical course:

Please describe the evaluation and treatment you've had for your injury/ies

Treatments & Response:

Treatment	# or Sessions or Type	Date (Approximate)	Benefit	No Change	Worse
Medications					
Physical therapy					
Hand therapy					
Massage therapy					
Aquatic therapy					
Independent exercise					
Chiropractic					
Acupuncture					
Pain management counseling					
Specialty consultation					
Trigger point injection					
Epidural injection					
Joint injection					
Other injection					
Surgery					
TENS unit /H-wave					
Brace					
Cane or walker					

Ergonomic evaluation					
Other:					

Any other injuries or problems to the body parts mentioned above:
(Please list the estimated date or year, how you were injured, whether it happened at work or not, which body parts were injured and whether the symptoms resolved.

Date	How were you injured?	Work Related?	Body Parts	Did symptoms resolve?

Any injuries or problems to other body parts <u>not</u> mentioned above.
(Please list the estimated date or year, how you were injured, whether it happened at work or not, which body parts were injured and whether the symptoms resolved.

Date	How were you injured?	Work Related?	Body Parts	Did symptoms resolve?

Job description at the time of injury:
Employer: _____
Title: _____
Duties: _____
Days/Hours/Breaks: _____

Physical Demands based on an 8 hour day:

Physical Activity	**Frequency** **C**onstant (100%) **F**requent (75%) **I**ntermittent (50%) **O**ccasional (25%) **N**ever (0%)	**Comments** Please include the amount of weight or the amount of time for those activities.
Lifting/carrying		
Pushing/pulling		

Overhead work		
Reaching below shoulder		
Reaching above shoulder		
Gripping/grasping		
Keyboarding/mousing/writing		
Phone		
Bending/twisting at the neck		
Bending/twisting at the waist		
Sitting		
Standing		
Walking		
Walking on uneven ground		
Kneeling		
Squatting		
Climbing stairs		
Climbing ladders		
Driving		
Operating machinery		
Equipment/tools		

What is your <u>current work status</u>: _____
If not working, date last worked:_____
If not working, what is the reason:_____

If you are working modified duty for the <u>same employer</u> please complete:
Work restrictions: _____
Days/Hours/Breaks: _____

If you are working <u>for a different employer</u> please complete:
Employer:_____
Title:_____
Duties:_____
Work restrictions: _____
Days/Hours/Breaks: _____

Physical Demands based on an 8 hour day:

Physical Activity	**Frequency** **C**onstant (100%) **F**requent (75%) **I**ntermittent (50%) **O**ccasional (25%) **N**ever (0%)	**Comments** Please include the amount of weight or the amount of time for those activities.
Lifting/carrying		
Pushing/pulling		
Overhead work		
Reaching below shoulder		

Reaching above shoulder		
Gripping/grasping		
Keyboarding/mousing/writing		
Phone		
Bending/twisting at the neck		
Bending/twisting at the waist		
Sitting		
Standing		
Walking		
Walking on uneven ground		
Kneeling		
Squatting		
Climbing stairs		
Climbing ladders		
Driving		
Operating machinery		
Equipment/tools		

Are you are currently receiving disability benefits? □ Yes □ No

If yes, what type:

_____

_____

Did you have other employment at the time of injury/ies? □ Yes □ No

If yes, where did you work and what were you doing?

_____

_____

Do you currently have other employment? □ Yes □ No

If yes, where do you work and what are you doing?

_____

_____

CURRENT SYMPTOMS:

Body Part	Frequency **C**onstant (100%) **F**requent (75%) **I**ntermittent (50%) **O**ccasional (25%)	VAS Range 0 = no pain 10 = worst pain imaginable Out of 10	Quality Dull Aching Throbbing Sharp stabbing Electrical Burning	Radiation or Associated Symptoms	Aggravating Activities
Example: *Low Back*	*F*	*Good: 2* *Bad: 8*	*Aching, Electrical*	*Down right leg*	*Lifting, carrying, pushing, pulling, and standing for long times.*

EFFECTS ON ACTIVITIES OF DAILY LIVING:

The difficulty level/limitations of any of the following activities (check the appropriate boxes):

Activity	No Difficulty	With Difficulty	Unable to do	N/A	Comments/Limited by which body part(s)
Brushing teeth					
Showering/bathing					
Toileting					
Dressing upper body					
Dressing lower body					
Putting on shoes/socks					
Eating					
Writing					
Typing/keyboard					
Using cell phone					
Buttoning					
Zippering					
Bending/twisting at the neck					
Reaching above the shoulders					
Bending/twisting at the waist					
Squatting					
Kneeling					
Walking up/downstairs					
Getting in/out of bed					
Climbing ladders					
Walking on uneven ground					
Food preparation					
Cooking					

Washing dishes					
Loading dishwasher					
Laundry					
Dusting					
Vacuuming					
Cleaning the shower/tub					
Grocery shopping					
Driving					

In POUNDS (or described in term of household items), are you able to do without causing a major flare-up: *Example: Lift: 10 pounds or 1 gallon of milk*

Lift: _____
Carry: _____
Push: _____
Pull: _____

In MINUTES, how much time are you able to do without causing a major flare-up:
Example: Sit: 20 minutes

Sit: _____
Stand: _____
Walk: _____

Do you use any assistive devices? ☐ Yes ☐ No

If yes, please list all devices:

_____

_____

List any hobbies/recreational activities:
Prior to the injury/ies: _____

Currently: _____

List educational/vocational history:
What is the highest grade level completed
☐Grade School ☐ High School ☐ College ☐ Post Graduate

Any college degrees: _____

Employment / Vocational history:

Employer	Job title	Duration of Employment	Injury (Y/N)	Comments

PAST MEDICAL HISTORY:

Personal and Family Medical Information:

	Current Problem	Yes, but resolved	No	Family History (grandparent, parent, sibling, children)
Alcohol abuse	☐	☐	☐	☐
Angina (chest pain)	☐	☐	☐	☐
Anxiety	☐	☐	☐	☐
Arthritis	☐	☐	☐	☐
Asthma	☐	☐	☐	☐
Bladder incontinence	☐	☐	☐	☐
Bladder infection	☐	☐	☐	☐
Bleeding disorder	☐	☐	☐	☐
Blood in stool	☐	☐	☐	☐
Blood in urine	☐	☐	☐	☐
Bowel incontinence	☐	☐	☐	☐
Cancer	☐	☐	☐	☐
Constipation (chronic)	☐	☐	☐	☐
Depression	☐	☐	☐	☐
Diabetes	☐	☐	☐	☐
Diarrhea (chronic)	☐	☐	☐	☐
Dizziness	☐	☐	☐	☐
Drug Abuse	☐	☐	☐	☐
Fever (unexplained)	☐	☐	☐	☐
Fracture(broken bones)	☐	☐	☐	☐
Gallbladder	☐	☐	☐	☐
Glaucoma	☐	☐	☐	☐
Gout	☐	☐	☐	☐
Headaches	☐	☐	☐	☐
Heart attack	☐	☐	☐	☐

Heart murmur	☐	☐	☐	☐
Hepatitis/liver disease	☐	☐	☐	☐
High blood pressure	☐	☐	☐	☐
High Cholesterol	☐	☐	☐	☐
Insomnia	☐	☐	☐	☐
Kidney disease	☐	☐	☐	☐
Lung disease	☐	☐	☐	☐
Recurrent fevers	☐	☐	☐	☐
Seizures	☐	☐	☐	☐
Shortness of breath	☐	☐	☐	☐
Stroke	☐	☐	☐	☐
Thyroid disease	☐	☐	☐	☐
Tobacco use	☐	☐	☐	☐
Tuberculosis	☐	☐	☐	☐
Ulcer	☐	☐	☐	☐

If other, please specify:

_____

For women: Are you currently pregnant? ☐ Yes ☐ No ☐ Uncertain

PAST SURGICAL HISTORY:
List all surgeries that you have undergone:

_____ _____

_____ _____

_____ _____

List all hospitalizations. Including psychiatric hospitalizations, drug and alcohol rehabilitations - exclude surgeries:

_____ _____

_____ _____

_____ _____

CURRENT MEDICATIONS:

List any current medications:

Name	Strength	Dosage (example: 2x day)	Average number taken weekly

Allergies to Medication and Adverse Reactions:

Name	Reaction

PERSONAL HISTORY:

Social History:

Are you:

☐ Single ☐ Married ☐ Separated ☐ Divorced ☐ Widow(er)

Do you have children?

☐ Yes ☐ No If Yes, please list ages: _____

Do you currently smoke cigarettes?

☐ Yes ☐ No If Yes, how many per day: _____

Do you currently drink alcohol?

☐ Yes ☐ No If Yes, ☐ socially ☐ regularly ☐ rarely

Currently use recreational drugs?

☐ Yes ☐ No If Yes, what kind: _____

If there is something else that you would like the doctor to know, please use additional sheets.

Thank you for taking the time to complete this questionnaire!

Sign & Date