

**WORKMEN'S COMPENSATION INFORMATION SHEET
DRS. HANLON / MEISEL / KEHOE**

PATIENT INFORMATION

LAST NAME: _____ FIRST NAME: _____ MI: _____

ADDRESS: _____ CITY: _____ STATE: _____ ZIP: _____

TELEPHONE NUMBER: _____ SOCIAL SECURITY NUMBER: _____

BIRTHDATE: _____ AGE: _____ SEX: _____ HEIGHT: _____ WEIGHT _____

EMPLOYER'S NAME: _____ THROUGH TEMPORARY SERVICES? ____ YES ____ NO

IF YES, NAME OF TEMP SERVICE: _____

EMPLOYER/TEMP SERVICE ADDRESS: _____

CITY: _____ STATE: _____ ZIP: _____ TELEPHONE NUMBER: _____

EMERGENCY CONTACT _____ TELEPHONE NUMBER: _____

ACCIDENT INFORMATION

Please complete the following questions in full. If any questions do not apply to you, please indicate with N/A. If you have any questions see the receptionist. We appreciate your cooperation.

WHO REFERRED YOU TO US? _____

CURRENT PROBLEM FOR THIS EVALUATION:

BODY PART: _____ RIGHT LEFT BOTH ARE YOU: RIGHT HANDED LEFT HANDED

EXACT DATE OF INJURY: _____ TIME OF INJURY: _____

PLEASE EXPLAIN EXACTLY HOW THE INJURY OCCURRED: _____

HAS AN ATTORNEY BEEN CONSULTED? ____ YES ____ NO

WHAT TREATMENT HAVE YOU HAD SO FAR FOR THIS INJURY AND BY WHOM? _____

HAVE YOU HAD X-RAYS? ____ YES ____ NO WHEN? _____ WHERE? _____

LIST ANY MEDICATIONS YOU ARE CURRENTLY TAKING AND REASON FOR TAKING: _____

DO YOU HAVE ANY ALLERGIES? ____ YES ____ NO (PLEASE LIST): _____

HAVE YOU HAD ANY SERIOUS ILLNESSES OR SURGERIES? (DIABETES, HEART DISEASE, CANCER?): _____

I authorize Drs. Hanlon, Meisel, Kehoe to release any necessary medical information about me to process these claims or related medical claims. I permit a copy of this authorization to be used in place of original. I understand I am financially responsible to the doctor for charges which are denied by the insurance company/employer

SIGNATURE: _____ DATE: _____

THANK YOU FOR HELPING US!

General Past Medical History:

Other Orthopedic Problems: None Rheumatoid or other arthritis Joint swelling _____ Pinched nerve
 Sprain of _____ Tendinitis _____ Other: _____

Circulation Problems: None Blood Clots Phlebitis Stroke Cold fingers or toes Swelling

Heart Disease: None Heart attack Chest pain Heart failure High blood pressure Other: _____

Respiration, Problems: None Asthma Wheezing Shortness of Breath Emphysema Other: _____

Gastrointestinal Problems.- None Ulcer Diarrhea Nausea Vomiting Loss of weight
 Bloody Stool Hepatitis

Genitourinary.- None Infection Pain on urination Frequency of urination Other _____

Neurological: None Headache Fainting Seizures Stroke Paralysis Numbness Head injury
 Other: _____

Emotional Problems: None Nervous breakdown Depression Stress Sleeplessness Alcohol/Drug abuse
 Other: _____

Bleeding Problems: None or explain: _____

Endocrine / Metabolic: None Diabetes Thyroid Hypoglycemia Other: _____

Genetic or Inherited Disorders: None List: _____

Gynecological.- (females) Last Menstrual Period: _____ Last Pap: _____

Pregnancies: _____ Complications: _____ Children: _____

Past Surgeries: Please list: _____

Life Style: Coffee / Tea / Caffeine beverages Amount _____/day

Tobacco: cigarettes / cigars / smokeless tobacco Amount _____/day

Other Substances: _____

Do you consider your overall health: Excellent Very Good Good Fair Poor

CERTIFICATE OF AUTHENTICITY

I hereby certify that the above information is true and correct to the best of my ability.

Signed: _____ Date: ____/____/____