HEALTH HISTORY — THE WORK CLINIC

1. Fill out information and check box ☒ for "yes" OR leave blank ☐ for "no"

Full Name		**Pregnant**	☐Yes ☐No
Hobbies		**Gender**	☐ Male ☐ Female ☐Other:
Allergies			
Current Medications		**Status**	☐Married ☐Single ☐Other:

Personal Health History

☐High blood pressure
☐Heart disease
☐Head/brain injury
☐Diabetes
☐Cancer (describe):
☐Surgeries (describe):
☐Asthma/lung disease
☐Kidney disease/dialysis
☐Liver disease/cirrhosis
☐Nervous or psychiatric disorder (ex: depression)
☐Other (describe):

Social History

☐Tobacco
☐Alcohol
☐Marijuana
☐Cocaine
☐Heroin

Immediate Family History

If yes, indicate whom (mother, father, sister, etc.)

☐Heart Disease:
☐Diabetes:
☐Alcoholism:
☐Cancer:
☐Nervous or psychiatric disorder (ex: depression):

2. Check box ☒ for "yes" if you have been experiencing these symptoms OR leave blank ☐ for "no":

General
☐Weight loss or gain
☐Fatigue
☐Fever or chills
☐Weakness

Skin
☐Rashes
☐Lumps
☐Itching
☐Dryness

Eyes
☐Vision changes
☐Pain
☐Redness
☐Flashing lights

Blood Disorder
☐Ease of bruising
☐Ease of bleeding
☐Anemia

Head
☐Headache
☐Head injury
☐Vertigo
☐Migraine

Ears
☐Decreased hearing
☐Ringing
☐Pain
☐Ear discharge

Nose
☐Congestion
☐Pain
☐Hay fever
☐Nosebleeds

Neck
☐Lumps
☐Pain
☐Stiffness

Respiratory
☐Cough/phlegm
☐Coughing blood
☐Shortness of breath

Throat
☐Difficulty swallowing
☐Pain
☐Sore throat
☐Hoarseness

Urinary
☐Blood in urine
☐Urgency
☐Burning or pain
☐Incontinence

Vascular
☐Calf pain with walking
☐Leg cramping
☐Varicose veins

Cardiovascular
☐Chest pain or discomfort
☐Murmur
☐Palpitations
☐Surgery

Gastrointestinal
☐Nausea or vomiting
☐Abdominal pain
☐Nausea
☐Heartburn
☐Constipation
☐Diarrhea

Neurological
☐Dizziness
☐Fainting
☐Numbness
☐Hand tremors
☐Tingling hands or feet

Endocrine
☐Heat or cold intolerance
☐Sweating
☐Thirst
☐Frequent urination

Psychiatric
☐Nervousness
☐Anxiety
☐Depression
☐Memory loss

Other (list/describe):

Not Applicable
☐No symptoms at all

3. Please sign and date below:

Signature:_____ **Date:**_____

OCCUPATIONAL HISTORY THE WORK CLINIC

1. Please fill out following information:

Patient Name		**Today's Date**	
Patient Job Title		**Date of Hire**	
Employer Name		**Date of Injury**	
Employer Address		**Claim Number**	
		Supervisor Name	
Type of Industry		**Supervisor Number**	
Employment Status	☐ Full-time ☐ Part-time	**Supervisor Job Title**	

- Do you undergo any routine medical tests related to work? ☐ Yes ☐ No
  If yes which one(s) and why? (silica, lead, isocyanates, asbestos, other)
  ☐ Hearing tests ☐ Chest x-rays ☐ Pulmonary function tests
  ☐ Bloods tests ☐ Other (please list): _____

- Do you wear Personal Protective Equipment? ☐ Yes ☐ No
  If yes, which one(s):
  ☐ Gloves ☐ Coveralls ☐Safety glasses ☐Hearing protection
  ☐ Mask ☐ Respirator ☐Safety shoes ☐Other (please list): _____

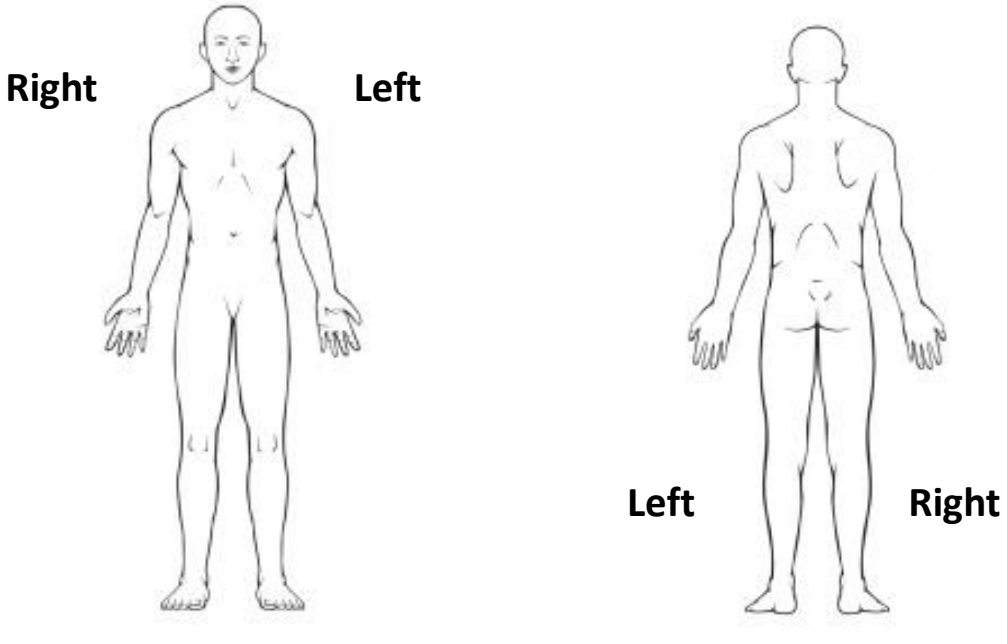
2. List past jobs and include short-term, seasonal, and part-time employment. Add complete job duties (welding, painting, etc)

Dates of Employment	Employer Name	Job Title	Job Duties

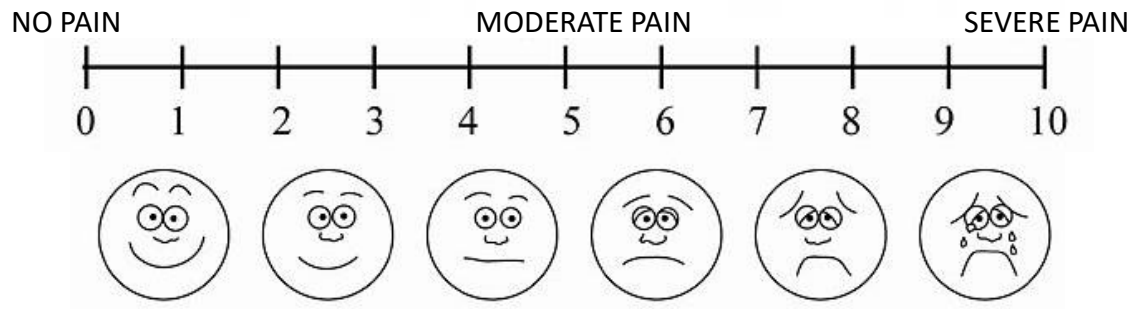
BRIEF PAIN INVENTORY — THE WORK CLINIC

Full Name: _____ Date: _____

1. Draw "x" to mark pain or draw "o" to mark numbness/tingling on the two images below.



2. Using the face rating scale below, rate your pain by circling the one number that best describes your pain.



3. Rate your pain by circling the one number that best describes your pain at its WORST in the last 24 hours.

1 2 3 4 5 6 7 8 9 10
No Pain — Worst Pain

4. Rate your pain by circling the one number that best describes your pain on the AVERAGE.

1 2 3 4 5 6 7 8 9 10
No Pain — Worst Pain

5. Rate your pain by circling the one number that best describes your pain at its LEAST in the last 24 hours.

1 2 3 4 5 6 7 8 9 10
No Pain — Worst Pain

6. Patient's Comments:

_____
_____
_____
_____
_____

CONSENT FOR TREATMENT, PAYMENT, & ACKNOWLEDGEMENT THE WORK CLINIC

CONSENT TO MEDICAL CARE: The undersigned consents to any laboratory, imaging, anesthetic, medical, surgical or emergency treatment and/or clinic services rendered the patient under the instruction of the Provider. The Patient understands that no guarantee or assurance has been made as to the results that may be obtained during treatment.

The patient also consents to observation of the patient during administration of medical treatment, surgical or diagnostic procedures for the purpose of education of medical students whose presence is deemed appropriate by the attending provider.

RELEASE OF PATIENT INFORMATION: The undersigned herby consents that THE WORK CLINIC may release to the guarantor's insurance company, or any third party payer, pertinent information related to the medical treatment including: HIV testing and treatment, sexually transmitted disease testing and treatment, psychiatric, alcohol and drug treatment records in order to secure contractual payments for services rendered (unless a restriction has been requested then see restriction agreement).

ASSIGNMENT OF INSURANCE BENEFITS: In the event the patient is entitled to medical benefits of any type whatsoever arising out of any policy of insurance insuring the patient or any other party liable to the patient, such benefits are hereby assigned to THE WORK CLINIC for application to patient's bill. The patient may be responsible for 100% of the charges not covered by this assignment. Patients eligible for Medicare hereby authorize THE WORK CLINIC to bill and collect from Medicare directly. Any charges not covered by Medicare or any supplementary insurance may be the responsibility of the patient.

PATIENT REPRESENTATIVE: Should you have any concerns about your care, please contact our Office Manager at (206) 971-7451.

THE UNDERSIGNED CERTIFIES: that he/she has read the foregoing, and is the patient, or is duly authorized by the patient as his/her legal representative to execute the above and accept its terms. If competent, the patient should sign in the space indicated. If a minor, or incapable of signing, responsible representative should sign in the space indicated.

TEXT AND EMAIL REMINDER AUTHORIZATION: The Work Clinic sends appointment reminders via text message and/or email. By signing you give permission for The Work Clinic to be able to send appointment reminders via text and/or email.

1. Initial below:

X_____ Please initial acknowledge of the receipt of the "Notice of Privacy Practices."
X_____ Please initial acknowledge of the receipt of the "Patient Rights & Responsibilities" notice.

2. Fill out following information:

REPRESENTITIVE OF PATIENT (*if applicable*)	
Name	
Date	
Signature	
Relationship	
Explain reason patient is incapable of signing	

EMERGENCY CONTACT	
Name	
Relationship	
Phone Number	

PATIENT	
Name	
Cell Phone Number	
Cell Phone Carrier	
Email Address	

3. Please sign and date below:

Signature:_____ **Date:**_____