ASC **Alabama Specialty Clinic and Urgent Care**

WORKERS COMP. PATIENT INFORMATION

Todays Date_______/________/_______

Patient's Name____Sex: M / F Marital Status:_________________

Date of Birth:_________/__________/__________ Age:_______________ Race:________________________________

Ethnicity: Not Hispanic, Hispanic, White, Other, Refuse Primary Language:__________________________________

SS#:__________-__________-__________ Home Phone:_______________________

Cell Phone:________________________, Work Phone:________________________, Email:________________________

Home Address:____City:___________________________State:___________

Emergency Contact:____Phone:_________________________________

Work Injury Information:

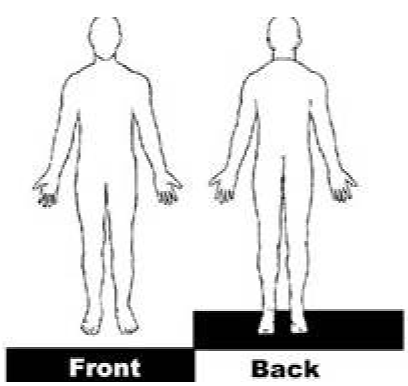
Employer at the time of injury:______________________________________Occupation:__________________________

Work Phone:__________________________________Person who sent you here today:___________________________

Date of Injury:______/______/_______

How did the injury Occur:____

____



Use the figure to mark where your pain is located

Have you ever had an MRI? YES or NO

If yes, please state where it was performed, when, and what part of the body was it performed on .____

Have you ever had Physical Therapy? YES or NO

Have you ever been to a Chiropractor? YES or NO

Primary Physician Name:____City:________________________State:________

Signature:____

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PATIENT HEALTH HISTORY FORM

PLEASE FILL OUT COMPLETELY

NAME:____**DATE OF BIRTH:**______/______/______**TODAYS DATE:**______/______/______

List the names of all the medicines you take including any supplements or over the counter drugs:

____ ____
____ ____
____ ____
____ ____
____ ____

Please list all allergies:

____ ____
____ ____

Your Medical History – Please check if you have or ever have any of the following diseases:

□ Acid Reflux (Gerd) □ Heart Failure □ Cancer
□ High Blood Pressure □ High Cholesterol □ Stroke
□ Chest Pain □ Irregular Heartbeats □ Thyroid Disorder
□ Dementia □ Diabetes □ Lung Disease/Emphysema
□ Ulcer □ Heart Attack □ Mitral Valve Prolapse
□ Depression □ Asthma □ Hepatitis
□ Seizures □ Migraines □ Anemia
□ Back pain □ Neck pain □ Shoulder pain
□ Knee pain □ Other:____

Your Surgical History – Please check if you have had any of the following Surgeries:

□ Hernia Repair □ Appendectomy □ Back Surgery
□ Breast Surgery □ C-section □ Cataracts
□ Cervical Disc □ Defibrillator □ Gallbladder
□ Heart bypass □ Heart Stent □ Heart Valve
□ Pacemaker □ Prostate □ Tonsils
□ Tubal Ligation □ Hysterectomy □ Shoulder Surgery
□ Knee Surgery □ Carpal tunnel □ None
□ Other:____

Your Family History – Please check if your Mother, Father, Brother or Sister ever had any of the following diseases:

□ Family History: High Blood Pressure □ Family History: Heart Disease □ Family History: Diabetes
□ Family History: Prostate Cancer □ Family History: Kidney Disease □ Family History:Thyroid Disease
□ Family History: High Cholesterol

Your Social History:

□ Married Alcohol? □ Current – Everyday □ Former Amount____________________
□ Divorced □ Current – Some Days □ Never
□ Single
□ Widowed Tobacco? □ Current – Everyday □ Former Amount____________________
□ Current – Some Days □ Never

I Certify that the above information is accurate to the best of my knowledge. I understand withholding information be it intentional or by negligence to fill out this form, could result in improper medical care and could be a detriment to my health or even life threatening. I also understand that it can be caused for the termination of my employment.

Signature:____

ASC Alabama Specialty Clinic

Authorization to Release Healthcare Information

Todays Date:________/_________/________

Print Name:____Signature:___________________________________

Date of Birth:______/_______/_______ SS#___________/__________/_____________

I understand that I am here for one of the following: worker's comp injury, drug screen, breath alcohol test, physical, PFT, RFT, audiogram, TB skin test, shots, blood work, or other occupational need. I hereby authorize ASC Alabama Specialty Clinic to release to and speak with my employer regarding any and all medical information including the diagnosis and records of treatment, radiology reports, MRI's, lab work, and any tests results that have been obtained from other medical facilities, or rendered to me at ASC Alabama Specialty Clinic.

You may release information or speak with ____

(Company or person who sent you)

Regarding my care at your facility.

Signature of Patient:____Todays Date:________/________/________

Witness Signature:____