

Phone: (510) 297-0550 13690 E 14th St #200 San Leandro, CA 94578

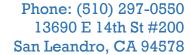
Home Address: Street	First			Middle			Maiden			
			City				State	Z	ip	
Home Phone:	Cell Pho	Birthdate:		Social Security Number:		er:	Sex: M	F		
Email Address:		)						<u> </u>		
Patient Occupation:	Employn	Part Time Employer:		Business Phone: E			Ext.			
Employer's Address: Street		☐ Unemploye	City	CIII			State	Z	ip	
Emergency Contact:	Phone Numb	er:	Address:	Address:						
Who referred you to our office?					Have you bee	n treated he	ere before? (ci	ircle o	one)	
FINANCIAL INFOR	MATIC	ON OF RE	SPONSI	[B]				IF SAN	ME AS ABO	OVE)
Name of responsible party:		Relationship to				Birthdate				,
Address: Street	Address: Street		City		State			Zip		
Home Phone:		Social Security	Number:			Driver's	License Num	iber:		
Occupation:	Employn	 nent: □ Full Time			Employer:		Business P	hone:		Ext.
Employer's Address: Street		☐ Unemploye	ed	ent			State		Zip	
INCLID ANCE INFO		ON								
INSURANCE INFOR		UN (PLEASE	FILL OUT	` AL						
CHECK TYPE OF COVERA					PRIMAR	Y INSURAN	ICE SE	ECON	DARY INS	UKAN
☐ GROUP PLAN		NAME OF THE INSURED								
		NAME OF INSURANCE COMPANY								
□ INDIVIDUAL PLAN		BILLING ADDRESS								
<del> -</del>		TELEPHONE NUMBER SUBSCRIBER ID NUMBER								
□ MEDICARE										
		GROUP OR LOCAL NUMBER								
□ HMO		SOCIAL SECURITY NUMBER								
		BIRTHDATE								
☐ INDUSTRIAL ACCIDEN		IM NUMBER  CAL INFOR	N. A. ENTONI		ID A COLON	A FENTER O	NE DEVIEE	TOO		



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## INITIAL WORKERS COMPENSATION PATIENT QUESTIONNAIRE

Name:		Age:_		Sex: M F	Date:
Which Hand do y	ou WRITE with:	RIGHT	LEFT	Height:	Weight:
Who referred you	to this office?			Da	te of injury:
Date you first not	iced symptoms	:			
History of Injury:	(Please describe	e symptoms	, how the inj	ury occurred,	and when symptoms began)
Describe your pa	• •	•	•	•	obbing / Burning
					n / Therapy / Surgery
	-		-		
-	-	-			(Nerve Study) / Arthrogram
Name of Employe					, , , , , , , , , , , , , , , , , , , ,
					s and how long you worked for the
What is your job	title?				
How many hours	per week did ye	ou work be	fore the pai	n started? _	
Describe your wo	rk duties (write	/type/lift/ove	rhead work)		
How much time h	ave you taken	off work for	this proble	em?	
Describe your wo	rk modification	s (lifting lim	it, limited/no	use, etc.)	
			Wh	en did modif	ications begin?
List any prior Wo	rkers Compens	ation Claim	ns:		
Current Medication	ons (please list F	PRESCRIBE	D and OVE	R THE COU	NTER):
Allergies to medi	cations: No	Yes	MEDICA	ATION and R	EACTION:
Cigarette use:	No Qui	t Whe	n Yes	Amoun	t (# per day)
Alcohol use:	No Qui	t Whe	n Yes	Amoun	t (# per week/month)
Medical Condition	n <b>s</b> : Diabetes / F	ligh Blood P	ressure / Hi	gh Cholester	ol / Hypo/Hyper Thyroid
Rheumatoid Arthri	tis / Stroke / Seiz	zure / Hepat	itis A / B / C	/ Tuberculos	is / Gout / Heart Disease
Heart Attack / COF	PD / Asthma / Ul	cers / Liv	ver Disease	/ Alcoholism	/ Osteoarthritis / Bursitis
Blocked Arteries /	Depression / Oth	ner:			
Prior Surgeries: (	please include a	ll surgeries o	during your l	lifetime):	
I library and a second			-1 >		
Highest grade yo Elementary	-	<b>school (cir</b> e Ir. High Scho	_	ligh School	College (# of years)
List your hobbies	s:				





## ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

I acknowledge that I was provided a copy of the Notice of Privacy Practices. I further acknowledge that a copy of the current Notice will be provided by the front desk staff.

You may request a copy of the Notice to keep for your records. If you have questions regarding the Notice, please do not hesitate to contact Karen Stein at (510) 297-0550.

Patient name	(please print)	Date
Signature		
Parent of Aut	chorized Representative (if ap	pplicable) Relationship
		, test results, surgery scheduling) may be left or Phone Number: ()
	rmation can be discussed wit Patient only (if checked, ST	
	Family Member or Friend (i	f checked, fill in name(s) below)
Name:	Restrictions*:	Relationship:
Name:		Relationship:
Nomo	Restrictions*:	Relationship:

<sup>\*</sup>Restriction examples: Appointment Date/Time only, No Prescription information, etc.