On the Mend
Occupational Medicine PLLC

Personal Information

Name: _____ Date: _____

Date of Birth: _____ Gender: _____

Address: _____

City: _____ State: _____ Zip: _____

Social Security #:_____ Date of Injury: _____

Home Phone: _____ Cell: _____ Email: _____

Emergency Contact: _____ Phone #: _____

Have you been seen somewhere else for this? If so, where? _____

Employer: _____

Employer Address: _____

Work Phone: _____ Employer Contact: _____

Contact Phone #: _____ Please circle how you would like to be reminded of your appointment:
Email Text (Charges may apply) Phone call - Best number to call: _____

Is it okay to leave a message: Y / N

Consent to Treatment

I, _____ ("patient"), hereby voluntarily request and consent to the rendering of medical services by On the Mend Occupational Medicine PLLC, the clinic's employees and other services or procedures which may be administered or performed by the clinic's providers under the general or specific instruction of my physician or his or her designees. I authorize that the clinic's health providers take such actions as are necessary and desirable in the exercise of their professional judgment.

I understand that I have the right and am encouraged to discuss proposed procedures or treatments with my Clinic's providers, and to consent to, or refuse, such procedures or treatments, and that my asking questions or voicing concerns will not compromise my care. I further understand that the practice of Medicine is not an exact science and the diagnosis and treatment may involve risks. I acknowledge that no guarantees have been made to me as to the results of my treatment or services rendered in the clinic.

Authorization for the use and release of information

Check one:

☐ **Patients Seeking Employment-Related Physicals:** I authorize the Clinic to use and disclose health information about me acquired in the course of my physical examination to my employer or potential employer. The information to be used and disclosed may include medical records, treatment records, diagnostic records, psychiatric and/or psychological records and alcohol and/or drug use information.

☐ **Other Patients:** I understand that at times it may be necessary for the clinic to obtain medical records and related information from third-parties in connection with my medical care. I hereby authorize any health care provider, hospital, clinic or healthcare institution who has attended or examined me, or who may attend or examine me in connection with my current injury/illness, to release and deliver to the clinic all medical records and related information they have about me as may relate to my current injury/illness, including, but not limited to, x-ray films, reports, medical histories, physicals, psychiatric and/or psychological information and diagnostic examinations, charts, and treatment notes. For purposes of this authorization, medical information specifically includes confidential information regarding HIV/Aids, communicable diseases, alcohol or drug abuse, and mental health. I also authorize my provider to access available medication history online.

I authorize the clinic to use and disclose individually identifiable health information about me acquired in the course of my examination or treatment or contained in my medical and/or psychiatric and psychological records to my employer (Worker's Compensation only), to the Worker's Compensation insurance underwriter (Worker's Compensation only) or their attorneys or other designated representatives, to any health care provider involved in my care, and to any person or entity which may be liable to me, to my clinic, or to my providers for charges and for quality management/utilization review, discharge planning, transfer and follow-up purposes. The information to be used and disclosed includes medical records, treatment records, diagnostic records, and psychiatric records. This authorization also includes the use and disclosure of alcohol and/or drug abuse information. The clinic will not be required to disclose confidential communications imparted for the purpose of treatment which are necessary to a proper understanding of the case.

I acknowledge that if I receive a prescription for a "controlled" (Schedule II through V) drug, my identifying prescription information will be entered into Colorado's electronic Prescription Drug Monitoring Database (PDMP) when this drug is dispensed to me. The PDMP may be accessed for limited purposes by qualified medical professionals.

For All Patients

I may revoke this authorization at any time by notifying On the Mend Occupational Medicine PLLC in writing at 3900 S Wadsworth Blvd, Suite 325, Lakewood CO 80235. If I do revoke this authorization, any information previously disclosed cannot be withdrawn. Once information about me is disclosed in accordance with this authorization, the recipient may re-disclose it and the information may no longer be protected by federal privacy regulations.

I agree to abide by the clinic's cancellation policy of a 12 hour notice if unable to attend a scheduled appointment.

A photocopy of this authorization shall be as valid and effective as the original.

This authorization expires:

30 years after today's date for all employment related physicals and

7 years after today's date for all other patients

I have read and understand the contents of the above consent and agreement.

I have been given a copy of the Notice of Health Information Privacy Practices.

Patient Signature: _____ Date: _____

Witness Signature: _____ Date: _____

If a personal representative executes this form, that representative represents that he or she has authority to sign this form on the basis of (description of personal representative's authority):_____

Relative/ Guardian/ Representative Signature: _____

Relationship to patient: _____ Date: _____

On the Mend
Occupational Medicine PLLC

Work Injuries

Date of Current Injury: _____ Time of Injury: _____

How did your current injury happen:

_____
_____
_____
_____

What part of your body is injured:

_____
_____
_____

Please check which side of your body is injured:

☐ Right ☐ Left ☐ Both

Mark the areas on the diagram where you feel pain.

Use appropriate symbol to indicate the character of the pain.

A = ACHE

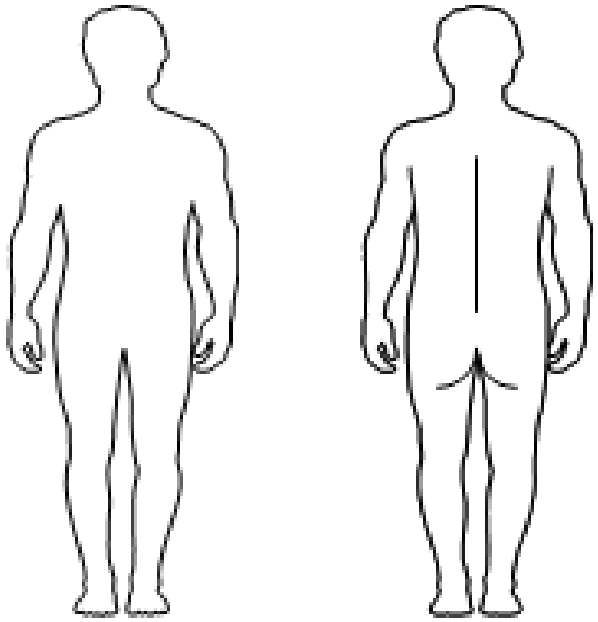
B = BURNING

N = NUMBNESS

P = PINS AND NEEDLES

S = STABBING

T = THROBBING



Front Back

What makes your pain better? _____

What makes your pain worse? _____

On a scale of 0-10:

0=No pain 1=Pain which does not interfere with daily activities 10= suicidal pain

What is your pain today? 0 1 2 3 4 5 6 7 8 9 10

What is your least pain? 0 1 2 3 4 5 6 7 8 9 10

What is your most pain? 0 1 2 3 4 5 6 7 8 9 10

Medications

Please list ALL medications that you take (not just for this injury)

☐ None

Name: _____ Frequency and # per day: _____ Reason: _____

Name: _____ Frequency and # per day: _____ Reason: _____

Name: _____ Frequency and # per day: _____ Reason: _____

Other: _____

Allergies

Medication/environmental or other allergies: ☐ None

☐ Yes, please list: _____

Medical History

Have you ever been diagnosed with any of the following conditions?

☐ Alcohol/Substance abuse	☐ Seizures	☐ Arthritis	☐ Thyroid problem
☐ Cancer	☐ Liver Disease	☐ Bone or joint problems	☐ Back pain/injury
☐ Diabetes	☐ Lung Disease	☐ Heart problems	☐ High Cholesterol
☐ Claustrophobia	☐ Kidney Disease	☐ Stomach problems	
☐ Migraines	☐ High blood pressure	☐ Depression	
Please list all other medical conditions:			

Hospitalizations/surgeries

Year	Reason	Year	Reason

Social History

Have you ever used **tobacco**? ☐ Yes ☐ No

If yes, what type? ☐ Cigarette ☐ Pipe/Cigar ☐ Snuff/Chew

☐ Use tobacco currently ☐ Quit _____ Years ago?

Average **alcohol** intake _____

Recreational **drug** use: ☐ Never ☐ What and when: _____

☐ Treatment/Rehab: _____

Family status: ☐ Single ☐ Married ☐ Divorced ☐ Widowed

Hobbies

_____
_____
_____

Occupational History

Position/Department: _____ Start date: _____

Employer: _____Second Job/other employment: _____

Have you ever had a work related injury? ☐ Yes ☐ No

Did you have an impairment rating? ☐ Yes ☐ No

If you answered yes, do you have any permanent restrictions? ☐ Yes ☐ No

Which of the following are current problems		
General / Constitutional	**Eyes**	**Ears/Nose/Throat**
☐ Fever > 100	☐ Wear Corrective Lenses	☐ Difficulty Hearing
☐ Recent weight loss/gain How much?	☐ Change in Vision	☐ Ringing/ Buzzing in ears
☐ Head Injury w/ loss of consciousness	☐ Foreign body in eye	☐ Wear a hearing aid

Heart/Lungs	**Digestive system**	**Genitourinary**
☐ Chest Pain	☐ Heartburn	☐ Difficult/Painful Urination
☐ Irregular Heart Beat	☐ Nausea	☐ Blood in Urine
☐ Palpitations	☐ Vomiting	☐ Incontinence
☐ New or changed cough	☐ Diarrhea	☐ Currently or Possibly Pregnant
☐ Coughing up blood		☐ Pain in Testicle
☐ Wheezing		
☐ Shortness of breath		

Endocrine/Hematologic	**Musculoskeletal**	**Neurological/Psychiatric**
☐ Increased Thirst	☐ Joint Pain, Where?	☐ Headaches
☐ Intolerance to Heat/Cold	☐ Back Pain	☐ Numbness/Tingling
☐ Bleed Easily	☐ Neck Pain	☐ Depression/Anxiety
☐ Bruise Easily	☐ Swollen Joints	☐ Insomnia

Skin
☐ Rash
☐ Itching
☐ Non Healing Wound or Ulcer

I certify I have answered these questions to the best of my knowledge and the answers are complete and true.

Patient Signature: _____ Date: _____

Provider Signature: _____ Date: _____