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ESTABLISHED 1947

INTERVENTIONAL PAIN MANAGEMENT

KEVIN T. TOLIVER, M.D.

Dr. Peter Wile

NAME: _____ DATE: _____

Type of Report: Workers' Compensation, AOE/COE, 2nd Opinion, Consult, QME, Treat

Interpreter _____ Company _____

Age: _____ Right/Left Handed _____

Job Description

Employer at the time of injury: _____

Number of years/months with employer: _____

Job Title: _____

Number of hours per day? _____ How many days per week? _____

Basic work duties at the time of injury: _____

Does your job involve:	<u>Occasionally</u>	<u>Frequently</u>	<u>Constantly</u>
Bending:		--	--
Twisting:		--	--
Stooping:		--	--
Lifting:		--	--
Carrying:		--	--
Pushing:		--	--
Pulling:		--	--

Climbing:	--	--
Squatting:	--	--
Kneeling:	--	--
Crawling:	--	--
Pivoting:	--	--
Work on uneven ground/surface:	--	--
Work at or above shoulder level:	--	--
Gripping:	--	--
Grasping:	--	--
Pinching:	--	--
Holding:	--	--
Torquing:	--	--
Finger dexterity:	--	--

Estimate the amount of weight you lift at any one time: _____

Did you work somewhere else at the same time you worked for this employer? _____
 If yes, what were your duties? _____

List places of employment for the last 10 years:

- 1) Employer _____ Position _____ How long? _____
- 2) Employer _____ Position _____ How long? _____
- 3) Employer _____ Position _____ How long? _____
- 4) Employer _____ Position _____ How long? _____

HISTORY OF INJURY

SPECIFIC DATE OF INJURY: _____

If there is no specific date of injury, when did you first begin to have problems? _____

Tell in your own words what happened: _____

Were you able to continue to work? _____

When did you report this injury? _____ To whom? _____

When did you **first** receive treatment? _____

Was this treatment through workers' compensation or private insurance? _____

At this initial evaluation/treatment, did you have: _____ X-rays? Medication?
_____ Injections? _____ Therapy? _____ Other (MRI, scan, cast)?

Please explain: _____

Subsequent physicians/healthcare practitioners that you have seen:

1) Dr. _____ Date seen: _____

What were you told was the problem? _____

Treatment provided: X-rays _____ Medication _____ MRI _____
Injections _____ Splints _____ Other _____

Physical therapy _____ times per week for _____ weeks

Did any treatment help? If yes, what helped? _____

Did you continue to work? If yes, full duty _____ or modified duty _____?

If modified duty, what were your restrictions? _____

Interval History:

2) Dr. _____ Date seen: _____

What were you told was the problem? _____

Treatment provided: X-rays _____ Medication _____ MRI _____
Injections _____ Splints _____ Other _____

Physical therapy _____ times per week for _____ weeks

Did any treatment help? If yes, what helped? _____

Did you continue to work? If yes, full duty _____ or modified duty _____?

If modified duty, what were your restrictions? _____

Interval History:

3) Dr. _____ Date seen: _____

What were you told was the problem? _____

Treatment provided: X-rays _____ Medication _____ MRI _____

Injections _____ Splints _____ Other _____

Physical therapy _____ times per week for _____ weeks

Did any treatment help? If yes, what helped? _____

Did you continue to work? If yes, full duty _____ or modified duty _____?

If modified duty, what were your restrictions? _____

Interval History:

4) Further/additional treatment: _____

Did you return to work? If yes, when? _____

Are you working for the same employer? _____ If no, who is your present employer?

What are your new duties? _____

If you did not return to work when you were released, why? _____

List all dates you did **not** work.

From _____ to _____

List all dates you performed **light** duty.

From _____ to _____

When did you return to regular duty? _____

Since this injury, have you had any other injuries? _____

Dates of injuries: _____

If yes, what body parts were injured? _____

Was this work related? _____ If yes, describe all treatment and where you received the treatment: _____