OccNOW
OCCUPATIONAL MEDICINE

Patient Name: _____ DOB: _____ Provider: _____ Date: _____
Current Employer: _____ Occupation: _____ Work Phone: ( ) _____
Employer's Address: _____
Street City State Zip

_____ _____ ( ) _____
Parent/Guardian name if patient is a minor Address (if different than patient) Work Phone

Details of Problem or Injury

Date Injury/Problem Occurred: _____

Were you injured in an accident? ☐ Yes ☐ No If yes? ☐ Work ☐ Auto ☐ Other: _____

What body area hurts? (specify left or right i.e. right knee) _____

How did it happen? _____

_____

Where did the injury occur? _____

Have you had treatment for this injury or problem? ☐ Yes ☐ No If yes, where? _____

Have you had an X-Ray for this injury or problem? ☐ Yes ☐ No If yes, do you have them? ☐ Yes ☐ No

Have you had an MRI for this injury or problem? ☐ Yes ☐ No If yes, do you have them? ☐ Yes ☐ No

What is the pain like? ☐ Sharp ☐ Dull ☐ Achy ☐ Throbbing ☐ Numb ☐ Other _____

How intense is the pain? ☐ Mild ☐ Moderate ☐ Severe

Is the pain constant? ☐ Yes ☐ No Is the pain intermittent? ☐ Yes ☐ No

What makes the pain better? _____

What makes the pain worse? _____

Please circle your level of pain

0	1	2	3	4	5	6	7	8	9	10
No Pain	Mild			Moderate			Severe		Worst Pain imaginable	

Review of Systems ***(please list any problems you currently have or check none)***

Constitutional:	☐ Weight Loss ☐ Decreased Appetite ☐ Weakness/Fatigue ☐ Fever	☐ None
Eyes:	☐ Visual Disturbances ☐ Difficulty seeing	☐ None
Ears, Nose, Throat:	☐ Sore Throat	☐ None
Cardiovascular:	☐ Chest Pain ☐ Irregular Heartbeat ☐ Hardening of Arteries ☐ Leg Swelling	☐ None
Respiratory:	☐ Shortness of Breath ☐ Asthma	☐ None
Gastrointestinal:	☐ Frequent Heartburn ☐ Hepatitis ☐ Ulcers ☐ Rectal Bleeding ☐ Colitis (Crohns or Ulcerative)	☐ None
Genitourinary:	☐ Kidney Stones ☐ Other Kidney Disease ☐ Burning with Urination ☐ Prostate Disease	☐ None
Skin:	☐ Rashes	☐ None
Neurological:	☐ Dizziness ☐ Seizures ☐ Headaches/Migraines ☐ Numbness	☐ None
Musculoskeletal:	☐ Joint Pain ☐ Muscle Pain ☐ Muscle Cramps ☐ Connective Tissue Disease ☐ Heel Pain	☐ None
Endocrine:	☐ Diabetes ☐ Thyroid Disease	☐ None
Psychological:	☐ Depression ☐ Anxiety Disorder	☐ None
Hematological/Lymphatic:	☐ Bleeding Disorder ☐ Blood Clots (DVT)	☐ None
Immunological:	☐ Immune Deficiency	☐ None

Medication(s) you are currently taking

Medication	Strength (mg)	Frequency

Please List any Allergies to Medication(s):		

Release of Medical Records

Is there someone we have permission to contact or share medical with on the patient's behalf?

☐ Yes ☐ No

Doctor's Name: _____ Phone Number: _____

Person's Name: _____ Relationship: _____ Phone Number: _____

Person's Name: _____ Relationship: _____ Phone Number: _____

Referral Information:

Referred By: ☐ Employer ☐ Workers Compensation ☐ Returning Patient ☐ Physician _____

Name of Physician

Referral Policy

If you are being treated for a work related injury and your employer issues a denial of coverage, we may bill your group health insurance for the services rendered.

If your health insurance plan requires you to get a referral from your Primary Care Physician (PCP) and you do not obtain a referral you may be charged for services rendered at Connecticut Orthopaedic Specialists.

Patient's Signature: _____

If you injured in an accident please complete the following:

If work related accident, employer at the time: _____ Phone: ( ) _____

Employer's Address: _____

Street City State Zip