PALOMAR HEALTH
Corporate Health Services

Initial Injury / Illness Evaluation

Note to patient: Please complete all shaded areas.

Name (Last, First, Middle)		**Birthdate** (Month / Day / Year)		**What date and time did symptoms start?**	
Sex ☐ Male ☐ Female	**Job Title**	**# of hours per week:**	**# of years with this company:**	**Date** (m/d/y)	**Last day worked?**

Injury Description (Where were you? What actions were you doing when the injury occurred?

Medical Assistant Intake

Height	Weight	BP	Drug Allergies & Reaction
Pulse	Temp	Last tetanus	
Other			MA Signature

Describe your symptoms. Include all BODY PARTS affected. (also see diagram, p. 2)

Physician Use Only

For any questions 1–14 below that require explanation, please write in the space labeled "Explanations to 'Yes' Answers"

1.	Have you ever had a work-related injury or illness? If yes, list the injuries and the dates of these injuries.	☐ Yes ☐ No
2.	If answer to #1 is yes, did you lose any time from work as a result of the work-related injury(s) or illness(es)? If so, how many full days/weeks? Specify the duration and nature of the disability that you had.	☐ Yes ☐ No
3.	Have you ever received permanent restrictions for an injury or illness (work-related or non work-related)? If yes, please write the restrictions below and provide the date they were issued.	☐ Yes ☐ No
4.	Are you currently being treated for any other work-related injury or illness? If yes, please list the injury(s) or illness(es).	☐ Yes ☐ No
5.	Have you ever had previous complaints similar to the current complaints? If yes, list the previous symptoms you have had and the approximate date of each.	☐ Yes ☐ No
6.	Do you have any other jobs other than the job listed above? If yes, please provide the job title and number of hours of hours you work this job each week.	☐ Yes ☐ No
7.	Have you received any previous treatment for the complaints prior to this evaluation? If so, when and where?	☐ Yes ☐ No
8.	Do you have any active medical and/or orthopedic problems? If yes, please list each problem and the date the problem started.	☐ Yes ☐ No
9.	Are you taking any medications? If yes, please list all medications, below. Include any over-the-counter medications you may be taking.	☐ Yes ☐ No
10.	Have you had prior surgeries? If yes, please list them with the approximate date of each.	☐ Yes ☐ No
11.	Have you had a bleeding ulcer? If yes, please describe when you had the problem, symptoms, and how it was diagnosed.	☐ Yes ☐ No
12.	Have you been addicted to or consistently used drugs? If yes, explain.	☐ Yes ☐ No
13.	Do you consume alcohol? If so, please specify the amount of drinks you consume each week.	☐ Yes ☐ No

Explanations to "Yes" Answers [Place the question # and your explanation(s) below]

Question #	Explanation

Physician Comment
(Provider use only)

☐ Spanish translator:
☐ Dictated

I declare that, to the best of my knowledge and belief, the information given above is correctly recorded complete and true.

Patient or Legal Guardian (print) _____ Signature _____ Date _____

Provider Review

Clinical Name (print) _____ Clinician Signature/Title _____ Date _____

PALOMAR HEALTH
Corporate Health Services

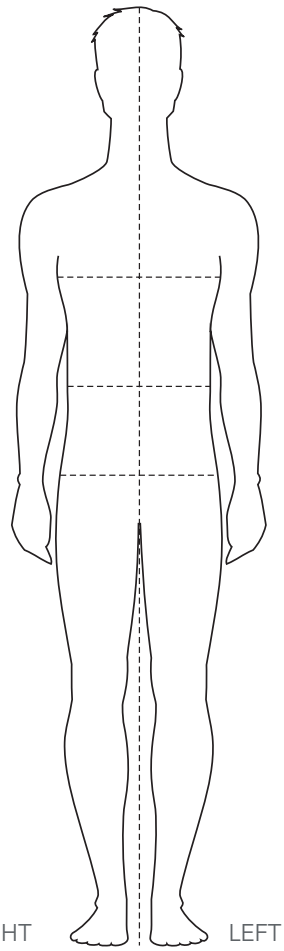
SYMPTOMS

Name (Last, First, Middle)	**DOB:**	**Date of visit:**

On the diagram below, please indicate where you are experiencing pain or other symptoms, right now, using the following symbols:

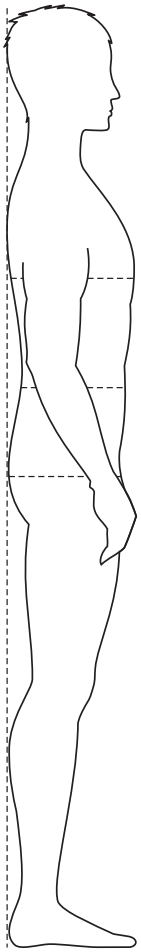
Quality					**Severity**	**Duration**
Numbness – – – – –	Pins & Needles ○○○○○	Burning ^^^^^	Aching ××××××	Throbbing ⊗⊗⊗⊗⊗	1: minimal 10: severe	hours/day
					1–10	**1–24 hrs**

FRONT

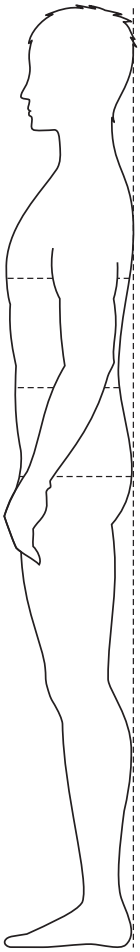


RIGHT LEFT

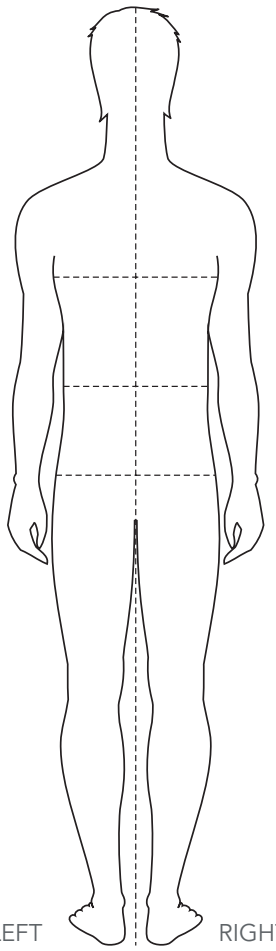
RIGHT SIDE



LEFT SIDE



BACK



LEFT RIGHT

Patient Initials: _____ Reviewed and discussed: Clinician initials: _____ Title: ☐ MD ☐ NP

☐ 15611 Pomerado Rd, Suite 580, Poway, CA 92064
858.613.6280 858.613.6281

☐ 2125 Citracado Parkway, Suite 130, Escondido, CA 92029
760.510.7373 760.510.7374

PALOMAR HEALTH
Corporate Health Services

SYMPTOM QUALITIES

Name (Last, First, Middle)	**DOB:**	**Date of visit:**

Please circle or check the appropriate responses for each item for **each body part** affected

Body Part:						
Pain Quality:	☐ burning	☐ shooting	☐ tingling	☐ radiating	☐ numbing	☐ cramping
	☐ achy	☐ throbbing	☐ pressure	☐ squeezing	☐ dull	☐ deep

Pain Severity: **Minimal** ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ 7 ☐ 8 ☐ 9 ☐ 10 **Severe**

Pain Timing: My pain is: ☐ always there ☐ comes and goes

Pain Duration: As a result of my injury, over a 24 hour period, I am in pain:

☐ Less than 1 hour	☐ 1–4 hours	☐ 4–8 hours	☐ 8–16 hours	☐ 16–24 hours	

Modifying Factors

What makes the pain better?	What makes the pain worse?

Associated Symptoms: When you are having pain in this area, what else bothers you?
(examples: light-headedness, nausea, shortness of breath, feeling depressed, difficulty concentrating
Other?:

Body Part:						
Pain Quality:	☐ burning	☐ shooting	☐ tingling	☐ radiating	☐ numbing	☐ cramping
	☐ achy	☐ throbbing	☐ pressure	☐ squeezing	☐ dull	☐ deep

Pain Severity: **Minimal** ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ 7 ☐ 8 ☐ 9 ☐ 10 **Severe**

Pain Timing: My pain is: ☐ always there ☐ comes and goes

Pain Duration: As a result of my injury, over a 24 hour period, I am in pain:

☐ Less than 1 hour	☐ 1–4 hours	☐ 4–8 hours	☐ 8–16 hours	☐ 16–24 hours	

Modifying Factors

What makes the pain better?	What makes the pain worse?

Associated Symptoms: When you are having pain in this area, what else bothers you?
(examples: light-headedness, nausea, shortness of breath, feeling depressed, difficulty concentrating
Other?:

Patient Initials: _____ Reviewed and discussed: Clinician initials: _____ Title: ☐ MD ☐ NP

☐ 15611 Pomerado Rd, Suite 580, Poway, CA 92064
858.613.6280 858.613.6281

☐ 2125 Citracado Parkway, Suite 130, Escondido, CA 92029
760.510.7373 760.510.7374

PALOMAR HEALTH
Corporate Health Services

SYMPTOM QUALITIES

Name (Last, First, Middle)	**DOB:**	**Date of visit:**

Please circle or check the appropriate responses for each item for **each body part** affected

Body Part:						
Pain Quality:	☐ burning	☐ shooting	☐ tingling	☐ radiating	☐ numbing	☐ cramping
	☐ achy	☐ throbbing	☐ pressure	☐ squeezing	☐ dull	☐ deep

Pain Severity: **Minimal** ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ 7 ☐ 8 ☐ 9 ☐ 10 **Severe**

Pain Timing: My pain is: ☐ always there ☐ comes and goes

Pain Duration: As a result of my injury, over a 24 hour period, I am in pain:

☐ Less than 1 hour	☐ 1–4 hours	☐ 4–8 hours	☐ 8–16 hours	☐ 16–24 hours	

Modifying Factors

What makes the pain better?	What makes the pain worse?

Associated Symptoms: When you are having pain in this area, what else bothers you?
(examples: light-headedness, nausea, shortness of breath, feeling depressed, difficulty concentrating
Other?:

Body Part:						
Pain Quality:	☐ burning	☐ shooting	☐ tingling	☐ radiating	☐ numbing	☐ cramping
	☐ achy	☐ throbbing	☐ pressure	☐ squeezing	☐ dull	☐ deep

Pain Severity: **Minimal** ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ 7 ☐ 8 ☐ 9 ☐ 10 **Severe**

Pain Timing: My pain is: ☐ always there ☐ comes and goes

Pain Duration: As a result of my injury, over a 24 hour period, I am in pain:

☐ Less than 1 hour	☐ 1–4 hours	☐ 4–8 hours	☐ 8–16 hours	☐ 16–24 hours	

Modifying Factors

What makes the pain better?	What makes the pain worse?

Associated Symptoms: When you are having pain in this area, what else bothers you?
(examples: light-headedness, nausea, shortness of breath, feeling depressed, difficulty concentrating
Other?:

Patient Initials: _____ Reviewed and discussed: Clinician initials: _____ Title: ☐ MD ☐ NP

☐ 15611 Pomerado Rd, Suite 580, Poway, CA 92064
858.613.6280 858.613.6281

☐ 2125 Citracado Parkway, Suite 130, Escondido, CA 92029
760.510.7373 760.510.7374

PALOMAR HEALTH
Corporate Health Services

REVIEW OF SYSTEMS

Name (Last, First, Middle)	**DOB:**	**Date of visit:**

1. Please check the "Yes" box to indicate if you have any of the following symptoms.
2. For any "Yes" responses, please check the "related" box if you believe the symptom is related to your work-related condition.

Constitutional	**Yes**	**Related**
Weight loss	☐	☐
Weight gain	☐	☐
Fevers	☐	☐
Chills	☐	☐
Night sweats	☐	☐
Fatigue	☐	☐
Falling asleep during the day	☐	☐
Eyes	**Yes**	**Related**
Blurry vision	☐	☐
Eye pain	☐	☐
Discharge	☐	☐
Dry eyes	☐	☐
Decreased vision	☐	☐
Ears / Nose / Throat	**Yes**	**Related**
Sore throat	☐	☐
Ringing in ears	☐	☐
Bloody nose	☐	☐
Hearing loss	☐	☐
Sinusitis	☐	☐
Respiratory	**Yes**	**Related**
Shortness of breath	☐	☐
Cough	☐	☐
Coughing up blood	☐	☐
Wheezing	☐	☐
Chest pain with breathing	☐	☐
Cardiovascular	**Yes**	**Related**
Chest pressure	☐	☐
Awake short of breath	☐	☐
Heart racing, extra beats	☐	☐
Ankles swelling	☐	☐
Shortness of breath lying flat	☐	☐
Chest tightness with exertion	☐	☐
Gastrointestinal	**Yes**	**Related**
Difficulty swallowing	☐	☐
Heartburn	☐	☐
Nausea/vomiting	☐	☐
Rectal bleeding	☐	☐
Abdominal pain	☐	☐
Skin or eyes turning yellow	☐	☐
Change in bowel habits	☐	☐
Loss of control of bowels	☐	☐
Allergy	**Yes**	**Related**
Sneezing fits	☐	☐
Frequent runny nose	☐	☐
Watery / Itchy eyes	☐	☐

Genitourinary	**Yes**	**Related**
Urinary frequency	☐	☐
Urination during sleep	☐	☐
Painful urination	☐	☐
Difficulty starting stream	☐	☐
Blood in urine	☐	☐
Loss of bladder control	☐	☐
Musculoskeletal	**Yes**	**Relate**
Joint pain	☐	☐
Stiffness	☐	☐
Joint swelling	☐	☐
Muscle weakness	☐	☐
Redness of joint(s)	☐	☐
Skin	**Yes**	**Related**
Rash	☐	☐
Itching	☐	☐
Open sores	☐	☐
Nail changes	☐	☐
Lesions	☐	☐
Neurologic	Yes	Related
Numbness	☐	☐
Paralysis	☐	☐
Changes in taste	☐	☐
Tremors	☐	☐
Gait disturbances	☐	☐
Headaches	☐	☐
Dizziness	☐	☐
Light-headedness	☐	☐
Loss of consciousness	☐	☐
Endocrine	**Yes**	**Related**
Often thirsty	☐	☐
Frequent urination	☐	☐
Cold intolerance	☐	☐
Heat intolerance	☐	☐
Swelling in front of neck	☐	☐
Psychiatric	**Yes**	**Related**
Depression	☐	☐
Anxiety	☐	☐
Stress	☐	☐
Alcohol use	☐	☐
Illicit drug use	☐	☐
Unable to sleep	☐	☐
Blood and Lymphatic	**Yes**	**Related**
Easy bruising > 4 cm	☐	☐
Blood clots	☐	☐
Swollen glands (groin/armpit)	☐	☐

Patient Initials: _____ Reviewed and discussed: Clinician initials: _____ Title: ☐ MD ☐ NP

☐ 15611 Pomerado Rd, Suite 580, Poway, CA 92064
858.613.6280 858.613.6281

☐ 2125 Citracado Parkway, Suite 130, Escondido, CA 92029
760.510.7373 760.510.7374

PALOMAR HEALTH
Corporate Health Services

MEDICAL & SURGICAL HISTORY

Name (Last, First, Middle)	**DOB:**	**Date of visit:**

ADULT ILLNESSES

☐ Arthritis	Date of Onset: _____
☐ Depression	Date of Onset: _____
☐ Anxiety	Date of Onset: _____
☐ Stroke	Date of Onset: _____
☐ Asthma	Date of Onset: _____
☐ Diabetes	Date of Onset: _____
☐ Anemia	Date of Onset: _____
☐ Hypertension (High blood pressure)	Date of Onset: _____
☐ Dizziness/Fainting	Date of Onset: _____
☐ Eating Disorder	Date of Onset: _____
☐ Sleeping Disorders	Date of Onset: _____
☐ Thyroid problems/condition	Date of Onset: _____
☐ Cholesterol problems	Date of Onset: _____
☐ Seizures	Date of Onset: _____
☐ Heart problems	Date of Onset: _____
☐ Gout	Date of Onset: _____
☐ Liver disease	Date of Onset: _____
☐ Ulcers	Date of Onset: _____
☐ Other: _____	Date of Onset: _____
☐ Other: _____	Date of Onset: _____
☐ Other: _____	Date of Onset: _____

SURGERIES

Body Part / Surgery	Work Related?	Date	Outcome
	☐ Yes ☐ No		☐ Better ☐ Same ☐ Worse
	☐ Yes ☐ No		☐ Better ☐ Same ☐ Worse
	☐ Yes ☐ No		☐ Better ☐ Same ☐ Worse

Have any additional surgeries been recommended to you? ☐ Yes ☐ No
If yes, please specify:

Patient Initials: _____ Reviewed and discussed: Clinician initials: _____ Title: ☐ MD ☐ NP

☐ 15611 Pomerado Rd, Suite 580, Poway, CA 92064
858.613.6280 858.613.6281

☐ 2125 Citracado Parkway, Suite 130, Escondido, CA 92029
760.510.7373 760.510.7374

PALOMAR HEALTH
Corporate Health Services

MEDICAL & SURGICAL HISTORY

Name (Last, First, Middle)	**DOB:**	**Date of visit:**

PAST INJURIES

Prior to your work-related injury, have you ever injured or had problems with any of the body parts that are currently injured?
Include any auto accidents and work-related injuries ☐ Yes ☐ No
If yes, please describe the injury(s) and approximate date(s)

Settlement: ☐ Yes ☐ No What $ amount? _____

FAMILY HISTORY

Family Member	**Deceased?**	**If deceased, please specify age and cause of death**
Mother	☐ Yes ☐ No	
Father	☐ Yes ☐ No	
Sisters	☐ Yes ☐ No	
Brothers	☐ Yes ☐ No	

Condition	**Family Members Affected?**	**If yes, which family member?**
Diabetes	☐ Yes ☐ No	☐ Mother ☐ Father ☐ Sibling ☐ Other
High Blood Pressure	☐ Yes ☐ No	☐ Mother ☐ Father ☐ Sibling ☐ Other
Cancer	☐ Yes ☐ No	☐ Mother ☐ Father ☐ Sibling ☐ Other

Other family conditions than above:

SOCIAL HISTORY

Ethnicity:	☐ Asian / Pacific Islander	☐ Latino(a)/Hispanic	☐ Native American
	☐ Black or African American	☐ Caucasian (not of Hispanic origin)	☐ Other:

What is your first language? ☐ English ☐ Spanish ☐ Other

Do you speak, read or write other languages? ☐ No ☐ Yes Specify:

Education: Please choose the highest level of education you have completed:

☐ K-12, Grade Completed:	☐ Some College - # of years completed:
☐ College Graduate, Degree:	☐ Graduate school, Degree:

Patient Initials: _____ Reviewed and discussed: Clinician initials: _____ Title: ☐ MD ☐ NP

☐ 15611 Pomerado Rd, Suite 580, Poway, CA 92064
858.613.6280 858.613.6281

☐ 2125 Citracado Parkway, Suite 130, Escondido, CA 92029
760.510.7373 760.510.7374

PALOMAR HEALTH
Corporate Health Services

LIFESTYLE

Name (Last, First, Middle)	**DOB:**	**Date of visit:**

Do you currently smoke cigarettes or use tobacco products? ☐ Yes ☐ No _____ pack/day

Have you smoked cigarettes or used tobacco products in the past? ☐ No ☐ Yes
If Yes: _____ packs/day # of years: _____ Have you tried to quit? ☐ No ☐ Yes

How much alcohol do you drink per week: ___ wine (glasses) ___beer (glasses) ____liquor (shots)

Do you use recreational drugs (i.e. marijuana, cocaine, etc.)? ☐ No ☐ Yes
If yes, specify: _____

Are you prescribed medical marijuana? ☐ No ☐ Yes

If yes, for how long and how much are you using? _____

Have you or anyone else ever felt you should cut down on your drinking? ☐ No ☐ Yes

If yes, explain: _____

Now, or anytime in the past have you used the following drugs:

☐ Sedatives ☐ Anti-anxiety agents ☐ Narcotics

☐ Hallucinogens ☐ Stimulants ☐ Other: _____

Have you ever had treatment for alcohol or drug use? (AA, NA, inpatient rehab, etc.)

☐ No

☐ Yes, please specify: _____

I hereby declare that, to the best of my knowledge and belief, the information given in this document is correctly recorded complete and true, and I understand that any falsification, misrepresentation or omission is cause for disqualification as an applicant or employee.

Name (print)	Signature	Date

Provider Review

Clinical Name (print)	Signature	Date

Patient Initials: _____ Reviewed and discussed: Clinician initials: _____ Title: ☐ MD ☐ NP

☐ 15611 Pomerado Rd, Suite 580, Poway, CA 92064
858.613.6280 858.613.6281

☐ 2125 Citracado Parkway, Suite 130, Escondido, CA 92029
760.510.7373 760.510.7374