



Patient Information

Yakima

Toppenish

307 S 12th AVE, Suite 12
Yakima, WA 98902

220 W 1st AVE
Toppenish, WA 98948

Patient Name: _____ Date of Birth: _____

Home PH: _____ Cell PH: _____ Social Security #

How would you like to receive appointment reminders? Phone Text Email (circle options)

Email _____ Cell/Text# _____ Cell Carrier _____

Address: _____ City: _____ ST: _____ Zip: _____

Primary Care Physician: _____ Height: _____ Weight: _____

Employer: _____ Patient's Occupation: _____

Employer Address: _____ City: _____ ST: _____ Zip: _____

Employer PH #: _____ Fax #: _____

How long have you worked for your current employer? _____

Are you currently working at job of injury? Y N

L & I Information

Is this a work-related injury? Y N

If yes, what was the date and time of the injury? Date: Time: AM PM

If yes, have you filed an L & I claim? Y N

If yes, where did you file the claim?

State L & I Claim #: Employer Self-Insured Claim #:

Emergency Contact Information

Emergency Contact Name: _____ Relationship: _____

Home Phone: _____ Cell Phone: _____

*****Notice: Video Surveillance Cameras in Use in Public Access Areas*****

Patient Signature: _____ Date: _____

Patient's PRINTED NAME: _____



Medical History Form

Name: _____ Date of Birth: ____/____/____

Employer: _____ Number of Children: _____

Adopted: Y N Current Status: Single Married Other

Are you Right-Handed or Left-Handed? R L

PRIOR JOB HISTORY (Position/Years Worked):

HOBBIES/INTERESTS:

Please check all appropriate health boxes below that apply to you:

- | | | | | | |
|------------------------|--------------------------|---------------|--------------------------|-------------|--------------------------|
| Psychiatric Disorder | <input type="checkbox"/> | Hypertension | <input type="checkbox"/> | Depression | <input type="checkbox"/> |
| Urinating Difficulties | <input type="checkbox"/> | Asthma | <input type="checkbox"/> | Hepatitis B | <input type="checkbox"/> |
| Hepatitis C | <input type="checkbox"/> | Seizures | <input type="checkbox"/> | Blood Clots | <input type="checkbox"/> |
| Bleeding Disorders | <input type="checkbox"/> | Heartburn | <input type="checkbox"/> | Diabetes | <input type="checkbox"/> |
| Thyroid Disease | <input type="checkbox"/> | Heart Disease | <input type="checkbox"/> | Stroke | <input type="checkbox"/> |
| Elevated Cholesterol | <input type="checkbox"/> | Cancer | <input type="checkbox"/> | Ulcers | <input type="checkbox"/> |
| Eye/Vision Trouble | <input type="checkbox"/> | Hay fever | <input type="checkbox"/> | Migraines | <input type="checkbox"/> |
| Hearing Trouble | <input type="checkbox"/> | Hernia | <input type="checkbox"/> | Hypotension | <input type="checkbox"/> |
| Kidney Disease | <input type="checkbox"/> | Liver Disease | <input type="checkbox"/> | Other: | _____ |

Please check if you have had have any of the following in the past:

Indicate if you had an injury or had surgery by circling one.

	<u>Current</u>	<u>Side</u>	<u>Past</u>	<u>Approximate Date</u>
Head pain	<input type="checkbox"/>		<input type="checkbox"/> Injury/Surgery	_____
Neck pain	<input type="checkbox"/>		<input type="checkbox"/> Injury/Surgery	_____
Upper back pain	<input type="checkbox"/>		<input type="checkbox"/> Injury/Surgery	_____
Lower back pain	<input type="checkbox"/>		<input type="checkbox"/> Injury/Surgery	_____
Abdomen/Chest pain	<input type="checkbox"/>		<input type="checkbox"/> Injury/Surgery	_____
Shoulder pain	<input type="checkbox"/>	<input type="checkbox"/> R <input type="checkbox"/> L	<input type="checkbox"/> Injury/Surgery	_____
Elbow pain	<input type="checkbox"/>	<input type="checkbox"/> R <input type="checkbox"/> L	<input type="checkbox"/> Injury/Surgery	_____
Wrist pain	<input type="checkbox"/>	<input type="checkbox"/> R <input type="checkbox"/> L	<input type="checkbox"/> Injury/Surgery	_____
Carpal Tunnel Syndrome	<input type="checkbox"/>	<input type="checkbox"/> R <input type="checkbox"/> L	<input type="checkbox"/> Injury/Surgery	_____
Hand pain	<input type="checkbox"/>	<input type="checkbox"/> R <input type="checkbox"/> L	<input type="checkbox"/> Injury/Surgery	_____
Hip pain	<input type="checkbox"/>	<input type="checkbox"/> R <input type="checkbox"/> L	<input type="checkbox"/> Injury/Surgery	_____
Knee pain	<input type="checkbox"/>	<input type="checkbox"/> R <input type="checkbox"/> L	<input type="checkbox"/> Injury/Surgery	_____
Ankle pain	<input type="checkbox"/>	<input type="checkbox"/> R <input type="checkbox"/> L	<input type="checkbox"/> Injury/Surgery	_____
Foot pain	<input type="checkbox"/>	<input type="checkbox"/> R <input type="checkbox"/> L	<input type="checkbox"/> Injury/Surgery	_____

Other, please specify: _____

Immunizations:

COVID-19: _____ Flu: _____

Last TB: _____ Was it Positive? Y N

Hepatitis A Series: _____ Hepatitis B Series: _____

Titers: _____ Last Tetanus: _____

Family History: (Blood Relatives Only)

Father: <input type="checkbox"/> Alive <input type="checkbox"/> Deceased	Present Health or Cause of Death:	Age?
Mother: <input type="checkbox"/> Alive <input type="checkbox"/> Deceased	Present Health or Cause of Death:	Age?
Brothers: _____ # Alive _____ # Deceased	Present Health or Cause of Death:	Age?
Sisters: _____ # Alive _____ # Deceased	Present Health or Cause of Death:	Age?

Immediate Family Member's Medical Problems

Medical Complaints	Mother	Father	Siblings	Comments-Age?
Heart Attack	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Diabetes	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Glaucoma	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Cancer (list type in comments)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Osteoporosis	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Stroke	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
High Blood Pressure	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Kidney Disease	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Brain Aneurysm	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Blood Clots	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	

Colon Polyps	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
High Cholesterol	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Thyroid Disease	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Depression	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	

Please mark any Surgeries or Hospitalizations, by marking an S or H:

Back _____ (S/H) Sinus _____ (S/H) Vasectomy _____ (S/H)

Bones _____ (S/H) Hernia _____ (S/H) Appendix _____ (S/H)

Tonsils _____ (S/H) Gall Bladder _____ (S/H) Tubal Ligation _____ (S/H)

Hysterectomy _____ (S/H) Ovaries Removed? _____ (Y/N)

Other/Comments: _____

Habits:

Tobacco Use: Y N _____ (packs/day)

Former Tobacco User: _____ (packs/day)

Alcohol: Y N _____ (drinks/week)

Recreational Drugs: Y N _____ (type)

Exercise: Y N _____ (times/week)

Medications:

List medications and dose you are currently taking. Include vitamins and herbal supplements.

Check here if no medication.

Allergies:

By Signing & Dating Below: You acknowledge this form is true and accurate. Willful inaccuracy or misrepresentation maybe cause for dismissal or disqualification of employment.

Patient's Acknowledgement Signature

____/____/____
Date

Physician's Acknowledgement Signature

____/____/____
Date



General Consent for Treatment

Patient Name: _____ Date of Birth: _____

Address: _____

Email: _____

I consent to have treatment or physical examination/testing performed by the physician, nurse practitioner, and/or professional staff at The Healthy Worker. I permit the physician, nurse practitioner, this facility, and its employees and all other persons caring for me to treat me in ways they judge are beneficial to me or have been requested by my employer or prospective employer. I understand that this care may include tests, examinations, x-rays, and in the drawing of my blood.

If You Intend to File a Claim for A Work-Related Injury

If you are claiming a work-related injury, you **MUST PROMPTLY** notify your employer of this injury and provide the necessary information for your employer to file a workers' compensation claim for the accident. A claim must be filed and approved for medical benefits to be paid. If your injury is ruled **NOT** work-related, or you fail to follow the required procedures for making a claim, you will be responsible for the payment of your bill for all medical services provided.

I have read this payment policy and understand it. My questions have been answered to my satisfaction.

Patient Name: _____

Patient Signature: _____ Date: _____