THE Healthy Worker
307 S 12th AVE, Suite 12
Yakima, WA 98902

# Patient Information

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: _____**

Revised04/09/2024


# 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 | ☐ | Hypertension | ☐ | Depression | ☐ |
| Urinating Difficulties | ☐ | Asthma | ☐ | Hepatitis B | ☐ |
| Hepatitis C | ☐ | Seizures | ☐ | Blood Clots | ☐ |
| Bleeding Disorders | ☐ | Heartburn | ☐ | Diabetes | ☐ |
| Thyroid Disease | ☐ | Heart Disease | ☐ | Stroke | ☐ |
| Elevated Cholesterol | ☐ | Cancer | ☐ | Ulcers | ☐ |
| Eye/Vision Trouble | ☐ | Hay fever | ☐ | Migraines | ☐ |
| Hearing Trouble | ☐ | Hernia | ☐ | Hypotension | ☐ |
| Kidney Disease | ☐ | Liver Disease | ☐ | 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.

| | Current | Side | Past | Approximate Date |
|---|---|---|---|---|
| Head pain | ☐ | | ☐ Injury/Surgery | _____ |
| Neck pain | ☐ | | ☐ Injury/Surgery | _____ |
| Upper back pain | ☐ | | ☐ Injury/Surgery | _____ |
| Lower back pain | ☐ | | ☐ Injury/Surgery | _____ |
| Abdomen/Chest pain | ☐ | | ☐ Injury/Surgery | _____ |
| Shoulder pain | ☐ | ☐R ☐L | ☐ Injury/Surgery | _____ |
| Elbow pain | ☐ | ☐R ☐L | ☐ Injury/Surgery | _____ |
| Wrist pain | ☐ | ☐R ☐L | ☐ Injury/Surgery | _____ |
| Carpal Tunnel Syndrome | ☐ | ☐R ☐L | ☐ Injury/Surgery | _____ |
| Hand pain | ☐ | ☐R ☐L | ☐ Injury/Surgery | _____ |
| Hip pain | ☐ | ☐R ☐L | ☐ Injury/Surgery | _____ |
| Knee pain | ☐ | ☐R ☐L | ☐ Injury/Surgery | _____ |
| Ankle pain | ☐ | ☐R ☐L | ☐ Injury/Surgery | _____ |
| Foot pain | ☐ | ☐R ☐L | ☐ 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:<br>☐ Alive<br>☐ Deceased | Present Health or Cause of Death: | Age? |
| Mother:<br>☐ Alive<br>☐ Deceased | Present Health or Cause of Death: | Age? |
| Brothers:<br>_____ # Alive<br>_____ # Deceased | Present Health or Cause of Death: | Age? |
| Sisters:<br>_____ # Alive<br>_____ # Deceased | Present Health or Cause of Death: | Age? |

## Immediate Family Member's Medical Problems

| Medical Complaints | Mother | Father | Siblings | Comments-Age? |
|---|---|---|---|---|
| Heart Attack | ☐ | ☐ | ☐ | |
| Diabetes | ☐ | ☐ | ☐ | |
| Glaucoma | ☐ | ☐ | ☐ | |
| Cancer (list type in comments) | ☐ | ☐ | ☐ | |
| Osteoporosis | ☐ | ☐ | ☐ | |
| Stroke | ☐ | ☐ | ☐ | |
| High Blood Pressure | ☐ | ☐ | ☐ | |
| Kidney Disease | ☐ | ☐ | ☐ | |
| Brain Aneurysm | ☐ | ☐ | ☐ | |
| Blood Clots | ☐ | ☐ | ☐ | |

| | | | | |
|---|---|---|---|---|
| Colon Polyps | ☐ | ☐ | ☐ | |
| High Cholesterol | ☐ | ☐ | ☐ | |
| Thyroid Disease | ☐ | ☐ | ☐ | |
| Depression | ☐ | ☐ | ☐ | |

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: _____