PATIENT PAIN DIAGRAM

THE Healthy Worker

YAKIMA
307 South 12th Avenue, Suite 12
Yakima WA 98902
P: 509-895-7340 • F: 509-895-7344

Please mark the area of injury or discomfort on the chart, using the appropriate symbols below.

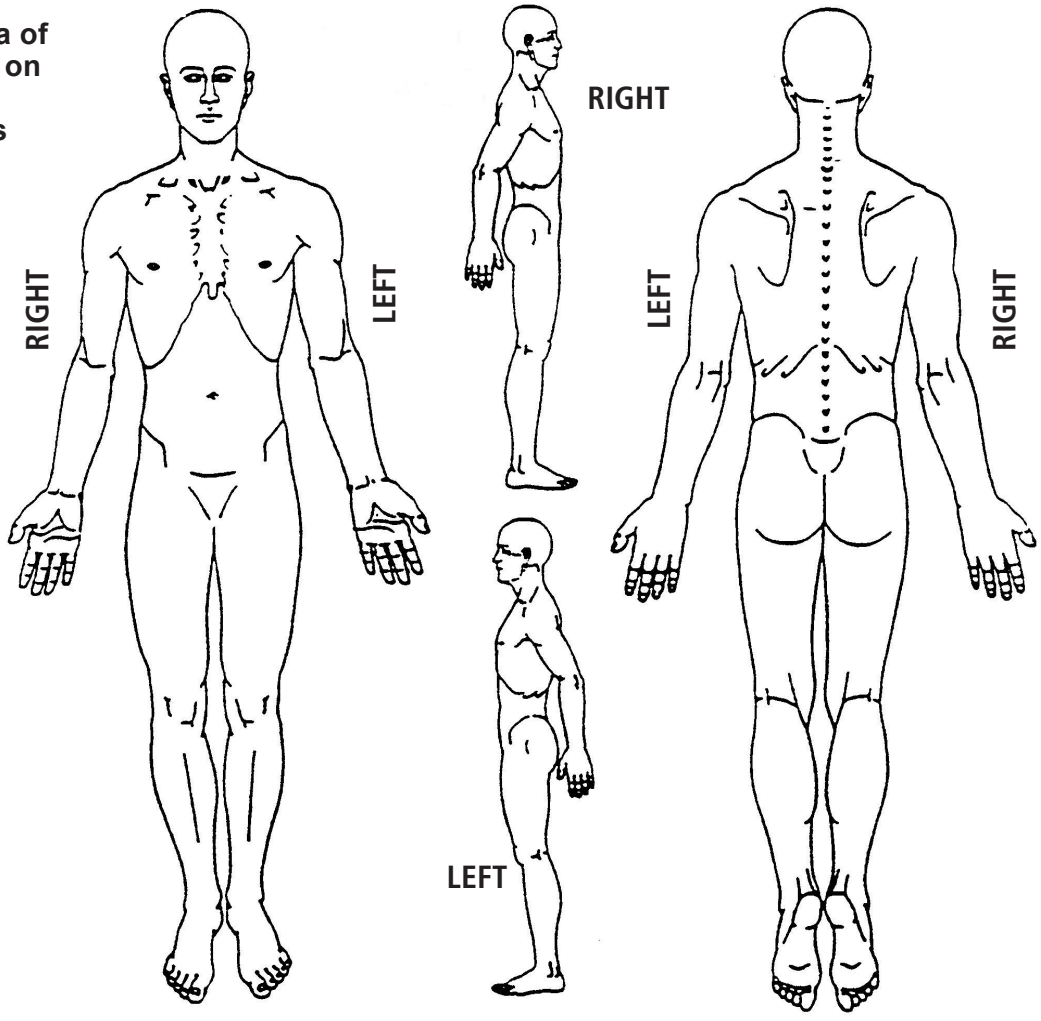
Numbness
— — — — — —
— — — — — —

Pins & Needles
○ ○ ○ ○ ○ ○
○ ○ ○ ○ ○ ○
○ ○ ○ ○ ○ ○

Burning
^ ^ ^ ^ ^ ^ ^
^ ^ ^ ^ ^ ^ ^
^ ^ ^ ^ ^ ^ ^

Aching
X X X X X X X
X X X X X X X
X X X X X X X

Stabbing
⊗ ⊗ ⊗ ⊗ ⊗ ⊗
⊗ ⊗ ⊗ ⊗ ⊗ ⊗
⊗ ⊗ ⊗ ⊗ ⊗ ⊗



Describe Your Pain _____

_____

_____

_____

Have you been treated for the same condition before coming to this clinic today? [Y] [N]

If yes, where were you treated? _____

If yes, by whom were you treated? _____

Patient Signature _____ Date _____

Patient PRINTED Name _____

Patient Information

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

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 #: _____

Are you currently working? ☐

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: _____

Revised 04/09/2024

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: ☐ Alive ☐ Deceased	Present Health or Cause of Death:	Age?
Mother: ☐ Alive ☐ 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	☐	☐	☐	
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: _____

PATIENT PAIN DIAGRAM

THE Healthy Worker

YAKIMA
307 South 12th Avenue, Suite 12
Yakima WA 98902
P: 509-895-7340 • F: 509-895-7344

TOPPENISH
220 West 1st Avenue
Toppenish WA 98948
P: 509-969-9270

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○ ○ ○ ○ ○ ○

Burning
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^ ^ ^ ^ ^ ^ ^
^ ^ ^ ^ ^ ^ ^

Aching
X X X X X X X
X X X X X X X
X X X X X X X

Stabbing
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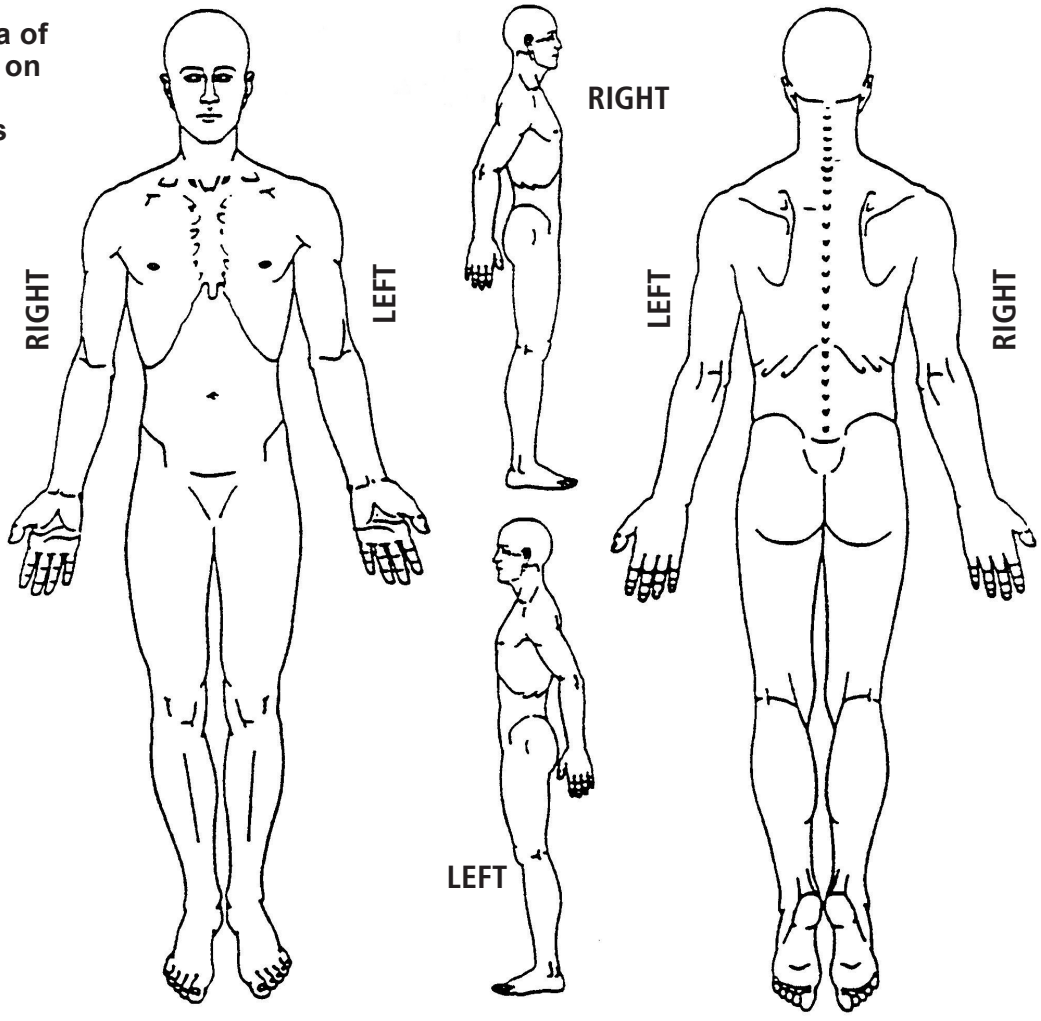

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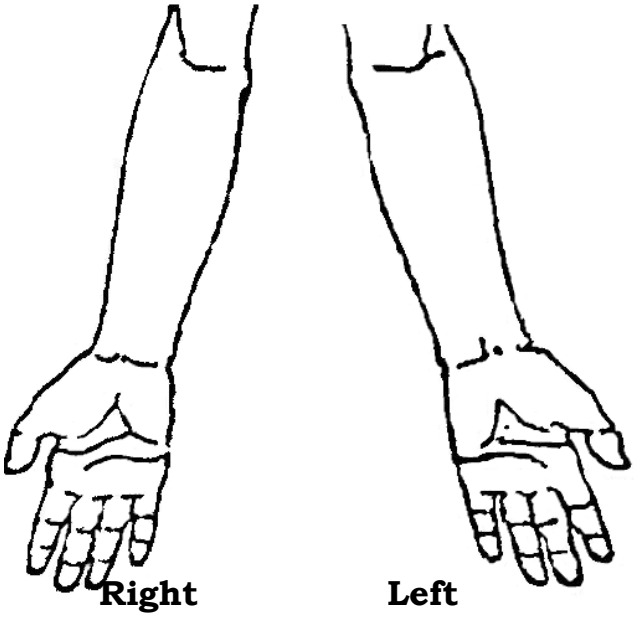
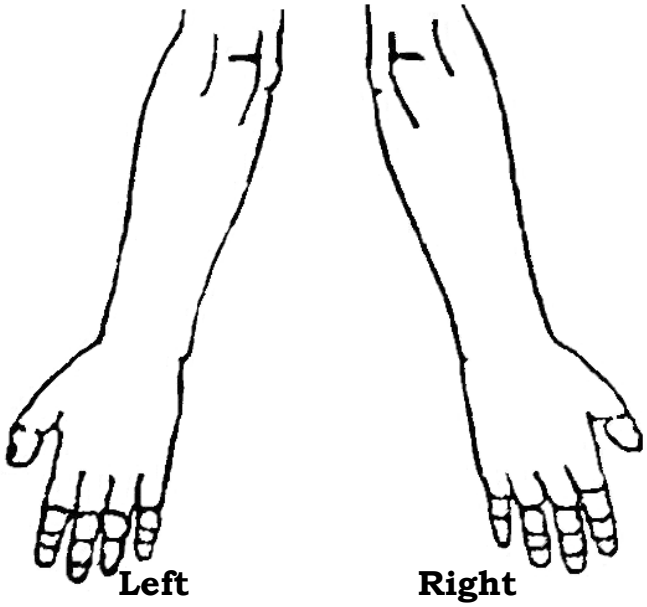


Right Left



Left Right