

**SCOTT M. TAYLOR, M.D.**  
**A Professional Corporation**  
400-29<sup>th</sup> Street, Suite 400, Oakland CA 94609

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Please PRINT and complete all sections

Dr.  
Mr.  
Mrs.  
Ms. Last Name \_\_\_\_\_ First Name \_\_\_\_\_ Middle Initial \_\_\_\_\_

Home Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip Code: \_\_\_\_\_ Male Female

Hm. Ph# \_\_\_\_\_ Cell Ph# \_\_\_\_\_ Work Ph# \_\_\_\_\_

Date of birth \_\_\_\_\_ Driver's Lic. #: \_\_\_\_\_ Fax #: \_\_\_\_\_

E-Mail Address: \_\_\_\_\_ SS#: \_\_\_\_\_

Employer: \_\_\_\_\_ Occupation: \_\_\_\_\_

Employer Address: \_\_\_\_\_

Spouse's Name: \_\_\_\_\_ Hm. Ph# \_\_\_\_\_

Spouse's Employer: \_\_\_\_\_ Wk Ph# \_\_\_\_\_

Employer's Address: \_\_\_\_\_

Circle One: Married Single Divorced Widow Separated Domestic Partner

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Name of Insurance: \_\_\_\_\_

Name of Insured (if different from above) \_\_\_\_\_

ID#.Policy#/Claim#: **(Please give insurance cards to receptionist)** \_\_\_\_\_

Primary Care Physician: \_\_\_\_\_

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Contact in case of emergency: \_\_\_\_\_

Phone Number: \_\_\_\_\_ Relationship: \_\_\_\_\_

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I, the above named patient hereby certify that all the above information is true and correct. I understand that if the above is not true or if I'M not eligible under the terms of my Medical Insurance Agreement, I am liable for all charges for services rendered. I authorize my Insurance Company to pay benefits directly to Dr. Scott M. Taylor and authorize Scott M. Taylor, M.D., to release any information required to process this claim.

I understand that all payments (medical services, co-pays, deductibles and deposits) are due at the time of service. Cash, checks and credit cards are acceptable methods of payment. **I also understand that I will be responsible to pay a \$25.00 charge due to all missed appointments which are not canceled 24 hours in advance. THIS RULE IS STRICTLY ENFORCED!**

\_\_\_\_\_  
Patient's Signature Date



**HISTORY OF TREATMENT**

**Who was the first physician you saw after the injury? What imaging studies or other tests were done? What was the first diagnosis? What was the first treatment and how did you respond? Were you taken off work or put on modified duty or restrictions?**

Date of first treatment: \_\_\_\_\_

First Treating Physician; \_\_\_\_\_

Facility (Name/Address or City): \_\_\_\_\_

Diagnosis: \_\_\_\_\_

Diagnostic Tests/Studies: \_\_\_\_\_

First Treatment: \_\_\_\_\_

Treatment Recommendations: \_\_\_\_\_

Work restrictions: \_\_\_\_\_

Physical therapy (type, how long, how often):  
\_\_\_\_\_

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**SUBSEQUENT COURSE OF TREATMENT**

(After First Evaluation)

Date: \_\_\_\_\_ Physician: \_\_\_\_\_

Facility: \_\_\_\_\_

Diagnosis: \_\_\_\_\_

Diagnostic Tests/Studies: \_\_\_\_\_

Treatment: \_\_\_\_\_

Treatment Recommendations: \_\_\_\_\_

Work restrictions: \_\_\_\_\_

Physical therapy (type, how long, how often): \_\_\_\_\_

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**JOB DESCRIPTION (WHEN YOU WERE INJURED)**

Employer (at time of injury): \_\_\_\_\_

Job Title: \_\_\_\_\_ Time with Company (@ time of injury): \_\_\_\_\_

Hours worked each day: \_\_\_\_\_ Hours each week: \_\_\_\_\_ Overtime (how much):  
\_\_\_\_\_

Describe your duties: \_\_\_\_\_

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Use letters below to describe the physical activities required for the job at which you were injured:

- N NEVER DO AT ALL
- O DO THIS OCCASIONALLY (AROUND 25% OF MY WORK DAY)
- I DO THIS INTERMITTENTLY (AROUND 50% OF MY WORK DAY)
- F DO THIS FREQUENTLY (AROUND 75% OF MY WORK DAY)
- C DO THIS CONSTANTLY (100% OF MY WORK DAY)

\_\_\_ STANDING \_\_\_ TWISTING \_\_\_ DRIVING \_\_\_ CLIMBING \_\_\_ SQUATTING

\_\_\_ KNEELING \_\_\_ BENDING \_\_\_ WALKING \_\_\_ PUSHING \_\_\_ PULLING

\_\_\_ DETAILED HAND WORK \_\_\_ LIFTING

\_\_\_ GREATEST NUMBER OF POUNDS TO BE CARRIED OR MOVED AT A TIME

Total number of years you have done this type of work: \_\_\_\_\_

Total number of years at the job where you were injured: \_\_\_\_\_

Did you miss time from work following this injury?: ( ) Yes ( ) No

Exact dates (if known) when you were off work due to these injuries: \_\_\_\_\_

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Are you working now?: ( ) Yes ( ) No If not, why?: \_\_\_\_\_

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If yes, for the same employer? ( ) No ( ) Yes Are you on regular duty? ( ) Yes ( ) No

Modified duty? ( ) No ( ) Yes If yes, describe modifications or restrictions: \_\_\_\_\_



PRINT YOUR NAME AGAIN \_\_\_\_\_  
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If you are not working now, would you like to return to the job you had at the time of your injury?

( ) Yes ( ) No. If not, why not? \_\_\_\_\_

**JOBS YOU HELD IN THE PAST (GIVE DATES OR YEARS)**

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**PAIN DRAWING**

Be sure to TAKE YOUR TIME and mark these drawings (front and back of your body) EXTREMELY ACCURATELY. Mark all the areas of your body where you feel the sensation described. Use the appropriate symbol. Mark the areas of radiation (where pain continues from one part of the body, where it originates, to another). Once again, include all affected areas, front and back.

Numbness =====

Pins & Needles 0000000

Burning pain xxxxxxxx

Stabbing Pain //////////////

Aching pain (((((((((

On this chart, circle one number, from 0 = no pain at all up to 10 = the most intense pain to describe your pain on each line:

Describe your pain:

Right now	0	1	2	3	4	5	6	7	8	9	10
At its worst	0	1	2	3	4	5	6	7	8	9	10
At its least	0	1	2	3	4	5	6	7	8	9	10

Check which of the following activities cause the pain from your work injury to:

	<u>Increase</u>	<u>Decrease</u>	<u>No Change</u>
Stand _____			
Sit _____			
Walk _____			
Turn _____			
Lift _____			
Extend _____			
Reach overhead _____			
Twist _____			
Strain _____			
Lie face down _____			
Lie face up _____			
Lie on side ( )Right ( ) Left _____			
Cough _____			
Sneeze _____			
Could you do the job where you were injured right now? ( ) Yes ( ) No. If not, why?: _____			

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### MEDICAL HISTORY

List all medications you are taking as of today:

<u>Name</u>	<u>Dosage Prescribed</u>	<u>How Often</u>	<u>Prescribing Doctor</u>	<u>Last Taken</u>
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____

PRINT YOUR NAME AGAIN \_\_\_\_\_

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Physicians caring for you NOW:

Name

Address

Specialty

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**PAST HISTORY OF INJURIES (WORK-RELATED AND OTHER)**

Have you ever injured the body parts described in this claim? ( )No ( ) Yes

If “yes”, describe these injuries with dates, treatment, when or if you felt completely better. If you are still disabled, did you have symptoms in these body parts just before the current injury? \_\_\_\_\_

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Other on-the-job injuries (other body parts)? ( ) No ( ) Yes. If “yes”, describe in detail, as above:

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Medication or Food Allergies? ( ) No ( ) Yes. If “yes”, list below with type of allergic reaction at any time in the past:

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What other materials (not medications or foods) are you allergic to?: \_\_\_\_\_

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Have you had or do you have now any foreign bodies such as metallic fragments, screws, metal from joint replacement surgery, a Pacemaker, etc., in your body? ( )No ( )Yes. If yes, describe: \_\_\_\_\_

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**MAJOR ILLNESSES OR CHRONIC HEALTH PROBLEMS (Check all that apply)**

Arthritis	Tuberculosis	Jaundice
Diabetes	High or Low Blood Sugar	Blood pressure
Respiratory disease	Heart disease	Kidney disease
Liver disease	Blood vessel disease	<u>Other</u>

If checked above, describe each in detail: \_\_\_\_\_

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Any surgeries or hospitalizations (Please describe specifically: which body parts involved, date or at least year, the type of operation and any details you can recall, including surgeon, how long disabled, how well you recovered, if you have any lasting symptoms or problems:

\_\_\_\_\_

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**PERSONAL HABITS**

Alcohol: ( ) No ( ) Yes. If "yes", how much each day \_\_\_\_\_

Tobacco: ( ) No ( ) Yes. If "yes", how many packs each day \_\_\_\_\_

Street drugs: ( ) No ( ) Yes. If "yes", how much each day \_\_\_\_\_

Have you ever had problems with or abused the substances above? ( ) No ( ) Yes

If "yes", describe with dates of treatment and current condition or recovery \_\_\_\_\_

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**SOCIAL HISTORY**

Where were you born (city, state, country)?: \_\_\_\_\_

If not born in U.S., when did you move here?: \_\_\_\_\_

Marital status: ( ) Single ( ) Married ( ) Divorced ( ) Widowed

How many children?: \_\_\_\_\_

Spouse's name and place of business (job title): \_\_\_\_\_

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