

SCOTT M. TAYLOR, M.D.
A Professional Corporation
400-29th Street, Suite 400, Oakland CA 94609

**

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

Name of Insurance: _____

Name of Insured (if different from above) _____

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

Primary Care Physician: _____

Contact in case of emergency: _____

Phone Number: _____ Relationship: _____

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

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COMPREHENSIVE PATIENT HISTORY FORM

OME/AOE-COE REEVALS.

*Please answer every question (Including Ones Starred)

Name: _____ Age Today: _____ Today's Date: _____

PLEASE COMPLETE WEIGHT BLANK IF THERE HAS BEEN A MAJOR GAIN OR LOSS

Male () Female () Date of Birth: _____ *Height: _____ *Weight: _____

History Taken By (if not patient): _____ Interpreter: _____

PLEASE COMPLETE BELOW IF THERE HAS BEEN A RE-INJURY INCLUDING AUTO ACCIDENTS, HOME INJURIES, ETC., AS WELL AS WORK RE-INJURIES.

Date of ORIGINAL injury _____

Parts of Body Injured: _____

Describe the re-injury/accident. Include parts of the body affected, how they were affected, your immediate symptoms/complaints, and symptoms that developed later: _____

PLEASE COMPLETE BELOW WITH DATES AS BEST YOU RECALL THEM AND WORK STATUS UP TO THE PRESENT TIME. PARTICULARLY NOTE IF YOU HAVE A DIFFERENT JOB, WHEN IT STARTED, YOUR DUTIES, ETC.

Currently working? YES ____ NO ____ Same job? YES ____ NO ____ If not, when did you last work? When did you leave the job you held at your last visit here? _____ Why?

Could you do RIGHT NOW the job where you were injured? ____ YES ____ NO. If NO, why not? _____

Where are you working now (if different)? _____

Job Title? _____ When did you start? _____

PRINT YOUR NAME AGAIN _____
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What is your current job status? REGULAR DUTY _____ MODIFIED DUTY _____
If modified, light duty, please list restrictions _____

If you had a period of modified or light duty between your last appointment here and today,
please give the dates as you recall them. _____

*(CONTINUATION OF DATES OF MODIFIED/LIGHT/RESTRICTED DUTY AT YOUR OLD
JOB OR A NEW ONE):*

HISTORY OF TREATMENT

PLEASE LIST (if more than two major courses of treatment, please use other side of sheet):

Date First Seen: _____ Date Last Seen: _____

Doctor's Name: _____ Location (City): _____

Treatment **(Include hospitalizations/surgeries/physical therapy/acupuncture/any other
conventional OR alternative care and dates if possible):** _____

Work restrictions **(with dates, please):** _____

Physical therapy (Please include **HOW MANY VISITS, START DATE AND END DATE –
DISCHARGE OR CANCELLATION**): _____

Date First Seen: _____ Date Last Seen: _____

Doctor's Name: _____ Location (City): _____

Treatment **(Include hospitalizations/surgeries/physical therapy/acupuncture/any other
conventional OR alternative care and dates if possible):** _____

Work restrictions **(with dates, please):** _____

Physical therapy (Please include **HOW MANY VISITS, START DATE AND END DATE –
DISCHARGE OR CANCELLATION**): _____

PRINT YOUR NAME AGAIN _____

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F YOUR JOB DUTIES OR OTHER WORK REQUIREMENTS HAVE CHANGED SINCE YOUR INITIAL QME/AOE-COE EXAM AT THIS OFFICE, PLEASE COMPLETE THIS SECTION.

- 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

IMPORTANT: PLEASE COMPLETE THIS SECTION FOR YOUR PAIN TODAY)

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 STILL cause the pain from your work injury to:

<u>Activities</u>	<u>Increase</u>	<u>Decrease</u>	<u>No Change</u>
Stand _____			
Sit _____			
Walk _____			
Turn _____			
Lift _____			
Extend _____			
Reach overhead _____			

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

IMPORTANT (Even if you have told us before and **ESPECIALLY** if there are new allergies):
Medication or Food Allergies? () No () Yes. If "yes", list below with type of allergic reaction at any time in the past:

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

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: _____

UPDATE OF MAJOR ILLNESSES OR CHRONIC HEALTH PROBLEMS (Check all that apply TO UPDATE YOUR HISTORY SINCE YOUR LAST VISIT HERE) THESE ARE EXAMPLES. ADD ANY OTHERS:

ILLNESSES	MEDICATIONS YOU ARE TAKING FOR THEM
Arthritis	
Diabetes	
Respiratory Disease	
Tuberculosis	
High or Low Blood Sugar	
Heart Disease	
Jaundice	
Blood Pressure (HIGH OR LOW)	
Kidney Disease	
OTHER	

PRINT YOUR NAME AGAIN _____
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Have you had any surgeries of any kind since your last visit here? _____ NO _____ YES
If YES, please give us the DATE of EACH SURGERY and the KIND OF SURGERY (BODY PART, SPECIFIC SURGERY IF YOU REMEMBER:

<u>BODY PART</u>	<u>KIND OF SURGERY</u>	<u>DATE</u>	<u>DATES IN HOSPITAL</u>	<u>HOW LONG DISABLED</u>

DID YOU RECOVER FROM EACH OF THESE SURGERIES? YES _____ NO _____
If you have NOT recovered, please explain what symptoms you still have: _____

HAVE YOU BEEN IN THE HOSPITAL NOT FOR SURGERY SINCE YOUR LAST VISIT HERE? _____ NO _____ YES. If YES, please explain:

<u>BODY PART</u>	<u>DATES IN HOSPITAL</u>	<u>HOW LONG DISABLED</u>

PERSONAL HABITS AS OF TODAY

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 _____

PRINT YOUR NAME AGAIN _____
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UPDATED SOCIAL HISTORY

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

How many children?: Girls and ages: _____ Boys and ages: _____

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

THANK YOU FOR YOUR ATTENTION TO THIS!!!