NEW ERA Physical Therapy

615 West Mermod. Carlsbad, NM 88220
Phone: (575)- 200-3465 Fax: (575)- 200-3470

INDUSTRIAL HEALTH SERVICES **PRE – EMPLOYMENT HISTORY AND PHYSICAL FORM**

PERSONAL DATA			
Name (Last, First, MI):			SSN:
Date of Birth: ___/ ____/	Age:		Ethnicity:
Phone Numbers:	Home (___) ___- ____	Mobile (___) ___- ____	Work (____) - ____- _____
Address:			
(street)	(city)	(state)	(zip)
Job Title & Department:		Union: (yes) (no) If yes specify:	

CURRENT MEDICAL PROVIDER			
Name of Doctor:			Phone Number: (____) - _____ - ____
Address:			
(street)	(city)	(state)	(zip)

PRIOR EMPLOYMENT (Start with most recent job)			
	Job Title	Employer/City/State	Dates of employment (mo/yr)
1.			_____/ ____ to _____/ _____
2.			_____/ ____ to _____/ _____
3.			_____/ ____ to _____/ _____
4.			_____/ ____ to _____/ _____

REVIEW OF SYSTEMS					
Do you have any of the following?:	Yes	No	Do you have any of the following?:	Yes	No
Weight loss / Weight gain (circle)			Palpitations or skipped beats		
Fevers			Chest pain or tightness		
Headaches			Indigestion/heartburn		
Difficulty with vision / Wear or glasses			Abdominal pain		
Dizziness / Vertigo			Diarrhea/Constipation		
Difficulty hearing			Irregular periods		
Seasonal allergies			Frequent urinary tract infections		
Sinus Problem			Kidney stones		
Tiredness or falling asleep during the day			Back pain		
Unable to breath with or without			Joint pain or swelling		
Shortness of breath with or with or exertion			Swelling on the legs		
(Wheezing) , (Cough)			Skin problems (rash, eczema, psoriasis)		

VACCINATION HISTORY/COMMUNICABLE DISEASES			
Have you had:	Yes	No	Unsure
The standard series of childhood vaccinations (to the best of your knowledge)?			
The disease “chicken pox” or the chicken pox vaccine (varicella)?			
A tetanus/diphtheria booster shot within the last 10 years			
Hepatitis B vaccination (this is a series of three injections spaced several months apart)?			
The disease “Tuberculosis”?			
A positive tuberculosis test (also called a PPD or Tine Test)?			
Vaccination against tuberculosis with BCG (this is un common n the United States			

NEW ERA Physical Therapy

615 West Mermod. Carlsbad, NM 88220
Phone: (575)- 200-3465 Fax: (575)- 200-3470

Have you ever had: ( ) a car accident ( ) loss of consciousness ( ) heart attack ( ) loss of vision ( ) abdominal heart rhythm
( ) Seizure ( ) panic attacks ( ) head injury ( ) stroke ( ) paralysis ( ) back injury ( ) psychiatric disorder

***CURRENT* MEDICAL CONDITIONS** Those that you are currently experiencing and/or receiving treatment for (diabetes, high blood pressure)					
	Please List	Date of onset (mo/yr)		Please List	Date of onset (mo/yr)
1.		/	5.		/
2.		/	6.		/
3.		/	7.		/
4.		/	8.		/

***Past* Medical Conditions** Those that you have had in the past but have recovered from (childhood asthma, gestational diabetes)					
	Please List	Date of onset (mo/yr)		Please List	Date of onset (mo/yr)
1.		/	3.		/
2.		/	4.		/

Surgeries/Hospitalizations List type of surgery (such as gall bladder) or condition for which you were hospitalized (heart attack, pneumonia)					
	Please List	Date of onset (mo/yr)		Please List	Date of onset (mo/yr)
1.		/	4.		/
2.		/	5.		/
3.		/	6.		/

When was your last visit to the emergency room? _____ For what symptom/condition? _____

Family History Please list any conditions that run in your biological family (even if relative is deceased)					
	Please List	Circle affected relative		Please List	Circle affected relative
1.		Father/Mother/Sister/Brother Child/Grandfather/Grandmother	4.		Father/Mother/Sister/Brother Child/Grandfather/Grandmother
2.		Father/Mother/Sister/Brother Child/Grandfather/Grandmother	5.		Father/Mother/Sister/Brother Child/Grandfather/Grandmother
3.		Father/Mother/Sister/Brother Child/Grandfather/Grandmother	6.		Father/Mother/Sister/Brother Child/Grandfather/Grandmother

Medications Please include non-prescription medications, vitamins, and herbal supplements in addition to prescription medications					
1.		4.		7.	
2.		5.		8.	
3.		6.		9.	

Do you have any allergies to medication or other substances? ( ) Yes ( ) No (if yes please specify on the next line)

Social History	
Do you smoke cigarettes? ( ) / ( ) ( ) used to smoke , but quit	If yes, how many cigarettes per day? _____Per week? ____
How many alcoholic drinks do you consume per day? ___Per week ____	Do you use illicit/illegal drugs? ( ) yes/ ( )
How many minutes of exercise do you get per day? _____	How many days of week do you exercise? _____
How many hours of television do you watch per day? _____	How many times do you eat fast food per week?

NEW ERA Physical Therapy

615 West Mermod. Carlsbad, NM 88220
Phone: (575)- 200-3465 Fax: (575)- 200-3470

Occupational Assessment			
Please answer the following questions regarding the job for which you have been hired:	**Yes**	**NO**	**Unsure**
Will you be required to wear respiratory protection (e. g., N(% mask or cartridge respirator)			
Do you anticipate working with hazardous chemical or materials, infections agents, or laboratory animals?			
Is there a chance that you will be exposed to human blood or body fluid as a result of routine job duties?			
If your job involves work at a computer, have you had or experiencing any discomfort, pain, or numbness			
Will you be required to drive a vehicle for any reason?			
Will you be required to move heavy objects regularly (i.e greater than found 50 occasionally or 25 pounds			
Have you ever had an occupational injury/illness (before (e.g back strain, needle- stick, chemical exposure?			

Do you have any condition (physical, medical, or psychological) that would require special accommodation in order for you to perform your job? ( ) yes ( ) No (If yes, please specify on next lines).

_____
_____
_____

Signature of employee: _____ Date: ___/ ____/ _____

Practitioner Notes:

_____
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____