Central Coast Med Plus

Dignity Health.
Pacific Central Coast
Health Centers

WORKERS' COMPENSATION REGISTRATION

Name (Last, First, MI)____

Address____________________City____________State____Zip Code______

Sex: M F Home Phone____________ Work Phone____________

Date of Birth____________ Social Security Number__________________

Employer______________________________ How Long?____________

Employer's
Address____________________City____________State_____Zip Code______

Type of Business (e.g. fast food)____________________ Job Title______________

Address where
injury occurred__________________City____________County _____________

Date of Injury________ Time of Injury ________Type of Injury____________________

Is this your first evaluation for this injury?______________________________

If no, on what date were you first seen & by which doctor?________________________

Last Date Worked________________ Have you been a patient here before?__________

Patient please complete this portion, if able to do so, otherwise, doctor please complete immediately. Inability or failure of a patient to complete this portion shall not affect his/her rights to workers' compensation under the California Labor Code.

Describe how the accident or exposure happened (Give specific object, machinery or chemical).

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FINANCIAL RESPONSIBILITY/MEDICAL RELEASE AUTHORIZATION

As the responsible party, I agree that all charges that are not directly paid by my insurance will be my responsibility. I authorize *Central Coast T ^åÄÜ|ˇ* • to release any medical or financial information requested by my insurance company or my employer with regard to this claim.
I certify that the information I furnish is true and correct. I know it is a crime to fill out this form with facts I know are false or to leave out facts I know are important.

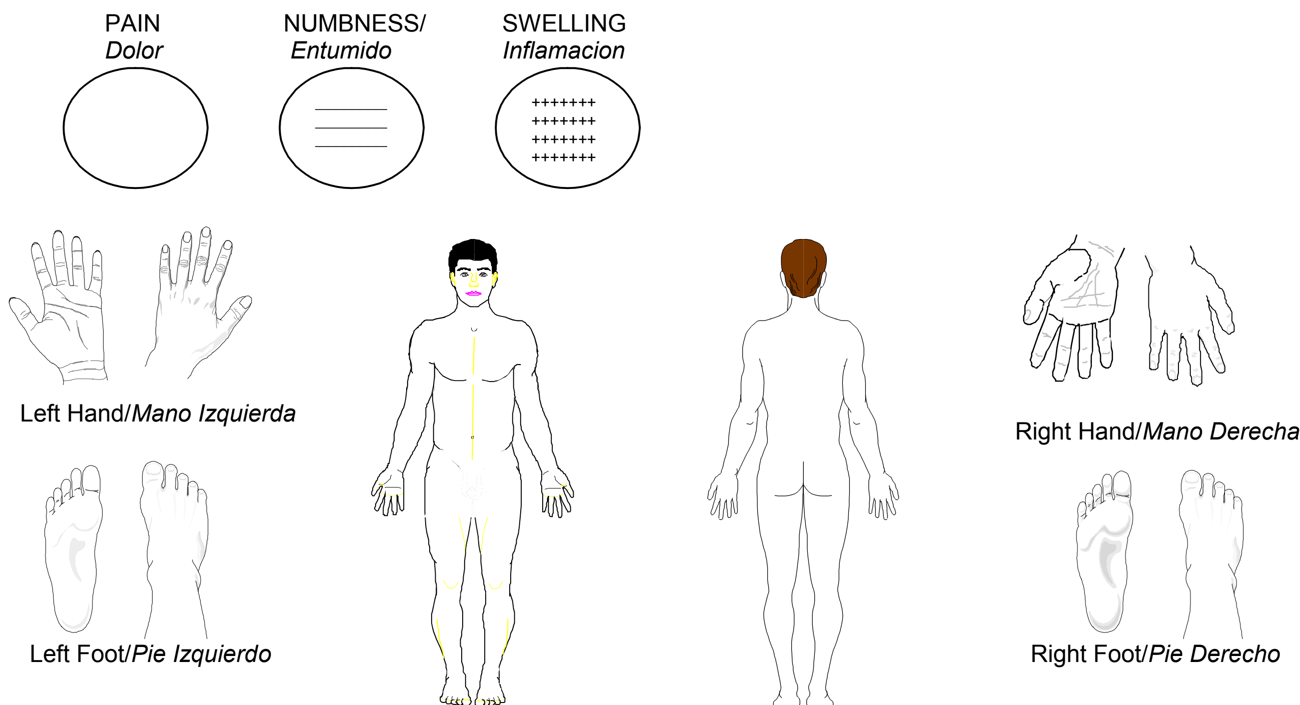
Also, I acknowledge that I have been offered a copy of Central Coast A YX˙D`i g Notice of Privacy Practices.

Signature____________________________________ Date__________

Treatment authorized by: (Name and Title):____________________________

PAIN DIAGRAM / DIAGRAMA DE DOLOR

CIRCLE & DRAW Below where you have any of the following symptoms:
CIRCULE Y DIBUJA *en la parte abajo, en que parte del cuerpo usted tiene sintomas*:



INSTRUCTIONS: Please circle your answers to the following questions.
INSTRUCTIONES: *Por Favor circule las respuestats a las siguentes preguntas.*

A	**GENERAL STATUS:** ***Condicion General:***	Better *Mejor*	Worse *Peor*	Same *Iqual*	Since your last visit to this office, what is your medical condition today? *Como esta su condicion medica desde su ultima visita a esta oficina*
B	**MEDICATION EFFECTS:** ***Medicamentos Effectos:***	Yes *Si*	No		Does the medicaton help to control, or to improve your medical symptoms? *Le ayuda el medicamento a mejorar o a controlarsus sintomas?*
C	**ANY SIDE EFFECTS:** ***Effectos Secundarios:***	Yes *Si*	No		Do you have any side effects from the medication? (Upset stomach, Rash)? *Tiene o sienta algun efecto secundario a causa del medicamento? (Molesta Estamacal o Comezon)?*
D	**SYMPTOMS:** ***Sintomas:***	Yes *Si*	No		Have you developed any a)Numbness b)Tingling c)Swelling d)Redness? *A usted desarollado alguna a)Sensation hormigueo b)Adormecimiento c)Hinchazon d)Enrojecimento?*
E	**WORK STATUS:** ***Esta tus de trabajo***	Yes *Si*	No		Are you performing the same work at your job that you were doing before your injury? *Esta usted ejucutando el mismo trabajo que estaba hacienda antes de lastimarse?*
F	**FULL DUTY?** ***Tiempo Completo***	Yes *Si*	No		Do you feel that you can perform your regular job now? *Cree usted que pueda ejercer su trabajo rutinal hoy?*
G	**RECOVERY:** ***Recuperacion:***	Yes *Si*	No		Do you feel that you have recovered from your medical condition? *Cree usted que se ha recuperado de su condicion medica?*
H	**THERAPY STARTED:** ***Terapia***	Yes *Si*	No		Have you started treatments in the Physical Therapy Department? *Ha usted comenzado tratamentos en el Departmento de Fisioterapia?*
I	**THERAPY RESULTS:** ***Teriapia Resultados:***	Better *Mejor*	Worse *Peor*	Same *Iqual*	As a result of Physical Therapy treatments, how do you feel? *Como se siente usted a resultado de los tratamientos de Fisioterapia?*
J	**PAIN SCALE:** ***Escala de Dolor:***	1 2 3 4 5 6 7 8 9 10			Please rate the severity of your pain by circling the number on the following scale. *Por favor evalue la severidad de su dolor cirulando el numero que corresponda con su tipo de dolor en la suigiente escala.*
K	**COMMENTS?** ***Commentarios?***	Yes *Si*	No		______________________________ ______________________________

Signature/*Firma*____Date/*Fecha*_______--_______200____

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Dignity Health.
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Company / Position
Empresa / Posicion

Medications
Medicinas

Drug Allergies — ***Alergias a medicamentos***
Last Tetanus — ***Ultima Vacuna para el tetanos***

Have you ever had or do you now have any of the following? (If yes, please describe below.)
Ha' tenido usted alguna de estas enfermedades?

	yes	no		si	no
1. Anemia or blood disease			1. Anemia o enf. de la sangre		
2. Heart trouble, rheumatic fever or murmur			2. Enf. Cardiaca, fiebre rehumatica		
3. High blood pressure			3. Alta precion		
4. Chest pain or angina			4. Dolor de pecho o angina		
5. Shortness of breath			5. Dificultad respiratoria		
6. Frequent colds or persistent cough			6. Enf.respiratorias frecuentes		
7. Diseases of the lungs, asthma			7. Enf.Pulmonares,asthma		
8. Allergy, hay fever			8. Alergias,fiebre del heno		
9. Eye trouble			9. Enfermedades de los ojos		
10. Deafness or ear trouble			10. Sordera o enf. de los oidos		
11. Major illness			11. Enfermedades mayores		
12. Surgeries			12. Cirujias		
13. Skin disease or rash			13. Enf. de la piel o salpullido		
14. Varicose veins or leg sores			14. Venas varicosas o piernas dolorosas		
15. Cancer or tumors			15. Cancer, tumores		
16. Stomach or intestinal trouble			16. Enf.estomacales o intestinales		
17. Liver, gallbladder problems, jaundice			17. Enf.del higado,vesicula, icterico		
18. Hemorrhoids, rectal bleeding			18. Hemorroides,sangrado rectal		
19. Hernia			19. Hernia		
20. Diabetes			20. Diabetes		
21. Thyroid problems			21. Problemas tiroideos		
22. Sugar or albumin in urine			22. Azucar o albumina en la orina		
23. Kidney or bladder trouble			23. Enf.renales o de vejiga		
24. Frequent headaches or migraines			24. Dolor de cabeza o migranas frecuentes		
25. Dizziness, fainting spell, epilepsy, fits			25. Mareos,desmayos,epilepsia,convulsiones		
26. Mental health, anxiety, depression			26. Enfermedad mental, anciedado, depresion		
27. Paralysis, nerve disease or injury			27. Paralisis o enf. de los nervios o lastimadura		
28. Severe injury			28. Lastimadura severa		
29. Broken bones			29. Fracturas		
30. Head injury			30. Lastimadura en la cabeza		
31. Back injury, ruptured disc			31. Lastimadura de la espalda o disco		
32. Arthritis, bursitis			32. Artritis, bursitis		
33. Bone or joint disease			33. Enf.de los huesos o articulaciones		
34. Sexually transmitted disease			34. Enf.transmitidas sexualmente		
35. Recent weight gain or loss			35. Aumento o perdida de peso reciente		
36. Been denied employment for health reasons			36. Se le ha negado empleo por razones de salud		
37. Been refused application for life insurance			37. Se le ha negado aplicacion para seguro de vida		

Continued/Continua:	Yes	No		si	No
38. Filed an industrial claim			38.Ha procedido en reclamo industrial		
39. Had health problems from exposure to chemicals			39.Enfermedades por exposicion quimica		
40. Handicaps or limitations			40.Discapacidades o limitaciones		
41. Had problems from vibrating tools			41.Problemas por el uso de herramientas vibrates		
42. Out of work more than a week due to injury/illness			42.Ha estado sin trabajar por mas de una semana por enfermedad o accidente?		
43. Been under the care of a doctor in the past year			43.Ha estado bajo cuidado medico durante el ultimo ano?		
44. Taken medication for several months or years			44.tomando medicamentos por varios meses o anos		
45. Been on street drugs or methadone program			45.Ha estado en drogas o programa de methadona		
46. Are you now taking drugs or medication?			46.Ahora,esta ud.tomando drogas o medicamentos		
47. Do you smoke?			47.Fuma?		
48. Packs per day____			48.Cuantas cajetillas por dia?____		
49. If no, have you ever smoked? Number of years?___			49.Si no, ha ud.fumado antes?cuantas anos?____		
50. Do you drink alcoholic beverages?			50.Toma bebidas alcoholicas?		
51. How many drinks per day____per week____			51.Cuantas copas al dia____		
52. Were you ever a heavy drinker or member of AA?			52.Fue ud. Bebedor o miembro de AA?		
53. When?			53.Cuando?		
FOR WOMEN ONLY:			**PARA MUJERES SOLAMENTE**		
54. Date of last PAP smear			54.Fecha de ultimo papanicolau		
55. Female disorders			55.Enf.de las mujeres		
56. Painful or irregular menstruation			56.Menstruaciones dolorosas o irregulares		
57. Date of last menstrual period			57.Fecha de ultimo periodo menstrual		
58. No. of pregnancies_____			58.Numero de embarazos____		
59. No. of children_____			59 Numero de hijos____		

PLEASE EXPLAIN YES ANSWERS TO THE ABOVE QUESTIONS:
Si contesto si a cualquiera de estas preguntas por favor explique.

CONSENT: I hereby certify that all of the above information is a true & complete history of my medical conditions, illnesses, operations, injuries & accidents.

Consentimiento: Certifico que toda la informacion anterior es la historia completa y verdadera de mi estado de salud, enfermedades, operaciones, lastimaduras y accidentes.

Applicant's Signature
*Firma*____ Date/*Fecha*____________________

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