



# Patient Demographic

Ventura Orthopedics

Account # :

Last Name		First Name		MI:
Address:				
Home Phone : leave msg		<input type="checkbox"/> OK to	Cell Phone: leave msg	
			<input type="checkbox"/> OK to	
Work Phone: leave msg		<input type="checkbox"/> OK to	Email :	
Family Physician (PCP):		Referring Provider:		
DOB:	Marital Status:	Sex: <input type="checkbox"/> M <input type="checkbox"/> F		Social Security:
Employer:		Employer Address:		
Emergency Contact:		Relationship:		Contact Phone:

**IF PATIENT IS A MINOR**

Student Status:  Full Time  Part Time

Father's Name:		Mother's Name:	
Work Phone:		Work Phone:	
Employer:		Employer:	
Email:		Email:	

**INSURANCE INFORMATION**

Primary Insurance:		Secondary Insurance:	
Subscriber:		Subscriber:	
Birth date:		Birth date:	
Subscriber Relationship to Patient:		Subscriber Relationship to Patient:	
Subscriber Employer:		Subscriber Employer:	
ID No:	Group No:	ID No:	Group No:

**INJURY INFORMATION**

Date of Onset:	Area of Pain:
Injury: <input type="checkbox"/> Yes <input type="checkbox"/> No      If yes, <input type="checkbox"/> AUTO <input type="checkbox"/> WORK <input type="checkbox"/> OTHER _____	
How did Injury Occur:	

Race: <input type="checkbox"/> Hispanic <input type="checkbox"/> White <input type="checkbox"/> Asia <input type="checkbox"/> African American <input type="checkbox"/> Native Hawaiian <input type="checkbox"/> other _____ <input type="checkbox"/> Refuse to Report
Ethnicity: <input type="checkbox"/> Hispanic <input type="checkbox"/> White <input type="checkbox"/> Asia <input type="checkbox"/> African American <input type="checkbox"/> Native Hawaiian <input type="checkbox"/> other _____ <input type="checkbox"/> Refuse to Report
Preferred Language: <input type="checkbox"/> English <input type="checkbox"/> Spanish <input type="checkbox"/> Chinese <input type="checkbox"/> Japanese <input type="checkbox"/> other _____

Each Patient (Or Responsible Party) is Financially Responsible for Services rendered. While we are please to assist in the Preparation of Insurance Forms, the obligation for payment of our fees remains that of the patient. I hereby authorize payment to Ventura Orthopedics for Medical Services rendered. I authorize the release of any information required in the course of my examination or treatment.

Responsible Party Name (Please Print)

\_\_\_\_\_

Date \_\_\_\_\_

Signature of Responsible Party

\_\_\_\_\_



**SOCIAL HISTORY:** Do you smoke cigarettes?     Yes     No  
 Number of packs per day:     < 1 pack     1-2 packs     3+ packs  
 Level of education completed:     Elementary     High School     College     Graduate  
 Marital Status:     Single     Married     Divorced     Widowed  
 Job/Occupation: \_\_\_\_\_

**FAMILY HISTORY:** Bubble all medical conditions below that pertain to your family members:

Back Problems	<input type="radio"/> Yes	<input type="radio"/> No	Neck Problems	<input type="radio"/> Yes	<input type="radio"/> No
Cancer	<input type="radio"/> Yes	<input type="radio"/> No	Heart Failure	<input type="radio"/> Yes	<input type="radio"/> No
Heart Attacks	<input type="radio"/> Yes	<input type="radio"/> No	Emphysema	<input type="radio"/> Yes	<input type="radio"/> No
Diabetes	<input type="radio"/> Yes	<input type="radio"/> No	Epilepsy	<input type="radio"/> Yes	<input type="radio"/> No
High Blood Pressure	<input type="radio"/> Yes	<input type="radio"/> No	Arthritis	<input type="radio"/> Yes	<input type="radio"/> No
Alcoholism	<input type="radio"/> Yes	<input type="radio"/> No	Stroke	<input type="radio"/> Yes	<input type="radio"/> No
Mental Illness	<input type="radio"/> Yes	<input type="radio"/> No	Other _____		

**REVIEW OF SYSTEMS:** Bubble all that pertain to you:

<b>Are you Pregnant?</b>	<input type="radio"/> Yes	<input type="radio"/> No	<b>Allergies:</b>	Allergic to medication	<input type="radio"/> Yes	<input type="radio"/> No
<b>General:</b>	Fever	<input type="radio"/> Yes	<input type="radio"/> No	Night Sweats/Chills	<input type="radio"/> Yes	<input type="radio"/> No
<b>Eyes:</b>	Cataracts	<input type="radio"/> Yes	<input type="radio"/> No	Double Vision	<input type="radio"/> Yes	<input type="radio"/> No
<b>Head/Neck:</b>	Sinusitis	<input type="radio"/> Yes	<input type="radio"/> No	Sore Throat	<input type="radio"/> Yes	<input type="radio"/> No
<b>Heart:</b>	Chest Pain	<input type="radio"/> Yes	<input type="radio"/> No	Irregular Heart Beat	<input type="radio"/> Yes	<input type="radio"/> No
	High Blood Pressure	<input type="radio"/> Yes	<input type="radio"/> No			
<b>Lungs:</b>	Shortness of Breath	<input type="radio"/> Yes	<input type="radio"/> No	Sputum Production	<input type="radio"/> Yes	<input type="radio"/> No
<b>Abdominal:</b>	Heartburn	<input type="radio"/> Yes	<input type="radio"/> No	Nausea and Vomiting	<input type="radio"/> Yes	<input type="radio"/> No
<b>Urinary:</b>	Incontinence	<input type="radio"/> Yes	<input type="radio"/> No			
<b>Skeletal:</b>	Joint Swelling	<input type="radio"/> Yes	<input type="radio"/> No	Joint Redness	<input type="radio"/> Yes	<input type="radio"/> No
	Muscle Cramps	<input type="radio"/> Yes	<input type="radio"/> No	Stiffness	<input type="radio"/> Yes	<input type="radio"/> No
<b>Neurologic:</b>	Seizures	<input type="radio"/> Yes	<input type="radio"/> No	Balance Problems	<input type="radio"/> Yes	<input type="radio"/> No
	Headaches	<input type="radio"/> Yes	<input type="radio"/> No			
<b>Mental:</b>	Depression	<input type="radio"/> Yes	<input type="radio"/> No	Anxious	<input type="radio"/> Yes	<input type="radio"/> No
	Fatigue	<input type="radio"/> Yes	<input type="radio"/> No	Difficulty Sleeping	<input type="radio"/> Yes	<input type="radio"/> No
<b>Blood:</b>	Prolonged Bleeding	<input type="radio"/> Yes	<input type="radio"/> No	Anemia	<input type="radio"/> Yes	<input type="radio"/> No

Medications (Please list name of medication and dosage)	
Hospitalization (Please list)	Surgeries (Please list surgery type and dates)
Medications you are allergic to (Please list)	

Patient Signature: \_\_\_\_\_ Date: \_\_\_\_\_



**Ventura Orthopedics**

**Acknowledgement of Receipt of Notice of Privacy Practices**

I hereby acknowledge that I received a copy of this medical practice's notice of privacy Practice. I further acknowledge that a copy of the current notice is posted in the reception area that I will be offered a copy of any amended Notice of Privacy Practice.

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Print Name

\_\_\_\_\_  
Telephone Number

If not signed by the patient, please indicate relationship:

- \_\_\_\_ Parent or guardian of minor patient.
- \_\_\_\_ Guardian or conservator of an incompetent patient.
- \_\_\_\_ Beneficiary or personal representative of deceased patient.

Name of patient \_\_\_\_\_



## Notice of Privacy Practices

Effective Date: April 14, 2003

California law. We may deny your request under limited circumstances. If we deny your request to access your child's records because we believe allowing access would be reasonably likely to cause substantial harm to your child, you will have a right to appeal our decision. If we deny your request to access your psychotherapy notes, you will have the right to have them transferred to another mental health professional.

**4. Right to Amend or Supplement.** You have a right to request that we amend your health information that you believe is incorrect or incomplete. You must make a request to amend in writing, and include the reasons you believe the information is inaccurate or incomplete. We are not required to change your health information, and will provide you with information about this medical practice's denial and how you can disagree with the denial. We may deny your request if we do not have the information, if we did not create the information (unless the person or entity that created the information is no longer available to make the amendment), if you would not be permitted to inspect or copy the information at issue, or if the information is accurate and complete as is. You also have the right to request that we add to your record a statement of up to 250 words concerning any statement or item you believe to be incomplete or incorrect.

**5. Right to an Accounting of Disclosures.** You have a right to receive an accounting of disclosures of your health information made by this medical practice. This medical practice does not have to account for the disclosures provided to you or pursuant to your written authorization, or as described in paragraphs 1 (treatment), 2 (payment), 3 (health care operations), 6 (notification and communication with family) and 16 (specialized government functions) of Section A of this Notice of Privacy Practices. This medical practice does not have to account for disclosures for purposes of research or public health which exclude direct patient identifiers, or which are incident to a use or disclosure otherwise permitted or authorized by law, or the disclosures to a health

oversight agency or law enforcement official to the extent this medical practice has received notice from that agency or official that providing this accounting would be reasonably likely to impede their activities.

### D. CHANGES TO THIS NOTICE OF PRIVACY PRACTICES

We reserve the right to amend this Notice of Privacy Practices at any time in the future. Until such amendment is made, we are required by law to comply with this Notice. After an amendment is made, the revised Notice of Privacy Practices will apply to all protected health information that we maintain, regardless of when it was created or received. We will keep a copy of the current notice posted in our reception area. We will also post the current notice on our website.

### E. COMPLAINTS

Complaints about this Notice of Privacy Practices or how this medical practice handles your health information should be directed to our group administrator (listed below).

If you are not satisfied with the manner in which this office handles a complaint, you may submit a formal complaint to U.S. Department of Health and Human Services, Office of Civil Rights.

Ventura Orthopedics  
Attention: Administrator  
3525 Loma Vista Road  
Ventura, California 93003  
805.641.6415 phone  
805.641.6495 fax

You will not be penalized for filing a complaint.

### THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

*We understand the importance of privacy and are committed to maintaining the confidentiality of your medical information. We make a record of the medical care we provide and may receive such records from others. We use these records to provide or enable other health care providers to provide quality medical care, to obtain payment for services provided to you as allowed by your health plan and to enable us to meet our professional and legal obligations to operate this medical practice properly. We are required by law to maintain the privacy of protected health information and to provide individuals with notice of our legal duties and privacy practices with respect to protected health information. This notice describes how we may use and disclose your medical information. It also describes your rights and our legal obligations with respect to your medical information. If you have any questions about this Notice, please contact our group administrator.*

### A. HOW THIS MEDICAL PRACTICE MAY USE OR DISCLOSE YOUR HEALTH INFORMATION

This medical practice collects health information about you and stores it in a chart and on a computer. This is your medical record. The medical record is the property of this medical practice, but the information in the medical record belongs to you. The law permits us to use or disclose your health information for the following purposes:

**1. Treatment.** We use medical information

about you to provide your medical care. We disclose medical information to our employees and others who are involved in providing the care you need. For example, we may share your medical information with other physicians or other health care providers who will provide services which we do not provide. Or we may share this information with a pharmacist who needs it to dispense a prescription to you, or a laboratory that performs a test. We may also disclose medical information to members of your family or others who can help you when you are sick or injured.

**2. Payment.** We use and disclose medical information about you to obtain payment for the services we provide. For example, we give your health plan the information it requires before it will pay us. We may also disclose information to other health care providers to assist them in obtaining payment for services they have provided to you.

**3. Health Care Operations.** We may use and disclose medical information about you to operate this medical practice. For example, we may use and disclose this information to review and improve the quality of care we provide, or the competence and qualifications of our professional staff. Or we may use and disclose this information to get your health plan to authorize services or referrals. We may also use and disclose this information as necessary for medical reviews, legal services and audits, compliance programs and business planning and management. We may also share your medical information with our "business associates", such as our billing service, that perform administrative services for us. We have a written contract with each of these business associates that contains terms requiring them

to protect the confidentiality of your medical information. Although federal law does not protect health information which is disclosed to someone other than another healthcare provider, health plan or healthcare clearinghouse, under California law all recipients of health care information are prohibited from re-disclosing it except as specifically required or permitted by law. We may also share your information with other health care providers, health care clearinghouses or health plans that have a relationship with you, when they request this information to help them with their quality assessment and improvement activities, their efforts to improve health or reduce health care costs, their review of competence, qualifications and performance of health care professionals, their training programs, their accreditation, certification or licensing activities, or their health care compliance efforts.

**4. Appointment Reminders.** We may use and disclose medical information to contact and remind you about appointments. If you are not home, we may leave this information on your answering machine or in a message left with the person answering the phone.

**5. Sign in Sheet.** We may use and disclose medical information about you by having you sign in when you arrive at our office. We may also call out your name when we are ready to see you.

**6. Notification and Communication with Family.** We may disclose your health information to notify or assist in notifying a family member, your personal representative or another person responsible for your care about your location, your general condition or in the event of your death. In the event of a disaster, we may disclose information to a relief organization so that they may coordinate these notification efforts. We may also disclose information to someone who is involved with your care or helps pay for your care. If you are able and available to agree or object, we will give you the opportunity to object prior to making these disclosures, although we may disclose this information in a disaster even over your objection if we believe it is necessary to respond to the

emergency circumstances. If you are unable or unavailable to agree or object, our health professionals will use their best judgment in communication with your family and others.

**7. Marketing.** We may give you information about products or services related to your treatment, case management or care coordination, or to direct or recommend other treatments or health-related benefits and services that may be of interest to you.

**8. Required by Law.** As required by law, we will use and disclose your health information, but we will limit our use or disclosure to the relevant requirements of the law. When the law requires us to report abuse, neglect or domestic violence, or respond to judicial or administrative proceedings, or to law enforcement officials, we will further comply with the requirement set forth below concerning those activities.

**9. Public Health.** We may, and are sometimes required by law to disclose your health information to public health authorities for purposes related to: preventing or controlling disease, injury or disability; reporting child, elder or dependent adult abuse or neglect; reporting domestic violence; reporting to the Food and Drug Administration problems with products and reactions to medications; and reporting disease or infection exposure. When we report suspected elder or dependent adult abuse or domestic violence, we will inform you or your personal representative promptly unless in our best professional judgment, we believe the notification would place you at risk of serious harm or would require informing a personal representative we believe is responsible for the abuse or harm.

**10. Health Oversight Activities.** We may, and are sometimes required by law to disclose your health information to health oversight agencies during the course of audits, investigations, inspections, licensure and other proceedings, subject to the limitations imposed by federal and California law.

**11. Judicial and Administrative Proceedings.** We may, and are sometimes required by law, to disclose your health information in

the course of any administrative or judicial proceeding to the extent expressly authorized by a court or administrative order. We may also disclose information about you in response to a subpoena, discovery request or other lawful process if reasonable efforts have been made to notify you of the request and you have not objected, or if your objections have been resolved by a court or administrative order.

**12. Law Enforcement.** We may, and are sometimes required by law, to disclose your health information to a law enforcement official for purposes such as identifying or locating a suspect, fugitive, material witness or missing person, complying with a court order, warrant, grand jury subpoena and other law enforcement purposes.

**13. Coroners.** We may, and are required by law, to disclose your health information to coroners in connection with their investigations of deaths.

**14. Organ or Tissue Donation.** We may disclose your health information to organizations involved in procuring, banking or transplanting organs and tissues.

**15. Public Safety.** We may, and are sometimes required by law, to disclose your health information to appropriate persons in order to prevent or lessen a serious and imminent threat to the health or safety of a particular person or the general public.

**16. Specialized Government Functions.** We may disclose your health information for military or national security purposes or to correctional institutions or law enforcement officers that have you in their lawful custody.

**17. Worker's Compensation.** We may disclose your health information as necessary to comply with worker's compensation laws. For example, to the extent your care is covered by workers' compensation, we will make periodic reports to your employer about your condition. We are also required by law to report cases of occupational injury or occupational illness to the employer or workers' compensation insurer.

**18. Change of Ownership.** In the event that this medical practice is sold or merged with another organization, your health information/record will become the property of the new owner, although you will maintain the right to request that copies of your health information be transferred to another physician or medical group.

## **B. WHEN THIS MEDICAL PRACTICE MAY NOT USE OR DISCLOSE YOUR HEALTH INFORMATION**

Except as described in this Notice of Privacy Practices, this medical practice will not use or disclose health information which identifies you without your written authorization. If you do authorize this medical practice to use or disclose your health information for another purpose, you may revoke your authorization in writing at any time.

## **C. YOUR HEALTH INFORMATION RIGHTS**

**1. Right to Request Special Privacy Protections.** You have the right to request restrictions on certain uses and disclosures of your health information, by a written request specifying what information you want to limit and what limitations on our use or disclosure of that information you wish to have imposed. We reserve the right to accept or reject your request, and will notify you of our decision.

**2. Right to Request Confidential Communications.** You have the right to request that you receive your health information in a specific way or at a specific location. For example, you may ask that we send information to a particular address or to your work address. We will comply with all reasonable requests submitted in writing which specify how or where you wish to receive these communications.

**3. Right to Inspect and Copy.** You have the right to inspect and copy your health information, with limited exceptions. To access your medical information, you must submit a written request detailing what information you want access to and whether you want to inspect it or get a copy of it. We will charge a reasonable fee, as allowed by

If you were hurt at **Work** or if this is a **Workman's Compensation Case**, please complete the form below.

Patient Name \_\_\_\_\_ Date \_\_\_\_\_

Referred by \_\_\_\_\_ Interpreter's Name \_\_\_\_\_

**History of Work Injury:**

	YES	NO	
Were you hurt at work?	<input type="checkbox"/>	<input type="checkbox"/>	Name of Employer at the time of your injury: _____
Is this an accepted Workman's Compensation case?	<input type="checkbox"/>	<input type="checkbox"/>	_____
Did you report the injury to your employer?	<input type="checkbox"/>	<input type="checkbox"/>	If <b>yes</b> , date: _____ To whom: _____
Were there any witnesses to this injury?	<input type="checkbox"/>	<input type="checkbox"/>	If <b>yes</b> , their name(s): _____
Was treatment sought immediately?	<input type="checkbox"/>	<input type="checkbox"/>	If <b>no</b> , why: _____
			_____
Are you still receiving treatment?	<input type="checkbox"/>	<input type="checkbox"/>	If <b>yes</b> , by whom: _____
			_____
			Date of last treatment: _____
Has surgery been recommended for this problem?	<input type="checkbox"/>	<input type="checkbox"/>	If <b>yes</b> , by whom: _____
Did you continue working following the injury?	<input type="checkbox"/>	<input type="checkbox"/>	If <b>no</b> , why did you stop working? ( <i>check the appropriate box(es) below</i> ):
			<input type="checkbox"/> Doctor's Request <input type="checkbox"/> Your Decision
			<input type="checkbox"/> Employer's Request <input type="checkbox"/> Other: _____
Are you presently working?	<input type="checkbox"/>	<input type="checkbox"/>	If <b>yes</b> , for the same company <input type="checkbox"/> Yes <input type="checkbox"/> No
			If <b>no</b> , name of new company: _____
Have you missed any work because of this injury?	<input type="checkbox"/>	<input type="checkbox"/>	If <b>yes</b> , what periods of time have you been off work?
			From ____/____/____ To ____/____/____
			From ____/____/____ To ____/____/____
Did you have to change jobs because of this injury?	<input type="checkbox"/>	<input type="checkbox"/>	If <b>yes</b> , are you back to your old job? <input type="checkbox"/> Yes <input type="checkbox"/> No
Has continuing to work made your condition worse?	<input type="checkbox"/>	<input type="checkbox"/>	
Have you been fired or laid-off from the company where you were injured?	<input type="checkbox"/>	<input type="checkbox"/>	
Did a doctor examine you before starting work ( <i>did you have a pre or post employment physical</i> )? If <b>yes</b> , answer the 3 questions below:	<input type="checkbox"/>	<input type="checkbox"/>	
Did they find anything wrong with your health?	<input type="checkbox"/>	<input type="checkbox"/>	If <b>yes</b> , please explain: _____
			_____
Were x-rays taken?	<input type="checkbox"/>	<input type="checkbox"/>	If <b>yes</b> , what body part: _____
			_____
When you began work did you start with any work restrictions?	<input type="checkbox"/>	<input type="checkbox"/>	If <b>yes</b> , please explain: _____
			_____
Are there any sports/hobbies/activities that you can no longer do because of your injury?	<input type="checkbox"/>	<input type="checkbox"/>	If <b>yes</b> , please explain: _____
			_____
Have you ever had any other Worker's Compensation injury(s)?	<input type="checkbox"/>	<input type="checkbox"/>	If <b>yes</b> , please explain: _____
			_____
Are you represented by an attorney?	<input type="checkbox"/>	<input type="checkbox"/>	If <b>yes</b> , by whom: _____

At the time of your injury, were you **also** working at another job (for more than one employer)?  Yes  No

If **yes**, answer the questions below:

Name and location of other employer(s): \_\_\_\_\_

Describe work duties for other employer(s): \_\_\_\_\_

Dates you have worked this job: From \_\_\_\_/\_\_\_\_/\_\_\_\_ To \_\_\_\_/\_\_\_\_/\_\_\_\_ Number of years \_\_\_\_\_

Hours per week worked:  <5  6-15  16-25  26-35  36-45  46-55  >55

Did you sustain an injury?  Yes  No If yes, please explain: \_\_\_\_\_

**Employment History:** Please list your last four (4) jobs with the most recent job first:

Dates of Employment	Employer	Job Title	Duties
From _____ To _____	_____	_____	_____
From _____ To _____	_____	_____	_____
From _____ To _____	_____	_____	_____
From _____ To _____	_____	_____	_____

**Work Duties:** Please list your usual job activities as follows. Please assume an 8 hour day, even if that does not apply.

**Occasionally** means approximately 25 percent of the time • **Intermittently** means approximately 50 percent of the time  
**Frequently** means approximately 75 percent of the time • **Constantly** means approximately 90 to 100 percent of the time

	Never	Occasionally	Intermittently	Frequently	Constantly
Sitting	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Standing	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Walking	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Climbing	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Reaching	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Twisting	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Bending	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Squatting	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Crawling	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Push/Pull	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Kneeling	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Lifting 1-10 lbs.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
11-24 lbs.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
25-50 lbs.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
51-74 lbs.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
>75 lbs.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Typing	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Driving	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Number of years doing this type of work:  <3 mo.  3-6 mo.  6 mo.- 1 yr.  1-2 yrs.  3-5 yrs.  6-8 yrs.  >8 yrs.

\_\_\_\_\_  
Patient Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
M.D. Signature

\_\_\_\_\_  
Date