

Center For Neurological Surgery, A Medical Group, Inc.  
Mark S. Schnitzer, M.D.

Surgery of the Nervous System and Spine  
(714) 525-7177 (562) 698-2054

**Workers' Compensation Information Sheet**

Patient Information:

Patient Name:	
Home Street Address:	
City, State, Zip Code:	
Home Phone Number:	( )
Work Phone Number:	( )
Social Security Number:	
Date of Birth (mm/dd/yyyy):	
Sex:	
Marital Status:	

Employer Information:

Company Name:	
Street Address:	
City, State, Zip Code:	
Name of Supervisor or Contact:	
Date of Injury (mm/dd/yyyy):	
Date last Worked (mm/dd/yyyy):	
Length of time with this Employer?:	

Insurance Company Information:

Name of Insurance Company:	
Street Address:	
City, State, Zip Code:	
Insurance Company Phone Number:	( )
Name of Adjuster:	
Adjuster's Phone Number:	( )
Claim Number:	

Referral Information:

Name of Individual/Company Referring:	
Phone Number:	( )
Diagnosis:	
WCAB #:	
Litigation (Yes/No)?:	
Interpreter (Yes/No/Language)?:	

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**History & Physical Exam**  
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<b>Patient Name:</b>	
<b>Today's Date:</b>	
<b>Referring Doctor:</b>	
<b>Family Doctor:</b>	

**ID:**

<b>How old are you?</b>	
<b>Are you right handed or left handed?</b>	
<b>What is your race?</b>	
<b>What is your sex?</b>	

**Past Surgical History:**

<b>Brain Surgery?</b>	<b>Yes</b>	<b>No</b>	
<b>Spine Surgery?</b>	<b>Yes</b>	<b>No</b>	
<b>Heart Surgery?</b>	<b>Yes</b>	<b>No</b>	
<b>Cancer/Tumor Surgery or Biopsy?</b>	<b>Yes</b>	<b>No</b>	
<b>Any Other Procedures? Describe:</b>	<b>Yes</b>	<b>No</b>	
<b>Any Problems With Anesthesia?</b>	<b>Yes</b>	<b>No</b>	
<b>Any Blood Transfusions?</b>	<b>Yes</b>	<b>No</b>	

**Prior Injuries:**

<b>Any prior, similar injuries?</b>	
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**Past Medical History:**

<b>Neurological Disorder (Alzheimer's, Multiple Sclerosis, Myasthenia Gravis, Seizures, Stroke etc.)? Describe:</b>	<b>Yes</b>	<b>No</b>	
<b>Heart Attack?</b>	<b>Yes</b>	<b>No</b>	
<b>High Blood Pressure?</b>	<b>Yes</b>	<b>No</b>	
<b>Irregular Heart Beat?</b>	<b>Yes</b>	<b>No</b>	
<b>Cancer? Describe:</b>	<b>Yes</b>	<b>No</b>	
<b>Thyroid Disease?</b>	<b>Yes</b>	<b>No</b>	
<b>Lung Disease (Asthma, Emphysema, etc.)? Describe:</b>	<b>Yes</b>	<b>No</b>	
<b>Diabetes?</b>	<b>Yes</b>	<b>No</b>	
<b>Ulcers?</b>	<b>Yes</b>	<b>No</b>	
<b>Any Other Conditions? Describe:</b>	<b>Yes</b>	<b>No</b>	

**Medications & Allergies:**

<b>What Medications do you Take?</b>		
<b>Do you Take <u>Aspirin</u> Regularly (<u>Not Tylenol, Motrin, etc.</u>)?</b>	<b>Yes</b>	<b>No</b>
<b>Do You Carry Nitroglycerin For Chest Pain?</b>	<b>Yes</b>	<b>No</b>
<b>What are you <u>Allergic</u> to?</b>		

**Any Diseases Run In The Family?**

<b>Father:</b>	
<b>Mother:</b>	
<b>Siblings:</b>	
<b>Other:</b>	

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**Review Of Systems...Any Recent...**

<b>Fever?</b>	<b>Yes</b>	<b>No</b>	
<b>Weight Change?</b>	<b>Yes</b>	<b>No</b>	
<b>Eye/Vision Problems?</b>	<b>Yes</b>	<b>No</b>	
<b>Ear/Nose/Throat Problems?</b>	<b>Yes</b>	<b>No</b>	
<b>Chest Pain?</b>	<b>Yes</b>	<b>No</b>	
<b>Shortness of Breath?</b>	<b>Yes</b>	<b>No</b>	
<b>Nausea/Vomiting?</b>	<b>Yes</b>	<b>No</b>	
<b>Incontinence?</b>	<b>Yes</b>	<b>No</b>	
<b>Musculoskeletal Problems?</b>	<b>Yes</b>	<b>No</b>	
<b>Skin Problems?</b>	<b>Yes</b>	<b>No</b>	
<b>Seizures?</b>	<b>Yes</b>	<b>No</b>	
<b>Psychiatric Condition?</b>	<b>Yes</b>	<b>No</b>	
<b>Do You Feel Hot/Cold/Thirsty?</b>	<b>Yes</b>	<b>No</b>	
<b>Abnormal Bruising/Glands?</b>	<b>Yes</b>	<b>No</b>	
<b>Risks for HIV/AIDS?</b>	<b>Yes</b>	<b>No</b>	

**Social History:**

<b>Marital Status?</b>	
<b>How Far Did You Go in School?</b>	
<b>Type Of Work? Describe Duties:</b>	
<b>Do You <b>Ever</b> Use Any Tobacco?</b>	
<b>Do You <b>Ever</b> Use Any Alcohol?</b>	
<b>Do You Ever Use Any "Recreational" Drugs?</b>	

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History...Briefly Tell Me, **In Your Own Words, What Brings You In.**

<b>When did it start?</b>	
<b>Where (on your body)?</b>	
<b>Continuous or Intermittent?</b>	
<b>When does it bother you?</b>	
<b>How bad is it? (1-10)</b>	
<b>Pain/Burning/Tingling/Weakness?</b>	
<b>What makes you Better? Worse?</b>	
<b>Anything else?</b>	