CRESTWOOD WORKERS CARE
7736 Madison Blvd • Huntsville, AL 35806
256-830-8930 • *fax* 256-830-8932

Patient Injury Recheck Form

Today's Date:______________

Name: ____ Date of Birth: __________________________

Gender: ☐ Male ☐ Female Social Security number______________________________

Employer: _______________________________ Job Title: ____

Where is your injury? ____ ☐ Left ☐ Right ☐ Both

Date/Time of Injury: ________________________________ Pain began: ☐ Suddenly ☐ Gradually

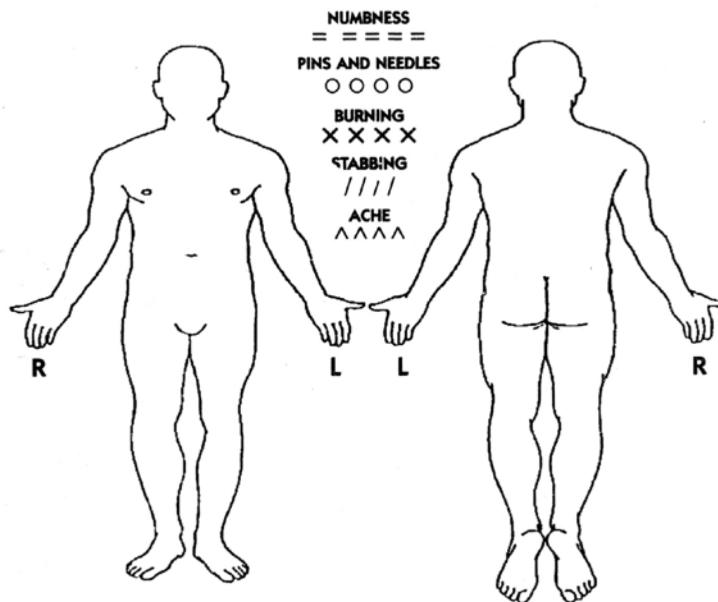
Briefly describe how the injury occurred: ____

____

Rate Your Pain:

AT ITS BEST No Pain 1 2 3 4 5 6 7 8 9 10

AT ITS WORST No Pain 1 2 3 4 5 6 7 8 9 10



What Makes Symptoms:

	Better	Worse
Walking	☐	☐
Standing	☐	☐
Sitting	☐	☐
Lying down	☐	☐
Bending	☐	☐
Twisting	☐	☐
Turning head	☐	☐
Raising arm	☐	☐
Deep breathing	☐	☐
Sudden movement	☐	☐
Coughing/sneezing	☐	☐
Hard gripping	☐	☐
Any movement	☐	☐
Nothing	☐	☐

What treatment have you attempted since the injury occurred?

☐ Nothing ☐ Ice ☐ OTC Meds: ____________________________________

☐ Prescription Meds: ____________________________________ ☐ Other: ______________________________

Has this treatment helped at all? ☐ Yes ☐ No

Have you ever injured this area previously? ☐ Yes ☐ No

Did you receive medical care at that time? ☐ Yes ☐ No

When: ______________________________ Where: ____

Medical History: Do you have any drug allergies? ☐ Yes ☐ No

Medication	Type of Reaction

List any medication you have taken this week: ☐ None

_____________________ _____________________ _____________________ _____________________

Last Tetanus Booster (year): ____________ Preferred Pharmacy/Location: _________________________________

Current Medical Problems (check all that apply): ☐ None

☐ Heart disease or heart attack	☐ Diabetes	☐ Depression/Anxiety
☐ Pacemaker	☐ Asthma	☐ Osteoporosis
☐ High blood pressure	☐ Emphysema/COPD	☐ Liver problems
☐ Irregular heart beat	☐ Ulcers or Reflux	☐ Kidney problems
☐ Stroke	☐ Thyroid Disease	☐ Back pain
☐ Blood Clots/DVT	☐ Arthritis/Gout	☐ Cancer - Type: ______________
☐ Bleeding condition	☐ Fibromyalgia	
☐ Seizures	☐ Neuropathy	

Surgical History: ☐ None

Type of Surgery	Year	Type of Surgery	Year

Social History:

Marital Status:	☐ Single	☐ Married	☐ Separated/Divorced	☐ Widowed
Tobacco use:	☐ None	☐ Smoke ______ packs/day	☐ Former Smoker	Years Smoked: _______
Alcohol use:	☐ None	☐ Occasional/Social	☐ Daily	
Family History:	☐ None	☐ ____		

Review of Systems:

		YES	NO		YES	NO		YES	NO
General:	Weight loss	☐	☐	Fatigue	☐	☐	Recurrent fevers	☐	☐
Skin:	Rash	☐	☐	Ulceration	☐	☐	Excessive dryness	☐	☐
Hematologic:	Bruising	☐	☐	Easy bleeding	☐	☐	Swollen glands	☐	☐
Head / Face:	Headaches	☐	☐	Hair loss	☐	☐	Facial pain	☐	☐
Eyes:	Blurry	☐	☐	Dry eyes	☐	☐	Excessive tearing	☐	☐
ENT:	Ringing ears	☐	☐	Nosebleeds	☐	☐	Trouble swallowing	☐	☐
Heart:	Chest pain	☐	☐	Racing heart	☐	☐	Ankle/leg swelling	☐	☐
Lung / Chest:	Coughing	☐	☐	Congestion	☐	☐	Shortness of breath	☐	☐
GI:	Tarry stools	☐	☐	Bloody stools	☐	☐	Abdominal pain	☐	☐
Urinary:	Frequency	☐	☐	Blood in urine	☐	☐	Burning with urination	☐	☐
Musculoskeletal:	Muscle pain	☐	☐	Joint pain	☐	☐	Joint swelling	☐	☐
Neurologic:	Dizziness	☐	☐	Weakness	☐	☐	Unsteady walking	☐	☐

Patient's Signature: ____ Date: ____________________

OFFICE USE ONLY:

BP: ___________ P: __________ PO2: _________ T: __________ HT: ___________ WT: ___________ Vision: B_________L_________R_________

Reviewed by: ____________________ Date: ________________