RALPH N. STEIGER, M.D., INC.

Orthopaedic Surgery
Phone 626.814.9191 • Fax 626.960.0943

PATIENT INFORMATION SHEET

PATIENT'S NAME:____

ADDRESS(NO P.O. BOX):_______________________________________

CITY______________________**STATE**_______**ZIP CODE**______________

HOME PHONE #:________________**CELL PHONE #:**________________

E-MAIL:____________________**DRIVER LICENSE/I.D. #:**__________

__ Please email for appointment reminder

AGE:______**DOB:**________________**SS#:**____________________

PLEASE CIRCLE: *RIGHT HANDED/LEFT HANDED* *MALE/ FEMALE*

EMPLOYER:____

EMPLOYER ADDRESS:____

EMPLOYER PHONE #:______________**OCCUPATION:**________________

NOTIFY IN CASE OF EMERGENCY:______________**RELATION:**__________

ADDRESS:__________________________**PHONE #:**________________

SPOUSE'S NAME (OR PARENT/LEGAL GUARDIAN IF PATIENT IS A MINOR):
____

EMPLOYER OF SPOUSE/PARENT:_________________________________

ADDRESS:______________________________**PHONE #:**____________

SPOUSE/PARENT SSN:________________ **SPOUSE/PARENT DOB:**__________

I authorize payment of medical benefits to Ralph N. Steiger M.D. I agree to pay any balance of professional service charges which exceed insurance payment (excluding worker's compensation).

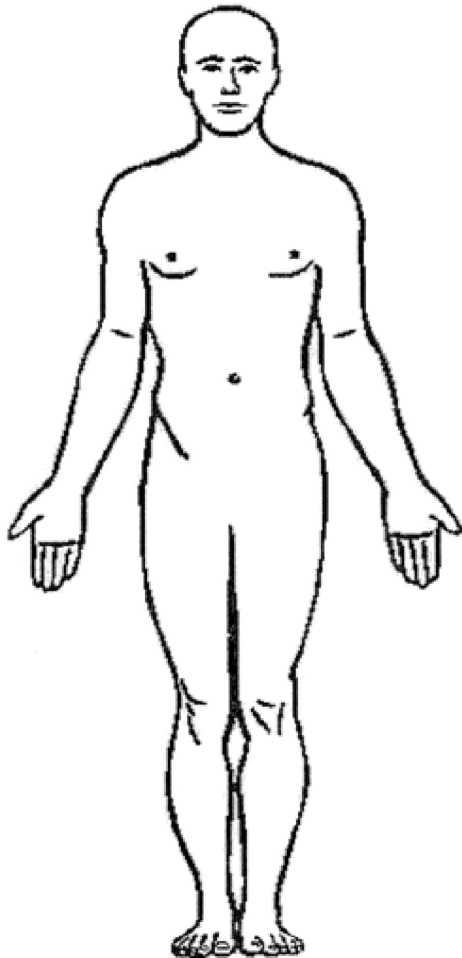
_______________________________ ______________

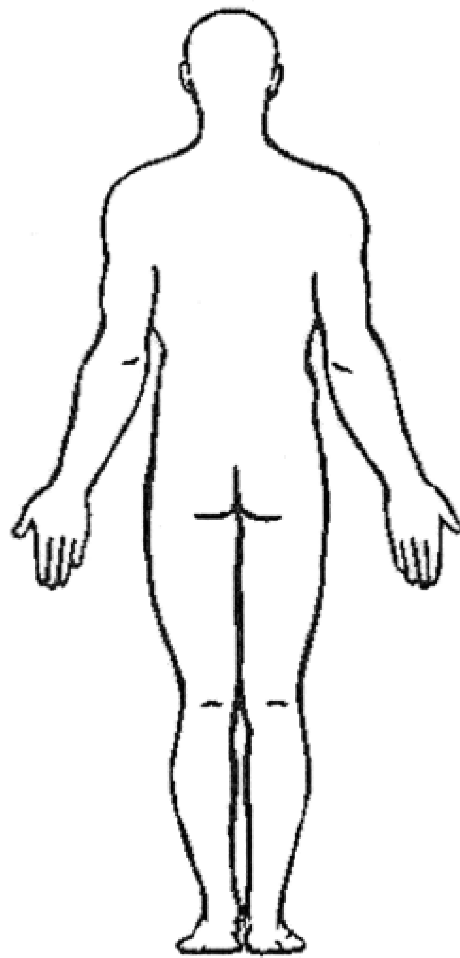
Patient's Signature (or authorized person) **Date**

NAME:____ DATE:________________________

DOI:____________________________

Please circle the body parts where you are having pain. Also mark if you are experiencing numbness (+++++), burning (//////), sharp/stabbing pain (~~~~~~) or tingling (<<<<<).





RALPH N. STEIGER, M.D., INC
Orthopaedic Surgery
1250 S. Sunset Avenue, Suite 350
West Covina, CA 91790
Phone 626.814.9191 Fax 626.960.0943

MEDICAL RECORDS RELEASE AUTHORIZATION

I, ___________________________, born on ___________________________, authorize ________________________________ to release any and all medical records concerning me to Ralph N. Steiger, M.D.

Signed ____________________________

Date ______________________________

Please fax to: (626) 960-0943

or mail to:

Ralph N. Steiger, M.D.
P.O. Box 550
West Covina, CA 91793-0550

DESCRIPTION OF EMPLOYEES JOB DUTIES

(THIS FORM PERTAINS TO JOB AT TIME OF INJURY)

NAME:____DATE:____________________________

Employer at the time of the injury: ______________________________________

Occupation at the time of injury: ____

List when you began and when you stopped working for the above company:

From: ______________________ To: _________________________

Hours per day __________ Days per week __________ Overtime __________

PHYSICAL REQUIREMENTS

Circle one for each requirement:

STAND:	Constant	Frequent	Occasionally	Not at all
WALK:	Constant	Frequent	Occasionally	Not at all
CLIMB:	Constant	Frequent	Occasionally	Not at all
SQUAT:	Constant	Frequent	Occasionally	Not at all
KNEEL:	Constant	Frequent	Occasionally	Not at all
SIT:	Constant	Frequent	Occasionally	Not at all
TWIST:	Constant	Frequent	Occasionally	Not at all
BEND:	Constant	Frequent	Occasionally	Not at all
PUSH:	Constant	Frequent	Occasionally	Not at all
PULL:	Constant	Frequent	Occasionally	Not at all
GRASP:	Constant	Frequent	Occasionally	Not at all
GRIP:	Constant	Frequent	Occasionally	Not at all
REACH:	Constant	Frequent	Occasionally	Not at all
OVERHEAD WORK:	Constant	Frequent	Occasionally	Not at all
TYPE/DATA INPUT:	Constant	Frequent	Occasionally	Not at all
WRITING:	Constant	Frequent	Occasionally	Not at all

Heaviest item lifted at work: Circle one

10 lbs 10-25 lbs 25-40 lbs 40-60 lbs 60-80 lbs 80-100 lbs 100+ lbs

Does the job require use of your feet to operate foot controls or for repetitive movement? YES NO

Does the job require you to work with or in:

Driving cars, trucks, forklifts or other moving equipment? YES NO

Working near hazardous equipment and machinery? YES NO

Walking on uneven ground? YES NO

Exposure to dust, gas or fumes? YES NO

Exposure to noise? YES NO

Exposure to extremes in temperature or humidity? YES NO

Work at heights of ____________________ feet?

Please provide a brief description of your job responsibilities at the time of the injury:

____

____

____

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EMPLOYEE'S MEDICAL ELECTION TO TREAT

Pursuant to Labor Code Section 4600 and 4601 I, ____, hereby elect Ralph N. Steiger, M.D., to provide all further medical treatment as my first choice physician for my industrial injury of _____________ (DATE OF INJURY)

____
Signed

____
Printed Name

____
Date

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MEDICAL RECORDS RELEASE AUTHORIZATION

I, ___________________________, authorize Ralph N. Steiger, M.D. to release any and all medical records concerning me to ___________________________ (Insurance Company)

____
Signed

____
Printed Name

____
Date

FUNCTION TEST

NAME: ______________________________
Date:____________

PLEASE CIRCLE THE NUMBER THAT CORRECTLY DESCRIBES YOUR PAIN

Rate how your pain is aggravated by Activity:

0 1 2 3 4 5 6 7 8 9 10

Rate how severe your pain is at its worst:

0 1 2 3 4 5 6 7 8 9 10

Rate how your pain is on the average:

0 1 2 3 4 5 6 7 8 9 10

Rate how severe your pain is right now, at this moment.

0 1 2 3 4 5 6 7 8 9 10

Rate how frequent you experience pain.

0 1 2 3 4 5 6 7 8 9 10

PLEASE CIRCLE THE NUMBER THAT CORRECTLY DESCRIBES THE LIMITATION OR INTERFERENCE THAT YOUR PAIN CAUSES.

How much does your pain interfere with your ability to walk 1 block?

0 1 2 3 4 5 6 7 8 9 10

How much does your pain prevent you from lifting 10 pounds?

0 1 2 3 4 5 6 7 8 9 10

How much does your pain interfere with your ability to sit for ½ hour?

0 1 2 3 4 5 6 7 8 9 10

How much does your pain interfere with your ability to stand for ½ hour?

0 1 2 3 4 5 6 7 8 9 10

NAME: <last>, <first>

How much does your pain interfere with your ability to get enough sleep?

0 1 2 3 4 5 6 7 8 9 10

How much does your pain interfere with your ability to participate in social activities?

0 1 2 3 4 5 6 7 8 9 10

How much does your pain interfere with your ability to travel up to 1 hour in a car?

0 1 2 3 4 5 6 7 8 9 10

In general how much does your pain interfere with your daily activities?

0 1 2 3 4 5 6 7 8 9 10

How much do you limit activities to prevent you pain from getting worse?

0 1 2 3 4 5 6 7 8 9 10

How much does your pain interfere with you relationship with your family/partner/significant others?

0 1 2 3 4 5 6 7 8 9 10

How much does your pain interfere with your ability to do jobs around your home?

0 1 2 3 4 5 6 7 8 9 10

How much does your pain interfere with your ability to shower or bath without help from someone else?

0 1 2 3 4 5 6 7 8 9 10

How much does your pain interfere with your ability to write or type?

0 1 2 3 4 5 6 7 8 9 10

How much does your pain interfere with your ability to dress yourself?

0 1 2 3 4 5 6 7 8 9 10

How much does your pain interfere with your ability to engage in sexual activities?

0 1 2 3 4 5 6 7 8 9 10

How much does your pain interfere with your ability to concentrate?

0 1 2 3 4 5 6 7 8 9 10

NAME: <last>, <first>

PLEASE CIRCLE THE NUMBER THAT CORRECTLY DESCRIBES THE EFFECT YOUR PAIN HAS ON YOU.

Rate your overall mood this past week:

0 1 2 3 4 5 6 7 8 9 10

During this past week, how anxious or worried have you been because of your pain?

0 1 2 3 4 5 6 7 8 9 10

During this past week, how depressed have you been because of your pain?

0 1 2 3 4 5 6 7 8 9 10

During this past week, how irritable have you been because of your pain?

0 1 2 3 4 5 6 7 8 9 10

In general, how anxious are you about performing activities because they might make your pain/symptoms worse?

0 1 2 3 4 5 6 7 8 9 10

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MEDICAL RECORDS RELEASE AUTHORIZATION

I, _____________________, authorize Ralph N. Steiger, M.D., to release any and all medical records concerning me to _______________________ (Attorney of Representation)

____
Signed

____
Printed Name

____
Date

WORK HISTORY

NAME: ________________________ Date: __________________

Please complete, giving details of your previous occupations prior to the injury you are being examined for today.

Occupation: ________________________________

List when you began and when you stopped working the above occupation:

From: _____________________ To: ________________________

BASIC PHYSICAL REQUIREMENTS:

____

____

____

Occupation: ________________________________

List when you began and when you stopped working the above occupation:

From: _____________________ To: ________________________

BASIC PHYSICAL REQUIREMENTS:

____

____

____

Occupation: ________________________________

List when you began and when you stopped working the above occupation:

From: _____________________ To: ________________________

BASIC PHYSICAL REQUIREMENTS:

____

____

____

ACTIVITIES OF DAILY LIVING

Name: ________________________ Date:________________________

How much does your injury interfere with the following activites?

Please mark the Difficulty range column for each item.

	Without Difficulty	**With Some Difficulty**	**With Much Difficulty**	**Unable To Do**
Self-care and Personal Hygiene:				
Getting on/off toilet	_____	_____	_____	_____
Wiping yourself after using toilet				
Urinating				
Defecating				
Brunshing Teeth				
Combing/brushing hair				
Washing/drying yourself				
Dressing yourself				
Tying shoes				
Physical Activites:				
Sitting				
Reclining				
Rising up from chair				
Standing				
Walking				
Climbing Stairs				
Working outdoors on flat ground				
Light housework including laundry				
Lifting				
Hand Activities:				
Grasping/Gripping				
Open milk carton				
Open previously opened jars				
Turn faucets on and off				
Open a car door				
Lifting				
Lift full cup/bottle/glass to mouth				
Make a meal				
Eating				
Cut food				

Name: <first> <last> Date:________________________

How much does your injury interfere with the following activites?

Please mark one column for each item.

	Without	**With Some**	**With Much**	**Unable**
Travel:				
Riding in a motor vehicle				
Driving a motor vehicle				
Getting in/out of car				
Flying				
Sexual Function:				
Engage in sexual function				
Sleep:				
Restful Sleep				
Fatigue during the day				
Communitcation:				
Writing				
Typing				
Sensory Function:				
Feel what you touch				
Tasting				
Smelling				
Hearing				
Seeing				

** Please Complete #'s 1-17 Only Please **

STATE OF CALIFORNIA

DOCTOR'S FIRST REPORT OF OCCUPATIONAL INJURY OR ILLNESS

Within 5 days of your initial examination, for every occupational injury or illness, send two copies of this report to the employer's workers' compensation insurance carrier or the insured employer. Failure to file a timely doctor's report may result in assessment of a civil penalty. In the case of diagnosed or suspected pesticide poisoning, send a copy of the report to Division of Labor Statistics and Research, P.O. Box 420603, San Francisco, CA 94142-0603, and notify your local health officer by telephone within 24 hours.

			PLEASE DO NOT USE THIS COLUMN
1. **INSURER NAME AND ADDRESS**			
2. **EMPLOYER NAME**			Case No.
3. Address No. and Street City Zip			Industry
4. Nature of business (e.g., food manufacturing, building construction, retailer of women's clothes.)			County
5. **PATIENT NAME** (first name, middle initial, last name)	6. Sex Male Female	7. Date of Birth Mo. Day Yr.	Age
8. Address: No. and Street City Zip		9. Telephone number ( )	Hazard
10. Occupation (Specific job title)		11. Social Security Number - -	Disease
12. Injured at: No. and Street City County			Hospitalization
13. Date and hour of injury or onset of illness Mo. Day Yr. Hour ________ a.m. ________ p.m.		14. Date last worked Mo. Day Yr.	Occupation
15. Date and hour of first examination or treatment Mo. Day Yr. Hour ________ a.m. ________ p.m.		16. Have you (or your office) previously treated patient? Yes No	Return Date/Code

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.

17. **DESCRIBE HOW THE ACCIDENT OR EXPOSURE HAPPENED.** (Give specific object, machinery or chemical. Use reverse side if more space is required.)

18. **SUBJECTIVE COMPLAINTS** (Describe fully. Use reverse side if more space is required.)

19. **OBJECTIVE FINDINGS** (Use reverse side if more space is required.)
   A. Physical examination

   B. X-ray and laboratory results (State if non or pending.)

20. **DIAGNOSIS** (if occupational illness specify etiologic agent and duration of exposure.) Chemical or toxic compounds involved? Yes No
ICD-9 Code ___ ___ ___ - ___ ___

21. Are your findings and diagnosis consistent with patient's account of injury or onset of illness? Yes No If "no", please explain.

22. Is there any other current condition that will impede or delay patient's recovery? Yes No If "yes", please explain.

23. **TREATMENT RENDERED** (Use reverse side if more space is required.)

24. If further treatment required, specify treatment plan/estimated duration.

25. If hospitalized as inpatient, give hospital name and location Date admitted Mo. Day Yr. Estimated stay

26. WORK STATUS -- Is patient able to perform usual work? Yes No
   If "no", date when patient can return to: Regular work ____/____/____
   Modified work ____/____/____ Specify restrictions ____

Doctor's Signature ____ CA License Number ________________________________

Doctor Name and Degree (please type) ____ IRS Number ________________________________

Address ____ Telephone Number (_____)__________________________

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Any person who makes or causes to be made any knowingly false or fraudulent material statement or material representation for the purpose of obtaining or denying workers' compensation benefits or payments is guilty of a felony.