Newhall Family Chiropractic & Acupuncture

# Pre-Employment History and Physical Form

## Personal Data

| | | | |
|---|---|---|---|
| Name (Last, First, MI): | | | SSN: |
| Date of Birth: / / Age: | | Ethnicity: | |
| Phone Numbers: | Home ( ) - | Mobile ( ) - | Work ( ) - |
| Address: | | | |
| (street) | (city) | (state) (zip) | |
| Job Title & Department: | | Union: ☐ Yes ☐ No If yes, specify: | |

## Current Medical Provider

| | |
|---|---|
| Name of doctor: | Phone Number: ( ) - |
| Address: | |
| (street) (city) (state) (zip) | |

## Prior Employment Start with most recent job

| | Job Title | Employer/City/State | Dates of employment (mo/yr) |
|---|---|---|---|
| 1 | | | / to / |
| 2 | | | / to / |
| 3 | | | / to / |
| 4 | | | / to / |

## Review of Symptoms

| Do you have any of the following?: | Yes | No | Do you have any of the following?: | Yes | No |
|---|---|---|---|---|---|
| Weight loss / Weight gain (circle) | | | Palpitations or skipped beats | | |
| Fevers | | | Chest pain or tightness | | |
| Headaches | | | Indigestion/heartburn | | |
| Difficulty with vision / Wear lenses or glasses | | | Abdominal pain | | |
| Dizziness / Vertigo | | | Diarrhea/constipation | | |
| Difficulty hearing | | | Irregular periods | | |
| Seasonal allergies | | | Frequent urinary tract infections | | |
| Sinus problems | | | Kidney stones | | |
| Tiredness or falling asleep during the day | | | Back pain | | |
| Unable to tolerate heat or cold | | | Joint pain or swelling | | |
| Shortness of breath with or without exertion | | | A history of broken bones | | |
| Wheezing | | | Swelling of the legs | | |
| Cough | | | Skin problems (rash, eczema, psoriasis) | | |

## Vaccination History/Communicable Diseases

| Have you had: | Yes | No | Unsure |
|---|---|---|---|
| The standard series of childhood vaccinations (to the best of your knowledge)? | | | |
| The disease "chicken pox" or the chicken pox vaccine (varicella)? | | | |
| A tetanus/diphtheria booster shot within the last 10 years? | | | |
| Hepatitis B vaccination (this is a series of three injections spaced several months apart)? | | | |
| The disease "Tuberculosis"? | | | |
| A positive tuberculosis test (also called a PPD or Tine test)? | | | |
| Vaccination against tuberculosis with BCG (this is uncommon in the United States)? | | | |

**Have you ever had:** a car accident loss of consciousness heart attack loss of vision abnormal heart rhythm seizure panic attacks head injury stroke paralysis back injury psychiatric disorder

## *Current* Medical Conditions Those that you are currently experiencing and/or receiving treatment for (such as diabetes, high blood pressure, migraine)

| Please List | | Date of onset (mo/yr) | Please List | | Date of onset (mo/yr) |
|---|---|---|---|---|---|
| 1 | | / | 5 | | / |
| 2 | | / | 6 | | / |
| 3 | | / | 7 | | / |
| 4 | | / | 8 | | / |

## *Past* Medical Conditions Those that you have had in the past but have recovered from (such as childhood asthma, gestational diabetes)

| Please List | | Date of onset (mo/yr) | Please List | | Date of onset (mo/yr) |
|---|---|---|---|---|---|
| 1 | | / | 3 | | / |
| 2 | | / | 4 | | / |

## Surgeries/Hospitalizations List type of surgery (such as gall bladder) or condition for which you were hospitalized (such as heart attack, pneumonia)

| Please List | | Date (mo/yr) | Please List | | Date (mo/yr) |
|---|---|---|---|---|---|
| 1 | | / | 4 | | / |
| 2 | | / | 5 | | / |
| 3 | | / | 6 | | / |

**When was your last visit to the emergency room? _____ For what symptom/condition? _____**

## Family History Please list any conditions that run in your biological family (even if relative is deceased)

| Please List | | Circle affected relative | Please List | | Circle affected relative |
|---|---|---|---|---|---|
| 1 | | Father / Mother / Sister / Brother / Child / Grandmother / Grandfather | 4 | | Father / Mother / Sister / Brother / Child / Grandmother / Grandfather |
| 2 | | Father / Mother / Sister / Brother / Child / Grandmother / Grandfather | 5 | | Father / Mother / Sister / Brother / Child / Grandmother / Grandfather |
| 3 | | Father / Mother / Sister / Brother / Child / Grandmother / Grandfather | 6 | | Father / Mother / Sister / Brother / Child / Grandmother / Grandfather |

## Medications Please include non-prescription medications, vitamins, and herbal supplements in addition to prescription medications

| | | | | | |
|---|---|---|---|---|---|
| 1 | | 4 | | 7 | |
| 2 | | 5 | | 8 | |
| 3 | | 6 | | 9 | |

**Do you have any allergies to medications or other substances?** ☐ **Yes** ☐ **No** (if yes, please specify on next line)

_____

## Social History

| | |
|---|---|
| Do you smoke cigarettes? yes / no / used to smoke, but quit | If yes, how many cigarettes per day? _____ Per week? _____ |
| How many alcoholic drinks do you consume per day? _____ Per week? _____ | Do you use illicit/illegal drugs? yes / no |
| How many minutes of exercise do you get per day? _____ | How many days a week do you exercise? _____ |
| How many hours of television do you watch per day? _____ | How many times do you eat fast food per week? _____ |

## Occupational Assessment

| **Please answer the following questions regarding the job for which you have been hired:** | **Yes** | **No** | **Unsure** |
|---|---|---|---|
| Will you be required to wear respiratory protection (e.g., N95 mask or cartridge respirator)? | | | |
| Do you anticipate working with hazardous chemicals or materials, infectious agents, or laboratory animals? | | | |
| Is there a chance that you will be exposed to human blood or body fluids as a result of routine job duties? | | | |
| If your job involves work at a computer, have you had or are you experiencing any discomfort, pain, or numbness when working at your desk? | | | |
| Will you be required to drive a vehicle for any reason? | | | |
| Will you be required to move heavy objects regularly (i.e., greater than 50 pounds occasionally or 25 pounds frequently)? | | | |
| Have you ever had an occupational injury/illness before (e.g., back strain, needle-stick, chemical exposure)? | | | |

**Do you have any condition (physical, medical, or psychological) that would require special accommodations in order for you to perform your job?** ☐ **Yes** ☐ **No** (if yes, please specify on next line)

_____

Signature of employee: _____ Date: _____

Practitioner Notes: _____

_____

_____

_____

_____

_____

_____

_____

## Physical Examination

| Height | Weight | BMI | Blood Pressure | Pulse | Respirations | Temperature |
|---|---|---|---|---|---|---|
| | | | | | | |

Vision: Uncorrected / Corrected (circle): Left - ____/____ Right - ____/____ Both - ____/____

HEENT: _____

Neck: _____

Chest/Lungs: _____

Heart: _____

Abdomen: _____

Musculoskeletal: _____

Neurological: _____

Skin: _____

Other: _____

Assessment: _____

_____

_____

_____

_____

_____

_____

Practitioner signature: _____ Date: _____

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