

**SCOR**  
*San Clemente Orthopaedic Rehabilitation*

*Rancho Santa Margarita*  
*Physical Therapy and Sports Medicine*

**PATIENT INFORMATION & BRIEF HISTORY**

**WORKER'S COMPENSATION CLAIM**

Patient's Name \_\_\_\_\_ Date \_\_\_\_\_  
 Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_  
 Home Phone \_\_\_\_\_ Age \_\_\_\_\_ Birth Date \_\_\_\_\_  
 SS# \_\_\_\_\_ Driver's License # \_\_\_\_\_  
 Marital Status \_\_\_\_\_ Spouse's Name \_\_\_\_\_  
 Employer \_\_\_\_\_  
 Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_  
 Work Phone \_\_\_\_\_ Supervisor's Name \_\_\_\_\_  
 Referred to this office by Doctor \_\_\_\_\_  
 Date of Injury \_\_\_\_\_ Date of Surgery \_\_\_\_\_  
 How did this injury occur? \_\_\_\_\_  
 Have you had previous physical therapy for your present condition for which you are to receive treatment here? Yes No  
 If yes, state where: \_\_\_\_\_ When? \_\_\_\_\_

Do you now have or had any of the following:

Diabetes	Yes	No	Sensitive to Heat / Ice	Yes	No
High Blood Pressure	Yes	No	Pregnant	Yes	No
Heart Disease	Yes	No	Other Allergies	Yes	No
Heart Attack	Yes	No	Previous Surgery	Yes	No
Pacemaker	Yes	No	Hernia (any)	Yes	No
Headaches	Yes	No	Seizures	Yes	No
Kidney Problems	Yes	No	Metal Implants	Yes	No
Nervous Disorders	Yes	No			

If yes to any of the above, please explain and give approximate dates: \_\_\_\_\_

Are you presently taking medications? Yes No If yes, please list what medications and for what condition: \_\_\_\_\_

The above information is correct to the best of my knowledge.

I hereby render my consent for evaluation and treatment of my injury / illness to Rancho Santa Margarita Physical Therapy and Sports Medicine (RSMPT) Orthopaedic Rehabilitation.

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

W/C Ins. \_\_\_\_\_ Phone # \_\_\_\_\_

Address \_\_\_\_\_ Fax # \_\_\_\_\_

Claim # \_\_\_\_\_

Adjustor \_\_\_\_\_ Auth. by \_\_\_\_\_

Case Manager \_\_\_\_\_ Phone # \_\_\_\_\_