

\*\*\* PLEASE PRINT \*\*\*

OCCUPATIONAL HISTORY

Please describe your current job: \_\_\_\_\_

How long have you worked at your current job? \_\_\_\_\_

How many hours per week do you work? \_\_\_\_\_

Does your work involve:

Standing:  No  Yes If yes, how long at a time? \_\_\_\_\_

Driving:  No  Yes If yes, how long at a time? \_\_\_\_\_

Walking:  No  Yes If yes, how long at a time? \_\_\_\_\_

Lifting:  No  Yes If yes, how many lbs. more than 6-8 times per hour? \_\_\_\_\_  
If yes, how many lbs. less than 6 times per hour? \_\_\_\_\_

Sitting:  No  Yes If yes, how many hours per day? \_\_\_\_\_

How much work have you missed in the last month due to pain? \_\_\_\_\_

**Treatment Goals** List at least four goals of your treatment.

- Return to work
- Be more active and function
- Play with kids
- Play with grandkids
- Have sexual relations
- Participate in sports
- \_\_\_\_\_
- \_\_\_\_\_

I certify that I have answered truthfully all the questions, and have not knowingly withheld any information concerning any of the above problems, either past or present.

\_\_\_\_\_  
Patient's Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Physician's Signature

\_\_\_\_\_  
Date