

COMPENSATION HISTORY: SPECIFIC OR CONTINUOUS TRAUMA

CAUSE OF INJURY: VEHICLE WORK (SPECIFIC) SLIP & FALL SPORTS INJURY CONTINUOUS TRAUMA

WHERE DID PATIENT DEVELOP GRADUAL PAIN?

DONDE EMPESO EL DOLOR

	RIGHT DERECHO	LEFT IZQUIRDO	BOTH LOS DOS		
HEAD CABEZA	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		
NECK CUELLO	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		
FOREHEAD FRENTE	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		
UPPER BACK ESPALDA	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		
BACK	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		
LOWER BACK CINTURA	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		
CHEST PECHO	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		
KIDNEYS BINONES	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		
EYES OJOS	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		
CHEEK CACHETES	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		
NOSE NARIZ	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		
CHIN BARBA	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		
MOUTH BOCA	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		
SHOULDER HOMORO	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		
ARM BRAZOS	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		
FOREARM ANTE BRAZO	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		
ELBOW CADO	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		
WRIST MUNECA	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		
HAND MANO	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		
FINGERS DEDOS	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		
ABDOMEN	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		
PELVIS	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		
HIP CADERA	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		
LEGS PIERNA	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		
KNEES RODILLA	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		
ANKLES TOBILLO	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		
FEET PIE	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		
RIGHT TOES DEDOS DERECHO	1ST	2ND	3RD	4TH	5TH
LEFT TOES DEDOS IZQUIRDOS	1ST	2ND	3RD	4TH	5TH

DESCRIBE THE ACCIDENT:

DESCRIBE EL ACCIDENTE

WAS PATIENT SUBJECTED TO:

<p>HARRASSMENT</p> <p>HUMILIATION</p> <p>MISTREATMENT</p> <p>OVERCROWDING</p> <p>PRESSURE</p>	<p>SEXUAL HARRASMENT</p> <p>STRESS</p> <hr/> <hr/> <hr/> <hr/> <hr/>
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