Workers' Compensation Questionnaire

Patient: PLEASE PRINT

First Name_____ M.I._____ Last_____
Home Address_____ Apt # _____
City_____ State_____ Zip_____
Home Phone_____ Cell Phone_____
Work Phone_____E-mail Address _____
Birthdate: _____/_____/_____ Gender: □ M □ F Age:_____
Social Status: ☐Single ☐Married ☐Divorced ☐Widowed ☐Separated
Social Security Number _____
How did you hear about us? □Coupon/Gift Cert. □Internet □Banner □Referred By:_____
Employer Name_____ Occupation_____
Employer Address_____
Claim # _____

Who to Contact in Case of Emergency:

Name_____ Relation to Patient_____
Home Phone _____ Work phone_____ Ext_____

Accident Information:

Give time and date of accident_____
Please explain in detail how your accident happened_____
_____
_____
_____
Did you feel pain immediately after the accident? ☐ Yes ☐ No If yes, Where?_____
Did you return to work? ☐ Yes ☐ No If so, date returned_____
Did you consult a doctor? ☐ Yes ☐ No If so, date name of doctor_____
Doctor's Diagnosis (if you saw another Dr.) _____
What treatment did you receive?_____
Pains are: ☐ Sharp ☐ Dull ☐ Throbbing ☐ Aching ☐ Numbness ☐ Shooting
☐ Burning ☐ Tingling ☐ Spasm ☐ Stiffness ☐ Swelling ☐ Other_____
Since this injury are your symptoms ☐ Better ☐ Worse ☐ Same
How do you feel in the a.m.? ☐ Better ☐ Worse ☐ Same
How do you feel in the p.m.? ☐ Better ☐ Worse ☐ Same
Activities or movements that are difficult to perform:
☐ Sitting ☐ Standing ☐ Walking ☐ Bending ☐ Lying Down ☐ Other_____
What treatment have you already received for this condition? ☐ Medications ☐ Physical Therapy
☐ Surgery ☐ Chiropractic ☐ None ☐ Other_____
Activities or movements that improve the condition:_____
Are your work activities restricted as a result of this accident? ☐ Yes ☐ No
Any radiation of pain into an extremity?_____Where?_____
Does any position relieve your condition? ☐ Yes ☐ No If yes, where_____
Location of pain_____

Patient Name_____ **Date**_____

Is the pain: ☐ Occasional (0-25%) ☐ Intermittent (25-50%) ☐ Frequent (50-75%) ☐ Constant (75-100%)

List of medication taken for this condition_____

Has a doctor recommended surgery? ☐ Yes ☐ No

Have you been disabled due to the accident? ☐ Yes ☐ Partially ☐ Totally ☐ No

Do you have a history of absenteeism caused from accidents on the job? ☐ Yes ☐ No

Explain_____

Before the injury were you capable of working on an equal basis with others your age? ☐ Yes ☐ No

Have you ever had a worker's compensation claim before? ☐ Yes ☐ No If so, date?_____

Have you ever injured this area? ☐ Yes ☐ No If so, when/where?_____

If injured before, do you lose time from work? ☐ Yes ☐ No

Give name and doctor who treated this injury before_____

Do any other diseases or accidents affect your employment? ☐ Yes ☐ No

Explain_____

Check symptoms you have noticed *SINCE THE ACCIDENT*:

☐ Headache	☐ Neck Pain	☐ Neck Stiffness	☐ Insomnia	☐ Tension
☐ Irritability	☐ Loss of Taste	☐ Loss of Smell	☐ Loss of Memory	☐ Diarrhea
☐ Neuritis	☐ Anxiety	☐ Fainting	☐ Chest pain	☐ Dizziness
☐ Constipation	☐ Depression	☐ Eye strain	☐ Nausea, vomiting	☐ Face flushed
☐ Palpitation	☐ Tremors	☐ Pallor	☐ Sinus trouble	☐ Mental Dullness
☐ Extreme Nervousness	☐ Extreme Fatigue	☐ Pain Behind Eyes	☐ Double Vision	☐ Digestive Disorder
☐ Equilibrium Disorder	☐ Head seems too heavy	☐ Shortness of breath	☐ Excessive perspiration	☐ Upper back- pain, stiff
☐ Mid-back- pain, stiff	☐ Feet cold; Hands cold	☐ Restricted Neck Motion	☐ Buzzing/Ringing Ears	☐ Eyes Sensitive to light
☐ Head/Shoulders Feel tired/heavy	☐ Pins and Needles in arms/legs	☐ Numbness in fingers/arms/legs	☐ Difficulty in prolonged riding in car	☐ Difficulty in excessive Lifting
☐ Neck/Low Back pain/stiffness upon rising	☐ Pain radiating into right/left/both arms/leg	☐ Difficulty in excessive standing/walking/bending	☐ Difficulty in excessive turning/twisting	☐ Difficulty in rising to walk after sitting

Mark only those conditions that you have either had in the past or currently have:

☐ AIDS/HIV	☐ Depression	☐ Liver Disease	☐ Psychiatric Care
☐ Alcoholism	☐ Diabetes	☐ Measles	☐ Rheumatoid Arthritis
☐ Allergies	☐ Emphysema	☐ Migraine Headaches	☐ Rheumatic Fever
☐ Anemia	☐ Epilepsy	☐ Miscarriage	☐ Sinus Problems
☐ Anorexia	☐ Fractures	☐ Mononucleosis	☐ Stroke
☐ Appendicitis	☐ Glaucoma	☐ Multiple Sclerosis	☐ Suicide Attempt
☐ Arthritis	☐ Goiter	☐ Mumps	☐ Thyroid Problems
☐ Bleeding Disorder	☐ Gonorrhea	☐ Osteoporosis	☐ Tonsillitis
☐ Breast Lump	☐ Gout	☐ Pacemaker	☐ Tuberculosis
☐ Bronchitis	☐ Heart Disease	☐ Parkinson's Disease	☐ Tumors, Growths
☐ Bulimia	☐ Hepatitis	☐ Pinched Nerve	☐ Typhoid Fever
☐ Cancer	☐ Hernia	☐ Pneumonia	☐ Ulcers
☐ Cataracts	☐ Herniated Disc	☐ Polio	☐ Vaginal Infections
☐ Chemical Dependency	☐ Herpes	☐ Psychiatric Problems	☐ Venereal Disease
☐ Chicken Pox	☐ High Cholesterol	☐ Prostate Problems	☐ Other_____

Patient Name_____ **Date**_____

Personal Health History

- Please list *ALL* Surgeries you've had:_____

_____

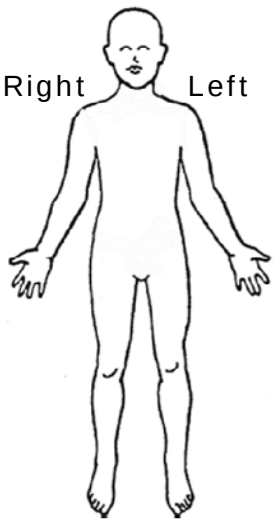
- Allergies: _____
- Please list *ALL* Medications you are taking?_____

_____

- Are you Pregnant? ☐ YES ☐ NO Nursing? ☐ YES ☐ NO Taking Birth Control? ☐ YES ☐ NO
- Do you Smoke? ☐ Yes ☐ No if Yes, how much? _____ packs/day
- Do you Drink Alcohol? ☐ Yes ☐ No How Much? _____glass/ (circle one) Day Week Month Year
- How much do you exercise? _____minutes/ (circle one) Day Week Month Year

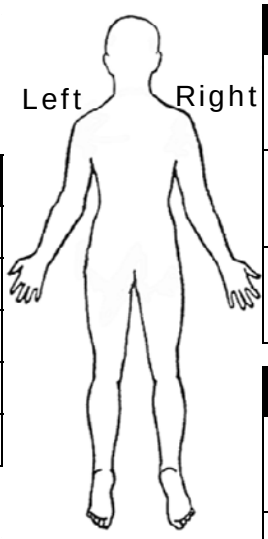
Pain Diagram:

On the drawings below, please indicate where you are experiencing pain by drawing the letter abbreviations on the diagrams that most accurately reflect the type of discomfort you have been experiencing.



Front

Key
xxx Stabbing
ooo Pins & Needles
= = = Numbness
+++ Aching
//// Burning



Back

Complaint #1 (Circle One)
Better Pain at Present: Worse
0—1—2—3—4—5—6—7—8—9—10
Pain at its Worse:
0—1—2—3—4—5—6—7—8—9—10
Pain at its Best:
0—1—2—3—4—5—6—7—8—9—10

Complaint #2 (Circle One)
Better Pain at Present: Worse
0—1—2—3—4—5—6—7—8—9—10
Pain at its Worse:
0—1—2—3—4—5—6—7—8—9—10
Pain at its Best:
0—1—2—3—4—5—6—7—8—9—10

Informed Consent:

I certify that I have read and understand the information I have provided to the best of my knowledge. The above questions have been accurately answered. I understand that providing incorrect information can be dangerous to my health. I Hereby request and consent to the performance of chiropractic adjustments and other chiropractic procedures, including various modes of physical modalities and diagnostic xrays, on me or the patient for whom I am legally responsible by the doctor of chiropractic who now or in the future treats me while employed at Raab Chiropractic Clinic. I have had an opportunity to discuss with the doctor of chiropractic and/or with other personnel the nature and purpose of chiropractic adjustments and procedures. I understand that results are not guaranteed. I understand and am informed that, as in the practice of medicine, in the practice of chiropractic there are some risks to treatment, including, but not limited to, fractures, disc injuries, strokes, dislocations and sprains. I do not expect the doctor to be able to anticipate and explain all risks and complications, and I wish to rely on the doctor to exercise judgment during the course of the procedure

I have read the above consent. I have also had an opportunity to ask questions about its content and by signing below I agree to the above named procedures. I intend to consent to cover the entire course of treatment for my present condition and for any future condition(s) for which I seek treatment.

SIGN HERE _____Date_____

Acknowledgement of Receipt of Notice of Privacy Practices

I acknowledge that I have been provided the Raab Chiropractic Notice of Privacy Practices ("Notice"):

- It tells me how Raab Chiropractic will use my health information for the purposes of my treatment, payment for my treatment, and Raab Chiropractic health care operations.
- The Notice also explains in more detail how Raab Chiropractic may use and share my health information for other than treatment, payment, and health care operations.
- Raab Chiropractic will also use and share my health information as required/permitted by law.

Patient's Complete Legal Name: _____

SIGN HERE _____Date_____
(Patient or Legally Authorized Representative)

Relationship of Legally Authorized Representative to Patient:_____

Financial Agreement

I understand and agree that health and accident policies are an arrangement between an insurance carrier and myself. Furthermore, I understand that Raab Chiropractic will prepare any necessary reports and forms to assist me in making collection from the insurance company and that any amount authorized to be paid directly to Raab Chiropractic & Massage Therapy will be credited to my account on receipt. However, I clearly understand and agree that all services rendered me are charged directly to me and that I am personally responsible for payment for services rendered. A late charge of 1.5% per month (but not to exceed lawful maximum) may be added to any amount sixty (60) days past due if not received prior to the next billing date. I also understand that if I suspend or terminate my care, any fees for professional services rendered me will be immediately due and payable.

SIGN HERE _____Date:_____