

WORK / COMP HISTORY

Patient _____ Phone () _____

Address _____ City _____ State _____ Zip _____

Age _____ Birthdate _____ Sex _____ S/S # _____

Name of Compensation Carrier: _____ Phone () _____

Address of Carrier: _____ City _____ State _____ Zip _____

Employer's Name: _____ Phone () _____

Employer's Address: _____ City _____ State _____ Zip _____

1. Type of Business _____ Your Occupation _____

2. Date Injured _____ Hour _____ AM / PM Last Date Worked _____ Are you off work? () Yes () No

3. Previous Workers' Compensation Injury? () Yes () No

4. Accident reported to employer? () Yes () No Name of person reported accident to _____

5. Injured at: _____ City _____ State _____ Zip _____

6. Length of time worked there prior to accident: _____

7. Type of work being done at time of injury: _____

8. In your own words, please describe accident: _____

9. Have you been treated by another doctor for this accident? () Yes () No

If yes, please list doctor's name and address: _____

What type of treatment did you receive? _____

How long were you treated by this doctor? _____

10. Are you: () improved () unchanged () getting worse

11. What types of medicines are you taking? _____

Do these medicines help? () Yes () No () Don't know

12. Have you had physical therapy? () Yes () No If yes, how often?

() Daily () Every other day () Several times a week () Weekly () Every other week

() Monthly () Other _____

Does the physical therapy help? () Yes () No () Don't know

13. Prior to this accident, have you ever had any of the physical complaints similar to what you have now?

() Yes () No () Don't know

If yes, describe: _____

Were these similar complaints the results of a previous accident(s)? () Yes () No

Please provide details of accident(s): _____

14. Have you had any other serious accidents which required medical care? () Yes () No

Describe: _____

15. Have you had any serious illnesses that required hospitalization? () Yes () No

Describe: _____

16. Have you had any surgeries? () Yes () No

If yes, list type of surgery and date: _____

17. Have you had any nervous or mental illnesses? () Yes () No

Have you had psychiatric care? () Yes () No

18. Have you received a medical discharge from the Armed Forces? () Yes () No

19. Have you returned to work since this accident? () Yes () No

If you have returned to work since your accident, please fill out the information below:

DATE	EMPLOYER	OCCUPATION	LIGHT DUTY REG. DUTY	FULL-TIME PART-TIME

CURRENT MEDICAL COMPLAINTS

BACK PAIN:

1. Currently, I have pain in my: () low back () mid back () upper back
2. My pain began: () gradually () suddenly
3. I have pain: () sometimes () all of the time
4. My pain goes into my: () right leg () left leg () both
5. I have tingling and/or numbness in my: () right leg () left leg () both
6. My pain is worse when I:
 - cough or sneeze () Yes () No
 - sit () Yes () No
 - bend () Yes () No
 - walk () Yes () No
 - lift () Yes () No
 - push () Yes () No
 - pull () Yes () No
7. My back is worse with sexual activity () Yes () No
8. My pain wakes me up during the night () Yes () No
9. Changes in the weather affect my pain () Yes () No

NECK PAIN:

- 1. My neck pain began: () gradually () suddenly
- 2. I have pain: () sometimes () all of the time
- 3. My pain goes into my: () right arm () left arm () both
- 4. I have tingling and/or numbness in my: () right arm () left arm () both
- 5. My pain is worse when I:
 - cough or sneeze () Yes () No
 - bend forward () Yes () No
 - lift () Yes () No
 - push () Yes () No
 - pull () Yes () No
 - turn my head () Yes () No
- 6. My pain wakes me up during the night () Yes () No
- 7. Changes in the weather affect my pain () Yes () No
- 8. I have neck stiffness () Yes () No
- 9. I have headaches () Yes () No
- 10. If I do get headaches, they occur: () sometimes () all of the time

OTHER PAIN:

Please describe any current medical complaints which you are experiencing and were not previously covered on this questionnaire, or list any additional comments you wish to make regarding your condition:

JOB DESCRIPTION:

(In terms of an 8-hour workday, "occasionally" means 33%, "frequently" means 34% to 66%, and "continuously" means 67% to 100% of the day).

1. In a typical 8-hour workday, I: () # of hours / activity)

Sit:	1	2	3	4	5	6	7	8	hours
Stand:	1	2	3	4	5	6	7	8	hours
Walk:	1	2	3	4	5	6	7	8	hours

2. On the job, I perform the following activities:

	NOT AT ALL	OCCASIONALLY	FREQUENTLY	CONTINUOUSLY
Bend / stoop	()	()	()	()
Squat	()	()	()	()
Crawl	()	()	()	()
Climb	()	()	()	()
Reach above shoulder level	()	()	()	()
Crouch	()	()	()	()
Kneel	()	()	()	()
Balancing	()	()	()	()
Pushing / Pulling	()	()	()	()

3. On the job, I lift:	NOT AT ALL	OCCASIONALLY	FREQUENTLY	CONTINUOUSLY
Up to 10 pounds	()	()	()	()
11 to 24 pounds	()	()	()	()
25 to 34 pounds	()	()	()	()
35 to 50 pounds	()	()	()	()
51 to 74 pounds	()	()	()	()
75 to 100 pounds	()	()	()	()

4. Do you have to bend over while doing any lifting? () Yes () No

5. Are your feet used for repetitive movements, such as in operating foot controls? () Yes () No

6. Do you use your hands for repetitive actions, such as:

	SIMPLE GRASPING		FIRM GRASPING		FINE MANIPULATING	
Right hand	() Yes	() No	() Yes	() No	() Yes	() No
Left hand	() Yes	() No	() Yes	() No	() Yes	() No

7. Are you required to work on unprotected heights? () Yes () No

Describe: _____

8. Are you required to be around moving machinery? () Yes () No

Describe: _____

9. Are you exposed to marked changes in temperature and humidity? () Yes () No

Describe: _____

10. Are you required to drive automotive equipment? () Yes () No

Describe: _____

11. Are you exposed to dust, fumes and/or gases? () Yes () No

Describe: _____

12. Please list any additional comments: _____

Signature: _____ Date: _____

Family Chiropractic and Acupuncture Center

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(707) 427-1222

Privacy Issues Protected By HIPAA

- I authorize the release of medical information to my primary care or referring physician, to consultants if needed and as necessary to process insurance claims, insurance applications and prescriptions.
- I authorize Family Chiropractic and Acupuncture Center to leave a message on my answering machine regarding lab results/medical information relevant to patient care.
- I authorize Family Chiropractic and Acupuncture Center to talk to my spouse in regards to my lab results/medical information relevant to patient care.
- I authorize Family Chiropractic and Acupuncture Center to leave a message on my answering machine regarding account balance information.
- I authorize Family Chiropractic and Acupuncture Center to talk with my spouse in regards to my account balance information.
- I authorize payment of medical benefits to the physician.
(Required Consent)
- I acknowledge that the information that I have given to Family Chiropractic and Acupuncture Center is correct and current. Any change and/or additional information will be given to them as soon as possible. If any information is incorrect or lacking, thus resulting in a delay or a denial in billing, I accept responsibility for the outstanding balance. (Required Consent)

Please Initial and Sign Below:

___ (initial) I acknowledge that I have read and understand the "Notice of Privacy Practice" form given to me by Family Chiropractic and Acupuncture Center to review. I know that I have the right to request and receive a copy of the full HIPAA disclosure form that I have just read. (Required Consent)

Signature: _____

Date: _____

Print Name: _____