NEW PATIENT INFORMATION – WORKER'S COMPENSATION

PERSONAL INFORMATION:

Name: ______________________________
Address: ______________________________
____
City: ______________________________
State: ____________ Zip Code: __________
Daytime Phone #: ______________________
Other Phone #(s): ______________________
Date Of Birth: ______ / ______ / ________
Age: ____________ Gender: *male / female*
Social Security #: ______ - _____ - _______

Marital Status: *minor / single / engaged / married / legally separated / divorced / widowed*
If Minor, Parent / Guardian: ______________
Spouse / Significant Other: ______________
If Children, Names & Ages: ______________
____
Any Special Circumstances: ______________
____
Emergency Contact Person: ______________
Relationship: ______________________
Phone #(s): ______________________

OCCUPATIONAL INFORMATION:

Employment Status: *full-time / part-time / retired / stay-at-home / unemployed / student*
Place Of Employment: ____________________
Occupation / Title: ______________________

At Work, Do You……………… (check all that apply)

_____ frequently sit
_____ frequently stand
_____ do repetitious tasks
_____ bend / stoop
_____ light / heavy lifting
_____ light / heavy labor
_____ use computers
_____ other: ________

FINANCIAL INFORMATION:

Have You Settled The Claim? *yes / no*
Did You Hire An Attorney? *yes / no*

Contact Person: ______________________
Phone Number: ______________________
Claim Number: ______________________

PRESENT HISTORY:

Rate Your Health: *excellent / fair / poor*
Rate Your Diet: *excellent / fair / poor*
Amount Of Exercise: *regular / irregular / none*
Rate Your Stress Level On The 1-10 Scale (10 = High)
At Home: _______ At Work: _______
Do You Use Any Of The Following? Amount / Day?
_____ Tobacco: ______________________
_____ Alcohol: ______________________
_____ Caffeine: ______________________
Are You Under Medical Care Now? yes / no
If So, For What? ____________________
Doctor's Name: ____________________
Last Physical Exam Date: ______________
Prescription Drugs? ____________________
____
Over – The – Counter Drugs? ______________
Supplements? ______________________

Amount Of Sleep Per Night: ______________
I Sleep On My: *back / right side / left side / stomach*
Please Check All That Apply………

_____ I sleep on my stomach.
_____ I sleep with my arms over my head.
_____ I sleep in the fetal position. (curled up)
_____ I sleep twisted. (½ side & ½ back / stomach)
_____ I use more than 1 pillow under my head.
_____ I use a waterbed / very soft mattress.
_____ I sit with my wallet in my back pocket.
_____ I cross my legs when I sit.
_____ I hold the phone with my neck.
_____ I carry a purse / bag / child usually on one side.
_____ I pop / crack my neck, back or other joints.

Females: Could You Be Pregnant? *yes / no*
Date of Last Menstrual Period: ______________
If yes, Estimated Due Date: ______________
Midwife / ObGyn: ______________

PAST HISTORY:

Please Check All That Apply & Explain…………..….

_____ Fractures: ______________________
_____ Dislocations: ____________________
_____ Head Injuries: ____________________
_____ Falls / Injuries: ____________________
_____ Car Accidents: ____________________
_____ Surgeries: ______________________
_____ Hospitalizations: __________________
_____ Stroke / Heart Attack: ______________
_____ Seizures / Black Outs: ______________
_____ Allergies / Asthma: ________________

Please List All Medical Conditions: __________
____
____
Significant Family History: *cancer / heart disease / stroke / diabetes / epilepsy / thyroid conditions / bleeding disorders / arthritis / allergies / asthma / other:* ______________
Do You Wear A Prostheses / Pacemaker ? *yes / no*
Do You Wear Lifts / Arch Supports? *yes / no*
Have You Had Chiropractic Care Before? *yes / no*
If Yes, When Was Your Last Visit? _________
Date Of Most Recent X-rays? ____________

INJURY DETAILS:

Date & Place Of Injury: ____

How Did The Injury Occur? (be specific) ____

____

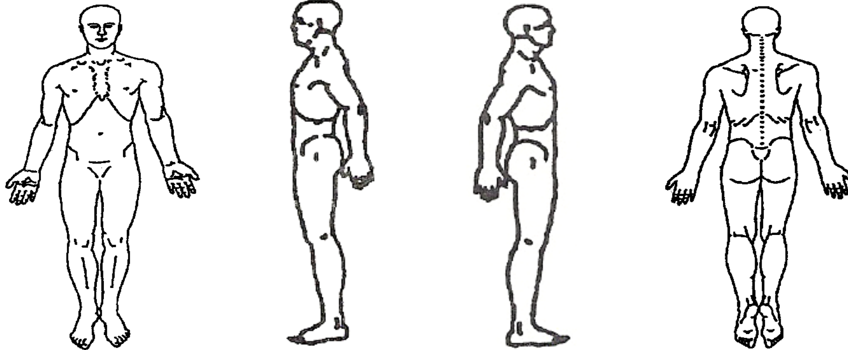
____

____

If Applicable, Did You See The Injury Coming? *yes / no* If Yes, Did You Brace Yourself At Injury? *yes / no*

How Were You Positioned? *standing / sitting / bending / stooping / reaching / facing forward / turned left / turned right / head left / head right / other:* ____________________

Use The Diagrams Below To Circle The Area Of The Injury, Then Use The Descriptors To Indicate Symptoms :



Abbreviations For Descriptors:
A = Ache
BP = Burning Pain
C = Cramp
D = Dull Pain / Soreness
N = Numbness
PNS = Pins & Needles Sensation
S = Stiffness
SSP = Sharp / Stabbing Pain
T = Throbbing
TSP = Traveling / Shooting Pain
O = Other

How Soon Did The Symptoms Start? *instantly / gradually / unsure / other:* ____________________

Since The Injury, Have The Symptoms Been………. *getting better / getting worse / staying the same / other*

How Frequent Are Your Symptoms? *comes & goes / constant / other:* ____________________

Would You Say It Is Worse In The……….. *mornings / afternoons / evenings / it doesn't change / other*

Does Your Problem Vary In Intensity? *yes / no* (if yes, in the question below- give rates for those variations)

Rate Any Pain On A Scale Of 1-10 (1 = Minimal & 10 = Worst Pain Ever): ____________________

What Things Make The Symptoms Worse? ____________________

What Things Make The Symptoms Better? ____________________

How Has Your Life Been Affected Since The Injury? *not at all / occasionally / minimally / moderately / severely*

More Specifically, Has Any Of The Following Been Affected? *work / sleep / daily routine / driving / hobbies*

Have You Lost Any Days Of Work Because Of This Injury? *yes / no* If yes, how many? __________

Have You Noticed Any Bodily Changes? *yes / no* If So, What? ____________________

What Have You Done To Try & Help The Problem & What Were The Results? ____________________

____

Did You Seek Medical Attention? *yes / no* If Yes, Where? ____________________

Did You Report The Injury To Your Supervisor? *yes / no* Supervisor's Name: ____________________

Have You Had Symptoms Like This Before? *yes / no* If Yes, Was It Also Work Related? *yes / no*

How Did You Find Out About Our Clinic? *yellow pages / website / advertisement / referral / other:* __________

To Whom May We Thank For Referring You? ____________________

Your health affects everything you do & everyone you know. That's why our mission at Westside Chiropractic Center, is to aid in the restoration of health by providing quality care through chiropractic, nutrition, massage & rehabilitation; so that our patients can achieve & maintain optimum health. We welcome the opportunity to help in your road back to health.

I, ______________________________, have answered the following questions to the best of my ability and do hereby acknowledge that the answers I have given are completely true. I do hereby authorize Westside Chiropractic Center (WCC) to treat me for the stated work related injuries and agree to comply with the doctor's management plan. If I do not comply with the recommended plan, I agree that WCC is not responsible for my outcome. I realize that I may never get back to my pre-injury status and will be treated to a point of maximum medical improvement. I agree to be responsible for all charges. In the event that the responsible party does not compensate WCC, I will pay for such charges. If a check is issued to me, I am responsible for paying WCC the amount owed.

I understand the above statements and agree to the terms by signing below. .

Signature: ______________________________ Date: ____________________

Parent / Guardian's Signature (if minor or legally unable to consent): ____________________