WORKERS' COMPENSATION INTRODUCTION FORM

Today's Date: _____

Last Name:	**MI:** **First Name:**	
Home Address:	**City:** **State:** **Zip:**	
Date Birth: Age:	Social Security No:	
Height: Weight:	Drivers License No:	
Employer's Name:	Marital Status (Circle): Single, Married, Divorced, Widowed	
Email Address:		

☐ **YES, ☐ NO I authorize the following telephone numbers:**
☐ **YES, ☐ NO I authorize the use of my name/address**

Home: _____Work _____

Cell: _____ Pager: _____

Indicate if you have a preferred mailing address: _____

_____

Signature: _____Date:_____

Expiration Date/Event for Authorization: ☐ No expiration date
☐When I have discontinued treatment and all bills have been paid.
☐ Date: _____

The Doctors office , needs to leave messages, return telephone calls, and send office mail to your home address as part of our normal practice. Federal/State HIPAA patient privacy laws allow you to restrict doctor/staff communication with you or to contact you through alternative means. Please list telephone numbers that are acceptable for our office to call. Your agreement will allow our office to use your name and the indicated mailing address for sending reminders about scheduled appointments, re-activation letters, sending birthday/holiday cards, office newsletters, or providing information about other health related matters that may be of interest to you, billing statements/questions, status of your account, and other office related matters. We will use your home address, noted above, unless you indicate a preferred address. You may indicate a preferred mailing address by indicating so on this form. This authorization may be revoked by you at any time, by advising our office (Privacy Officer) of this revocation in writing. If you choose not to sign this authorization, this will not have any adverse effect on your treatment, eligibility for benefits, enrollment, or payment.

Name, Address, Relationship, and Telephone Number of your nearest adult relative (for emergencies):
_____

Date of Injury:	Date: Time:
Name Employer at Time of Injury:	
Address of Employer:	
Job Title at Time of Injury:	Title: Length of time employed (months/yrs): ____
Name of Current Employer:	

DESCRIBE HOW INJURY HAPPENED: _____
_____
_____

☐ YES, ☐ NO Have you notified your employer about your injury?
☐ YES, ☐ NO Has your employer notified their workers' compensation insurance carrier?
☐ YES, ☐ NO Have you filled out an injured workers' claim form?
☐ YES, ☐ NO Do you have an attorney representing you for this work-related injury?

WORKERS' COMPENSATION INSURANCE INFORMATION

Name of Insurance Carrier:	
Address of Insurance Carrier:	
Claim Adjuster's Name/Telephone:	Name: Telephone:
Claim Number:	

Doctor's Name/Address:

GENERAL HEALTH HISTORY

Check only those conditions that apply to you and indicate if you have had in the past or presently have.

YES	GENERAL QUESTIONS	PAST	PRESENT
☐	I heal slowly	☐	☐
☐	Smoke cigarettes or use tobacco products	☐	☐
☐	Diabetes, hypoglycemia, thyroid disorder, kidney or liver disease, or tuberculosis	☐	☐
☐	Heart attack or have a heart pacemaker or neck or chest shunt?	☐	☐
☐	Currently or recently had any infectious disease such as AIDS, Tuberculosis, etc	☐	☐
☐	Do you have difficulties or intolerance to heat packs or ice packs on your skin?	☐	☐
☐	Do you have problems with dizziness, blacking out, balance, fainting, or tripping	☐	☐
☐	Epilepsy-Seizure-Convulsion history or other neurological disease	☐	☐
☐	History of multiple sclerosis, lupus, psoriasis, temporary paralysis, or meningitis	☐	☐
☐	Cancer history or cancer treatment of any type	☐	☐
☐	Stroke history (Indicate any suspected strokes or transient ischemic attacks)	☐	☐
☐	Told that you have scoliosis, spondylolisthesis, spina bifida, or fused vertebrae	☐	☐
☐	Told that you have a bulging/herniated disc or disc degeneration in the spine	☐	☐
☐	Have you ever been hospitalized? Why:	☐	☐
☐	Blood clots, bleeding or vascular disorder, or told you have an abdominal aneurysm	☐	☐
☐	Hypertension or high blood pressure	☐	☐
☐	Told you have weak bones, osteoporosis, osteopenia, or ankylosing spondylitis	☐	☐
☐	Told you have osteoarthritis, rheumatoid arthritis, or gout of your spine or joints	☐	☐
☐	**Do you have any type of chest or breast implants presently (males & females)?**	N/A	☐
☐	**Women only**: Check box to left if there any chance that you are currently pregnant		

PRIOR INJURY OR PREVIOUS MUSCULOSKELETAL PAIN

(☐ I have no history of previous painful injury or pain) If you have had prior injuries or pain, please check below:

☐ Work Injury	☐ Fall	☐ Sports Injury	☐ Lifting Injury	☐ Car Accident
☐ Motorcycle Injury	☐ Head Injury	☐ Pedestrian Injury	☐ Military Injury	☐ Other Injury
☐ Headaches/Migraines	☐ Neck Pain	☐ Middle Back Pain	☐ Low Back Pain	☐ Shoulder Pain
☐ Arm numb-tingling	☐ Arm Pain	☐ Leg pain-numb-tingling	☐ Other Pain:	

FRACTURES/BROKEN BONES HISTORY

(☐ I have never had any broken bones). If you have broken any bones, indicate where and when below:

Region	Year	Region	Year
☐ Spinal Vertebra		☐ Skull	
☐ Collar bone (clavicle)		☐ Rib bone	
☐ Arm or hand bones		☐ Leg or foot bones	
☐ Pelvis or hip bones		☐ Other: List	

PREVIOUS SURGERIES

(☐ I have never had any surgical procedure). If you have had any previous surgery, indicate type and when:

Surgery	Year	Surgery	Year
☐ Spine Surgery (neck, back, or pelvis)		☐ Appendix or stomach	
☐ Disc surgery in neck or back		☐ Gallbladder/Stomach/Kidney	
☐ Heart		☐ Cancer (any type)	
☐ Head/Brain		☐ Hernia (inguinal or hiatal)	
☐ Shoulder/Arm/Hip/Leg		☐ Other	

Have you ever been to a Chiropractor before for any condition?

☐ No, ☐ Yes If yes, Chiropractor's Name : _____ Year:_____

Problem(s) seen by Chiropractor for:

Doctor's Name:	Patient's Name:

GENERAL HEALTH HISTORY (Page 2)

LIST ALL SYMPTOM REGIONS AND HOW LONG YOU HAVE HAD THEM

CHECK ALL SYMPTOM AREAS	HOW LONG	CHECK ALL SYMPTOM AREAS	HOW LONG
☐ Headaches/Migraines		☐ Upper Back Pain, Soreness, or Stiffness	
☐ Neck Pain, Soreness, or Stiffness		☐ Hip Pain	
☐ Low Back Pain, Soreness, Stiffness		☐ Leg or Foot Pain, Numbness, or Tingling	
☐ Arm/Hand Pain, Numbness, or Tingling		☐ Other:	

Did your current symptoms come on? ☐ Suddenly, ☐ Gradually

SYMPTOM/PAIN DESCRIPTION

Please circle any word or all words below that best describes how your symptoms currently feel to you.

Pain	Pinching	Spreading	Vicious	Unbearable
Ache	Pricking	Shooting	Sickening	Soreness
Cutting	Tingling	Stabbing	Miserable	Pins and Needles
Tearing	Gnawing	Dull	Troublesome	Radiating
Crushing	Nagging	Bony	Pressing	Weakness
Pulling	Boring	Terrifying	Deep pain	Falls asleep
Irritating	Burning-Hot	Dreadful	Superficial pain	Suffocating
Annoying	Drill like	Fearful	Stinging	Punishing
Stiff or tight	Heavy	Unhappy	Throbbing	Crawling
Exhausting	Numbness	Torturing	Sharp	Tender

☐ No, ☐ Yes Do you have any problems laying face down on an examination table? If yes, why: _____

ARE YOU TAKING ANY MEDICATIONS?

☐ **I am not taking any medications currently.** Check any of the following that you are taking currently.

☐ Muscle Relaxants	☐ Blood pressure/Stroke prevention medications	☐ Cortisone injections
☐ Pain/Anti-inflammatory meds	☐ Osteoporosis (bone strengthening) medications	☐ Other:

WHEN IS YOUR PAIN WORSE & WHAT ACTIVITIES INCREASE YOUR PAIN?

☐ Morning is when pain is worse	☐ Bending your back increases pain	☐ Walking increases pain
☐ Afternoon/evening pain worse	☐ Lying down flat increases pain	☐ Standing increases pain
☐ During sleep hours pain worse	☐ Sitting increases pain	☐ Exercise/Stretching increases pain
☐ Standing up from sitting	☐ Poor posture increases pain	☐ Other:

WHAT ACTIVITIES LESSEN YOUR PAIN?

☐ Walking	☐ Being flat on your back	☐ Exercise/Stretching
☐ Sitting	☐ Standing	☐ Other:

DO YOU EXERCISE?

☐ I do no regular exercise	☐ I exercise 1-2 times a week	☐ I exercise 3-5 times a week
☐ I stretch regularly	☐ I do weight lifting at gym/home	☐ I do cardiovascular work outs
☐ I am willing to do exercise	☐ I am not willing to do exercises	☐ I do regular sports activities

HAS YOUR PAIN BEEN ASSOCIATED WITH ANY OF THE FOLLOWING?

☐ Excessive fatigue-malaise	☐ Bowel or bladder disorders	☐ Night pain or night time sweats
☐ Weight loss	☐ Ovarian pain	☐ Abdominal pain
☐ Low grade fever	☐ Kidney pain/painful urination	☐ Balance problems

Doctor's Name :	Patient's Name :

EMPLOYMENT INFORMATION

Patient's Name:_____
Address:_____ City: _____ Zip: _____
Work Telephone: _____Home Telephone: _____

CURRENT EMPLOYMENT STATUS (Check your present status)

☐	Full time employee	☐	Self employed
☐	Part time employee	☐	Unemployed

EMPLOYMENT HISTORY

EMPLOYER AT THE TIME OF THE INCIDENT FOR WHICH YOU ARE BEING SEEN

What is the name of your employer at the time of the injury? _____
Job title: _____ Number of hours working each week: _____
How many months or years had you been employed at the time of the injury? _____
What type of activities did you do at this job? (Describe details such as lifting, sitting, stooping, bending, and computer work)_____
_____

CURRENT EMPLOYER

☐ Yes, ☐ No Are you currently working for the same employer as when you had this injury? If no, indicate:
Name of current employer (if different than above): _____
Job Title: _____ Number of hours working per week: _____

SELF EMPLOYED INFORMATION

If you are self-employed or own a business, please describe your job duties.
_____
_____

PREVIOUS EMPLOYMENT (PAST 10 YEARS)

List in descending order, your three past employers or work positions from your last job backwards.

EMPLOYER NAME	DATES EMPLOYED	JOB TITLE/DUTIES
A.		
B.		
C.		
D.		
E.		
F.		

Doctor's Name/Address:

JOB DESCRIPTION (DUTIES) AT TIME OF INJURY

Patient Name: _____Date: _____

What was your job title/description at the time of your injury? _____
How many hours did you work in a typical day at the time of your injury? _____
How many hours did you work in a typical week at the time of your injury? _____

JOB DUTIES AT TIME OF INJURY *(Check column that applies to the frequency of a specific activity at your job)*	**Never** (0 hours)	**Occasionally** (1-15 x/hr) (Up to 3 hours)	**Frequently** (16-60 x/hr) (3-6 hours a day)	**Constant** (More than 60 x/hr) (6-8 hours a day)
Bending head and neck				
Twisting head and neck				
Bending waist				
Twisting waist				
Lifting less than 25 pounds				
Lifting heavier than 25 pounds				
Bending while lifting				
Reaching above the level of your head				
Reaching above the level of your shoulder				
Carrying objects in hand				
Gripping or fingering objects left hand				
Gripping or fingering objects right hand				
Fine movement with fingers				
Handwriting				
Pushing and pulling with left hand				
Pushing and pulling with right hand				
Keyboarding on computer				
Heavy or power use of hands				
Crawling				
Crouching or squatting				
Walking				
Kneeling				
Standing				
Climbing				
Sitting while driving a vehicle				
Sitting (other than driving)				

CHECK ALL THAT APPLIED TO YOUR EMPLOYMENT AFTER YOUR INJURY

YES	**NO**	
☐	☐	Has your employer modified your work environment/job tasks to make it easier for you to work?
☐	☐	Did you have to ask other employees to help you perform job related tasks after the injury?
☐	☐	Did you make changes in how you worked on the job to allow yourself to keep working?

If you indicated yes for any of the last three questions, please explain in detail: _____

_____

_____

Doctor's Name/Address: