

Workers Compensation Form

Date: ___/___/___

Patient Name: _____ DOB: ___/___/___ Gender: Male/Female
Home Phone: (____)____ - _____ Cell Phone: (____)____ - _____ Marital Status: M, S, D, or W
Address: _____ City: _____ State: _____ Zip: _____
Social Security #: ___ - ___ - ___ Driver's License #: _____ State: _____
E-mail Address: _____ Spouses Name: _____ Num of Children _____

Who referred you to our office? _____

Emergency Contact
Name: _____ Phone Number: (____)____ - _____
Address: _____ Relationship: _____

Who referred you to our office? : _____

Emergency Contact
Name: _____ Phone Number: (____)____ - _____
Address: _____ Relationship: _____

Employer
Name: _____ Occupation/Job Title: _____
Business Address: _____
Business Phone: _____ Can you be Contacted at Work: Yes/ No
SUPERVISOR: _____

Workers Compensation Carrier: _____ Phone: _____ Claim #: _____

Current Height: _____ Current Weight: _____ Date of Injury: ___/___/___ Time of Injury: _____

Please describe the accident in detail: _____

Please describe your symptoms in detail:
First day: _____
Second day: _____
Thereafter: _____

What is your work status:
__ currently off work __ currently working full duty __ currently working light duty?

If you were off work, and have now returned to work, what date did you return _____, and what date did you return to full duty? _____ What hours do you work when working full duty? _____
Have you injured this area of the body at any time in the past? NO YES
If yes, please describe: _____

Did you have symptoms prior to this injury? NO YES

If yes, please describe: _____

Was the accident reported? NO YES If yes, to whom: _____

What were the hours you had worked the day the accident occurred? _____

Were you hospitalized? NO YES

When were you hospitalized? ___ immediately ___ Later Same Day ___ Next Day ___ Date: _____

What did the hospital recommend? ___ No instructions ___ see chiropractor ___ See primary physician
___ See orthopedist ___ prescription medication ___ Other: _____

Did you have X-rays taken? NO YES

If yes, what areas? _____

Have you missed any work from this accident? : _____ If so, how much? : _____

Have you returned to work: ___NO ___YES If yes, what date did you return? _____

What hours are you working? _____

Have you seen any other physicians for this condition? : NO YES

If yes, whom? : _____

Condition Classification:

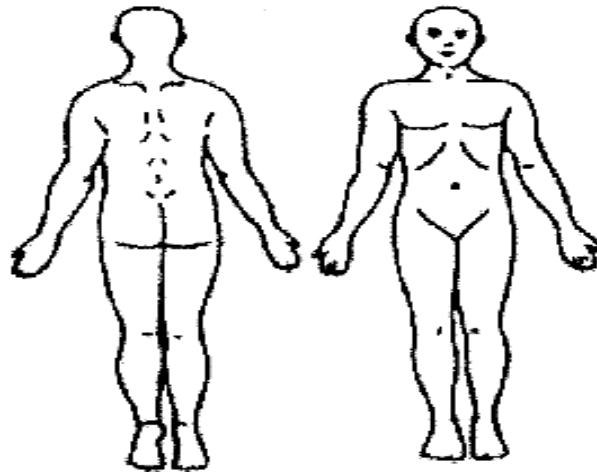
_____ New (happened in the last 6 weeks)

_____ Recurring (a complaint related to a previously resolved condition)

_____ Exacerbation (complaints related to a flare up of an underlying chronic condition)

_____ Chronic (have had this problem for longer than 6 weeks.)

Please indicate on the diagram to the right where it hurts.



Job Classification: ___ Sed (<5lbs) ___ Light (<6-20lbs) ___ Moderate (21-49lbs) ___ Heavy (>50lbs)

Lifting Frequency: ___ Constant (66-100%/day) ___ Frequent (33-65%/day) ___ Occasional (0-32%/day)

Lifting Postures: ___ Floor-Waist ___ Knee ___ Overhead ___ Waist-Shoulder ___ High near ___ Off Posture

Work Activity Postures:

___ Sitting ___ Standing ___ Walking ___ Climbing ___ Pushing ___ Pulling ___ Kneeling ___

Reaching ___ Twisting

Repetitive Activities:

___ Computer ___ Phone ___ Machinery ___ Hand Tools ___ Assembly ___ Grasping

Condition's Effect on Job Performance

___ Mild Painful (can do) ___ Moderate Painful (limits ability) ___ Moderate/Severe (limited duty)

___ Severe (can't do even limited duty) ___ Severe (no limited duty available)

HEAD AND NECK AREA

(This section would also include any problems you may be having with numbness or tingling in your hands)

Main Symptoms: Pain Numbness Stiffness Weakness (where) _____

Quality: Burning Diffuse Dull/Aching Localized Sharp Shooting Stabbing
 Throbbing Tightness Tingling Radiating to _____
Other: _____

Associated Signs and Symptoms: Blurred Vision Depression Dizziness Irritability/Mood Swings
 Localized Tingling Nausea Ringing in Ears Stiffness Aches Cold Limb Panic
 Shortness of Breath (SOB) Echymosis/ Bruising Fatigue Fever Heartburn
 Muscle Spasm Pale Bluish Skin Pins and Needles Runny Nose Sweating (more than usual)
 Swelling Vomiting

Headaches:

Location: Back of head Front of Head Side of Head Top of Head Sinus
Quality of Headache: Dull Sharp Throbbing Stabbing Aura No Aura
Types: Hat Band Cluster Migraine Tension

Duration: Symptom(s) Started: _____ Symptom(s) Worsened: _____ Symptom(s) Last Occurred: _____

Timing: Worse in the: Morning Afternoon Night Activity Constant Intermittent

Modifying Factors:

Head/Neck Symptoms are better with: Activity Bending Cold Heat Massage Movement
 Over the Counter Medications Rx Medications Rest Stretching Sitting Standing
 Twisting Walking Nothing Helps

SPINE, RIBS AND PELVIS AREA

(This section would also include any problems you may be having with your legs (tingling, numbness etc))

Main Symptoms: Pain Numbness Stiffness Weakness (where) _____

Quality: Burning Diffuse Dull/Aching Localized Sharp Shooting Stabbing
 Throbbing Tightness Tingling Radiating to _____
Other: _____

Associated Signs and Symptoms: Blurred Vision Depression Dizziness Irritability/Mood Swings
 Localized Tingling Nausea Ringing in Ears Stiffness Aches Cold Limb Panic
 Shortness of Breath (SOB) Echymosis/ Bruising Fatigue Fever Heartburn
 Muscle Spasm Pale Bluish Skin Pins and Needles Runny Nose Sweating (more than usual)
 Swelling Vomiting

Duration: Symptom(s) Started: _____ Symptom(s) Worsened: _____ Symptom(s) Last Occurred: _____

Timing: Worse in the: Morning Afternoon Night Activity Constant Intermittent

Modifying Factors:

Spine/Ribs/ Pelvis Symptoms are better with: Activity Bending Cold Heat Massage Movement
 Over the Counter Medications Rx Medications Rest Stretching Sitting Standing
 Twisting Walking Nothing Helps

Activities of Daily Living

RATE THE AVERAGE INTENSINITY OF YOUR SYMPTOMS BY CIRCLING A NUMBER ON A SCALE OF 1 TO 10.

1, 2, 3= Mild pain that is uncomfortable, but you are still able to continue with daily activities. **4, 5, 6** = Moderate pain that prevents you from doing some daily activities. **7, 8, 9** = Severe pain that prevents you from taking care of yourself. You are dependent on others. **10**=Extreme pain. You should be in the hospital.

Pain/Symptom Level When Resting:

0 1 2 3 4 5 6 7 8 9 10

Pain/Symptom Level When Active:

0 1 2 3 4 5 6 7 8 9 10

Daily Activities: Effects of Current Condition on Performance (check only those that apply)

- | | | | | |
|--------------------------|---|---|---|---|
| Bending: | <input type="checkbox"/> No Effect | <input type="checkbox"/> Mild Painful (Can do) | <input type="checkbox"/> Mod Painful (Limited) | <input type="checkbox"/> Sev Unable to Perform |
| Care –Infirm Family: | <input type="checkbox"/> No Effect | <input type="checkbox"/> Mild Painful (Can do) | <input type="checkbox"/> Mod Painful (Limited) | <input type="checkbox"/> Sev Unable to Perform |
| Carrying Groceries: | <input type="checkbox"/> No Effect | <input type="checkbox"/> Mild Painful (Can do) | <input type="checkbox"/> Mod Painful (Limited) | <input type="checkbox"/> Sev Unable to Perform |
| Change Posn–Sit-Stand: | <input type="checkbox"/> No Effect | <input type="checkbox"/> Mild Painful (Can do) | <input type="checkbox"/> Mod Painful (Limited) | <input type="checkbox"/> Sev Unable to Perform |
| Climb Stairs: | <input type="checkbox"/> No Effect | <input type="checkbox"/> Mild Painful (Can do) | <input type="checkbox"/> Mod Painful (Limited) | <input type="checkbox"/> Sev Unable to Perform |
| Driving: | <input type="checkbox"/> No Effect | <input type="checkbox"/> Mild Painful (Can do) | <input type="checkbox"/> Mod Painful (Limited) | <input type="checkbox"/> Sev Unable to Perform |
| Extended Computer Use: | <input type="checkbox"/> No Effect | <input type="checkbox"/> Mild Painful (Can do) | <input type="checkbox"/> Mod Painful (Limited) | <input type="checkbox"/> Sev Unable to Perform |
| Feeding: | <input type="checkbox"/> No Effect | <input type="checkbox"/> Mild Painful (Can do) | <input type="checkbox"/> Mod Painful (Limited) | <input type="checkbox"/> Sev Unable to Perform |
| Household Chores: | <input type="checkbox"/> No Effect | <input type="checkbox"/> Mild Painful (Can do) | <input type="checkbox"/> Mod Painful (Limited) | <input type="checkbox"/> Sev Unable to Perform |
| Kneeling: | <input type="checkbox"/> No Effect | <input type="checkbox"/> Mild Painful (Can do) | <input type="checkbox"/> Mod Painful (Limited) | <input type="checkbox"/> Sev Unable to Perform |
| Lift Children: | <input type="checkbox"/> No Effect | <input type="checkbox"/> Mild Painful (Can do) | <input type="checkbox"/> Mod Painful (Limited) | <input type="checkbox"/> Sev Unable to Perform |
| Lifting: | <input type="checkbox"/> No Effect | <input type="checkbox"/> Mild Painful (Can do) | <input type="checkbox"/> Mod Painful (Limited) | <input type="checkbox"/> Sev Unable to Perform |
| Pet Care: | <input type="checkbox"/> No Effect | <input type="checkbox"/> Mild Painful (Can do) | <input type="checkbox"/> Mod Painful (Limited) | <input type="checkbox"/> Sev Unable to Perform |
| Reading (Concentration): | <input type="checkbox"/> No Effect | <input type="checkbox"/> Mild Painful (Can do) | <input type="checkbox"/> Mod Painful (Limited) | <input type="checkbox"/> Sev Unable to Perform |
| Self Care –General: | <input type="checkbox"/> No Effect | <input type="checkbox"/> Mild Painful (Can do) | <input type="checkbox"/> Mod Painful (Limited) | <input type="checkbox"/> Sev Unable to Perform |
| Self Care–Bathing: | <input type="checkbox"/> No Effect | <input type="checkbox"/> Mild Painful (Can do) | <input type="checkbox"/> Mod Painful (Limited) | <input type="checkbox"/> Sev Unable to Perform |
| Self Care–Dressing: | <input type="checkbox"/> No Effect | <input type="checkbox"/> Mild Painful (Can do) | <input type="checkbox"/> Mod Painful (Limited) | <input type="checkbox"/> Sev Unable to Perform |
| Self Care–Shaving: | <input type="checkbox"/> No Effect | <input type="checkbox"/> Mild Painful (Can do) | <input type="checkbox"/> Mod Painful (Limited) | <input type="checkbox"/> Sev Unable to Perform |
| Sexual Activities: | <input type="checkbox"/> No Effect | <input type="checkbox"/> Mild Painful (Can do) | <input type="checkbox"/> Mod Painful (Limited) | <input type="checkbox"/> Sev Unable to Perform |
| Sleep: | <input type="checkbox"/> No Effect | <input type="checkbox"/> Mild Painful (Can do) | <input type="checkbox"/> Mod Painful (Limited) | <input type="checkbox"/> Sev Unable to Perform |
| Static Sitting: | <input type="checkbox"/> No Effect | <input type="checkbox"/> Mild Painful (Can do) | <input type="checkbox"/> Mod Painful (Limited) | <input type="checkbox"/> Sev Unable to Perform |
| Static Standing: | <input type="checkbox"/> No Effect | <input type="checkbox"/> Mild Painful (Can do) | <input type="checkbox"/> Mod Painful (Limited) | <input type="checkbox"/> Sev Unable to Perform |
| Walking: | <input type="checkbox"/> No Effect | <input type="checkbox"/> Mild Painful (Can do) | <input type="checkbox"/> Mod Painful (Limited) | <input type="checkbox"/> Sev Unable to Perform |
| Yard Work: | <input type="checkbox"/> No Effect | <input type="checkbox"/> Mild Painful (Can do) | <input type="checkbox"/> Mod Painful (Limited) | <input type="checkbox"/> Sev Unable to Perform |

Recreational Activity: Effects of Current Condition of Performance (check only those that apply)

- | | | | | |
|----------------|---|---|---|---|
| Basketball: | <input type="checkbox"/> No Effect | <input type="checkbox"/> Mild Painful (Can do) | <input type="checkbox"/> Mod Painful (Limited) | <input type="checkbox"/> Sev Unable to Perform |
| Church: | <input type="checkbox"/> No Effect | <input type="checkbox"/> Mild Painful (Can do) | <input type="checkbox"/> Mod Painful (Limited) | <input type="checkbox"/> Sev Unable to Perform |
| Cycling: | <input type="checkbox"/> No Effect | <input type="checkbox"/> Mild Painful (Can do) | <input type="checkbox"/> Mod Painful (Limited) | <input type="checkbox"/> Sev Unable to Perform |
| Dancing: | <input type="checkbox"/> No Effect | <input type="checkbox"/> Mild Painful (Can do) | <input type="checkbox"/> Mod Painful (Limited) | <input type="checkbox"/> Sev Unable to Perform |
| Exercise: | <input type="checkbox"/> No Effect | <input type="checkbox"/> Mild Painful (Can do) | <input type="checkbox"/> Mod Painful (Limited) | <input type="checkbox"/> Sev Unable to Perform |
| Gardening: | <input type="checkbox"/> No Effect | <input type="checkbox"/> Mild Painful (Can do) | <input type="checkbox"/> Mod Painful (Limited) | <input type="checkbox"/> Sev Unable to Perform |
| Golf: | <input type="checkbox"/> No Effect | <input type="checkbox"/> Mild Painful (Can do) | <input type="checkbox"/> Mod Painful (Limited) | <input type="checkbox"/> Sev Unable to Perform |
| Hiking: | <input type="checkbox"/> No Effect | <input type="checkbox"/> Mild Painful (Can do) | <input type="checkbox"/> Mod Painful (Limited) | <input type="checkbox"/> Sev Unable to Perform |
| Hunting: | <input type="checkbox"/> No Effect | <input type="checkbox"/> Mild Painful (Can do) | <input type="checkbox"/> Mod Painful (Limited) | <input type="checkbox"/> Sev Unable to Perform |
| Running: | <input type="checkbox"/> No Effect | <input type="checkbox"/> Mild Painful (Can do) | <input type="checkbox"/> Mod Painful (Limited) | <input type="checkbox"/> Sev Unable to Perform |
| Sewing: | <input type="checkbox"/> No Effect | <input type="checkbox"/> Mild Painful (Can do) | <input type="checkbox"/> Mod Painful (Limited) | <input type="checkbox"/> Sev Unable to Perform |
| Snow Skiing: | <input type="checkbox"/> No Effect | <input type="checkbox"/> Mild Painful (Can do) | <input type="checkbox"/> Mod Painful (Limited) | <input type="checkbox"/> Sev Unable to Perform |
| Soccer: | <input type="checkbox"/> No Effect | <input type="checkbox"/> Mild Painful (Can do) | <input type="checkbox"/> Mod Painful (Limited) | <input type="checkbox"/> Sev Unable to Perform |
| Swimming: | <input type="checkbox"/> No Effect | <input type="checkbox"/> Mild Painful (Can do) | <input type="checkbox"/> Mod Painful (Limited) | <input type="checkbox"/> Sev Unable to Perform |
| Tennis: | <input type="checkbox"/> No Effect | <input type="checkbox"/> Mild Painful (Can do) | <input type="checkbox"/> Mod Painful (Limited) | <input type="checkbox"/> Sev Unable to Perform |
| Weightlifting: | <input type="checkbox"/> No Effect | <input type="checkbox"/> Mild Painful (Can do) | <input type="checkbox"/> Mod Painful (Limited) | <input type="checkbox"/> Sev Unable to Perform |
| OTHER (s): | _____ | | | |

FINANCIAL POLICY

I understand and agree that health and accident insurance policies are an arrangement between an insurance carrier and me. Furthermore, I understand that Mountain View Chiropractic Center, PLLC, will prepare any necessary reports and forms to assist me in making collection from my insurance company and that any amount authorized to be paid directly to the chiropractic center will be credited to my account upon 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. I also understand that if I suspend or terminate my care or treatment, any fees for professional services rendered me will be immediately due and payable. Should any amount on this account become delinquent, I agree to pay all interest, court cost, attorney fees, and reasonable collection cost with or without suit. Accounts on which no payment is made in a 30 day period are subject to 1 ½ % per month or 18% annual interest charge.

Print Patient Name: _____ Patient's Signature: _____ Date: __/__/____
Guardian's Signature of Authorizing Care: _____ Date: __/__/____

CONSENT

By signing below I consent to the performance of chiropractic adjustments and other chiropractic procedures, including various modes of physical therapy and diagnostic x-rays, on me (or the patient named below for whom I am legally responsible) by Louis S. Carr, D.C. and/or other licensed Doctors of Chiropractic or those working at the clinic or office who now or in the future may treat me while employed by, working in association with, or serving as a backup for Louis S. Carr, D.C.. I understand and I am informed that, in the practice of chiropractic there are some risks to exam and treatment including but not limited to fractures, disc injuries, strokes, dislocations, sprains/strains and increased symptoms and pain or no improvement of symptoms or pain. I do not expect the doctor to be able to anticipate and explain all risks and complications, and I wish to rely on Louis S. Carr, D.C., to exercise judgment during the course of the procedure which the doctor feels at the time, based on the facts then known is in my best interest. I further acknowledge that no guarantee or assurances have been made to me concerning the results intended for the treatment.

I hereby authorize Louis S. Carr, D.C., to treat my condition as he deems appropriate through the use of Chiropractic Health Care, and I give authority for these procedures to be performed. It is understood and agreed that x-ray negatives will remain the property of this office, being on file, where they may be seen at any time while a patient of this office. Any fee paid for x-rays is strictly for the examination and report and in no way makes the x-rays the property of the patient.

Print Patient Name: _____ Patient's Signature: _____ Date: __/__/____
Guardian's Signature of Authorizing Care: _____ Date: __/__/____

HIPAA

We are very concerned with protecting your privacy. While the law requires us to give you this disclosure, please understand that we have and always will respect the privacy of your health information. There are several circumstances in which we may have to disclose your health information. We may have to disclose your health information to another health care provider or a hospital if it is necessary to refer you to them for the diagnosis, assessment, or treatment of your health condition. We may have to disclose your health information and billing records to another party if they are potentially responsible for the payment of your services. We may need to use your health information within our practice for quality control and other operational purposes. You have the right to review a more complete notice before you sign this form. We reserve the right to change our privacy notice; if we do we will notify you in writing. Please fill free to call us at any time for a copy of our privacy notices.

You may revoke your consent to us at any time; however, your revocation must be in writing. We will not be able to honor your revocation if we have already released your health information before we receive your request. If you were required to give your authorization as a condition of obtaining health insurance, the insurance company may have a right to your health information if they decide to contest any of your claims.

Print Patient Name: _____ Patient's Signature: _____ Date: __/__/____
Guardian's Signature of Authorizing Care: _____ Date: __/__/____

