Mt. View Chiropractic Center, PLLC. – 207 North State St Orem, UT 84057- (801)225-3481 - Louis S. Carr, D.C.

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: _____

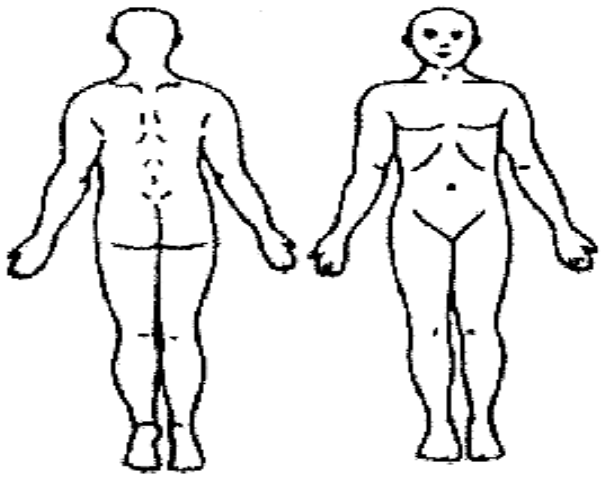
Was the accident reported? NO YES If yes, to whom: _____

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

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

Basketball:	☐ **No Effect**	☐ **Mild** Painful (Can do)	☐ **Mod** Painful (Limited)	☐ **Sev** Unable to Perform
Church:	☐ **No Effect**	☐ **Mild** Painful (Can do)	☐ **Mod** Painful (Limited)	☐ **Sev** Unable to Perform
Cycling:	☐ **No Effect**	☐ **Mild** Painful (Can do)	☐ **Mod** Painful (Limited)	☐ **Sev** Unable to Perform
Dancing:	☐ **No Effect**	☐ **Mild** Painful (Can do)	☐ **Mod** Painful (Limited)	☐ **Sev** Unable to Perform
Exercise:	☐ **No Effect**	☐ **Mild** Painful (Can do)	☐ **Mod** Painful (Limited)	☐ **Sev** Unable to Perform
Gardening:	☐ **No Effect**	☐ **Mild** Painful (Can do)	☐ **Mod** Painful (Limited)	☐ **Sev** Unable to Perform
Golf:	☐ **No Effect**	☐ **Mild** Painful (Can do)	☐ **Mod** Painful (Limited)	☐ **Sev** Unable to Perform
Hiking:	☐ **No Effect**	☐ **Mild** Painful (Can do)	☐ **Mod** Painful (Limited)	☐ **Sev** Unable to Perform
Hunting:	☐ **No Effect**	☐ **Mild** Painful (Can do)	☐ **Mod** Painful (Limited)	☐ **Sev** Unable to Perform
Running:	☐ **No Effect**	☐ **Mild** Painful (Can do)	☐ **Mod** Painful (Limited)	☐ **Sev** Unable to Perform
Sewing:	☐ **No Effect**	☐ **Mild** Painful (Can do)	☐ **Mod** Painful (Limited)	☐ **Sev** Unable to Perform
Snow Skiing:	☐ **No Effect**	☐ **Mild** Painful (Can do)	☐ **Mod** Painful (Limited)	☐ **Sev** Unable to Perform
Soccer:	☐ **No Effect**	☐ **Mild** Painful (Can do)	☐ **Mod** Painful (Limited)	☐ **Sev** Unable to Perform
Swimming:	☐ **No Effect**	☐ **Mild** Painful (Can do)	☐ **Mod** Painful (Limited)	☐ **Sev** Unable to Perform
Tennis:	☐ **No Effect**	☐ **Mild** Painful (Can do)	☐ **Mod** Painful (Limited)	☐ **Sev** Unable to Perform
Weightlifting:	☐ **No Effect**	☐ **Mild** Painful (Can do)	☐ **Mod** Painful (Limited)	☐ **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: __/__/_____