Work Injury History – Bryn Mawr Chiropractic

Name _____ Birth Date _____
Occupation _____ Date _____
Address _____ City & Zip _____
Phone: home _____ work _____ cell _____
Email _____
(Purpose of email address is to enable you to get our free email Health Tip of the Week)
___Single ___Married If dependent children, names & ages _____

Date, time & place of accident _____

Please describe the accident circumstances_____
_____
_____
_____
_____

Did you require hospitalization after the accident? __ yes __ no. If yes, which hospital and how long were you in? _____
Have you lost any days at work? _____ How many days? _____
Did you have any days of work restriction due to this accident? _____
If so, how many days of partial disability, and when did you return to unrestricted work? _____
What are your primary accident related injuries & how are they affecting your work, home, and recreational life? _____
_____
_____
_____
_____
_____

My insurance company _____ Claim # _____
Address & phone where claims should be sent _____
Have you contacted an attorney for this injury? ___ yes ___ no.
If so, Name & phone number _____
Parent/Siblings Health History: (circle) diabetes, hypoglycemia, osteoporosis, thyroid problems, arthritis, Intestinal problems, heart/stroke/circulatory problems, prostate or female problems, cancer – type, Other _____

Your health history: Please circle any of the following health problems that **you** have or have had in the past: thyroid, asthma, acid reflux or other digestive problems, high blood pressure, heart, stroke or circulatory problems, dizziness, diabetes, hypoglycemia, arthritis, osteoporosis, , prostate, PMS or other female problems, cancer(explain)___ Other_____ Check if you have __ medical implants, __ pacemaker.

Please grade your symptoms in any of these areas, that you believe are caused by OR AGGRAVATED BY, the accident that you are currently being examined and treated for in this clinic. Then add the numbers up, and enter the total numbe in the bottom space. Thank you. 1=mild & infrequent 10 = severe & constant.

Headaches												
Head feels heavy												
Neck pain												
Ringing in Ear												
Jaw pain												
Fingers-numb												
Arms-numb												
Shoulder pain												
Arm/elbow pain												
Wrist pain												
Cold hands												
Cold feet												
Upr/MidBackPain												
Low Back pain												
LowBackStiffness												
Leg numb												
Toes numb												
Chest pain												
Hip/pelvis pain												
Leg pain												
Knee pain												
Ankle pain												
Foot pain												
Unusual mood swings												
Foggy Thinking												
Dizziness												
DigestiveProblems												
Total Score												

I hereby state that the information on this form is correct. I authorize Bryn Mawr Chiropractic to examine and treat me and/or my minor child for the care and management of the injuries related to this work injury. I authorize assignment of benefits to Bryn Mawr Chiropractic, while understanding that ultimately I am responsible for the services rendered by Bryn Mawr Chiropractic. I hereby authorize the release of my examination and treatment records to my attorney and insurance company.

_____ Date: _____

Patient or Parent/Guardian's signature (for patient who is a minor)

TERMS OF ACCEPTANCE

When an individual or family seeks and is accepted for chiropractic care, it is essential for all parties to be working toward the same objective.

Chiropractic has only one goal. It is important that everyone understands both the objective and the method that will be used to achieve it. This will prevent any confusion or disappointment.

Definitions:

Health: A dynamic state of wholeness in which your body can accurately perceive its constantly changing needs and respond appropriately in a timely manner. In short, *Health is the ability to adapt* to both internal and external stresses, whether they are physical, chemical, or emotional.

S**ubluxation Process:** A disruption in the normal flow of Life Energy in the nerves between the brain and the cells of the body. This causes an alteration of the normal physiology and leads to a state of "dis-ease" (the inability of the body to adapt).

Chiropractic Adjustment: the specific application of a gentle force to facilitate the body's correction of subluxation, and restore its innate healing processes so as to progressively bring about a state of health and wholeness.

We only offer to diagnosis either the subluxation process or neuro-musculoskeletal conditions. We do not offer treat any disease other then the subluxation process. However, during the course of a chiropractic assessment, if we encounter non-chiropractic or unusual findings, we will advise you. If you desire, we will recommend the services of a health care provider who specializes in that area.

OUR ONLY PRACTICE OBJECTIVE is to eliminate major interference to the full outward expression of your body's innate wisdom. Our only method is the use of the specific chiropractic adjustment to reverse the subluxation process. However, we may use other procedures to help your body hold the adjustments.

I, _____have read and fully understand the above statements.
(print name)

All questions regarding the doctor's objective pertaining to my care in this office have been answered to my complete satisfaction.

Therefore, I accept chiropractic care on this basis.

I also understand & agree that payment is always either prepaid or due at the time of the visit, unless other arrangements have been made, and that I am responsible for all bills incurred at this office.

_____ _____
(signature) (date)

Consent to evaluate and adjust a minor child

I, _____ being the parent or legal guardian of _____
have read and fully understand the above terms of acceptance and hereby grant permission for my child to receive chiropractic care.

Pregnancy Release

This is to certify that to the best of my knowledge I am not pregnant and the above doctor and his/her associates have my permission to refer me for an x-ray evaluation. I have been advised that x-ray can be hazardous to an unborn child.

Date of last menstrual cycle. _____

_____ _____
(signature) (date)