RAINIER VALLEY CHIROPRACTIC P.S.
David A. Butters D.C.– Natasha Butters D.C.
4236 36th Avenue S. Seattle, WA 98118
Phone 206-723-2820 Fax 206-722-3664

On The Job Injury Health History Form

** Was your injury caused by an automobile collision while On The Job? If Yes, Please fill out The Automobile Collision History Form instead of this form.*

Full Name_____ Date_____

Street Address_____

City & State_____ Zip _____

Phone Number _____Gender_____ Date of Birth_____ Age_____

SSN_____ How did you hear about our office? _____

Marital Status_____ # of Children? ____ Currently Pregnant? / How Long? _____

Occupation_____ Employer_____

Place of Business Address_____ Phone_____

Date of On The Job Injury: ____/____/_____ Have you reported your injuries to your employer? ❑No ❑Yes

Today's Major Complaints

Please check ✓ ***Please*** **Circle** ***Your Level of Pain.***

Area of Pain and Type of Pain							***0= No Pain through 10=Extreme Pain***										
❑Headache	❑Lt ❑Rt	❑Ache	❑Dull	❑Sharp	❑Stabbing		0	1	2	3	4	5	6	7	8	9	10
❑Neck Pain	❑Lt ❑Rt	❑Ache	❑Dull	❑Sharp	❑Stabbing		0	1	2	3	4	5	6	7	8	9	10
❑Shoulder Pain	❑Lt ❑Rt	❑Ache	❑Dull	❑Sharp	❑Stabbing		0	1	2	3	4	5	6	7	8	9	10
❑Arm Pain	❑Lt ❑Rt	❑Ache	❑Dull	❑Sharp	❑Stabbing		0	1	2	3	4	5	6	7	8	9	10
❑Mid Back Pain	❑Lt ❑Rt	❑Ache	❑Dull	❑Sharp	❑Stabbing		0	1	2	3	4	5	6	7	8	9	10
❑Low Back Pain	❑Lt ❑Rt	❑Ache	❑Dull	❑Sharp	❑Stabbing		0	1	2	3	4	5	6	7	8	9	10
❑Hip Pain	❑Lt ❑Rt	❑Ache	❑Dull	❑Sharp	❑Stabbing		0	1	2	3	4	5	6	7	8	9	10
❑Leg Pain	❑Lt ❑Rt	❑Ache	❑Dull	❑Sharp	❑Stabbing		0	1	2	3	4	5	6	7	8	9	10
❑Other _____							0	1	2	3	4	5	6	7	8	9	10
❑Other _____							0	1	2	3	4	5	6	7	8	9	10

I feel more pain when doing the following activities:

Check ✓ **the activities that cause pain and then** **Circle** **minimal, mild, moderate or severe.**

❑Sleeping	Minimal	Mild	Moderate	Severe
❑Sitting	Minimal	Mild	Moderate	Severe
❑Walking	Minimal	Mild	Moderate	Severe
❑Standing	Minimal	Mild	Moderate	Severe
❑Lifting	Minimal	Mild	Moderate	Severe
❑Household Chores	Minimal	Mild	Moderate	Severe
❑Routine Personal Care	Minimal	Mild	Moderate	Severe
❑Pushing	Minimal	Mild	Moderate	Severe
❑Squatting	Minimal	Mild	Moderate	Severe
❑Reaching	Minimal	Mild	Moderate	Severe
❑Carrying	Minimal	Mild	Moderate	Severe
❑Pulling	Minimal	Mild	Moderate	Severe
❑Bending	Minimal	Mild	Moderate	Severe
❑Computer Work	Minimal	Mild	Moderate	Severe
❑Typing	Minimal	Mild	Moderate	Severe

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Name_____ Date: _____/_____/_____

What happened to cause your injuries?

_____

_____

_____

Have you had similar injuries or problems **Before**? Please describe _____

_____

Please list **other health care providers** you have seen for the condition(s), and **treatment** received.

_____

_____

Have you found any activities that make your injuries feel better? (Examples are ice, heat, stretching, other treatment)

_____

_____

Describe briefly and give approximate dates for any **major injuries, illnesses, surgeries or accidents**:

_____

_____

_____

Does your immediate family have a history of any diseases? (Cancer, Heart Disease, Diabetes, Etc.)

Mother's side _____

Father's side _____

Are you presently on any medications? (please specify)

_____

_____

Do you drink alcohol?	❑No	❑Yes,	____ Drinks	❑Daily	❑Weekly	❑Monthly
Do you smoke?	❑No	❑Yes,	____ Packs	❑Daily	❑Weekly	❑Monthly
Do you exercise?	❑No	❑Yes,	If yes, then how often?	❑Daily	❑2-3 times a Week	❑Monthly

Height_____ Weight_____

Have you been to a chiropractor before? ❑Yes ❑No

Chiropractor's name/ location: _____ Last seen: _____

Name of Primary Care Physician_____ Date of last Physical_____

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 perform an x-ray evaluation. I have been advised that x-ray can be hazardous to an unborn child.

Date of last menstrual period:_____

Signature:_____ ***Date:***____/____/_____

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Name_____ Date: _____/_____/_____

Employer at time of injury: _____ Employer's Phone #:_____
Employer's Address:_____
L & I / Self-Insured Co.:_____ Self-Ins. Co Phone #: _____
Self-Insured Co. Address:_____

Since the injury is your condition ❑ Improving ❑ Getting Worse ❑ Same

Have you lost time from work as a result of this injury? ❑No ❑Yes

If Yes, please list
dates:_____

Date you returned to work or expect to return to work***:*** **____/____/_____**

Check those activities that are required of you at work

❑Lifting	❑Occasionally	❑Frequently	❑Continuously	Up to _____ lb.
❑Carrying	❑Occasionally	❑Frequently	❑Continuously	Up to _____ lb.
❑Pushing	❑Occasionally	❑Frequently	❑Continuously	Up to _____ lb.
❑Pulling	❑Occasionally	❑Frequently	❑Continuously	Up to _____ lb.
❑Sitting	❑Occasionally	❑Frequently	❑Continuously	
❑Standing	❑Occasionally	❑Frequently	❑Continuously	
❑Walking	❑Occasionally	❑Frequently	❑Continuously	
❑Bending	❑Occasionally	❑Frequently	❑Continuously	
❑Squatting	❑Occasionally	❑Frequently	❑Continuously	
❑Computer work	❑Occasionally	❑Frequently	❑Continuously	
❑Reaching	❑Occasionally	❑Frequently	❑Continuously	
❑Typing	❑Occasionally	❑Frequently	❑Continuously	

Please provide your email address if you wish to be added to our monthly e-newsletter list.

Email: _____

Signature (Guardian if under 18):_____ ***Date:*****____/____/_____**

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Name_____ Date: _____/_____/_____

Authorization To Release Medical Records:

PATIENT INFORMATION:

Name (print) DOB SSN

_____ _____ _____

INFORMATION TO BE RELEASED FROM:

1) Name of facility or provider
_____ Ph#_____ Pt. Initials _____
Address
_____ Fax#_____ Date Sent ___/___/___
2) Name of facility or provider
_____ Ph#_____ Pt. Initials _____
Address
_____ Fax#_____ Date Sent ___/___/___
3) Name of facility or provider
_____ Ph#_____ Pt. Initials_____
Address
_____ Fax#_____ Date Sent ___/___/___

INFORMATION TO BE SENT TO:

Rainier Valley Chiropractic, P.S.
4236 36th Avenue S., Seattle, WA 98118
206-723-2820 (fax # 207-722-3664)

INFORMATION TO BE RELEASED: **(check one)**

__**X**__The most recent 2 years of pertinent information (chart notes, labs, x-rays and special tests)
_____ All medical records
_____ Specific information (please specify):

PURPOSE FOR WHICH THE DISCOSURE IS BEING MADE: (please check one)

_____ Attorney _____Insurance ___**X**___Doctor _____Personal

PATIENT AUTHORIZATION:

I understand that my records may contain information regarding the diagnosis or treatment of HIV/AIDS, sexually transmitted diseases, drug and/or alcohol abuse, mental illness, or psychiatric treatment. I give my specific authorization for these records to be released.

*EXCLUDE the following information from the records released (please initial)

_____ Drug/Alcohol abuse/treatment & diagnosis _____ Sexually transmitted disease
_____ HIV/AIDS diagnosis/treatment testing _____ Mental illness or psychiatric diagnosis/treatment

MY RIGHTS:

I understand I do not have to sign this authorization in order to obtain health care benefits (treatment, payment or enrollment). I may revoke this authorization in writing. To view the process for revoking this authorization, please read the Privacy Notice to patients posted at the facility where your information is being released. I understand that once the health information I have authorized to be disclosed reaches the noted recipient, that person or organization ma re-disclose it, at which time it may no longer be protected under Privacy laws.

Signature: _____ Date: _____
(Patient, guardian*, or Authorized representative*)

This authorization will expire 90 days from the date signed