Workers' Compensation Questionaire

Please answer all questions completely.

Dear Patient,

This information is considered confidential. We need this information because we care enough to want to know, and your answers will help us determine if chiropractic can help you. If we do not sincerely believe you condition will respond satisfactorily, we will not accept your case. In order for us to understand your condition properly, please be as neat and accurate as possible while completing this form. Thank you.

Personal Information

Name_____

Sex _____ Marital Status_____

Date of Birth_____

Home Phone _____

Address _____

City/State/Zip_____

Occupation _____

(Indicate if child, student, housewife, unemployed, retired)

Who referred you
to our office? _____

Social Security # _____

Business Phone_____

Company Name_____

Location_____

Spouse's Information

Name_____

Social Security # _____

Employer _____

Location_____

Back on Track Chiropractic
3335 S. Airport Road W., Ste 6A
Traverse City, MI 49684
(231) 922-0421 Phone
(231) 922-9904 Fax
www.backontrackmi.com

Accident Information/Details

Please explain in detail how your accident happened_____

_____

_____

_____

Time and date present injury occured _____ am / pm _____

Where did you feel pain immediately after the accident? _____

_____

Did you return to work? Yes No
If so, date returned to work_____

Have you ever injured this area before? Yes No
If so, date returned to work_____

If injured before, did you lose time from work? Yes No

Before the injury, were you capable of
working on an equal basis with others your age? Yes No

Have you tried any home remedies for your condition such as aspirin, heating pad, ice packs, etc.? _____

What aggreavates your condition? _____
(For example: walking, sitting, bending, etc.)

Is there any position that you can get
into that makes your condition better?_____

Does your condition interfere with your work? Yes No
If so, how? _____

Since this injury, are your symptoms:
Getting better Worse About the same

List all medications you are now taking_____

_____

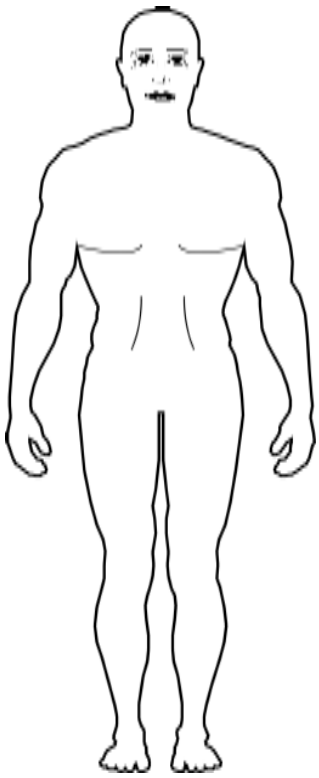
List any other comments relative to this accident _____

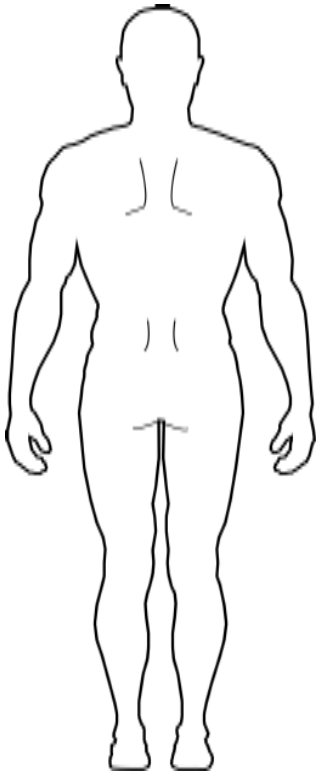
_____

_____

_____

Please mark your areas of pain on the figures below.





Accident Information/Details Continued

Have you retained an attorney? Yes No
Litigation? Yes No Maybe

If so, name and address _____

_____

Did you consult any other doctor? Yes No

If so, give doctor's name _____ D.C. / M.D. / D.O. / D.D.S.

Doctor's diagnosis _____

_____

What treatment did you receive? _____

_____

Do any other diseases or
accidents affect your employment? Yes No
If so, please explain _____

If you lost time from work with injuries
prior to this injury, give name of doctor(s) consulted _____

_____

In your work do you have
to favor any part of your bady? Yes No
If so, please explain _____

Do you have a history of
absenteeism caused from accidents on the job? Yes No

Have you ever had a
Workmen's Compensation claim before? Yes No

List all previous surgeries _____

_____

_____

List secondary complaints not directly related to this accident _____

_____

_____

Other comments _____

_____

_____

_____

_____

_____

Patient Signature: _____ Date: _____

Website Membership Enrollment

The information on our website will help you

Get Well and Stay Well.

Please provide the following details so we can establish you as a member of our website today:

First name: _____

Last name: _____

Date of birth: _____ / _____ / _____

Email address: _____

Please check the health subjects that most interest you:

- ❑ Headaches and Neck Pain
- ❑ Backaches and Sciatica
- ❑ Children's Health Issues
- ❑ Exercise and Fitness
- ❑ Diet and Nutrition
- ❑ Stress Management
- ❑ Wellness Topics
- ❑ Women's Health Issues

By joining our website, you authorize us to send occasional health care related emails to you. Naturally, you may opt-out at any time. Please review our complete privacy policy on our website.

Lifecycle:	
Chiropractor:	

Acknowledgement of Receipt of Notice of Privacy Policy

I acknowledge that Back on Track Chiropractic's “Notice of Privacy Practices” has been provided to me. I understand that I have a right to review Back on Track Chiropractic's Notice of Privacy Practices prior to signing this document. The Notice of Privacy Practices describes the types of uses and disclosures of my protected health information that will occur in my treatment, payment of my bills or in the performance of health care operations of Back on Track Chiropractic. It describes my rights as they concern the limited use of health information, including my demographic information, collected from me and created or received by my physician. The Notice of Privacy Practices for Back on Track Chiropractic is also provided on request at the main administration desk of this practice and on Back on Track Chiropractic's website at www.backontrackmi.com.

Back on Track Chiropractic reserves the right to change the privacy practices that are described in the Notice of Privacy Practices. I may obtain a revised notice of privacy practices by accessing Back on Track Chiropractic's website, calling the office and requesting a revised copy be sent in the mail or asking for one at the time of my next appointment.

_____ _____

Signature of Patient or Personal Representative Date

_____

Name of Patient or Personal Representative

_____

Description of Personal Representative’s Authority