WORKER'S COMPENSATION QUESTIONAIRE

IN ORDER FOR US TO BEST SERVE YOU, WE MUST, NATURALLY, HAVE ALL AVAILABLE INFORMATION REGARDING YOUR PRESENT HEALTH. WOULD YOU PLEASE COMPLETE THE FOLLOWING:

Patient Information

Date: _____

Name: _____ **Social Security No.: _____**

Address: _____ **City/State/Zip: _____**

Home Phone: _____ _____ **Work Phone:_____** **Cell Phone: _____**

Email: _____ **Date of Birth: _____** **Age:_____**

Sex: Male / Female Marital Status: Married / Single / Divorced / Widowed Employer:_____

Spouses Name:_____ **Spouses Employer: _____**

Children(s) Ages:_____ **Are you pregnant? □ Yes / □ No**

Emergency Contact: _____ **Relationship:_____** **Phone: _____**

Who or What Source Referred You:_____

Ethnicity: Hispanic or Latino/Other Preferred Language: _____

Race: Asian / African Am. Am. Indian or Alaskan Native / Other / Native Hawaii or Pacific Island / White

Smoking Status: Every Day / Some Days / Former / Never Education : High School / Some College /College Grad / Graduate School

Are you taking any medications? Yes / No OTC/Prescriptions: _____

Allergies to Medications? Yes / No _____

Have you had any surgeries? □ Yes □ No If Yes, Please Explain: _____

Have you Broken any Bones? □ Yes □ No If Yes, Please Explain: _____

Primary Care Physician: _____ **Doctor's Phone: _____**

History or Current Condition:

Please explain in detail how your injury occurred? _____

_____

Give time and date present injury occurred_____ □AM □PM Date ____/____/____ Reported Injury to Employer □Yes □No

Where did you feel pain immediately after the accident? □ Neck □ Upper-Back □ Mid-Back □ Low Back □ Other:_____

How would you Rate your Pain? □ Mild (2 3 4) □ Mod (5 6) □ Sev (7 8 9) Is the Pain: □ Constant □ Intermittent

Type of Discomfort: □ Sharp □ Stabbing □ Burning □ Achy □ Dull □ Stiff & Sore □ Numbness/Tingling

Radiating: □ Y □ N □Left/□Right □Base of Skull □Shoulder □Arm □Hand □Hip □Leg □Knee □Foot □Ribs Other:_____

What Makes it Better? □ Ice □ Heat □ Rest □ Movement □ Stretching □ OTC □ Prescription Other:_____

What Makes it Worse? □ Sitting □ Standing □ Walking □ Lying Down □ Sleep □ Overuse Other: _____

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

Activities of Daily Living affected by Health Complaint: _____

Does Your Pain Awaken you at night? □ Yes / □ No Describe:_____

Have You Noticed any Changes in Bodily Function [Urination, Defecation, Respiration, Digestion, Vision, Sexual, other] since the onset of your complaint? □ Yes / □ No Describe:_____

Did you consult any other doctor? □ Yes □No Did employer send you to any other doctor? □Yes □ No

If so, give doctor's name_____□D.C., □ M.D., □ D.O., □ D.D.S. □ _____

Doctor's Diagnosis_____ Did you lose time from work? □Yes □No

Do any other diseases or accidents affect your employment? □Yes □ No If so, explain_____

In your work, do you have to favor any part of your body? □Yes □ No If so, explain_____

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

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

Are your work activities restricted as a result of this accident? □Yes □No

Since the injury, are your symptoms? □Improving □Getting worse □The same

Have you retained an attorney? □ Yes □ No Is Litigation Pending? □ Yes □ No

If so, name, address & phone #_____

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Insurance Information

I understand and agree that health and accident insurance policies are an agreement between an insurance carrier and myself. Furthermore, I understand that this chiropractic office will prepare any necessary reports and forms to assist me in making collection from the insurance company and that any amount authorized to be paid directly to this chiropractic office will be credited to my account upon receipt. However, I clearly understand and agree the all services rendered to 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 and treatment any fees for professional services rendered to me will be immediately due and payable.

Signature: _____

Consent of Professional Services and Release of Information

I hereby authorize and release the doctor and whomever he may designate as his assistants to administer treatment, physical examination, x-ray studies, laboratory procedures, chiropractic care, or any clinic services that he/she deems necessary in my care; and further authorize him/her to disclose all or any of my (patient's) record to any person or corporation which is or may be liable under a contract to the clinic or to the patient or to a family member or employer of the patient for all or part of the clinic's charges, including and not limited to, hospital or medical service companies, insurance companies, workers compensation carrier, welfare funds or the patient's employer.

By signing below, I authorize Wills Chiropractic Clinic, P.C., 1335 M Street, Gering, NE 69341, to obtain and/or disclose my medical records, imaging reports, or any chiropractic/medical imaging. I understand that this authorization may be revoked by the authorizer, in writing, at any time. I also understand that the revocation of this authorization will not have any effect on disclosure occurring prior to the execution of any revocation. I understand that the information used or disclosed pursuant to this authorization may be subject to being disclosed again by the recipient and that this information will no longer be subject to protection as protected health information.

Patient Signature: _____

Parent or Guardian's Signature: _____

Internal Use Only

☐ NP ☐ New Incident ☐ Re-Exam

Patients Appearance/Mood: ☐ Distress ☐ Mild ☐ Moderate ☐ Severe

Nourished: ☐ Well ☐ Obese ☐ Morbid

Other_____

Additional Info: _____

_____

X-RAY ORDERED:

Cervical	Thoracic	Lumbar
☐ 3 Views	☐ 2 Views	☐ 2 Views
☐ 5 Views	☐ 4 Views	☐ 4 Views
☐ 7 Views	☐ Flex / Ext	☐ Flex / Ext.
☐ Oblique's		☐ Oblique's
☐ Flex/Ext		☐ AP Spot

Other: ☐ R ☐ L ☐ Hip ☐ Knee ☐ Ankle ☐ Foot ☐ R ☐ L ☐ Shoulder ☐ Elbow ☐ Wrist ☐ Hand

_____

VITALS:

HGT: _____

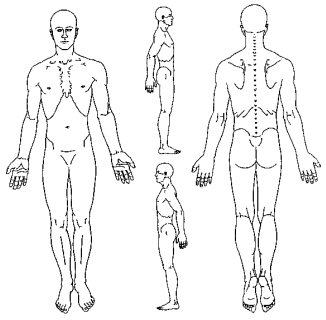
WGT: _____

BP: _____

Pulse: _____

TREATMENT:

Exam M A DJ X LLL



H	___	Hypoesthesia	T	___	Tenderness upon palpation
N	___	Numb			
P	___	Pain	S	___	Spasm

Wills Chiropractic Clinic PC
1335 M St., Gering, NE 69341
created 12/1/15

CA_____DR_____