PATIENT WORKERS COMPENSATION HISTORY

JOINT & SPINE

2327 Neva Road
Antigo, WI 54409

Today's Date: _____

Personal Information

Name:	Home Phone:
Street Address:	Work Phone:
City/State/Zip:	Cell Phone:
Social Security #:	Date of Birth:
Driver's License #:	Email:
Emergency Contact:	Emergency Contact's Phone:

Status: ☐ Male ☐ Female ☐ Single ☐ Married ☐ Other: _____ ☐ Student: ☐ Full-Time ☐ Part-Time

Occupation: _____ Employer: _____

Who Is Your Medical Doctor? _____ Medical Doctor City / State: _____

Spouse's Name: _____ Insurance Subscriber's Name: _____

Spouse's Dob: _____ Subscriber's Dob: _____

Why Did You Choose This Office? ☐ Referred by (Name) _____

☐ Prior patient ☐ Friend of Dr./Staff ☐ Shopper ☐ Newspaper ☐ Phonebook ☐ Radio ☐ Sign ☐ Location ☐ Internet

☐ Doctor's Presentation ☐ Other _____

Date of injury: Time of Injury:	Last Day Worked:
What date did you report the injury?	Who did you report it to?
Did anyone observe the injury? ☐ Yes ☐ No If yes, who?	What is his/her position?

What were you doing at the time you were injured?

How did the accident/injury happen? (lifting, bending, walking, carrying, standing, etc.)

When did the pain begin?	Where did you first feel the pain?

Was the pain intense at first or did it gradually worsen?

Length of time at this job prior to injury:	Previous workers compensation injury? Date:

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

If Yes, dates: _____

☐ Yes ☐ No Have you gone back to work? When? _____

If Yes, what status of work: ☐ Modified ☐ Regular

List restrictions you have been placed on: _____

If you have gone back to work, list activities that are:

Painful: _____

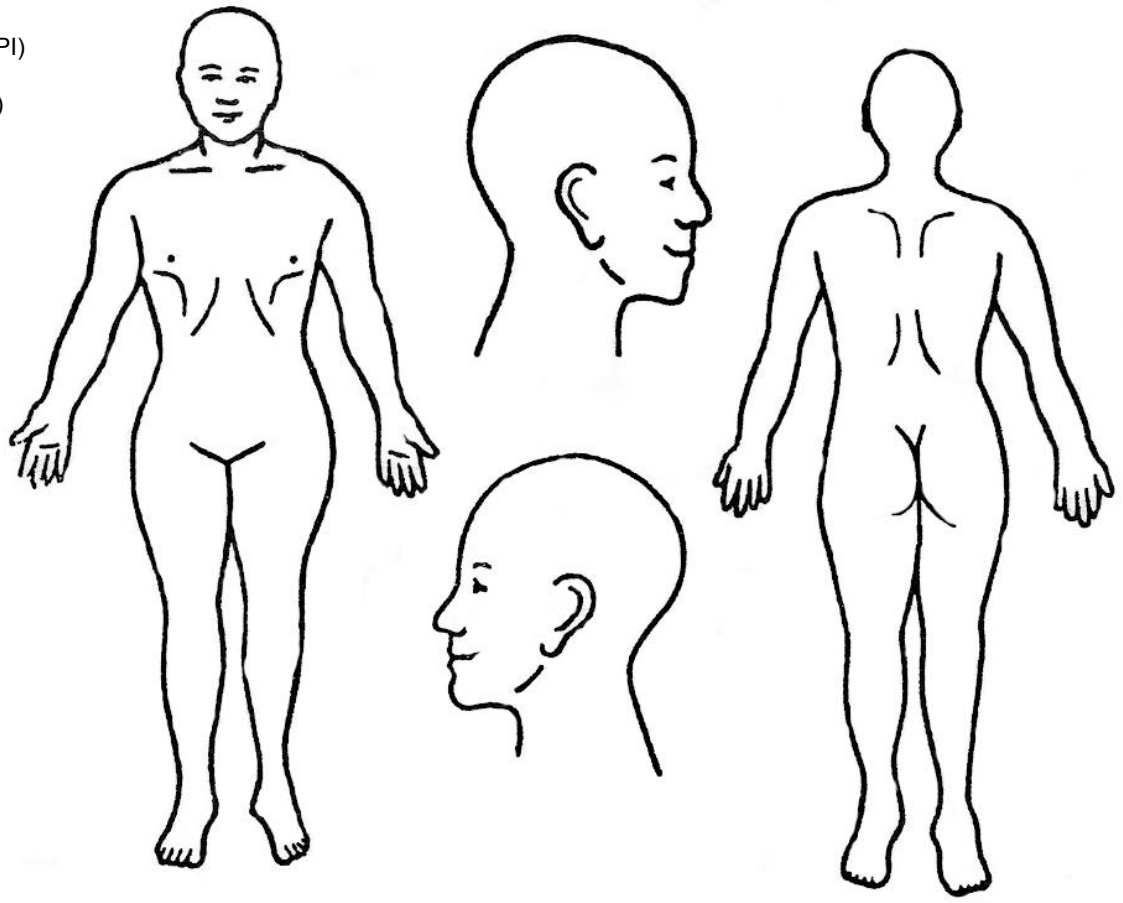
Difficult: _____

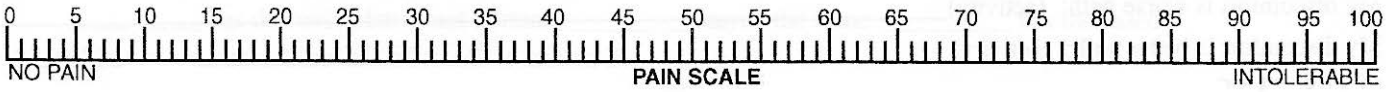
☐ Yes ☐ No Are you currently on disability (time loss), If Yes, do you want to go back to work doing your regular job?

If No, why not?: _____

Be sure to fill out this section as accurately as possible. Mark the area with the described sensation. Use the appropriate symbols. If there is more than one area of discomfort, please rate the pain on a scale of 0 to 100 next to each are, with 0 being no pain and 100 being intolerable pain.

XXX Burning (BU)
(((Aching Pain (AC)
000 Pins & Needles (PI)
- - - Numbness (NU)
: : : Sharp Pains (SH)





Please answer the first four questions below using a pain scale of 0-100 with 0 being no pain and 100 being the worst pain.

1. What is your pain level now? _____
2. What is your pain level most of the time? _____
3. What is your pain level at its best? _____
4. What is your pain level at its worst? _____

5. How often are you at a zero pain level?
   a. At least once a day
   b. Once a week
   c. Once every other week
   d. Once a month
   e. More than once a week
   f. Other _____

Social Health History

Work Hours Per Week: _____ Recreational Activities (Hobbies): _____

☐ Yes ☐ No Do You Commute to Work? How Far? _____
☐ Yes ☐ No Do You Exercise? Times Per Day? _____
☐ Yes ☐ No Tobacco Use? Packs Per Day? _____
☐ Yes ☐ No Do You Consume Caffeine? How Much Per Day? _____
☐ Yes ☐ No Do You Consume Alcohol? Glasses Per Day / Week? _____

Have you had any problems with the following areas? (Please mark Y for Yes or N for No in each of the following:)

☐ Eyes ☐ Urinary ☐ Internal Organs ☐ Ears, Nose, Mouth, Throat ☐ Muscles
☐ Blood ☐ Heart ☐ Nerves ☐ Allergies ☐ Lungs/Breathing
☐ Skin ☐ Intestines ☐ Psychological ☐ Other _____

Please Describe for Yes Responses: _____

- ☐ I stay at home most of the time because of the pain.
- ☐ I change position frequently to try to decrease my pain.
- ☐ I walk more slowly than usual because of the pain.
- ☐ Because of my pain, I am not doing any jobs that I usually do around the house.
- ☐ Because of my pain, I use a handrail to get upstairs.
- ☐ Because of my pain, I lie down to rest more often.
- ☐ Because of my pain, I have to hold on to something to get out of an easy chair.
- ☐ Because of my pain, I try to get other people to do things for me.
- ☐ I get dressed more slowly than usual because of my pain.
- ☐ I only stand up for short periods of time because of my pain.
- ☐ Because of the pain, I try not to bend or kneel down.
- ☐ I find it difficult to get out of a chair because of the pain.
- ☐ I have pain almost all of the time.
- ☐ I find it difficult to turn over in bed because of the pain.
- ☐ My appetite is not very good because of the pain.
- ☐ I have trouble putting on my sock (stockings) because of the pain.
- ☐ I can only walk short distances because of the pain.
- ☐ I sleep less well because of the pain.
- ☐ Because of the pain, I get dressed with the help of someone else.
- ☐ I sit down for most of the day because of the pain.
- ☐ I avoid heavy jobs around the house because of the pain.
- ☐ Because of the pain, I am more irritable and bad tempered with people than usual.
- ☐ Because of the pain, I go upstairs more slowly than usual.
- ☐ I stay in bed most of the time because of the pain.

Past Medical History

How many times have you had the condition that you are seeing us for today? ❑ 0-3 Times ❑ 4 Or More Times

❑ Yes ❑ No Do you suffer from any condition other than that for which you are now consulting us? (Diabetes, High Blood Pressure, Arthritis, etc.) If yes, what?_____

❑ Yes ❑ No Have you ever seen a chiropractor before?

Date	Dr. Name	Condition	Results
1.			❑ Complete Recover ❑ Complications
2.			❑ Complete Recover ❑ Complications

❑ Yes ❑ No Have you ever seen a Doctor for this Condition?

Date	Dr. Name	Condition	Results
1.			❑ Complete Recover ❑ Complications
2.			❑ Complete Recover ❑ Complications

❑ Yes ❑ No Allergies? To what? _____

❑ Yes ❑ No Do you now take prescription drugs, over-the-counter drugs, vitamins, or supplements?

PRODUCT / DRUG	REASON	FREQUENCY	DOSAGE	HELPING?
1.				
2.				
3.				

❑ Yes ❑ No Have you ever had major illnesses, injuries, falls, hospitalizations, auto accidents, or surgeries?

Date	Dr. Name	Condition	Results
1.			❑ Complete Recover ❑ Complications
2.			❑ Complete Recover ❑ Complications
3.			❑ Complete Recover ❑ Complications

Family Health History

Select below medical conditions of your blood relatives (mother, father, brothers, sisters, children)

- ☐ Cardiovascular Disease (heart disease) Who _____
- ☐ Diabetes Who _____
- ☐ Cancer - Type _____ Who _____
- ☐ Arthritis Who _____

My signature is an acknowledgement that all of the above statements are true. I hereby authorize the doctor to examine and treat my condition as he/she deems appropriate through the use of chiropractic health care, and I give authority for these procedures to be performed.

Patient signature:_____ Date: _____

Parent/Guardian/Legal representative signature:_____ Date: _____

D.C./C.A. signature:_____ Date: _____

Informed Consent

Chiropractic, as well as other types of health care, is associated with potential risks in the delivery of treatment. While chiropractic treatment is remarkably safe, you need to be informed about the potential risks related to your care to allow you to be fully informed when consenting to treatment prior to initiating care.

Chiropractic offices use trained personnel to assist with portions of your consultation, examination, X-rays, physical therapy applications, exercise instruction, etc. Occasionally, when your chiropractor is unavailable, another qualified Doctor of Chiropractic may treat you.

Specific risk possibilities associated with Chiropractic care:

Stroke — stroke is the most serious complication of chiropractic treatment. It is, on rare occasions, due to injury of the vertebral artery caused by a cervical spine adjustment or manipulation. If it occurs it may cause temporary or permanent brain dysfunction. On extremely rare occasions death occurs. Because the vertebral arteries, which supply the brain with blood, are located within the bones of the cervical spine, cervical treatment poses a small risk. The chances of this occurring are estimated at 1 per 400,000 treatments to 1 to 5.85 million treatments. (CMAJ 2001 Oct. 2; 165 (7):905-6). The annual incidence of a spontaneous stroke is estimated at 1 to 1.5 per 100,000 (NEJM, 1994; 330:339-397). The results of a retrospective study conducted by Haldeman S, Et. Al, suggested that stroke should be considered a random and unpredictable complication of any neck movement including cervical manipulation (J Neurol 2002 Aug: 249(8): 1098-104).

Soreness — chiropractic adjustments and physical therapy procedures may be accompanied by post treatment soreness. This is a normal and acceptable response to chiropractic care. While it is not generally dangerous, please advise your Doctor of Chiropractic if you experience soreness or discomfort.

Soft Tissue Injury — Occasionally Chiropractic treatment may aggravate a disc injury. It may cause other minor joint, ligament, tendon, or soft tissue injury.

Rib Injury — Manual adjustments to the thoracic spine, in rare cases, may cause rib injury or fracture. Precautions such as pre-adjustment x-rays are taken for cases considered at risk. Treatment is performed carefully to minimize such risk.

Physical Therapy Burns — Heat generated by physical therapy modalities may cause minor burns to the skin. These are rare, but should be reported to your Doctor of Chiropractic or staff if they occur.

Other Problems — There are occasionally other types of side effects associated with Chiropractic care. While these are rare, they should be reported to your Doctor of Chiropractic promptly.

Chiropractic is a system of health care delivery and therefore, as with any health care delivery system, we cannot promise a cure for any symptom, condition, or disease as a result of treatment in this office. An attempt to provide the very best care is our goal. If the results are not acceptable, we will refer you to another provider.

If you have any questions concerning the above, please ask your Doctor of Chiropractic. When you fully understand, please print your name, sign and date below, signifying informed consent for treatment

Consent to treat a minor:

Having carefully read the above, I hereby give my informed consent to have Dr. _____ And /or whomever he /she may designate as his/her assistants to examine , X-ray and administer chiropractic care to my child as he /she deems necessary, in my presence or absence.

Patient's Name Printed

Today's Date

Patient's Signature

Parent or Guardian Signature for Minor