PATIENT WORK HISTORY

PATIENT INFORMATION

NAME _____ TELEPHONE (Home) _____

STREET _____ TELEPHONE (Cell) _____

CITY _____ STATE _____ ZIP _____ EMAIL ADDRESS _____

DATE OF BIRTH _____ ☐ M ☐ F SOCIAL SECURITY NUMBER _____

MARITAL STATUS: ☐ S ☐ M ☐ D ☐ W SPOUSE'S NAME: _____

DATE OF INJURY: _____ OCCUPATION: _____

PRIMARY CARE PHYSICIAN: _____ PHONE: _____

EMERGENCY CONTACT: _____ PHONE: _____

NAME OF PARENT if MINOR PATIENT (if applicable) _____

INSURANCE INFORMATION

INSURANCE COMPANY _____ CLAIM NUMBER _____

ADJUSTER'S NAME _____ ADJUSTER'S PHONE NUMBER _____ EXT. _____

ADJUSTER'S MAILING ADDRESS _____ CITY/STATE _____ ZIP CODE _____

INJURY INFORMATION

1. Name of employer at time of accident: _____
2. Length of time worked there prior to accident: _____
3. Type of work being done at time of injury: _____

4. In your own words, please describe accident: _____

5. Have you been treated by another doctor for this accident? ( ) Yes ( ) No
If yes, please list doctor's name and address: _____

What type of treatment did you receive? _____
How long were you treated by this doctor: _____

6. Are you: ( ) Improved ( ) unchanged ( ) getting worse

7. What types of medicines are you taking? _____

_____

Do these medicines help? ( ) Yes ( ) No ( ) Don't know

8. Have you had physical therapy? ( ) Yes ( ) No

If yes, how often? ( ) Daily ( ) Every other day ( ) Several times a week ( ) Weekly ( ) Every other week ( ) Monthly ( ) Other

Does the physical therapy help? ( ) Yes ( ) No ( ) Don't know

9. Prior to this accident, have you ever had any of the physical complaints similar to what you have now?

( ) Yes ( ) No ( ) Don't know

If yes, describe: _____

_____

_____

Were these similar complaints the results of a previous accident(s)? ( ) Yes ( ) No ( ) Not Applicable

Please provide details of accident(s): _____

_____

_____

10. Have you had any other serious accidents which required medical care? ( ) Yes ( ) No

Describe: _____

11. Have you had any serious Illnesses that required hospitalization? ( ) Yes ( ) No

Describe: _____

_____

_____

12. Have you had any surgeries? ( ) Yes ( ) No If yes, list type of surgery and date:

13. Have you had any nervous or mental illnesses? ( ) Yes ( ) No

Have you had psychiatric care? ( ) Yes ( ) No

14. Have you received a medical discharge from the Armed Forces? ( ) Yes ( ) No

15. Have you returned to work since this accident? ( ) Yes ( ) No

If you have returned to work since your accident, please fill out the information below:

DATE	EMPLOYER	OCCUPATION	LIGHT DUTY REG. DUTY	FULL-TIME PART-TIME

CURRENT MEDICAL COMPLAINTS

BACK PAIN:

1. Currently, I have pain in my: .....( ) low back ( ) mid back ( ) upper back
2. My pain began: .....( ) gradually ( ) suddenly
3. I have pain:.....( ) sometimes ( ) all of the time
4. My pain goes into my: .....( ) right leg ( ) left leg ( ) both ( ) neither
5. I have tingling and/or numbness in my:.....( ) right leg ( ) left leg ( ) both ( ) neither
6. My pain is worse when I:
   - cough or sneeze.....( ) Yes ( ) No
   - sit.....( ) Yes ( ) No
   - bend.....( ) Yes ( ) No
   - walk.....( ) Yes ( ) No
   - lift .....( ) Yes ( ) No
   - push.....( ) Yes ( ) No
   - pull.....( ) Yes ( ) No
7. My back is worse with sexual activity.....( ) Yes ( ) No
8. My pain wakes me up during the night.....( ) Yes ( ) No
9. Changes in the weather affect my pain .....( ) Yes ( ) No

NECK PAIN:

Complete only if applicable.

1. My neck pain began: .....( ) gradually ( ) suddenly
2. I have pain:.....( ) sometimes ( ) all of the time
3. My pain goes into my: .....( ) right arm ( ) left arm ( ) both
4. I have tingling and/or numbness in my:.....( ) right arm ( ) left arm ( ) both
5. My pain is worsens when I:
   - cough or sneeze.....( ) Yes ( ) No
   - bend forward .....( ) Yes ( ) No
   - lift .....( ) Yes ( ) No
   - push.....( ) Yes ( ) No
   - pull.....( ) Yes ( ) No
   - turn my head.....( ) Yes ( ) No
6. My pain wakes me up during the night.....( ) Yes ( ) No
7. Changes in the weather affect my pain .....( ) Yes ( ) No
8. I have neck stiffness.....( ) Yes ( ) No
9. I have headaches .....( ) Yes ( ) No
10. If I do get headaches, they occur:.....( ) sometimes ( ) all of the time

OTHER PAIN:

Please describe any current medical complaints which you are experiencing and were not previously covered on this questionnaire, or list any additional comments you wish to make regarding your Condition: _____

_____

_____

_____

_____

JOB DESCRIPTION:

(In terms of an 6-hour workday, "occasionally" means 33%, "frequently" means 34% to 66% and "continuously" means 67% to 100% of the day.)

1. In a typical 6-hour workday, I: (Circle # of hours / activity)

Sit:	1	2	3	4	5	6	7	8	hours
Stand:	1	2	3	4	5	6	7	8	hours
Walk:	1	2	3	4	5	6	7	8	hours

2. On the job, I perform the following activities:

	NOT AT ALL	OCCASIONALLY	FREQUENTLY	CONTINUOUSLY
Bend / stoop	( )	( )	( )	( )
Squat	( )	( )	( )	( )
Crawl	( )	( )	( )	( )
Climb	( )	( )	( )	( )
Reach above shoulder level	( )	( )	( )	( )
Crouch	( )	( )	( )	( )
Kneel	( )	( )	( )	( )
Balancing	( )	( )	( )	( )
Pushing/ Pulling	( )	( )	( )	( )

3. On the job, I lift

	NOT AT ALL	OCCASIONALLY	FREQUENTLY	CONTINUOUSLY
Up to 10 pounds	( )	( )	( )	( )
11 to 24 pounds	( )	( )	( )	( )
25 to 34 pounds	( )	( )	( )	( )
35 to 60 pounds	( )	( )	( )	( )
61 to 74 pounds	( )	( )	( )	( )
75 to 100 pounds	( )	( )	( )	( )
Kneel	( )	( )	( )	( )
Balancing	( )	( )	( )	( )
Pushing/ Pulling	( )	( )	( )	( )

4. Do you have to bend over while doing any lifting? ( ) Yes ( ) No

5. Are your feet used for repetitive movements, such as in operating foot controls? ( ) Yes ( ) No

6. Do you use your hands for repetitive actions, such as:

	SIMPLE GRASPING	FIRM GRASPING	FINE MANIPULATING
Right hand	( ) Yes ( ) No	( ) Yes ( ) No	( ) Yes ( ) No
Left hand	( ) Yes ( ) No	( ) Yes ( ) No	( ) Yes ( ) No

7. Are you required to work on unprotected heights? ( ) Yes ( ) No
Describe: _____

8. Are you required to be around moving machinery? ( ) Yes ( ) No
Describe: _____

9. Are you exposed to marked change in temperature and humidity? ( ) Yes ( ) No
Describe: _____

10. Are you required to drive automotive equipment? ( ) Yes ( ) No
Describe: _____

11. Are you exposed to dust, fumes and/or gases? ( ) Yes ( ) No
Describe: _____

12. Please list any additicnal comments: _____

Signature _____ Date _____

FINANCIAL RESPONSIBILITIES

I understand and agree that health and accident policies are an arrangement between an insurance carrier and myself. I authorize payment directly from my insurance company to Back on Track Physical Medicine. Furthermore, I understand that this 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 office will be credited to my account upon receipt. However, I clearly understand and agree that all services rendered to me are ultimately my personal responsibility. I also understand that if I suspend or terminate my care and treatment any fees for professional service rendered me will be immediately due and payable.

If I have insurance, I am responsible for my insurance deductible, co-payments and any service rejected by my insurance company. I am also aware that if I have not made a payment on my outstanding balance within a 30 day period, a service fee of 2 % will be added to my account. If I have an outstanding balance that may be served to a collection agency, there will be an additional fifty dollar fee added.

This office cannot promise that an insurance company will pay. In the event that the insurance company disputes or rejects the claim, we will pursue on your behalf as far as we are able to. If unsuccessful, you will be expected to take responsibility for any outstanding balance.

I authorize this clinic to release any information pertinent to my case to any insurance company, adjuster and/or attorney involved in this case, and hereby release this clinic of any consequences thereof.

Although our office will call to verify your insurance coverage, it is your responsibility to confirm and know your benefits. If you have limited coverage, you need to be aware of when your insurance will stop paying your claims.

I certify that the information provided in this four-part form is correct to the best of my knowledge. I will not hold my doctor or any staff member of Back on Track Physical Medicine responsible for any errors or omissions that I may have made in the completion of this form

Signature of Patient: _____ Date: _____

Signature of Parent or Guardian: _____ Date: _____

ACKNOWLEDGEMENT AND UNDERSTANDING

I acknowledge and agree to the following: The doctor will not be held responsible for any pre-existing medically diagnosed conditions.

Chiropractic is not a treatment for any condition or symptom. It is a care system that is aimed toward the reduction and correction of spinal subluxations so that your body as a whole may function better.

Although Chiropractic care is one of the safest forms of health care, it is associated with some minor risks and it is my responsibility to be informed about those risks by asking the doctor or a staff member prior to treatment.

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 you with the very best care is our goal and if the results are not acceptable, we will refer you to another health care professional whom we feel can further assist you.

I hereby authorize the doctors and staff affiliated with Back on Track Physical Medicine to treat my condition as deemed appropriate.

Signature of Patient: _____ Date: _____

Signature of Parent or Guardian: _____Date: _____

RECORDS RELEASE

To _____, I hereby authorize you to release to Back On Track Physical Medicine any information including the diagnosis and records of treatment or examination rendered to me for all care during the period of _____ to _____.

Signature of Patient: _____ Date: _____

CONSENT OF TREATMENT OF MINOR CHILD

I hereby authorize Dr. _____ and whomever he may designate for assistance to administer chiropractic care as he deems necessary to my _____ (indicate relationship to child).

Name of Child: _____ Date: _____

Signature of Parent or Guardian: _____