Back on Track Physical Medicine

WORKER'S COMPENSATION INTAKE FORM

PATIENT INFORMATION

TODAY'S DATE ________________________

FULL 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: ____________________ TIME OF INJURY: ____________AM / PM

INJURY ADDRESS ______________________

PRIMARY CARE PHYSICIAN: ______________________ PHONE: ______________________

EMERGENCY CONTACT: ______________________ PHONE: ______________________

NAME OF PARENT if MINOR PATIENT (if applicable) ______________________

EMPLOYER INFORMATION

EMPLOYER NAME ______________________

EMPLOYER ADDRESS______________________

LENGTH OF EMPLOYMENT: ______________ (YRS) JOB TITLE: ______________________

NUMBER OF HOURS WORKED PER WEEK BEFORE INJURY: ___________ DID YOU REPORT INJURY? ▫Y ▫N

SUPERVISOR: ______________________ PHONE NUMBER: ______________________

WORKERS COMPENSATION INSURANCE INFORMATION

INSURANCE COMPANY ______________________ CLAIM NUMBER ______________________

POLICYHOLDER ______________________ POLICY NUMBER ______________________

ADJUSTER'S NAME ______________________ ADJUSTER'S PHONE NUMBER ______________________

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

INJURY INFORMATION

1. In your own words, please describe how injury occurred: ______________________________________
____
____

2. Was injury directly related to work? ☐Y ☐N Were there any witnesses? ☐Y ☐N
3. Has this type of accident happened to you before? ☐Y ☐N
4. Please list the location of your injury(s) ____
5. When did symptom(s) begin? ☐Immediately ☐Later, same day ☐Next Day ☐2 or more days later
6. Since being injured, has your condition ☐Stayed Same ☐Improved ☐Worsened
7. Have you been treated by another doctor for this injury? ☐Y ☐N Name: ____________________
8. When did you go? ☐Same Date ☐Next Day ☐2 or more days later
9. How did you get there? ☐Ambulance ☐Private Transportation
10. What type of treatment did you receive? ____
11. Were X-rays done? ☐Y ☐N MRI? ☐Y ☐N CT Scan? ☐Y ☐N
12. Medications prescribed? ☐Y ☐N Name ________________________ Do they help? ☐Y ☐N
13. Have you missed any work since the accident? ☐Y ☐N Dates: ______________________
14. How many hours are in your normal workday? __________ (hrs)
15. While in recovery, are there any light duty tasks that you could request? ☐Y ☐N Please describe________
____
16. Prior to this accident, have you ever had any complaints in the involved area before? ☐Y ☐N
If yes, please describe ____
____
17. Were these similar complaints the result of a previous accident(s)? ☐Y ☐N
If yes, please provide details of accident(s) ______________________________________
____
18. Have you had any other serious accidents which require medical care? ☐Y ☐N
Describe: ____
19. Have you had any serious illnesses that required hospitalization? ☐Y ☐N
Describe: ____
20. Have you had any surgeries? ☐Y ☐N If yes, list type and date: ______________________
21. Have you had any nervous or mental illnesses? ☐Y ☐N Have you had psychiatric care? ☐Y ☐N
22. Have you received a medical discharge from the Armed Forces? ☐Y ☐N
23. Have you returned to work since this accident? ☐Y ☐N
If yes, please fill out the information below:

Date	Employer	Occupation	Light Duty Reg. Duty	Full-Time Part-Time

CURRENT MEDICAL COMPLAINTS

BACK PAIN: *(Complete only if applicable)*

1. Currently, I have pain in ………… ( ) 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 pain began……………………… ( ) gradually ( ) suddenly
2. I have pain……………………… ( ) sometimes ( ) all of the time
3. My pain goes into my……………… ( ) right arm ( ) left arm ( ) both ( )neither
4. I have tingling and/or numbness in my… ( ) right arm ( ) left arm ( ) both ( )neither
5. My pain is worse 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…………………………………….. ( ) sometimes ( ) all of the time ( ) not at all

Please indicate your degree of difficulty (on a scale of 1-5, with 1 being comfortable, 3 being uncomfortable, and 5 being painful) in performing the following activities:

_____ Lying on Back _____ Lying on Side _____ Lying on stomach _____ Sitting
_____ Standing _____ Stretching _____ Walking _____ Running
_____ Sports _____ Working _____ Lifting _____ Bending
_____ Kneeling _____Pulling _____ Reaching _____ Climbing

OTHER PAIN: *(Complete only if applicable)*

Please describe any current medical complaints which you are experiencing that were not previously covered on this questionnaire, or list any additional comments you will to make regarding your condition ____
____
____

Indicate any other symptoms you are experiencing as a result of this accident:

☐Dizziness ☐Difficulty Sleeping ☐Jaw Problems ☐Nausea ☐Memory Loss ☐Irritability
☐Back Pain ☐Arm/Shoulder Pain ☐Headache(s) ☐Fatigue ☐Blurred Vision ☐Tension
☐Chest Pain ☐Numbness/Tingling ☐Short of Breath ☐Leg Pain ☐Ear Ringing ☐Neck Pain
☐Other ________________________

JOB DESCRIPTION:

1. In a typical 8-hour workday: (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
Twisting	( )	( )	( )	( )
Bend/stoop	( )	( )	( )	( )
Squat	( )	( )	( )	( )
Crawl	( )	( )	( )	( )
Climb	( )	( )	( )	( )
Kneel	( )	( )	( )	( )
Balancing	( )	( )	( )	( )
Pushing/Pulling	( )	( )	( )	( )
Typing	( )	( )	( )	( )
Driving	( )	( )	( )	( )
Operating Equipment	( )	( )	( )	( )

3. On the job, I ***lift***:

	NOT AT ALL	OCCASIONALLY	FREQUENTLY	CONTINUOUSLY
Up to 10 pounds	( )	( )	( )	( )
11-24 pounds	( )	( )	( )	( )
25-34 pounds	( )	( )	( )	( )
35-60 pounds	( )	( )	( )	( )
61-74 pounds	( )	( )	( )	( )
75-100 pounds	( )	( )	( )	( )

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

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

6. Do you use your hands for repetitive actions, such as grasping items? ( ) Yes ( ) No

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

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

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

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

11. Please list any additional comments: ______________________________

X ______________________________ ______________________________

Patient Signature Date

HIPAA's Patient Consent Form

I acknowledge that Back On Track Physical Medicine Notice has provided me with a Notice of Privacy Practices.

I understand I have a right to review the 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 Physical Medicine. The Notice of Privacy Practices is also provided on request at the front desk of this practice. This Notice of Privacy Practices also describes my rights and Back On Track Physical Medicine's duties with respect to my protected health information.

Back On Track reserves the right to modify the privacy practices to keep up with changes in the law or office practices. Protected health information may be disclosed or used for treatment, payment, or health care operations. The patient may revoke this Consent in writing at any time.

X ___________________________________ **X**__________________

Signature Date

Consent to Chiropractic Treatment

I do hereby authorize and consent to the performance of chiropractic adjustments and other chiropractic procedures including traction, manual muscle therapy, electrical muscle stimulation, therapeutic ultrasound, and therapeutic exercises, and if necessary x-rays, on me (or the patient named below, for whom I am legally responsible) by the chiropractic physician and/or anyone working in this office authorized by the chiropractic physician. Although these are considered safe and effective methods of care, as in all health care, you may experience minimal complications that may include, but are not limited to: soreness, inflammation, soft tissue injury, dizziness, burns, bruising, and temporary worsening of symptoms. More serious complications such as fracture and stroke are extremely rare. While the chances of experiencing complications are minimal, it is the practice of Back On Track Physical Medicine to inform the patients about them.

I do hereby authorize Back On Track Physical Medicine my permission to obtain any information regarding my present or past medical records, to include but not limited to, records, reports, x-ray, and laboratory findings.

I have read and understand the above statements regarding treatment side effects. I also understand that there is no guarantee or warranty for a specific cure or result. It is understood that this authorization is given in advance of any specific diagnosis or treatment being required.

I have read, or have had read to me, the above content. I have also had the opportunity to ask questions about its contents, and by signing below, I consent to the provisions of care. I understand that this care may include treatment, special tests, exams, evaluations, and rehabilitation. I understand that no guarantees have been given to me as to the outcome of any examination or treatment and all results of any examination and/or treatment are kept confidential. I intend for this consent form to cover the entire course of treatment for my present condition(s) and for any condition(s) for which I seek treatment at Back On Track Physical Medicine.

X___________________________________ **X**__________________

Signature Date

Consent to Chiropractic Treatment (Minor)

I hereby request and authorize Back On Track Physical Medicine to perform diagnostic tests and render chiropractic adjustments and other treatment to my minor son/daughter: ________________________________. This authorization also extend to all other doctors and office staff members and is intended to include radiographic examination at the doctor's discretion.

I do hereby grant Back On Track Physical Medicine my permission to obtain information regarding my minor child's present or past medical records to include, but not limited to, records, reports, x-ray, and laboratory findings.

As of this date, I ____ have the legal right to select and authorize health care services for the minor child named above.

X___________________________________ **X**__________________

Signature Date