Cornerstone **CHIROPRACTIC**
804 N. 16th Street, Montevideo, MN 56265 Ph. 320.269.3211

Name: _____ *DOB:* _____ *Date:* _____

Worker's Compensation Patient Case History

Please complete this questionnaire as thoroughly as possible so we can learn about your health and better help you.

Address _____ City _____ State _____ Zip _____
Home Phone _____ Work Phone _____ Cell Phone _____
E-mail Address _____ **Gender**: □ Male □ Female

Preference for Appointment Reminders & Other General Contact:

□Phone (□Home □Cell □Work) □Email □Text (Need Cell Company for text:_____)

Preferred Language: □ English □ Spanish □ Other: _____

Race & Ethnicity: □ White □ Hispanic or Latino □ Black or African American □ American Indian or Alaska Native □ Asian □ Native Hawaiian or Pacific Islander □ Other or Decline to answer

Social Security Number _____
Marital Status □ M □ S □ D □ W Spouse's Name _____
Children's Names & Ages _____
Who referred you to us? _____
How else did you hear about us? _____

INJURY DETAILS

Employer's business name (at the time of accident) _____
Employer's Address _____
City _____State _____ Zip _____
Employer's Phone _____
Employer's Human Resources / Work Comp Contact Person _____

Occupation _____Describe your job_____
Date of injury _____Time of injury _____□ AM □ PM Date last worked_____
What date did you report this injury? _____
To whom did you report it? _____ What is his/her position? _____
Was there a witness to your injury? _____ What is his/her position? _____
Other witnesses' names? _____ Positions? _____

What were you doing at the time you were injured? How did the accident/injury happen (lifting/bending, walking, carrying. standing, etc.)? _____
_____
_____

Describe the environmental conditions that may have contributed to your present injury: Darkness, faulty equipment, slippery floor, limited space. (Distinguish natural hazards from hazards by other employees):
_____
_____

WORK STATUS HISTORY

Have you lost any time from work as a result of this new injury? □ Yes □ No
If yes, give dates and time of loss:_____
If you are currently on **disability (time loss)**, do you want to go back to doing your **regular** work duties? □ Yes □ No If no, state reason: _____
Have you gone back to work? □ Yes □ No If yes, when? _____ Status □ Modified □ Regular
Please list any restriction which have been placed upon you_____

Cornerstone **CHIROPRACTIC**
804 N. 16th Street, Montevideo, MN 56265 Ph. 320.269.3211

Name: _____ *DOB:* _____ *Date:* _____

If you have gone back to work, please list the activities as:
Those that are painful _____
Those that are difficult _____
Are there any problems that you have with a fellow employee, supervisor or management that need to be discussed? □ Yes □ No If yes, please discuss_____

SYMPTOMS FROM INJURY

1. Please describe how you felt:
   Immediately after the injury _____
   Later that day _____
   The next days _____
2. Check symptoms apparent **since** the injury:

□ Headache	□ Neck pain/ stiffness	□ Mid-back pain	□ Low-back pain
□ Eyes light sensitive	□ Pain behind eyes	□ Dizziness	□ Fainting
□ Sleeping problems	□ Fatigue	□ Loss of smell	□ Loss of taste
□ Numbness in fingers	□ Numbness in toes	□ Loss of memory	□ Loss of balance
□ Shortness of breath	□ Ringing/ buzzing	□ Irritability	□ Depression
□ Cold hands	□ Cold feet	□ Diarrhea	□ Constipation
□ Tension	□ Nervousness	□ Anxiety	□ Cold sweats
□ Chest pain	□ Facial pain	□ Clicking or popping jaw	

□ Other _____

3. Describe your primary complaints, name the body parts: _____
_____

a. How often does it affect you? □constant □intermittent
b. Symptom is currently: □increasing □decreasing □not changing
c. Symptom is worse in the: □morning □afternoon □night □same all day
d. If there is pain, is it: □sharp □dull □ache □shooting □tingling □radiating □stabbing □other_____

***PAIN LEVEL**: On a scale of 0 - 10, with 0 being pain free and can function quite well, and 10 being excruciating pain all the time, where would you rate the intensity of your pain?*

0	1	2	3	4	5	6	7	8	9	10
No Pain		Low Pain		Moderate Pain			Intense Pain			Excruciating Pain

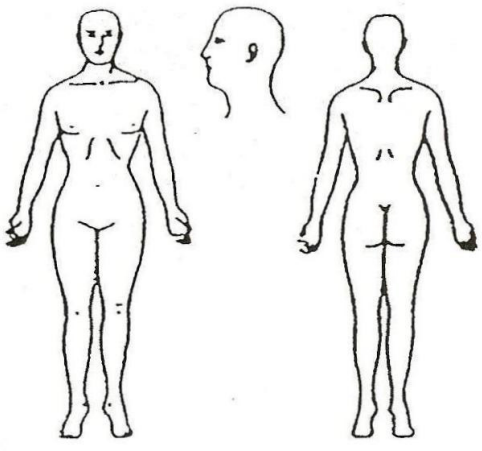
e. What is your ability to perform the following activities? U=unable, P=painful, L=limited, N=normal

____ Coughing or sneezing	____ Climbing	____ Kneeling
____ Getting in or out of car	____ Balancing	____ Looking back
____ Putting on clothes	____ Putting on shoes	____ Stooping
____ Turning over in bed	____ Getting out of bed	____ Pushing
____ Lying flat on stomach	____ Gripping	____ Pulling
____ Lying on side with knees bent	____ Reaching	

f. What makes the symptom better? □nothing □sitting □lying down □walking □moving □bending/twisting □other_____
g. What makes the symptom worse? □nothing □sitting □lying down □walking □moving □bending/twisting □other_____

MARK THE AREAS OF YOUR SYMPTOMS ON THE FIGURE TO THE RIGHT. Use the following symbols:

Aches ^^^^ Numbness oooo Pins/Needles ·••• Stabbing ////



Cornerstone **CHIROPRACTIC**
804 N. 16th Street, Montevideo, MN 56265 Ph. 320.269.3211

Name: _____ DOB: _____ Date: _____

Modified Oswestry Pain Disability Questionnaire

Please answer every question by placing a mark in the **one** box that best describes your condition today. We realize you may feel that 2 of the statements may describe your condition, but **please mark only the box that most closely describes your current condition.**

Pain Intensity

[ ] The pain comes and goes and is very mild.
[ ] The pain is mild and does not vary much.
[ ] The pain comes and goes and is moderate.
[ ] The pain is moderate and does not vary much.
[ ] The pain is severe but comes and goes.
[ ] The pain is severe and does not vary much.

Sleeping

[ ] Pain does not prevent me from sleeping well.
[ ] I get pain in bed, but it does not prevent me from sleeping.
[ ] Because of pain, my normal night's sleep is reduced by less than one-quarter.
[ ] Because of pain, my normal night's sleep is reduced by less than one-half.
[ ] Because of pain, my normal night's sleep is reduced by less than three-quarters.
[ ] Pain prevents me from sleeping at all.

Personal Care (e.g., Washing, Dressing)

[ ] I can take care of myself normally without causing increased pain.
[ ] I can take care of myself normally, but it increases my pain.
[ ] It is painful to take care of myself, & I am slow & careful.
[ ] I need help, but I am able to manage most of my personal care.
[ ] I need help every day in most aspects of my care.
[ ] I do not get dressed, wash with difficulty, & stay in bed.

Lifting

[ ] I can lift heavy weights without increased pain.
[ ] I can lift heavy weights, but it causes increased pain.
[ ] Pain prevents me from lifting heavy weights off the floor, but I can manage if the weights are conveniently positioned (e.g., on a table).
[ ] Pain prevents me from lifting heavy weights, but I can manage light to medium weights if they are conveniently positioned.
[ ] I can lift only very light weights.
[ ] I cannot lift or carry anything at all.

Sitting

[ ] I can sit in any chair as long as I like.
[ ] I can only sit in my favorite chair as long as I like.
[ ] Pain prevents me from sitting for more than 1 hour.
[ ] Pain prevents me from sitting for more than 1/2 hour.
[ ] Pain prevents me from sitting for more than 10 minutes.
[ ] Pain prevents me from sitting at all.

Standing

[ ] I can stand as long as I want without increased pain.
[ ] I can stand as long as I want, but it increases my pain.
[ ] Pain prevents me from standing for more than 1 hour.
[ ] Pain prevents me from standing for more than 1/2 hour.
[ ] Pain prevents me from standing for more than 10 min.
[ ] Pain prevents me from standing at all.

Walking

[ ] Pain does not prevent me from walking any distance.
[ ] Pain prevents me from walking more than 1 mile.
[ ] Pain prevents me from walking more than 1/2 mile.
[ ] Pain prevents me from walking more than 1/4 mile.
[ ] I can walk only with crutches or a cane.
[ ] I am in bed most of the time and have to crawl to the toilet.

Employment / Homemaking

[ ] My normal homemaking / job activities do not cause pain.
[ ] My normal homemaking / job activities increase my pain, but I can still perform all that is required of me.
[ ] I can perform most of my homemaking / job duties, but pain prevents me from performing more physically stressful activities (e.g., lifting, vacuuming).
[ ] Pain prevents me from doing anything but light duties.
[ ] Pain prevents me from doing even light duties.
[ ] Pain prevents me from performing any job/ homemaking chores.

Social Life

[ ] My social life is normal and does not increase my pain.
[ ] My social life is normal, but it increases my level of pain.
[ ] Pain prevents me from participating in more energetic activities (e.g., sports, dancing).
[ ] Pain prevents me form going out very often.
[ ] Pain has restricted my social life to my home.
[ ] I have hardly any social life because of my pain.

Traveling

[ ] I can travel anywhere without increased pain.
[ ] I can travel anywhere, but it increases my pain.
[ ] My pain restricts my travel over 2 hours.
[ ] My pain restricts my travel over 1 hour.
[ ] My pain restricts my travel to short necessary journeys under 1/2 hour.
[ ] My pain prevents all travel except for visits to the doctor/chiropractor or hospital.

Cornerstone **CHIROPRACTIC**
804 N. 16th Street, Montevideo, MN 56265 Ph. 320.269.3211

Name: _____ *DOB:* _____ *Date:* _____

INJURY TREATMENT

1. Have you treated your symptoms at home? □ice □heat □medication □other_____

2. Did you seek medical help immediately after the accident? □ Yes □ No
   If yes, what hospital/clinic did you go to? _____
   If yes, how did you get there? □ Ambulance □ Someone else drove me □ Drove myself □ Other _____
   Were you hospitalized as a result of this accident? □ Yes □ No

Doctor 1: Name_____ Date of first visit_____
   Were you examined? □ Yes □ No Were X-rays taken? □ Yes □ No
   Did you receive treatment? □ Yes □ No
   If yes, what kind of treatment did you receive? _____
   What benefits did you receive from the treatment? _____
   Date of last treatment _____

Doctor 2: Name_____ Date of first visit_____
   Were you examined? □ Yes □ No Were X-rays taken? □ Yes □ No
   Did you receive treatment? □ Yes □ No
   If yes, what kind of treatment did you receive? _____
   What benefits did you receive from the treatment? _____
   Date of last treatment _____

PRIOR SIMILAR SYMPTOMS

1. Did you have any physical complaints **just before this accident**? □ Yes □ No
   If yes, please describe any physical complaints **just before this accident**: _____
   _____

2. Have you EVER had any PRIOR injuries, accidents, diseases, or treatment to the area of your body now affected? □ Yes □ No
   If yes, state what part of your body was previously injured and describe the injury:
   _____
   Were you treated? □ Yes □ No If yes, who treated you? _____
   What date did the treatment begin? _____ When did the treatment end? _____
   When was the last time (date) that you felt pain or problems from that injury? _____

HEALTH HISTORY

1. Have you suffered injuries in the past? □yes □no
   □car accident date_____ □falls date_____ □hospitalization date_____
   □fracture date_____ □sprain/strain date_____ □other_____
2. Do you have a family history of:
   □heart disease □cancer □arthritis □diabetes □lung conditions □high blood pressure
   □stroke/vascular problems □kidney or liver conditions □other_____
3. Do you have a family physician? Name: _____
4. **Please list any disease or condition with which you have been diagnosed:** _____
   _____ □ *No Diagnoses*
5. Please list any nutritional supplements that you are currently taking: _____
   _____ □ *No Supplements*
6. **Please list any medications that you are currently taking:** _____
   _____ □ *No Medications*
7. **Please list any medication allergies that you have:** _____
   _____ □ *No Known Med. Allergies*
8. Please list any surgical operations and dates _____
   _____ □ *No Surgeries*
9. **Current Height:** _____ **Current Weight:** _____
10. **Smoking status (age 13 & over)**: □ Never smoked □ Former smoker □ Current smoker

Cornerstone **CHIROPRACTIC**
804 N. 16th Street, Montevideo, MN 56265 Ph. 320.269.3211

Name: _____ *DOB:* _____ *Date:* _____

Review of Systems

Past	Present		Past	Present	
☐	☐	Neck or back pain	☐	☐	Difficulty swallowing
☐	☐	Headaches	☐	☐	Heartburn or indigestion
☐	☐	Jaw pain	☐	☐	Ulcer
☐	☐	Arm, shoulder, elbow, wrist or hand pain	☐	☐	Aortic aneurysm
☐	☐	Leg, hip, knee, ankle or foot pain	☐	☐	High blood pressure
☐	☐	Swelling or stiffness of joints	☐	☐	Heart murmur
☐	☐	Numbness, loss of sensation, or tingling	☐	☐	Heart palpitations
☐	☐	General fatigue	☐	☐	Chest pains or angina
☐	☐	Depression	☐	☐	Heart attack
☐	☐	Troubled sleep	☐	☐	Stroke
☐	☐	Loss of memory	☐	☐	Asthma or Allergies
☐	☐	Fainting	☐	☐	Skin rashes
☐	☐	Seizures	☐	☐	Cancer or non-cancerous tumor
☐	☐	Visual disturbances	☐	☐	Blood disorder
☐	☐	Dizziness	☐	☐	Emphysema
☐	☐	Ear noises or ringing	☐	☐	Arthritis (or Rheumatoid arthritis)
☐	☐	Hard of Hearing	☐	☐	Diabetes
☐	☐	Earache	☐	☐	Hepatitis
☐	☐	Ear Fluid	☐	☐	Epilepsy
☐	☐	Shortness of breath or wheezing	☐	☐	Lupus
☐	☐	Chronic cough or chronic sinusitis	☐	☐	HIV/AIDS
☐	☐	Runny nose or post nasal drip	☐	☐	Other_____
☐	☐	Throat soreness or hoarseness			
☐	☐	Chronic ear or throat infections	**Men Only**		
☐	☐	Loss of taste or appetite	☐	☐	Prostate problems
☐	☐	Abnormal weight gain or loss	☐	☐	Erectile dysfunction
☐	☐	Excessive thirst	☐	☐	Testicular pain
☐	☐	Heat or cold intolerance			
☐	☐	Loss of bladder control	**Women Only**		
☐	☐	Painful or frequent urination	☐	☐	Irregular menstrual flow
☐	☐	Bladder infection	☐	☐	Breast soreness or lumps
☐	☐	Kidney disorder or stones	☐	☐	Menstrual cramping
☐	☐	Abdominal pain	☐	☐	PMS
☐	☐	Constipation/irregular bowel habits	☐	☐	Endometriosis
☐	☐	Liver or gallbladder problems	☐	☐	Recurrent yeast or fungal infection
☐	☐	Hernia	☐	☐	Hot flashes
☐	☐	Irritable bowel or colitis			
☐	☐	Nausea			
☐	☐	Bloating or gas			
☐	☐	Diarrhea			
☐	☐	Hemorrhoids			

Duration of cycle _____ Duration of flow _____
Menstrual flow: ☐ Heavy ☐ Moderate ☐ Light
Last period _____
No. Pregnancies _____ No. Births _____
Contraception Type _____

Please list any other health concerns you have that you would like the doctor to be aware of _____
_____

Patient's signature: _____ **Date:** _____

Parent/ Guardian signature: _____ **Date:** _____

Cornerstone **CHIROPRACTIC**
804 N. 16th Street, Montevideo, MN 56265 Ph. 320.269.3211

Name: _____ *DOB:* _____ *Date:* _____

CLAIM INFORMATION
Have you been given a claim number for your injury? _____
What company services your employer's worker's compensation claims? _____

LEGAL INFORMATION
Do you have an attorney on this case? □ Yes □ No If yes, whom? _____
Note: Patients involved in litigation (lawsuits) or third party payment are ultimately responsible for payment of services.

OFFICE FINANCIAL POLICY

Once we have a claim number for your injury, all claims will first be submitted to the worker's compensation carrier and, following receipt of benefits, a statement of your responsibility will be sent to you. In order to avoid accumulating an unmanageable balance, individual accounts are not allowed to exceed $200 and family accounts cannot surpass $300. Chiropractic care will not be rendered if balances exceed these amounts. We welcome periodic payments while we wait to hear back from your insurance company in order to keep your account balance manageable.

Our fees are considered usual, customary and reasonable by most companies, and therefore are covered up to the maximum allowance determined by each carrier. This statement does not apply to companies who reimburse based on an arbitrary schedule of fees bearing no relationship to the current standard of care in this area.

If your carrier has not paid a claim within sixty (60) days of submission, you agree to take an active part in the recovery of your claim. If your insurance carrier has not paid within ninety (90) days of submission, you accept responsibility for payment in full of any outstanding balance.

****

Your signature on this intake form denotes that you understand the above policies and agree to abide by the same. You understand that you are ultimately responsible for all charges whether or not it is covered by the worker's compensation company. For your convenience, we accept cash, check, Visa and MasterCard. Your signature below also authorizes the doctor(s) to release all information necessary to secure the payment of benefits from your employer's worker's compensation carrier.

In addition, your signature authorizes the use of your signature here on all claim submissions.

_____ _____
Patient or Legal Guardian Signature Relationship or authority if not signed by patient

_____ _____
Date Cornerstone Chiropractic Staff