

Name: _____ DOB: _____ Date: _____

Worker's Compensation Patient Case History

Please complete this questionnaire. This confidential history will be part of your permanent records. THANK YOU!

Address _____ City _____ State _____ Zip _____

Home Phone _____ Work Phone _____ Cell Phone _____

E-mail Address _____ Social Security Number _____

Sex M F 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 _____

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 _____

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

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

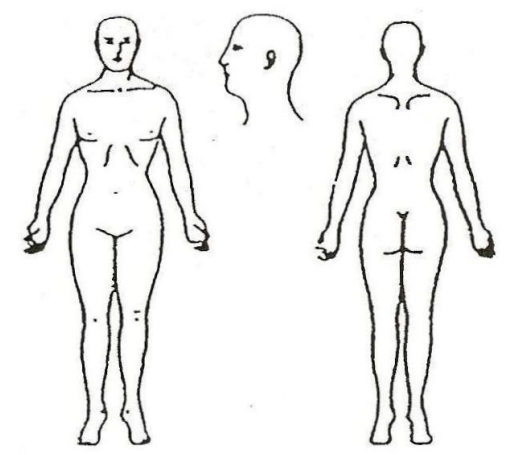
- a. How often does it affect you? constant intermittent
 b. Symptom severity is currently: mild moderate severe
 c. Symptom is currently: increasing decreasing not changing
 d. Symptom is worse in the: morning afternoon night same all day
 e. If there is pain, is it: sharp dull ache shooting tingling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

- f. 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 | |
- g. What makes the symptom better? nothing sitting lying down walking moving bending/twisting
other _____
- h. 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 ////



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 from 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.

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 _____

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 _____
5. Please list any medications or nutritional supplements that you are currently taking _____
6. Please list any surgical operations and dates _____

Name: _____ DOB: _____ Date: _____

Review of Systems

- | Past | Present | |
|--------------------------|--------------------------|--|
| <input type="checkbox"/> | <input type="checkbox"/> | Neck or back pain |
| <input type="checkbox"/> | <input type="checkbox"/> | Headaches |
| <input type="checkbox"/> | <input type="checkbox"/> | Jaw pain |
| <input type="checkbox"/> | <input type="checkbox"/> | Arm, shoulder, elbow, wrist or hand pain |
| <input type="checkbox"/> | <input type="checkbox"/> | Leg, hip, knee, ankle or foot pain |
| <input type="checkbox"/> | <input type="checkbox"/> | Swelling or stiffness of joints |
| <input type="checkbox"/> | <input type="checkbox"/> | Numbness, loss of sensation, or tingling |
| <input type="checkbox"/> | <input type="checkbox"/> | General fatigue |
| <input type="checkbox"/> | <input type="checkbox"/> | Depression |
| <input type="checkbox"/> | <input type="checkbox"/> | Troubled sleep |
| <input type="checkbox"/> | <input type="checkbox"/> | Loss of memory |
| <input type="checkbox"/> | <input type="checkbox"/> | Fainting |
| <input type="checkbox"/> | <input type="checkbox"/> | Seizures |
| <input type="checkbox"/> | <input type="checkbox"/> | Visual disturbances |
| <input type="checkbox"/> | <input type="checkbox"/> | Dizziness |
| <input type="checkbox"/> | <input type="checkbox"/> | Ear noises or ringing |
| <input type="checkbox"/> | <input type="checkbox"/> | Hard of Hearing |
| <input type="checkbox"/> | <input type="checkbox"/> | Earache |
| <input type="checkbox"/> | <input type="checkbox"/> | Ear Fluid |
| <input type="checkbox"/> | <input type="checkbox"/> | Shortness of breath or wheezing |
| <input type="checkbox"/> | <input type="checkbox"/> | Chronic cough or chronic sinusitis |
| <input type="checkbox"/> | <input type="checkbox"/> | Runny nose or post nasal drip |
| <input type="checkbox"/> | <input type="checkbox"/> | Throat soreness or hoarseness |
| <input type="checkbox"/> | <input type="checkbox"/> | Chronic ear or throat infections |
| <input type="checkbox"/> | <input type="checkbox"/> | Loss of taste or appetite |
| <input type="checkbox"/> | <input type="checkbox"/> | Abnormal weight gain or loss |
| <input type="checkbox"/> | <input type="checkbox"/> | Excessive thirst |
| <input type="checkbox"/> | <input type="checkbox"/> | Heat or cold intolerance |
| <input type="checkbox"/> | <input type="checkbox"/> | Loss of bladder control |
| <input type="checkbox"/> | <input type="checkbox"/> | Painful or frequent urination |
| <input type="checkbox"/> | <input type="checkbox"/> | Bladder infection |
| <input type="checkbox"/> | <input type="checkbox"/> | Kidney disorder or stones |
| <input type="checkbox"/> | <input type="checkbox"/> | Abdominal pain |
| <input type="checkbox"/> | <input type="checkbox"/> | Constipation/irregular bowel habits |
| <input type="checkbox"/> | <input type="checkbox"/> | Liver or gallbladder problems |
| <input type="checkbox"/> | <input type="checkbox"/> | Hernia |
| <input type="checkbox"/> | <input type="checkbox"/> | Irritable bowel or colitis |
| <input type="checkbox"/> | <input type="checkbox"/> | Nausea |
| <input type="checkbox"/> | <input type="checkbox"/> | Bloating or gas |
| <input type="checkbox"/> | <input type="checkbox"/> | Diarrhea |
| <input type="checkbox"/> | <input type="checkbox"/> | Hemorrhoids |

- | Past | Present | |
|--------------------------|--------------------------|-------------------------------------|
| <input type="checkbox"/> | <input type="checkbox"/> | Difficulty swallowing |
| <input type="checkbox"/> | <input type="checkbox"/> | Heartburn or indigestion |
| <input type="checkbox"/> | <input type="checkbox"/> | Ulcer |
| <input type="checkbox"/> | <input type="checkbox"/> | Aortic aneurysm |
| <input type="checkbox"/> | <input type="checkbox"/> | High blood pressure |
| <input type="checkbox"/> | <input type="checkbox"/> | Heart murmur |
| <input type="checkbox"/> | <input type="checkbox"/> | Heart palpitations |
| <input type="checkbox"/> | <input type="checkbox"/> | Chest pains or angina |
| <input type="checkbox"/> | <input type="checkbox"/> | Heart attack |
| <input type="checkbox"/> | <input type="checkbox"/> | Stroke |
| <input type="checkbox"/> | <input type="checkbox"/> | Asthma or Allergies |
| <input type="checkbox"/> | <input type="checkbox"/> | Skin rashes |
| <input type="checkbox"/> | <input type="checkbox"/> | Cancer or non-cancerous tumor |
| <input type="checkbox"/> | <input type="checkbox"/> | Blood disorder |
| <input type="checkbox"/> | <input type="checkbox"/> | Emphysema |
| <input type="checkbox"/> | <input type="checkbox"/> | Arthritis (or Rheumatoid arthritis) |
| <input type="checkbox"/> | <input type="checkbox"/> | Diabetes |
| <input type="checkbox"/> | <input type="checkbox"/> | Hepatitis |
| <input type="checkbox"/> | <input type="checkbox"/> | Epilepsy |
| <input type="checkbox"/> | <input type="checkbox"/> | Lupus |
| <input type="checkbox"/> | <input type="checkbox"/> | HIV/AIDS |
| <input type="checkbox"/> | <input type="checkbox"/> | Other _____ |

Men Only

- | | | |
|--------------------------|--------------------------|----------------------|
| <input type="checkbox"/> | <input type="checkbox"/> | Prostate problems |
| <input type="checkbox"/> | <input type="checkbox"/> | Erectile dysfunction |
| <input type="checkbox"/> | <input type="checkbox"/> | Testicular pain |

Women Only

- | | | |
|--------------------------|--------------------------|-------------------------------------|
| <input type="checkbox"/> | <input type="checkbox"/> | Irregular menstrual flow |
| <input type="checkbox"/> | <input type="checkbox"/> | Breast soreness or lumps |
| <input type="checkbox"/> | <input type="checkbox"/> | Menstrual cramping |
| <input type="checkbox"/> | <input type="checkbox"/> | PMS |
| <input type="checkbox"/> | <input type="checkbox"/> | Endometriosis |
| <input type="checkbox"/> | <input type="checkbox"/> | Recurrent yeast or fungal infection |
| <input type="checkbox"/> | <input type="checkbox"/> | Hot flashes |
- Duration of cycle _____ Duration of flow _____
 Menstrual flow: Heavy Moderate Light
 Last period _____
 No. Pregnancies _____ No. Births _____
 Contraception Type _____

Men & Women: Height _____ Weight _____

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

Thank you!



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's signature: _____ Date: _____

Parent/ Guardian or other signature: _____

Cornerstone Chiropractic Staff: _____