WORK / COMP HISTORY

Patient _____ Phone ( ) _____

Address _____ City _____ State _____ Zip _____

Age _____ Birthdate _____ Sex _____ S/S # _____

Name of Compensation Carrier: _____ Phone ( ) _____

Address of Carrier: _____ City _____ State _____ Zip _____

Employer's Name: _____ Phone ( ) _____

Employer's Address: _____ City _____ State _____ Zip _____

1. Type of Business _____ Your Occupation _____
2. Date Injured _____ Hour _____ AM / PM Last Date Worked _____ Are you off work? ( ) Yes ( ) No
3. Previous Workers' Compensation Injury? ( ) Yes ( ) No
4. Accident reported to employer? ( ) Yes ( ) No Name of person reported accident to _____
5. Injured at: _____ City _____ State _____ Zip _____
6. Length of time worked there prior to accident: _____
7. Type of work being done at time of injury: _____

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

   _____

   _____

   _____
9. 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? _____
10. Are you: ( ) improved ( ) unchanged ( ) getting worse
11. What types of medicines are you taking? _____

    _____

    Do these medicines help? ( ) Yes ( ) No ( ) Don't know
12. 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
13. 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

    Please provide details of accident(s): _____

    _____

    _____

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

    Describe: _____

15. Have you had any serious illnesses that required hospitalization? ( ) Yes ( ) No

    Describe: _____

    _____

    _____

16. Have you had any surgeries? ( ) Yes ( ) No

    If yes, list type of surgery and date: _____

    _____

    _____

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

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

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

19. 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
5. I have tingling and/or numbness in my: ( ) right leg ( ) left leg ( ) both
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:

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

1. In a typical 8-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 50 pounds	( )	( )	( )	( )
51 to 74 pounds	( )	( )	( )	( )
75 to 100 pounds	( )	( )	( )	( )

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 changes 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 additional comments: _____

_____

_____

Signature: _____ Date: _____

Family Chiropractic and Acupuncture Center
2801 Waterman Blvd Ste 260
Fairfield, CA 94534
(707) 427-1222

Privacy Issues Protected By HIPAA

- I authorize the release of medical information to my primary care or referring physician, to consultants if needed and as necessary to process insurance claims, insurance applications and prescriptions.

- I authorize Family Chiropractic and Acupuncture Center to leave a message on my answering machine regarding lab results/medical information relevant to patient care.

- I authorize Family Chiropractic and Acupuncture Center to talk to my spouse in regards to my lab results/medical information relevant to patient care.

- I authorize Family Chiropractic and Acupuncture Center to leave a message on my answering machine regarding account balance information.

- I authorize Family Chiropractic and Acupuncture Center to talk with my spouse in regards to my account balance information.

- I authorize payment of medical benefits to the physician. (Required Consent)

- I acknowledge that the information that I have given to Family Chiropractic and Acupuncture Center is correct and current. Any change and/or additional information will be given to them as soon as possible. If any information is incorrect or lacking, thus resulting in a delay or a denial in billing, I accept responsibility for the outstanding balance. (Required Consent)

Please Initial and Sign Below:

___ (initial) I acknowledge that I have read and understand the "Notice of Privacy Practice" form given to me by Family Chiropractic and Acupuncture Center to review. I know that I have the right to request and receive a copy of the full HIPAA disclosure form that I have just read. (Required Consent)

Signature: _____ Date: _____

Print Name: _____

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DOCTOR-PATIENT RELATIONSHIP AND INFORMED CONSENT

CHIROPRACTIC

It is important to acknowledge the difference between the health care specialties of Chiropractic, Osteopathy, and Medicine, and for the patient to understand what to expect from chiropractic care. It is the chiropractic premise that proper spinal alignment allows normal nerve transmission throughout the body and gives the body an opportunity to use its inherent recuperative powers. In this way, chiropractic health care seeks to restore health through natural means without the use of drugs or surgery. This gives the body maximum opportunity to utilize its inherent recuperative powers. The success of chiropractic procedures often depends on environment, underlying causes, and the physical and spinal conditions of each individual patient. It is important that the patient understands what to expect from your chiropractic care. Due to the complexities of nature, and the many variables (both known and unknown) that can affect a patient's response, no doctor can promise specific results. The Doctor of Chiropractic provides a specialized, unique, non-duplicating health service. The Doctor of Chiropractic is licensed in a special area of practice and is available to work with other types of providers in your health care regime.

ANALYSIS

Your doctor will conduct a clinical analysis for the express purpose of determining whether there is evidence that your situation may be the result of a vertebral subluxation and that you might respond satisfactorily to chiropractic care. If such is found, chiropractic care will be recommended in an attempt to restore spinal integrity.

RESULTS

The purpose of chiropractic care is to promote natural health through the reduction of the vertebral subluxation. Since there are so many variables, it is difficult to predict the time schedule or the efficacy of the chiropractic adjustment on any given patient. Sometimes the response is phenomenal, however, in most cases, there is a more gradual, but quite satisfactory response. Occasionally, the results are less than expected. Two or more similar conditions may respond differently to the same type of care and actual response is not predictable. Many medical failures have found significant benefit through chiropractic care.

In turn, many conditions, which do not respond to chiropractic care, may be helped through medical treatment. Chiropractic and medicine may never be so exact as to provide definite answers to all problems; however, both have made great strides in patient care.

DIAGNOSIS

Although Doctors of Chiropractic are experts in the analysis of the structural alignment of the human spine, and its effects on the nervous system, they are not internal medical specialists. Every patient should be mindful of his/her own symptoms and should secure other opinions should he/she have any concerns as to the nature of his/her total condition. Your Doctor of Chiropractic may express an opinion as to whether or not you should take this step, but you are responsible for the final decision.

INFORMED CONSENT FOR CHIROPRACTIC CARE

By signing below, the patient gives the doctor permission and authority to care for him/her in accordance with recognized and acceptable chiropractic analytical and corrective procedures. The chiropractic adjustment is usually beneficial and seldom causes any adverse reactions. In rare cases, undetected physical defects, deformities, or pathologies may render the patient susceptible to injury. The doctor, of course, will not give an adjustment if he is aware that such care may be contra-indicated. Again, it is the responsibility of the patient to make it known or to learn through other health care procedures whether he/she is suffering from pathological conditions (latent or otherwise), illnesses, injuries, or deformities which would otherwise not come to the attention of the doctor.

TO THE PATIENT

Please discuss any questions or problems with the doctor before signing this statement of understanding and consent for care.

I have read and understand the foregoing explanation of chiropractic care given to me. I hereby give my consent for the doctor to render chiropractic care to me.

Signature:_____ Date:_____

Print Name:_____

I have verbally informed the patient of the material risk of proposed care.

Doctor's Signature:_____Date:_____