NEW PATIENT INTAKE FORM – Worker's Compensation

Today's Date_____/_____/___

PATIENT INFORMATION **CONFIDENTIAL**

Thank you for the opportunity to serve you. If you have any questions, do not hesitate to ask. We will be happy to help.

Name _____ DOB_____/_____/_____ S/S_____-_____-_____

First MI Last

Address_____ City_____ State_____ Zip_____

Please check your preferred method of contact

❒Home Phone: _____ ❒Work Phone: _____

❒Cell Phone: _____ ❒e-mail address*:_____

** Your e-mail will not be shared with any 3rd parties and is used for occasional office announcements and promotions.*

Height_____ Weight_____ Last known Blood Pressure: _____ *(Unsure? We can take a reading today)*

Do you smoke: ❒ No❒ Yes (If yes, how often_____) If you quit: Start date: _____ End Date: _____

Sex: ❒ Female ❒ Male **Status:** ❒ Minor ❒Married ❒Single ❒ Other:_____

Ethnicity/Race: _____ Employed: ❒Full-Time ❒Part-Time

Your Employer_____ Phone_____

Business Address_____ City_____ State_____ Zip_____

Type of Business_____ Your Occupation_____

Name of Compensation Carrier _____ Phone_____

Address _____

Who may we thank for referring you to us? _____

Person to contact in case of an emergency_____ Phone _____

HEALTH HISTORY

Please check the following symptoms you have noticed **SINCE THE ACCIDENT** (❍) or **BEFORE THE ACCIDENT** (❒):

❍ ❒ Headaches	❍ ❒ Irritability	❍ ❒ Loss of Smell
❍ ❒ Neck Pain	❍ ❒ Mood Swings	❍ ❒ Loss of Taste
❍ ❒ Neck Stiffness	❍ ❒ Sleeping Problems	❍ ❒ Upset Stomach
❍ ❒ Mid Back Pain	❍ ❒ Fatigue	❍ ❒ Constipation
❍ ❒ Low Back Pain	❍ ❒ Depression	❍ ❒ Diarrhea
❍ ❒ Arm Pain	❍ ❒ Chest Pain	❍ ❒ Urinary Problems
❍ ❒ Leg Pain	❍ ❒ Shortness of Breath	❍ ❒ Heartburn
❍ ❒ Pins and Needles in Arms	❍ ❒ Cold Sweats	❍ ❒ Ulcers
❍ ❒ Pins and Needles in Legs	❍ ❒ Fever	❍ ❒ Allergies
❍ ❒ Numbness in Fingers	❍ ❒ Fainting	❍ ❒ Menstrual Pain
❍ ❒ Numbness in Toes	❍ ❒ Dizziness	❍ ❒ Menstrual Irregularity
❍ ❒ Cold Hands	❍ ❒ Loss of Balance	❍ ❒ Hot flashes
❍ ❒ Cold Feet	❍ ❒ Light Sensitivity with Eyes	❍ ❒ Other _____
❍ ❒ Nervousness	❍ ❒ Ringing/ Buzzing in Ears	❍ ❒ Other _____
❍ ❒ Tension	❍ ❒ Loss of Memory	

Continued on back...

Have **YOU** (❍) or **A FAMILY MEMBER** (❒) ever been diagnosed with any of the following conditions**:**

❍ ❒ AIDS/HIV	❍ ❒ Heart Disease	❍ ❒ None
❍ ❒ Cancer	❍ ❒ Diabetes	❍ ❒ Unknown
❍ ❒ High Blood Pressure	❍ ❒ Stroke	❍ ❒ Other _____

ACCIDENT INFORMATION:

Date of accident _____/_____/_____ Time of Day _____ Location of accident _____

Was the accident reported to your employer? ❒ No ❒ Yes, name of person reported accident to _____

What type of work were you doing at the time of the accident? _____

Please describe the accident in your own words: _____

_____

_____

Did you lose consciousness? ❒ No ❒ Yes, for how long? _____

What was your mental and emotional state immediately following the accident? _____

Where did you go immediately following the accident? _____

Have you been treated by another doctor since the accident? ❒ No ❒ Yes , If yes…

Please list the name of the doctor and address: _____

Please explain what type of treatment you received: _____

What type of X-rays were taken if any? _____

Was there any other imaging done? (i.e., MRI, CT, etc.) _____

Do you have any congenital (from birth) factors that may relate to this problem? ❒ No ❒ Yes, _____

Do you have any previous illnesses which relate to this case ❒ No ❒ Yes, _____

Have you ever been involved in a work comp accident before? ❒ No ❒ Yes, _____

Have you lost time from work as a result of this accident? ❒ No ❒ Yes, If yes Last day worked: _____/_____/_____

JOB DESCRIPTION:

In a typical 8-hour work day, I: (circle the number 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

On the job, I perform the following activities:

	NOT AT ALL	OCCASIONALLY	FREQUENTLY	CONTINUOUSLY
Bend/stoop	❒	❒	❒	❒
Squat	❒	❒	❒	❒
Crawl	❒	❒	❒	❒
Climb	❒	❒	❒	❒
Reach above head	❒	❒	❒	❒
Kneel	❒	❒	❒	❒
Balancing	❒	❒	❒	❒
Pushing/pulling	❒	❒	❒	❒
Lifting	❒	❒	❒	❒
Typing	❒	❒	❒	❒

Please add any other information that you feel is pertinent: _____

_____

_____

PLEASE LIST YOUR CURRENT AREAS OF COMPLAINT:

(chief complaint)

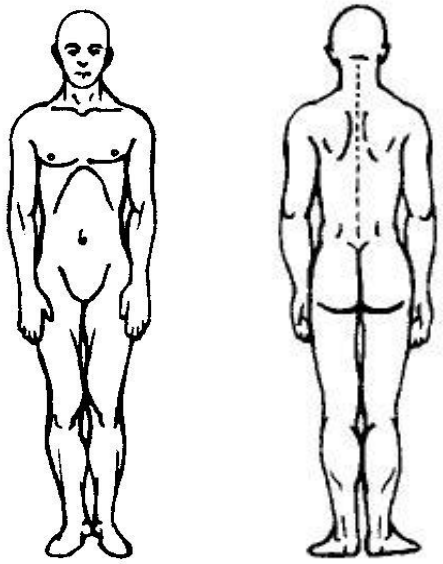
1) _____ 2) _____ 3) _____ 4) _____

0 1 2 3 4 5 6 7 8 9 10 0 1 2 3 4 5 6 7 8 9 10 0 1 2 3 4 5 6 7 8 9 10 0 1 2 3 4 5 6 7 8 9 10

CIRCLE THE NUMBER THAT BEST DESCRIBES THE INTENSITY OF YOUR PAIN: 1 = Mild, 10 = Severe

PLEASE MARK YOUR AREAS OF COMPLAINT ON THE BODY DIAGRAM USING THE FOLLOWING KEY:

Dull	= D
Aching	= A
Stiffness	= S
Burning	= B
Tingling	= T
Numbness	= N
Sharp	= !!!
Shooting	= XXX
Other_____	= ***



How often do you notice your symptoms? ❒ Constantly ❒ Frequently ❒ Occasionally

Does anything relieve your pain? _____

What activities are difficult to perform? ❒Sitting ❒Standing ❒Walking ❒Bending ❒Lying Down

Please describe any other activities that are restricted due to this injury?_____

_____

Is the condition getting worse? ❒ No ❒ Yes

Have you had this problem before? ❒ No ❒ Yes, When?_____

Have you had x-rays before? ❒ No ❒ Yes, When? _____ What areas? _____

I am currently taking the following medications for the following reasons: ❒ None

_____

_____

List Allergies: _____

Surgical History: _____

For Women Only: Is there a possibility that you may be pregnant? ❒ No ❒ Yes

I certify that the above information is true and accurate to the best of my knowledge

DATE: ____/____/____ **SIGNATURE:** _____

PARENT/GUARDIAN: _____

Cole Family Chiropractic
68 North High Street, Ste. E-106 New Albany, OH 43054
(614) 855-5454 (p) ~ (614) 283-5400 (f)

Patient Name: _____ **Date: _____**

Terms of Acceptance

The goal of our office is to enable patients to gain control of their health. To attain this we believe communication is the key. There are often topics that are hard to understand and we hope this document will clarify those issues for you.

Please read the below and if you have any questions please feel free to ask one of our staff members.

Informed Consent:

A patient, in coming to the chiropractic doctor, gives the doctor permission and authority to care for the patient in accordance with the chiropractic tests, diagnosis, and analysis. The chiropractic adjustment or other clinical procedures are usually beneficial and seldom cause any problems. In rare cases, underlying physical defects, deformities or pathologies may render the patient susceptible to injury. The doctor, of course, will not give any treatment or care if he/she 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 healthcare procedures what he/she is suffering from: latent pathological defects, illnesses or deformities which would otherwise not come to the attention of the chiropractic physician. The chiropractic doctor provides a specialized, non-duplicating health care service. Your doctor of chiropractic is licensed in a special practice and is available to work with other types of providers in your health care regimen. I understand that if I am accepted as a patient by a physician at Cole Family Chiropractic, I am authorizing them to proceed with any treatment that they deem necessary. Furthermore, any risk involved, regarding chiropractic treatment, will be explained to me upon my request.

Women Only:

To the best of my knowledge I **am / am NOT** pregnant and (**give my permission / don't give permission**) to x-ray me for diagnostic interpretation.
(Circle one above) *(Circle one above)*

Missed Appointments:

There is a possible fee charged for all appointments that are not canceled prior to scheduled visit.

Consent to Evaluate and Treat a Minor:

I, _____ being the parent or legal guardian of _____, have read and fully understand the above terms of acceptance and hereby grant permission for my child to receive chiropractic care.

Communications:

In the event that we would need to communicate your healthcare information, to whom may we do so?

Spouse: _____

Children: _____

Others: _____

No one: ____

May we leave messages regarding your personal healthcare information on any answering device,
i.e. home answering machines or voicemails? Yes [ ] No [ ]

Acknowledgement

I have read and fully understand the above statements. I have reviewed the notice of privacy practices (HIPAA) and have been provided an opportunity to discuss my right to privacy. Upon request I will be given a copy.

Print Name: _____

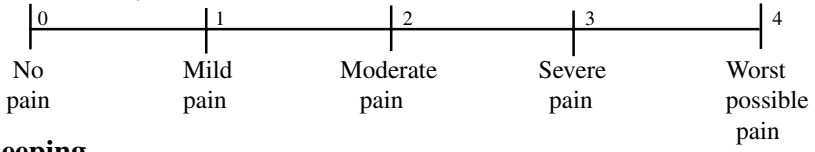
Signature: _____ Date: _____

Functional Rating Index

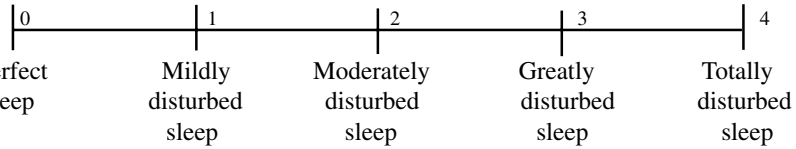
For use with **Neck and/or Back Problems** only.

In order to properly assess your condition, we must understand how much your **neck and/or back problems** have affected your ability to manage everyday activities.
For each item below, **please circle the number which most closely describes your condition right now.**

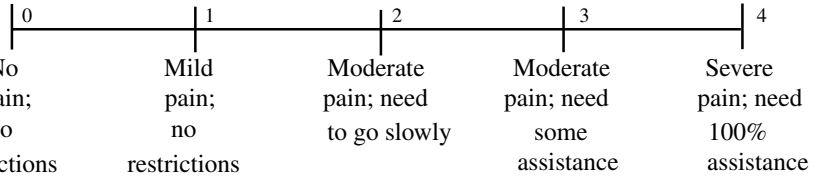
1. Pain Intensity



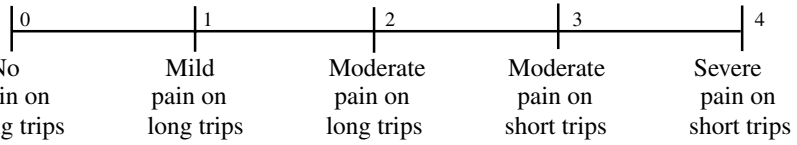
2. Sleeping



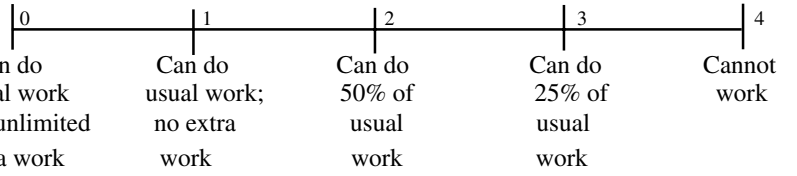
3. Personal Care (washing, dressing, etc.)



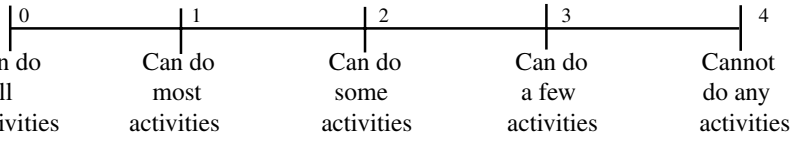
4. Travel (driving, etc.)



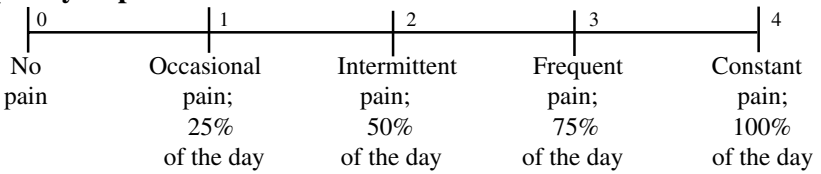
5. Work



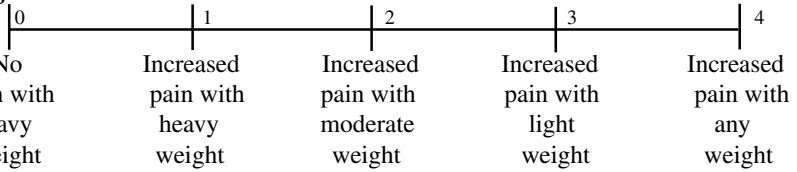
6. Recreation



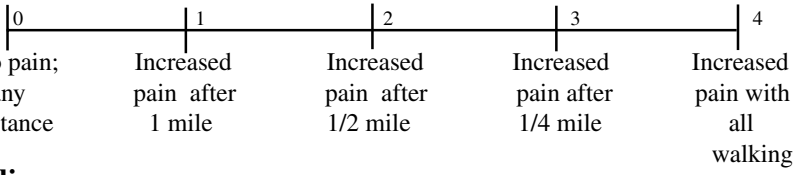
7. Frequency of pain



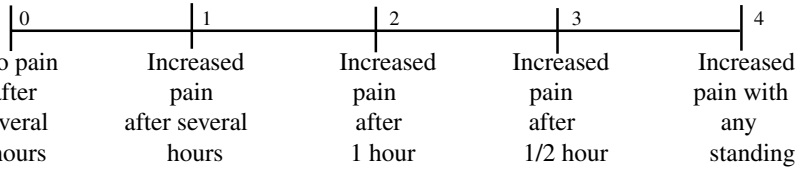
8. Lifting



9. Walking



10. Standing



Name _____
PRINTED

Total Score _____

_____
Signature

_____
Date