WORKER COMPENSATION INFORMATION

Date _____

PATIENT INFORMATION

Name _____ Birthdate _____ Soc. Sec.# _____

Address _____ (Street) _____ (City) _____ (State) _____ (Zip)

Home Phone (____) _____ E-mail _____

Cell Phone (____) _____ Occupation _____

EMPLOYER

Employer Name _____

Employer Address _____ (Street) _____ (City) _____ (State) _____ (Zip)

Employer Phone (____) _____ Injury Verified by (For Office Use) _____

Contact Person _____ E-mail _____

WORKER COMPENSATION CARRIER (FOR OFFICE USE)

Worker Compensation Carrier _____

Carrier Address _____ (Street) _____ (City) _____ (State) _____ (Zip)

Carrier Phone (____) _____ Coverage Verified by _____

Adjuster's Name _____ Claim Number _____

INJURY INFORMATION

Date of Injury _____ Time _____ ☐ AM ☐ PM Place of Injury _____

Accident reported to employer? ☐ Yes ☐ No Name of person you reported accident to _____

Give full description of how accident happened _____

_____

_____

_____

Have you lost time from work? ☐ Yes ☐ No How much? _____

Other doctors seen for this condition: Doctor's Name _____

Diagnosis _____ Were X-Rays taken? ☐ Yes ☐ No Other Tests? ☐ Yes ☐ No

If yes, by whom? Please list test(s) and result(s) _____

_____

_____

_____

Any previous Worker Compensation injuries? ☐ Yes ☐ No Date(s) of previous injuries _____

Describe previous Worker Compensation injuries _____

AUTHORIZATION

I clearly understand and agree that all services rendered to me are charged directly to me and that I am personally responsible for payment in the event that my claim for Worker Compensation benefits is denied. I understand that filing for Worker Compensation benefits does not relieve me from my responsibility for the payment of all charges.

_____ _____

Signature of Patient, Parent, Guardian or Personal Representative Date

_____ _____

Please print name of Patient, Parent, Guardian or Personal Representative Relationship to Patient

phillipsfamily CHIROPRACTIC

Confidential Patient Information

Thank you for choosing our practice for your chiropractic needs. Please complete this form in ink. If you have any questions or concerns, do not hesitate to ask for assistance. We will be happy to help.

(Please Print)

Name _____ Date _____
First Middle Initial Last

Address _____ City _____ State _____ Zip _____

Sex: ❑ Female ❑ Male **Birthdate** _____ E-mail _____

Home Phone (____) _____ Cell Phone (____) _____ Work Phone(____) _____

Do you prefer to receive calls at: ❑ Home ❑ Work ❑ Cell ❑ No Preference

❑ Married ❑ Widowed ❑ Single ❑ Minor ❑ Separated ❑ Divorced ❑ Partnered

Patient Employer/School _____ Occupation _____

Employer/School Address _____ City _____ State _____ Zip _____

Spouse or Parent's name _____ Employer _____

Whom may we thank for referring you to us? _____ Family Physician _____

Person to contact in case of emergency _____ Phone (____) _____

Insurance Information Please list your Work Comp Insurance.

Please check the type of insurance that applies to your case:

❑ Auto Accident ☑ Work Injury ❑ Group ❑ Medicare ❑ Other

If Auto Accident or Work Injury: Date of Injury _____

Name of insured _____ Relationship to Patient _____

Birthdate _____ Social Security # _____

Name of employer _____ Work Phone (____) _____

Insurance Co. _____ Group # _____

Insurance ID# _____

Auto Accident/Work Injury/Medicare Patients Only Please list your Private Insurance.

Do you have additional insurance? If so, complete the following:

Name of insured _____ Relationship to Patient _____

Birthdate _____ Social Security # _____ Date employed _____

Name of employer _____ Work Phone (____) _____

Insurance Co. _____ Group # _____

Insurance ID# _____

Expectations/Desires for Care

- ❑ **Acute Care** (I am interested in relief from my current pain or condition only)
- ❑ **Wellness Care** (I am interested in participating in care that helps me to remain healthy when I am no longer in acute pain)

In addition to my chiropractic care, I would be interested in utilizing the following additional methods of getting and staying healthy:

- ❑ **Massage Therapy:** A helpful adjunct to your chiropractic care. Useful in treating and managing a number of different health conditions.
- ❑ **Nutrition:** Attention to proper diet and supplementation needs can "Help your body to help itself"
- ❑ **Exercise/Stretching:** It truly is "the best medicine". Exercise and stretching can be used to rehabilitate an injured area or to maintain and improve your health.

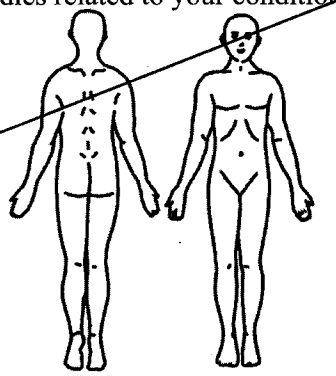
See Worker Compensation Form

Patient Condition

Reason for today's visit: _____
When did your symptoms first appear?: _____
What occurred to contribute to the onset of your symptoms? _____
_____
Rate the severity of your pain: 1 2 3 4 5 6 7 8 9 10
Is the pain constant or does it come and go? (Circle correct answer)
Has the intensity of your pain been getting better, worse or staying the same? (Circle the correct answer)
Activities or movements that are painful to perform: ❑ Sitting ❑ Standing ❑ Walking ❑ Bending ❑ Lying Down
Other treatments for this condition: ❑ Medication ❑ Physical Therapy ❑ Massage ❑ Surgery
Are there any existing diagnostic studies related to your condition or area of complaint? Yes/No

Please indicate the location of your **pain** by placing an "X" over the involved area(s).

Please indicate any areas of **numbness or tingling** by placing a "✓" over the involved area(s).



Any additional information on your condition you would like to add: _____
_____
_____
_____
_____

* Please list all medications currently used (Prescription or Over the Counter): _____
_____
_____
Please list all nutritional supplements currently used: _____
_____
Do you exercise? _____ If so, what type? _____ How often? _____

* Health History

❑ AIDS/HIV	❑ Diabetes	❑ High Blood Pressure	❑ Osteopenia	❑ Spinal Surgery
❑ Allergy Shots	❑ Emphysema	❑ High Cholesterol	❑ Osteoporosis	❑ Stroke
❑ Anemia	❑ Epilepsy	❑ Irritable Bowel Synd.	❑ Pacemaker	❑ Thyroid Problems
❑ Arthritis	❑ Fibromyalgia	❑ Joint Replacement	❑ Parkinson's Disease	❑ Tuberculosis
❑ Asthma	❑ Glaucoma	❑ Kidney Disease	❑ Polio	❑ Tumors
❑ Breast Cancer	❑ Gout	❑ Liver Disease	❑ Prostate Problems	❑ Ulcers
❑ Cancer	❑ Heart Disease	❑ Meniere's Disease	❑ Psoriasis	❑ Vertigo
❑ Carotid Artery Surgery	❑ Hepatitis	❑ Migraine Headaches	❑ Rheumatoid Arthritis	❑ Other _____
❑ Chronic Fatigue Synd.	❑ Hernia	❑ Mononucleosis	❑ Shoulder Surgery	_____
❑ Colitis	❑ Herniated Disc	❑ Multiple Sclerosis	❑ Spinal Fractures	_____

Female Specific

Are you currently pregnant? Yes/No Date of last menstrual flow: _____
Are you currently experiencing symptoms associated with menopause? Yes/No
Are you post-menopausal? Yes/No If so, for how long? _____

* Certification and Assignment

To the best of my knowledge, the above information is complete and correct. I understand that it is my responsibility to inform my doctor if I, or my minor child, ever have a change in health.

I certify that I, and/or my dependent(s), have insurance coverage with _____
Name of Insurance Company(ies)
and assign directly to Phillips Family Chiropractic all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I authorize the use of my signature on all insurance submissions.

The above-named doctor may use my health care information and may disclose such information to the above-named Insurance Company(ies) and their agents for the purpose of obtaining payment for services and determining insurance benefits or the benefits payable for related services.

* _____ * _____
Signature of Patient, Parent, Guardian or Personal Representative — Date

_____ _____
Please print name of Patient, Parent, Guardian or Personal Representative — Relationship to Patient