CONFIDENTIAL PATIENT INFORMATION – WORKER'S COMPENSATION

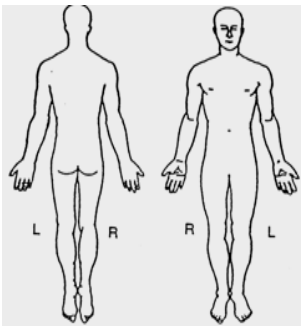
Name_____ Date _____ SSN_____
Home Ph._____ Cell Ph._____
Address _____City _____State _____ Zip _____ Sex M F
Age _____ Birth Date_____ Marital Status M S W D How many children? _____
Occupation_____ Employer_____ Office Ph. _____
Work Address_____ Email Address_____
Name of Spouse _____ Occupation _____ Employer_____
Who may we thank for referring you? _____
Have you had chiropractic care? ☐ Yes ☐ No If so, who was the doctor and when?_____
Would you like to receive ☐ Email Reminders ☐ Text Reminders, Cellular Carrier: _____
Please list your most recent traumas (auto accidents, major falls, sport injuries, etc.):
1. _____ Date: _____
2. _____ Date: _____
3. _____ Date: _____

PRIMARY CONDITION – PLEASE DESCRIBE ONE AREA OF COMPLAINT

Please describe your primary complaint: _____
When did it start? _____ Have you had it in the past: ☐ Y ☐ N When: _____
Please check the appropriate box: The pain is ☐ constant ☐ it comes and goes
On a scale from 1-10 with 10 being the worst circle the level of pain: 1 2 3 4 5 6 7 8 9 10
Please check the box(es) that best describes the pain: ☐ Sharp/Stabbing Pain ☐ Burning
☐ Dull Pain ☐ Tingling ☐ Numbness ☐ Weakness ☐ Restriction ☐ Other _____
Does your pain travel from the point of pain? ☐ Y ☐ N If yes, where: _____
What makes it better? ☐ Chiropractic ☐ Ice ☐ Heat ☐ Massage ☐ Medication
☐ Resting ☐ Sitting ☐ Standing ☐ Walking ☐ Lying Down ☐ Other _____
What makes it worse? ☐ Bowel Movements ☐ Breathing ☐ Coughing ☐ Driving
☐ Sitting ☐ Lying Down ☐ Sneezing ☐ Walking ☐ Working ☐ Other _____
Have you missed any school/work due to this complaint? ☐ Y ☐ N
Is this the result of an automobile accident: ☐ Y ☐ N Work related injury: ☐ Y ☐ N
If yes, to either question above, please explain: _____

Please mark your areas of pain on the figure below

++ Sharp/Stabbing ## Burning
XX Tingling/Numb 00 Dull



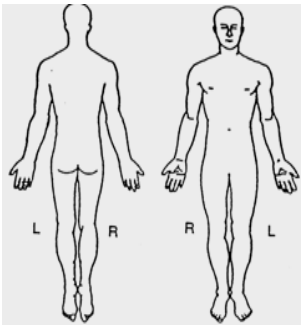
Have you received any other treatment for this condition: ☐ Y ☐ N If yes, indicate treatment ☐ Chiropractic ☐ Physical Therapy ☐ Surgery ☐ Other _____ Doctor's Name who provided Treatment: _____
*DOCTOR USE ONLY: _____
_____

SECONDARY CONDITION – (if applicable)

Please describe your secondary complaint: _____
When did it start? _____ Have you had it in the past: ☐ Y ☐ N When: _____
Please check the appropriate box: The pain is ☐ constant ☐ it comes and goes
On a scale from 1-10 with 10 being the worst circle the level of pain: 1 2 3 4 5 6 7 8 9 10
Please check the box(es) that best describes the pain: ☐ Sharp/Stabbing Pain ☐ Burning
☐ Dull Pain ☐ Tingling ☐ Numbness ☐ Weakness ☐ Restriction ☐ Other _____
Does your pain travel from the point of pain? ☐ Y ☐ N If yes, where: _____
What makes it better? ☐ Chiropractic ☐ Ice ☐ Heat ☐ Massage ☐ Medication
☐ Resting ☐ Sitting ☐ Standing ☐ Walking ☐ Lying Down ☐ Other _____
What makes it worse? ☐ Bowel Movements ☐ Breathing ☐ Coughing ☐ Driving
☐ Sitting ☐ Lying Down ☐ Sneezing ☐ Walking ☐ Working ☐ Other _____
Have you missed any school/work due to this complaint? ☐ Y ☐ N
Is this the result of an automobile accident: ☐ Y ☐ N Work related injury: ☐ Y ☐ N
If yes, to either question above, please explain: _____

Please mark your areas of pain on the figure below

++ Sharp/Stabbing ## Burning
XX Tingling/Numb 00 Dull



Have you received any other treatment for this condition: ☐ Y ☐ N If yes, indicate treatment ☐ Chiropractic ☐ Physical Therapy ☐ Surgery ☐ Other _____ Doctor's Name who provided Treatment: _____

*DOCTOR USE ONLY: _____

_____

ADDITIONAL CONDITION – (if applicable)

Please describe your additional complaint: _____

When did it start? _____ Have you had it in the past: ☐ Y ☐ N When: _____

Please check the appropriate box: The pain is ☐ constant ☐ it comes and goes

On a scale from 1-10 with 10 being the worst circle the level of pain: 1 2 3 4 5 6 7 8 9 10

Please check the box(es) that best describes the pain: ☐ Sharp/Stabbing Pain ☐ Burning ☐ Dull Pain ☐ Tingling ☐ Numbness ☐ Weakness ☐ Restriction ☐ Other _____

Does your pain travel from the point of pain? ☐ Y ☐ N If yes, where: _____

What makes it better? ☐ Chiropractic ☐ Ice ☐ Heat ☐ Massage ☐ Medication ☐ Resting ☐ Sitting ☐ Standing ☐ Walking ☐ Lying Down ☐ Other _____

What makes it worse? ☐ Bowel Movements ☐ Breathing ☐ Coughing ☐ Driving ☐ Sitting ☐ Lying Down ☐ Sneezing ☐ Walking ☐ Working ☐ Other _____

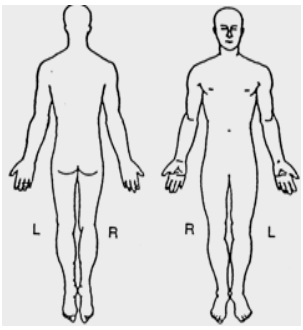
Have you missed any school/work due to this complaint? ☐ Y ☐ N

Is this the result of an automobile accident: ☐ Y ☐ N Work related injury: ☐ Y ☐ N

If yes, to either question above, please explain: _____

Please mark your areas of pain on the figure below

++ Sharp/Stabbing ## Burning
XX Tingling/Numb 00 Dull



Have you received any other treatment for this condition: ☐ Y ☐ N If yes, indicate treatment ☐ Chiropractic ☐ Physical Therapy ☐ Surgery ☐ Other _____ Doctor's Name who provided Treatment: _____

*DOCTOR USE ONLY: _____

_____

Activities of Daily Living: Please circle the activities that are affected by your current complaint.

Bathing	Cooking	Laying down	Sleeping
Bending	Daily pet care	Lifting items	Sneezing
Brushing teeth	Dressing	Reading	Sports
Caring for family	Swallowing	Reaching	Static sitting
Carrying items	Driving	Running	Static standing
Changing of pos.	Eating	Shaving	Washing body/hair
Climbing stairs	Exercising	Showering	Work activities
Computer use	Getting out of bed	Sexual activities	Yard work
Concentration	Household chores		

Medication: Please list all medications you are currently taking. We offer information as to what nutrient deficiencies will be caused by the medications you are taking. If you desire this information please inform your doctor.

1. _____ 3. _____ 5. _____ 7. _____
2. _____ 4. _____ 6. _____ 8. _____

Nutrients: Please list all nutrients you are currently taking. We offer to evaluate the formulations of your supplementation. If you desire this evaluation please bring your nutrients on your next visit.

1. _____ 3. _____ 5. _____ 7. _____
2. _____ 4. _____ 6. _____ 8. _____

Females Only: Are you currently having menstrual cycles? ☐ Y ☐ N If yes, when was the first day of your last cycle? _____ Is there any chance you are pregnant? ☐ Y ☐ N If yes, how many weeks? _____

Please sign to verify the above information is correct to the best of your knowledge. _____

Family History: Insert age and check any box that applies

	Age (if living)	Heart Dx	High Cholest	High Bl Pressure	Diabetes	Cancer	Anemia	Neck Pain	Low Bck Pain	Carpal Tunnel	Head aches	Obesity
Self												
Mom												
Dad												
Brother												
Sister												
Other ____												

Doctor's Use Only: _____
_____

LIFESTYLE: Your lifestyle, diet and exercise habits play an extremely important role in your overall health and risk of chronic disease. The following questions are designed to help us understand your habits, desires as well as commitments to make changes to those habits if necessary.

Diet:

1. How much do you drink? _____8-oz. glass water/day _____caffeinated drinks/day _____alcoholic drinks/week
2. How many times do you eat fast food each week? _____
3. Y N Do you smoke? If yes, how many packs a day? _____
4. Y N Do you have any food allergies? If yes, please name:_____
5. How many servings of fruits & vegetables are you eating a day? 0 1 2 3 4 5 6 7 8 9 10
   1 medium fruit = 1 serving 1 cup raw vegetables = 1 serving

Body Composition and Exercise:

1. Y N Are you at your ideal weight? Current Weight _____ If no, what is your desired weight? _____
2. Y N Are you interested in weight management?
3. Y N Do you engage in any cardiovascular exercise (e.g. aerobics, walking, swimming, etc.)?
   If yes, which activities?_____ _____Days Per Wk____ Duration _____
4. Y N Do you do any form of resistance exercises (lift weights) on a consistent basis? Days per week _____
5. Y N Do you ever experience pain after exercising? If yes, where? _____Type of Pain_____

Commitment and Goals:

1. On a scale of 1 to 10, what level of stress do you experience daily? 1 2 3 4 5 6 7 8 9 10
2. On a scale of 1 to 10, what is your commitment to making a lifestyle improvement? 1 2 3 4 5 6 7 8 9 10
3. What are your health goals for the next 6 months?_____
_____

Primary Care Physician

Primary Care Physician: _____ Physician Phone #: _____

Address: _____ City:_____ State:_____

Check here if you do NOT authorize this office to communicate with my primary physician about the care I receive. ☐

I verify that the information I have provided in this document is true and I give the doctor consent to treat me.

Name: _____ Signature: _____ Date: _____

Subjective Health Assessment

Please rate the following symptoms that you have experienced during the past 30 days

0 = Never 1 = Occasional and Mild 2 = Occasional and Severe 3 = Often and Mild 4 = Often and Severe

	Head		**Heart, Lungs**
0 1 2 3 4	Headache	0 1 2 3 4	Irregular Heart Beat

0	1	2	3	4	Faintness		0	1	2	3	4	Rapid, Pounding Heart Beat	
0	1	2	3	4	Dizziness		0	1	2	3	4	Chest Pain	
0	1	2	3	4	Sleeplessness	___Total	0	1	2	3	4	Chest Congestion	
							0	1	2	3	4	Asthma	
					Eyes, Ears, Nose, Throat		0	1	2	3	4	Bronchitis	___Total
0	1	2	3	4	Stuffy Nose								
0	1	2	3	4	Sinus Trouble							**Skin**	
0	1	2	3	4	Hay Fever		0	1	2	3	4	Acne	
0	1	2	3	4	Sneezing		0	1	2	3	4	Dry, Scaly Skin	
0	1	2	3	4	Nasal Congestion		0	1	2	3	4	Hair Loss	
0	1	2	3	4	Swollen Eyes		0	1	2	3	4	Hot Flashes	___Total
0	1	2	3	4	Reddened Eyes								
0	1	2	3	4	Watery, Itchy Eyes							**Digestion**	
0	1	2	3	4	Dark Circles Under Eyes		0	1	2	3	4	Nausea, Vomiting	
0	1	2	3	4	Earache, Ear Infection		0	1	2	3	4	Diarrhea	
0	1	2	3	4	Ringing in the Ears		0	1	2	3	4	Constipation	
0	1	2	3	4	Coughing		0	1	2	3	4	Heartburn	
0	1	2	3	4	Sore Throat		0	1	2	3	4	Stomach Pain	
0	1	2	3	4	Hoarseness, Loss of Voice		0	1	2	3	4	Bloating	
0	1	2	3	4	Canker Sore	___Total	0	1	2	3	4	Belching, Gas	___Total
					Memory, Emotions							**Joints**	
0	1	2	3	4	Mood Swings		0	1	2	3	4	Stiffness/Lack of Motion	
0	1	2	3	4	Anxiety, Nervousness		0	1	2	3	4	Arthritis	
0	1	2	3	4	Anger, Irritability		0	1	2	3	4	Pain in the Joints	
0	1	2	3	4	Aggressiveness		0	1	2	3	4	Pain in the Muscles	___Total
0	1	2	3	4	Depression								
0	1	2	3	4	Poor Memory							**Energy Levels**	
0	1	2	3	4	Confusion		0	1	2	3	4	Weakness	
0	1	2	3	4	Lack of Concentration		0	1	2	3	4	Fatigue	
0	1	2	3	4	Difficulty in Making Decisions	___Total	0	1	2	3	4	Hyperactivity	
							0	1	2	3	4	Restlessness	___Total
					Sleep							**Weight**	
0	1	2	3	4	Trouble Getting Asleep		0	1	2	3	4	Binge Eating/Drinking	
0	1	2	3	4	Trouble Staying Asleep		0	1	2	3	4	Craving Certain Foods	
0	1	2	3	4	Snoring		0	1	2	3	4	Excessive Weight	
0	1	2	3	4	Wake Up with Fatigue		0	1	2	3	4	Water Retention	
0	1	2	3	4	Fall Asleep During the Day	___Total	0	1	2	3	4	Overweight	___Total

Grand Total _____

PATIENT CONSENT FORM

FOR USE AND/OR DISCLOSURE OF PROTECTED HEALTH INFORMATION TO CARRY OUT ANALYSIS, TREATMENT, PAYMENT AND HEALTHCARE OPERATIONS.

I hereby state that by signing this consent, I acknowledge and agree as follows:

___ 1. The practice's Privacy Notice has been provided to me prior to my signing this consent. The Privacy Notice includes a complete description of the uses and/or disclosures of my protected health information (PHI) necessary for the practice to provide analysis and treatment for me, and also necessary for the practice to obtain payment for that treatment and to carry out its healthcare operations. The practice explained to me that the privacy notice would be available to me in the future at my request. The practice has encouraged me to read the privacy notice carefully prior to signing this consent.

____ 2. The practice reserves the right to change its privacy practices that are described in its privacy notice, in accordance with applicable law.

____ 3. I understand that, and consent to, the following appointment reminders that will be used by the practice:

- Postcards mailed to the addresses I have provided.
- Telephoning me at the numbers I have provided and leaving messages for me on my answering machine or with the individual answering the phone.

____ 4. The practice may use and/or disclose my PHI (which includes information about my health or condition, analysis, and the treatment provided to me) in order for the practice to make analyses about my condition(s), treat me, obtain payment for that treatment, and as necessary for the practice to conduct its specific health care operations.

____ 5. I understand that I have the right to request that the practice restrict how my PHI is used and/or disclosed except to obtain payment for treatment provided. However, the practice is not required to agree to any restrictions that I have requested, and I have the right to refuse treatment.

____ 6. I understand that this consent is valid as long as I am a patient in this office. I further understand that I have the right to revoke this consent, in writing at any time for all future transactions, with the understanding that any such revocation shall not apply to the extent that the practice has already taken action in reliance on this consent. If I revoke this consent at any time, the practice has the right to refuse to treat me.

____ 7. I give AlignLife permission to treat me in a room that is not fully enclosed. I am aware that other persons in the office may overhear some of my protected health information during the course of care. Should I need to speak with the doctor at any time in private, I understand the doctor will provide a private room for consultations.

____ 8. The doctor recommends that my spouse be present at my report of findings visit; therefore, I hereby give permission for my protected health information to be disclosed at that time and at any time my spouse contacts the office to check on my status.

____ 9. This office posts a notice for Patient of the Week. If I receive that designation I authorize AlignLife to post my name in the office.

____ 10. I give AlignLife the authority to utilize my name, written or video story and pictures to help educate others. I give AlignLife the rights to use the testimonial in the “Our Patients Speak” testimonial book, our website, diverse web marketing campaigns, print/TV ads and other marketing campaigns to help others understand the different types of problems AlignLife has helped with.

I have read and understand the above statements. I understand that I have the right to refuse to sign this authorization. If I choose to decline signing this consent form, this practice will not treat me.

Patient's Name (Printed) _____

Patient Name (Signed)_____

Date:_____

TERMS OF ACCEPTANCE

When a patient seeks chiropractic care and we accept a patient for such care, it is essential for both to be working towards the same objective. Chiropractic has only one goal: To restore the health potential of the body by removing spinal nerve impingements (called subluxations) which may be contributing or causing certain health condition. To

remove the spinal nerve impingement a specific process is used which is called a chiropractic adjustment. It is important that each patient understand both the objective and the method that will be used to attain it. This will prevent any confusion or disappointment.

Although chiropractic has clinically been associated with the reduction of many symptoms and health conditions, we do not offer to diagnose or treat any disease. We only offer to diagnose either vertebral subluxations or musculoskeletal conditions. However, if during the course of a chiropractic spinal examination, we encounter non-chiropractic or unusual findings, we will advise you. Regardless of what the disease is called, we do not offer to treat it. When pressure is removed off a nerve, the nerve will begin to heal and that will increase the function of the muscles, joints and organ systems the nerve supplies. Additional information is provided on our website at www.AlignLife.com.

I have read and understand the information above.
Print Name:_____ Sign:_____ Date:_____

AUTHORIZATION AND ASSIGNMENT OF BENEFITS

1. I authorize the release of any information deemed appropriate concerning my health condition to any insurance company, attorney or adjuster in order to process any claim for reimbursement of charges incurred at this office.
2. I authorize and assign the direct payment to you of any sum I now or hereafter owe to your office by my attorney out of the proceeds of any settlement of my case, and by any insurance company obligated to reimburse me for the charges for your services or otherwise obligated to make payment to me or you based in whole or in part upon the charges for your services.
3. I give assignment lien against any claims against a third party whose negligence may have caused my injury, up to the bill for treatment.
4. In the event any insurance company under contractual agreement refuses to make payment upon demand by you, I hereby assign and transfer to you the cause of action that exists in my favor against any such company and authorize you to prosecute said action either in my name or your name as you see fit. I further authorize you to comprise, settle or otherwise resolve said claim as you see fit. I understand that whatever amounts you do not collect from insurance proceeds (whether it is all or part of what is due) I personally owe you.

I have read and understand the information above.
Print Name:_____ Sign:_____ Date:_____

FINANCIAL ARRANGEMENT

Our office has conservative fees and comfortable payment arrangements. We want to make sure that our patients are able to receive the needed care in an affordable manner. If you have insurance coverage, our office will provide the courtesy of billing your insurance company. Although we provide the service of billing the insurance, any payments that are not received from your insurance company within 60 days will ultimately become your responsibility. Although we strive to provide the most accurate predictions in regards to our recommendations there are numerous insurance and healthcare variables that cannot be controlled. I have read and understand the statements above and give the doctor permission to evaluate me. (If under 18, parent or guardian must sign the form).

I have read and understand the information above.
Print Name:_____ Sign:_____ Date:_____

WORKERS COMPENSATION QUESTIONNAIRE

Name: _____ Date: _____

Have you retained legal counsel for this injury? YES NO If yes, give name and address:

_____

INJURY DESCRIPTION

Date present injury was received _____ Time of Injury _____ AM / PM Overtime __ Yes __No

Who saw the accident? _____ Title _____

Who reported the accident?_____ Title _____

What medical attention was rendered? _____

By whom __ Nurse __ M.D. __ D.O. __D.C. __ Other employee __ Other _____

How did the injury occur? _____

CHIEF COMPLAINT _____

Symptoms _____

Since the injury, are your symptoms ____ Improving ____The Same ____Getting Worse

JOB SPECIFICS

If working on a machine, give description _____

Do you use foot or hand levers? __ Yes __ No Do you work overhead? ___ Yes ___ No

Do you have to reach? __ Yes __ No Where? _____

Movements on the job: Do you move to your __ Right __ Left __ Up __ Down __ Under __Over

Do you pick up or lift __ Yes __ No If "Yes" how much? _____ How often? _____

From where to where? _____

Do you lift from __ Ground __ Bench __Platform __ Box __ Pallet __ Other (Please Describe) _____

_____

Do you lift in or out of a machine? __ Yes __ No If working at a machine, do you __ Sit __ Stand __ Kneel

Is your work environment cluttered? __ Yes __ No If "yes", with what? _____

Is your work area __ Oily __Dirty __ Slippery __ Other _____

In your job do you push or pull? __ Yes __ No If "Yes" give specifics _____

Do you use a cart? __ Yes __ No What kind __ Two-wheel __ Four-wheel Condition __ Good __ Bad __ Other

Total amount of weight being pushed or pulled on a daily basis _____

OFFICE WORK SPECIFICS

If your injury has occurred from office work only, please fill out the following: (Give percentage if applicable)

__ Sit at desk __ Walk __ Stand __ Stoop __ Hold __ Carry __ Other

Do you operate office machinery? __ Yes __ No If "Yes" what type? _____

Do you carrying anything or pick anything up? __ Yes __ No If "Yes" what? _____

If your work is at a desk give specifics of computer and phone positions _____

WORK HISTORY

Give a job description of work performed for each job classification or source of employment for the proceeding ten years.

1. _____
2. _____
3. _____
4. _____
5. _____

Was a pre-employment exam performed or required? __ Yes __ No Date _____ Doctor_____

Have you ever applied for Workers' Compensation benefits before? __Yes __ No Date_____

Reason _____

Was there a time loss for work? __ Yes __ No From _____ To _____ Year _____

State the degrees of recovery _____

Did you retain legal counsel for these injuries? __ Yes __ No If "Yes" give name and address _____

_____

PRESENT WORK HISTORY

What is the job classification of your normal job? _____

Were you performing your normal job? __ Yes __ No What shift were you working? _____

How long have you been at your present job? _____Has there been absenteeism caused from job injury? __Yes __No

If "Yes" explain _____

Average work week _____ Hours _____ Days

How many employees are in the plant? _____ How many employees per shift _____ How many employees do your job? ____

Do you like your job? Please explain _____

_____ _____

Patient Signature Date

WOKERS' COMPENSATION AUTHORIZATION FORM

Patient Name: _____ Date: _____

Address: _____

Date of Accident: _____

Employer: _____

Address: _____

TO THE PATIENT: It is necessary that your employer sign the following Authorization for treatment and return to our office. If not, you will be responsible for payment.

TO THE EMPLOYER: I acknowledge the work related injury of the above named patient. You are authorized to render the appropriate care needed for this injury and we will file the proper forms with our insurance carrier.

Authorized By: _____

Title: _____

Date: _____

Telephone # _____

PLEASE RETURN THIS FORM IMMEDIATELY TO:

Clinic Name: _____

Attention: _____

Address: _____

_____

Telephone: _____

Health Care Lien

To Attorneys: _____

Patient's Name: _____

Doctor's Name: _____

I hereby recognize a lien in favor of the above doctor for injuries incurred on _____ ____, 20___ and caused by _____, whose address is _____.

I hereby authorize the above doctor to furnish you, my attorney(s), with a full report of the case history, examination, diagnosis, treatment and prognosis of myself in regard to the accident in which I was involved.

I hereby authorize and direct you, my attorney(s), to pay directly to said doctor such sums as may be due and owing him/her for professional services rendered to me both by reason of the aforesaid accident and by reason of any other bills that are due and owing to his/her office and to withhold such sums from any settlement, judgment or verdict as may be necessary to adequately protect said doctor. I hereby further give a lien on my case to said doctor against any and all proceeds of any settlement, judgment or verdict which may be paid to you, my attorney(s), or myself as the result of the injuries for which I have been treated or injuries in connection therewith.

I fully understand that I am directly and fully responsible to said doctor for all professional bills submitted by him/her for services rendered to me and that this agreement is made solely for said doctor's additional protection and in consideration of pending payment. I further understand that such payment is not contingent on any settlement, judgment or verdict by which I may eventually recover said fee.

Patient's Signature: _____ Date_____

Patient's Address: _____

City: _____State: _____Zip_____

Telephone_____

Attorney(s): Please sign, date, and return this document to the doctor's office named above.

The undersigned being attorney(s) of record for the above patient does hereby agree to observe all of the terms and conditions of the above lien and agree(s) to withhold such sums from any settlement, judgment or verdict as may be necessary to adequately protect the said doctor named above.

Attorney(s)

Signature:_____Date:_____