Workers Compensation Intake Form

ABOUT YOU

Name:	Date:	Social Security Number:	
Address:	City:	Sate	Zip Code
Date of Birth:	Age	Gender	Marital Status	Dominant hand: [ ] RIGHT [ ] LEFT
Emergency Contact:	Relation:	Emergency Phone Number:	
Home Phone:	Mobile:	Email:	

EMPLOYER INFORMATION

Employer Name:	Supervisor Name:		
Employer Address:	City:	State:	Zip Code
Work Phone:	Occupation:		

COMPENSATION CARRIER INFORMATION

Compensation Carrier Name:	Compensation Carrier Phone:		
Compensation Carrier Address:	City:	State:	Zip Code:
Carrier Claim Number:	Workers Comp. Board Claim #:		

ACCIDENT INJURY DETAILS

Date of Injury:	Time of Injury:	Reported to your supervisor? [ ] YES [ ] NO Name reported to: Date of report:
Explain the details of the accident:		

Are you off work? [ ] YES [ ] NO	Date you left work:
Have you return to work since the accident? [ ] YES [ ] NO	Date you returned to work:
Have you been treated other doctors for this condition? [ ] YES [ ] NO	Doctor's name & phone:
Have you had any previous workers compensation injuries? [ ] YES [ ] NO	Dates of previous workers compensation injuries:

Prior to this accident, had you had similar complaints to the ones you are experiencing now? If yes, please describe:

SIGNATURE

Patient Signature:	Date:

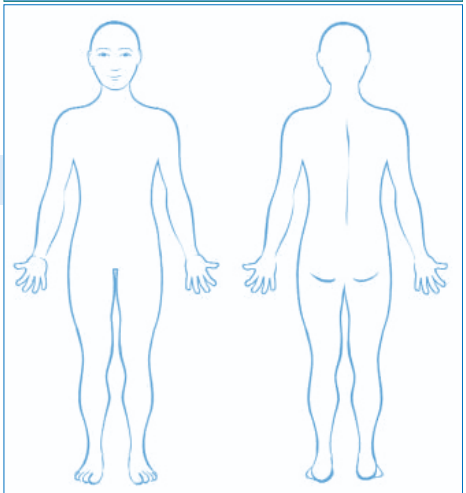
HEALTH HISTORY

[ ] Severe/frequent headache
[ ] Heart surgery/ pacemaker
[ ] Low back problems
[ ] Digestive issues
[ ] Heart defects
[ ] Low blood pressure
[ ] Rheumatic fever
[ ] Frequent neck pain

[ ]Pain between shoulders
[ ] Pain in arms/legs
[ ] Thyroid problems
[ ] Sinus problems
[ ] Hepatitis
[ ] Difficulty breathing
[ ] Kidney problems
[ ] High blood pressure

[ ] Chemotherapy
[ ] Numbness
[ ] Allergies
[ ] Surgeries
[ ] Asthma
[ ] Loss of sleep
[ ] Dizziness

Please indicate with an "X" on the body diagram where you are experiencing pain/ discomfort.



Please rate your pain on a scale of **1** (little to no pain) to **10** (severe pain):

1 2 3 4 5 6 7 8 9 10

CURRENT HEALTH

Do you smoke?: [ ] YES [ ] NO Do you drink alcohol?: [ ] YES [ ] NO

Do you wear: [ ] Heel lifts [ ] Sole lifts [ ] Inner soles [ ] Arch supports

Do you exercise regularly?: [ ] YES [ ] NO

FOR WOMEN ONLY: Are you pregnant or planning to be? [ ] YES [ ] NO

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MEDICATIONS YOU TAKE:

[ ] Cholesterol Medications
[ ] Stimulants
[ ] Tranquilizers
[ ] Vitamins & Supplements

[ ] Muscle Relaxers
[ ] Insulin
[ ] Blood Pressure
[ ] Blood Thinners

[ ] Pain Killers
[ ] Antidepressants
[ ] Other:
_____
_____

TERMS OF ACCEPTANCE

When a patient seeks chiropractic care and we accept such a patient for care, it is essential for both to be working towards the same objective. Chiropractic has only one goal. It is only when the patient understands both the objective and the method that they will be able to attain it. This will prevent any confusion or disappointment.

An adjustment is the specific application of forces to facilitate the body's correction of vertebral subluxation. Our chiropractic method of correction is by specific adjustments to the spine.

Health is a state of optimal physical, mental and social well being, not merely the absence of disease.

Vertebral Subluxation is a misalignment of one or more of the joints of the body. This can cause pain or alteration of nerve function and interference of the transmission of nerve impulses, lessening the body's innate ability to maintain maximum health.

We do not offer to diagnose or treat any disease or condition other than vertebral subluxation. However, if during the course of a chiropractic spinal evaluation, we encounter non-chiropractic or unusual findings, we will advise you. If you desire advice, diagnosis or treatment for those findings, we will recommend that you seek the services of a health care provider who specializes in that area. Regardless of what the disease is called, we do not offer to treat it. Nor do we offer advice regarding treatment prescribed by others. OUR ONLY PRACTICE OBJECTIVE is to eliminate a major interference to the expression of the body's innate wisdom. Our only method is specific adjusting to correct vertebral subluxation.

I have read and fully understand the above statement. Any questions regarding the doctor's objectives pertaining to my care in this office have been answered to my complete satisfaction. I therefore accept chiropractic care on this basis.

Signature:	Date:
Witness signature:	Date:

FOR THE DOCTOR

NOTES

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AUTHORIZATION FOR CARE

I hereby authorize the Doctor to work with my condition through the use of adjustments to my spine, as he or she deems appropriate. I clearly understand and agree that all services rendered me are charged directly to me and that I am personally responsible for payment. I agree that I am responsible for all bills incurred at this office. The doctor will not be held responsible for any pre-existing medically diagnosed conditions nor for any medical diagnosis. I also understand that if I suspend or terminate my care, any fees for professional services rendered me will become immediately due and payable.

I hereby authorize assignment of my insurance rights and benefits (if applicable) directly to the provider for services rendered. I understand and agree that health and accident insurance policies are an arrangement between an insurance carrier and myself. I understand that the doctor's office will prepare any necessary reports and forms to assist me in collecting from the insurance company and that any amount authorized to be paid directly to the doctor's office will be credited to my account on receipt.

Signature:	Date:
Signature of guardian or spouse authorizing care:	Date:

HIPPA COMPLIANCE PATIENT CONSENT FORM

Our Notice of Privacy Practices provides information about how we may use or disclose protected health information.
The notice contains a patient's rights section describing your rights under the law. You ascertain that by your signature that you have reviewed our notice before signing this consent.
The terms of the notice may change, if so, you will be notified at your next visit to update your signature/date.
You have the right to restrict how your protected health information is used and disclosed for treatment, payment or healthcare operations. We are not required to agree with this restriction, but if we do, we shall honor this agreement.
The HIPAA (Health Insurance Portability and Accountability Act of 1996) law allows for the use of the information for treatment, payment, or healthcare operations.

By signing this form, you consent to our use and disclosure of your protected healthcare information and potentially anonymous usage in a publication. You have the right to revoke this consent in writing, signed by you.
However, such a revocation will not be retroactive.

By signing this form, I understand that:

- Protected health information may be disclosed or used for treatment, payment, or healthcare operations.
- The practice reserves the right to change the privacy policy as allowed by law.
- The practice has the right to restrict the use of the information but the practice does not have to agree to those restrictions.
- The patient has the right to revoke this consent in writing at any time and all full disclosures will then cease.
- The practice may condition receipt of treatment upon execution of this consent.

I understand that, under the Health Insurance Portability & Accountability Act of 1996 (HIPPA), I have certain rights to privacy regarding my protected health information I understand that this information can and will be used to:

- Conduct, plan and direct my treatment and follow up with multiple healthcare providers who may be involved in that treatment directly or indirectly.
- Obtain payment form third party payers.
- Conduct normal healthcare operations such as quality assessments and physician's certifications.

May we phone, email, or send a text to you to confirm appointments? [ ] YES [ ] NO
May we leave a message on your answering machine at home or on your cell phone? [ ] YES [ ] NO
May we discuss your medical condition with any member of your family? [ ] YES [ ] NO

If YES, please name the members allowed:	
This consent was signed by:	
Patient Signature:	Date:
Witness Signature:	Date: