WORKERS COMPENSATION INTRODUCTION PATIENT CASE HISTORY

PATIENT INFORMATION

Name: *(First MI Last)* _____**Preferred Name**: _____

Address: _____ **City:** _____**State:** _____ **Zip:** _____

Home: _____**Mobile:** _____**Work:** _____

Email: _____**Gender:** M / F **Marital Status:** Single / Married / Other

Social Security #: _____ **Date of Birth:** _____

Student Status: Full Student / Part Student / Non-Student **Employed:** Y / N

Ethnicity: Hispanic or Latino / Not Hispanic or Latino / Decline

Preferred Language: English / Decline / Other: _____

Race: Asian / African American / American Indian or Alaskan Native / Other / Native Hawaii or Pacific Islander / White / Decline

***Referred By:** (*Name):* _____Family / Friend / Co-Worker / Doctor / Other Source

EMERGENCY CONTACT INFORMATION

Name: *(First MI Last)* _____**Home:** _____

Mobile: _____**Relationship**: Child / Parent / Spouse / Other: _____

Primary Care Physician: _____**Doctor's Phone:** _____

FINANCIAL INFORMATION

___ Insurance ___ Worker's Comp ___ Self-Pay *(Cash)* ___ Personal Injury/Auto ___

Other *(please explain)*: _____

Workers Compensation Information

Employer:_____ Occupation:_____ Claim Number:_____

Address:_____ City:_____ State:_____ Zip:_____ Number:_____

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General Accident Information

Date of Accident:_____ Time:_____

Describe_____
_____
_____
_____

Before the Accident:

Have you ever had similar symptoms that you are experiencing sense the accident?___No___Yes

If YES, summarize the symptoms:_____

_____

At the Time of the Accident:

When did the pain come on? _____

Were you taken anywhere after the accident?_____

How:_____

Treatment:_____

Since the Accident:

Are your symptoms___Improving___Getting Worse___Same

Any activities restricted due to the accident?_____

Attorney Name:_____**Attorney Cell:**_____

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HISTORY OF CURRENT CONDITION

Describe Major Complaint: _____
Describe any Secondary Complaints: _____
Describe WHEN and HOW this began: _____
_____
_____

Grade Intensity/Severity of Complaint: None (0) / Mild (1-2) / Mild-Mod (2-4) / Moderate (4-6) / Mod-Severe (6-8) / Severe (8-10)
Quality of the complaint/pain: Sharp / Stabbing / Burning / Achy / Dull / Stiff & Sore / Other: _____
How frequent is the complaint present? Off & On / Constant

Does this complaint radiate/shoot to any areas of your body? No / Yes
(Describe) _____

Head - Base of Skull / Forehead / Sides-Temple R / L / Both
Arm – Across Shoulder / Elbow / Hand-Fingers R / L / Both
Leg - Hip / Thigh-Knee / Calf / Foot-Toes R / L / Both
*Other Area:*_____

Does anything make the complaint better? Ice / Heat / Rest / Movement / Stretching / OTC / Other: _____
Does anything make the complaint worse? Sit / Stand / Walk / Lying / Sleep / Overuse / Other: _____

Which daily activities are being affected by this condition?
*(Describe)*_____

For this CURRENT condition, have you:
• **Received any other treatment?** None / DC / MD / PT / Massage / ER / Other: _____
When and Where? _____
• **Had any diagnostic testing?** X-rays / MRI / CT / Other: _____
When and Where? _____

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Current Medications and Supplements

Name	Dosage	Frequency
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

Major Injuries / Traumas / Hospitalizations:

Date	Describe	Limitations
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

Social History

Habit	Amount	Year Started
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

Family Health History

Problem	Parent	Other
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

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General: *(constitutional)*
__ Recent Weight Change
__ Fever
__ Fatigue
__ *None in this Category*

Musculoskeletal:
__ Low Back Pain
__ Mid Back Pain
__ Neck Pain
__ Arm Problems
__ Leg Problem
__ Painful Joints
__ Stiff/Swollen Joints
__ Sore/Weak Muscles or Joints
__ Muscle Spasms/Cramps
__ Broken Bones_____
__ Other: _____
__ *None in this Category*

Neurological:
__ Numbness or tingling sensations
__ Loss of Feeling
__ Dizziness or light headed
__ Frequent / Recurrent Headaches
__ Convulsions or seizures
__ Tremors
__ Stroke
__ Other: _____
__ *None in this Category*

Mind/Stress:
__ Nervousness
__ Depression
__ Sleep Problems
__ Memory Loss or Confusion
__ Other: _____
__ *None in this Category*

Genitourinary:
__ Sexual Difficulty
__ Kidney Stones
__ Burning/Painful Urination
__ Change Urination
__ Frequent Urination
__ Blood in Urine
__ Incontinence or Bed Wetting
__Other: _____
__ *None in this Category*

Gastrointestinal:
__ Loss of Appetite
__ Blood in Stool
__ Change in Bowel Movements
__ Painful Bowel Movements
__ Nausea or Vomiting
__ Abdominal Pain
__ Frequent Diarrhea
__ Constipation
__ Other: _____
__ *None in this Category*

Cardiovascular & Heart:
__ Chest Pains
__ Rapid or Heartbeat changes
__ Blood Pressure Problems
__ Swelling of Hands, Ankles, Feet
__ Heart Problems
__ Other: _____
__ *None in this Category*

Respiratory:
__ Difficulty Breathing
__ Persistent Cough
__ Coughing Blood
__ Asthma or Wheezing
__ Lung Problems
__ Other: _____
__ *None in this Category*

Eyes and Vision:
__ Wear contacts/glasses
__ Blurred or double vision
__ Glaucoma
__ Eye disease or injury
__ Other: _____
__ *None in this Category*

Ears, Nose, and Throat:
__ Bleeding gums / mouth sores
__ Bad Breath or bad taste
__ Dental Problems
__ Swollen throat or voice change
__ Swollen glands in neck
__ Ringing in the ears
__ Ear - Ache/Ringing/Drainage
__ Sinus / Allergy problems
__ Nose Bleeds
__ Hearing Loss
__ Other: _____
__ *None in this Category*

Endocrine, Hematologic, and Lymphatic:
__ Thyroid problems
__ Diabetes
__ Excessive Thirst or urination
__ Cold Extremities
__ Heat or Cold intolerance
__ Change in hat or glove size
__ Dry skin
__ Glandular or hormone problem
__ Swollen Glands
__ Anemia
__ Easily Bruise or Bleed
__ Phlebitis
__ Transfusion
__ Immune system disorder
__ Other: _____
__ *None in this Category*

Skin and Breasts:
__ Rash or Itching
__ Change in Skin Color
__ Change in hair or nails
__ Non-healing sores
__ Change of appearance of a mole
__ Breast Pain
__ Breast Lump
__ Breast Discharge
__ Other: _____
__ *None in this Category*

Women Only:
Are you pregnant?
__ **Yes: *Due Date* ___/____/____**
__ **No: *Last Menstrual Period*___/____/____**
__ Infertility
__ Painful or Irregular periods
__ Vaginal Discharge
__ Other: _____
__ *None in this Category*

*Number of Pregnancies*_____

Functional Rating Index for Neck and/or Back Pain

To properly assess your condition, we must understand how much your pain has affected your ability to manage everyday activities. For each item below, please circle the number that most closely describes your condition right now.

1. Pain Intensity

0	1	2	3	4
No pain				Worst pain

2. Sleeping disturbances

0	1	2	3	4
No sleep				Worst sleep

3. Personal Care (washing, dressing)

0	1	2	3	4
No pain				Worst pain

4. Traveling on long trips

0	1	2	3	4
No pain				Worst pain

5. Work

0	1	2	3	4
No pain				Worst pain

6. Recreation

0	1	2	3	4
Can do				Can’t do all

7. Frequency of pain

0	1	2	3	4
No pain				Constant pain

8. Lifting

0	1	2	3	4
No pain				Worst pain

9. Walking

0	1	2	3	4
No pain				Worst pain

10. Standing

0	1	2	3	4
No pain				Worst pain

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Consent for Chiropractic Services

By reading below I have been made aware: **1.** The process of delivering a "Chiropractic Adjustment (manipulation)" may be performed manually, with a table mechanism, or with an instrument to the vertebra(e) of the spine and/or associated structures (legs, arms etc.), often resulting in an audible, pop or click sound; **2.** As an addition to the Chiropractic Adjustment "Supportive Therapies and/or Procedures" may be applied by the chiropractor or by staff under the chiropractor's direction or supervision incorporating the use of vibration, electricity, traction, motion, bracing, nutritional advice, heat, or cold; **3.** On occasion some temporary soreness and/or stiffness may occur; less frequently aggravation of presenting symptoms or initiation of new symptoms; rarely bruising, and/or swelling, even more rare separation/fracture; and extremely rare, nerve or vascular injury may occur in conjunction with the process of a Chiropractic Adjustment; **4.** The chiropractor has made no guarantee of a positive outcome from treatment. Additionally: I have been afforded many opportunities for questions and answers. Therefore, by signing below: I consent to the performance of the diagnostic and therapeutic procedures performed by the doctor and or staff under the direction and supervision of the office chiropractor(s) involved in my case; I consent to the performance of other diagnostic and therapeutic procedures in the future that may be deemed reasonable and necessary by the doctor and or staff under the direction and supervision of the office chiropractor(s) involved in my case.

Before this office begins any health care operations we require you to read and sign this form stating that you understand the below items. If you refuse to sign this form the doctor reserves the right to refuse care. **AUTHORIZATION:** By signing below you authorized this office/provider to complete a consultation and examination on the above individual.

AUTHORIZATION FOR X-RAY WITH RELEASE:

By signing below, you have declared, to the best of your knowledge, that there is no chance you are pregnant at this time. By signing below, you have declared that you have no known limitations that would be contraindicated for an x-ray evaluation. By signing below, you consent to the taking of x-rays if there is a determined need.

ACKNOWLEDGMENT OF ASSIGNMENT OF BENEFITS:

By signing below, you have acknowledged that you are fully responsible for all services rendered. By signing below, you further acknowledge you understanding that your health and accident insurance information policies are an arraignment between you and your carrier, and that you may be required to pay some or all the fees charged to your account. By signing below, you hereby assign benefits to paid directly to this office/provider by your third-party payer, e.g. insurance company, attorneys, etc. By signing below, you agree that this is a non-rescindable agreement and failure to fulfill this obligation will be considered a breach of contract between you and this office. CMS-1500 HEALTH INSURANCE CLAIM FORM: By signing below you acknowledge and agree that the CMS-1500 Health Insurance Claim Form Box 12 and Box 13 will state "Signature on File". Box 12 Reads as follows: "PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below." Box 13 Reads as follows: **"INSURED'S OR AUTHORIZED PERSON'S** SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for services described below."

ACKNOWLEDGEMENT OF NOTICE OF PRIVACY PRACTICES:

We are very concerned with protecting your personal health information. There may be times our office needs to contact you regarding office matters. By signing below, you have authorized this office to contact you for office related matters in the following ways: work, home or mobile phone, e-mail, and regular mail. Messages may be left on an answering device/voicemail, or with the person answering your work, home, or mobile phone. Also in accordance with the Health Insurance Portability and Accountability act of 1996 (HIPAA), updated September 23, 2013, this office is obliged to supply you with a copy of the office privacy policies and procedures upon request. This document outlines the use and limitations of the

disclosure of your personal health information and your rights as a patient. By signing below, you have acknowledged that you have been made aware of this document and your right to request it.

ACKNOWLEDGEMENT OF TREATMENT PLAN:

By signing below, I acknowledge that, if accepted for care, I may be presented with a chiropractic treatment plan resulting in one or more of the following services: chiropractic adjustments, examinations, and supportive therapies and procedures. ACKNOWLEDGEMENT: By signing below you acknowledge that you understand and agree with the policies and procedures outlined in this TERMS of ACCEPTANCE form. By signing below, you acknowledge and certify that all the information given to the office/provider in the INTAKE forms is a true and accurate to the best of your knowledge

Notices of Privacy Practices HIPAA

I understand that, under the Health Insurance Portability & Accountability Act of 1996 (HIPAA) and updated laws on 9/23/2013, 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 among the multiple healthcare providers who may be involved in that treatment directly and indirectly. *Obtain payment from third-party payers. *Conduct normal healthcare operations such as quality assessments and physician certifications. You and your Notice of Privacy Practices containing a more complete description of the uses and disclosures of my health information have informed me. I have been given the right to review such Notice of Privacy Practices prior to signing this consent I understand that this organization has the right to change its Notice of Privacy Practices from time to time and that I may contact this organization on at any time to obtain a current copy of the Notice of Privacy Practices. I understand that I may request in writing that you restrict how my private information is used or disclosed to carry out treatment, payment, or health care operations. I also understand you are not required to agree to my requested restriction, but if you do agree then you are bound to abide by such restrictions. I further authorize disclosure of all or any part of my patients record to any person or corporation which is or may be liable under a contract to the clinic or to the patient or to a family member or employer of the patient for all or part of the clinics charge including, and not limited to, hospital or medical services companies, insurance companies, worker's compensation carriers, welfare funds or the patient's employer. I understand that I may revoke this consent in writing at any time, except to the extent that you have acted relying on this account.

Consent of Professional Services and Release of Information

I hereby authorize and release the doctor and whomever he may designate as his assistants to administer treatment, physical e examination, orthopedic and neurological evaluation, visual inspection, palpation, X-ray studies, laboratory procedures, chiropractic care, or any clinic services that he deems necessary in my case. The undersigned also consents to observation of therapeutic or diagnostic procedures by staff personnel or medical personnel in training as permitted by the attending practitioner and allowed by clinic policy. Treatment procedures that may be used in your treatment include, but are not limited to, manipulative therapy, activator, joint mobilization, myofascial release, trigger-point therapy, electrical therapy, intersegmental traction, muscle stretching, and any directional handouts. Cases will be managed with all due concern and with the evaluation of response to previous care provided. Home care instructions will be given as appropriate to enhance your treatment program. Compliance with the recommendations for home care and follow-up care is necessary for the resolution of your complaint. Because of modern techniques and equipment, examination and therapeutic procedures involve a very low risk of complication. Even though serious problems rarely occur with these procedures, risks must be recognized and considered. Any procedure that is intended to help may also do harm. While examination and therapeutic procedures used in this clinic are considered remarkably safe and effective, understand that occasionally there may be adverse reactions that occur. Although the chances of experiencing any of these complications are extremely small, it is the

practice of this office to fully inform and educate our patients. These complications include but are not limited to pain, swelling, bruising, discoloration, inflammation, disc injury, sensory changes, bleeding, fracture, fainting, irregular heartbeat, heart attack, spinal cord damage, nausea, burns, soft tissue injury, stroke, dizziness, or weakness. A patient, in coming to Harmony Chiropractic, gives. Dr. Melissa Volk (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 Dr. Melissa Volk. The doctor provides a specialized, non-duplicating health care service. Dr. Melissa Volk 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 a physician at Harmony Chiropractic accepts me as a patient. 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. No guarantee or warranty for a specific cure or result is implied by the acceptance of your case. All patients respond differently to the treatment procedures. Each case must be evaluated separately. If you do not fully understand the above or have questions about anything mentioned in this document, please do not sign it until these matters have been resolved with further discussion. I have read the above explanation of treatment and diagnostic procedures used in this clinic and have myself decided that it is in my best interest to submit to these procedures. I declare that, to the best of my knowledge, (I am not pregnant, my child is not pregnant), nor are there any known complicating limitations which would forbid taking x-rays. I understand that in the event x-rays are taken that need a second opinion, that they will be referred out for further interpretation and give consent for their release. I understand that there will be a fee for this service of $25.00. Clinical Summary Report (CCR) regarding EHR I understand that a clinical summary report is created after each visit for EHR and is available for my review. Now, I am asking Harmony Chiropractic to save these electronically for me and not print them out after each visit. I understand that, upon request that these reports are available to be printed or emailed to me for review.

Assignment of Benefits

I understand and agree that health and accident insurance policies are an agreement between an insurance carrier and myself. Furthermore, I understand that this Chiropractic Office will prepare any necessary reports and forms to assist me in making collection from the insurance company and that any amount authorized to be paid directly to this Chiropractic Office will be credited to my account upon re kept. However, I clearly understand and agree that all services rendered to me are charged directly to me and that I am personally responsible for payment. I also understand that if I suspend or terminate my care and treatment, any fees for professional services rendered to me will be immediately due and payable.

Patient Name: _____

Patient Signature: _____

Date: _____