WORKERS' COMPENSATION PATIENT QUESTIONNAIRE

Dear Patient/Injured Worker:

It is important in a workers' compensation case to establish a complete and accurate base of personal and historical information. This information often becomes a critical part of the decision making process in coming to final determinations or conclusions about your case. Therefore, **your help and cooperation in answering this questionnaire as completely and accurately as possible is necessary and appreciated**. This is very important to the people involved in handling your case and for you to receive appropriate and fair compensation.

PLEASE, REVIEW AND COMPLETE THIS PATIENT QUESTIONNAIRE. DOING THIS, WILL SIGNIFICANTLY REDUCE YOUR TIME IN THE OFFICE. THE AMOUNT OF TIME, WHICH HAS BEEN SCHEDULED FOR YOUR APPOINTMENT, DOES TAKE INTO CONSIDERATION THAT THIS HAS BEEN DONE. THANK YOU VERY MUCH!

PHYSICIAN USE ONLY:

Evaluation Date: _____
Evaluation Began: _____ A.M. ____ P.M. _____
Evaluation Ended: _____ A.M. ____ P.M. _____

EMPLOYEE INFORMATION:

Name: _____ Birthday: _____ Sex ☐ M ☐ F

Address: _____ City _____ State _____ Zip _____

Social Security #_____ Home Ph: _____ Work/Cell _____

E-Mail _____ Height: _____ Weight: _____

__ Right Handed __ Left Handed __ Both

Employer Information: ***(Your Employer At The Time You Were Injured)***

Name Of Business: _____ Phone No.: (____) _____

Address: _____

WORKERS' COMPENSATION INSURANCE CARRIER INFORMATION:

Name: _____ Phone No.: (____) _____

Address: _____

Claims Representative: _____ Fax No.: (____) _____

Claim No.: _____

INFORMATION ABOUT YOUR WORK INJURY:

Date Of Injury: _____ Time The Injury Occurred: _____ ____ A.M. ____ P.M.

Date You Reported Your Injury To Your Employer/Supervisor: _____

Name Of Person You Reported Your Injury To: _____

Where Did Your Injury Occur? (Address Or Description Of Location): _____

_____

ATTORNEY INFORMATION: ( ) Check If None

Name: _____ Phone No.: (____) _____

Address: _____

Our office offers appointment reminders via text messages OR E-Mail, which would you prefer?

If you prefer text message, what is your cell provider (i.e. Verizon, Sprint)?

When would you prefer to receive your reminder? 1 hour 2 hours 4 hours 1 day 2 days

JOB DESCRIPTION:

What Is Your Job Title? **(AT THE TIME OF YOUR INJURY):** _____

When Did You Start Working For This Employer? _____

How Many Hours Per Day Do You Normally Work? _____

What Hours Do You Normally Work? _____

How Many Days Per Week Do You Work? _____How Many Days In A Row? _____

How Long Is Your Lunch Break? _____ How Long Are Your Rest Breaks? _____

How Many Rest Breaks Do You Get In A Normal Work Shift? _____

What Percent Of Your Work Day Do You Work Indoors? _____% Outdoors? _____%

Check any that you perform	___ Sit	___ Walk	___ Stand	___ Kneel
throughout your day?	___ Squat	___ Climb	___ Bend	___ Twist
	___ Reach	___ Crawl	___ Push	___ Pull
Leave blank if it doesn't apply.	___ Keyboard	___ Type	___ Mouse	___ Write
	___ Finger	___ Grasp		
	___ Work Overhead			
	___ Flex/Twist/Side-Bend/Extend Your Neck			

Please List Your Job Duties/Activities At Work: (WHEN YOU WERE INJURED)

A) _____

B) _____

C) _____

D) _____

E) _____

F) _____

G) _____

What Type Of Surface(s) Do You Work On? _____

Are You Required To **Lift At Work?** ___ YES ___ NO If 'YES', Please Answer The Following:

	Objects Lifted	Weight In Pounds	Times Per Day	Distance Carried/Feet
1)				
2)				
3)				
4)				
5)				

What Is the Heaviest Weight That You Are Required To Lift At Work? _____ Pounds

Do You Have To Bend Over Or Lean Forward While Lifting? ___ YES ___ NO

Are You Able To Lift The Same Amount Of Weight Now, As Before The Injury? ___ YES ___ NO
If 'NO', Please Explain What You Could Lift Before And What You Can Lift Now: _____

_____

_____

Does Your Job Require You To Reach Below, Above Or At Shoulder Level? ___ YES ___ NO
If 'YES', Please Explain: _____

_____

Are You Required To Move Your Feet In A Repetitive Movement/Activity? ___ YES ___ NO
If 'YES', Please Describe: _____

_____

Are You Required To Use Your Hands For Fine Manipulation, Grasping, Pushing, Pulling, Torquing?
___ YES ___ NO If 'YES', Please Describe: _____

_____

Are You Exposed To Dust, Gas, Fumes, Vapors, Noise, Or Extreme Temperatures Or Humidity?
___ YES ___ NO If 'YES', Please Explain: _____

_____

Are You Required To Work At Heights Or Walk On Uneven Ground? ___ YES ___ NO If 'YES',
Please Describe: _____

_____

Are You Required to Drive Vehicles Or Work Near Hazardous Equipment? ___ YES ___ NO

If 'YES', Please Describe: _____

Do You Have Any Special Seeing/Visual Or Hearing Requirements? ___ YES ___ NO If 'YES', Please Describe: _____

_____

Are You Able To Perform Your Normal *Work Duties*? ___ YES ___ NO **If 'NO', Please Explain What Activities You Can't Do, Or Have Difficulty Performing:** _____

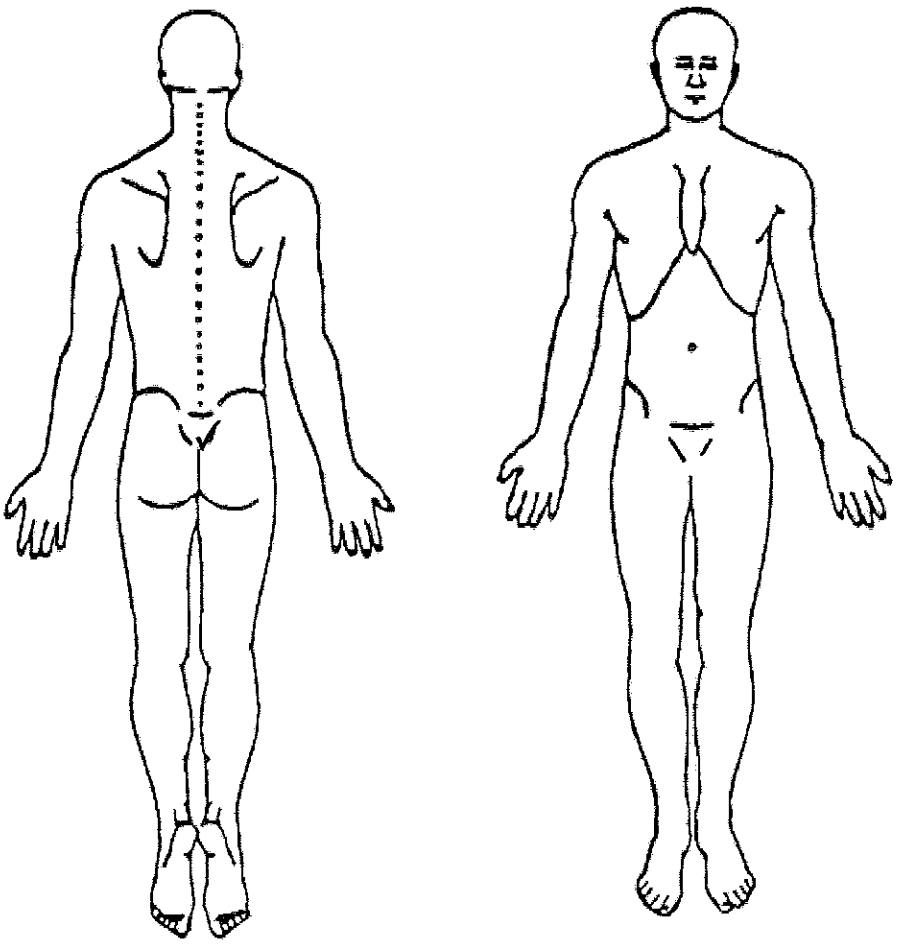
_____

_____

CURRENT SYMPTOMS:

Mark The Areas On Your Body Where You Are Having Symptoms From Your **Work Injury**(ies). Also, Review The Pain Scale On The Bottom Of This Page. The Doctor Will Be Asking You Questions.

P = Pain **N** = Numbness/Tingling **T** = Tenderness **B** = Burning **R** = Radiating



PAIN SCALE

0-1	=	**Minimal**	=	The pain is an annoyance but does not stop me from working.
2-3	=	**Slight**	=	I can tolerate the pain but it causes some difficulty in doing my work. However, it does not stop me from working.
5	=	**Moderate**	=	The pain causes a marked handicap in my ability to work, but I can continue.
7-8	=	**Moderate To Severe**	=	The pain is approaching the worst I have ever experienced or could imagine. It causes a significant problem with working and most of the time I can't.
10	=	**Severe**	=	The pain is the worst I have ever experienced or could imagine and causes me to stop all work and activity.

Please list your <u>current</u> symptoms/complaints RESULTING FROM YOUR WORK INJURY:

Complaint #1: _____

What Percentage Of The Time Do You Experience/Feel This Symptom? _____%

What Activities Make This Symptom Worse? _____

_____

What Makes This Symptom Better? _____

_____

Can/Do You Have This Symptom Without Activity? _____

Pain Scale _____ 0 - 10. The Doctor Will Discuss This With You.

Complaint #2: _____

What Percentage Of The Time Do You Experience/Feel This Symptom? _____%

What Activities Make This Symptom Worse? _____

_____

What Makes This Symptom Better? _____

_____

Can/Do You Have This Symptom Without Activity? _____

Pain Scale _____ 0 - 10. The Doctor Will Discuss This With You.

Complaint #3: _____

What Percentage Of The Time Do You Experience/Feel This Symptom? _____%

What Activities Make This Symptom Worse? _____

_____

What Makes This Symptom Better? _____

_____

Can/Do You Have This Symptom Without Activity? _____

Pain Scale _____ 0 - 10. The Doctor Will Discuss This With You.

Complaint #4: _____

What Percentage Of The Time Do You Experience/Feel This Symptom? _____%

What Activities Make This Symptom Worse? _____

What Makes This Symptom Better? _____

_____

Can/Do You Have This Symptom Without Activity? _____

Pain Scale _____ 0 - 10. The Doctor Will Discuss This With You.

Complaint #5: _____

What Percentage Of The Time Do You Experience/Feel This Symptom? _____%

What Activities Make This Symptom Worse? _____

_____

What Makes This Symptom Better? _____

_____

Can/Do You Have This Symptom Without Activity? _____

Pain Scale _____ 0 - 10. The Doctor Will Discuss This With You.

Is There A Time Of Day That You Feel Worse? ___ YES ___ NO If 'YES', Please Explain:

_____

_____

_____

In The Last **Two Months** Has Your Condition?___ Stayed The Same ___ Improved ___ Worsened
___ Fluctuated But Overall Has Stayed About The Same

If Your Condition Has **Worsened,** Please Explain: _____

_____

If Your Condition **Continues To Improve,** Please Explain: _____

_____

Do You Feel That Your **Condition Will Improve** With Time? ___ YES ___ NO Please Explain:

_____

Before This Work Injury, How Would You Describe Your Health? ___ Excellent ___ Good ___ Fair
Or ___ Poor If 'Fair' Or 'Poor', Please Explain: _____

_____

HISTORY OF THE INJURY:

Please Describe How Your Work Injury Occurred: _____

_____

_____

_____

_____

_____

_____

_____

_____

Please List The Injured Body Parts, **As A Result Of Your Work Injury:**

_____

How Did Your Symptoms Come On? ___ Suddenly ___ Gradually **If 'Gradually'**, Over What Period of Time? _____

_____

_____

When Did Your Realize/Know That You Were Injured? Explain: _____

_____

_____

HISTORY OF TREATMENT:

When Did You First Seek Treatment For Your Injury? Date: _____

Did Your Employer Send You For Treatment? ___ YES ___ NO

Did You Seek Treatment On Your Own? ___ YES ___ NO

'INITIALLY', Did You Go To A Hospital/Emergency Room? ___ YES ___ NO **If 'YES',** Answer The Questions Below. **If 'NO',** Go To The ***Name Of Doctor/Facility #1*** On This Page.

Name Of Hospital/ER? _____ City: _____

Were You Admitted To The Hospital? ___ YES ___ NO If 'YES', How Long? _____

Name Of Doctor(s) At The Hospital/ER Who Treated You? _____

Describe The Type Of Treatment &/Or Diagnostic Testing That Was Done: _____

_____

What Did The Hospital Doctor(s) Say Was Wrong With You? _____

_____

Were You Told That You Would Need More Treatment? ___YES ___NO If 'YES', Explain:

_____

Did The Doctor(s) Restrict Or Modify Your Work Activities? ___ YES ___NO If 'YES', How?

_____

Please list **ALL** Doctors You Have Seen Regarding Your Work Injury. Please List Them In Chronological Order/***The Order You Saw Them In:***

Name Of Doctor/Facility #1: _____ City/Location:_____

Type Of Doctor (degree or specialty): _____

Describe Treatment And/Or Tests: _____

_____

What Did This Doctor Say Was Wrong With You? _____

_____

Date When Treatment Started: _____ Date When Treatment Stopped: _____

How Many Treatments/Visits Were There? _____ How Long Were The Treatments? _____

What Was The Result/Outcome Of The Treatment? _____

_____

Still Treating With This Doctor? ___ YES ___NO If 'YES', How Often? _____

Did This Doctor Take You Off Work? ___ YES ___NO If 'YES', Give Dates: _____

Did This Doctor Restrict Or Modify Your Work Activities? ___ YES ___NO If 'YES', How?

_____

Did This Doctor Say You Would Need More Treatment? ___ YES ___NO If 'YES', Explain:

_____

Did This Doctor Refer You Anywhere Else? ___ YES ___NO If 'YES', Where And Why?

_____

Name Of Doctor/Facility #2: _____ City/Location: _____

Type Of Doctor (degree or specialty): _____

Describe Treatment And/Or Tests: _____

_____

What Did This Doctor Say Was Wrong With You? _____

_____

Date When Treatment Started: _____ Date When Treatment Stopped: _____

How Many Treatments/Visits Were There? _____ How Long Were The Treatments? _____

What Was The Result/Outcome Of The Treatment? _____

_____

Still Treating With This Doctor? ___ YES ___ NO If 'YES', How Often? _____

Did This Doctor Take You Off Work? ___ YES ___ NO If 'YES', Give Dates: _____

Did This Doctor Restrict Or Modify Your Work Activities? ___ YES ___ NO If 'YES', How?

_____

Did This Doctor Say You Would Need More Treatment? ___ YES ___ NO If 'YES', Explain:

_____

Did This Doctor Refer You Anywhere Else? ___ YES ___ NO If 'YES', Where And Why?

_____

Name Of Doctor/Facility #3: _____ City/Location: _____

Type Of Doctor (degree or specialty): _____

Describe Treatment And/Or Tests: _____

_____

What Did This Doctor Say Was Wrong With You? _____

_____

Date When Treatment Started: _____ Date When Treatment Stopped: _____

How Many Treatments/Visits Were There? _____ How Long Were The Treatments? _____

What Was The Result/Outcome Of The Treatment? _____

_____

Still Treating With This Doctor? ___ YES ___ NO If 'YES', How Often? _____

Did This Doctor Take You Off Work? ___ YES ___ NO If 'YES', Give Dates: _____

Did This Doctor Restrict Or Modify Your Work Activities? ___ YES ___ NO If 'YES', How?

Did This Doctor Say You Would Need More Treatment? ___ YES ___ NO If 'YES', Explain:

Did This Doctor Refer You Anywhere Else? ___ YES ___ NO If 'YES', Where And Why?

If you saw any additional physicians please list them on the back and answer the same questions as previous physicians.

Were Any Other Tests, Examinations, Treatments, or Therapy Done That Were Not Described Above? ___ YES ___ NO If 'YES', Please Describe What Was Done And What The Result Was: **(use the back of this page if necessary):**

Do You Treat Yourself? ___ YES ___ NO If 'YES', Please Explain How:

Are You Currently Taking Medication To Relieve The Effects Of This Injury? ___ YES ___ NO If 'YES', Please Describe What You Take, (Prescription or Non-Prescription), How Much It Helps, How Often You Take It, Etc.:

Are You Currently Using A Brace, Support, Cane, Crutch(es), Wheelchair, TENS Unit, Or Other Aid Because Of The Effects Of This Injury? ___ YES ___ NO If 'YES', Please Describe Type And How Often It Is Used:

What Treatment(s) Offer You The Most Relief, And How Long Do The Benefits Last?

Have There Been Any Recommendations For Diagnostic Testing Or Treatment That You Have Not Received? If 'YES', What Was Recommended, And Who Recommended It?

_____

_____

HISTORY OF OTHER INJURIES:

Have You Ever Experienced The Same Or Similar Symptoms/Problems ***BEFORE*** This Work Injury?

___ YES ___ NO If 'YES', Please Explain In Detail:

_____

_____

_____

Have You Ever Had A ***PRIOR,*** Work Injury(ies)? ___ YES ___ NO If 'YES', Please Explain:

_____

_____

_____

Have You Ever Received a ***PRIOR,*** Workers' Compensation Disability Award? ___ YES ___ NO

If 'YES', Please Explain: _____

_____

_____

Have You Ever Served In The **Military**? ___ YES ___ NO If 'YES', Did You Receive A Medical Discharge? ___ YES ___ NO If 'YES', Please Explain Why: _____

_____

_____

Have You Ever Had Any ***PRIOR, NON-WORK RELATED INJURIES?*** (e.g. Sprains/Strains, Slips/Falls, Motor Vehicle Accidents, Cumulative Or Repetitive Traumas, etc.) ___ YES ___ NO

If 'YES', Please Explain: _____

_____

_____

Have You Had Any ***NEW INJURIES*** Involving Body Parts Which Are A Part Of Your Current Work Injury? ___ YES ___ NO If 'YES', Please Explain: _____

_____

_____

WORK HISTORY:

Did You Have **More Than One Employer When You Were Injured?** ___ YES ___ NO

If 'YES', Please List The Employer(s), And The Activities Required At That Employment?

_____

_____

_____

If 'YES', Did The Other Employment/Activities Listed Above **Contribute To, Or Further Worsen Your Condition?** ___ YES ___ NO If 'YES', Please Explain How? _____

_____

_____

Please List Your **Employers, Where Your Current Injury Occurred:**

	Employer	Dates Of Employment	Job Title/Duties
A)	_____	_____	_____
B)	_____	_____	_____
C)	_____	_____	_____
D)	_____	_____	_____
E)	_____	_____	_____
F)	_____	_____	_____

Are You Still Working For The *Same Employer* Where Your Work Injury Occurred? ___ YES ___ NO

If 'NO', Answer The Questions Below. **If 'YES',** Skip The Following Questions And Go To The Next Section Entitled **'PAST MEDICAL HISTORY.'**

Why Aren't You Working For The Same Employer Now? _____

_____

_____

When Did You Stop Working For The Same Employer? _____

If You Are Not Working For The Same Employer As When You Were Injured, **Please List Your Employment Since Leaving:** ___ I Have Not Worked Since Leaving That Employment

	Employer	Dates Of Employment	Job Title/Duties
A)			
B)			
C)			
D)			
E)			
F)			

Who Is Your **Current Employer(s)**? _____

Are You Doing The Same Type Of Work? ___ YES ___ NO

If 'NO', Describe The Type Of Work You Are Doing Now, Including Details On Physical Activity:

_____

_____

Has Any **NEW** Job Or Employment **Contributed To, Or Further Worsened Your Condition?**

___ YES ___ NO If 'YES', Please Name The Employer(s) And Explain How?

_____

_____

Are You Going To Be **Retrained For Another Job/Occupation** As A Result Of This Work Injury?

___ YES ___ NO ___ I DO NOT KNOW ___ RECOMMENDED Please Describe:

_____

_____

PAST MEDICAL HISTORY:

Please List **The Information About Your Medical History** In The Sections Below, With The **Approximate Dates.** If A Section Does Not Apply To You, Simply Mark An **(X)** In The 'Denied' Box:

Childhood Illnesses: ( ) Denied _____

Childhood Injuries: ( ) Denied _____

Allergies: ( ) Denied _____

Present Medications Taken (Prescription & Over-The-Counter): ( ) Denied _____

_____

Surgeries: ( ) Denied _____

Hospitalizations: ( ) Denied _____

Adult Illnesses: ( ) Denied _____

Doctor(s) Seen Previous To Your Current Work Injury: Name & Location/City: ( ) Denied _____

_____

FAMILY HISTORY:

List Any Health Problems In **Your Immediate Family**: (Mother, Father, Brother, Sister) ( ) Denied

_____

_____

_____

REVIEW OF SYSTEMS:

Please List Any Problems That You **Now Have** With The Following Body Systems:

Ears/Nose/Throat: ( ) Denied _____

Eyes: ( ) Denied _____

Lungs: ( ) Denied _____

Liver: ( ) Denied _____

G-I Tract (Stomach, Intestines, Bowels, Etc.): ( ) Denied _____

Kidney/Bladder: ( ) Denied _____

[Women] Reproductive System: ( ) Denied _____

Skin: ( ) Denied _____

Neurological: ( ) Denied _____

Heart/Circulation: ( ) Denied _____

Psychological: ( ) Denied _____

OFF WORK ACTIVITIES:

Do You Exercise? ___ YES ___ NO If 'YES', Please Describe Type & Frequency. If 'NO', Please Explain Why You Don't: _____

_____

Do You Participate In Any Sports Activities? ___ YES ___ NO If 'YES', Please Describe Type & Frequency: _____

Do You Have Any Hobbies? ___ YES ___ NO If 'YES', Please Describe Type & Frequency:

_____

_____

Are You Able To Perform Your Normal/Regular Household Chores/Activities? ___ YES ___ NO
If 'NO', Please Explain What You Cannot Do & Why: _____

_____

SOCIAL HISTORY:

Are You? ( ) Married ( ) Single ( ) Separated ( ) Divorced ( ) Widowed

How Many Years Of Schooling Have You Had? _____

List Degrees, Diplomas, Licenses, Certifications You Hold: _____

Do You Use Alcohol? ___ YES ___ NO If 'YES', How Many Drinks Per Week? _____

Do You Use Tobacco? ___ YES ___ NO If 'YES', What Kind & Times Per Day Or Week?

_____

Do You Use Drugs? ___ YES ___ NO If 'YES', What Kind & How Many Times Per Day Or Week?

_____

Do You Drink Coffee? ___YES ___NO If "YES", How Many Cups Per Week? _____

List Any Other Habits, Describing Their Type & Frequency: _____

_____

THANK YOU FOR YOUR TIME IN COMPLETING THIS QUESTIONNAIRE!

Injured Worker's Signature: _____ Date: _____

Informed Consent for Examination and Treatment

I (we) hereby consent to the performance of examination and treatment on me or on _____, by the licensed doctors of chiropractic, medical doctors, and/or licensed physical therapists who may be employed by or engaged in practice in this clinic.

I have had an opportunity to discuss with the doctor(s) or other clinic personnel the nature and purpose of the different physical therapy procedures and chiropractic treatment (manipulation/adjustment). I understand that neither chiropractic nor medical treatment is an exact science and that my care may involve judgments based upon facts and information known to the doctor. The doctor uses this judgment to attempt to anticipate or explain risks and complications and an undesirable result does not necessarily indicate an error in judgment. No guarantee for results can be made or expected but rather I wish to rely on the doctor to choose and recommend a best course of treatment based upon facts known that is in my best interests.

I further understand that there are certain degrees of risk associated with chiropractic health care and physical therapy, which includes rarely, but not limited to fractures, disc injuries, strokes, and strain/sprains and am therefore willing to accept and consent to the risk associated with the care that I am about to receive.

I have read, or the above information has been explained regarding consent. I have had an opportunity to ask questions about my examination and treatment. By signing below, I agree and intend this consent form to cover the procedures prescribed for my condition and for any future conditions for which I seek treatment.

Female Patients: By my signature on this form I do hereby state that to the best of my knowledge, I am not pregnant, nor is pregnancy suspected or confirmed at this particular time. Date of last menstrual period _____.

_____ _____

Patient's Name (Print) Patient's Signature

_____ _____

Date Relationship or authority if not signed By patient

_____

Witness

OFFICE FINANCIAL POLICY

Our policy is to extend to you the courtesy of allowing you to assign your insurance benefits directly to us. The policy reduces your out-of-pocket expense and allows you to place your family under care.

1. If You Do Not Have Insurance: All payments are expected at the time of service or by an authorized payment plan. Your personal balance may not exceed $100 at any time or care may be terminated. Our payment plans make care an affordable part of your family budget.

2. If You Have Insurance: I acknowledge that I am legally responsible for all charges in connection with the medical care and treatment provided by representatives of Unruh Chiropractic, Inc. or Thrive Medical, Inc. I assign and authorize payments to Unruh Chiropractic, Inc. or Thrive Medical, Inc. I understand my insurance carrier may not approve or reimburse my medical services in full due to usual and customary rates, benefit exclusions, coverage limits, lack of authorization, or medical necessity. I understand I am responsible for fees not paid in full, co-payments, and policy deductibles and co-insurance except where my liability is limited by contract or State or Federal law.

All deductibles and co-payments are expected at the time of service or by an authorized payment plan. Your co-insurance balance may not exceed $100 or care may be terminated. Our payment plans make care an affordable part of your family budget.

Insurance figures are **ESTIMATES ONLY!** It is not easy for an office to become familiar with the exact details of every Insurance Plan it encounters. **It is the responsibility of the patient, NOT the doctors' office to know what is covered and what is excluded from their particular Insurance Plan.**

You are considered a cash patient until you bring in your completed insurance forms, and we qualify and accept your insurance coverage. **We DO NOT accept assignment for secondary insurance carriers, but will be happy to provide you with a claim form for your secondary carrier.**

Our fees are considered usual, customary and reasonable by most companies, and therefore are covered up to the maximum allowance determined by each carrier. This statement does not apply to companies who reimburse based on arbitrary schedule of fees bearing no relationship to the current standard of care in this area. **If your carrier has not paid a claim within sixty (60) days of submission, you agree to take an active part in the recovery of your claim.**

If your insurance carrier has not paid within ninety (90) days of submission, you accept responsibility for payment in full of any outstanding balance.

As the patient you agree that you are seeking care under your accord if your insurance denies your care for any reason, including but not limited to medical necessity, timely filing, etc.

Cancellation Fee: We do not over-book our physician's schedules. We want every patient to be able to receive the care that they need. Therefore, when you cancel or do not show up to your appointment you are preventing someone else from getting the care they need.

If you do not cancel your appointment within 4 hours of your scheduled time or if you do not show up to your appointment you will be charge a **$25 cancellation fee** due on your next date of service.

_____ _____

Signature of Patient or Guardian Date

_____ _____

Printed Name of Patient or Guardian Relationship to Patient