Dunns Corners Chiropractic Center

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Work Comp History

Name_____ Date of Birth: _____Email Address_____

Home Phone: _____ Work Phone: _____ Cell Phone: _____

Address_____ City_____State_____Zip_____

Name of wife/husband/significant other: _____

Referred by: _____ Newspaper __ Yellow pages __ Self: __ Coupon _____

Nearest relative not living with you: _____ Ph: _____

Emergency Contact: _____ Ph: _____

Name of Compensation Carrier:_____Phone (____)_____
Address of Carrier: _____City_____State_____Zip_____

NATURE OF ACCIDENT

Employer: _____Address:_____

Contact at employment for this accident (Personnel): _____ Ph: _____

1. Type of Business:_____ Your Occupation_____
2. Date Injured: _____ Hour _____AM/PM Last Date Worked: _____
3. Are you out of work? ( ) Yes ( ) No
4. Previous Workers' Compensation Injury? ( ) Yes ( ) No
5. Accident reported to employer? ( ) Yes ( ) No
   Name of Person accident reported to _____
6. Injured at: _____City_____State_____Zip_____
7. Length of time worked there prior to accident: _____
8. Type of work being done at time of injury:_____
   _____
9. In your own words, please describe accident:_____
   _____
10. Have you been treated by another doctor for this accident: ( ) Yes ( ) No
    If yes, please list doctor's name and address:_____
    _____
    What type of treatment did you receive? _____
    How long were you treated by this doctor? _____
11. Are you: ( ) improved ( ) unchanged ( ) getting worse.
12. What types of medicines are you taking?_____
    _____
    Do these medicines help? ( ) Yes ( ) No ( ) Don't know
13. Have you had physical therapy? ( ) Yes ( ) No If yes, how often?
    ( ) Daily ( ) Every other day ( ) Several times a week ( ) Weekly
    ( ) Every other week ( ) Monthly ( ) Other _____

14. Prior to this accident, have you ever had any of the physical complaints similar to what you have now?
( ) Yes ( ) No ( ) Don't know. If yes, describe:_____
_____
_____
Were these similar complaints the results of a previous accident(s)? ( ) Yes ( ) No
Please provide details of accident(s)?_____
_____
_____

15. Have you had any other serious accidents that required medical care? ( ) Yes ( ) No
If yes, please describe: _____
_____

16. Have you had any serious illnesses that required hospitalization? ( ) Yes ( ) No
Describe: _____
_____
_____

17. Have you had any surgeries? ( ) Yes ( ) No
If yes, list type of surgery and date: _____
_____
_____

18. Have you had any nervous or mental illnesses? ( ) Yes ( ) No
Have you had psychiatric care? ( ) Yes ( ) No
19. Have you received a medical discharge from the Armed Forces? ( ) Yes ( ) No
20. Have you returned to work since this accident? ( ) Yes ( ) No
If you have returned to work since your accident, please fill out the information below:

Date	Employer	Occupation	Light Duty/Reg. Duty	Full-Time/Part-Time

CURRENT MEDICAL COMPLAINTS

BACK PAIN:

1. Currently, I have pain in my: ( ) low back ( ) mid back ( ) upper back
2. My pain began: ( ) gradually ( ) suddenly
3. I have pain: ( ) sometimes ( ) all of the time
4. My pain goes into my: ( ) right leg ( ) left leg ( ) both
5. I have tingling and /or numbness in my: ( ) right leg ( ) left leg ( ) both
6. My pain is worse when I:
   a. Cough or sneeze ( ) Yes ( ) No
   b. Sit ( ) Yes ( ) No
   c. Bend ( ) Yes ( ) No
   d. Walk ( ) Yes ( ) No
   e. Lift ( ) Yes ( ) No
   f. Push ( ) Yes ( ) No

g. Pull ( ) Yes ( ) No
7. My back is worse with sexual activity ( ) Yes ( ) No
8. My pain wakes me up during the night ( ) Yes ( ) No
9. Changes in the weather affect my pain ( ) Yes ( ) No

NECK PAIN:

1. My neck pain began: ( ) gradually ( ) suddenly
2. I have pain: ( ) sometimes ( ) all of the time
3. My pain goes into my: ( ) right arm ( ) left arm ( ) both
4. I have tingling and/or numbness in my: ( ) right arm ( ) left arm ( ) both
5. My pain is worse when I:
   a. Cough or sneeze ( ) Yes ( ) No
   b. Bend forward ( ) Yes ( ) No
   c. Lift ( ) Yes ( ) No
   d. Push ( ) Yes ( ) No
   e. Pull ( ) Yes ( ) No
   f. Turn my head ( ) Yes ( ) No
6. My pain wakes me up during the night ( ) Yes ( ) No
7. Changes in the weather affect my pain ( ) Yes ( ) No
8. I have neck stiffness ( ) Yes ( ) No
9. I have headaches ( ) Yes ( ) No
10. If I do get headaches, they occur: ( ) sometimes ( ) all of the time

OTHER PAIN:

Please describe any current medical complaints which you are experiencing and were not previously covered on this questionnaire, or list any additional comments you which to make regarding your condition:

_____

_____

_____

JOB DESCRIPTION

(In terms of an 8-hour workday, “occasionally” means 33%, “frequently” means 34% to 66%, and “continuously” means 67% to 100% of the day.)

1. In a typical 8-hour workday, I: (Circle # of hours / activity)

Sit:	1	2	3	4	5	6	7	8	hours
Stand:	1	2	3	4	5	6	7	8	hours
Walk:	1	2	3	4	5	6	7	8	hours

2. On the job, I perform the following activities:

	NOT AT ALL	OCCASIONALLY	FREQUENTLY	CONTINUOUSLY
Bend/Stoop	( )	( )	( )	( )
Squat	( )	( )	( )	( )
Crawl	( )	( )	( )	( )
Climb	( )	( )	( )	( )
Reach above shoulder level	( )	( )	( )	( )
Crouch	( )	( )	( )	( )
Kneel	( )	( )	( )	( )
Balancing	( )	( )	( )	( )
Pushing / Pulling	( )	( )	( )	( )

3. On the job, I lift NOT AT ALL OCCASIONALLY FREQUENTLY CONTINUOUSLY

Up to 10 pounds	( )	( )	( )	( )
11 to 24 pounds	( )	( )	( )	( )
25 to 34 pounds	( )	( )	( )	( )
35 to 50 pounds	( )	( )	( )	( )
51 to 74 pounds	( )	( )	( )	( )
75 to 100 pounds	( )	( )	( )	( )

4. Do you have to bend over while doing any lifting? ( ) Yes ( ) No

5. Are your feet used for repetitive movements, such as in operating foot controls?
   ( ) Yes ( ) No

6. Do you use your hands for repetitive actions, such as:

	SIMPLE GRASPING	FIRM GRASPING	FINE MANIPULATING
Right hand	( ) Yes ( ) No	( ) Yes ( ) No	( ) Yes ( ) No
Left hand	( ) Yes ( ) No	( ) Yes ( ) No	( ) Yes ( ) No

7. Are you required to work on unprotected heights? ( ) Yes ( ) No
   Describe:_____
   _____
   _____

8. Are you required to be around moving machinery? ( ) Yes ( ) No
   Describe:_____
   _____
   _____

9. Are you exposed to marked changes in temperature and humidity? ( ) Yes ( ) No
   Describe:_____
   _____
   _____

10. Are you required to drive automotive equipment? ( ) Yes ( ) No
    Describe:_____
    _____
    _____

11. Are you exposed to dust, fumes and/or gases? ( ) Yes ( ) No
    Describe:_____
    _____
    _____

12. Please list any additional comments:
    _____
    _____
    _____

Signature:_____ Date:_____

The Oswestry Disability Index for Back Pain

This questionnaire has been designed to give us information as to how your back pain has affected your ability to manage everyday life activities. Please answer every section, and mark in each section the one box that applies to you. We realize you may consider that two of the statements in any one section relate to you, but please just mark the box that most closely describes your present day situation.

Section 1. Pain Intensity

_____A. My pain is mild to moderate. I do not need pain killers
_____B. The pain is bad, but I manage without taking painkillers
_____C. Pain killers give me complete relief from pain
_____D. Pain killers give me moderate relief from pain
_____E. Pain killers give me very little relief form pain.
_____F. Pain killers have no effect on the pain.

Section 2 Personal Care

_____A. I can look after myself mormally without causing extra pain.
_____B. I can look after myself mormally but it causes extra pain.
_____C. It is painful to look after myself and I am slow and careful.
_____D. I need some help but manage most of my personal care.
_____E. I need help every day in most aspects of self-care.
_____F. I do not get dressed, I wash with difficulty and stay in bed.

Section 3. Lifting

_____A. I can lift heavy weights without causing extra pain.
_____B. I can lift heavy weights but it gives me extra pain.
_____C. Pain prevents me from lifting heavy weights off the floor, but I can manage if they are conveniently positioned, for example on a table.
_____D. Pain prevents me from lifting heavy weights, but I can manage light to medium weights if they are conveniently positioned.
_____E. I can lift very light weights.
_____F. I cannot lift or carry anything at all.

Section 4. Walking

_____A. I can walk as far as I wish.
_____B. Pain prevents me from walking more than 1 mile.
_____C. Pain prevents me from walking more than ½ mile.
_____D. Pain prevents me from walking more than 1/4 mile.
_____E. I can walk only if I use a cane or crutches.
_____F. I am in bed or in a chair for most of the day.

Section 5. Sitting

_____A. I can sit in any chair for as long as I like.
_____B. I can sit in my favorite chair only, but for as long as I like
_____C. Pain prevents me from sitting for more than 1 hour.
_____D. Pain prevents me from sitting for than ½ hour.
_____E. Pain prevents me from sitting for more than 10 minutes.
_____F. Pain prevents me from sitting at all.

Section 6. Standing

_____ A. I can stand as long as I want without extra pain.
_____ B. I can stand as long as I want but it gives me extra pain.
_____ C. Pain prevents me from standing for more than 1 hour.
_____ D. Pain prevents me from standing for more than ½ hour.
_____ E. Pain prevents me from standing for more than 10 minutes.
_____ F. Pain prevents me from standing at all.

Section 7. Sleeping

_____ A. Pain does not prevent me from sleeping well.
_____ B. I sleep well but only when taking medicine.
_____ C. Even when I take medication, I sleep less than 6 hours.
_____ D. Even when I take medication, I sleep less than 4 hours.
_____ E. Even when I take medication, I sleep less than 2 hours.
_____ F. Pain prevents me from sleeping at all.

Section 8. Social Life

_____ A. My social life is normal and causes me no extra pain.
_____ B. My social life is normal, but increases the degree of pain.
_____ C. Pain affects my social life by limiting only my more energetic interests, such as dancing, sports, etc.
_____ D. Pain has restricted my social life and I do not go out as often.
_____E. Pain has restricted my social life to my home.
_____F. I have no social life because of pain.

Section 9. Sexual Activity

_____A. My sexual activity is normal and causes no extra pain.
_____B. My sexual activity is normal, but causes some extra pain.
_____C. My sexual activity is nearly normal, but it is very painful.
_____D. My sexual activity is severely restricted by pain.
_____E. My sexual activity is nearly absent because of pain.
_____F. Pain prevents any sexual activity at all.

Secrion 10. Traveling

_____A. I can travel anywhere without extra pain.
_____B. I can travel anywhere, but it gives me extra pain.
_____C. Pain is bad, but I manage journeys over 2 hours.
_____D. Pain restricts me to journeys of less than 1 hour.
_____E. Pain restricts me to necessary journeys under ½ hour.
_____F. Pain prevents traveling except to the doctor/hospital.

Patient Name:_____

Date:_____ Score_____ _____

Signature

NECK DISABILITY INDEX

This questionnaire helps us to understand how much your neck pain has affected your ability to perform everyday activities. Please check the one box in each section that most clearly describes your problem right now.

SECTION 1 – Pain Intensity

- ☐ I have no pain at the moment.
- ☐ The pain is very mild at the moment.
- ☐ The pain is moderate at the moment.
- ☐ The pain is fairly severe at the moment.
- ☐ The pain is very severe at the moment.
- ☐ The pain is the worst imaginable at the moment.

SECTION 2 – Personal Care (Washing, Dressing, etc.)

- ☐ I can look after myself normally without causing extra pain.
- ☐ I can look after myself normally but it causes extra pain.
- ☐ It is painful to look after myself and I am slow and careful.
- ☐ I need some help but manage most of my personal care.
- ☐ I need help every day in most aspects of self-care.
- ☐ I do not get dressed, I wash with difficulty and stay in bed.

SECTION 3 – Lifting

- ☐ I can lift heavy weights without extra pain.
- ☐ I can lift heavy weights but it gives extra pain.
- ☐ Pain prevents me from lifting heavy weights off the floor, but I can manage if they are conveniently positioned.
- ☐ Pain prevents me from lifting heavy weights, but I can manage light to medium weights if they are conveniently positioned
- ☐ I can lift very light weights.
- ☐ I cannot lift or carry anything at all.

SECTION 4 – Reading

- ☐ I can read as much as I want with no pain in my neck.
- ☐ I can read as much as I want with slight pain in my neck.
- ☐ I can read as much as I want with moderate pain in my neck.
- ☐ I can't read as much as I want because of moderate pain in my neck.
- ☐ I can hardly read at all because of severe pain in my neck.
- ☐ I cannot read at all due to pain.

SECTION 5 – Headaches

- ☐ I have no headaches at all.
- ☐ I have slight headaches that come infrequently.
- ☐ I have moderate headaches that come infrequently.
- ☐ I have moderate headaches that come frequently.
- ☐ I have severe headaches that come frequently.
- ☐ I have headaches almost all the time.

Date:_____

File #:_____

_____

Name

SECTION 6 – Concentration

- ☐ I can concentrate fully when I want to with no difficulty.
- ☐ I can concentrate fully when I want to with slight difficulty.
- ☐ I have a fair degree of difficulty in concentrating when I want to.
- ☐ I have a lot of difficulty in concentrating when I want to.
- ☐ I have a great deal of difficulty in concentrating when I want to.
- ☐ I cannot concentrate at all.

SECTION 7 – Work

- ☐ I can do as much work as I want to.
- ☐ I can only do my usual work, but no more.
- ☐ I can do most of my usual work, but no more.
- ☐ I cannot do my usual work.
- ☐ I can hardly do any work at all.
- ☐ I can not do any work at all.

SECTION 8 – Driving

- ☐ I can drive my car without any neck pain.
- ☐ I can drive my car as long as I want with slight pain in my neck.
- ☐ I can drive my car as long as I want with moderate pain in my neck.
- ☐ I can't drive my car as long as I want because of moderate pain in my neck.
- ☐ I can hardly drive at all because of severe pain in my neck
- ☐ I can't drive my car at all.

SECTION 9 – Sleeping

- ☐ I have no trouble sleeping
- ☐ My sleep is slightly disturbed (less than 1 hr sleepless).
- ☐ My sleep is mildly disturbed (1-2 hrs sleepless).
- ☐ My sleep is moderately disturbed (2-3 hrs sleepless).
- ☐ My sleep is greatly disturbed (3-5 hrs sleepless).
- ☐ My sleep is completely disturbed (5-7 hrs sleepless).

SECTION 10 – Recreation

- ☐ I am able to engage in all my recreation activities with no neck pain at all.
- ☐ I am able to engage in all my recreation activities, with some pain in my neck.
- ☐ I am able to engage in most, but not all of my usual recreation activities because of neck pain.
- ☐ I am able to engage in a few of my usual recreation activities because of pain in my neck.
- ☐ I can hardly do any recreation activities because of pain in my neck.
- ☐ I can't do any recreation activities at all.

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Important Notice
To Patients on Workers' Compensation

Please be advised that due to stringent scrutiny and documentation requirements to your Insurance Company regarding Workers' Compensation cases, if you should miss an appointment or not show up for a scheduled appointment, a notification may go to your Employer stating that **YOU HAVE BEEN IMMEDIATELY RELEASED TO RETURN TO FULL-TIME WORK WITHOUT RESTRICTIONS AS PER NON-COMPLIANCE WITH TREATMENT SCHEDULES, AND YOUR BENEFITS MAY BE TERMINATED.**

If you are on Workers' Compensation and have been ***returned to work*** and you are still treating in our office for injuries sustained at work and you miss an appointment, continuation of any benefits due to you, including payment of medical bills, may be seriously jeopardized.

If you need to miss an appointment for any reason, please be sure to call our office with the reason why and be sure to **RE-SCHEDULE THAT APPOINTMENT EITHER THAT DAY OR THE FOLLOWING DAY.** Your job, while you are out of work, is to get well as quickly as possible. We will assist you in any way we can, but we must have your cooperation. Both this office, and you as the patient must adhere strictly to your treatment schedule. We appreciate your anticipated cooperation.

Dr. Campbell and Staff
DUNNS' CORNERS CHIROPRACTIC CENTER

Patient Signature:_____ Date:_____

Date of Injury: _____

Dunns Corners Chiropractic Center

Robert C. Campbell, D.C., D.A.C.N.B. Michael T. Macijeski, D.C.

Privacy Policy

1. All patient information is confidential.
2. Every attempt will be made to respect confidentiality when communicating with patients.
3. Patients will be informed of this policy upon entering the practice, and then yearly thereafter.
4. It is our policy to release patient information to other providers only with written patient consent.
5. Only patients themselves may call for test results unless they have authorized us to give information to family members.
6. Employees will review this policy upon hiring, and then yearly thereafter.

BLANKET AUTHORIZATION/RELEASE FORM

____ **Insurance Assignment –** I authorize payment of medical benefits from _____ insurance company to be paid directly to: Robert C. Campbell, D.C., D.A.C.N.B., for services rendered to me. If my current policy prohibits the direct payment to the doctor, then I also instruct and direct you to make out the check to me and mail it to our office. I also acknowledge that all services rendered to me are ultimately my financial responsibility. I agree to pay any balance that remains after my insurance company has made payment, and any unpaid balance that remains 60 days after services are rendered.

____ **Cash Policy** – I do not have insurance benefits available and agree to pay for all services rendered to me, at the time they incur, unless otherwise agreed to in the form of a financial payment contract.

____ **Records Release** – I hereby authorize the release of my x-rays and medical records from any medical provider, hospital, attorney or insurance company upon receipt of a copy of this form, to Dunn's Corners Chiropractic Center. SPECIFIC REQUEST FOR RECORDS FROM_____

____ **Authorize to Release Information** – I authorize your office to release any information you deem appropriate concerning my condition to any insurance company, attorney or adjuster in order to process any claim for reimbursement of charges incurred by me in this chiropractic office. I hereby release you from any consequences thereof.

____ **Termination of Care Waiver** – I hereby acknowledge and understand that if I do not keep appointments as recommended to me by my attending chiropractor, I cannot expect maximum chiropractic results and the doctor has full and complete right to terminate my case and discharge me from care.

____ **Consent to Treat a Minor** – I hereby give my consent for Dr. Robert Campbell and/or Dr. Macijeski to examine and render treatment to my son/daughter_____who is a minor.

____ **Pregnancy Release** – To the best of my knowledge I am not pregnant. I understand that x-ray radiation may pose risks to an unborn child. I consent to having x-rays taken, and I release Dr. Robert Campbell, Dr.Michael Macijeski, and the office from any responsibility that could in any way associate damage to an unborn child with the x-ray examination. If you have any concerns, please consult the doctor.

____**Consent to Care --** A patient coming to the doctor gives him/her permission and authority to care for the patient in accordance with appropriate tests, diagnosis and analysis. The clinical procedures performed are usually beneficial and seldom cause any problem. In rare cases underlying physical defects, deformities or pathologies, may render the patient susceptible for injury. The doctor, of course, will not provide specific healthcare, if he/she is aware that such care may be contraindicated. It is the responsibility of the patient to make it known or to learn through health care procedures from whatever he/she is suffering from: latent pathological defects, illnesses or deformities which would otherwise not come to the attention of the physician.

I have read the above blanket authorization/release form and agree to the _____ items checked off.

I do hereby consent and acknowledge my agreement to the terms set forth in the HIPPA INFORMATION FORM (copy attached to clipboard to read) and any subsequent changes in the policy. I understand that this consent shall remain in force from this time forward. If there are any changes in the future, I must do so in writing.

_____ _____ Date: _____

Patient Name (print) Patient/Guardian Signature Witness_____