Turning Leaf Chiropractic Worker's Compensation Info.

Personal Information

Name: _____

Birth Date: _____ Social Security Number: _____

Address: _____

City: _____ State: _____ Zip: _____

Home Phone: _____ Cell Phone: _____

Gender: _____ Marital Status: Single/Married/Divorced/Widowed

Spouse/Partner Name: _____ Number of Children:_____

Children's Names: _____

Email Address: _____

Have you been to a chiropractor before? Yes No

If yes, what was the reason for those visits? _____

Chiropractor's name? _____ Date of last visit? _____

Reason for leaving? _____

Has any other adult in your family seen a chiropractor? Yes No

Has any child in your family seen a chiropractor? Yes No

Whom may we thank for your referral? _____

Employer Information

Employer: _____ Work Phone: _____

Work Address: _____

City: _____ State: _____ Zip: _____

Type of Work: _____

Supervisor/ Contact Name: _____ Phone: _____

Workers Compensation Carrier: _____

Carrier Phone: _____ Adjustors' Name:_____

Claim Number:_____

Goals For Your Care

People see chiropractors for a variety of reasons. Some go for relief of pain, some to correct the cause of pain and others for correction of whatever is malfunctioning in their bodies. Your doctor will weigh your needs and desires when recommending your treatment program.

Please check the type of care desired so that we may be guided by your wishes wherever possible.

☐ **Relief Care** – Symptomatic relief of pain or discomfort

☐ **Corrective Care** – Correcting and relieving the cause of the problem as well as the symptoms.

☐ **Comprehensive Care** – Bring whatever is malfunctioning in the body to the highest state of health possible with chiropractic care

☐ I want the doctor to select the type of care appropriate for my condition.

Thank you for choosing our chiropractic office. We are excited about the possibility of assisting you on your journey towards greater health and wellness.

Chiropractic is a lifestyle and a family affair. We give you the opportunity to have your immediate family members examined at no additional charge as long as these exams are done within two weeks. We encourage all parents to have their children examined.

Part 1: Injury Information

Date of Injury: _____ Time: _____AM / PM

Place of Injury: _____

Have you made a report of your accident to your employer? Yes No

Name of person accident was reported to: _____

Give a full description of how accident happened: _____

_____

_____

_____

Have you lost time from work? Yes No How much? _____

Have you seen other doctors for this condition? Yes No

Doctor's Name(s):_____

Diagnosis: _____

Type of Treatment:_____

Results _____

Were X-rays taken? Yes No

Other tests? _____

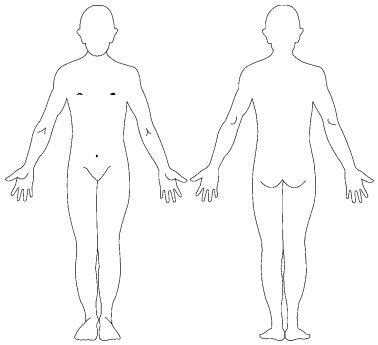
If yes, please list findings _____

_____

Any previous work compensation injuries? Yes No

When: _____ Describe injuries: _____

Please indicate areas of pain or discomfort:



Part 2: After Injury

Describe how you felt immediately following your accident: _____

_____

_____

Is your condition (please circle one): Improving Worsening Staying the Same

Indicate the symptoms that you are experiencing as a result of the accident:

☐Dizziness	☐Jaw Pain	☐Chest Pain
☐Memory Loss	☐Joint Swelling/Pain	☐Shortness of Breath
☐Neck Pain	☐Headache	☐Upset Stomach
☐Upper Back Pain	☐General Fatigue	☐Numb Toes/Feet
☐Mid Back Pain	☐Ear Ringing	☐Numb Fingers
☐Lower Back Pain	☐Tension	☐Difficulty Sleeping
☐Shoulder/Arm Pain	☐Knee/Leg Pain	☐Other:_____
☐Blurred Vision	☐Ankle/Foot Pain	

Which of the following stressors are you currently experiencing in you life?

Please rate (Circle)	**Mild**	**Moderate**	**Extreme**
Physical Stress	Mild	Moderate	Extreme
Family Stress	Mild	Moderate	Extreme
Personal Relationships	Mild	Moderate	Extreme
Work Related Stress	Mild	Moderate	Extreme
Loss of a loved one	Mild	Moderate	Extreme

Part 3: Recovery

To evaluate the effects that continuing to work will have on your recovery, please complete the following:

How many hours is your normal work day? _____ How many days per week? _____

What position can you work in with minimal physical effort or pain and for how long?

_____

Please indicate your daily job duties and any activities which you are occasionally asked to perform:

☐Standing	☐Sitting	☐Driving
☐Walking	☐Lifting	☐Twisting
☐Neck Pain	☐Crawling	☐Typing
☐Stooping	☐Operating Equipment	☐Working with arms over head

Prior to the injury, were you capable of working on an equal basis with others your own age? Yes No

Do you work with others who can help you with any heavy lifting? _____

While recovering is there any light duty work you could request? _____

Part 4: Medication, Health Habits and Health Conditions

Please list any and all medications (prescription and non-prescription) that you have taken within the past 60 days: _____

In the past, have you taken any medication for more than 3months? Yes No

a) What did you take? _____

b) What was the reason for taking this medication? _____

_____

Please list any herbs, nutritional supplements or natural home remedies you take regularly:

_____

Do you smoke? Yes No	Amount per week?	< 1pk	1-2 pks	2 pks <
Do you drink alcohol? Yes No	Amount per week?	1-5	5-10	10+
Do you drink coffee? Yes No	Amount per day?	1-5	5-10	10+

Do you wear: Heel Lifts Sole Lifts Inner Soles Arch Supports

Do you have an exercise program or are you involved in a sports/recreational activity. Yes No

If yes, please explain: _____

_____

Have you broken any bones, or significantly sprained any part of your body? Yes No

If yes, please explain: _____

Please check each of the diseases or conditions that you have now or have had in the past year. While they may seem unrelated to the purpose of this appointment, they can affect the overall diagnosis, care plan and the possibility of being accepted for care.

☐Headaches	☐Heart problems	☐Diabetes	☐Migraines
☐Stroke	☐Shingles	☐Sinus Problems	☐High/Low blood pressure
☐Kidney problems	☐Dizziness	☐Liver problems	
☐Loss of sleep	☐Difficulty breathing	☐Asthma/Allergies	☐Digestive probs
☐Upper back pain	☐Thyroid problems	☐Alcohol/Drug abuse	☐Ulcers/Colitis
☐ Neck pain	☐Constipation/Diarrhea	☐Psychiatric problems	☐Depression
☐Lower back problems	☐Numbness or pain in arms/hands	☐Numbness or pain in legs/feet	☐Compromised immune system
☐Arthritis	☐Cancer	☐Other: _____	

AUTHORIZATION FOR CARE

I hereby authorize the doctors in this chiropractic office and whomever they may designate as their assistant to administer chiropractic care, to work with my condition through the use of adjustments and procedures the doctor deems appropriate. The Dr. will not be held responsible for any pre-existing medically diagnosed conditions nor for any medical diagnosis.

TERMS OF ACCEPTANCE

When a patient seeks chiropractic health care and we accept a person for such care, it is essential for both to be working towards the same objective.

Chiropractic has only one goal. It is important that each person understand both the objective and the method that will be used to attain it. This will prevent any confusion or disappointment.

Adjustment: 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 of the spine.

Health: A state of optimal physical, mental, and social well-being, not merely the absence of infirmity.

Vertebral Subluxation: A misalignment of one or more of the 24 vertebra in the spinal column which causes alteration of nerve function and interference to the transmission of mental impulses resulting in a lessening of the body's innate ability to express its maximum health potential.

We do not offer to diagnose or treat any disease or condition other than vertebral subluxation. However, if during the course of chiropractic spinal examination, we encounter non-chiropractic or unusual findings, we will advise you. If you desire advice, diagnose or treatment for those findings, we will recommend that you seek the services of a health care provider that 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 subluxations.

PAYMENT OF SERVICES

I clearly understand and agree that all services rendered to me are charged directly to me, and I am responsible for my account balance in the event that my worker compensation claim benefits are denied. I hereby authorize the doctor to release all information necessary to secure payment of benefits. I authorize the use of this signature on any insurance submissions.

*I,*_____ *have read and fully understand the above statements.*
(Print name)

All questions regarding the doctors' 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)

PATIENT HEALTH INFORMATION CONSENT FORM

We want you to know how your Patient Health Information (PHI) is going to be used in this office and your rights concerning those records. Before we will begin any health care operations we must require you to read and sign this consent form stating that you understand and agree with how your records will be used. If you would like to have a more detailed account of our policies and procedures concerning the privacy of your PHI we encourage you to read the HIPPA NOTICE that is available to you at the front desk before signing this consent.

1. The patient understands and agrees to allow this chiropractic office to use their PHI for the purpose of treatment, payment, healthcare operations, and coordination of care. As an example, the patient agrees to allow this chiropractic office to submit requested PHI to the Health Insurance Company (or companies) provided to us by the patient for the purpose of payment. Be assured that this office will limit the release of all PHI to the minimum needed for what the insurance companies require for payment.

2. The patient has the right to examine and obtain a copy of his or her own health records at any time and request corrections. The patient may request to know what disclosures have been made and submit in writing any further restrictions on the use of their PHI. Our office is not obligated to agree to those restrictions.

3. A patient's written consent only needs to obtained one time for all subsequent care given the patient in this office.

4. The patient may provide a written request to revoke consent at anytime during care. This would not effect the use of those records for the care given prior to the written request to revoke consent but would apply to any care given after the request has been presented.

5. For your security and right to privacy, all staff has been trained in the area of patient record privacy and a privacy official has been designated to enforce those procedures in our office. We have taken all precautions that are known by this office to assure that your records are not readily available to those who do not need them.

6. Patients have the right to file a formal complaint with our privacy official about any possible violations of these policies and procedures.

7. If the patient refuses to sign this consent for the purpose of treatment, payment and health care operations, the chiropractic physician has the right to refuse to give care.

I have read and understand how my Patient Health Information will be used and I agree to these policies and procedures.

_____ _____

Patient Signature Date