



IRVING PARK CHIROPRACTIC CENTER

WORKER'S COMPENSATION

Patient: Name _____

When did the injury occur: _____

When was the injury reported to a supervisor: _____

Date last worked: _____

What is supervisor's name and telephone number: _____

Ask Supervisor

When was it reported to them _____

Who is the worker's compensation carrier for the company _____

What is the w/c address and telephone number _____

What is the claim number _____

Ask Worker's Compensation Carrier

Who is the adjuster _____

What is their direct telephone and fax number _____

To what address are bills to be sent. _____



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Thank you for choosing Irving Park Chiropractic Center. To help us complete our records and submit accurate bills to your insurance company, please assist us by providing the following information. If you have any questions about these forms the receptionist will gladly help you.

Today's Date: _____ Patient's Social Security # _____
 First Name: _____ M.I. _____ Last Name: _____
 Date of Birth: _____ Sex: M F
 Address: _____
 City: _____ State: _____ Zip Code: _____
 Home Phone: (_____) _____ Work Phone: (_____) _____
 Cell Phone: (_____) _____ Pager: (_____) _____
 Email: _____

How did you find us?: Friend / Family Member (Name) _____
Yellow Pages Website Insurance Provider Directory Clinic Location
Presentation (Where & When) _____
Other (Please Describe) _____

Worker's Comp Patients:

- Insurance Carrier Name: _____
- Insurance Carrier Address: _____
- Insurance Carrier City, State, Zip: _____
- Date of Injury: _____ Claim Number: _____
- Adjuster's Name: _____ Adjuster's Telephone: (_____) _____

I, the undersigned, hereby authorize the staff to perform such services as deemed necessary by the physician to diagnose and treat my condition(s). Further, I authorize assignment of my Insurance rights and benefits directly to this provider and also release of such information as is needed to process Insurance claims by provider or agent. I understand that I am responsible for all charges which may include legal fees, collection fees or other expenses incurred by the provider in collecting my account. I hereby order all parties to accept a copy of this release and assignment in lieu of the original. This shall remain in effect until revoked by me in writing.

 **Patient Signature:** _____ **Date:** _____



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Patient's Name: _____

Date: _____

Case Number: _____

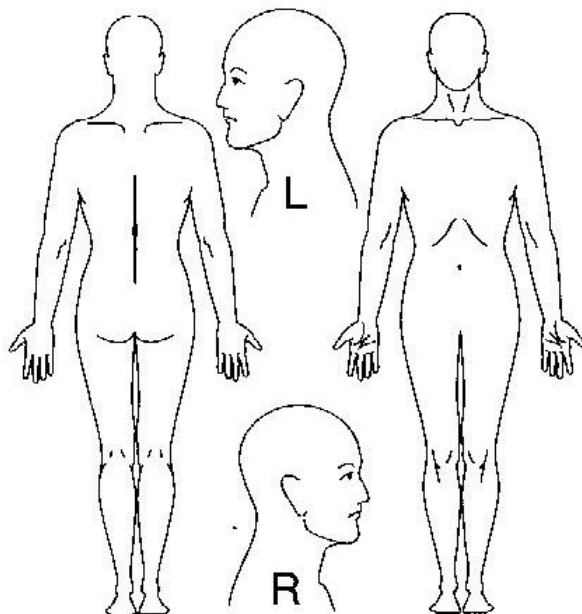
Please Mark your painful spots on the chart. Use the following symbols to describe the pain.

Burning: *****

Sharp/Stabbing: //////////////

Aching: oooooooooo

Dull: ~~~~~



1. Pain right now 1 -----10

2. Average pain 1 -----10

3. Pain at its best 1 -----10

4. Pain at its worst 1 -----10

Percentage of time pain is at its worst _____%

Percentage of time pain is at its best _____%

Patient Signature: _____



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WORK COMP HISTORY

Employer's Name: _____ Phone (____) _____

Employer's Address: _____ City _____ State _____ Zip _____

1. Type of Business _____ Your Occupation _____

2. Previous Worker's Compensation Injury? ()Yes ()No

3. Length of time worked there prior to accident: _____

4. Type of work being done at time of injury: _____

5. In your own words, please describe accident: _____

6. 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? _____

7. Are you: ()Improved ()Unchanged ()Getting worse

8. What types of medicines are you taking? _____

Do these medicines help? ()Yes ()No ()Don't Know

9. 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 _____

Is the physical therapy helping? ()Yes ()No ()I don't know



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10. 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 previous accident(s)? ()Yes ()No

Please Provide details of accident(s): _____

11. Have you had any other serious accidents, which required medical care? ()Yes ()No

Describe: _____

12. Have you had any serious illnesses that required hospitalization? ()Yes ()No

Describe: _____

13. Have you had any surgeries? ()Yes ()No

If yes, list type of surgery and date: _____

14. Have you had any nervous or mental illnesses? ()Yes ()No

Have you had psychiatric care? ()Yes ()No

15. Have you received a medical discharge from the Armed forces? ()Yes ()No

16. 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/PartTime



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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:
 - Cough or sneeze Yes No
 - Sit Yes No
 - Bend Yes No
 - Walk Yes No
 - Lift Yes No
 - Push Yes No
 - 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:
 - Cough or sneeze Yes No
 - Bend forward Yes No
 - Turn my head Yes No
 - Lift Yes No
 - Push Yes No
 - Pull Yes No
6. My pain wakes me up during the night Yes No
7. I have neck stiffness Yes No
8. Changes in the weather affect my pain Yes No
9. I have headaches
10. If I do get headaches, they occur: Sometimes all of the time

Other Pain

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



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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 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 _____



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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: _____