Synchrony ChiroCare

Harmony of Structure and Function

Work Accident History

Please Print

Patient Information

Acct#_____

We want to get to know you and appreciate you filling in our forms!

_____

Name Address

_____

City State Zip Code

Home Phone: _____ Cell Phone: _____

Date of Birth: _____ Sex: ○ M ○ F Marital Status: ○ M ○ S ○ D ○ W

Email Address: _____

Social Security Number: _____ Primary Care Physician: _____

Females; are you pregnant? ○ Y ○ N Date of Last Menstrual Cycle: _____

Have you ever received chiropractic care in the past? ○ Y ○ N Last Date Treated:_____

Employer

Occupation: _____ Employer: _____

_____

Employer Address City State Zip Code Employer Phone

Spouse

_____

Spouse's Name Spouse's Employer Occupation

Children and Ages: _____

_____

Emergency Contact

_____

Name Address

_____

City State Zip Code

Contact phone: _____ Cell Phone: _____

I understand and agree that health and accident insurance policies are an arrangement between the insurance carrier and myself. I authorized the release of any medical information necessary to process this claim and authorize payment of services to this office. I understand any amount paid directly to the office will be credited to my account. I permit this office to endorse co-issued remittances for the conveyance of credit to my account. However, I clearly understand and agree that all services rendered me are charged directly to me and I am personally responsible for payment. I will make payment for my portion of charges at each visit unless other arrangements are made.

Patient's Signature: _____ Date: _____

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(signature of parent or guardian if the patient is a minor)

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Accident/Injury History

1. Date of Accident/Injury: _____ ○ Gradual ○ Sudden ○ Progressive

2. Address/Location where you were injured? _____
   _____
   No. and Street City County

3. Time of day when accident occurred: _____ am/pm Date Last Worked: _____

4. Did you report this to your employer? ○ Y ○ N If so, to whom? _____

5. Did you go to the hospital or another doctor's office after the accident? ○ Y ○ N
   If so, where: _____ Were x-rays taken? ○ Y ○ N
   What type of treatment did you receive? _____
   Was a diagnosis made? ○ Y ○ N If so, what was it? _____

6. Describe how the accident/injury happened? _____
   _____
   _____

7. What is your number-one problem or the one area of greatest pain? _____

8. Have you ever experienced this problem before? ○ Y ○ N When? _____

9. Please rate the level of this pain on the following scale: 0 is no pain, 10 is severe pain or the worst pain you have ever felt. If your pain varies from day to day, please circle two numbers to indicate a range of your pain.
   0 1 2 3 4 5 6 7 8 9 10

10. How often do you experience the pain?
    ○ 1-2 hours per day ○ About half of the day ○ Most of the day ○ The pain never goes away

11. How does the pain affect your daily activities?
    ○ It does not affect my daily work or home activities.
    ○ I have had to change how I do my work or home activities. Please explain: _____
    ○ I cannot do the following due to my present problem: _____
    ○ I am unable to do nearly everything I am accustomed to doing.

12. What increases your pain? _____

13. What decreases your pain? _____

14. List any other complaints currently bothering you and rate your pain level for each using the same scale as above.
    a) _____ 0 1 2 3 4 5 6 7 8 9 10
    b) _____ 0 1 2 3 4 5 6 7 8 9 10
    c) _____ 0 1 2 3 4 5 6 7 8 9 10
    d) _____ 0 1 2 3 4 5 6 7 8 9 10

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15. Do you feel you could perform your usual job right now? ○ Y ○ N

16. Describe your routine job duties: _____
_____
_____

17. If you are working, how has your current condition affected your normal duties? _____
_____
_____

18. Is there any activity or duty you are unable to perform? _____
_____
_____

19. How often does your job require you to do the following:
    - ○ Lifting (_____lbs) ○ Sitting (_____hrs/day) ○ Standing (_____hrs/day)
    - ○ Computer (_____hrs/day) ○ Telephone (_____hrs/day) ○ Driving (_____hrs/day)
    - ○ Push/pull: ○ Once in a while ○ Often ○ Frequently ○ Almost all the time
    - ○ Reach overhead: ○ Once in a while ○ Often ○ Frequently ○ Almost all the time
    - ○ Grasping: ○ Once in a while ○ Often ○ Frequently ○ Almost all the time
    - ○ Twisting/bending: ○ Once in a while ○ Often ○ Frequently ○ Almost all the time
    - ○ Squatting/kneeling: ○ Once in a while ○ Often ○ Frequently ○ Almost all the time
    - ○ Walking: ○ Once in a while ○ Often ○ Frequently ○ Almost all the time
    - ○ Climbing/ladders: ○ Once in a while ○ Often ○ Frequently ○ Almost all the time
    - ○ Other Please explain:_____

20. Have you ever been injured at work prior to this accident/injury? ○ Y ○ N
    a. If yes, when? _____
    b. Please explain: _____

21. Have you ever been involved in an automobile accident before? ○ Y ○ N
    a. If yes, when? _____
    b. Were you injured? ○ Y ○ N Please explain: _____

22. List all surgeries you have had (with date) _____
_____

23. List all medication you are currently taking (prescribed and over the counter) _____
_____

Please add anything else you would like the doctor to know: _____

_____

_____

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If you have experienced any of the following conditions in the past, mark a "P" on the line provided. If you are currently experiencing any of the following conditions, please mark a "C" on the line provided. (check all that apply)

__ heart attack
__ diabetes
__ difficulty with urination
__ prostate trouble
__ AIDS
__ dizziness
__ constipation
__ nausea
__ ears ringing
__ gout
__ knee/hip replacement
__ broken bones (specify) _____

__ stroke
__ glaucoma
__ anemia
__ ulcers
__ loss of memory
__ diarrhea
__ muscle cramping
__ headache
__ tuberculosis
__ arthritis
__ fainting spells

__ bloody stools
__ cancer
__ diverticulosis
__ chest pain
__ general fatigue
__ soreness in joints
__ migraine
__ syphilis
__ gall bladder trouble
__ kidney stones
__ tobacco use

__ difficulty w/bowel movements
__ asthma
__ menstrual cramping
__ shortness of breath
__ sudden weight loss
__ loss of hearing
__ epilepsy
__ sprained ankle
○ R ○ L

General Activities (check all that apply)

○ sleep on waterbed
○ read in bed
○ fall asleep in recliner / on couch
○ sleep on stomach
○ needlepoint/ knitting
○ use two or more pillows to sleep with
○ sewing
○ lift weights / weight machine

○ play video games (__ hrs per day)
○ exercise ____ x/wk.
○ jog ____x/wk.
○ computer use (__ hrs per day)
○ swim
○ use treadmill / elliptical machine
○ watch television (__ hrs per day)

Authorization

I certify that I have read and I understand the above information to the best of my knowledge. The questions above have been accurately answered. I understand that providing incorrect information can be dangerous to my health. I authorize this office to release any information including the diagnosis and the records of any treatment or examination rendered to me or my child during the period of such chiropractic care to third party payers and/or health practitioners. I authorize and request my insurance company to pay directly to this office benefits otherwise payable to me. I understand that my insurance carrier may pay less than the actual bill for services. I agree to be responsible for payment of all services rendered on my behalf or my dependents.

Patient's Signature _____ Date _____
(signature of parent if the patient is a minor)

Doctor's Comments:_____

_____

_____

_____

_____

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Pain Diagram

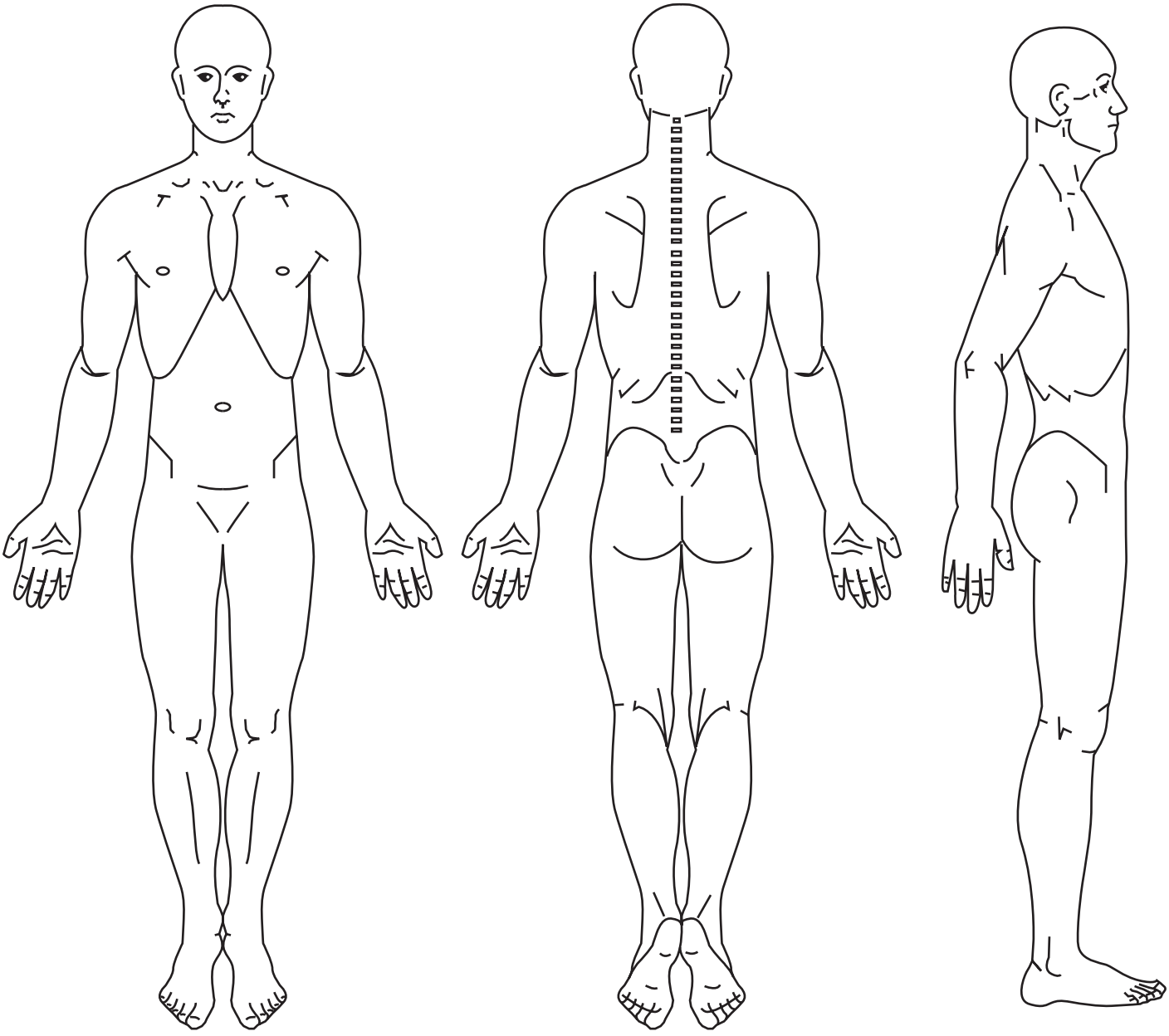
Please Print

Body Diagram Date _____ Acct# _____

Last Name _____ First Name _____

Please mark the diagrams according to where you experience your symptoms and pain using the following symbols:

X for Sharp Pain ***O*** Dull Ache /// Burning Pain *** Numbness



Patient's Signature _____ Date _____