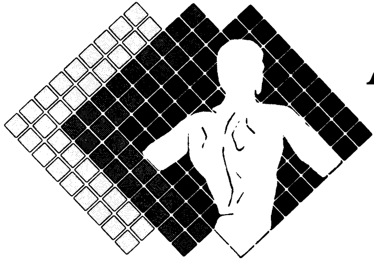


ATLANTIC
CHIROPRACTIC GROUP

Workers Compensation Questionnaire

Atlantic Chiropractic of Patchogue
145 Waverly Ave.
Patchogue, NY 11772
(631) 758-6444
Fax (631) 758-6379

Atlantic Chiropractic of Shirley
409 William Floyd Parkway
Shirley, NY 11967
(631) 395-7424
Fax (631) 395-7420

Patients Name ______________________________

Reference Number __________________________

CONFIDENTIAL PATIENT CASE HISTORY

Dear Patient:
Please complete this questionnaire. Your answers will help us determine if chiropractic can help you. If we do not sincerely believe your condition will respond satisfactorily, we will not accept your case.
THANK YOU.

Name ______________________________ Social Security # ______________

Address ______________________ City __________ State ______________ Zip __________

Home Telephone ____________ Age ______ Birthdate ____________ Marital Status: M S W D

Children ____________ Spouse's Name ________________ Referred by ______________

Patients Employer: ______________________________ Telephone ______________

Address ____

____

PRESENT COMPLAINTS

PLEASE CHECK ALL ANSWERS AND FILL IN THE BLANKS WHERE APPROPRIATE. In the space below, please describe the present complaint(s) which brought you to this clinic for care. After completing thas first section, please complete the questionnaire on the next page. The information you provide concerning past and present symptoms nd diseases assists your doctor in obtaining an early understanding of your state of health.

1. Present Complaint: ____
____
2. Please describe the character of your current pain (you may check one or more answers): ☐ Sharp/Stabbing ☐ Sharp/Dull ☐ Aches ☐ Dull ☐ Soreness ☐ Weakness ☐ Throbbing/Gnawing ☐ Numbness ☐ Shooting ☐ Gripping/Constricting ☐ Burning ☐ Tingling
3. How often are your complaints present? ☐ Constant, (76-100%) ☐ Frequent (51-75%) ☐ Occasional (26-50%) ☐ Intermittent (25% or less).
4. How bad is your pain or ache? Please circle a number: 0 (NO PAIN) 1 2 3 4 5 6 7 8 9 10 (UNBEARABLE PAIN)
5. Since your problem began is the pain: ☐ Increasing ☐ Decreasing ☐ Not Changing
6. When did your problem begin: (Specific date if possible?) ______________
7. Did your problem begin: ☐ Immediately after a specific incident ☐ Multiple incidents ☐ Gradually developed over time ☐ No specific reason
8. Describe how your problem began: ____
____
9. What treatment have you received for this present condition? ☐ Sugery ☐ Spinal injection ☐ Therapy from a PT ☐ A back support ☐ Medication(s) ______________ ☐ Other ______________ If none check here☐
10. Were you previously treated for a different occurence of this same condition? ☐ Yes ☐ No If yes by: ☐ Chiropactor ☐ MD ☐ Therapist ☐ Other __________ (Specify dates & type of treatment with results) ______________
____
11. What makes your problem better? ☐ Nothing ☐ Lying Down ☐ Walking ☐ Standing ☐ Sitting ☐ Movement/Exercise ☐ Inactivity ☐ Other ______________
12. What makes your problem worse? ☐ Nothing ☐ Lying Down ☐ Walking ☐ Standing ☐ Sitting ☐ Movement/Exercise ☐ Inactivity ☐ Other ______________
13. How would you grade your general stress level? ☐ No Stress ☐ Minimal Stress ☐ Moderate Stress ☐ Greatly Stressed
14. Physical activity at work: ☐ Sitting More Than 50% of Workday ☐ Light Manual Labor ☐ Manual Labor ☐ Heavy Manual Labor
15. General physical activity: ☐ No Regular Exercise Program ☐ Light Exercise Program ☐ Strenuous Exercise Program
16. Are your complaints affecting your ability to work or otherwise be active?
   - ☐ No effect
   - ☐ Some physical restrictions (able to perform light duty work and household tasks).
   - ☐ Need limited assistance with everyday tasks.
   - ☐ Need assistance often.
   - ☐ Have a significant inability to function without assistance.
   - ☐ Am totally disabled (impaired). Cannot care for self.

Occupation ____

Employer at the time of injury (Name, Address, Phone) ______________________________

____

Name of person who reported the injury ______________________________

Date of Injury ______________ Time of Injury ______________ AM/PM

Town that the injury occured in ______________________________

HAVE YOU LOST TIME FROM WORK? ______ Dates Lost ______________________________

____

Please describe the accident/injury ______________________________

____

____

Did you go to the hospital?__________ Name of Hospital ______________________________

Were X-Rays Taken__________ Have you been treated by any other doctors for this injury? ______________

If yes, give names and address' ______________________________

____

Workers Compensation # (If Known) ______________________________

Insurance Company (Name and Address) ______________________________

Do you have a Workers Compensation Lawyer? _____ If yes, please give name, address and phone ______________

____

In the event that I fail to prosecute the claim for workers compensation for this injury or it is determined by the workers compensation board that this condition is not a result of compensable workers compensation case, I agree to pay Atlantic Chiropractic their usual and customary fee for any services rendered for the above injury.

Signature ______________________ Date ______________________

1) In terms of an 8 hour workday I: (Circle number of hours for each 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: (Circle as many as apply)

A) Bend/Stoop B) Squat C) Crawl D) Climb E) Reach above shoulders F) Crouch

G) Kneel H) Push/Pull I) Maintain awkward posture

3) On the job, I regularly lift between:
A) 1-10 lbs. B) 11-24 lbs. C) 25-34 lbs. D) 35-50 lbs. E) 51-74 lbs. F) 75-100 lbs.

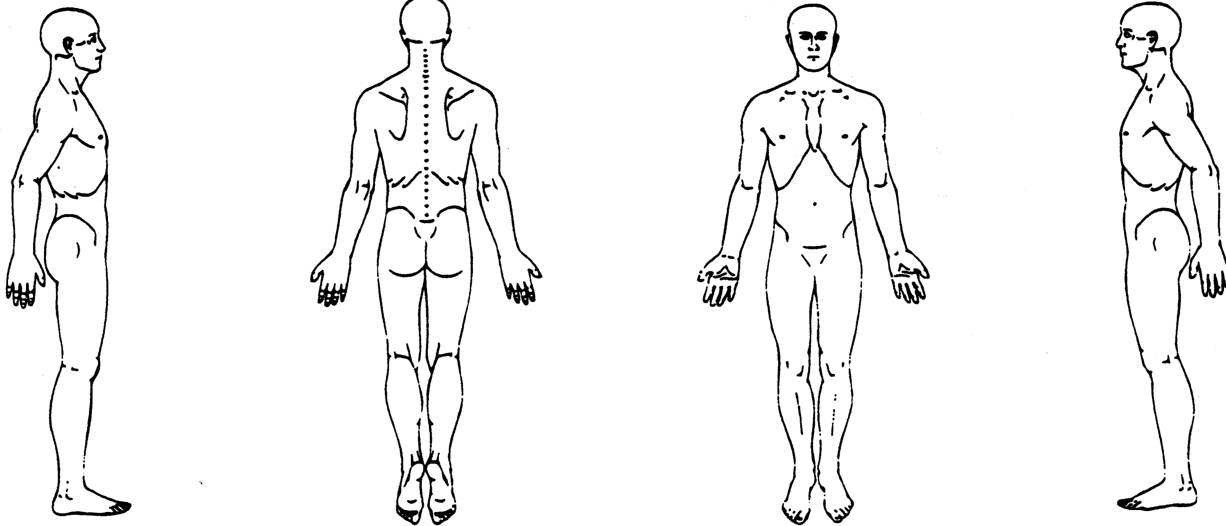
4) Are you required to bend over while lifting? (Y / N)

5) Do you use your hands for repetitive movements such as: (Circle as many as apply)

A) Simple Grasping (left hand) B) Firm Grasping (left hand) C) Fine Manipulating (left hand)

A) Simple Grasping (right hand) B) Firm Grasping (right hand) C) Fine Manipulating (lright hand)

MARK AN X ON THE PICTURE WHERE YOU HAVE PAIN OR OTHER SYMPTONS.
INCLUDE SYMPTONS OF PAIN, NUMBNESS OR TINGLING



INSURANCE INFORMATION

Do you have health insurance? _____Yes _____ No Company Name ____________________

Name of insured ______________________________ Policy # ____________________

Do you have additional insurance? _____Yes _____ No Company Name ____________________

Name of insured ______________________________ Policy # ____________________

I understand and agree that health and accident policies are an arrangement between an Insurance carrier and myself. Furthermore, I understand that this Chiropractic Office will prepare any necessary reports and forms to assist me in making collection from the insurance company and that any amount authorized to be paid directly to this Chiropractic Office will be credited to my account upon receipt. However, I clearly understand and agree that all services rendered me are charged directly to me and that I am personally responsible for payment. I also understand that if I suspend or terminate my care and treatment, any fees for professional services rendered me will be immediately due and payable.

I will be paying today by ☐ Cash ☐ Check ☐ Credit Card

☐ Master Card ☐ Visa ☐ American Express Card # ____________________ Exp. Date __________

All Accounts not paid within 90 days will automatically be put through on your credit card.

Patient's Signature ______________________________ Date __________

Guardian or Spouse's Signature ______________________________ S.S. #__________