WORKER'S COMPENSATION INSURANCE INFORMATION

Please fill out the questions below to the best of your ability. This information can be found on the back of your insurance card. Thank you.

Worker's Compensation Insurance Carrier:

Company Name _____
Adjuster's Name _____Phone _____Ext. ____
Claim Number _____Date of Injury_____

Your Mailing Address:

Address _____
City _____ State _____ Zip _____
Phone _____ Work _____ Cell_____

WORKER'S COMPENSATION CASE HISTORY

Please fill in this questionnaire **COMPLETELY**. If a section does not apply to you, simply cross it out. This confidential history will be part of your permanent records. **Please initial the bottom of each page.**

CHIEF COMPLAINT

FOR OFFICE USE ONLY

Please be sure to fill in each area completely. Mark the area(s) on your body where you feel the described sensation(s**). Use the appropriate symbol(s).** Mark areas of radiating pain, and include all affected areas. You may draw on the face as well.
Note diagram on the left is front and on right is the back.

Aches ^^^^ Numbness ooooo

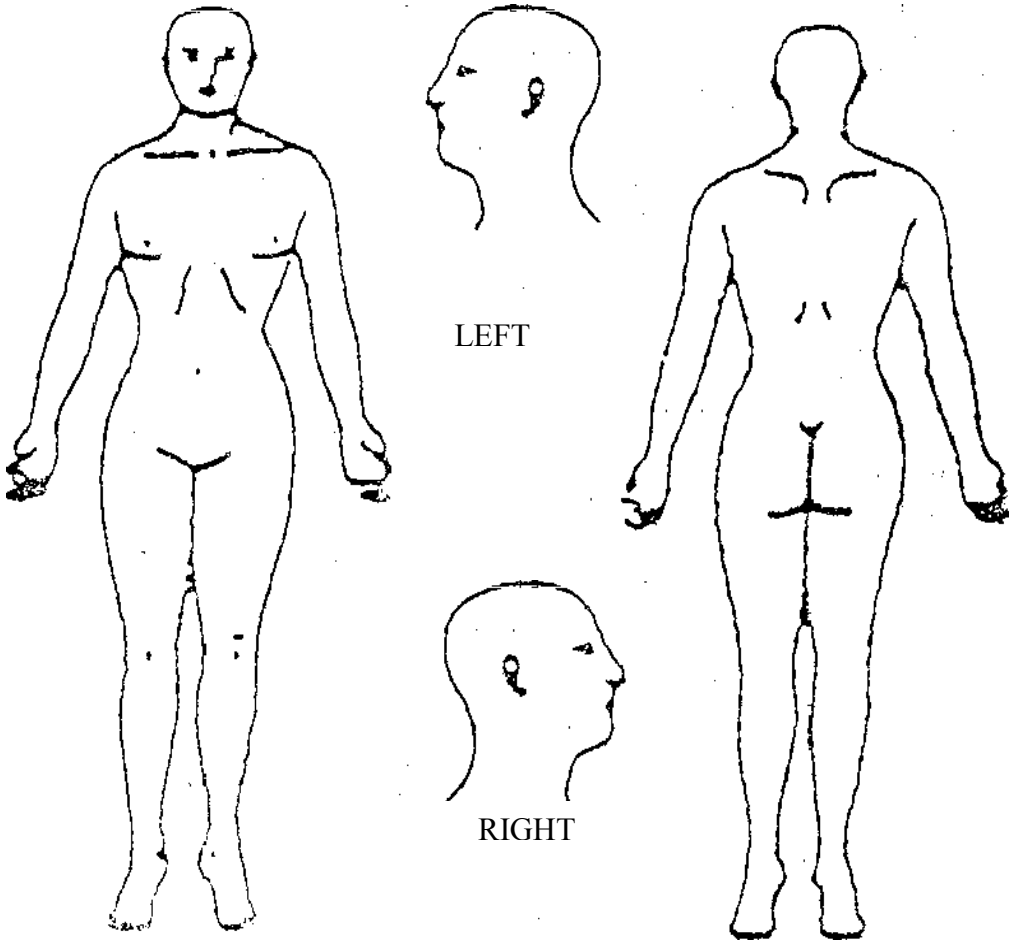
Throbbing TTTTT

Electrical EEEE

Pins/Needles ●●●●

Cramping CCCCC

Burning xxxx Sharp ////



Patient ID Sticker

What are your major complaints in order of intensity?

What are your major complaints in order of intensity? (#1 most bothersome)	Complaint #1	Complaint #2	Complaint #3
	_____	_____	_____
Circle How often is your pain	No pain Occasional Intermittent Constant	No pain Occasional Intermittent Constant	No pain Occasional Intermittent Constant
List for your complaint which movement makes each area worse			
List for your complaint which movement makes each area better			
When during your day are your symptoms worse?			
When during your day are your symptoms better?			
Is this condition _____ (please circle)	Improved Mildly improved Unchanged Mildly Worse Getting Worse	Improved Mildly improved Unchanged Mildly Worse Getting Worse	Improved Mildly improved Unchanged Mildly Worse Getting Worse

On a scale of one-to-ten, how bad are your symptoms **now**?
(With 1 meaning 'no pain', and 10 meaning 'worst possible pain)
On a scale of one-to-ten, how bad are your symptoms **most of the time**?
(With 1 meaning 'no pain', and 10 meaning 'worst possible pain)
On a scale of one-to-ten, how bad have they been **in the past**?
(With 1 meaning 'no pain', and 10 meaning 'worst possible pain)

HISTORY OF PRESENT CONDITION

Please describe your problem in your own words, including dates when possible. (**Please be as complete as possible**.)_____

_____

_____

What do you think caused this condition? Have you had it in the past? _____

_____

FUNCTIONAL INFORMATION

Has pain interfered with your social life, hobbies or sexual ability? Please draw a line to the match ability level of change.

Social Life	No Change
Hobbies	Minimal Change
Sexual Ability	Considerable Change

Does pain frequently awaken you? ☐Yes ☐No How many hours do you sleep at night? _____

Sleep position: ☐ Back ☐ Stomach ☐ Right side ☐ Left side

In a typical workday, your job requires that you: (8 hrs total)

Sit ___hrs Walk ___hrs Stand ___hrs Bend ___hrs

Is this condition interfering with: (Please Circle) Work, Sleep or other Daily Routines such as reading, housecleaning, driving, sitting, dressing, etc? Discuss what areas of your body you have more problems with due to each activity.

_____

In a typical workday, your job requires that you: (8 hrs total)

Sit ___hrs Walk ___hrs Stand ___hrs Bend ___hrs

At any one time, how many hours can you:

Sit ___hrs Walk ___hrs Stand ___hrs Bend ___hrs

How many pounds can you carry?	Never	Sometimes	Often	Continuously
Up to 5 pounds	☐	☐	☐	☐
6 to 10 pounds	☐	☐	☐	☐
11 to 20 pounds	☐	☐	☐	☐
21 to 25 pounds	☐	☐	☐	☐
26 to 50 pounds	☐	☐	☐	☐
51 to 100 pounds	☐	☐	☐	☐

How many pounds can you lift?	Never	Sometimes	Often	Continuously
Up to 5 pounds	☐	☐	☐	☐
6 to 10 pounds	☐	☐	☐	☐
11 to 20 pounds	☐	☐	☐	☐
21 to 25 pounds	☐	☐	☐	☐
26 to 50 pounds	☐	☐	☐	☐
51 to 100 pounds	☐	☐	☐	☐

Can you use your hands for:	Right hand	Left hand
Simple grasping…….	☐Yes ☐No	☐Yes ☐No
Pushing and pulling arm controls…….	☐Yes ☐No	☐Yes ☐No
Fine manipulation…….	☐Yes ☐No	☐Yes ☐No
Repetitive movements (pushing)…….	☐Yes ☐No	☐Yes ☐No
Repetitive movements (pulling) …….	☐Yes ☐No	☐Yes ☐No

How far can you walk? ☐Less than one block ☐1-3 blocks ☐4-6 blocks ☐A mile or more ☐As far as I want to

Are you able to:	Never	Sometimes	Often	Continuously
Bend ...	☐	☐	☐	☐
Squat	☐	☐	☐	☐
Crawl	☐	☐	☐	☐
Climb	☐	☐	☐	☐
Reach	☐	☐	☐	☐
Get on knees	☐	☐	☐	☐

Are you performing an exercise program? When? How often? _____

PREVIOUS TREATMENT

If applicable, what have you been told is your diagnosis/ problem and by whom? _____

Who is your primary care provider?

Doctor _____ Clinic Name/Address _____

Last seen _____ Condition _____

Would you like us to refer you to a primary care provider or to a specialist for another condition you have? Yes / No

What other doctors have you seen in for problem? Please give address if possible.

Doctor _____ Clinic Name/Address _____ Last seen _____ Condition _____

PREVIOUS TREATMENT & RESULTS	When ?	Have not had treatment	Significant Benefit	Some Benefit	No Help	Worsened Condition
Physical Therapy						
Chiropractic Manipulation						
Heating pads, ultrasound, whirlpool, massage, etc						
Nerve blocks/ Spinal injections						
Other: _____						

DIAGNOSTIC TESTS

Please tell us what tests have been performed in evaluating your condition.

TEST	Date/ Year	Ordering Physician	Location Performed
X-rays/CT scan/MRI			
EMG/NCV (Nerve tests)			
Other: _____			

PAST INJURY HISTORY

Is this a work related or auto accident injury? ☐ Auto Accident ☐ Work Accident ☐ Neither

Have you had any prior on-the-job injuries? ☐ Yes ☐ No Explain: _____

_____

Have you had any automobile accident injuries? ☐ Yes ☐ No Explain: _____

_____

PREVIOUS HOSPITALIZATIONS/ INJURIES/SURGERIES

Condition?	**When?**	**Operation (if any):**

MEDICATIONS

Please list all the medication that you have been taking recently.

Name of Medication	**Dosage**	**How often**

REVIEW OF SYSTEMS

Please review the following list of medical problems and mark any that apply to you now or in the past.

Skin (changes in skin, skin conditions, etc)_____

Blood (anemia, lymph nodes, etc)_____

Neurologic (dizziness, vertigo, paralysis, numbness, etc)_____

Endocrine (thyroid, liver, diabetes, etc)_____

Lungs (bronchitis, emphysema, etc)_____

Heart(heart attack, pacemaker, stroke, high blood pressure, etc)_____

Musculoskeletal (weakness, arthritis, pain & stiffness, etc)_____

Gastrointestinal (stomach, intestines, hemorrhoids, etc)_____

Genitourinary (urinary tract, impotence, kidneys, bladder, etc)_____

Psychiatric (depression, drug addiction, hallucinations, suicidal thoughts, irritability)_____

Other condition/disease not mentioned_____

SOCIAL HISTORY

Date of Birth:_____Age:_____Social Security Number: _____E-Mail: _____

Occupation: _____Employer: _____

Work status: ☐Full time ☐Part time ☐Student ☐Disabled ☐Unemployed ☐Retired

Physical Work ☐Heavy ☐Moderate ☐Light Hours per day _____

Marital Status (check one or more): ☐Single ☐Married ☐Widowed ☐Divorced ☐Separated

How long? _____Spouse Name: _____

Number of children: _____Ages: _____

Circle your highest year of school completed:

High School / Tech School / Associates / Bachelors / Masters / Doctorate

Please list an emergency contact:

Name _____ Address _____

Phone# _____ Phone# _____Relation: _____

Current Weight_____ Height _____Tobacco (type, amount per day/week): _____Previous smoker? ☐Yes☐No

Alcohol (amount per day/week): _____

FAMILY HISTORY

Please list any medical conditions that run in your family:_____

Do you have a family history of spinal/physical problems? (i.e. neck pain, back pain, herniated disc, degenerated disc, sciatica, etc…)

Relation: _____ Condition: _____

_____ _____

RESULTS OF TREATMENT

What are the results you hope for: **(Check all that are apply)**

☐Pain reduction ☐Increased recreation ☐Improved emotional well-being

☐Return to work ☐ Elimination of drugs ☐Better daily function

What other activities would you like for us to help you get back to?_____

_____

What do you hope will be the results of this evaluation: **(Check all that apply to you)**

☐Medical diagnosis (discover the cause of the pain) ☐Recommendation for treatment

☐Recommendation for rehabilitation ☐Recommendation for surgery

☐Other, describe _____

If you were treated at another office and were dissatisfied with your care, how can we improve on your experience with us?_____

Is there an attorney handling your injury case?

Name: _____Phone Number: _____

Address:

_____

REFERRAL INFORMATION

Who can we thank for referring you?

Patient: _____ Physician:_____

Advertisement: _____ Other: _____

CURRENT TREATMENT INTERESTS

Are you interested in: **(Check all that apply)**

- ☐ DRS Low Back Treatment
- ☐ Chiropractic with Occupational or Physical Therapy
- ☐ Free Spinal Health Care Workshop Classes
- ☐ MCU Neck Pain Therapy
- ☐ Massage Therapy

PATIENT CONSENT:I understand that there is a certain degrees of risk associated with chiropractic health care and physical rehabilitation therapy, which may include, but is not limited to: soreness, inflammation, soft tissue injury, dizziness, burns, and temporary worsening of symptoms, fractures, disc injuries, strokes, and strain/sprains. I am willing to accept and consent to the risk associated with the care that I will receive.

I voluntarily consent to the rendering of care, including treatment and performance of diagnostic procedures. I understand that I am under the care and supervision of the attending physician and it is the responsibility of the staff to carry out the instructions of such physician(s). I understand treatments rendered by Better Health Pain & Wellness Centers, LLC are intended to aid in the reduction of my pain and that there is no guarantee or warranty for a specific cure or result.

FINANCIAL POLICY: If your carrier has not paid a claim within thirty (30) days of submission, you agree to take an active part in the recovery of your claim. If your insurance carrier has not paid within sixty (60) days of submission, you accept responsibility for payment in full of any outstanding balance.

Auto Accident, Workers Compensation or Personal Injury Patients:

BHPW will submit claims to your (or your employer if w/c) insurance carrier for payment and keep your private health insurance on file as secondary coverage; in the event of exhaustion or controversion of your claim. If you are involved in a 3rd party claim we will submit claims to the 3rd party carrier only when no other coverage is available. Once your claim becomes a 3rd party auto or your w/c claim is controverted, and after your active treatment plan, you become responsible for making monthly payments until account is paid in full. We understand that settlement of these cases may take time; however all auto accounts, workers compensation and personal injury cases must be paid in full within 12 months.

Private/Group Health Insurance Patients:
Until a "Customized Co-Pay Calculation Agreement" is signed, payment shall be made on each treatment date and applied toward deductible and/or co-pay as necessary. The pre-calculated co-payments are an estimate of your copay responsibility. Your actual portion may be more or less than the estimate, depending on services provided. Any additional information requested by insurance will be subject to a $35 processing fee, additionally, a special report will be $350 for the first page and $100 for each additional page (to be paid by insurance co.).

Non-Covered (Cash/Self Pay) Patients:
Payment in full is expected at the time of service or by an authorized payment plan.

Our fees are considered usual, customary, and reasonable by most companies and therefore, are usually covered up to the maximum allowance determined by each carrier. This statement does not apply to companies who reimburse based on an arbitrary schedule of fees bearing no relationship to the current standard of care in this area.

By signing below I understand and agree to the above conditions. I understand that I am responsible for all charges incurred at Better Health Pain and Wellness Centers, LLC and if I fail to make payments as arranged I will be subject to collection activity. I am responsible for any collection agency fees and interest of 10% annually incurred.

ASSIGNMENT OF BENEFITS: I hereby assign payment directly to the physician(s) accepting this assignment of medical benefits applicable and otherwise payable to me but not to exceed the physician's regular charges. I understand that I am financially responsible for charges not covered by this assignment or for any and all charges that the insurance carrier declines to pay.

RELEASE OF INFORMATION: The physician(s) may disclose all or part of the patient's record to any person or corporation which is or may be liable under a contract to the physician(s) or the patient or to a family member or employer of the patient for all part or part of the physician(s) charges, including but not limited to, insurance companies, workers' compensation carriers, welfare funds, or the patient's employer. This documents may include, but are not limited to: Office notes, Physician notes, ER notes, Treatment plans, Diagnostic reports, Radiology/MRI films, Transcribed reports, Pathology reports, Consults, Admit/discharge records.

As a courtesy, we may send your primary care physician reports about your treatment with our office. By signing below, I authorize my records to be sent to my primary care physician and the release of any medical or other information necessary to process my claims. Our office may photograph you on your first visit for identification purposes. Your photograph may be sent to your insurance company with your medical records. Any other use will require your consent. Except to the extent that action has already been taken in reliance upon this authorization, I understand that I may revoke this authorization at any time by giving written notice to Better Health Pain & Wellness Centers, LLC.

Printed Name of Patient or Legal Representative	**DOB**
Signature of Patient of Legal Representative	**Date**