RECOVERY
CHIROMED

Work-Related Injury Questionnaire/Medical History

Full Name: _____ Birthdate: _____ Sex: ___ M ___ F
Address: _____
City: _____ State: _____ Zip: _____
Height: _____ Weight: _____ Social Security #: _____
Marital Status: ___ Single ___ Married ___ Divorced ___ Separated ___ Widowed
Home Phone: _____ Employer: _____
Cell Phone: _____ Occupation: _____
Work Phone: _____ Email Address: _____
Emergency Contact Name: _____ Contact Phone #: _____
Date of Accident: _____ How were you referred to this office? _____

Chief Complaints: (please circle all that you have experienced since the accident)

Headaches Neck Pain Lower Back Pain Middle Back Pain Hip Pain: L R
Dizziness Weakness Shoulder Pain: L R Arm/Hand Pain: L R Leg/Pain: L R
Other: _____

Is the pain/discomfort constant? ____ Yes ____ No **Is pain on and off (intermittent)** ___ Yes ___ No

How would you describe the pain/discomfort? (please circle all that apply)

Sharp/Stabbing Dull Achy Cramping Soreness
Other: _____

How would you rate the pain? 10 being the worst possible pain and 0 being no pain. (please circle)

0 1 2 3 4 5 6 7 8 9 10

What makes your pain/discomfort worse? (please circle all that apply)

Sitting Standing Sneezing Coughing Moving arms or legs Lifting
Twisting Bathing Dressing Moving head Bending forward Rising from a chair
Driving Moving head Other: _____

Do you have any of the following? (please circle all that apply)

Right arm/hand: numbness pain tingling **Right leg/foot**: numbness pain tingling
Left arm/hand: numbness pain tingling **Left leg/foot**: numbness pain tingling

What have you been doing to decrease your pain/discomfort? (please circle all that apply)

Heating Pad Moving around Resting Sitting Ice
Standing Leaning forward Leaning to Side Laying on back Hot bath/shower
Other: _____

When did the pain/discomfort begin after the accident? (please circle)

Immediately Within 12 Hours Next Day 2 days later 3 days later Other: _____

Have you ever experienced this pain/discomfort before? __ Yes __ No If so, how long ago? _____

Describe in detail what happened when you go injured: _____

_____

_____

_____

_____

Have you lost any time at work due to your work related injury? ____ Yes ____ No

If yes, how many days have you taken off of work? _____

Please circle and explain all work activities you do during work hours:

Standing – Please list type of ground surface (i.e. concrete, wood) _____

Sitting – Please list type of chair (i.e. high or low, old or new) _____

Walking – Please list approximate distance per day (i.e. 1 mile) _____

Bending/Twisting – Please list approximately how many times an hour you bend/twist: _____

Raising Arms Above Head - Approximately how many times an hour you raise your arms: _____

Lifting – Please list the approximate weight of the heaviest object you lift: _____

Operating Equipment – Please list type of machinery (i.e. tractor, forklift) _____

Driving – Please list type of vehicle (i.e. large diesel truck) _____

Did you receive medical treatment after the accident? ____ Yes ____ No

If yes, where did you go: _____

Were x-rays, MRI, or CT scans performed? ____ Yes ____ No

What, if any, treatment was recommended? (please circle)

Prescription Drugs Injection Advised me to see another doctor

Did you see another doctor for these conditions? ____ Yes ____ No

If yes, what was the Doctor's name? _____

What is this Doctor's specialty? (please circle)

Orthopedist Chiropractor Neurologist Family/General

Other: _____

Were further diagnostic test performed? (please circle)

MRI CT Scan Myelogram Other: _____

If so, where were they performed? _____

What type of treatment was rendered?

Prescriptions/Injections – please list _____

Chiropractic – Approximately how many treatments? _____

Physical Therapy – Approximately how many treatments? _____

Surgery (please list) _____

What percent better do you feel since beginning these treatments? (please circle)

0% 10% 20% 30% 40% 50% 60% 70% 80% 90% 100%

What medications/vitamins/supplements do you currently take? (please circle and write dosage)

Blood Pressure: _____ Cholesterol: _____ Diabetic: _____
Multi-Vitamins: _____ Supplements: _____
Over the counter meds: _____
Other Medication: _____

Have you ever had a broken/fractured bone? _____ Yes _____ No
If so, please specify what was fractured and how long ago _____

Please list all past surgeries/hospitalizations and include approximate date(s):

_____

_____

Do you suffer from or have you been diagnosed with any of the following conditions? (please check)

___ AIDS	___ Alcoholism	___ Anorexia	___ Arthritis
___ Asthma	___ Bed Wetting	___ Bladder Trouble	___ Bleeding Disorders
___ Breast Disease	___ Cancer	___ Cataracts	___ Diabetes
___ Discolored Urine	___ Dizziness	___ Emphysema	___ Epilepsy
___ Glaucoma	___ Gout	___ Heart Problems	___ Hepatitis
___ Herniated Disc	___ High Blood Pressure	___ High Cholesterol	___ Irritability
___ Kidney Problems	___ Liver Problems	___ Menstrual Cramping	___ Menstrual Irregularity
___ Mononucleosis	___Multiple Sclerosis	___ Nervousness	___ Pacemaker
___ Prostate Problems	___ Psychiatric Care	___ Rheumatoid Arthritis	___ Sexual Dysfunction
___ Stroke	___ Stress	___ Thyroid Problems	___ Tumors

Other: _____

Do you exercise? ____ Yes ____ No **Approximately how much per week?** _____
Do you smoke cigarettes/cigars? ____ Yes ____ No **Approximately how many per day?** _____
Do you drink alcohol? ____ Yes ____ No **Approximately how many per week?** _____

FEMALES ONLY: When was your last menstrual cycle? _____ Are you pregnant? ____ Yes ____ No

Do the following relatives suffer from any of the following? (please check the condition)

	Mother	Father	Sibling 1	Sibling 2	Sibling 3	Sibling 4
Diabetes						
Heart Disease						
High Blood Press						
Stroke						
Cancer						
Living						
Deceased						

I certify that this information is true to the best of my knowledge.

_____ _____
Patient/Guardian Signature Date

Patient's Name_____ Number_____ Date_____

NECK DISABILITY INDEX

This questionnaire has been designed to give the doctor information as to how your neck pain has affected your ability to manage in everyday life. **Please answer every section and mark in each section only ONE box** which applies to you. We realize you may consider that two of the statements in any one section relate to you, but **please just mark the box which MOST CLOSELY describes your problem.**

Section 1 - Pain Intensity

- ☐ I have no pain at the moment.
- ☐ The pain is very mild at the moment.
- ☐ The pain is moderate at the moment.
- ☐ The pain is fairly severe at the moment.
- ☐ The pain is very severe at the moment.
- ☐ The pain is the worst imaginable at the moment.

Section 2 -- Personal Care (Washing, Dressing, etc.)

- ☐ I can look after myself normally without causing extra pain.
- ☐ I can look after myself normally but it causes extra pain.
- ☐ It is painful to look after myself and I am slow and careful.
- ☐ I need some help but manage most of my personal care.
- ☐ I need help every day in most aspects of self care.
- ☐ I do not get dressed, I wash with difficulty and stay in bed.

Section 3 – Lifting

- ☐ I can lift heavy weights without extra pain.
- ☐ I can lift heavy weights but it gives extra pain.
- ☐ Pain prevents me from lifting heavy weights off the floor, but I can manage if they are conveniently positioned, for example on a table.
- ☐ Pain prevents me from lifting heavy weights, but I can manage light to medium weights if they are conveniently positioned.
- ☐ I can lift very light weights.
- ☐ I cannot lift or carry anything at all.

Section 4 – Reading

- ☐ I can read as much as I want to with no pain in my neck.
- ☐ I can read as much as I want to with slight pain in my neck.
- ☐ I can read as much as I want with moderate pain.
- ☐ I can't read as much as I want because of moderate pain in my neck.
- ☐ I can hardly read at all because of severe pain in my neck.
- ☐ I cannot read at all.

Section 5-Headaches

- ☐ I have no headaches at all.
- ☐ I have slight headaches which come infrequently.
- ☐ I have slight headaches which come frequently.
- ☐ I have moderate headaches which come infrequently.
- ☐ I have severe headaches which come frequently.
- ☐ I have headaches almost all the time.

Scoring: Questions are scored on a vertical scale of 0-5. Total scores and multiply by 2. Divide by number of sections answered multiplied by 10. A score of 22% or more is considered a significant activities of daily living disability.
(Score___ x 2) / (____Sections x 10) = _____ %ADL_____

Section 6 – Concentration

- ☐ I can concentrate fully when I want to with no difficulty.
- ☐ I can concentrate fully when I want to with slight difficulty.
- ☐ I have a fair degree of difficulty in concentrating when I want to.
- ☐ I have a lot of difficulty in concentrating when I want to.
- ☐ I have a great deal of difficulty in concentrating when I want to.
- ☐ I cannot concentrate at all.

Section 7—Work

- ☐ I can do as much work as I want to.
- ☐ I can only do my usual work, but no more.
- ☐ I can do most of my usual work, but no more.
- ☐ I cannot do my usual work.
- ☐ I can hardly do any work at all.
- ☐ I can't do any work at all.

Section 8 – Driving

- ☐ I drive my car without any neck pain.
- ☐ I can drive my car as long as I want with slight pain in my neck.
- ☐ I can drive my car as long as I want with moderate pain in my neck.
- ☐ I can't drive my car as long as I want because of moderate pain in my neck.
- ☐ I can hardly drive my car at all because of severe pain in my neck.
- ☐ I can't drive my car at all.

Section 9 – Sleeping

- ☐ I have no trouble sleeping.
- ☐ My sleep is slightly disturbed (less than 1 hr. sleepless).
- ☐ My sleep is moderately disturbed (1-2 hrs. sleepless).
- ☐ My sleep is moderately disturbed (2-3 hrs. sleepless).
- ☐ My sleep is greatly disturbed (3-4 hrs. sleepless).
- ☐ My sleep is completely disturbed (5-7 hrs. sleepless).

Section 10 – Recreation

- ☐ I am able to engage in all my recreation activities with no neck pain at all.
- ☐ I am able to engage in all my recreation activities, with some pain in my neck.
- ☐ I am able to engage in most, but not all of my usual recreation activities because of pain in my neck.
- ☐ I am able to engage in a few of my usual recreation activities because of pain in my neck.
- ☐ I can hardly do any recreation activities because of pain in my neck.
- ☐ I can't do any recreation activities at all.

Comments_____

%ADL

Reference: Vernon, Mior. JMPT 1991; 14(7): 409-15

Patient's Name_____ Number_____ Date_____

LOW BACK DISABILITY QUESTIONNAIRE (REVISED OSWESTRY)

This questionnaire has been designed to give the doctor information as to how your back pain has affected your ability to manage in everyday life. **Please answer every section and mark in each section only ONE box** which applies to you. We realize you may consider that two of the statements in any one section relate to you, but **please just mark the box which MOST CLOSELY describes your problem.**

Section 1 - Pain Intensity

- ☐ I can tolerate the pain without having to use painkillers.
- ☐ The pain is bad but I can manage without taking painkillers.
- ☐ Painkillers give complete relief from pain.
- ☐ Painkillers give moderate relief from pain.
- ☐ Painkillers give very little relief from pain.
- ☐ Painkillers have no effect on the pain and I do not use them.

Section 2 -- Personal Care (Washing, Dressing, etc.)

- ☐ I can look after myself normally without causing extra pain.
- ☐ I can look after myself normally but it causes extra pain.
- ☐ It is painful to look after myself and I am slow and careful.
- ☐ I need some help but manage most of my personal care.
- ☐ I need help every day in most aspects of self care.
- ☐ I do not get dressed, I wash with difficulty and stay in bed.

Section 3 – Lifting

- ☐ I can lift heavy weights without extra pain.
- ☐ I can lift heavy weights but it gives extra pain.
- ☐ Pain prevents me from lifting heavy weights off the floor, but I can manage if they are conveniently positioned, for example on a table.
- ☐ Pain prevents me from lifting heavy weights, but I can manage light to medium weights if they are conveniently positioned.
- ☐ I can lift very light weights.
- ☐ I cannot lift or carry anything at all.

Section 4 – Walking

- ☐ Pain does not prevent me from walking any distance.
- ☐ Pain prevents me from walking more than one mile.
- ☐ Pain prevents me from walking more than one-half mile.
- ☐ Pain prevents me from walking more than one-quarter mile
- ☐ I can only walk using a stick or crutches.
- ☐ I am in bed most of the time and have to crawl to the toilet.

Section 5 -- Sitting

- ☐ I can sit in any chair as long as I like
- ☐ I can only sit in my favorite chair as long as I like
- ☐ Pain prevents me from sitting more than one hour.
- ☐ Pain prevents me from sitting more than 30 minutes.
- ☐ Pain prevents me from sitting more than 10 minutes.
- ☐ Pain prevents me from sitting almost all the time.

Scoring: Questions are scored on a vertical scale of 0-5. Total scores and multiply by 2. Divide by number of sections answered multiplied by 10. A score of 22% or more is considered significant activities of daily living disability.
(Score___ x 2) / (____Sections x 10) = _____ %ADL

Section 6 – Standing

- ☐ I can stand as long as I want without extra pain.
- ☐ I can stand as long as I want but it gives extra pain.
- ☐ Pain prevents me from standing more than 1 hour.
- ☐ Pain prevents me from standing more than 30 minutes.
- ☐ Pain prevents me from standing more than 10 minutes.
- ☐ Pain prevents me from standing at all.

Section 7 -- Sleeping

- ☐ Pain does not prevent me from sleeping well.
- ☐ I can sleep well only by using tablets.
- ☐ Even when I take tablets I have less than 6 hours sleep.
- ☐ Even when I take tablets I have less than 4 hours sleep.
- ☐ Even when I take tablets I have less than 2 hours sleep.
- ☐ Pain prevents me from sleeping at all.

Section 8 – Social Life

- ☐ My social life is normal and gives me no extra pain.
- ☐ My social life is normal but increases the degree of pain.
- ☐ Pain has no significant effect on my social life apart from limiting my more energetic interests, e.g. dancing.
- ☐ Pain has restricted my social life and I do not go out as often.
- ☐ Pain has restricted my social life to my home.
- ☐ I have no social life because of pain.

Section 9 – Traveling

- ☐ I can travel anywhere without extra pain.
- ☐ I can travel anywhere but it gives me extra pain.
- ☐ Pain is bad but I manage journeys over 2 hours.
- ☐ Pain is bad but I manage journeys less than 1 hour.
- ☐ Pain restricts me to short necessary journeys under 30 minutes.
- ☐ Pain prevents me from traveling except to the doctor or hospital.

Section 10 – Changing Degree of Pain

- ☐ My pain is rapidly getting better.
- ☐ My pain fluctuates but overall is definitely getting better.
- ☐ My pain seems to be getting better but improvement is slow at the present.
- ☐ My pain is neither getting better nor worse.
- ☐ My pain is gradually worsening.
- ☐ My pain is rapidly worsening.

Comments_____

Reference: Fairbank, Physiotherapy 1981; 66(8): 271-3, Hudson-Cook. In Roland, Jenner (eds.), Back Pain New Approaches To Rehabilitation & Education. Manchester Univ Press, Manchester 1989: 187-204

RECOVERY
CHIROMED

Informed Consent

Patient Name: _____ **Patient #:** _____

Every type of health care is associated with some risk of potential problem. Health care providers, including chiropractors, are required by law to tell you the nature of your condition, the general nature of the treatment, and the risk involved. In keeping with the Louisiana law of informed consent, you are being asked to sign and date this form which confirms our discussion of these matters.

We want to give each patient the best possible care with the least possible risk of complications. To accomplish this, we format treatment plans to suit the distinctive needs of each patient. The following paragraphs describe the most severe risks associated with chiropractic care which are extremely rare in occurrence.

1. Stroke: Stroke is the most serious problem associated with spinal manipulation. The consequences can be temporary or permanent dysfunction of the brain with a very rare complication of death (1 in 20 million). Spinal manipulations have been associated with strokes that arise from the vertebral artery, which runs on each side of your neck. This problem occurs so rarely that there is no conclusive data to quantify the probability.
2. Disc Herniation Aggravation: Disc herniations that create pressure on the spinal nerve and/or spinal cord are successfully treated by chiropractors on a daily basis. Chiropractic manipulation can aggravate an existing disc herniation resulting in an increase of symptoms, which may last for a few days but seldom for longer periods of time.
3. Soft Tissue Injury: Soft tissue primarily refers to muscles and ligaments. Muscles move bones and ligaments limit bone movement. Rarely, chiropractic manipulation can result in minor damage to a particular soft tissue. This may cause a temporary increase in pain and necessary treatments for resolution, but there are no long term effects on the patient.
4. Rib Fractures: The rib cage is found in the thoracic spine or middle back area. Rarely, chiropractic manipulation can cause a fracture to occur. Patients who have weakened bones (osteoporosis or osteopenia) have a higher risk of rib fractures because their bones are weaker than normal. We adjust all patients carefully, especially those who have indications of osteoporosis on their x-rays.
5. Other Possible Complications: There are many other side effects and/or complications that may also rarely occur due to spinal manipulations. These possible complications include, but are not limited to, the following: headaches, skin burns, dizziness, radiating pains into arms and/or legs, exacerbation of pain/problem, soreness, etc

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I hereby authorize Recovery ChiroMed, together with assistance of their choice, to provide chiropractic treatment including examination/diagnostics, spinal manipulations/adjustments, and various modes of physical therapy that may be deemed necessary or reasonable. I have read and understand all information set forth in this document, including any attachments. I acknowledge that I had the opportunity to ask any questions about the contemplated procedure and that my questions have been answered to my satisfaction. This authorization for and consent to chiropractic treatment is and shall remain valid until revoked.

_____ _____

Patient or Responsible Party Signature **Date**

RECOVERY
CHIROMED

Office Policies

Patient Name: _____ **Patient #:** _____

Thank you for choosing us as your health care provider. Please understand that payment of your bill is considered part of your treatment. The following statements refer to our office policies which we require that you read, accept, sign, and date before any treatment can begin.

1. Every new patient is required to fill out our forms concerning his/her history and general information prior to being examined.

2. Each insurance company or group has specific guidelines that we must follow to warrant payments for our services. As a courtesy to you, we file all claims to your insurance company or group. Please remember that YOU have the contract with the insurance company or group and YOU are ultimately responsible for payment. We cannot accept responsibility for collecting from your insurance company or group nor negotiating a settlement on a disputed claim. If you do need assistance with your insurance, please see our office manager; who will readily assist you.

3. Our practice is committed to providing the best treatment possible for our patients and we charge what is usual and customary for our area. Please understand that you are responsible for payment in full regardless of an insurance company's arbitrary determination of usual and customary rates.

4. Open accounts with no acceptable payment activity for 60 days will be considered past due. A billing charge may be accessed to the account balance along with a finance charge of 1.5% per month. You will be responsible for the original past due balance along with these additional charges. Acceptable payment activity will be determined on an individual basis. Please speak with our office manager to avoid any misunderstandings.

5. Open accounts with no acceptable payment activity for 120 days will automatically be placed with our collection agency. You will be responsible for payment of the original balance plus any billing charges, finance charges, collection fees, and attorney fees assessed to your account.

6. The adult accompanying the minor is responsible for full payment. The adult (i.e. parent, legal guardian) must be present with a minor and sign the Treatment Consent Form before any services can be administered.

_____ _____

Patient or Responsible Party's Signature **Date**

RECOVERY
CHIROMED

CONSENT TO THE USE & DISCLOSURE OF HEALTH INFORMATION FOR TREATMENT, PAYMENT, OR HEALTHCARE OPERATIONS

Patient's Name: _____ Id #: _____

I understand that as part of my healthcare, this organization originates and maintains health records describing my health history, symptoms, examination and test results, diagnosis, treatment, and any plans for future care or treatment.

I understand that this information serves as:

- A basis for planning my care and treatment.
- A mean of communication among the many healthcare professionals who contribute to my care.
- A source of information for applying my diagnosis and surgical information to my bill.
- A means by which a third party payer can verify that services billed were actually provided.
- A tool for routine healthcare operations such as assessing care quality and reviewing the competence of healthcare professionals.

I understand that I have the right:

- To object to the use of my health information for directory purposes.
- To request restrictions as to how my health information may be used or disclosed to carry out treatment, payment, or healthcare operations – and that the organization is not required to agree to the restrictions requested.
- To revoke this consent in writing, except to the extent that the organization has already taken action in reliance thereon.

I request the following restrictions to the use or disclosure of any healthcare information:

_____

_____

_____

_____

Patient's Signature: _____

Date: _____ Witness Signature: _____

RECOVERY
CHIROMED

Pregnancy Warning and Consent to X-Ray

Patient Name: _____ **Patient #:** _____

I understand that if I am pregnant and have X-rays taken, which expose my lower torso to radiation, it is possible to injure the fetus.

I have been advised that the 10 days following onset of a menstrual period are generally considered to be safe for X-ray exams.

With those factors in mind, I am advising my doctor that:

	Yes	No	Don't Know
I am pregnant	___	___	___
I could be pregnant	___	___	___
I am late with my menstrual period	___	___	___
I am taking oral contraceptives	___	___	___
I have an IUD	___	___	___
I have had a tubal ligation	___	___	___
I have had a hysterectomy	___	___	___
I have irregular menstrual periods	___	___	___

My last menstrual period began on: _____

With full understanding of the above, and believing that I am not currently at risk, I wish to have an X-ray examination performed now.

_____ _____

Signature Date

NOTICE
TO INJURED WORKERS

YOU HAVE THE RIGHT TO CHOOSE YOUR OWN DOCTOR!

WHEN YOU ARE INJURED AT WORK OR BECOME SICK BECAUSE OF SOMETHING THAT HAPPENED AT WORK, THE LAW GIVES YOU THE RIGHT TO CHOOSE YOUR OWN DOCTOR IN ANY FIELD OR SPECIALTY OF MEDICINE FOR MEDICAL TREATMENT.

THE LAW ALSO ALLOWS YOUR EMPLOYER TO HAVE YOU SEE HIS/HER DOCTOR, BUT YOU DO NOT HAVE TO AGREE TO CONTINUE TREATMENT WITH YOUR EMPLOYER'S DOCTOR UNLESS THAT IS WHAT YOU WANT.

IF YOU WANT YOUR EMPLOYER'S DOCTOR TO CONTINUE TREATING YOU AFTER YOUR FIRST VISIT WITH HIM/HER, AND AFTER RECEIVING THIS FORM, YOU MAY CHOOSE YOUR EMPLOYER'S DOCTOR AS YOUR TREATING DOCTOR.

ONCE YOU CHOOSE EITHER YOUR EMPLOYER'S DOCTOR OR YOUR OWN DOCTOR AS YOUR TREATING DOCTOR, YOU MAY NOT BE PERMITTED TO CHOOSE ANOTHER DOCTOR IN THAT SAME FIELD OR SPECIALTY OF MEDICINE TO TREAT YOU FOR YOUR INJURY OR ILLNESS LATER ON. HOWEVER, YOU ARE NOT REQUIRED TO GET YOUR EMPLOYER'S APPROVAL TO CHANGE TO A DOCTOR IN ANOTHER FIELD OR SPECIALTY OF MEDICINE (La. R.S. 23:1121(B)(1).

IF YOUR EMPLOYER DENIES YOUR RIGHT TO CHOOSE YOUR DOCTOR, YOU HAVE A RIGHT TO A SPEEDY HEARING BEFORE A WORKERS' COMPENSATION JUDGE TO RESOLVE THE DENIAL OF YOUR RIGHT (La. R.S. 23 1121 (B)(1) and 1124 (B).

I HEREBY CHOOSE MY OWN DOCTOR TO TREAT ME FOR MY INJURY OR ILLNESS:
DR. _____.

OR

BY SIGNING THIS FORM, I STATE THAT I KNOW ABOUT MY RIGHT TO CHOOSE MY OWN TREATING DOCTOR, AND BEING SO ADVISED, I HEREBY ACCEPT AND CHOOSE TO CONTINUE TREATING WITH MY EMPLOYER'S DOCTOR:
DR. _____.

_____ _____
DATE SIGNATURE OF EMPLOYEE

_____ _____
DATE SIGNATURE OF EMPLOYER REPRESENTATIVE

(Note: If the employee is illiterate or has a language barrier, an authorized representative of the employer/insurer shall attest by their signature that this form and right of physician choice has been reasonably explained to that employee prior to his/her signature on this form. Failure to do so can jeopardize the employer's/insurer's right to subsequently refuse consent to the employee's request for treatment by a different physician within the same field or specialty.)

(Form LWC – WC 1121)