Family Chiropractic of Fairfax:
A Creating Wellness Center

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Fairfax, VA 22030

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WORKERS' COMPENSATION

CONFIDENTIAL PATIENT INFORMATION

Date_____/_____/_____

First Name_____M.I._____Last Name_____

Address_____

City_____State_____ZIP_____

Home Phone (_____)_____Cell Phone (_____)_____Work Phone (_____)_____

E-Mail_____DOB___/____/____Age_____Sex M F SSN_____-_____-_____

Employer_____ Occupation_____

Name of Spouse_____ Employer_____

Occupation_____ Work Phone (_____)_____

Nearest Relative_____ Phone (_____)_____

Referred to this office by_____

How do you prefer to be addressed: Mr. Mrs. Miss Ms. Dr. First Name Other _____

ACCOUNT INFORMATION

EMPLOYER'S WORKERS' COMPENSATION INSURANCE INFORMATION

Employer's Company Name:_____Phone (_____)_____

Address_____

City_____State_____ZIP_____Supervisor_____

Insurance Company_____ Phone (_____)_____

Address_____

City_____State_____ZIP_____Adjustor_____

Policy No._____ Claim No._____

PATIENT'S HEALTH INSURANCE

Policy Holder's Name_____DOB___/___/___Policy Holder's SSN_____-_____-_____

Insurance Company_____Phone (_____)_____

Address_____City_____State_____ZIP_____

Policy No._____Group Name/No._____

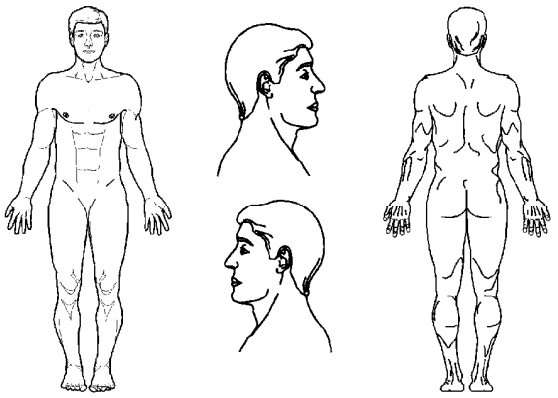
WORKERS' COMPENSATION INJURY INFORMATION

Date and Time of Incident?_____/_____/_____ ____ ____AM/PM
Where did you feel pain after the incident?_____
_____
When did you feel pain after the incident?_____
_____
Did you seek medical attention after the incident? ❑ Y ❑ N
If yes, when, where and with whom?_____
_____
_____
Do you have a report? ❑ Y ❑ N
If yes, have the receptionist make a copy.
Were x-rays, lab tests or other diagnostic tests performed?
❑ Y ❑ N Describe_____
_____
What treatment was given?_____
How did you respond to treatment?_____
_____

Please mark your area(s) of pain (P), numbness(N), tingling(T) on the figure below and note the severity of pain on the following scale.

No Pain — Unbearable Pain

0	1	2	3	4	5	6	7	8	9	10



What kind of activities are involved in your job? (Please check all that apply)

LIFTING
❑ Occasional
❑ Frequent
❑ Constant

BENDING
❑ Occasional
❑ Frequent
❑ Constant

DRIVING
❑ Less than 2 hours/day
❑ 2 - 4 hours/day
❑ Most of the day

Approximate maximum weight you need to lift ❑ Under 20 lbs. ❑ 20 - 50 lbs. ❑ Over 50 lbs.

SITTING
❑ Less than 30 minutes at a time
❑ 30 - 60 minutes at a time
❑ More than 60 minutes at a time

STANDING
❑ Less than 30 minutes at a time
❑ 30 - 60 minutes at a time
❑ More than 60 minutes at a time

WALKING
❑ Occasional
❑ Frequent
❑ Constant

Before the incident were you capable of working on an equal basis with others your age? ❑ Y ❑ N
Are your work activities restricted as a result of your injuries? ❑ Y ❑ N
Since the incident are your symptoms ❑ improving ❑ same ❑ worse
Have you retained an attorney? ❑ Y ❑ N If yes, name, address and phone_____
_____
Please explain, in detail, how the incident happened._____
_____
_____
_____
_____

Please indicate, for each of the questions below, your experience by use of the following codes:

1 - never had **2** - previously had **3** - presently have

MUSCULO-SKELETAL SYSTEM

___Sore muscles ___ Weak muscles ___ Leg problems ___ Painful joints ___ Walking problems___Pain between shoulders
___ Arm problems___ Swollen joints ___ Stiff joints ___ Broken bones Other _____

NERVOUS SYSTEM

___ Loss of feeling ___ Confusion ___ Forgetfulness ___ Convulsions ___ Paralysis ___ Muscle jerking

EYE, EAR, NOSE AND THROAT

___Eye strain ___Ear pain ___Hearing loss ___Nose discharge ___Hoarseness
___Eye inflammation ___Ear noises ___Nose pain ___Difficult breathing thru nose ___Difficult speech
___Vision problems ___Ear discharge ___Nose bleeding ___Sore throat

_____ _____
Patient's Signature Date

Use a scale of 1 to 10 (1=none, 10=extreme)

and briefly describe your emotional/ psychological/lifestyle stress levels in the following areas:

Occupational Stress level = ___ , Briefly describe _____

_____

Personal Stress level= ___, Briefly describe_____

_____

Please check all symptoms you currently have or recently have had:

__ Headaches	__ Buzzing in ears	__ Irritability	__ Diarrhea
__ Pins and needles in arms	__ Ringing in ears	__ Cold hands	__ Cold sweats
__ Pins and needles in legs	__ Numbness in toes	__ Cold feet	__ Mood swings
__ Dizziness	__ Depression	__ Fever	__ Loss of smell
__ Numbness in fingers	__ Constipation	__ Urinary problem	__ Loss of taste
__ Fatigue	__ Menstrual cramps	__ Fainting	__ Back pain
__ Sleeping problems	__ Menstrual irregularity	__ Eyes bothered by light	__ Neck pain
__ Tension	__ Hot flashes	__ Stomach upset	__ Stiff neck
__ Ulcers	__ OTHER (briefly describe) _____		

Present Occupation _____ How long have you had this job? _____

Type of activity involved Sitting Moderately Active Heavy Labor

List any previous jobs in the last 2 years (specify dates) _____

_____

Activity when not working _____

Please list the sports or other physical activities you participate in_____

_____

How often? More than once a week Once a week Once a month

Age of mattress _____ (Comfortable or Uncomfortable?)

In which position do you sleep?

Stomach Right Side Left Side Back All Over Other _____

Have you ever:	Yes	No	**Do you**:	Yes	No	
been knocked unconscious?	__	__	take vitamins or supplements?	__	__	Type_____
used a cane, crutch, other support?	__	__	smoke?	__	__	Amount _____
			drink?	__	__	Amount _____
been treated for a spine or nerve disorder?	__	__	have any drug allergies?	__	__	Type _____
			drink ½ your weight (in lbs.) in ounces of water daily	__	__	

FOR WOMEN ONLY

Number of days from the beginning of one period to the beginning of the next period _____

Date of last menstrual period _____ How many days do you usually menstruate? _____

Are you pregnant? __ Yes __ No Do you use __ Birth control pills? __ Diaphragm? __ IUD?

YOUR GOALS

We're committed to supporting you in achieving your best vision of yourself and your life. Please take a few moments to answer the following questions.

1. How do you feel in your body? (energy, weight, flexibility, etc.)_____

_____

2. Are you craving some foods more than others? Which ones? _____

_____

3. Do you experience any discomfort after eating certain foods? (bloat, headaches, fatigue, etc.)_____

4. Is there something that seems to get in the way of you feeling your best? (physically, emotionally)_____

_____

5. Have you asked for support in the past? Please describe._____

_____

6. What are the 3 most important changes you would like to see for yourself in the next 3-6 months? _____

_____

Are there any other health concerns you think the doctor would need to know? _____

_____

Thank you for providing the information to begin your journey into the Creating Wellness Lifestyle!

Patient's Signature_____ Date_____

DOCTOR'S NOTES

_____

_____

_____

_____