Worker's Compensation Questionnaire

Personal Info:

Name: ______________________________________ Social Security#:________________

Address: ___________________________________ Marital Status: S M D W

City: ____________________________ State: ________ Zip: _____________

Phone: (H) __________________ (Alt) ___________ Spouse's Name__________________

Date of Birth: _______________ Age: ___________ Spouse's Occupation_____________

Email: _____________________________________

Referred by: ________________________________

Employment Info:

Employer: ____ Phone: ________________

Address: ____

Type of Business: _________________________ Your Occupation_____________________

Name of Carrier: _____________________________________ Phone: ________________

Address: ____

Carrier Case#:_____________________________ WCB#___________________________

Injury Info:

Date Injury Occurred: __________________________ Time of Day: ___________ AM/PM

Last Date of Work: _______________________ Are You Off Work? ☐ Yes ☐ No

Where were you when your injury occurred (actual address or location)? ___________

____

Was employer notified? ☐ Yes ☐ No

Do you have a Worker's Compensation Attorney? ☐ Yes ☐ No

If yes, please provide info: ____

Injury Info Cont'd:

In your own words, please describe the accident in detail ________________________

____

____

Have you treated with another doctor for this injury?

If yes, please list names: ____

What type of treatment did you receive? ________________________________

How long were you treated by this doctor? ______________________________

Was this injury due to an existing work related injury? ☐ Yes ☐ No

If yes, was your employer notified? ☐ Yes ☐ No

Have you had any other previous worker's comp injuries? ☐ Yes ☐ No

Current Medical Complaints:

Prior to this accident have you had any physical complaints similar to what you have now?
☐ Yes ☐ No
If yes, please explain: ____

Current medical complaints since injury: (check all that apply)

☐ Neck Pain
☐ Upper Back Pain
☐ Mid Back Pain
☐ Low Back Pain
☐ Leg Pain
☐ Knee Pain
☐ Numbness in fingers/hands
☐ Numbness in toes/foot
☐ Pins/Needles in arm/hands
☐ Pins/Needles in legs/feet
☐ Sleeping Problems
☐ Arm/Shoulder Pain
☐ fainting
☐ Ears Ringing
☐ Dizziness
☐ Headache
☐ Loss of Balance
☐ Blurred Vision

Is pain worsened by?

☐ Sitting ☐ Walking ☐ Laying Down ☐ Lifting
☐ Bending ☐ Standing ☐ Pushing ☐ Pulling

Does your pain radiate (travel)? ____

Is condition worse during certain times of the day? ______________________________

What aggravates your condition/pain? ____

Is your pain getting progressively worse, better, or staying the same? _____________

Current Medical Complaints Cont'd:

Any home remedies? ____

Is this condition interfering with Sleep? _______ Routine? ________ Other?_________

Please describe any other symptoms you have that are not listed here:
____

____

Current Health Habits:

Did/ do you...

Smoke/Use tobacco products?	Y	N
Drink alcohol/Take Drugs?	Y	N
Diet (do you eat healthy foods?)	Y	N
Drink water, how many glasses?	Y	N
Exercise regularly?	Y	N
Have teeth problems?	Y	N
Have eye problems?	Y	N
Have hearing problems?	Y	N
Have sleeping problems?	Y	N
Have occupational stress?	Y	N
Have physical stress?	Y	N
Have mental stress?	Y	N
Have hobbies/sports injuries?	Y	N

Sleeping posture: side – stomach – back

What is your height? ________________ Weight? _________________

Have you been under medical and/or drug care? ____________________________

Do you have a primary care physician? Who? ________________________________

What medications are you taking? ____
____

What side effects have you experienced from the medications and/or surgery?
____

Do you take vitamins or supplements? ____

Past Health Conditions And/Or Symptoms:

☐ Headaches	☐ Muscular In coordination	☐ Prostate Problems	☐ Depression
☐ Neck Pain	☐ Visual Disturbances	☐ Abnormal Weight Gain/Loss	☐ Light Bothers Eyes
☐ Upper Back Pain	☐ Dizziness		☐ Loss of Memory
☐ Lower Back Pain	☐ Loss of Balance	☐ Loss of Appetite	☐ Ears Ring
☐ Shoulder Pain	☐ Nervousness	☐ Abdominal Pain	☐ Fever
☐ Irritability	☐ Elbow/Upper Arm Pain	☐ Ulcer	☐ Fainting
☐ Wrist pain	☐ High Blood Pressure	☐ Hepatitis	☐ Loss of taste
☐ Hand Pain	☐ Heart Attack	☐ Liver/Gall Bladder Disorder	☐ Diarrhea
☐ Chest Pains	☐ Hip/Upper Leg Pain		☐ Feet Cold
☐ Stroke	☐ Knee/Lower Leg Pain	☐ Cancer	☐ Hands Cold
☐ Ankle/Foot Pain	☐ Angina	☐ Tumor	☐ Stomach Upset
☐ Jaw Pain	☐ Kidney Stones	☐ Asthma	☐ Constipation
☐ Kidney Disorders	☐ Joint Swelling/Stiffness	☐ Pins & Needles in legs	☐ Loss of Balance
☐ Arthritis	☐ Bladder Infection	☐ Pins & Needles in arms	☐ Buzzing
☐ Painful Urination	☐ Rheumatoid Arthritis	☐ Numbness in fingers	
General Fatigue	☐ Loss of bladder control	☐ Numbness in Toe	

Family History:

	Heart Disease	Arthritis	Cancer	Diabetes	Other
Fathers Side	☐	☐	☐	☐	☐
Mothers Side	☐	☐	☐	☐	☐

How old is, or was, your oldest living relative? _________years old

As a result of my chiropractic care, I would like to:

Please check all that apply

☐ Feel better quickly
☐ Have a healthier spine
☐ Have a healthier body by keeping my nervous system healthy
☐ Live a healthier lifestyle

Assignment of Benefits

I irrevocably assign to Dr. Emil A. Tocci, IV all my rights and benefits under any insurance contracts for payment services rendered to me by Dr. Emil A. Tocci, IV. I irrevocably authorize all information regarding my benefits under any insurance policy relating to any claims by Dr. Emil A. Tocci, IV to be released to him. I irrevocably authorize Dr. Emil A. Tocci, IV to file insurance claims on my behalf for services rendered to me. I irrevocably direct that all such payments go directly to Dr. Emil A. Tocci, IV. I irrevocably authorize Dr. Emil A. Tocci, IV to act in my behalf and report any suspected violations of proper claims practices to the proper regulatory authorities. This assignment of benefits has been explained to my full satisfaction and I understand its nature and effect. I understand that I am personally responsible for payment for all services rendered in accordance with the regulations of New York.

___________________________________ ________________________

Signature Date

<u>Terms of Acceptance</u>

When a patient seeks chiropractic health care and we accept a patient for such care, it is essential for both to be working towards the same objective.

Chiropractic has only one goal. It is important that each patient understands both the objective and the method that will be able to attain it. This will prevent any confusion or disappointment.

Adjustment: An adjustment is the specific application of forces to facilitate the body's correction of vertebral subluxations. Our chiropractic method of correction is by specific adjustments of the spine.

Health: A state of optimal physical, mental and social well-being, not merely the absence of disease of infirmity.

Vertebral Subluxation: A misalignment of one or more of the 24 vertebra in the spinal column which causes alteration of nerve function and interference to the transmission of mental impulses, resulting in a lessening of the body's innate ability to express its maximum health potential.

We do not offer to diagnose or treat any disease or condition other than vertebral subluxation. However, if during the course of a chiropractic spinal evaluation, we encounter non-chiropractic or unusual findings, we will advise you. If you desire advice, diagnosis or treatment for those findings, we will recommend that you seek the services of a health care provider who specializes in that area.

Regardless of what the disease is called, we do not offer to treat it. Nor do we offer advice regarding treatment prescribed by others. **OUR ONLY PRACTICE OBJECTIVE** is to eliminate a major interference to the expression of the body's innate wisdom. Our only method is specific adjusting to correct vertebral subluxations.

I, ___________________________ have read and fully understand the above statements.
(Print name)
All questions regarding the doctor's objectives pertaining to my care in this office have been answered to my complete satisfaction.

I therefore accept chiropractic care on this basis.

_____________________________________ _____________________________

(Signature) (Date)

Office Use Only
1
4-5
>5

Pain Drawing

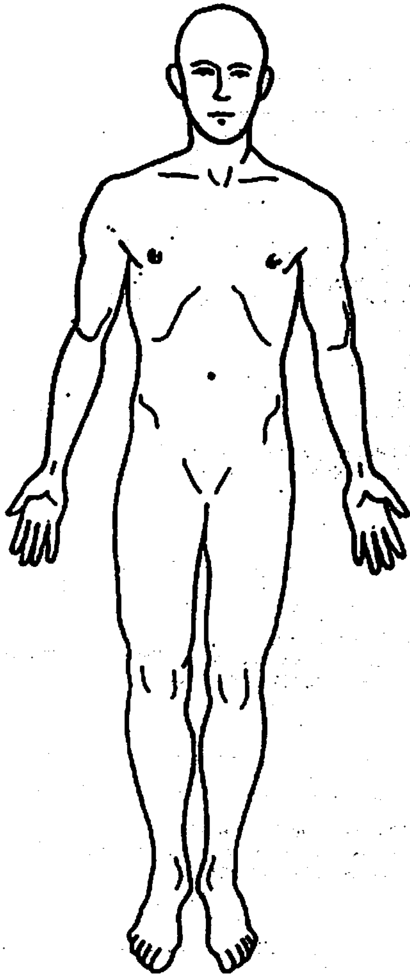
Name:______________________ Date:______________________

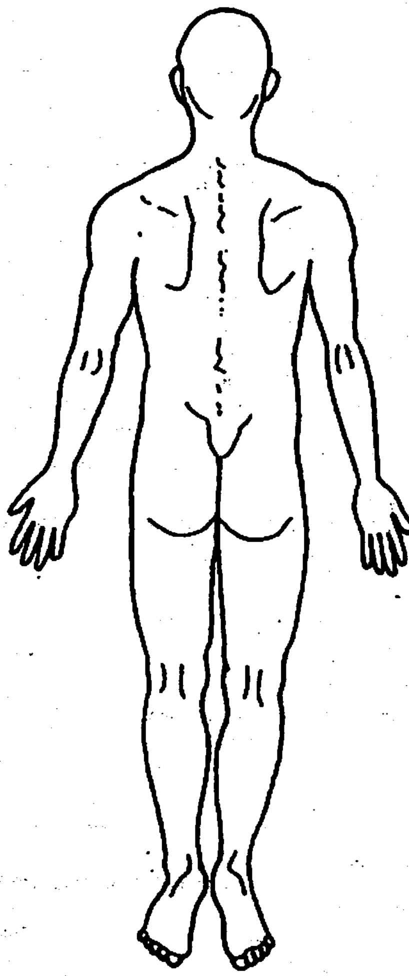
Date of Birth:______________________ Examiner:______________________

TELL US WHERE YOU HURT.

Please read carefully:
Mark the areas on your body where you feel your pain. Include all affected areas. Mark areas of radiation. If your pain radiates, draw an arrow from where it start to where it stops. Please extend the arrow as far as the pain travels. Use the appropriate symbol(s) listed below.

Ache > > > > >   Numbness = = = = = =   Pins & Needles o o o o
Burning x x x x   Stabbing / / / / /   Throbbing ~ ~ ~ ~ ~ ~





Emil A. Tocci, D.C.
2421 Long Beach Road
Oceanside, NY 11572
(516) 766-1717

NOTICE OF PRIVACY PRACTICES
PATIENT ACKNOWLWDGEMENT

Patient Name: ______________________________________

Date of Birth: ______________________________________

I have received this practice's Notice of Private Practices written in plain language. The notice provides in detail the uses and disclosures of my protected health information that may be made by this practice, my individual rights, how I may exercise these rights, and the practice's legal duties with respect to my information.

I understand that this practice reserves the right to change the terms of its Notice of Private Practices, and to make changes regarding all protected health information resident at, or controlled by this practice. I understand I can obtain this practice's current Notice of Privacy Practices on request.

Signature: ____

Relationship to patient (if other that self): ____________________________________

Date: ______________________