Welcome To Auerbach Family Chiropractic Center!

Name_____ Phone _____ Cell_____
Street Address_____ Email:_____
City_____ State_____ Zip_____ Date of Birth _____
Please Check ✔ Sex: Male_____, Female _____ Marital Status: S M W D # of Children_____
Who referred you, or how did you hear about us?_____ SS#_____

Personal & Family History: Occupation:_____ Employer:_____
Employer Address:_____ Phone:_____
Spouse's Name:_____ Employer:_____ Phone:_____

Health History:

Is this a wellness visit ____, or for a specific concern? _____ Explain:_____
Describe any health concerns, including when & how they began:_____

What area(s) of your life has this problem affected the most? Family___ Relationships___ Work___ Exercise___ Recreation___
What activity does this problem prevent you from doing, either partially or totally, that you would really like to do? _____

Are you under the care of any other doctor? Yes___ No ___ Primary Care Dr's Name:_____
If Yes, the conditions being treated for: _____
List any current Medications:_____
List any past surgeries & dates:_____
List any past accidents & dates:_____
List any x-rays in the past 2 years:_____

Chiropractic History: Have you ever been to a Chiropractor before? Yes ___ No___ If Yes, Date of Last Visit_____
Chiropractor's Name:_____ Reason for care_____

If you have had the following or if you suffer from the following: *Please Check* ✔

Condition	*Occasionally*	*Frequently*
Headache	_____	_____
Migraines	_____	_____
Neck Pain	_____	_____
Shoulder Pain	_____	_____
Arm/Hand Pain	_____	_____
Mid Back Pain	_____	_____
Low Back Pain	_____	_____
Hip Pain	_____	_____
Leg/Foot Pain	_____	_____
Jaw Pain	_____	_____
Disc Problems	_____	_____
Arthritis	_____	_____
Joint Swelling	_____	_____
Numbness	_____	_____

Condition	*Occasionally*	*Frequently*
Dizziness	_____	_____
Nausea	_____	_____
Chest Pains	_____	_____
Cough	_____	_____
Weakness	_____	_____
Fatigue	_____	_____
Nervousness	_____	_____
Insomnia	_____	_____
Vision Changes	_____	_____
Nose Bleeds	_____	_____
Ringing in Ears	_____	_____
Earaches	_____	_____
Hearing Loss	_____	_____
Frequent Colds	_____	_____

Condition	*Occasionally*	*Frequently*
Allergies	_____	_____
Asthma	_____	_____
Digestive Problems	_____	_____
Urinary Problems	_____	_____
Skin Conditions	_____	_____
Diabetes	Check if yes:	_____
Gout	Check if yes:	_____
Cancer	Check if yes:	_____
Osteoporosis	Check if yes:	_____
Hypoglycemia	Check if yes:	_____
Heart Problems	Check if yes:	_____
Lung Problems	Check if yes:	_____

Other : _____
Smoker?____ Alcohol/How Often?_____
Female Problems _____ _____
Possibly Pregnant? Yes____ No_____

Present Health Goals:

___Improve Nutrition/Eating Habits
___Weight Loss/Fat Loss
___Increase Lean Muscle Mass
___Increase Bone Density
___Reduce Stress
___Lower Cholesterol
___Lower Blood Pressure
___Start Exercising
___Look Better
___ Feel Better
___Get Off Medications
___Improve Sleep
___Improve Energy
___Improve Posture
___Improve Outlook/Happiness

On a scale of 1 to 10 with 1=Poor and 10=Excellent, please rate how well you think you're doing in the following categories:
Exercise_____ Sleep_____ Diet_____ Stress Level _____ Water Intake_____ Energy Level _____

Your Signature:_____ **Date:**_____

Employee Claim

C-3

State of New York - Workers' Compensation Board

Fill out this form to apply for workers' compensation benefits because of a work injury or work-related illness. Type or print neatly. This form may also be filled out on-line at www.wcb.state.ny.us.

WCB Case Number (if you know it): _____

A. YOUR INFORMATION (Employee)

1. Name: _____ (First / MI / Last) 2. Date of Birth: ____/____/____

3. Mailing address: _____ (Number and Street/PO Box / City / State / Zip Code)

4. Social Security Number: ___ - ___ - ____ 5. Phone Number: (____)_____ 6. Gender: ☐ Male ☐ Female

7. Will you need a translator if you have to attend a Board hearing? ☐ Yes ☐ No If yes, for what language? _____

B. YOUR EMPLOYER(S)

1. Employer when injured: _____ 2. Phone Number: (____)_____

3. Your work address: _____ (Number and Street / City / State / Zip Code)

4. Date you were hired: ____/____/____ 5. Your supervisor's name: _____

6. List names/addresses of any other employer(s) at the time of your injury/illness: _____

_____

_____

7. Did you lose time from work at the other employment(s) as a result of your injury/illness? ☐ Yes ☐ No

C. YOUR JOB on the date of the injury or illness

1. What was your job title or description? _____

2. What types of activities did you normally perform at work? _____

_____

3. Was your job? (check one) ☐ Full Time ☐ Part Time ☐ Seasonal ☐ Volunteer ☐ Other: _____

4. What was your gross pay (before taxes) per pay period? _____ 5. How often were you paid? _____

6. Did you receive lodging or tips in addition to your pay? ☐ Yes ☐ No If yes, describe: _____

_____

D. YOUR INJURY OR ILLNESS

1. Date of injury or date of onset of illness: ____/____/____ 2. Time of injury: _____ ☐ AM ☐ PM

3. Where did the injury/illness happen? (e.g., 1 Main Street, Pottersville, at the front door) _____

_____

4. Was this your usual work location? ☐ Yes ☐ No If no, why were you at this location? _____

_____

5. What were you doing when you were injured or became ill? (e.g., unloading a truck, typing a report) _____

_____

6. How did the injury/illness happen? (e.g., I tripped over a pipe and fell on the floor) _____

_____

_____

7. Explain fully the nature of your injury/illness; list body parts affected (e.g., twisted left ankle and cut to forehead): _____

_____

_____

YOUR NAME: _____ **DATE OF INJURY/ILLNESS:** ____/____/____
First MI Last

D. YOUR INJURY OR ILLNESS *continued*

8. Was an object (e.g., forklift, hammer, acid) involved in the injury/illness? ☐ Yes ☐ No If yes, what? _____

9. Was the injury the result of the use or operation of a licensed motor vehicle? ☐ Yes ☐ No
   If yes, ☐ your vehicle ☐ employer's vehicle ☐ other vehicle License plate number (if known): _____
   If your vehicle was involved, give name and address of your motor vehicle insurance carrier: _____

10. Have you given your employer (or supervisor) notice of injury/illness? ☐ Yes ☐ No
    If yes, notice was given to: _____ ☐ orally ☐ in writing Date notice given: ____/____/____

11. Did anyone see your injury happen? ☐ Yes ☐ No ☐ Unknown If yes, list names: _____

E. RETURN TO WORK

1. Did you stop work because of your injury/illness? ☐ Yes, on what date? ____/____/____ ☐ No, skip to Section F.
2. Have you returned to work? ☐ Yes ☐ No If yes, on what date? ____/____/____ ☐ regular duty ☐ limited duty
3. If you have returned to work, who are you working for now? ☐ Same employer ☐ New employer ☐ Self employed
4. What is your gross pay (before taxes) per pay period? _____ How often are you paid? _____

F. MEDICAL TREATMENT FOR THIS INJURY OR ILLNESS

1. What was the date of your first treatment? ____/____/____ ☐ None received (skip to question F-5)
2. Were you treated on site? ☐ Yes ☐ No
3. Where did you receive your first off site medical treatment for your injury/illness? ☐ none received ☐ Emergency Room
   ☐ Doctor's office ☐ Clinic/Hospital/Urgent Care ☐ Hospital Stay over 24 hours
   Name and address where you were first treated: _____
   _____ Phone Number: (____)_____
4. Are you still being treated for this injury/illness? ☐ Yes ☐ No
   Give the name and address of the doctor(s) treating you for this injury/illness: _____
   _____ Phone Number: (____)_____
5. Do you remember having another injury to the same body part or a similar illness? ☐ Yes ☐ No
   If yes, were you treated by a doctor? ☐ Yes ☐ No If yes, provide the names and addresses of the doctor(s) who treated you and **COMPLETE AND FILE FORM C-3.3 TOGETHER WITH THIS FORM:**
   _____
   _____
   _____
6. Was the previous injury/illness work related? ☐ Yes ☐ No
   If yes, were you working for the same employer that you work for now? ☐ Yes ☐ No

I am hereby making a claim for benefits under the Workers' Compensation Law. My signature affirms that the information I am providing is true and accurate to the best of my knowledge and belief.

Any person who knowingly and with INTENT TO DEFRAUD presents, causes to be presented, or prepares with knowledge or belief that it will be presented to, or by an insurer, or self-insurer, any information containing any FALSE MATERIAL STATEMENT or conceals any material fact, SHALL BE GUILTY OF A CRIME and subject to substantial FINES AND IMPRISONMENT.

Employee's Signature: _____ Print Name: _____ Date: ____/____/____

On behalf of Employee: _____ Print Name: _____ Date: ____/____/____

An individual may sign on behalf of the employee only if he or she is legally authorized to do so and the employee is a minor, mentally incompetent or incapacitated.

I certify to the best of my knowledge, information and belief, formed after an inquiry reasonable under the circumstances, that the allegations and other factual matters asserted above have evidentiary support, or are likely to have evidentiary support after a reasonable opportunity for further investigations or discovery.

Signature of Attorney/Representative (if any): _____ Date: ____/____/____

Print Name: _____ Title: _____

ID No., if any: **R** _____ If Licensed Representative, License No.: _____ Expiration Date: ____/____/____