



BURTIS CHIROPRACTIC CENTER WORKER'S COMPENSATION WAIVER

TODAY'S DATE: _____

PATIENT INFORMATION

First Name: _____ Middle Name: _____ Last Name: _____

Address: _____

City: _____ State: _____ Zip: _____

Home Phone: _____ Cell Phone: _____

Email: _____

Date of Birth: ____/____/____ Social Security #: ____-____-____

Gender: [male] or [female]

MARITAL STATUS: Single / Married / Divorced / Widowed / Other

Spouse's Name: _____ Number of Children: _____

Preferred method of communication for patient reminders (Circle one): Email / Phone / Mail / Text Message
1 day before appointment or 2 hours before appointment

Cell Phone Carrier (Circle one): Verizon / Sprint / AT & T / Virgin Mobile / Other _____

EMERGENCY CONTACT

Name: _____

Relationship: _____

Phone: _____

HOW DID YOU FIND OUT ABOUT OUR OFFICE?

Did someone refer you here? [YES] or [NO]

If yes, name: _____

Did you hear or see us in an Advertisement? [YES] or [NO]

If yes, where: _____

EMPLOYMENT

Regular Work Status: (circle one)

EMPLOYED / PART-TIME EMPLOYED / RETIRED / UNEMPLOYED / FULL-TIME STUDENT / PART-TIME STUDENT

Employer: _____

Employer City and State: _____

Occupation: _____ Employer Phone #: _____

CURRENT SYMPTOMS

Purpose of visit today: [] Injury

Where did the injury occur? [] Automobile [] Work [] 3rd Party Premise

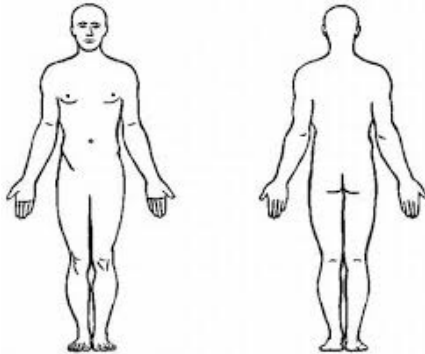
Date of Injury: _____

Have you notified your supervisor/employer? [] Yes [] No

Describe how the injury happened: _____

Rate your pain on a scale of 1-10: (1 being the least pain and 10 is the maximum pain)
At its best: _____ At its worse: _____ Current level: _____

Please indicate the areas affected by the injury:



Describe the pain/discomfort you are feeling and where: (i.e. numbness in right arm, shooting pains from hip down left leg, back pain more on left or right side)

Indicate the areas of your life it has impacted:
 Work Daily Activities Sleep Appetite Other

Please describe: _____

Frequency you are experiencing pain from this condition?
 Always Hourly Daily Occasionally

Has this concern:
 Gotten Worse Stayed Constant Come and Gone

Have you reduced or limited your work hours because of this condition? [YES] or [NO]

If yes, explain: _____

Have you missed any work due to this injury? [YES] or [NO]

If yes, dates of missed work: _____ TO _____

Is your pain/discomfort worse at certain times of the day? [YES] or [NO]

If yes, when: _____

List anything that aggravates your condition: _____

List anything that relieves or improves your condition: _____

HAVE YOU SEEN ANY OTHER DOCTORS FOR THIS CONCERN? [YES] or [NO]

If yes: Doctor's name: _____ Where: _____

Type of Treatment: _____ X-rays/MRI taken? [YES] or [NO]

Results: [GOOD] [BAD] OR [INDIFFERENCE]

PERSONAL INCIDENT HISTORY

Broken any bones? [YES] or [NO]

If yes, did you get professional treatment? [YES] or [NO]

Briefly explain: _____

Had any major sprains or strains? [YES] or [NO]

If yes, did you get professional treatment? [YES] or [NO]

Briefly explain: _____

Been hospitalized? [YES] or [NO]

Briefly explain: _____

Had surgery? [YES] or [NO]

Briefly explain: _____

Been in an Auto Accident? [YES] or [NO]

If yes, did you get professional treatment? [YES] or [NO]

Briefly explain: _____

Been Struck Unconscious? [YES] or [NO]

If yes, did you get professional treatment? [YES] or [NO]

Briefly explain: _____

Been diagnosed with an eating disorder? [YES] or [NO]

Briefly explain: _____

Had a stroke? [YES] or [NO]

Briefly explain: _____

FAMILY HEALTH HISTORY

List diagnosed health conditions and untimely deaths of your blood-related family members:
(Condition and relationship to you) (ex: arthritis, cancer, diabetes, heart disease, high blood pressure)

SOCIAL HISTORY AND LIFE CHOICES

- Alcohol: Daily Weekly Occasionally Never
- Diet Food Products: Daily Weekly Occasionally Never
- Energy Products & Over-the-Counter Stimulants: Daily Weekly Occasionally Never
- Caffeine Drinks & Products: Daily Weekly Occasionally Never
- Soft Drinks: Daily Weekly Occasionally Never
- Water: Daily Weekly Occasionally Never
- Fresh & Homemade Foods: Daily Weekly Occasionally Never
- Preprocessed, Packaged, & Restaurant Food: Daily Weekly Occasionally Never
- Exercise: Daily Weekly Occasionally Never
- Tobacco: Daily Weekly Occasionally Never

HEALTH PROBLEMS AND CONCERNS

Please check all that you have had or currently have.

- | | | | |
|---|---|--|--|
| <input type="checkbox"/> Allergies | <input type="checkbox"/> Cramps | <input type="checkbox"/> Hot Flashes | <input type="checkbox"/> Sciatica |
| <input type="checkbox"/> Alcoholism | <input type="checkbox"/> Dementia/Alzheimer’s | <input type="checkbox"/> Irregular Heart Beat | <input type="checkbox"/> Seizures |
| <input type="checkbox"/> Anemia | <input type="checkbox"/> Depression | <input type="checkbox"/> Irregular Menstrual Cycle | <input type="checkbox"/> Shortness of Breath |
| <input type="checkbox"/> Arteriosclerosis | <input type="checkbox"/> Diabetes | <input type="checkbox"/> Kidney Infection | <input type="checkbox"/> Sinus Infection |
| <input type="checkbox"/> Arthritis | <input type="checkbox"/> Digestion Problems | <input type="checkbox"/> Kidney Stones | <input type="checkbox"/> Sleep Problems/Insomnia |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Diagnosed emotional/
mental disorders | <input type="checkbox"/> Liver disease/cirrhosis | <input type="checkbox"/> Skin Sensitivity |
| <input type="checkbox"/> Autoimmune Disease | <input type="checkbox"/> Dizziness | <input type="checkbox"/> Loss of Memory | <input type="checkbox"/> Spinal Curvatures |
| <input type="checkbox"/> Back Pain | <input type="checkbox"/> Epilepsy | <input type="checkbox"/> Loss of Balance | <input type="checkbox"/> Stroke |
| <input type="checkbox"/> Bleeding Disorders | <input type="checkbox"/> Excessive Menstruation | <input type="checkbox"/> Loss of Smell | <input type="checkbox"/> Swelling of Ankles |
| <input type="checkbox"/> Breast Lump | <input type="checkbox"/> Eye Pain or Difficulties | <input type="checkbox"/> Loss of Taste | <input type="checkbox"/> Swollen Joints |
| <input type="checkbox"/> Bronchitis | <input type="checkbox"/> Fatigue | <input type="checkbox"/> Lung disease | <input type="checkbox"/> Thyroid Condition |
| <input type="checkbox"/> Bruise Easily | <input type="checkbox"/> Frequent Urination | <input type="checkbox"/> Macular Degeneration | <input type="checkbox"/> Tuberculosis |
| <input type="checkbox"/> Cancer | <input type="checkbox"/> Gallbladder disease/
stones | <input type="checkbox"/> Migraines | <input type="checkbox"/> Ulcers |
| <input type="checkbox"/> Cataracts | <input type="checkbox"/> Glaucoma | <input type="checkbox"/> Nosebleeds | <input type="checkbox"/> Varicose Veins |
| <input type="checkbox"/> Chest Pain | <input type="checkbox"/> Gout | <input type="checkbox"/> Pacemaker | <input type="checkbox"/> Venereal Disease(STD) |
| <input type="checkbox"/> CHF (congestive heart disease) | <input type="checkbox"/> Headache | <input type="checkbox"/> Parkinson’s | <input type="checkbox"/> Other: _____ |
| <input type="checkbox"/> Cold Extremities | <input type="checkbox"/> Hemorrhoids | <input type="checkbox"/> Polio | _____ |
| <input type="checkbox"/> Constipation | <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Poor Posture | _____ |
| <input type="checkbox"/> COPD/emphysema | | <input type="checkbox"/> Prostate Trouble | _____ |
| <input type="checkbox"/> CVA (stroke/TIA) | | <input type="checkbox"/> Retinal Disease | _____ |

AUTHORIZATION

I certify that I'm the patient or legal guardian listed below. I understand the information given on this intake form is true and accurate to the best of my knowledge. I consent to the collection and use of that information to this office of chiropractic. I authorize this office and its staff to examine and treat my condition as the doctors see fit. I hereby authorize the doctor to release all information necessary to any insurance company, attorney, or adjuster for the purpose of claim reimbursement of charges incurred by me. I grant the use of my signed statement of authorization with my signature for required insurance submissions.

I agree with this statement of authorization.

Name (Please Print): _____

Patient's Signature: _____ **Date:** _____