GREEN CHIROPRACTIC
BETTER SPINE, BETTER LIFE

Worker's Compensation Patient Application

WELCOME, and THANK YOU for applying as a patient in our clinic. We are a very unique team specializing in research-based spinal and postural rehabilitation. These methods have enabled our patients to achieve their optimal health; even when many other systems have failed.

Because of this specialized approach, we may not accept you as a patient until we perform the necessary tests that will give us insight into the cause of your condition, allowing us to develop an optimal rehab program for you, and are confident we can help you. If we accept you as a patient, we will make your health a priority and expect you will as well.

Patient Information

Full Name:_____ Date: _____ / _____ / _____ Gender: M F

Home Address:_____ Cell Phone: ( )_____

City, State, Zip:_____ Home Phone: ( )_____

Email Address:_____ Work Phone: ( )_____

Birth Date: _____ / _____ / _____ Age:_____ Social Security #: _____ - _____ - _____

Occupation:_____ Employer's Name:_____

Marital Status: S M D W Number of children: _____

Spouse's Name:_____ Occupation:_____

Spouse's Employer:_____

How were you referred to this office?_____

List two persons way may contact in case of an emergency

Name:_____ Phone #: ( )_____ Relationship:_____

Name:_____ Phone #: ( )_____ Relationship:_____

Health & Lifestyle

Do you smoke? ☐ No Packs per day:_____ Years: _____

Do you drink alcohol? ☐ No ☐ Social ☐ Light ☐ Moderate ☐ Heavy

Do you drink coffee? ☐ No Cups per day: _____

Do you exercise? ☐ No ☐ Occasionally ☐ Regularly Times per week:_____

If yes, what type of exercise? _____

Please list hobbies/leisure activities:_____

Work is mostly: ☐ Office/Clerical ☐ Homemaker ☐ Light Labor ☐ Moderate Labor ☐ Heavy Labor

Do you take any supplements (i.e. vitamins, minerals, herbs)? ☐ None ☐ Yes, please list:

_____

Purpose for this Visit - **MAIN** Reason - **ONE** area only

Main reason for this visit (describe): _____

When did these symptoms begin? _____

Is this related to an accident or specific injury? ☐ No ☐ Yes

If yes, explain: _____

Are the symptoms: ☐ Constant ☐ Intermittent ☐ Activity-related

Are the symptoms: ☐ Improving ☐ Getting Worse ☐ Remaining the same

What aggravates your symptoms? _____

Is there anything that relieves the symptoms? ☐ No ☐ Yes: _____

Have you experienced these symptoms before? ☐ No ☐ Yes, when? _____

Have you already been treated for this? ☐ No ☐ Yes, who did you see? _____

What treatment was performed, and how did you respond? _____

What is your pain **RIGHT NOW**? None 0 - 1 - 2 - 3 - 4 - 5 - 6 - 7 - 8 - 9 - 10 Severe

What is your **TYPICAL** or **AVERAGE** pain? None 0 - 1 - 2 - 3 - 4 - 5 - 6 - 7 - 8 - 9 - 10 Severe

What is your pain level **AT ITS BEST**? None 0 - 1 - 2 - 3 - 4 - 5 - 6 - 7 - 8 - 9 - 10 Severe

What is your pain level **AT ITS WORST**? None 0 - 1 - 2 - 3 - 4 - 5 - 6 - 7 - 8 - 9 - 10 Severe

Purpose for this Visit - **SECONDARY** Reason - any other areas

Other reason for this visit (describe): _____

When did these symptoms begin? _____

Is this related to an accident or specific injury? ☐ No ☐ Yes

If yes, explain: _____

Are the symptoms: ☐ Constant ☐ Intermittent ☐ Activity-related

Are the symptoms: ☐ Improving ☐ Getting Worse ☐ Remaining the same

What aggravates your symptoms? _____

Is there anything that relieves the symptoms? ☐ No ☐ Yes: _____

Have you experienced these symptoms before? ☐ No ☐ Yes, when? _____

Have you already been treated for this? ☐ No ☐ Yes, who did you see? _____

What treatment was performed, and how did you respond? _____

What is your pain **RIGHT NOW**? None 0 - 1 - 2 - 3 - 4 - 5 - 6 - 7 - 8 - 9 - 10 Severe

What is your **TYPICAL** or **AVERAGE** pain? None 0 - 1 - 2 - 3 - 4 - 5 - 6 - 7 - 8 - 9 - 10 Severe

What is your pain level **AT ITS BEST**? None 0 - 1 - 2 - 3 - 4 - 5 - 6 - 7 - 8 - 9 - 10 Severe

What is your pain level **AT ITS WORST**? None 0 - 1 - 2 - 3 - 4 - 5 - 6 - 7 - 8 - 9 - 10 Severe

Symptoms Chart

Please **shade** the areas of symptoms and **label** the diagram using the following abbreviations.

A Ache

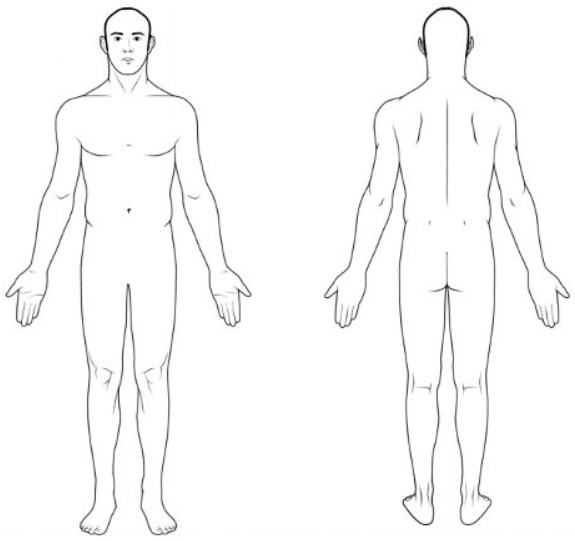
B Burning

S Sharp / stabbing

N Numbness

T Tingling

O Other



Activities of Daily Life

Please identify how your current condition(s) is affecting your ability to carry out routine activities.

Choose one for each of the activities below: • Activity has no effect, • You can do activity, but it is painful, • You are limited in the activity, and it is painful, • You are unable to perform the activity.

Activities:	Effects:			
Carrying	☐ No Effect	☐ Painful (Can do)	☐ Painful (Limits)	☐ Unable to Perform
Lifting	☐ No Effect	☐ Painful (Can do)	☐ Painful (Limits)	☐ Unable to Perform
Sitting	☐ No Effect	☐ Painful (Can do)	☐ Painful (Limits)	☐ Unable to Perform
Standing	☐ No Effect	☐ Painful (Can do)	☐ Painful (Limits)	☐ Unable to Perform
Sit to Stand	☐ No Effect	☐ Painful (Can do)	☐ Painful (Limits)	☐ Unable to Perform
Extended Computer Use	☐ No Effect	☐ Painful (Can do)	☐ Painful (Limits)	☐ Unable to Perform
Walking	☐ No Effect	☐ Painful (Can do)	☐ Painful (Limits)	☐ Unable to Perform
Exercise	☐ No Effect	☐ Painful (Can do)	☐ Painful (Limits)	☐ Unable to Perform
Going Up & Down Stairs	☐ No Effect	☐ Painful (Can do)	☐ Painful (Limits)	☐ Unable to Perform
Sleeping	☐ No Effect	☐ Painful (Can do)	☐ Painful (Limits)	☐ Unable to Perform
Reading/Concentrating	☐ No Effect	☐ Painful (Can do)	☐ Painful (Limits)	☐ Unable to Perform
Getting Dressed	☐ No Effect	☐ Painful (Can do)	☐ Painful (Limits)	☐ Unable to Perform
Shaving	☐ No Effect	☐ Painful (Can do)	☐ Painful (Limits)	☐ Unable to Perform
Washing/Bathing	☐ No Effect	☐ Painful (Can do)	☐ Painful (Limits)	☐ Unable to Perform
Sexual Activities	☐ No Effect	☐ Painful (Can do)	☐ Painful (Limits)	☐ Unable to Perform
Dishes	☐ No Effect	☐ Painful (Can do)	☐ Painful (Limits)	☐ Unable to Perform
Laundry	☐ No Effect	☐ Painful (Can do)	☐ Painful (Limits)	☐ Unable to Perform
Sweeping/Vacuuming	☐ No Effect	☐ Painful (Can do)	☐ Painful (Limits)	☐ Unable to Perform
Yard Work	☐ No Effect	☐ Painful (Can do)	☐ Painful (Limits)	☐ Unable to Perform
Driving	☐ No Effect	☐ Painful (Can do)	☐ Painful (Limits)	☐ Unable to Perform
Pet Care	☐ No Effect	☐ Painful (Can do)	☐ Painful (Limits)	☐ Unable to Perform

Health Conditions

Your spine is the foundation of health and core strength in your body. Shifts in the vertebrae or sections of the spine will spread ultimately causing weakness and distortion to ALL areas of the spine. These distortions are reflected in abnormal posture. Misalignment of the individual vertebrae or distortion of the normal spinal curves may result in many health conditions. Please answer the following questions accurately so we may determine the full extent of your condition.

Please indicate next to all conditions you've experienced: (N) = Now (P) = Past (B) = Both

Cervical Spine (Neck)

☐ None

___Neck pain
___Pain in shoulders/arms/hands
___Numbness/tingling in arms/hands
___Coldness in hands
___Weakness in grip
___Headaches
___Dizziness
___Visual disturbances
___Hearing disturbances
___Jaw pain/clicking
___Thyroid conditions
___Low energy/fatigue
___Recurrent colds/Flu
___Sinus infections
___Allergies/Hay fever

Please explain: _____

_____

Thoracic Spine (Upper Back)

☐ None

___Upper back pain
___Pain on deep inspiration/expiration
___Shortness of breath
___Asthma/wheezing
___Recurrent lung infections/bronchitis
___Heart attack/angina
___Heart palpitations
___Tachycardia (rapid heartbeat)
___Heart murmurs

Thoracic Spine (Mid Back)

☐ None

___Mid back pain
___Pain in chest/ribs
___Indigestion/heartburn
___Reflux
___Nausea/upset stomach
___Ulcers/gastritis
___Diabetes
___Tired/irritable after eating or when not have eaten for a while
___High/low blood sugar

Please explain: _____

_____

Lumbar Spine (Lower Back)

☐ None

___Low back pain
___Pain in hips/legs/feet
___Numbness/tingling in legs/feet
___Coldness in legs/feet
___Weakness/injuries in hips/ knees/ankles Muscle
___cramps in legs/feet
___Constipation/diarrhea
___Irritable bowel syndrome
___Frequent/difficulty in urinating
___Recurrent bladder infections
___Sexual dysfunction
___Menstrual irregularities/ cramping

Please explain: _____

_____

Other Health Information

Current primary care provider: _____

Do you have allergies? ☐ No ☐ Yes: _____

Do you take any over-the-counter medication? ☐ No ☐ Yes, list how much/often:

_____

Do you take any prescription medication? ☐ No ☐ Yes, see below

Please list any prescription medications:

Medication	How much/often	Starting Date

Please list any surgeries (include type of surgery and date performed) ☐ None

Surgery	Date

Health History

Are you aware of any poor posture habits? ☐ No ☐ Yes

If yes, explain: _____

Do you have or have you had any of the following? Please check the boxes below for the conditions that apply.

☐ None

☐ Cancer	☐ ADHD/ADD	☐ Hernia	☐ Shingles
☐ Heart disease	☐ Depression	☐ Lung disease	☐ Lyme disease
☐ High blood pressure	☐ Migraine headaches	☐ Liver disease	☐ Autoimmune disorder
☐ High cholesterol	☐ Diabetes	☐ Kidney disease	☐ Osteoporosis
☐ Circulatory problems	☐ Low blood sugar levels	☐ Thyroid problems	☐ Arthritis
☐ Stroke	☐ Gallbladder problems	☐ Fibromyalgia	☐ Broken bones/fractures
☐ Neurological problems	☐ Tonsillectomy	☐ Eczema/psoriasis	☐ Scoliosis
☐ Epilepsy/seizures	☐ Appendectomy		

Please explain: _____

_____

Please list any health conditions not mentioned: _____

Family Health History

Is there any history of spinal problems in your family? ☐ No ☐ Yes

If yes, explain: _____

Is there a family history of: ☐ None

	Cancer	Heart Disease	Diabetes	Arthritis	Other
Father	☐	☐	☐	☐	_____
Mother	☐	☐	☐	☐	_____
Sister	☐	☐	☐	☐	_____
Brother	☐	☐	☐	☐	_____

Experience with Chiropractic

Have you seen a chiropractor before? ☐ No ☐ Yes Who? _____

For what? _____

How long were you treated? _____ Last treatment: _____ / _____ / _____

How did you respond? _____

Did your previous chiropractor take 'before' and 'after' x-rays? ☐ No ☐ Yes

Did he/she recommend a specific course of treatment? ☐ No ☐ Yes

Did he/she recommend a home health care program? ☐ No ☐ Yes

If yes, what? _____

_____

Green Chiropractic Financial Policies

Green Chiropractic will do everything we can to bring out the best in you and your health, but we wish to make it very clear that your health is your responsibility. Our financial options are listed below. Please select the appropriate one and sign your acknowledgement of our policy below.

_____Cash

Payment is due at the time services are rendered. We accept cash, check, debit, Visa, Mastercard, Discover and AmEx cards.

_____Insurance Plan

Many insurance policies provide coverage for chiropractic care. Benefits will vary from policy to policy and cannot be guaranteed until an Explanation of Benefits (EOB) is received. Payment on your first visit is required to establish your account. We will contact your primary carrier to obtain benefits and process your claims. Any remaining balance is your responsibility.

_____Medicare

Payment is due at the time services are rendered. Exams, x-rays and supplements are a non-covered service with Medicare. We will submit your charges to Medicare. We are considered non-assignment; therefore, any EOB's and/or payments made by Medicare will be sent directly to you.

_____Medicaid

For managed care plans, WellCare Health Plan, Nebraska Total Care and United Health Care Medicaid are accepted. Visit limits and co-pays may apply.

_____Personal Injury

Please provide Green Chiropractic with any accident reports and attorney information. We will send your claims to your auto insurance carrier if you have a MedPay policy. Any remaining balance is your responsibility.

_____Worker's Comp

Prior approval is typically required before any services are rendered. Obtain and provide Green Chiropractic with the name of your employer's work comp insurance carrier and claim number.

I clearly understand that all insurance coverage is an arrangement between my insurance carrier and myself. If this office chooses to bill any services to my insurance carrier that they are performing these services strictly as a convenience to me. The chiropractic office will provide any necessary reports or required information to aid in insurance reimbursement of services, but I understand that insurance carriers may deny my claims and that I am ultimately responsible for any unpaid balances. Any monies received will be credited to my account.

Patient's Signature

Date

WORK / COMP HISTORY

Patient _____ Phone ( ) _____

Address _____ City _____ State _____ Zip _____

Age _____ Birthdate _____ Sex _____ S/S # _____

Name of Compensation Carrier: _____ Phone ( ) _____

Address of Carrier: _____ City _____ State _____ Zip _____

Employer's Name: _____ Phone ( ) _____

Employer's Address: _____ City _____ State _____ Zip _____

1. Type of Business _____ Your Occupation _____
2. Date Injured _____ Hour _____ AM / PM Last Date Worked _____ Are you off work? ( ) Yes ( ) No
3. Previous Workers' Compensation Injury? ( ) Yes ( ) No
4. Accident reported to employer? ( ) Yes ( ) No Name of person reported accident to _____
5. Injured at: _____ City _____ State _____ Zip _____
6. Length of time worked there prior to accident: _____
7. Type of work being done at time of injury: _____

   _____
8. In your own words, please describe accident: _____

   _____

   _____

   _____
9. Have you been treated by another doctor for this accident? ( ) Yes ( ) No

   If yes, please list doctor's name and address: _____

   _____

   What type of treatment did you receive? _____

   How long were you treated by this doctor? _____
10. Are you: ( ) improved ( ) unchanged ( ) getting worse
11. What types of medicines are you taking? _____

    _____

    Do these medicines help? ( ) Yes ( ) No ( ) Don't know
12. Have you had physical therapy? ( ) Yes ( ) No If yes, how often?

    ( ) Daily ( ) Every other day ( ) Several times a week ( ) Weekly ( ) Every other week

    ( ) Monthly ( ) Other _____

    Does the physical therapy help? ( ) Yes ( ) No ( ) Don't know
13. Prior to this accident, have you ever had any of the physical complaints similar to what you have now?

    ( ) Yes ( ) No ( ) Don't know

    If yes, describe: _____

    _____

    _____

    Were these similar complaints the results of a previous accident(s)? ( ) Yes ( ) No

    Please provide details of accident(s): _____

    _____

    _____

14. Have you had any other serious accidents which required medical care? ( ) Yes ( ) No

Describe: _____

15. Have you had any serious illnesses that required hospitalization? ( ) Yes ( ) No

Describe: _____

_____

_____

16. Have you had any surgeries? ( ) Yes ( ) No

If yes, list type of surgery and date: _____

_____

_____

17. Have you had any nervous or mental illnesses? ( ) Yes ( ) No

Have you had psychiatric care? ( ) Yes ( ) No

18. Have you received a medical discharge from the Armed Forces? ( ) Yes ( ) No

19. Have you returned to work since this accident? ( ) Yes ( ) No

If you have returned to work since your accident, please fill out the information below:

DATE	EMPLOYER	OCCUPATION	LIGHT DUTY REG. DUTY	FULL-TIME PART-TIME

CURRENT MEDICAL COMPLAINTS

BACK PAIN:

1. Currently, I have pain in my: ( ) low back ( ) mid back ( ) upper back
2. My pain began: ( ) gradually ( ) suddenly
3. I have pain: ( ) sometimes ( ) all of the time
4. My pain goes into my: ( ) right leg ( ) left leg ( ) both
5. I have tingling and/or numbness in my: ( ) right leg ( ) left leg ( ) both
6. My pain is worse when I:
   - cough or sneeze ( ) Yes ( ) No
   - sit ( ) Yes ( ) No
   - bend ( ) Yes ( ) No
   - walk ( ) Yes ( ) No
   - lift ( ) Yes ( ) No
   - push ( ) Yes ( ) No
   - pull ( ) Yes ( ) No
7. My back is worse with sexual activity ( ) Yes ( ) No
8. My pain wakes me up during the night ( ) Yes ( ) No
9. Changes in the weather affect my pain ( ) Yes ( ) No

NECK PAIN:

1. My neck pain began: ( ) gradually ( ) suddenly
2. I have pain: ( ) sometimes ( ) all of the time
3. My pain goes into my: ( ) right arm ( ) left arm ( ) both
4. I have tingling and/or numbness in my: ( ) right arm ( ) left arm ( ) both
5. My pain is worse when I:
   - cough or sneeze ( ) Yes ( ) No
   - bend forward ( ) Yes ( ) No
   - lift ( ) Yes ( ) No
   - push ( ) Yes ( ) No
   - pull ( ) Yes ( ) No
   - turn my head ( ) Yes ( ) No
6. My pain wakes me up during the night ( ) Yes ( ) No
7. Changes in the weather affect my pain ( ) Yes ( ) No
8. I have neck stiffness ( ) Yes ( ) No
9. I have headaches ( ) Yes ( ) No
10. If I do get headaches, they occur: ( ) sometimes ( ) all of the time

OTHER PAIN:

Please describe any current medical complaints which you are experiencing and were not previously covered on this questionnaire, or list any additional comments you wish to make regarding your condition:

_____

_____

_____

_____

JOB DESCRIPTION:

(In terms of an 8-hour workday, "occasionally" means 33%, "frequently" means 34% to 66%, and "continuously" means 67% to 100% of the day).

1. In a typical 8-hour workday, I: (Circle # of hours / activity)

Sit:	1	2	3	4	5	6	7	8	hours
Stand:	1	2	3	4	5	6	7	8	hours
Walk:	1	2	3	4	5	6	7	8	hours

2. On the job, I perform the following activities:

	NOT AT ALL	OCCASIONALLY	FREQUENTLY	CONTINUOUSLY
Bend / stoop	( )	( )	( )	( )
Squat	( )	( )	( )	( )
Crawl	( )	( )	( )	( )
Climb	( )	( )	( )	( )
Reach above shoulder level	( )	( )	( )	( )
Crouch	( )	( )	( )	( )
Kneel	( )	( )	( )	( )
Balancing	( )	( )	( )	( )
Pushing / Pulling	( )	( )	( )	( )

3. On the job, I lift:

	NOT AT ALL	OCCASIONALLY	FREQUENTLY	CONTINUOUSLY
Up to 10 pounds	( )	( )	( )	( )
11 to 24 pounds	( )	( )	( )	( )
25 to 34 pounds	( )	( )	( )	( )
35 to 50 pounds	( )	( )	( )	( )
51 to 74 pounds	( )	( )	( )	( )
75 to 100 pounds	( )	( )	( )	( )

4. Do you have to bend over while doing any lifting? ( ) Yes ( ) No

5. Are your feet used for repetitive movements, such as in operating foot controls? ( ) Yes ( ) No

6. Do you use your hands for repetitive actions, such as:

	SIMPLE GRASPING	FIRM GRASPING	FINE MANIPULATING
Right hand	( ) Yes ( ) No	( ) Yes ( ) No	( ) Yes ( ) No
Left hand	( ) Yes ( ) No	( ) Yes ( ) No	( ) Yes ( ) No

7. Are you required to work on unprotected heights? ( ) Yes ( ) No

Describe: _____

_____

_____

8. Are you required to be around moving machinery? ( ) Yes ( ) No

Describe: _____

_____

_____

9. Are you exposed to marked changes in temperature and humidity? ( ) Yes ( ) No

Describe: _____

_____

_____

10. Are you required to drive automotive equipment? ( ) Yes ( ) No

Describe: _____

_____

_____

11. Are you exposed to dust, fumes and/or gases? ( ) Yes ( ) No

Describe: _____

_____

_____

12. Please list any additional comments: _____

_____

_____

Signature: _____ Date: _____