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State of New York – Workers' Compensation

Please answer all questions completely. Failure to do so may delay the payment of necessary treatment and/or prevent the timely payment of wage loss benefits. You may be responsible for provider fees in the event your claim is denied for insurance carrier non-covered services.

A. Patient's Information

1. Name: _____ (First MI Last) 2. Social Security #: _____

3. Phone #: (____) _____ Cell # _____ 4. WCB Case # (If Known): _____ 5. Carrier Case # _____

6. Mailing Address: _____ (Number and Street City State Zip Code)

7. Date of Injury/onset of illness: __/__/__ 8. Date of Birth: __/__/__ 9. Gender ☐ Male ☐ Female

10. On the Date of injury/illness what was you job title or description: _____

11. On the Date of injury/illness what were your usual work activities: _____

12. How did you hear about WNY Chiropractic? (circle) Staff Ph. Bk. Screen/Health Fair Web Location Ad **OR**

Referred By: _____ (Name & Relationship)

B. Employer Information

1. Employer when injury occurred: _____ 2. Employer's Phone #: (____) _____

3. Employer's Address: _____ (Number and Street City State Zip Code)

C. Billing Information

1. Employer's insurance carrier: _____ 2. Carrier Code#: **W** _____

3. Insurance carrier's address: _____ (Number and Street City State Zip Code)

4. Insurance Carrier contact and phone number: _____ (Name Phone Number Extension)

D. History

1. Where and how did the injury/illness happen?: _____

2. Did another health provider treat this injury/illness including hospitalization and/or surgery? ☐ Yes ☐ No If yes, give details:

3. Was this injury/illness reported to your employer? ☐ Yes ☐ No Who?; _____

E. Work Status

1. Have you missed work because of the injury/illness? Yes No

If yes, Date first missed: __/__/__ Date resumed: __/__/__

2. Are you currently working: ☐ Yes ☐ No If yes, did you return to: ☐ usual work activities ☐ Limited work activities

SIGNATURE_____ **DATE**_____

F. After the Injury

1. Did the accident render you unconscious? ☐ Yes ☐ No If yes, For how long? _____

2. Were X-Rays taken? ☐ Yes ☐ No If yes, at what facility/hospital? _____

3. Was medication prescribed? ☐ Yes ☐ No If yes, list: _____

4. Indicate the symptoms that are a result of this accident:

☐	Dizziness	☐	Difficulty Sleeping	☐	Jaw Problems	☐	Nausea
☐	Memory Loss	☐	Irritability	☐	Arm/Shoulder Pain	☐	Back Pain
☐	Headaches	☐	Fatigue	☐	Numb Hands/Fingers	☐	Lower Back Pain
☐	Blurred Vision	☐	Tension	☐	Chest Pain	☐	Back Stiffness
☐	Buzzing in ear	☐	Neck Pain	☐	Stomach Upset	☐	Numbness/Tingling
☐	Stiffness	☐	Swelling	☐	Weakness	☐	Other:

5. Is your condition ☐ Getting Worse ☐ Constant ☐ Comes & Goes

6. Indicate your degree of comfort while performing the following activities:

	Comfortable	Uncomfortable	Painful
Lying on back			
Lying on side			
Lying on stomach			
Sitting			
Standing			
Stretching			
Walking			
Running			
Sports			
Working			
Lifting			
Bending			
Kneeling			
Pulling			
Reaching			

7. Have you retained an attorney? ☐ Yes ☐ No If yes, whom: _____ Phone #: _____

G. Recovery

1. How many hours are in your normal work day? _____

2. Please indicate your daily job duties and any activities which you are occasionally asked to perform:

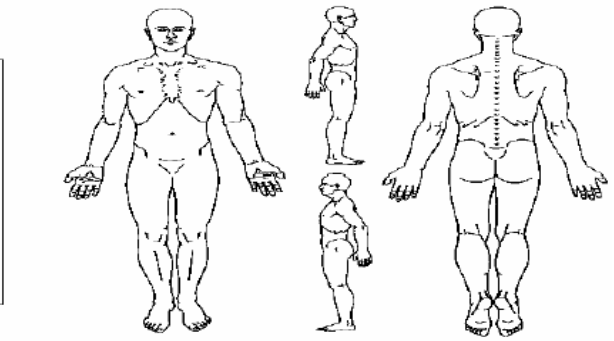
- ☐ Standing
- ☐ Sitting
- ☐ Walking
- ☐ Lifting
- ☐ Other: _____
- ☐ Driving
- ☐ Twisting
- ☐ Crawling
- ☐ Bending
- ☐ Operating equipment
- ☐ Working with arms above head
- ☐ Typing
- ☐ Stooping

3. Do you work with others who can help you with any heavy lifting? ☐ Yes ☐ No

4. While in recovery, is there any light duty work you could request? ☐ Yes ☐ No

5. My Pain Level right now: **No Pain** ⓪ ① ② ③ ④ ⑤ ⑥ ⑦ ⑧ ⑨ ⑩ **Worst Possible**

A = ACHE
B = BURNING
N = NUMBNESS
P = PINS & NEEDLES
S = STABBING
O = OTHER_____



On the diagram, please indicate where, and what type of symptoms that you are experiencing, right now. Write the appropriate abbreviations (See next to diagram) over the area of the body where those symptoms are occurring.

SIGNATURE_____ **DATE**_____

Please check any of the following symptoms which you now have or have had previously.
THIS IS A CONFIDENTIAL HEALTH REPORT.

ALLERGIES

- ☐ Environmental _____
- ☐ Food _____
- ☐ Medications_____
- ☐ Other _____

Gastro-Intestinal

- ☐ Abdominal Pain
- ☐ Black Stool
- ☐ Bloody Stool
- ☐ Constipation
- ☐ Diarrhea
- ☐ Gall Bladder
- ☐ Hemorrhoids
- ☐ Liver Trouble
- ☐ Nausea
- ☐ Poor Appetite
- ☐ Vomiting Blood
- ☐ Vomiting Food
- ☐ Excessive Weight loss

Genito-Urinary System

- ☐ Bladder Trouble
- ☐ Burning
- ☐ Cloudy Urine
- ☐ Discharge
- ☐ Discolored Urine
- ☐ Dribbling
- ☐ Excessive Urination
- ☐ Impotence
- ☐ Painful Urination
- ☐ Scanty Urination

Eyes

- ☐ Blurred Vision
- ☐ Burning Eyes
- ☐ Cataracts
- ☐ Dryness
- ☐ Glasses
- ☐ Glaucomas
- ☐ Itchy Eyes
- ☐ Tearing
- ☐ Vision Headaches

Respiratory System

- ☐Congestion
- ☐Coughing up Blood
- ☐Difficulty Breathing
- ☐Inhalent Exposure
- ☐Non Productive Cough
- ☐Phlegm
- ☐Productive Cough
- ☐Short of Breath
- ☐Wheezing

Cardiovascular

- ☐ Chest Pain
- ☐ Coughing Blood
- ☐ Coughing Phlegm
- ☐ Difficulty Breathing
- ☐ Heart Problem
- ☐ High Blood Pressure
- ☐ Low Blood Pressure
- ☐ Lung Problem
- ☐ Pain over heart
- ☐ Persistent cough
- ☐ Rapid Heart Beat
- ☐ Varicose Veins

Ear, Nose, Throat

- ☐ Bleeding gums
- ☐ Dental Problems
- ☐ Deviated Septum
- ☐ Dry Mouth
- ☐ Ear Discharge
- ☐ Ear Noises
- ☐ Ear Pain
- ☐ Eye Inflammation
- ☐ Eye Strain
- ☐ Hearing Loss
- ☐ Hoarseness
- ☐ Nose Bleeding
- ☐ Nasal Discharge
- ☐ Recurrent infections
- ☐ Sore Gums
- ☐ Sore Throat
- ☐ Throat Pain
- ☐ Ulcers

Nervous System

- ☐ Confusion
- ☐ Convulsions
- ☐ Depression
- ☐ Dizziness
- ☐ Fainting
- ☐ Hand Trembling
- ☐ Headaches
- ☐ Loss of Feeling
- ☐ Loss of Balance
- ☐ Loss of Memory
- ☐ Numbness
- ☐ Paralysis
- ☐ Seizures
- ☐ Tingling
- ☐ Weak grip

OSWESTRY DISABILITY INDEX

Name:_____ Age:_____ Date:_____ Raw Score:_____

Please complete this questionnaire by circling ***one*** answer in each section. It is designed to give us information as to how your back (or leg) trouble has affected your ability to manage in everyday life.

SECTION 1 – Pain Intensity A. I have no pain at the moment. B. The pain is very mild at the moment. C. The pain is moderate at the moment. D. The pain is fairly severe at the moment. E. The pain is very severe at the moment. F. The pain is the worst imaginable at the moment.	**SECTION 6 –Standing** A. I can stand as long as I want without extra pain. B. I can stand as long as I want but it gives me extra pain. C. Pain prevents me from standing for more than one hour. D. Pain prevents me from standing for more than half an hour. E. Pain prevents me from standing for more than ten minutes. F. Pain prevents me from standing at all.
SECTION 2 – Personal Care A. I can look after myself normally without causing extra pain. B. I can look after myself normally but it is painful. C. It is painful to look after myself and I am slow and careful. D. I need some help but manage most of my personal care. E. I need help every day in most aspects of self care. F. I do not get dressed, wash with difficulty and stay in bed.	**SECTION 7 – Sleeping** A. My sleep is never disturbed by pain. B. My sleep is occasionally disturbed by pain. C. Because of pain I have less than 6 hours sleep. D. Because of pain I have less than 4 hours sleep. E. Because of pain I have less than 2 hours sleep. F. Pain prevents me from sleeping at all.
SECTION 3 – Lifting A. I can lift heavy weights without extra pain. B. I can lift heavy weights but it gives extra pain C. Pain prevents me from lifting heavy weights off the floor but I can manage if they are conveniently positioned, e.g., on a table. D. Pain prevents me from lifting heavy weights but I can manage light to medium weights if they are conveniently positioned. E. I can lift only very light weights. F. I cannot lift or carry anything at all.	**SECTION 8 – Social Life** A. My social life is normal and gives me no extra pain. B. My social life is normal but increases the degree of pain. C. Pain has no significant effect on my social life apart from limiting my more energetic interests, e.g. dancing, etc. D. Pain has restricted my social life and I do not go out as often. E. Pain has restricted social life to my home. F. I have no social life because of pain.
SECTION 4 –Walking A. Pain does not prevent me walking any distance. B. Pain prevents me walking more than one mile. C. Pain prevents me walking more than a quarter of a mile. D. Pain prevents me from walking more than 100 yards. E. I can only walk using a stick or crutches. F. I am in bed most of the time and have to crawl to the toilet.	**SECTION 9 – Traveling** A. I can travel anywhere without pain. B. I can travel anywhere but it gives extra pain. C. Pain is bad but I manage journeys over two hours. D. Pain restricts me to journeys of less than one hour. E. Pain restricts me to journeys of less than 30 minutes. F. Pain prevents me from traveling except to receive treatment.
SECTION 5 –Sitting A. I can sit in any chair as long as I like. B. I can sit in my favorite chair as long as I like. C. Pain prevents me from sitting for more than one hour. D. Pain prevents me from sitting for more than half an hour. E. Pain prevents me from sitting for more than ten minutes. F. Pain prevents me from sitting at all.	**SECTION 10 – Changing Degree of Pain** A. My pain is rapidly getting better. B. My pain fluctuates, but overall is definitely getting better. C. My pain seems to be getting better, but improvement is slow at present. D. My pain is neither getting better nor worse. E. My pain is gradually worsening. F. My pain is rapidly worsening.

Patient Signature_____ Date_____

NECK DISABILITY INDEX QUESTIONNAIRE

Please Read: This questionnaire is designed to enable us to understand how much your neck pain has affected your ability to manage everyday activities. Please answer each section by circling the **ONE CHOICE** that most applies to you. We realize that you may feel that more than one statement may related to you, but ***PLEASE JUST CIRCLE THE ONE CHOICE THAT MOST CLOSELY DESCRIBES YOUR PROBLEM RIGHT NOW.***

SECTION 1--Pain Intensity
A. I have no pain at the moment
B. The pain is mild at the moment.
C. The pain comes and goes and is moderate.
D. The pain is moderate and does not vary much.
E. The pain is severe but comes and goes.
F. The pain is severe and does not vary much.

SECTION 2--Personal Care (Washing, Dressing, etc.)
A. I can look after myself without causing extra pain.
B. I can look after myself normally but it causes extra pain.
C. It is painful to look after myself and I am slow and careful.
D. I need some help, but manage most of my personal care.
E. I need help every day in most aspects of self-care.
F. I do not get dressed; I wash with difficulty and stay in bed.

SECTION 3--Lifting
A. I can lift heavy weights without extra pain.
B. I can lift heavy weights, but it causes extra pain.
C. Pain prevents me from lifting heavy weights off the floor but I can if they are conveniently positioned, for example on a table.
D. Pain prevents me from lifting heavy weights, but I can manage light to medium weights if they are conveniently positioned.
E. I can lift very light weights.
F. I cannot lift or carry anything at all.

SECTION 4 --Reading
A. I can read as much as I want to with no pain in my neck.
B. I can read as much as I want with slight pain in my neck.
C. I can read as much as I want with moderate pain in my neck.
D. I cannot read as much as I want because of moderate pain in my neck.
E. I cannot read as much as I want because of severe pain in my neck.
F. I cannot read at all.

SECTION 5--Headache
A. I have no headaches at all.
B. I have slight headaches which come infrequently.
C. I have moderate headaches which come infrequently.
D. I have moderate headaches which come frequently.
E. I have severe headaches which come frequently.
F. I have headaches almost all the time.

SECTION 6 -- Concentration
A. I can concentrate fully when I want to with no difficulty.
B. I can concentrate fully when I want to with slight difficulty.
C. I have a fair degree of difficulty in concentrating when I want to.
D. I have a lot of difficulty in concentrating when I want to.
E. I have a great deal of difficulty in concentrating when I want to.
F. I cannot concentrate at all.

SECTION 7--Work
A. I can do as much work as I want to.
B. I can only do my usual work, but no more.
C. I can do most of my usual work, but no more.
D. I cannot do my usual work.
E. I can hardly do any work at all.
F. I cannot do any work at all.

SECTION 8--Driving
A. I can drive my car without neck pain.
B. I can drive my car as long as I want with slight pain in my neck.
C. I can drive my car as long as I want with moderate pain in my neck.
D. I cannot drive my car as long as I want because of moderate pain in my neck.
E. I can hardly drive my car at all because of severe pain in my neck.
F. I cannot drive my car at all.

SECTION 9--Sleeping
A. I have no trouble sleeping
B. My sleep is slightly disturbed (less than 1 hour sleepless).
C. My sleep is mildly disturbed (1-2 hours sleepless).
D. My sleep is moderately disturbed (2-3 hours sleepless).
E. My sleep is greatly disturbed (3-5 hours sleepless).
F. My sleep is completely disturbed (5-7 hours sleepless).

SECTION 10--Recreation
A. I am able engage in all recreational activities with no pain in my neck at all.
B. I am able engage in all recreational activities with some pain in my neck.
C. I am able engage in most, but not all recreational activities because of pain in my neck.
D. I am able engage in a few of my usual recreational activities because of pain in my neck.
E. I can hardly do any recreational activities because of pain in my neck.
F. I cannot do any recreational activities all.

SIGNATURE:_____

DATE:_____

DISABILITY INDEX SCORE:_____

NOTICE THAT YOU MAY BE RESPONSIBLE FOR MEDICAL COSTS IN THE EVENT OF FAILURE TO PROSECUTE, OR IF COMPENSATION CLAIM IS DISALLOWED, OR IF AGREEMENT PURSUANT TO WCL §32 IS APPROVED

WCB CASE NO. (If Known)	CARRIER CASE NO. (If Known)	DATE OF INJURY	NATURE OF INJURY OR ILLNESS	INJURED PERSON'S SOC. SEC. NO.

CLAIMANT	NAME	ADDRESS	APT. NO.
EMPLOYER			
INSURANCE CARRIER			

You may become responsible for the medical costs of treatment for your illness or condition with the provider listed below if (1) you fail to prosecute the claim for workers' compensation or (2) it is determined by the Workers' Compensation Board that the illness or condition which required treatment was not a result of a compensable workplace accident or occupational disease or (3) if an agreement is executed by you and approved pursuant to Workers' Compensation Law §32 in which you waive your right to medical benefits from the workers' compensation carrier/self-insured employer for treatment/ services performed after the date the agreement is approved. If any of the above events occurs, the provider may bill you directly instead of the employer or insurance carrier, and you will be responsible for the provider's fees for services rendered.

I hereby acknowledge that I have read the above and understand the circumstances under which I may become responsible for payment.

Claimant's Signature_____ Date _____

Provider's Name and Address _____

_____

TO THE CLAIMANT

Workers' Compensation Board Regulation 325-1.23 permits your doctor or therapist to request that you sign this A-9 notice. By signing this notice, you acknowledge your obligation to pay the provider's fees for the services you receive if it turns out that such fees are not legally required to be paid by your employer or its workers' compensation insurance carrier and if such fees are not covered by other insurance. The employer or carrier may not be required to pay the doctor's fees if, for example, you fail to file a claim for workers' compensation, or fail to notify your employer of your injury or illness, or fail to attend a Board hearing if your employer challenges your right to benefits. Even if you make all required efforts to prosecute your claim, the Workers' Compensation Board may still find that you are not entitled to benefits. In such cases, this notice advises your health provider that you acknowledge your personal liability for payment of his/her bills.

Workers' Compensation Law Section 32

The A-9 notice also covers instances in which a claimant with an existing valid workers' compensation case comes to an agreement with his/her employer or its insurance carrier settling his/her case in accordance with Section 32 of the Workers' Compensation Law. A Section 32 agreement may include a provision which relieves the employer or carrier of the liability to pay future medical bills associated with the case. Your health care provider may ask you to sign this A-9 notice to insure that you acknowledge your personal liability for payment of his/her bills if you have waived your right to future medical benefits under a Section 32 agreement.

If you have any questions, contact your attorney or licensed hearing representative, if you have one. You may also contact your local district office of the Workers' Compensation Board.

TO THE HEALTH CARE PROVIDER

This notice is meant to advise the workers' compensation claimant that he/she may be responsible for payment. Failure of the claimant to sign this form does not relieve the provider of the obligation to treat the claimant, nor does it negate the claimant's responsibility for payment.

Keep the original of this form for your records and give a copy to the claimant. **Do not file with the Workers' Compensation Board.** You will receive Notices of Decisions in which the compensability of a claim, authorization of treatment, or payment of medical bills is included. You will also be notified if the claimant submits a Section 32 Agreement with the Board for approval. Do not bill the claimant unless and until you receive a Board decision finding that 1) claimant failed to prosecute the claim, or 2) the claim is denied, or 3) the treatment is not causally related to the work injury, or 4) a Section 32 agreement relieving the carrier of liability for medical treatment is approved.