WORKER'S COMPENSATION INTAKE FORM

Greenway Chiropractic Clinic
Dr. R. W. Breitenstein
8070 S.W. Hall Blvd. Suite 100
Beaverton, Oregon 97008

CONFIDENTIAL PATIENT INFORMATION

Name:_____ Today's Date: _____/_____/_____

Address:_____ City:_____State:_____Zip:_____

Age:_____D.O.B. _____Gender:_____ Marital Status:_____# of Children: _____

Home Phone: _____ Cell Phone:_____

Occupation: _____ Employer:_____

Work Phone:_____ Social Sec. #: _____-_____-_____

Referred by: _____

Worker's Compensation Information

Insurance Company: _____ Status: _____

Date of Injury: _____ Adjustor Name: _____

Attorney Name: _____ Accepted Condition:_____

Description of Accident:

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

Treatment since the accident:

Did you seek treatment the same day/next day after the accident? [ ] Yes [ ] No

If yes, where did you go? [ ] Home [ ] Work [ ] Hospital ER [ ] Urgent Care
Other_____

If yes, how did you get there? [ ] Drove self [ ] Friend/Family [ ] Ambulance

If yes, did your treatment include: [ ] Medication [ ] X-Rays [ ] Brace [ ] Work loss

List any other doctors you have seen and any benefits you've received from treatment:

_____

_____

Prior History:

[ ] I did NOT have prior symptoms similar to my current complaints.
[ ] My current symptoms ALREADY existed, but have not bothered me since.
[ ] My current symptoms ALREADY existed and were worsened by the accident.

If you experienced similar symptoms, when was the most recent occurrence?
_____ Months _____Years (or) on ___/___/___

Check off current symptoms:

[ ] Headache
[ ] Neck pain
[ ] Neck stiffness
[ ] Arm pain / symptoms
[ ] Mid-back pain
[ ] Low-back pain
[ ] Leg pain/symptoms
[ ] Pain behind eyes
[ ] Cold hands
[ ] Cold feet
[ ] Loss of smell
[ ] Loss of taste
[ ] Toe numbness
[ ] Chest pain
[ ] Ringing in ears
[ ] Shortness of breath
[ ] Dizziness
[ ] Diarrhea
[ ] Nausea
[ ] Fatigue
[ ] Sleeping problems
[ ] Irritability
[ ] Fainting
[ ] Tension
[ ] Nervousness
[ ] Confusion
[ ] Constipation
[ ] Depression
[ ] Anxiety

Other: _____

_____

_____

Patient Signature:_____ **Date:**_____

Chiropractic Registration and History

Patient Information

Date _____

SS/HIC/Patient ID # _____

Patient Name _____
Last Name

_____
First Name Middle Initial

Address _____

City _____

State _____ Zip _____

E-mail _____

Sex ☐ M ☐ F Age _____

Birthdate _____

☐ Married ☐ Widowed ☐ Single ☐ Minor

☐ Separated ☐ Divorced ☐ Partnered for _____ years

Occupation _____

Patient Employer/School _____

Employer/School Address _____

_____

Employer/School Phone (_____) _____

Spouse's Name _____

Birthdate _____

SS# _____

Spouse's Employer _____

Whom may we thank for referring you? _____

Insurance

Who is responsible for this account? _____

Relationship to Patient _____

Insurance Co. _____

Group # _____

Is patient covered by additional insurance? ☐ Yes ☐ No

Subscriber's Name _____

Birthdate _____ SS# _____

Relationship to Patient _____

Insurance Co. _____

Group # _____

ASSIGNMENT AND RELEASE

I certify that I, and/or my dependent(s), have insurance coverage with

_____ and assign directly to
Name of Insurance Company(ies)

Dr. _____ all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I authorize the use of my signature on all insurance submissions.

The above-named doctor may use my health care information and may disclose such information to the above-named Insurance Company(ies) and their agents for the purpose of obtaining payment for services and determining insurance benefits or the benefits payable for related services. This consent will end when my current treatment plan is completed or one year from the date signed below.

_____
Signature of Patient, Parent, Guardian or Personal Representative

_____
Please print name of Patient, Parent, Guardian or Personal Representative

_____ _____
Date Relationship to Patient

Phone Numbers

Home Phone (_____) _____ Cell Phone (_____) _____

Best time and place to reach you _____

IN CASE OF EMERGENCY, CONTACT

Name _____ Relationship _____

Home Phone (_____) _____ Work Phone (_____) _____

Accident Information

Is condition due to an accident? ☐ Yes ☐ No Date _____

Type of accident ☐ Auto ☐ Work ☐ Home ☐ Other

To whom have you made a report of your accident?
☐ Auto Insurance ☐ Employer ☐ Worker Comp. ☐ Other

Attorney Name (if applicable) _____

Patient Condition

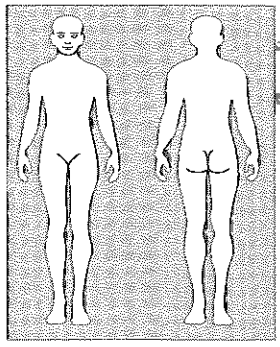
Reason for Visit _____

When did your symptoms appear? _____

Is this condition getting progressively worse? ☐ Yes ☐ No ☐ Unknown

Mark an X on the picture where you continue to have pain, numbness, or tingling.

Rate the severity of your pain on a scale from 1 (least pain) to 10 (severe pain) _____



Type of pain: ☐ Sharp ☐ Dull ☐ Throbbing ☐ Numbness ☐ Aching ☐ Shooting
☐ Burning ☐ Tingling ☐ Cramps ☐ Stiffness ☐ Swelling ☐ Other

How often do you have this pain? _____

Is it constant or does it come and go? _____

Does it interfere with your ☐ Work ☐ Sleep ☐ Daily Routine ☐ Recreation

Activities or movements that are painful to perform ☐ Sitting ☐ Standing ☐ Walking ☐ Bending ☐ Lying Down

Consent for Purposes of Treatment, Payment and Health Care Operations

I consent to the use or disclosure of my protected health information by **Greenway Chiropractic Clinic** for the purpose of diagnosis or providing treatment to me, obtaining payment for my health care bills or to conduct health care operations of **Greenway Chiropractic Clinic.**

I understand that diagnosis or treatment of me by **Greenway Chiropractic Clinic** may be conditioned upon my consent as evidenced by my signature on this document.

I understand I have the right to request a restriction as to how my protected health information is used or disclosed to carry out treatment, payment or health care operations of the practice. **Greenway Chiropratic Clinic** is not required to agree to the restrictions that I may request. However, if **Greenway Chiropractic Clinic** agrees to a restriction that I request, the restriction is binding on **Greenway Chiropractic Clinic** and **R. W. Breitenstein, D. C.**

I have the right to revoke this consent, in writing, at any time, except to the extent that **Greenway Chiropractic Clinic or R. W. Breitenstein, D. C.** has taken action in reliance on this consent.

My "protected health information" means health information, including my demographic information, collected from me and created or received by my physician, another health care provider, a health plan, my employer or health care clearinghouse. This protected health information releates to my past, present or future physical or mental health or condition and identifies me, or there is a reasonable basis to believe the inofrmation may identify me.

I understand I have a right to review **Greenway Chiropractic Clinic's** Notice of Privacy Practices prior to signing this document.

The **Greenway Chiropractic Clinic's** Notice of Privacy Practices has been provided to me.

The Notice of Privacy Practices for **Greenway Chiropractic Clinic** is also provided at 8070 S.W. Hall Blvd. Suite 100, Beaverton, Oregon.

This Notice of Privacy Practices also describes my rights and the duties of **Dr. R. W. Breitenstein, D. C.** with respect to my protected health information.

Greenway Chiropractic Clinic reserves the right to change the privacy practices that are described in the Notice of Privacy Practices.

I may obtain a revised notice of privacy practices by calling the office of **Greenway Chiropractic Clinic** and requesting a revised copy be sent in the mail or asking for one at the time of my next appointment.

_____ _____

Signature of Patient or Personal Representative | Description of Personal Representative's Authority

_____

Printed Name of Patient or Personal Representative

_____

Date

Website Membership Enrollment

The information on our website will help you

Get Well and Stay Well.

Please provide the following details so we can establish you as a member of our website today:

First name: _____

Last name: _____

Date of birth: _____ / _____ / _____

Email address: _____

Please check the health subjects that most interest you:

- ❑ Headaches and Neck Pain
- ❑ Backaches and Sciatica
- ❑ Children's Health Issues
- ❑ Women's Health Issues
- ❑ Wellness Topics
- ❑ Diet and Nutrition
- ❑ Exercise and Fitness
- ❑ Stress Management

By joining our website, you authorize us to send occasional health care related emails to you. Naturally, you may opt-out at any time. Please review our complete privacy policy on our website.

Lifecycle:	
Chiropractor:	