Workman's Compensation

Name: _____ Sex: _____

Phone Number: _____ Age: _____

Address (Street/City/State/Zip) _____

Name of Employer: _____ Phone: _____

Address of Employer (Street/City/State/Zip) _____

Date and time of accident?: _____

Where were you taken after the accident?: _____

Where did you feel pain?: _____

What are your symptom?: _____

Name of any other doctors who consulted you since your accident: _____

Treatment received?: _____

How often did you receive care from another doctor?: _____

Did you miss any work?: _____ Date returned to work: _____

Are your work activities restricted as a result of the accident?: _____

Have you previously been injured in a similar manner?: _____

If so, when?: _____

Do you have to favor any part of your body in employment?: _____

History of absenteeism caused from accidents on the job?: _____

Were you capable of working on an equal basis with others your age before your accident?: _____

What is your occupation?: _____

Length of present occupation: _____

Since the injury are your symptoms: Improving _____ Getting worse _____ Same _____

Have you retained an attorney?: _____

If so, His/Her name and phone: _____

Please explain fully how your accident happened (use reverse side if necessary): _____

_____

_____

_____

_____

FAMILY HISTORY: Please place an X in the appropriate square if applicable.

	Allergy	Asthma	Alcohol Abuse	Arthritis	Gout	Bleeding Disorder	Cancer	Diabetes	Epilepsy	Glaucoma	Heart Disease	High Blood Pressure	Kidney Disease	Psychiatric Problems	Spine or Back Disorder	Stroke	Tuberculosis	Other
Maternal Grandmother																		
Maternal Grandfather																		
Mother																		
Paternal Grandmother																		
Paternal Grandfather																		
Father																		
Brothers and Sisters																		
Spouse																		
Children																		

Are you currently experiencing or in the past have experienced: (Please mark all that apply)

	Currently	**Past**
Back pain or stiffness	☐	☐
Neck pain or stiffness	☐	☐
Shoulder pain	☐	☐
Hip pain	☐	☐
Foot pain or trouble	☐	☐
Swollen or painful joint	☐	☐
Cold hands or feet	☐	☐
Numbness or pain in the arms, hands, or fingers	☐	☐
Numbness or pain in the legs, feet, or toes	☐	☐

MALES ONLY: Do you have

☐ Changes in urine stream ☐ Prostate trouble Date of last prostate exam: _____

☐ Lumps in testicles ☐ Sex concerns

FEMALES ONLY: Do you have

☐ Menstrual problems ☐ Vaginal discharge ☐ Tubal infections

☐ Abnormal bleeding ☐ Sex concerns ☐ Breast lumps or pain

☐ Problems getting pregnant

Age periods began: _____ Number of pregnancies: _____

Number of miscarriages or abortions: _____ Number of Cesarean sections: _____

Date of last gynecological exam: _____ Are you currently or possibly pregnant?: _____

Patient Name: _____ Date: _____

Do you currently or in the past have:
(Please mark all that apply)

	Currently	Past
Weight gain or loss	☐	☐
Unusual fatigue	☐	☐
Sleep problems	☐	☐
Disabled	☐	☐
Nervous tension	☐	☐
Depression	☐	☐
Irritability	☐	☐
Mood swings/changes	☐	☐

	Currently	Past
Asthma	☐	☐
Eczema	☐	☐
Hay fever	☐	☐
Sinus Problems	☐	☐
Diabetes	☐	☐
High cholesterol or triglycerides	☐	☐
Thyroid trouble	☐	☐
Gall bladder trouble	☐	☐
Liver trouble	☐	☐
Anemia	☐	☐
Bleeding trouble	☐	☐

	Currently	Past
High blood pressure	☐	☐
Low blood pressure	☐	☐
Chest pain	☐	☐
Racing, pounding heart	☐	☐
Ankle swelling	☐	☐
Shortness of breath	☐	☐
Lung or breathing problems	☐	☐
Chronic cough	☐	☐
Pneumonia	☐	☐
Stroke	☐	☐
Heart disease or murmur	☐	☐

Patient Name: _____

Date: _____

Do you currently or in the past have:
(Please mark all that apply)

	Currently	Past
Growing moles or lumps	☐	☐
Other skin problems	☐	☐
Wear glasses or contacts	☐	☐
Glaucoma	☐	☐
Light bothers eyes	☐	☐
Other eye problems	☐	☐

Date of last eye exam: _____

	Currently	Past
Hearing difficulties	☐	☐
Ringing in ears	☐	☐
Dizziness	☐	☐
Sinus infections	☐	☐
Motion sickness	☐	☐
Dental problems	☐	☐

Date of last dental exam: _____

	Currently	Past
More frequent urination	☐	☐
Pain or blood with urination	☐	☐
Leaking urine	☐	☐
Urinating at night	☐	☐
Kidney or bladder infection	☐	☐
Kidney stones	☐	☐
Recurrent abdominal pain	☐	☐
Ulcers	☐	☐
Vomiting blood	☐	☐
Bloody or black stools	☐	☐
Heartburn	☐	☐
Change in appetite	☐	☐
Swallowing problems	☐	☐
Hernia	☐	☐
Hemorrhoids	☐	☐
Polyps	☐	☐
Loss of smell	☐	☐

	Currently	Past
Arthritis or gout	☐	☐
Bursitis	☐	☐
Fractured bones	☐	☐
Headaches	☐	☐
Seizures	☐	☐
Tremor	☐	☐
Passing out	☐	☐
Speech problems	☐	☐
Weakness or paralysis	☐	☐
Coordination problems	☐	☐
Memory loss	☐	☐
Trouble concentrating	☐	☐
Diarrhea or constipation	☐	☐
Varicose veins	☐	☐

TESTS: Please list the most recent date.

Chest X-ray _____
Tuberculosis _____
EKG _____
Tetanus Shot _____

Other X-rays (Please explain)
_____
_____
_____

HABITS:	YES	NO	If yes, please explain
Tobacco Use	☐	☐	
Alcohol Consumption	☐	☐	
Coffee or Tea Consumption	☐	☐	
Other Drug Use	☐	☐	
Exercise	☐	☐	

MEDICINES: Please list all currently used medicines. Include prescription and non-prescription drugs, vitamins, and herbs.

_____
_____
_____
_____

ALLERGIES: Please list all known allergies.

_____
_____
_____
_____

HOSPITALIZATIONS, OPERATION, AND INJURIES: Include auto and on-the-job accidents.

Cause and Type	Year

SERIOUS ILLNESSES: List current and past illnesses not mentioned above (including cancer, diabetes, etc.)

_____
_____
_____
_____
_____

Are you presently receiving:	☐ Medical Care	☐Chiropractic Care	☐ Other Therapy
Are your current complaints related to:	☐ Auto Accident	☐ Work-related Accident	☐ Other Accident
Are you:	☐ Right Handed	☐ Left Handed	☐ Ambidextrous

Patient Name: _____ Date: _____

Notice of Doctor's Lien

Patient's Name: _____

Healthcare Provider: Release Chiropractic and Wellness Center
640 East Eisenhower Blvd. Suite 100
Loveland, CO 80537
Phone: 970-667-3393 Fax: 970-203-9690

I hereby authorize the above-mentioned healthcare provider to furnish the below-mentioned attorney with a full report of his/her examination, diagnosis, treatments records, etc., of myself in regard to the accident in which I was involved.

I hereby further authorize and direct you, my attorney to pay directly to said healthcare provider such sums as may be due and owing the office for professional services rendered me both by reason of this accident and by reason of any other bills that are due to the office and to withhold such sums from any settlement, judgment or verdict as may be necessary to adequately protect said healthcare provider. I hereby further give a lien on my case to said healthcare provider against any and all proceeds of any settlement, judgment or verdict which may be paid to you, my attorney, or myself as the result of the injuries for which I have been treated or injuries in connection therewith.

I fully understand that I am directly and fully responsible to said healthcare provider for all professional bills submitted by him/her for services rendered me and that this agreement is solely for said healthcare provider's additional protection and in consideration of his/her awaiting payment. Further, I understand that such payment is not contingent on any settlement, judgment or verdict by which I may eventually recover said fee.

_____
Name

_____ _____
Signature Date

(Patient, please do not write below this line.)
****

The undersigned being attorney of record for the above patient does hereby agree to observe all the terms of the above and agrees to withhold such sums from any settlement, judgment or verdict as may be necessary to adequately protect the said healthcare provider named above.

Attorney Name: _____

Attorney Address: _____

_____

Date: _____ Attorney's Signature: _____

Please return to: Release Chiropractic and Wellness Center
640 East Eisenhower Blvd. Suite 100
Loveland, CO 80537
Phone: 970-667-3393 Fax: 970-203-9690

Please maintain a copy for your records.

Release Chiropractic HIPAA Acknowledgement

Patient Acknowledgment and Receipt of Notice of Privacy Practices Pursuant to HIPAA and Consent for Use of Health Information

Patient Name: _____

Date of Birth: _____

The undersigned does hereby acknowledge that he or she has received a copy of this office's Notice of Privacy Practices Pursuant to HIPAA and has been advised that a full copy of this office's HIPAA Compliance Manual is available upon request.

The undersign does hereby consent to the use of his or her health information in a manner consistent with the Notice of Privacy Practices Pursuant to HIPAA, the HIPAA Compliance Manual, State Law, and Federal Law.

Date: _____

By: _____
Patient's Signature

If patient is a minor or under a guardianship order as defined by State law:

By: _____
Signature of Parent/Guardian (circle one)