## Worker's Compensation Questionnaire

*Please answer all the questions as completely as possible.*

Dear Patient: This information is considered confidential. If we do not sincerely believe your condition will respond satisfactorily to treatment, we will not accept your case. In order for us to understand your condition properly, please be as neat and accurate while completing this form. Thank you.

Name: _____ Home Phone: _____ SS#: _____
Address: _____ Apt. #: _____ City: _____ State: _____ Zip: _____
Date of birth: _____ ☐ Male ☐ Female
☐ Single ☐ Widowed ☐ Divorced ☐ Married; if yes, does spouse work? _____
Occupation when injured: _____
Date of injury: _____ Time of injury: _____ AM/PM
Employer's Name: _____ Employer's Phone Number: _____
Employer's Address: _____ City: _____ State: _____ Zip: _____
Employer's Insurance Company: _____ Policy #: _____
Mailing Address: _____ City: _____ State: _____ Zip: _____
Please explain in detail how your accident happened: _____

_____

_____

Did you report the injury to your foreman or employer? _____ Did he/she recommend care at our clinic? _____
List the extent of the injuries as you know them: _____

_____

Did you continue work after the accident? _____
Before the injury, were you capable of working on an equal basis with others your age? _____
Have you lost any days/hours of work? _____ If yes, how long/what dates? _____
Since this injury, are your symptoms: ☐ improving? ☐ getting worse? ☐ the same?
Did you consult any other doctor(s)? ☐ Yes ☐ No
If so, give doctor's name: _____ D.C., M.D., D.O., D.D.S.
Doctor's diagnosis: _____
What treatments did you receive? _____
How often did you see the doctor? _____
Have you been using any remedies? _____ If so, what and were they effective? _____

_____

Have you ever been injured in this area before? ☐ No ☐ Yes, and when? _____
If injured before, did you lose time from work? ☐ No ☐ Yes, how long? _____
If you lost time from work with injuries, give name of doctor(s) you consulted: _____

_____

Have you ever been involved in any other type of accident, fall, or had a broken bone, etc? Please give a brief description _____

_____

Do you have any other diseases or accidents that affect your employment? ☐ No ☐ Yes If so, explain: ____

_____

In your work, do you favor any part of your body? ☐ No ☐ Yes If so, explain: _____

_____

Have you ever had a Worker's Compensation claim before? ☐ No ☐ Yes
Have you been contacted by an insurance adjuster or company representative regarding this claim? ☐ Yes ☐ No
Name of your insurance adjuster: _____
Have you retained an attorney? ☐ Yes ☐ No Litigation? ☐ Yes ☐ No ☐ Maybe
If so, name and address: _____

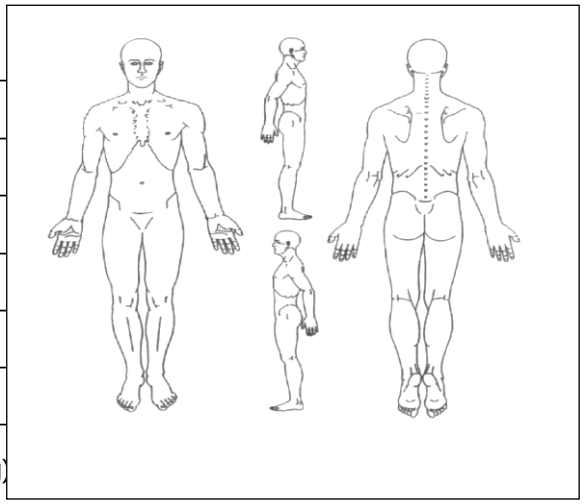
**CHECK ANY OF THE FOLLOWING SYMPTOMS YOU HAVE NOTICED SINCE THE CRASH/ACCIDENT:**

| | | | |
|---|---|---|---|
| ☐ Headache | ☐ Middle Back Pain | ☐ Lower Back Pain | ☐ *Ears Ring* |
| ☐ Neck Pain | ☐ Chest Pain | ☐ Lower Back Stiffness | ☐ *Buzzing in Ears* |
| ☐ Neck Stiffness | ☐ Bruised Chest | ☐ Radiating Pain | ☐ *Dizziness* |
| ☐ Sleeping Problems | ☐ Bruising Anywhere | ☐ Tingling in Legs | ☐ Loss of Smell |
| ☐ *Depression* | ☐ *Blurred Vision* | ☐ Tingling in Arms | ☐ Loss of Taste |
| ☐ *Anxiety* | ☐ Sensitivity to Light | ☐ Jaw Pain | ☐ *Any Burns* |
| ☐ *Fainting* | ☐ Upper Arm Pain | ☐ Upper Leg Pain | ☐ *Any Stitches* |
| ☐ Muscle Spasms | ☐ Lower Arm Pain | ☐ Lower Leg Pain | ☐ *Any Cuts* |

☐ Other Symptoms: _____

**Current Symptoms / last 30 days**: Rate the severity of your pain on a scale from **1 (least pain) to 10 (severe pain**)

(mark symptoms on body in box)



1._____ Pain Level _____

2._____ Pain Level _____

3._____ Pain Level _____

4._____ Pain Level _____

When did your symptoms begin? _____

In general what makes your symptoms better? _____

In general what makes your symptoms worse? _____

In general how would you describe your pain? (ache, burn, dull, sharp, throbbing)

Are your symptoms interfering with any daily activities? _____

Are symptoms; ☐Constant >76% ☐Frequent 51-75% ☐Occasional 26-50% ☐Intermittent <25% **of your waking hours**

**Have you lost time from work?** ☐ Yes ☐ No: If Yes, Dates: _____ to _____

**HIPAA Compliance**

Our office is required by law to maintain the HIPAA Notice of Privacy Practices. This notice explains our legal duties and privacy practices with respect to your protected health information. Signature below acknowledges that I have read this Notice of our Privacy Practices. A copy will be provided to me upon request.

Patient Signature:_____ Date:_____

**I give Active Family Chiropractic & Acupuncture permission to release the following:**

☐ Medical Information ☐ Account Information ☐ Both

To _____, _____

(name of person) (relationship to patient)

_____ _____

Signature Date

## Wellness Evaluation

Please check all that apply to you:

**Sub-Clinical Symptoms Including:**

- ☐ Headaches
- ☐ Migraines

**Hormonal Imbalance Including:**

- ☐ PMS
- ☐ Emotional Imbalance

**Gastrointestinal Issues Including:**

- ☐ Abdominal bloating, cramps, or painful gas
- ☐ Irritable Bowel Syndrome
- ☐ Ulcerative Colitis and Crohn's Disease

**Respiratory Conditions Including:**

- ☐ Chronic sinusitis
- ☐ Asthma
- ☐ Allergies

**Joint Conditions Including:**

- ☐ Knee, shoulder, or spine

**Autoimmune Conditions Including:**

- ☐ Diabetes
- ☐ Lupus
- ☐ Rheumatoid Arthritis
- ☐ Fibromyalgia
- ☐ Chronic Fatigue

**Thyroid Conditions Including:**

- ☐ Hashimoto's
- ☐ Hypothyroidism
- ☐ Hyperthyroidism

**Developmental Concerns Including:**

- ☐ Autism
- ☐ ADD/ADHD

**Skin Conditions Including:**

- ☐ Eczema
- ☐ Skin rashes
- ☐ Hives

Circle the number that most closely fits, then add up your results:

*0 - None; 1 - Mild; 2 - Moderate; 3 - Severe*

| | | | | | |
|---|---|---|---|---|---|
| Constipation and/or diarrhea | 0 1 2 3 | | Asthma, hay fever, or allergies | 0 1 2 3 | |
| Abdominal pain or bloating | 0 1 2 3 | | Confusion or poor memory | 0 1 2 3 | |
| Mucous or blood in stool | 0 1 2 3 | | PMS or mood swings | 0 1 2 3 | |
| Joint pain or swelling, arthritis | 0 1 2 3 | | Use of NSAIDS (Aspirin, Tylenol) | 0 1 2 3 | |
| Chronic fatigue or tiredness | 0 1 2 3 | | History of antibiotic use | 0 1 2 3 | |
| Food allergies or sensitivities | 0 1 2 3 | | Alcohol makes you feel sick | 0 1 2 3 | |
| Sinus or nasal congestion | 0 1 2 3 | | Gluten sensitivity or Celiac Disease | 0 1 2 3 | |
| Chronic or frequent inflammation | 0 1 2 3 | | Nausea | 0 1 2 3 | |
| Eczema, skin rashes, or hives | 0 1 2 3 | | Weight Issues | 0 1 2 3 | |

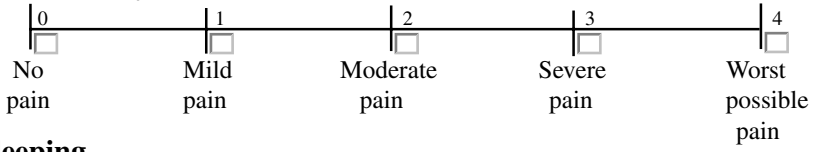
Your Total: _____

# Functional Rating Index

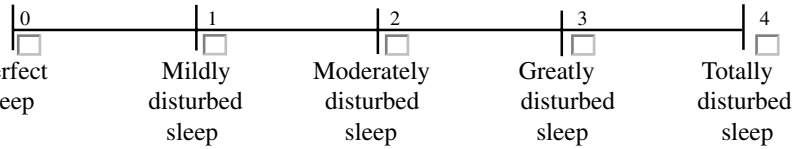
For use with **Neck and/or Back Problems** only.

In order to properly assess your condition, we must understand how much your **neck and/or back problems** have affected your ability to manage everyday activities.
For each item below, **please circle the number which most closely describes your condition right now.**

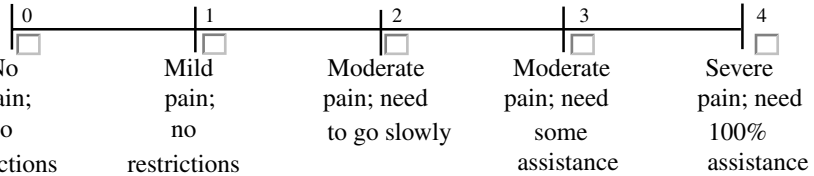
**1. Pain Intensity**



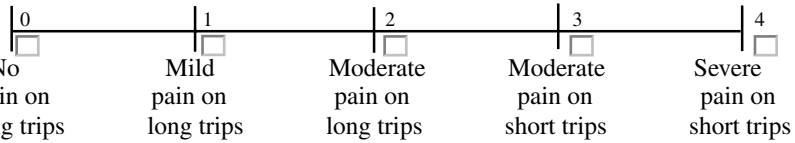

**2. Sleeping**



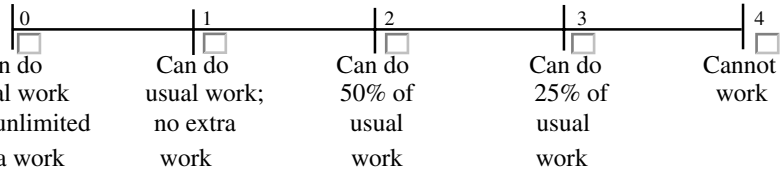

**3. Personal Care (washing, dressing, etc.)**



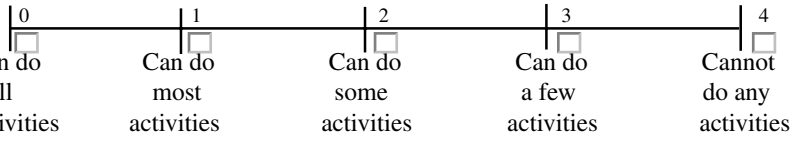

**4. Travel (driving, etc.)**



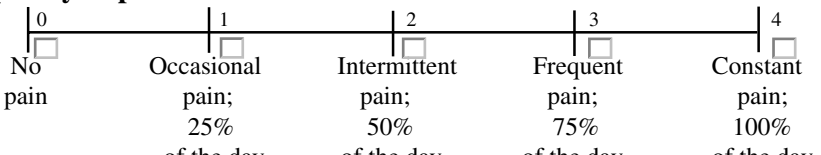

**5. Work**



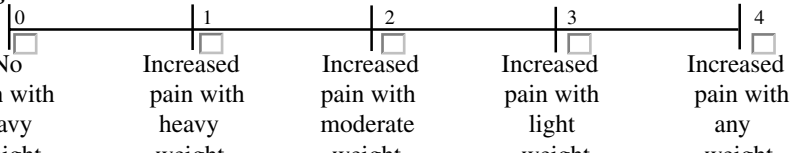

**6. Recreation**



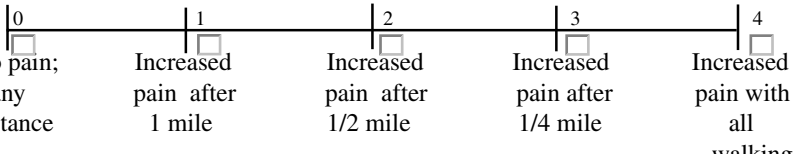

**7. Frequency of pain**



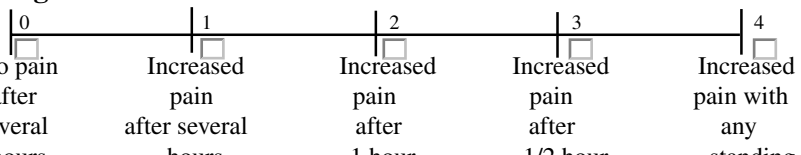

**8. Lifting**




**9. Walking**




**10. Standing**




**Name** _____
**PRINTED**

**Total Score** _____

_____
**Signature**

_____
**Date**

ACTIVE FAMILY
Chiropractic & Acupuncture

# Consent to Chiropractic and/or Acupuncture Services

1. I request and consent to the performance of the following procedures: initial consultation, examination, x-rays, chiropractic adjustments, and chiropractic modalities on me (or the patient named below, for whom I am legally responsible for: (_____) by the chiropractic physician and/or anyone working in this office authorized by the chiropractic physician.
2. I also consent to the performance of other diagnostic and therapeutic procedures in addition to or different from those stated above, whether or not arising from presently unknown conditions, that the chiropractic physician, associates, or assistants may consider necessary or advisable in the course of my healthcare.
3. The nature and purpose of the procedures, possible alternatives, the risks involved, the possible consequences and the possibility of complications have been explained to my satisfaction by the chiropractic physician, associate, or assistants.
4. Acknowledge that no guarantee or assurance of the results that may be obtained from the procedure has been given by the above chiropractic physician, associate, or assistant.

**To be Completed by the patient:**

_____

Print Patient's Name

_____

Signature of Patient

_____

Date

**To be Completed by the patient's representative and or guardian, if necessary, (eg: if the patient is a minor or is physically or mentally incapacitated):**

_____

Print Name of Patient

_____

Name of Representative

_____

Signature of Representative

_____

Date

## Consent to Text Messaging Communication:

I authorize Active Family Chiropractic & Acupuncture to send text message appointment reminders to me on my provided cell phone number. I understand that I may reply with various commands to receive account information such as balances, future appointments, office location and other alerts. By accepting these terms, I agree that all individuals associated with my account may receive alerts referencing the account holder and/or dependents. Text message charges from my cell phone provider may apply.

_____ _____ _____

Patient Name Signature Date

ACTIVE FAMILY
Chiropractic & Acupuncture

**FINANCIAL POLICY**

Our recommendations are based on a desire to see you get well and stay well. Chiropractic care is covered under many insurance plans. Most of our patients that have health or accident insurance will fall under one of the plans discussed in this policy. Regardless of your coverage, we will suggest the chiropractic care that we think you need. We ask that you read and understand our policy as it applies to your situation.

**BLUE PRINT**

Payment is due at the time of service for Blue Print programs. Patients that pay in full with an existing payment method will receive a 10% discount. Financing options available however, due to the provider fees there will not be a 10% discount applied to programs that are financed. The following services are non-refundable: professional fees, opened products, services that are already rendered, and payment processing fees. I acknowledge that Blue Print services will not be submitted to my health insurance and understand the office refund policy.

**PATIENTS WITHOUT INSURANCE**

Payment is due at the time of service for all services. Self pay patients will be given a time of service discount of 20%. I acknowledge that I do not have &/or did not provide health insurance to AFCA. Patient Initials_____

**GROUP AND INDIVIDUAL INSURANCE**

Your insurance is an agreement between you and your insurance company. When possible we will call to verify your benefits on your insurance; however the benefits quoted to us by your insurance company are not guarantee of payment. As a courtesy to you as our valued patient we will submit the necessary insurance forms at no extra charge. <u>It is to be understood and agreed that all services rendered are charged directly to you and you are personally responsible for any non-covered services, deductibles, co-pays, and coinsurance. If services that you received are denied for any reason you are financially responsible. This includes, but is not limited to, services deemed not medically necessary.</u>

**MEDICARE**

We do accept Medicare in our office as a form of insurance. Medicare will pay for your chiropractic adjustment as long as they deem the service medically necessary. All Medicare patients are responsible to present secondary insurance information so that we can file that on your behalf. Medicare patients are also responsible for any deductible and/or coinsurance that are not covered by insurance. Medicare will not pay for exams, X-rays, therapy, or acupuncture.

**MEDICAID**

We accept Medicaid insurance in our office. Medicaid will pay for 1 set of x-rays per year, medically necessary adjustments & pre-approved therapies. Medicaid does not have coverage for extremity adjustments or acupuncture. Do you have a health plan primary to Medicaid? Y or N Patient Initials_____ If your claims are denied as needing primary information, you will be responsible for payment.

**PERSONAL INJURY**

We will submit all claims to the appropriate insurance company. If you have BCBS, we are required to submit claims to BCBS, as well as your auto insurance. Any payment received by BCBS will be refunded upon subrogation settlement, and any benefits used will be reversed. If you do not wish to have claims sent to BCBS, you may sign a waiver. It is to be understood and agreed that you are personally responsible for all charges for all services rendered. If services you receive are denied for any reason, you are financially responsible. If you do not have a Medical Payments claim opened through your auto insurance, you will be responsible for payment at the time of service and should be reimbursed by a Third Party at the time of Settlement.

**WORKER'S COMPENSATION**

We will submit all claims to your employer's worker's compensation insurance. It is to be understood and agreed that you are personally responsible for all charges for all services rendered. If services you receive are denied for any reason, you are financially responsible.

**ASSIGNMENT OF BENEFITS**

I have read and understand the financial policy of Active Family Chiropractic and Acupuncture. I understand that my insurance is an agreement between myself and the insurance company, NOT between Active Family Chiropractic and Acupuncture and my insurance company. I request that Active Family Chiropractic and Acupuncture prepare the customary forms, at no charge, so that I may obtain insurance benefits. I authorize the release of medical or other information necessary to process my claims and authorize payment of medical benefits to be paid directly to Active Family Chiropractic and Acupuncture.I understand that if insurance does not pay within 60 days, fees will be due and payable immediately.

I understand that payment is due at the time of service and have brought the following form of payment with me today. _____ Cash _____ Check _____ Credit/Debit card

Patient Initials_____

_____ _____ _____

Printed Name Signature Date