WORKERS' COMPENSATION PATIENT HISTORY

Name______________________________ Date______________

Address ______________ City ______________ State ________ Zip ________

Home#(_____)______________ Work#(_____)______________ Cell (_____)______________

Age _____ Birth date __________ Sex _____ Marriage Status: M S W D No. Children ____ SS#_____-_____-______

Occupation ______________ Employer ______________ Yrs. Employed _____

Employer'sAddress______________ City______________ Zip________ Spouse's Name______________

How did you hear about us? ______________ E-mail Address(monthly newsletter)______________

IN CASE OF EMERGENCY: (Name of relative or close friend not living in your home)

Name ______________ Address ______________ Phone ______________

Do you have any group, union or personal health and accident insurance? YES ☐ NO ☐ Policy # ______________

Name of Insurance Company ______________ Phone # ______________

Address ______________ Insured ______________

HISTORY OF OCCURRENCE

Employer's business name (at time of accident) ______________

Employer's phone ______________ Employer's address ______________

City ______________ State ________ Zip ________

Employer's workers' compensation insurance company ______________ Address ______________

______________ Phone ______________

Date of injury: ______________ Time of injury: __________ ☐ AM ☐ PM Last date worked: ______________

What were you doing at the time you were injured? How did the accident/injury happen (lifting, bending, walking, carrying, standing, etc.)? ______________

____

When did pain begin? ______________ **Where** in your body did you first feel it? ______________

Was pain intense at first, or did you feel pain that gradually worsened?______________

Describe the environmental conditions which may have contributed to your present injury: Darkness, faulty equipment, slippery floor, limited space. (Distinguish natural hazards from hazards created by other employees such as housekeepers):

____

FIRST DOCTOR/HOSPITAL SEEN

Were you hospitalized as a result of this accident? ☐ YES ☐ NO

If yes, where? ______________

DOCTOR 1: Name ______________ Date of first visit: ______________

Were your examined? ☐ YES ☐ NO Were X-rays taken? ☐ YES ☐ NO Did you receive treatment? ☐ YES ☐ NO

If yes, what kind of treatment did you receive? ______________

What benefits did you receive from the treatment? ______________

Date of last treatment: ______________

SECOND DOCTOR/CLINIC SEEN

DOCTOR 2: Name ______________ Date of first visit: ______________

Were your examined? ☐ YES ☐ NO Were X-rays taken? ☐ YES ☐ NO Did you receive treatment? ☐ YES ☐ NO

If yes, what kind of treatment did you receive? ______________

What benefits did you receive from the treatment? ______________

Date of last treatment:

THIRD DOCTOR/CLINIC SEEN

DOCTOR 3: Name ____________________ Date of first visit: ____________________

Were you examined? ☐ Yes ☐ No Were X-rays taken? ☐ Yes ☐ No

Did you receive treatment? ☐ Yes ☐ No

If yes, what kind of treatment did you receive? ____________________

What benefits did you receive from the treatment? ____________________

Date of last treatment: ____________________

REPORT ACCIDENT TO/ACCIDENT WITNESS

What date did you report this injury? ____________________

Whom did you report this to? ____________________

What is their position? ____________________

Was there a witness to your injury? ☐ Yes ☐ No

If yes, what was their name? ____________________

What is their position? ____________________

PRIOR SIMILAR SYMPTOMS

Did you have any physical complaints **just before this accident?** ☐ Yes ☐ No

If yes, please describe in detail: ____________________

Have you ever had any **prior** injuries, accidents, diseases, or treatment to the area of your body now affected? ☐ Yes ☐ No

If yes, state what part of your body was **previously** injured: ____________________

Date hurt: ____________________ Describe the injury: ____________________

____

____

Were you treated? ☐ Yes ☐ No

If yes, who treated you? ____________________

What date did treatment begin? ____________________ and end: ____________________

When was the last time you felt pain or problems from that injury? ____________________

WORK STATUS HISTORY

Have you lost any time from work as a result of this new injury? ☐ Yes ☐ No

If yes give dates: ____________________

If you are currently on **disability (time loss)** do you want to go back to work doing your **regular** work duties? ☐ Yes ☐ No

If no, state why: ____________________

Have you gone back to work? ☐ Yes ☐ No

If yes, what status of work? ☐ Modified ☐ Regular When ____________________

Please list what restrictions you have been placed on: ____________________

____

If you have gone back to **work,** please list the activities as:

Those that are painful: ____________________

Those that are difficult: ____________________

Are there any problems you have with a fellow employee, supervisor, or management that need to be discussed? ☐ Yes ☐ No

If yes, please discuss: ____________________

____

____

ACTIVITIES OF DAILY LIVING

Do you find any activities that you perform at **home painful** or **difficult?** ☐ Yes ☐ No

If yes, those **home** activities that you are **unable** to do *(be specific)*: ____________________

____

Those **home** activities that are **painful** are *(be specific)*: ____________________

____

Those **home** activities that are **difficult** are *(be specific)*: ____________________

____

Are you performing exercises at **home** at this time? ☐ Yes ☐ No

If yes, what exercises are they? ____________________

How frequently do you perform them? ____________________

Who prescribed these exercises to you? ____________________

What exercises or activities could you do before the work-related injury that you no longer do because of pain or loss of function?

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PAIN LEVEL/SCALE OF RECOVERY

On a scale of 0–10, with 0 being (examiner's quote), *"You're pain free and can function quite well,"* and 10 being, *"You're in pain all the time and cannot function at all,"* where would you rate yourself?

NORMAL	LOW PAIN	MODERATE PAIN	INTENSE PAIN	EMERGENCY
0	1 2 3	4 5 6	7 8 9	10

Please explain why: ____________________

____

Relative to where you were before this injury, how would you rate how much you have recovered so far? ________%

Do you have an attorney on this case? ☐ Yes ☐ No

If yes, who? Name ____________________

Address ____________________ City ____________________ State __________ Zip __________

FAMILY HEALTH HISTORY

Many health problems are hereditary in nature and may be handed down generation after generation.

Patient ______________________________ DATE ______________________________

Please review the below-listed diseases and conditions and indicate those that are current health problems of a family member. Leave blank those spaces that do not apply. If you require more space, use the reverse side of this form. Circle your answers if your relative lives around this locality, as some hereditary conditions are affected by similar climate.

CONDITION	FATHER Age [ ]	MOTHER Age [ ]	SPOUSE Age [ ]	BROTHER(S) Age [ ]	BROTHER(S) Age [ ]	SISTER(S) Age [ ]	SISTER(S) Age [ ]	CHILDREN Age [ ]	CHILDREN Age [ ]	CHILDREN Age [ ]
Arthritis										
Asthma - Hay Fever										
Back Trouble										
Bursitis										
Cancer										
Constipation										
Diabetes										
Disc Problem										
Emphysema										
Epilepsy										
Headaches										
Heart Trouble										
High Blood Pressure										
Insomnia										
Kidney Trouble										
Liver Trouble										
Migraine										
Nervousness										
Neuritis										
Neuralgia										
Pinched Nerve										
Scoliosis										
Sinus Trouble										
Stomach Trouble										
Other:										

If any of the above family members are deceased, please list their age at death and cause: ______________________________

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AUTHORIZATION TO RELEASE MEDICAL INFORMATION

This authorization or photocopy hereof, will authorize Caring Chiropractic Center,P.A. to release any medical information necessary to process my insurance claim(s) with regards to my condition while under their observation or treatment. They are authorized to provide this information in accordance with an injury protection endorsement of a policy with ____________________ .
(company)

Signature ______________________________ Date _________________ Witness ________________________

REQUEST FOR PAYMENT OF BENEFITS TO PROVIDE CARE

I hereby authorize the _________________Insurance Company/Insurance Administrators to pay by check made out and mailed directly to: Caring Chiropractic Center, P.A., 2996 111th Ave NW, Coon Rapids, MN 55433 for the expense benefits allowable, and otherwise payable to me under my current policy, as payment toward the total charges for professional services rendered, and I have agreed to pay, in a current manner any balance of said professional charges, I agree that this office be given power of attorney to endorse/sign my name on any and all drafts for payment of my bill.

Patient's Signature: ____________________________ Date: ____________ Witness ______________________

DOCTOR'S LIEN

TO: Attorney/Insurance Carrier

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Kenneth H. Ruf, D.C.
Caring Chiropractic Center, P.A.
2996 111th Ave NW
Coon Rapids, MN 55433

I do hereby authorize Kenneth H. Ruf, D.C. to furnish you, my attorney/insurance carrier, with a full report of his case history, examination, diagnosis, treatment, and prognosis of myself in regard to my accident/illness which occurred/began on ______________________.

I hereby give a lien to said doctor on any settlement, claim, judgment, or verdict as a result of said accident/illness, and authorize and direct you, my attorney/insurance carrier, to pay directly to said doctor such sums as may be due and owing him for service rendered me, and to withhold such sums from such settlement, claim, judgment, or verdict as may be necessary to protect said doctor adequately.

I fully understand that I am directly and fully responsible to said doctor for all chiropractic bills submitted by him for service rendered me, and that this agreement is made solely for said doctor's additional protection and in consideration of his awaiting payment. And I further understand that such payment is not contingent on any settlement, claim, judgment, or verdict by which I may eventually recover said fee.

Dated: ____________________ Patient's signature: _______________________________

The undersigned, being attorney of record or authorized representative of insurance carrier for the above patient does hereby acknowledge receipt of the above lien, and does agree to honor the same to protect adequately said above named doctor.

Dated _____________________ Authorized signature: ______________________________

NOTICE: Please date, sign, and return one copy to doctor's office at once.