DRAEGER
CHIROPRACTIC & LASER CENTER

2114 Schofield Ave. Weston, WI 54476

Patient Worker's Compensation History

Today's Date: _____

Patient Personal Information

Name:	
Address:	Home Phone:
City/State/Zip:	Cell Phone:
Date of Birth:	Email:
Driver's License#:	Emergency Contact Name:
Social Security Number:	Emergency Contact Phone:

Social Health History

Status: ☐ Male ☐ Female ☐ Single ☐ Married ☐ Other:_____ ☐ Student: ☐ Full-Time ☐ Part-Time

Recreational Activities (Hobbies):_____

☐ Yes ☐ No Do You Commute to Work? How Far? _____

☐ Yes ☐ No Do You Exercise? Times Per _____

☐ Yes ☐ No Are You a Smoker? Packs Per Day? _____

☐ Yes ☐ No Do You Consume Caffeine? How Much Per Day?_____

☐ Yes ☐ No Do You Consume Alcohol? Glasses Per Day / Week? _____

Spouse's Name:_____ Spouse's Employer: _____

Names / Ages of Children at Home:_____ Spouse's DOB:_____

Who is Your Medical Doctor?_____ Medical Doctor City / State:_____

Patient Employer Information

Employer Name:	Employer Phone:
Employer Address:	Date of Injury
Employer City/State/Zip:	Time of Injury:
Patient's Occupation:	Last Day Worked:
What date did you report the injury?	Who did you report it to?
Did anyone observe the injury? ☐ Yes ☐ No If yes, who?	What is his/her position?
Insurance Carrier:	Claim Number:
Adjuster Name:	Adjuster Phone Number:

What were you doing at the time you were injured?

How did the accident/injury happen? (lifting, bending, walking, carrying, standing, etc.)

When did the pain begin?	Where did you first feel the pain?

Was the pain intense at first or did it gradually worsen?

Length of time at this job prior to injury:	Previous workers compensation injury? Date:

Mechanism of Injury

Please explain the mechanism of the injury (only fill in those sections that apply to you)

Fall

☐ Yes ☐ No Did you hit anything when you fell? If yes, what?

☐ Yes ☐ No Were you carrying anything when you fell? If yes, what?

How much did the object weigh approximately?

☐ Yes ☐ No Did you twist when you fell? If yes, which side? ☐ Left ☐ Right

☐ Yes ☐ No Did it land on you? If yes, where?

☐ Yes ☐ No Was the area well lit?

Describe the condition of the area (slippery, graveled, etc.)

What part of the body did you fall on?

How far did you fall? (feet)

What did you land on?

Lift/Pull

☐ Yes ☐ No Did you fall after the injury? If yes, how far?

☐ Yes ☐ No Did you hit anything when you fell? What?

☐ Yes ☐ No Were you twisting when you were lifting/pulling? If yes, which side? ☐ Left ☐ Right

☐ Yes ☐ No Did you drop the object when the pain started?

☐ Yes ☐ No Did it land on you? Where?

How much did the object weigh?

How far off the ground did you have the object before the pain started?

Did you lift with your ☐ Legs ☐ Back ☐ Other

Bend

☐ Yes ☐ No Were you lifting when you were bent over? If yes, how much did the object weigh?

☐ Yes ☐ No Did you fall when the pain started? How far?

☐ Yes ☐ No Were you twisting when you bent forward? If yes, which side? ☐ Left ☐ Right

☐ Yes ☐ No Did you land on anything? If so, what?

How far were you bent over?

Work Status History

☐ Yes ☐ No Have you lost time from work as a result of this injury? If yes, give dates:

☐ Yes ☐ No Have you gone back to work? When?

If yes, did you go back: ☐ Modified Duty ☐ Regular Duty

If modified please list restrictions:

If you have gone back to regular duty please list any activities that you find painful or difficult:

☐ Yes ☐ No If you are currently on disability, do you want to go back to work doing your regular job? If no, why not?

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

If yes, please explain.

☐ Yes ☐ No Did you seek medical help immediately after the accident? If yes, how did you get there?

☐ Someone drove you ☐ You drove ☐ Police ☐ Ambulance

Where did you go?

☐ Yes ☐ No Were you examined?

☐ Yes ☐ No Were x-rays taken?

☐ Yes ☐ No Were you given treatment? If so, what type?

Did you receive any benefit from this treatment?

Date of your last treatment?

☐ Yes ☐ No Did the doctor refer you to another health professional? If so, to who and for what?

☐ Yes ☐ No Did you follow the doctor's recommendations? If no, why not?

Second Doctor/Clinic

Doctor/Clinic: Date of first visit:

☐ Yes ☐ No Were you examined?

☐ Yes ☐ No Were x-rays taken?

☐ Yes ☐ No Were you given treatment? If yes, what type?

What benefits did you receive from this treatment?

Date of last treatment?

Prior Similar Symptoms

☐ Yes ☐ No Did you have any physical complaints just before the accident? If yes, please describe in detail:

☐ Yes ☐ No Have you ever had any prior injuries, accidents, diseases or treatment to the area of your body now affected?
If yes, what part was previously injured?

Date hurt: Describe injury:

☐ Yes ☐ No Were you treated? If yes, by whom?
Date treatment began: Date treatment ended:
The last date you felt pain or problems from that injury:

Symptoms

Indicate your ability to perform the following activities. Please use these codes:

U – Unable L – Limited P – Painful D – Difficult N – Normal H – Haven't tried

	Lying on back		Gripping		Pushing		Turning over in bed
	Lying on side		Climbing		Kneeling		Standing 1 hr+
	Bending forward		Pulling		Stooping		Walking short distances
	Getting in/out car		Dressing self		Sitting at table		Cough/Sneeze
	Sleeping		Sexual Activity		Reaching		Lying flat on stomach
	Balancing	Other activities:					

Please describe how you felt. Please be specific.

Immediately after the injury:

Later that date:

The next day(s):

Check symptoms that have become apparent since the accident/injury:

	Nervousness		Loss of balance		Sleeping trouble		Headache
	Neck pain/stiffness		Loss of smell		Toe numbness		Fainting
	Mid back pain		Loss of taste		Finger numbness		Anxiety
	Low back pain		Loss of memory		Cold hands		Seizures
	Eye sensitivity		Pins/needles arms		Cold feet		Visual changes
	Pain behind eyes		Pins/needles legs		Chest pain		Forgetfulness
	Dizziness		Short of breath		Constipation		Blurred vision
	Cold sweats		Head being heavy		Diarrhea		Double vision
	Face flushed		Irritability		Fatigue		Confused
	Ringing in ears		Depression		Tension		Disoriented

☐ Yes ☐ No Does the pain interfere with your sleep? If so, how many times per night?

☐ Yes ☐ No Does heat affect the pain? If so, how?

☐ Yes ☐ No Does cold affect the pain? If so, how?

☐ Yes ☐ No Do you wear a heel lift? If so, which side?

☐ Yes ☐ No Did you have any physical complications just before the injury? If yes, please describe in detail:

☐ Yes ☐ No Prior to this injury, have you ever had similar symptoms? If yes, please explain.

☐ Yes ☐ No Have you had any injuries prior to this one? If yes, when? Where?

How was it treated?

Results of treatment.

☐ Yes ☐ No Do you have any congenital (birth) factors which relate to this problem? If yes, please describe:

Have you had any problems with the following areas? Mark Y if yes – Mark N if no

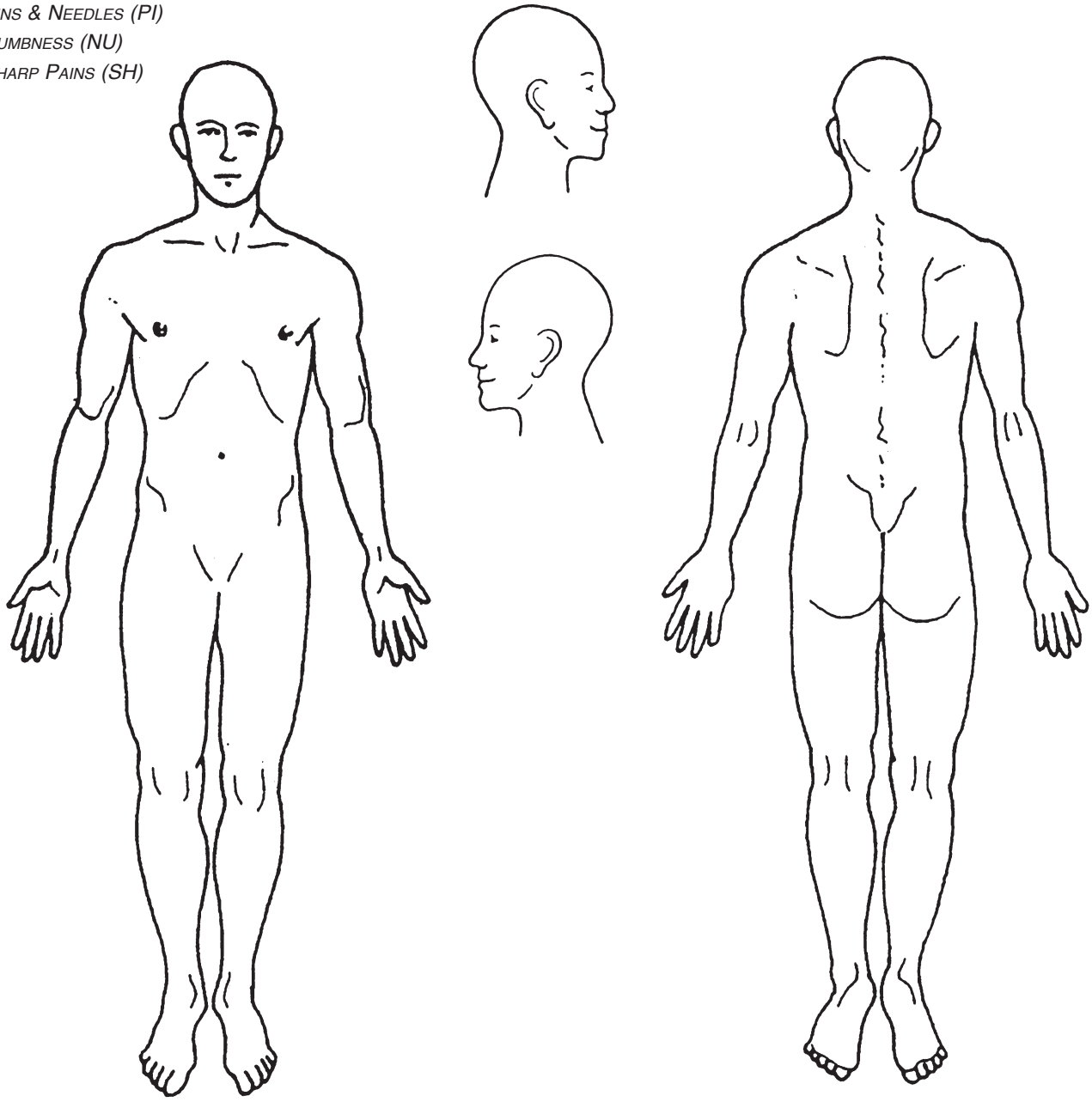
	Eyes		Urinary		Internal Organs		Ears, nose, mouth
	Muscles		Blood		Heart		Nerves
	Allergies		Lungs/breathing		Skin		Other
	Intestines		Psychological				

Additional Comments:

Chief Complaint

Be sure to fill out this section as accurately as possible. Mark the area with the described sensation. Use the appropriate symbols. If there is more than one area of discomfort, please rate the pain on a scale of 0 to 100 next to each are, with 0 being no pain and 100 being intolerable pain.

XXX Burning (BU)
(((Aching Pain (AC)
000 Pins & Needles (PI)
- - - Numbness (NU)
: : : Sharp Pains (SH)



0 5 10 15 20 25 30 35 40 45 50 55 60 65 70 75 80 85 90 95 100

NO PAIN — PAIN SCALE: — INTOLERABLE

What Makes the Condition Better?

Head Neck _____
Mid Back _____
Low Back _____
Shoulder, Arm, Hand _____
Hip, Leg, Foot _____
Other _____

What Makes the Condition Worse?

Head Neck _____
Mid Back _____
Low Back _____
Shoulder, Arm, Hand _____
Hip, Leg, Foot _____
Other _____

Job Description

In terms of an 8-hour workday, "occasionally" means 33%, "frequently" means 34% to 66%, and "continuously" means 67% to 100% of the day.

In a typical 8-hour workday, I (circle the number of hours of activity):

Sit:	1	2	3	4	5	6	7	8	*hours*
Stand:	1	2	3	4	5	6	7	8	*hours*
Walk:	1	2	3	4	5	6	7	8	*hours*

On the job, I perform the following activities:

	Not at all	*Occasionally*	*Frequently*	*Continuously*
Bend/stoop	☐	☐	☐	☐
Squat	☐	☐	☐	☐
Crawl	☐	☐	☐	☐
Climb	☐	☐	☐	☐
Reach above	☐	☐	☐	☐
Shoulder level	☐	☐	☐	☐
Crouch	☐	☐	☐	☐
Kneel	☐	☐	☐	☐
Balancing	☐	☐	☐	☐
Pulling/Pushing	☐	☐	☐	☐

On the job, I lift:	*Not at all*	*Occasionally*	*Frequently*	*Continuously*
Up to 10 pounds	☐	☐	☐	☐
11 to 24 pounds	☐	☐	☐	☐
25 to 34 pounds	☐	☐	☐	☐
35 to 50 pounds	☐	☐	☐	☐
51 to 74 pounds	☐	☐	☐	☐
57 to 100 pounds	☐	☐	☐	☐

☐ *Yes* ☐ *No* *Are you required to work at unprotected heights? If yes, describe:* _____

_____

☐ *Yes* ☐ *No* *Are you required to be around moving machinery? If yes, describe:* _____

_____

☐ *Yes* ☐ *No* *Are you exposed to marked changes in temperature and humidity? If yes, describe:* _____

_____

☐ *Yes* ☐ *No* *Are you required to drive automotive equipment? If yes, describe:* _____

_____

☐ *Yes* ☐ *No* *Are you exposed to dust, fumes, and/or gases? If yes, describe:* _____

_____

Please list any additional comments: _____

_____

_____

My signature is an acknowledgement that all of the above statements are true. I hereby authorize the doctor to examine and treat my condition as he/she deems appropriate through the use of chiropractic health care, and I give authority for these procedures to be performed. I also give permission for my case to be used for research purposes if it is so approved.

patient signature: _____ *Date:* _____

guardian/legal representative signature: _____ *Date:* _____

d.c./c.a. signature: _____ *Date:* _____

Informed Consent

Chiropractic, as well as other types of health care, is associated with potential risks in the delivery of treatment. Therefor it is necessary to inform the patient of such risks prior to initiating care. While Chiropractic treatment is remarkably safe, you need to be informed about the potential risks related to your care to allow you to be full informed in consenting to treatment.

Chiropractic offices use trained staff personnel to assist with portions of your consultation, examination, x-rays, physical therapy applications, exercise instruction, etc. Occasionally, when your Chiropractor is unavailable, another qualified Doctor of Chiropractic may treat you.

Specific risk possibilities associated with Chiropractic care:

Stroke– *Stroke is the most serious complication of Chiropractic treatment. It is, on rare occasions, due to injury of the vertebral artery caused by a cervical spine adjustment or manipulation, and when occurs, may cause temporary or permanent brain dysfunction. On extremely rare occasions death occurs. Because the vertebral arteries, which supply the brain with blood, are located withing the bones of the cervical spine, cervical treatment poses a small risk. The chances of this occurring are estimated at 1 per 400,000 treatments to 1 to 5.85 million treatments. (CMAJ 2001 Oct. 2; 165 (7):905-6). The annual incidence of a spontaneous stroke is estimated at 1 to 1.5 per 100,000 (NEJM, 1994; 330:339-397). The results of a retrospective study conducted by Haldeman S, Et. Al, suggested that stroke should be considered a random and unpredictable complication of any neck movement including cervical manipulation (J Neurol 2002 Aug: 249(8): 1098-104).*

Soreness– *Chiropractic adjustments and physical therapy procedures are sometimes accompanied by post treatment soreness. This is a normal and acceptable accompanying response to chiropractic care. While is is not general dangerous, please advise your Doctor of Chiropractic if you experience soreness or discomfort.*

Soft Tissue Injury– *Occasionally Chiropractic treatment may aggravate a disc injury, or cause other minor joint, ligament, tendon, or other soft tissue injury.*

Rib Injury– *Manual adjustments to the thoracic spine, in rare cases, May cause rib injury or fracture. Precautions such as pre-adjustment x-rays are taken for cases considered at risk. Treatment is performed carefully to minimize such risk.*

Physical Therapy Burns– *Heat generated by physical therapy modalities may cause minor burns to the skin. These are rare, but should be reported to your Doctor of Chiropractic or staff if they occur.*

Other Problems– *There are occasionally other types of side effects associated with Chiropractic care. While these are rare, they should be reported to your Doctor of Chiropractic promptly.*

Chiropractic is a system of health care delivery and therefore, as with any health care delivery system, we cannot promise a cure for any symptom, condition, or disease as a result of treatment in this office. An attempt to provide the very best care is your goal and if the results are not acceptable, we will refer you to another provider who we feel will assist your situation.

If you have any questions concerning the above, please ask your Doctor of Chiropractic. When you have full understanding and consent to have care provided, please print your name and sign and date below.

Having carefully read the above, I hereby give my informed consent to have chiropractic treatment administered.

Patient's Name Printed _____ *Today's Date* _____

Patient's Signature _____ *Parent of Guardian Signature for Minor* _____