WORK COMP HISTORY

Patient Name: _____ Phone: ( )_____

Address: _____ City:_____ State: _____ Zip:_____

Age: ____ Birthdate: _____ Sex: _____ Social Security #: _____

Name of Compensation Carrier: _____ Phone: ( )_____

Address of Carrier:_____ City: _____ State: _____ Zip:_____

Employer's Name:_____ Phone: ( )_____

Employer's Address: _____ City: _____ State:_____ Zip:_____

1. Type of business_____ Your Occupation: _____
2. **Date injured**: _____ **Hour**: ____AM/PM **Last date worked**:_____ Are you off work? □YES □NO
3. Previous Worker's Compensation Injury? □YES □NO
4. Accident reported to employer? □YES □NO Name of person reported accident to? _____
5. Injured at:_____ City:_____ State:_____ Zip:_____
6. Length of time worked there prior to accident? _____
7. Type of work being done at time of injury: _____
   _____.
8. In your own words, please describe accident:
   _____
   _____
   _____
   _____.
9. Have you been treated by another doctor for this accident? □YES □NO

   If yes, please list doctor's name and address:_____
10. Are you: □IMPROVED □UNCHANGED □GETTING WORSE
11. What types of medicines are you taking?_____
    _____.
    Do these medicines help? □YES □NO □Not Sure
12. Have you had physical therapy? □YES □NO
    If yes, How often? □DAILY □Every other day □Several times a week □Weekly □Every other week
    □Monthly □Other: _____
    Does therapy help? □YES □NO □Not Sure
13. Prior to this accident, have you ever had any of the physical complaints similar to what you have now?
    □YES □NO □Unsure If yes, please describe:_____
    _____.
    Were these similar complaints the results of a previous accident(s)? □YES □NO
    Please provide details of accident(s): _____
    _____
    _____.

14. Have you had any other serious accidents which required medical care? □YES □NO
    Describe:_____
15. Have you had any serious illnesses that required hospitalization? □YES □NO
    Describe:_____
    _____
    _____.
16. Have you had any surgeries? □YES □NO
    If yes, list type and date of surgery:_____
    _____.
17. Have you had any nervous or mental illnesses? □YES □NO
    Have you had psychiatric care? □YES □NO
18. Have you received a medical discharge from the Armed Forces? □YES □NO
19. Have you returned to work since this accident? □YES □NO
    If you HAVE returned to work since your accident, please fill our the information below:

Date	Employer	Occupation	Light Duty/ Reg. Duty	Full-Time Part-Time

CURRENT MEDICAL COMPLAINTS

BACK PAIN:

1.	Currently, I have pain in my:	□low back	□mid back	□upper back
2.	My pain began:	□gradually	□suddenly	
3.	I have pain:	□sometimes	□all the time	
4.	My pain goes into my:	□right leg	□left leg	□both
5.	I have tingling and/or numbness in my:	□right leg	□left leg	□both
6.	My pain is worse when I:			
	Cough or sneeze	□YES	□NO	
	Sit	□YES	□NO	
	Bend	□YES	□NO	
	Walk	□YES	□NO	
	Lift	□YES	□NO	
	Push	□YES	□NO	
	Pull	□YES	□NO	
7.	My back is worse with sexual activity:	□YES	□NO	
8.	My pain wakes me up during the night:	□YES	□NO	
9.	Changes in the weather affect my pain:	□YES	□NO	

NECK PAIN:

1.	My neck pain began:	□gradually	□suddenly	
2.	I have pain:	□sometimes	□all the time	
3.	My pain goes into my:	□right arm	□left arm	□both
4.	I have tingling and/or numbness in my:	□right arm	□left arm	□both
5.	My pain is worse when I:			
	Cough or sneeze	□YES	□NO	
	Bend forward	□YES	□NO	
	Lift	□YES	□NO	
	Push	□YES	□NO	
	Pull	□YES	□NO	
	Turn my head	□YES	□NO	
6.	My pain wakes me up during the night:	□YES	□NO	
7.	Changes in the weather affect my pain:	□YES	□NO	
8.	I have neck stiffness:	□YES	□NO	
9.	I have headaches:	□YES	□NO	
10.	If I do get headaches, they occur:	□sometimes	□all the time	

OTHER PAIN:

Please describe any current medical complaints which you are experiencing and were not previously covered on this questionnaire, or list any additional comments or concerns you wish to make regarding your condition: _____

_____

_____

_____.

JOB DESCRIPTION:

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

1. In a typical 8-hour workday I: (circle number of hours/ 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

2. On the job, I perform the following activities:

	NOT AT ALL	OCCASIONALLY	FREQUENTLY	CONTINUOUSLY
Bend/stoop	□	□	□	□
Squat	□	□	□	□
Crawl	□	□	□	□
Climb	□	□	□	□
Reach above Shoulders	□	□	□	□
Crouch	□	□	□	□
Kneel	□	□	□	□
Balancing	□	□	□	□
Pushing/pulling	□	□	□	□

3. On the job, I lift:

	NOT AT ALL	OCCASIONALLY	FREQUENTLY	CONTINUOUSLY
Up to 10 lbs.	□	□	□	□
11 to 24 lbs.	□	□	□	□
25 to 34 lbs.	□	□	□	□
35 to 50 lbs.	□	□	□	□
51 to 74 lbs.	□	□	□	□
75 to 100 lbs.	□	□	□	□

4. Do you have to bend over while doing and lifting: □ YES □NO
5. Are your feet used for repetitive movements, such as in operating foot controls? □YES □NO
6. Do you use your hands for repetitive actions, such as:

	SIMPLE GRASPING		FIRM GRASPING		FINE MANIPULATING	
Right hand	□YES	□NO	□YES	□NO	□YES	□NO
Left hand	□YES	□NO	□YES	□NO	□YES	□NO

7. Are you required to work on unprotected heights? □YES □NO
   Describe: _____
   _____
   _____.
8. Are you required to be around moving machinery? □YES □NO
   Describe: _____
   _____
   _____.
9. Are you exposed to marked changes in temperature and humidity? □YES □NO
   Describe: _____
   _____
   _____.
10. Are you required to drive automotive equipment? □YES □NO
    Describe: _____
    _____
    _____.
11. Are you exposed to dust, fumes and/or gases? □YES □NO
    Describe: _____
    _____
    _____.
12. Please list any additional comments or concerns: _____
    _____
    _____
    _____.

Signature: _____ Date: _____

IMPORTANT Please X all present symptoms. Rate pain by intensity levels using scale from 0-10.

Absent 0 1 2 3 4 5 6 7 8 9 10 excruciating pain

HEAD:

__Headache (R/L) rate pain (0-10)___
- __sinus (allergy) (0-10)
- __entire head (0-10)
- __back of head (0-10)
- __forehead (0-10)
- __temples (0-10)
- __migraine (0-10)

__Head feels heavy
__Loss of memory
__Light headedness
__Fainting
__Light bothers eyes
__Blurred vision
__Double vision
__Loss of vision
__Loss of taste
__Loss of balance
__Dizziness
__Loss of hearing
__Pain in ears (0-10)
__Ringing in ears
__Buzzing in ears

NECK:

__Pain in the neck (R/L) (0-10)
__Neck pain with movement
- __forward (0-10)
- __backward (0-10)
- __bending right (0-10)
- __bending left (0-10)
- __turning right (0-10)
- __turning left (0-10)

__Pinched nerve in neck
__Neck feels out of place
__Muscle spasms in neck
__Grinding sounds in neck
__Popping sounds in neck
__Arthritis in neck

MIDBACK (blade area)

__Mid-back pain (R/L) (0-10)
__Pain in between blades (R/L) (0-10)
__Sharp stabbing
__Dull ache
__Pain in kidney area (0-10)
__Muscle spasms (R/L)

ARMS & HANDS:

__Pain in upper arm (R/L) (0-10)
__Pain in elbow (R/L) (0-10)
__Pain in forearm (R/L) (0-10)
__Pain in hands (R/L) (0-10)
__Pain in fingers (R/L) (0-10)
__Pins and needles sensation
- __arms (R/L)
- __hands/fingers (R/L)

__Numbness
- __arms (R/L)
- __hands/fingers (R/L)

__Pain aggravated by movement
__Tennis elbow (R/L)
__Hands feel cold
__Swollen fingers
__Loss of grip strength (R/L)
__Arthritis
__Shoulders (R/L)
__Elbow (R/L) __Fingers (R/L)

SHOULDER JOINTS:

__Pain in shoulder joint (R/L) (0-10)
__Pain across shoulders (0-10)
__Bursitis (R/L)
__Arthritis (R/L)
__Can't raise arm
- __above shoulder level
- __above head

__Tension in shoulders
__Pinched nerve in shoulder (R/L)
__Muscle spasms in shoulders (R/L)

CHEST:

__Chest pain (0-10)
__Shortness of breath
__Pain around ribs (0-10)
__Breast pain (0-10)
__Dimpled/ orange peel breast

ABDOMEN:

__Nervous stomach
__Nausea
__Gas
__Constipation
__Diarrhea
__Hemorrhoids
__Foods can't eat _____

LOW BACK:

__Upper lumbar (R/L) (0-10)
__Lower lumbar (R/L) (0-10)
__Sacroiliac (R/L) (0-10)
__Low back pain is worse when:
- __working (0-10)
- __lifting (0-10)
- __stooping (0-10)
- __standing (0-10)
- __sitting (0-10)
- __bending (0-10)
- __coughing (0-10)
- __lying down (sleeping) (0-10)
- __walking (0-10)
- __low back feel better_____
- __slipped disc
- Pain from front to back
- __Low back feels out of place
- __Muscle spasms
- __Arthritis

HIPS, LEGS & FEET:

__Pain in buttocks (R/L) (0-10)
__Pain in hip joints (R/L) (0-10)
__Pain down leg (R/L) (0-10)
__Knee pain (R/L)
- __inside/medial (R/L) (0-10)
- __outside/lateral (R/L) (0-10)
- __Leg cramps (R/L) (0-10)
- __Foot cramps (R/L) (0-10)

__Pins & needles sensation in legs (R/L)
__Numbness
- __Legs (R/L)
- __Feet (R/L)
- __Toes (R/L)

__Swelling
- __Legs (R/L)
- __Ankles (R/L)
- __Feet (R/L)

__Feet feel cold (R/L)

WOMEN ONLY:

__Menstrual pain (where)_____(0-10)
__Cramping (severe/ mod/ mild)
__Irregularity
__Cycle _____ days
__Birth Control _____type
__Hysterectomy _____year
- __Complete
- __Partial

__Hormone replacement therapy
__Genital Cancer
__Discharge _____color
_____Treatment
__Tumors
__Fibroids
__Menopause
- __Premenstrual Syndrome
- __Abortions

MEN ONLY:

__Frequent urination
__Difficulty in starting
__Difficulty in emptying completely
__Frequent night urination
__Prostate cancer (year diagnosed _____)
__treatment _____
__Enlarged Prostate

GENERAL:

__Nervousness
__Irritable
__Depressed
__Fatigue
__Feel run-down
__Arthritis
__Osteoarthritis
- where_____

__Rheumatoid
__Gout
__Fibromyalgia
__Diabetes
- __Insulin dependent
- __Non-insulin dependent
- __Blood sugar
- __control thru diet and exercise only
- __Hypoglycemia

__Normal hours of sleep_____
__Lost hours of sleep_____
__Weight gain_____lbs. 1/3/6/12 months
__Weight loss_____lbs. 1/3/6/12 months
__Soda____12oz. cans/day type_____
cola/non-cola/diet/caffeine free
__Coffee/Tea___cups/day____Decaf
__Cigarettes_____packs/day
__Vitamins (list) _____
_____

REMARKS:

_____

_____

_____

NAME: _____

DATE: _____

ACTIVITIES DISCOMFORT SCALE

In the boxes below, mark the appropriate statements with an "X".

Activity	Doesn't Hurt At All	Hurts A Little (1, 2, 3)	Hurts Moderate (4, 5, 6)	Hurts Severly (7, 8, 9, 10)	Unbearable Pain Prevents Activity
1.Walking					
2. Sitting					
3. Bending					
4. Standing					
5. Sleeping					
6. Lifting					
7. Running or Jogging					
8. Climbing stairs					
9. Carrying					
10. Pushing and pulling					
11. Driving					
12. Dressing					
13. Reading					
14. Watching TV					
15. Household chores					
16. Gardening					
17. Sports					
18. Employment					

Past History:

1: If you have ever experienced any of the following conditions at any time please mark with an X:

(even if it seems as insignificant as falling off the monkey bars as a child)

___Moving Vehicle Accident ___Injury: Lifting/Falling, etc. ___Broken Bones

___Heart Attack ___Convulsions/Epilepsy ___Vascular Issues

___Disability ___Jaw Pain/TMJ ___Tremors

___Stroke ___Cancer

Social History:

1: Height_____ Weight_____ Blood Pressure_____/_____

2: Smoking: Cigars Pipe Cigarettes (Circle one) How often? Daily Weekends Occasionally Never

3: Alcoholic beverage: Consumption occurs… Daily Weekends Occasionally Never

4: Recreational Drug use: Daily Weekends Occasionally Never

5: List prescription drugs you take:

_____

_____

6: Allergies to prescription drugs:

_____

_____

7: List Vitamins and Supplements or non-prescription drugs you take:

_____

_____

Family History:

1: Does anyone in your family suffer the same condition(s) you currently have? **Yes/No** (if yes whom)

Grandmother Grandfather Mother Father Sister(s) Brother(s) Son(s) Daughter(s)

Have they ever been treated for their condition? **Yes No I Don't Know**

2: Any other hereditary conditions the doctor should be aware of? **Yes/No** (if yes what)

_____

I HEREBY AUTHORIZE PAYMENT TO BE MADE DIRECTLY TO GEM CITY CHIROPRACTIC FOR ALL BENEFITS WHICH MAY BE PAYABLE UNDER A HEALTHCARE PLAN OR FROM ANY OTHER COLLATERAL SOURCES. I AUTHORIZE UTILIZATION OF THIS APPLICATION OR COPIES FOR THE PURPOSE OF PROCESSING CLAIMS ND EFFECTING PAYMENTS. I ALSO FURTHER ACKNOWLEDGE THAT THIS ASSIGNMENT OF BENEFITS DOES NOT IN ANY WAY RELIEVE ME OF PAYMENT LIABILITY AND THAT I WILL REMAIN FINANCIALLY RESPONSIBLE TO GEM CITY CHIROPRACTIC FOR ANY AND ALL SERVICES AT THE OFFICE.

_____

SIGNATURE OF PATIENT OR AUTHORIZED PERSON DATE COMPLETED

GEM CITY CHIROPRACTIC
521 South 24th Street
Quincy, IL 62301

NOTICE OF HEALTH CARE PROFESSIONAL LIEN

Date: _____
Provider: Gem City Chiropractic, LLC

Date of accident: _____
Licensed Illinois Physician:
Dr. Becky Grimm
Gem City Chiropractic, LLC
521 South 24th St.
Quincy, IL 62301
Phone: (217) 222-4363

Patient: _____
Address: _____
City/State/Zip: _____

Liable Party: _____
Address: _____
City/State/Zip: _____

If injured person is a minor or disabled adult,
Name of parent or responsible party:
_____

Insurance Co: _____
Address: _____
City/State/Zip: _____
Claim #: _____

Insurance Co: _____
Address: _____
City/State/Zip: _____
Claim #: _____

YOU ARE FORMALLY ON NOTICE THAT WE HAVE A LIEN UPON ALL CLAIMS AND CAUSES OF ACTION IN THIS CASE FOR ALL MEDICAL SERVICES RENDERED, PROVIDED THAT THE TOTAL AMOUNT OF ALL LIENS SHALL NOT EXCEED ONE-THIRD (1/3) OF THE SUM PAID OR DUE TO THE INJURED PERSON ON THE CLAIM OR RIGHT OF ACTION. YOU ARE INSTRUCTED TO PAY US DIRECTLY FOR THE CARE THIS PATIENT NEEDED IN TREATMENT OF THEIR ACCIDENT RELATED INJURIES.

If you need any additional information, please do not hesitate to contact our office.

SIGNED: _____ DATE: _____
Patient or responsible party

SIGNED: _____ DATE: _____
Witness

SIGNED: _____ DATE: _____
Doctor

Sincerely,
Gem City Chiropractic
Notices Served Registered Mail or Certified Mail

Patient _____
if patient is a minor or disabled adult,
parent or responsible party _____
Liable party _____
Medical Pay Ins. _____
Liable Insurance Co _____