



# Welcome

*chiropractic care*

## PATIENT INFORMATION

Date \_\_\_\_\_

SS/HIC/Patient ID # \_\_\_\_\_

Patient Name \_\_\_\_\_  
Last Name \_\_\_\_\_  
First Name \_\_\_\_\_ Middle Initial \_\_\_\_\_

Address \_\_\_\_\_

E-mail \_\_\_\_\_

City \_\_\_\_\_

State \_\_\_\_\_ Zip \_\_\_\_\_

Sex ☐ M ☐ F Age \_\_\_\_\_

Birthdate \_\_\_\_\_

☐ Married ☐ Widowed ☐ Single ☐ Minor  
☐ Separated ☐ Divorced ☐ Partnered for \_\_\_\_\_ years

Patient Employer/School \_\_\_\_\_

Occupation \_\_\_\_\_

Employer/School Address \_\_\_\_\_

Employer/School Phone (\_\_\_\_) \_\_\_\_\_

Spouse's Name \_\_\_\_\_

Birthdate \_\_\_\_\_

SS# \_\_\_\_\_

Spouse's Employer \_\_\_\_\_

Whom may we thank for referring you? \_\_\_\_\_

## INSURANCE INFORMATION

Who is responsible for this account? \_\_\_\_\_

Relationship to Patient \_\_\_\_\_

Insurance Co. \_\_\_\_\_

Group # \_\_\_\_\_

Is patient covered by additional insurance? ☐ Yes ☐ No

Subscriber's Name \_\_\_\_\_

Birthdate \_\_\_\_\_ SS# \_\_\_\_\_

Relationship to Patient \_\_\_\_\_

Insurance Co. \_\_\_\_\_

Group # \_\_\_\_\_

### ~~ASSIGNMENT AND RELEASE~~

I certify that I, and/or my dependent(s), have insurance coverage with \_\_\_\_\_ and assign directly to \_\_\_\_\_  
Name of Insurance Company(ies)

Dr. \_\_\_\_\_ all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I authorize the use of my signature on all insurance submissions.

The above-named doctor may use my health care information and may disclose such information to the above-named Insurance Company(ies) and their agents for the purpose of obtaining payment for services and determining insurance benefits or the benefits payable for related services. This consent will end when my current treatment plan is completed or one year from the date signed below.

\_\_\_\_\_  
Signature of Patient, Parent, Guardian or Personal Representative

\_\_\_\_\_  
Please print name of Patient, Parent, Guardian or Personal Representative

\_\_\_\_\_  
Date

\_\_\_\_\_  
Relationship to Patient

## PHONE NUMBERS

Cell Phone (\_\_\_\_) \_\_\_\_\_ Home Phone (\_\_\_\_) \_\_\_\_\_

Best time and place to reach you \_\_\_\_\_

### IN CASE OF EMERGENCY, CONTACT

Name \_\_\_\_\_ Relationship \_\_\_\_\_

Home Phone (\_\_\_\_) \_\_\_\_\_ Work Phone (\_\_\_\_) \_\_\_\_\_

## ACCIDENT INFORMATION

Is condition due to an accident? ☐ Yes ☐ No Date \_\_\_\_\_

Type of accident ☐ Auto ☐ Work ☐ Home ☐ Other

To whom have you made a report of your accident?

☐ Auto Insurance ☐ Employer ☐ Worker Comp. ☐ Other

Attorney Name (if applicable) \_\_\_\_\_

## PATIENT CONDITION

Reason for Visit \_\_\_\_\_

When did your symptoms appear? \_\_\_\_\_

Is this condition getting progressively worse? ☐ Yes ☐ No ☐ Unknown

Mark an X on the picture where you continue to have pain, numbness, or tingling.

Rate the severity of your pain on a scale from 1 (least pain) to 10 (severe pain) \_\_\_\_\_

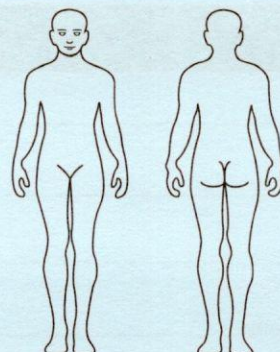
Type of pain: ☐ Sharp ☐ Dull ☐ Throbbing ☐ Numbness ☐ Aching ☐ Shooting  
☐ Burning ☐ Tingling ☐ Cramps ☐ Stiffness ☐ Swelling ☐ Other

How often do you have this pain? \_\_\_\_\_

Is it constant or does it come and go? \_\_\_\_\_

Does it interfere with your ☐ Work ☐ Sleep ☐ Daily Routine ☐ Recreation

Activities or movements that are painful to perform ☐ Sitting ☐ Standing ☐ Walking ☐ Bending ☐ Lying Down





# HEALTH HISTORY

What treatment have you already received for your condition? ☐ Medications ☐ Surgery ☐ Physical Therapy

☐ Chiropractic Services ☐ None ☐ Other \_\_\_\_\_

Name and address of other doctor(s) who have treated you for your condition \_\_\_\_\_

Date of Last: Physical Exam \_\_\_\_\_ Spinal X-Ray \_\_\_\_\_ Blood Test \_\_\_\_\_  
 Spinal Exam \_\_\_\_\_ Chest X-Ray \_\_\_\_\_ Urine Test \_\_\_\_\_  
 Dental X-Ray \_\_\_\_\_ MRI, CT-Scan, Bone Scan \_\_\_\_\_

Place a mark on "Yes" or "No" to indicate if you have had any of the following:

AIDS/HIV	<input type="checkbox"/> Yes <input type="checkbox"/> No	Emphysema	<input type="checkbox"/> Yes <input type="checkbox"/> No	Migraine Headaches	<input type="checkbox"/> Yes <input type="checkbox"/> No	Sexually Transmitted Disease	<input type="checkbox"/> Yes <input type="checkbox"/> No
Alcoholism	<input type="checkbox"/> Yes <input type="checkbox"/> No	Epilepsy	<input type="checkbox"/> Yes <input type="checkbox"/> No	Miscarriage	<input type="checkbox"/> Yes <input type="checkbox"/> No	Stroke	<input type="checkbox"/> Yes <input type="checkbox"/> No
Allergy Shots	<input type="checkbox"/> Yes <input type="checkbox"/> No	Fractures	<input type="checkbox"/> Yes <input type="checkbox"/> No	Mononucleosis	<input type="checkbox"/> Yes <input type="checkbox"/> No	Suicide Attempt	<input type="checkbox"/> Yes <input type="checkbox"/> No
Anemia	<input type="checkbox"/> Yes <input type="checkbox"/> No	Glaucoma	<input type="checkbox"/> Yes <input type="checkbox"/> No	Multiple Sclerosis	<input type="checkbox"/> Yes <input type="checkbox"/> No	Thyroid Problems	<input type="checkbox"/> Yes <input type="checkbox"/> No
Anorexia	<input type="checkbox"/> Yes <input type="checkbox"/> No	Goiter	<input type="checkbox"/> Yes <input type="checkbox"/> No	Mumps	<input type="checkbox"/> Yes <input type="checkbox"/> No	Tonsillitis	<input type="checkbox"/> Yes <input type="checkbox"/> No
Appendicitis	<input type="checkbox"/> Yes <input type="checkbox"/> No	Gonorrhea	<input type="checkbox"/> Yes <input type="checkbox"/> No	Osteoporosis	<input type="checkbox"/> Yes <input type="checkbox"/> No	Tuberculosis	<input type="checkbox"/> Yes <input type="checkbox"/> No
Arthritis	<input type="checkbox"/> Yes <input type="checkbox"/> No	Gout	<input type="checkbox"/> Yes <input type="checkbox"/> No	Pacemaker	<input type="checkbox"/> Yes <input type="checkbox"/> No	Tumors, Growths	<input type="checkbox"/> Yes <input type="checkbox"/> No
Asthma	<input type="checkbox"/> Yes <input type="checkbox"/> No	Heart Disease	<input type="checkbox"/> Yes <input type="checkbox"/> No	Parkinson's Disease	<input type="checkbox"/> Yes <input type="checkbox"/> No	Typhoid Fever	<input type="checkbox"/> Yes <input type="checkbox"/> No
Bleeding Disorders	<input type="checkbox"/> Yes <input type="checkbox"/> No	Hepatitis	<input type="checkbox"/> Yes <input type="checkbox"/> No	Pinched Nerve	<input type="checkbox"/> Yes <input type="checkbox"/> No	Ulcers	<input type="checkbox"/> Yes <input type="checkbox"/> No
Breast Lump	<input type="checkbox"/> Yes <input type="checkbox"/> No	Hernia	<input type="checkbox"/> Yes <input type="checkbox"/> No	Pneumonia	<input type="checkbox"/> Yes <input type="checkbox"/> No	Vaginal Infections	<input type="checkbox"/> Yes <input type="checkbox"/> No
Bronchitis	<input type="checkbox"/> Yes <input type="checkbox"/> No	Herniated Disk	<input type="checkbox"/> Yes <input type="checkbox"/> No	Polio	<input type="checkbox"/> Yes <input type="checkbox"/> No	Whooping Cough	<input type="checkbox"/> Yes <input type="checkbox"/> No
Bulimia	<input type="checkbox"/> Yes <input type="checkbox"/> No	Herpes	<input type="checkbox"/> Yes <input type="checkbox"/> No	Prostate Problem	<input type="checkbox"/> Yes <input type="checkbox"/> No	Other _____	
Cancer	<input type="checkbox"/> Yes <input type="checkbox"/> No	High Blood Pressure	<input type="checkbox"/> Yes <input type="checkbox"/> No	Prosthesis	<input type="checkbox"/> Yes <input type="checkbox"/> No		
Cataracts	<input type="checkbox"/> Yes <input type="checkbox"/> No	High Cholesterol	<input type="checkbox"/> Yes <input type="checkbox"/> No	Psychiatric Care	<input type="checkbox"/> Yes <input type="checkbox"/> No		
Chemical Dependency	<input type="checkbox"/> Yes <input type="checkbox"/> No	Kidney Disease	<input type="checkbox"/> Yes <input type="checkbox"/> No	Rheumatoid Arthritis	<input type="checkbox"/> Yes <input type="checkbox"/> No		
Chicken Pox	<input type="checkbox"/> Yes <input type="checkbox"/> No	Liver Disease	<input type="checkbox"/> Yes <input type="checkbox"/> No	Rheumatic Fever	<input type="checkbox"/> Yes <input type="checkbox"/> No		
Diabetes	<input type="checkbox"/> Yes <input type="checkbox"/> No	Measles	<input type="checkbox"/> Yes <input type="checkbox"/> No	Scarlet Fever	<input type="checkbox"/> Yes <input type="checkbox"/> No		

## EXERCISE

☐ None  
☐ Moderate  
☐ Daily  
☐ Heavy

## WORK ACTIVITY

☐ Sitting  
☐ Standing  
☐ Light Labor  
☐ Heavy Labor

## HABITS

☐ Smoking Packs/Day \_\_\_\_\_  
☐ Alcohol Drinks/Week \_\_\_\_\_  
☐ Coffee/Caffeine Drinks Cups/Day \_\_\_\_\_  
☐ High Stress Level Reason \_\_\_\_\_

Are you pregnant? ☐ Yes ☐ No Due Date \_\_\_\_\_

Injuries/Surgeries you have had	Description	Date
Falls	_____	_____
Head Injuries	_____	_____
Broken Bones	_____	_____
Dislocations	_____	_____
Surgeries	_____	_____

## MEDICATIONS

## ALLERGIES

## VITAMINS/HERBS/MINERALS

Pharmacy Name \_\_\_\_\_

Pharmacy Phone (\_\_\_\_) \_\_\_\_\_



# Protecting Your Confidential Health Information is Important to Us

## To The U.S. Department of Health and Human Services (HHS)

We may disclose your health information to HHS, the government agency responsible for overseeing compliance with federal privacy law and regulations regulating the privacy and security of health information.

## For Research

We may use or disclose your health information for research, subject to conditions. "Research" means systemic investigation designed to contribute to generalized knowledge.

## In Connection With Your Death or Organ Donation

We may disclose your health information to a coroner for identification purposes, to a funeral director for funeral purposes, or to an organ procurement organization to facilitate transplantation of one of your organs.

If applicable State law does not permit the disclosure described above, we will comply with the stricter State law.

## Authorization to Use or Disclose Health Information

We are required to obtain your written authorization in the following circumstances: (a) to use or disclose psychotherapy notes (except when needed for payment purposes or to defend against litigation filed by you); (b) to use your PHI for marketing purposes; (c) to sell your PHI; and (d) to use or disclose your PHI for any purpose not previously described in this Notice. We also will obtain your authorization before using or disclosing your PHI when required to do so by (a) state law, such as laws restricting the use or disclosure of genetic information or information concerning HIV status; or (b) other federal law, such as federal law protecting the confidentiality of substance abuse records. You may revoke that authorization in writing at any time.

## PATIENT RIGHTS

You have the following rights related to your health information.

### Restrictions

You have the right to request restrictions on the use or disclosure of your health information for treatment, payment, or healthcare operations in addition to the restrictions imposed by federal law. Our office is not required to agree to your request, unless (a) you request that we not disclose your PHI to a health insurance company, Medicare or Medicaid for payment or healthcare operations purposes; (b) you, or someone on your behalf, has paid us in full for the healthcare item or service to which the PHI pertains; and (c) we are not required by law to disclose to the insurer, Medicare, or Medicaid the PHI that is the subject of your request, but we will endeavor to honor reasonable requests. We generally are not required to agree to a requested restriction. Our office will honor your request that we not disclose your health information to a health plan for payment or healthcare operation purposes if the health information relates solely to a healthcare item or service for which you have paid us out-of-pocket in full.

## Patient Acknowledgment

Patient Name(s): \_\_\_\_\_

Thank you very much for taking time to review how we are carefully using your health information. If you have any questions we want to hear from you. If not, we would appreciate very much your acknowledging your receipt of our policy by signing this form.

\_\_\_\_\_  
Patient Signature

Date \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_

For additional information about the matters discussed in this notice, please contact our Privacy Officer.

## Confidential Communications

You have the right to request that we communicate with you by alternative means or at an alternative location. You may, for example, request that we communicate your health information only privately with no other family members present or through mailed communications that are sealed. We will honor your reasonable requests for confidential communications.

## Inspect and Copy Your Health Information

You have the right to read, review, and copy your health information, including your complete chart, x-rays and billing records. If you would like a copy of your health information, please let us know. We may need to charge you a reasonable, cost-based fee to duplicate and assemble your copy. If there will be a charge, we will first contact you to determine whether you wish to modify or withdraw your request.

## Amend Your Health Information

*You have the right* to ask us to update or modify your records if you believe your health information records are incorrect or incomplete. We will be happy to accommodate you as long as our office maintains this information. In order to standardize our process, please provide us with your request in writing and describe the information to be changed and your reason for the change.

Your request may be denied if the health information record in question was not created by our office, is not part of our records or if the records containing your health information are determined to be accurate and complete. If we deny your request, we will provide you with a written explanation of the denial.

## Accounting of Disclosures of Your Health Information

You have the right to ask us for a description of how and where your health information was disclosed. Our documentation procedures will enable us to provide information on health information disclosures that we are required to disclose to you. Please let us know in writing the time period for which you are interested. Thank you for limiting your request to no more than six years at a time. We will provide the first accounting during any 12-month period without charge. We may charge a reasonable, cost-based fee for each additional accounting during the same 12-month period. If there will be a charge, the Privacy Officer will first contact you to determine whether you wish to modify or withdraw your request.

## Request a Paper Copy of this Notice

You have the right to obtain a copy of this Notice of Privacy Practices directly from our office at any time. Stop by or give us a call and we will mail or email a copy to you.

## Receive Notice of a Security Breach

You have the right to receive notification of a breach of your unsecured health information.

## Changes to the Notice

We are required by law to maintain the privacy of your health information and to provide to you or your personal representative with this Notice of our Privacy Practices. We are required to practice the policies and procedures described in this notice but we do reserve the right to change the terms of our Notice. If we change our privacy practices we will be sure all of our patients receive a copy of the revised Notice.

## Complaints

You have the right to express complaints to us or to the Secretary of Health and Human Services if you believe your privacy rights have been compromised. We encourage you to express any concerns you may have regarding the privacy of your information. We will not retaliate against you for submitting a complaint. Please let us know of your concerns or complaints in writing by submitting your complaint to our Privacy Officer.

Effective Date: 9/23/2013



# NOTICE OF PRIVACY PRACTICES

## Protecting Your Confidential Health Information is Important to Us

### Notice of Privacy Practices

THIS NOTICE DESCRIBES HOW HEALTH INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

#### Our Promise

Dear Patient:

This notice is not meant to alarm you. Quite the opposite! It is our desire to communicate to you that we are taking seriously Federal law (HIPAA—Health Insurance Portability and Accountability Act) enacted to protect the confidentiality of your health information. We never want you to delay treatment because you are afraid your personal health history might be unnecessarily made available to others outside our office.

#### Why do you have a privacy policy? Very good question!

The Federal government legally enforces the importance of the privacy of health information largely in response to the rapid evolution of computer technology and its use in healthcare. The government has appropriately sought to standardize and protect the privacy of the electronic exchange of your health information. This has challenged us to review not only how your health information is used within our computers but also with the Internet, phone, faxes, copy machines, and charts. We believe this has been an important exercise for us because it has disciplined us to put in writing the policies and procedures we follow to protect your health information when we use it.

We want you to know about these policies and procedures which we developed to make sure your health information will not be shared with anyone who does not require it. Our office is subject to State and Federal law regarding the confidentiality of your health information and in keeping with these laws, we want you to understand our procedures and your rights as our valuable patient.

We will use and communicate your HEALTH INFORMATION only for the purposes of providing your treatment, obtaining payment, conducting healthcare operations, and as otherwise described in this notice.

## NOTICE OF PRIVACY PRACTICES

Federal law generally permits us to make certain uses or disclosures of health information without your permission. Federal law also requires us to list in the Notice each of these categories of uses or disclosures. The listing is below.

#### As Required By Law

We may use or disclose your health information as required by any statute, regulation, court order or other mandate enforceable in a court of law.

#### Abuse or Neglect

We may disclose your health information to the responsible government agency if (a) the Privacy Official reasonably believes that you are a victim of abuse, neglect, or domestic violence, and (b) we are required or permitted by law to make the disclosure. We will promptly inform you that such a disclosure has been made unless the Privacy Official determines that informing you would not be in your best interest.

#### Public Health and National Security

We may be required to disclose to Federal officials or military authorities health information necessary to complete an investigation related to public health or national security. Health information could be important when the government believes that the public safety could benefit when the information could lead to the control or prevention of an epidemic or the understanding of new side effects of a drug treatment or medical device.

#### For Law Enforcement

As permitted or required by State or Federal law, we may disclose your health information to a law enforcement official for certain law enforcement purposes, including, under certain limited circumstances, if you are a victim of a crime or in order to report a crime.

## How Your HEALTH INFORMATION May be Used to Provide Treatment

We will use your HEALTH INFORMATION within our office to provide you with care. This may include administrative and clinical office procedures designed to optimize scheduling and coordination of care. In addition, we may share your health information with pharmacies or other healthcare personnel providing you treatment.

## To Obtain Payment

We may include your health information with an invoice used to collect payment for treatment you receive in our office. We may do this with insurance forms filed for you in the mail or sent electronically. We will be sure to only work with companies with a similar commitment to the security of your health information.

## To Conduct Health Care Operations

Your health information may be used during performance evaluations of our staff. Some of our best teaching opportunities use clinical situations experienced by patients receiving care at our office. As a result, health information may be included in training programs for students, interns, associates, and business and clinical employees. It is also possible that health information will be disclosed during audits by insurance companies or government appointed agencies as part of their quality assurance and compliance reviews. Your health information may be reviewed during the routine processes of certification, licensing or credentialing activities.

## In Patient Reminders

Because we believe regular care is very important to your health, we will remind you of a scheduled appointment or that it is time for you to contact us and make an appointment. Additionally, we may contact you to follow up on your care and inform you of treatment options or services that may be of interest to you or your family. These communications are an important part of our philosophy of partnering with our patients to be sure they receive the best care. They may include postcards, folding postcards, letters, telephone reminders or electronic reminders such as email (unless you tell us that you do not want to receive these reminders).

## To Business Associates

We have contracted with one or more third parties (referred to as a business associate) to use and disclose your health information to perform services for us, such as billing services. We will obtain each business associate's written agreement to safeguard your health information.

## Family, Friends and Caregivers

We may share your health information with those you tell us will be helping you with your treatment, medications, or payment. We will be sure to ask your permission first. In the case of an emergency, where you are unable to tell us what you want, we will use our best judgment when sharing your health information only when it will be important to those participating in providing your care.

## Workers' Compensation Purposes

We may disclose your health information as required or permitted by State or Federal workers' compensation laws.

## Judicial and Administrative Proceedings

We may disclose your health information in an administrative or judicial proceeding in response to a subpoena or a request to produce documents. We will disclose your health information in these circumstances only if the requesting party first provides written documentation that the privacy of your health information will be protected.

## Incidental Uses and Disclosures

We may use or disclose your health information in a manner which is incidental to the uses and disclosures described in this Notice.

## Health Oversight Activities

We may disclose your health information to a government agency responsible for overseeing the health care system or health-related government benefit program.

## To Avert a Serious Threat to Health or Safety

We may use or disclose your health information to reduce a risk of serious and imminent harm to another person or to the public.

**Brodheadsville Chiropractic**

**134 Pilgrim Way • Brodheadsville, PA 18322 • (570) 992-7626**



**Brodheadsville Chiropractic**  
**Robert J. Van Metter, D.C.**  
P.O. Box 447, 134 Pilgrim Way  
Brodheadsville, PA 18322  
Phone 570-992-7626 • Fax 570-992-8759

## **TERMS OF ACCEPTANCE**

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When a patient seeks chiropractic health care and we accept a patient for such care, it is essential for both to be working towards the same goal.

Chiropractic has only one unique goal. It is important that each patient understand both the objective and the method that will be used to attain it. This will prevent any confusion or disappointment.

**Adjustment:** An adjustment is the specific application of forces to facilitate the body's correction of vertebral subluxation to restore more optimum body function. The chiropractic method of correction is by specific adjustments to the spine.

**Health:** A state of optimal physical, mental, and social well-being, not merely the absence of disease or infirmity.

**Vertebral Subluxation:** A misalignment of one or more of the 24 vertebra in the spinal column which causes alteration or nerve function and interference to the transmission of mental impulses resulting in a lessening of the body's innate ability to express its maximum health potential.

We do not offer to diagnose or treat any disease or condition other than vertebral subluxation. However, if during the course of a chiropractic spinal examination, we encounter non-chiropractic or unusual findings, we will advise you. If you desire advice, diagnosis or treatment for those findings, we will recommend that you seek the services of a health care provider that specializes in that area.

Regardless of what the disease is called, we do not offer to treat it. Nor do we offer advice regarding treatment prescribed by others. OUR ONLY PRACTICE OBJECTIVE is to eliminate a major interference to the expression of the body's innate healing ability. Our only method is specific adjusting to correct vertebral subluxations.

I, \_\_\_\_\_ have read and fully understand the above statements.  
(Please print your name)

All questions regarding the doctor's objectives pertaining to my care in this office have been answered to my complete satisfaction.

I therefore accept chiropractic care on this basis.

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Date

Patient ID #: \_\_\_\_\_

**Brodheadsville Chiropractic  
Robert J. Van Metter D.C.**

**Authorization of Disclosure of Protected Health Information by Another  
Covered Entity for Use by Brodheadsville Chiropractic**

**Notice of Privacy Practices Acknowledgement**

I acknowledge that Brodheadsville Chiropractic provided me with a copy of its Notice of Privacy Practices as required under the Health Insurance Portability and Accountability Act of 1996.

I authorize Brodheadsville Chiropractic and/or their staff to leave medical information pertaining to my care by the following methods and will assume responsibility to notify them should this information change.

Home Telephone	Yes	No	Number:
Answering Machine	Yes	No	
Work Telephone	Yes	No	Number:
Cell Phone/Texting	Yes	No	Number:
Voicemail	Yes	No	
Fax to other physicians	Yes	No	

Please list names, relationship and number of family members and/or friends you wish us to release medical information pertaining to your healthcare.

Name	Relationship	Telephone Number

**[ ] I DO NOT WISH ANY INFORMATION PERTAINING TO MY HEALTHCARE TO BE  
RELEASED TO FAMILY AND/OR FRIENDS.**

Patient Signature: \_\_\_\_\_

Print Name: \_\_\_\_\_

Date: \_\_\_\_\_



**WRITE LEGIBLY****WORKERS' COMPENSATION PATIENT HISTORY****WRITE LEGIBLY**

Name \_\_\_\_\_ Date \_\_\_\_\_ File # \_\_\_\_\_

**30 HISTORY OF OCCURRENCE**

- 10 Employer's business name (at the time of accident) \_\_\_\_\_  
Employer's phone \_\_\_\_\_ Employer's address \_\_\_\_\_  
City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_  
Occupation: \_\_\_\_\_ Describe your job: \_\_\_\_\_  
Date of injury: \_\_\_\_\_ Time of injury: \_\_\_\_\_ ☐ AM ☐ PM Date last 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? *(Be specific):* \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

- 20 Describe the environmental conditions which may have contributed to your present injury: Darkness, faulty equipment, slippery floor, limited space. *(Distinguish natural hazards from hazards by other employees):* \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**40 FIRST DOCTOR/HOSPITAL/CLINIC SEEN**

- 10 Were you hospitalized as a result of this accident? ☐ No  
20 What doctor/hospital/clinic did you go to? \_\_\_\_\_ Date of first visit: \_\_\_\_\_  
DOCTOR 1: Name \_\_\_\_\_  
Were you examined? ☐ Yes ☐ No Were X-rays taken? ☐ Yes ☐ No  
30 Did you receive treatment? ☐ No  
40 If yes, what kind of treatment did you receive? \_\_\_\_\_  
What benefits did you receive from the treatment? \_\_\_\_\_  
50 Date of last treatment? \_\_\_\_\_

**50 SECOND DOCTOR/CLINIC SEEN**

- 10 DOCTOR 2: Name \_\_\_\_\_ Date of first visit: \_\_\_\_\_  
Were you examined? ☐ Yes ☐ No Were X-rays taken? ☐ Yes ☐ No  
20 Did you receive treatment? ☐ No  
30 If yes, what kind of treatment did you receive? \_\_\_\_\_  
What benefits did you receive from the treatment? \_\_\_\_\_  
40 Date of last treatment? \_\_\_\_\_

**GO TO NEXT PAGE**



**60 THIRD DOCTOR/CLINIC SEEN**

- 10 DOCTOR 3: Name \_\_\_\_\_ Date of first visit: \_\_\_\_\_  
Were you examined? ☐ Yes ☐ No Were X-rays taken? ☐ Yes ☐ No  
20 Did you receive treatment? ☐ No  
30 If yes, what kind of treatment did you receive? \_\_\_\_\_  
What benefits did you receive from the treatment? \_\_\_\_\_  
40 Date of last treatment? \_\_\_\_\_

**70 REPORT ACCIDENT TO/ACCIDENT WITNESS**

- 10 What date did you report this injury? \_\_\_\_\_  
Whom did you report this to? \_\_\_\_\_ What is their position? \_\_\_\_\_  
20 Was there a witness to your injury? ☐ No  
30 If yes, what was the witness' name? \_\_\_\_\_ What is their position? \_\_\_\_\_  
Other witness' name? \_\_\_\_\_ What is their position? \_\_\_\_\_

**80 PRIOR SIMILAR SYMPTOMS**

- 10 Did you have any physical complaints **just before this accident?** ☐ No  
20 If yes, please describe any physical complaints **just before this accident?** \_\_\_\_\_  
30 Have you **EVER** had any **PRIOR** injuries, accidents, diseases, or treatment to the area of your body now affected? ☐ No  
40 If yes, state what part of your body was **previously** injured: \_\_\_\_\_  
Describe the injury: \_\_\_\_\_ Date Injured: \_\_\_\_\_  
50 Were you treated? ☐ No  
60 If yes, who treated you? \_\_\_\_\_  
What date did treatment begin? \_\_\_\_\_ When did treatment end? \_\_\_\_\_  
70 When was the last time (date) you felt pain or problems from that injury? \_\_\_\_\_

**90 WORK STATUS HISTORY**

- 10 Have you lost any time from work as a result of this new injury? ☐ No  
20 If yes, give dates of time loss: \_\_\_\_\_  
30 If you are currently on **disability (time loss)** do you want to go back to work doing your **regular** work duties? ☐ Yes  
40 If no, state why you don't want to go back to your regular work duties: \_\_\_\_\_  
50 Have you gone back to work? ☐ No  
51 If yes, what status of work? ☐ Modified ☐ Regular When (Date): \_\_\_\_\_  
60 Please list what restrictions you have been placed on: \_\_\_\_\_  
70 If you have gone back to work, please list the activities as:  
Those that are painful: \_\_\_\_\_  
80 Those that are difficult: \_\_\_\_\_  
90 Are there any problems you have with a fellow employee, supervisor, or management that need to be discussed? ☐ No  
100 If yes, please discuss: \_\_\_\_\_

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**100 ACTIVITIES OF DAILY LIVING**

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

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

30 Those **home** activities that are **painful** are (be specific): \_\_\_\_\_

40 Those **home** activities that are **difficult** are (be specific): \_\_\_\_\_

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

60 If yes, what exercises are they? \_\_\_\_\_

How frequently do you perform them? \_\_\_\_\_

Who prescribed these exercises to you? \_\_\_\_\_

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

DO YOU HAVE AN ATTORNEY ON THIS CASE? ☐ No

If yes, who? Name \_\_\_\_\_ Phone \_\_\_\_\_

Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_