



HENDRICKSON CHIROPRACTIC & WELLNESS CENTER

NEW PATIENT INTAKE FORM – Worker’s Compensation

Today’s Date: ____/____/____

PATIENT INFORMATION

CONFIDENTIAL

Thank you for the opportunity to serve you. If you have any questions, do not hesitate to ask. We will be happy to help.

Name _____ DOB ____/____/____ S/S ____ - ____ - ____
First MI Last

Address _____ City _____ State ____ Zip _____

Please check your preferred method of contact

Home Phone: _____ Work Phone: _____

Cell Phone: _____ e-mail address*: _____

** Your e-mail will not be shared with any 3rd parties and is used for occasional office announcements and promotions.*

Height _____ Weight _____ Last known Blood Pressure: _____ (Unsure? We can take a reading today)

Do you smoke: No Yes (If yes how often _____) If you quit: Start date: _____ End Date: _____

Sex: Female Male Status: Minor Married Single Other: _____

Ethnicity/Race: _____ Employed: Full-Time Part-Time

Your Employer _____ Phone _____

Business Address _____ City _____ State ____ Zip _____

Type of Business _____ Your Occupation _____

Name of Compensation Carrier _____ Phone _____

Address _____

Who may we thank for referring you to us? _____

Person to contact in case of an emergency _____ Phone _____

HEALTH HISTORY

Please check the following symptoms you have noticed SINCE THE ACCIDENT (○) or BEFORE THE ACCIDENT (□):

- | | | |
|---|--|---|
| <input type="radio"/> <input type="checkbox"/> Headaches | <input type="radio"/> <input type="checkbox"/> Irritability | <input type="radio"/> <input type="checkbox"/> Loss of Smell |
| <input type="radio"/> <input type="checkbox"/> Neck Pain | <input type="radio"/> <input type="checkbox"/> Mood Swings | <input type="radio"/> <input type="checkbox"/> Loss of Taste |
| <input type="radio"/> <input type="checkbox"/> Neck Stiffness | <input type="radio"/> <input type="checkbox"/> Sleeping Problems | <input type="radio"/> <input type="checkbox"/> Upset Stomach |
| <input type="radio"/> <input type="checkbox"/> Mid Back Pain | <input type="radio"/> <input type="checkbox"/> Fatigue | <input type="radio"/> <input type="checkbox"/> Constipation |
| <input type="radio"/> <input type="checkbox"/> Low Back Pain | <input type="radio"/> <input type="checkbox"/> Depression | <input type="radio"/> <input type="checkbox"/> Diarrhea |
| <input type="radio"/> <input type="checkbox"/> Arm Pain | <input type="radio"/> <input type="checkbox"/> Chest Pain | <input type="radio"/> <input type="checkbox"/> Urinary Problems |
| <input type="radio"/> <input type="checkbox"/> Leg Pain | <input type="radio"/> <input type="checkbox"/> Shortness of Breath | <input type="radio"/> <input type="checkbox"/> Heartburn |
| <input type="radio"/> <input type="checkbox"/> Pins and Needles in Arms | <input type="radio"/> <input type="checkbox"/> Cold Sweats | <input type="radio"/> <input type="checkbox"/> Ulcers |
| <input type="radio"/> <input type="checkbox"/> Pins and Needles in Legs | <input type="radio"/> <input type="checkbox"/> Fever | <input type="radio"/> <input type="checkbox"/> Allergies |
| <input type="radio"/> <input type="checkbox"/> Numbness in Fingers | <input type="radio"/> <input type="checkbox"/> Fainting | <input type="radio"/> <input type="checkbox"/> Menstrual Pain |
| <input type="radio"/> <input type="checkbox"/> Numbness in Toes | <input type="radio"/> <input type="checkbox"/> Dizziness | <input type="radio"/> <input type="checkbox"/> Menstrual Irregularity |
| <input type="radio"/> <input type="checkbox"/> Cold Hands | <input type="radio"/> <input type="checkbox"/> Loss of Balance | <input type="radio"/> <input type="checkbox"/> Hot flashes |
| <input type="radio"/> <input type="checkbox"/> Cold Feet | <input type="radio"/> <input type="checkbox"/> Light Sensitivity with Eyes | <input type="radio"/> <input type="checkbox"/> Other _____ |
| <input type="radio"/> <input type="checkbox"/> Nervousness | <input type="radio"/> <input type="checkbox"/> Ringing/ Buzzy in Ears | <input type="radio"/> <input type="checkbox"/> Other _____ |
| <input type="radio"/> <input type="checkbox"/> Tension | <input type="radio"/> <input type="checkbox"/> Loss of Memory | |

Have **YOU** (○) or **A FAMILY MEMBER** (□) ever been diagnosed with any of the following conditions:

- | | | |
|--|--|--------------------------------------|
| <input type="checkbox"/> AIDS/HIV | <input type="checkbox"/> Heart Disease | <input type="checkbox"/> None |
| <input type="checkbox"/> Cancer | <input type="checkbox"/> Diabetes | <input type="checkbox"/> Unknown |
| <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Stroke | <input type="checkbox"/> Other _____ |

ACCIDENT INFORMATION:

Date of accident ____/____/____ Time of Day _____ Location of accident _____

Was the accident reported to your employer? No Yes, name of person reported accident to _____

What type of work were you doing at the time of the accident? _____

Please describe the accident in your own words: _____

Did you lose consciousness? No Yes, for how long? _____

What was your mental and emotional state immediately following the accident? _____

Where did you go immediately following the accident? _____

Have you been treated by another doctor since the accident? No Yes, If yes...

Please list the name of the doctor and address: _____

Please explain what type of treatment you received: _____

What type of X-rays were taken if any? _____

Was there any other imaging done? (i.e., MRI, CT, etc.) _____

Do you have any congenital (from birth) factors that may relate to this problem? No Yes, _____

Do you have any previous illnesses which relate to this case No Yes, _____

Have you ever been involved in a work comp accident before? No Yes, _____

Have you lost time from work as a result of this accident? No Yes, If yes Last day worked: ____/____/____

JOB DESCRIPTION:

In a typical 8-hour work day, I: (circle the 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

On the job, I perform the following activities:

| | NOT AT ALL | OCCASIONALLY | FREQUENTLY | CONTINUOUSLY |
|------------------|--------------------------|--------------------------|--------------------------|--------------------------|
| Bend/stoop | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Squat | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Crawl | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Climb | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Reach above head | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Kneel | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Balancing | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Pushing/pulling | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Lifting | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Typing | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |

Please add any other information that you feel is pertinent: _____

PLEASE LIST YOUR CURRENT AREAS OF COMPLAINT:

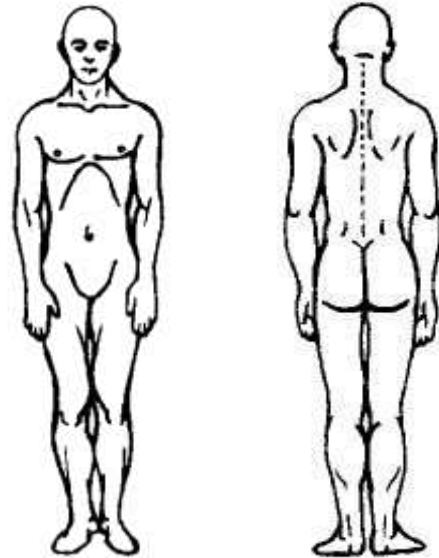
(chief complaint)

1) _____ 2) _____ 3) _____ 4) _____
0 1 2 3 4 5 6 7 8 9 10 0 1 2 3 4 5 6 7 8 9 10 0 1 2 3 4 5 6 7 8 9 10 0 1 2 3 4 5 6 7 8 9 10

CIRCLE THE NUMBER THAT BEST DESCRIBES THE INTENSITY OF YOUR PAIN: 1 = Mild, 10 = Severe

PLEASE MARK YOUR AREAS OF COMPLAINT ON THE BODY DIAGRAM USING THE FOLLOWING KEY:

- Dull = D
- Aching = A
- Stiffness = S
- Burning = B
- Tingling = T
- Numbness = N
- Sharp = !!!
- Shooting = XXX
- Other _____ = ***



How often do you notice your symptoms? Constantly Frequently Occasionally

Does anything relieve your pain? _____

What activities are difficult to perform? Sitting Standing Walking Bending Lying Down

Please describe any other activities that are restricted due to this injury? _____

Is the condition getting worse? No Yes

Have you had this problem before? No Yes, When? _____

Have you ever been diagnosed with a Subluxation? No Yes, When? _____

Have you had x-rays before? No Yes, When? _____ What areas? _____

I am currently taking the following medications for the following reasons: None

List Allergies: _____

Surgical History: _____

For Women Only: Is there a possibility that you may be pregnant? No Yes

Which best describes your health goals: pain relief only correct entire problem wellness/ preventative care

I certify that the above information is true and accurate to the best of my knowledge

DATE: ___/___/___ SIGNATURE: _____

PARENT/GUARDIAN: _____