NEW PATIENT HEALTH QUESTIONAIRRE (Worker's Compensation)

New Smyrna Beach Chiropractic Clinic, PLC

Date:_____ Patient's Name:_____
SSN:_____ Sex: M F Age:_____ Birth Date (MM/DD/YYYY):_____
Height: _____ Weight:_____ O Right Handed O Left Handed

Home Address (Street, City, Postal Code):_____
_____
Telephone: Home: _____ Bus:_____ Cell:_____ Email Address:_____

INSURANCE INFO: CO. Name:_____ Address:_____
Phone #:_____ Group#:_____ Insured's Name:_____
Relation:_____ DOB:_____ Insured's Employer:_____

Referred By:_____

Have you ever had previous chiropractic care? Y N If so when:_____ With Whom?_____

Primary Care Physician:_____ Office Phone Number:_____ Date of Last Visit:_____

Are there recent X-Rays, MRI's, or CT Scans available? Y N
Date Taken?_____ Where?_____

ABOUT YOUR PAIN:

- Date pain started? _____ How did it occur?_____
- Where does it hurt?_____ Have you ever had this before? Y N when?_____
- Is the problem getting: O worse O no change O better
- Any pain at night? Y N Does coughing, sneezing or straining aggravate the pain? Y N

How would your rate the pain?
1 = I feel no pain 10 = I hurt so bad I could go to the hospital
1 2 3 4 5 6 7 8 9 10

PAST MEDICAL HISTORY:
Have you ever: (Be as accurate as possible)

- Had an accident (car, fall, sports, other)? Y N
  - If Yes, please tell us about it:_____
- Had an operation? Y N Describe (WITH DATES):_____
- Been hospitalized? Y N Describe (WITH DATES):_____
- Major Illness? Y N Describe (WITH DATES):_____

Please list any and all medication or herbal supplements and reason for taking:_____
_____

FAMILY HISTORY:
Do you have any family history in your mother, father, siblings or grandparents of BACK PAIN, HEADACHES, CANCER, DIABETES, STROKE, ARTHRITIS OR HEART DISEASE? Y N Please list conditions not mentioned:_____

If yes: Who?_____What conditions?_____Age Deceased?_____

SOCIAL HISTORY:
Smoke? Y N pks/day?_____ Alcohol? Y N drinks/day?_____
Exercise? Y N times/wk?_____Sleep_____hrs/day on: O back O left side O right side O stomach
How would you describe your stress level? O minimal O moderate Osevere O intolerable

Health History Questionnaire (PLEASE MARK ALL PAST/PRESENT CONDITIONS AS THIS SECTION IS VERY IMPORTANT)
Please circle any conditions you currently have and place an "x" on the line if you have had this condition in the past.

General
___Chronic Fever
___ Chills
___ Night Sweats
___ Loss of Sleep
___ Chronic Fatigue
___ Nervousness
___ Weight Loss/Gain
___ Allergies
___ Bleeding Problems
___ Anemia
___ Diabetes
___ Cancer
___ Thyroid Disease
___ High Cholesterol
___ Osteoporosis
___ Alcoholism
___ Drug Abuse

Cardiovascular
___ Irregular Heartbeat
___ High Blood Pressure
___ Pain in Chest
___ Heart Disease
___ Ankle Swelling
___ Varicose Veins
___ Stroke
___ Heart Attack
___ Heart Murmur

Eyes, Ears, Nose, Throat
___ Poor Vision
___ Pain in eye(s)
___ Deafness/Difficulty hearing
___ Nosebleeds
___ Nose Problems
___ Sinus Problems
___ Hoarsness
___ Difficulty Swallowing
___ Dental Problems
___ Reccurent Ear Infection

Genitourinary
___ Frequent Urination
___ Painful Urination
___ Blood in Urine
___ Urinary Infection
___ Kidney Disease
___ Inability to Control Urine
___ Difficulty Starting Urine Flow
___ Frequent Night Urination
___ Breat Lumps or Pain
___ Venereal Disease
___ Sexual Dysfuntion
___ Kidney Stones

GastroIntestinal
___ Poor Appetite
___ Poor Digestion
___ Belching or Gas
___ Chronic Nausea
___ Vomiting Blood
___ Pain over Abdomen
___ Ulcer
___ Black or Bloody Stool
___ Liver Problems
___ Gallbladder Problems
___ Jaundice
___ Hernia
___ Chronic Diarrhea
___ Chronic Constipation
___ Hemorrhoids
___ Appendicitis

Skin
___ Itchy/Dry/Flaky
___ Bruise Easily
___ Change in Mole
___ Skin Cancer
___ Rashes
___ Abnormal Scars
___ Inability to stop bleeding

Respiratory
___ Difficulty Breathing
___ Chronic Cough
___ Coughing up Phlegm
___ Coughing up Blood
___ COPD
___ Asthma
___ Pneumonia
___ Tuberculosis
___ Emphysema

Male Only
___ Testicular Swelling
___ Prostate Problems
___ Undescended Testicle
___ Painful Intercourse

Neurological
___ Weakness
___ Twitching
___ Tremors
___ Chronic Headaches
___ Fainting
___ Dizziness
___ Convulsions
___ Epilepsy
___ Numbness/Tingling
___ Arm/Leg Pain
___ Mental Disorder

Musculoskeletal
___ Neck Stiffness/Pain
___ Pain between shoulder blades
___ Low Back Pain
___ Swollen Joints
___ Stiff/Painful Joints
___ Muscle Aches/Sorness
___ Spinal Curvature
___ Arthritis
___ Knee Pain
___ Shoulder Pain
___ Wrist/Hand Pain
___ Ankle/Foot Pain
___ Radiating Pain into Arms
___ Radiating Pain into Legs
___ Disc Herniation
___ Disc Bulge

Habits/Exercise
___ Smoking ___pks/day
___ Alcohol ___drinks/wk
___ Recreational Drug Use
___ Exercise _____ times/wk
___ Caffeinated drinks __ drinks/day
___ Water _____ cups/day

Other
___ Memory Loss
___ Concentration Loss
___ Convulsions
___ Vertigo
___ Chronic Fatigue
___ Osteoporosis
___ Fibromyalgia
___ Aneurysm
___ HIV/AIDS
___ Fibromyalgia
___ Recent *UNITENTIONAL* weight loss

Please list all other past medical diagnosis: _____

WOMEN ONLY:

O excessive menstruation O irregular cycle O hot flashes O breast pain/lumps
O painful menstration O painful intercourse O other_____

ANY CHANCE YOU ARE PREGNANT? Y N HOW MANY MONTHS?_____
LAST DAY OF LAST MENSTRAL CYCLE?_____ DATE OF LAST PAP TEST?_____

ABOUT YOUR ACCIDENT:

Date & Time of Accident:_____
Was Your Accident Directly Related To Your Work? O Yes O No
Employer's Address:_____
Address where Accident Occurred: (if different from employer's address)_____
Was anyone else present during your accident? O Yes O No
Did you report your accident to your employer? O Yes ONo
What recommendations did your employer make just after your accident?_____
Has this type of accident happened to you before? O Yes O No
To the best of your knowledge, has this accident occurred in your workplace before? O Yes O No
In general: Is your job physically stressful? O Yes O No
Is your job mentally stressful? O Yes O No
Have you changed jobs in the last year? O Yes O No
Describe the accident in your own words:_____
_____

After Injury:

After the accident did you experience: O Loss of Consciousness O Dizziness O Dazed O other_____
Have you gone to a Hospital or seen any other Doctor? O Yes O No
Name of Hospital and/or Attending Doctor:_____
When did you go? O Immediately O Next day O 2 Days plus Transportation? O Ambulance O Private Vehicle
Describe any treatment you received?_____
Were X-rays taken? Y N If yes, of what areas?_____Were MRI's or CT scans taken? Y N If yes, of what areas?_____
Was medication prescribed? O Yes O No If yes name of medication and dose_____
Have you returned to work since the accident? O Yes O No
Are your work activities restricted as a result of this injury? O Yes O No
Do you have any (from the accident): O Bruises O Scars O Cuts O Broken Bones O NONE

To evaluate the effect that continuing work will have on your recovery please complete the following:

How many hours are in your normal work day?_____
Prior to the injury were capable of working on an equal basis with others our age? O Yes O No O N/A
While in recovery, is there any light duty work you could request? O Yes O No O N/A

Please indicate with checkmarks your daily job duties and any activities which you are occasionally asked to perform.

O Standing	O Driving	O Operating equipment	O Sitting	O Twisting
O Walking	O Crawling	O Typing	O Lifting	O Bending
O Stooping	O Work with arms above your head		O Other	

Indicate with a check mark the symptoms that are a result of this accident:

O Dizziness	O Difficulty sleeping	O Jaw problems	O Nausea	O Memory loss
O Irritability	O Arms/ shoulder pain	O Back pain	O Headache(s)	O Fatigue
O Numb hands/ fingers		O Lower back pain	O Blurred vision	O Tension
O Chest pain	O Back stiffness	O Buzzing in ear	O Neck pain	O Shortness of breath
O Leg pain	O Ears ringing	O Neck stiff	O Stomach upset	O Numb feet/ toes O Other

Is your condition getting worse? O Yes O No O Constant O Comes & goes

Have you retained an attorney? O Yes O No If yes, whom?_____ Phone #_____

Indicate your degree of comfort while performing the following activities: (even if only sometimes)

	Comfortable	Uncomfortable	Painful		Comfortable	Uncomfortable	Painful
Lying on back	O	O	O	Lying on side	O	O	O
Lying on stomach	O	O	O	Sitting	O	O	O
Standing	O	O	O	Stretching	O	O	O
Sexual Intercourse	O	O	O	Walking	O	O	O
Running	O	O	O	Sports	O	O	O
Working	O	O	O	Lifting	O	O	O
Bending	O	O	O	Kneeling	O	O	O
Pulling	O	O	O	Reaching	O	O	O

My Healthcare Benefits:

I fully understand when the insurance company verifies my benefits IT IS NOT A GUARANTEE OR AUTHORIZATION TO PAY ON CLAIMS SUBMITTED. I agree to pay my patient portion, plus any balance insurance does not reimburse for, at each visit. I agree to pay/settle any denied and unpaid claim. I further understand all claims submitted by this office are my responsibility and require my participation to settle regardless of my insurance company or assignment of benefits.

_____ ____/____/____
Signature of Patient or Parent/Guardian Date

Treatment Authorization and Assignment of Benefits:

This office has my permission to copy my driver's license or photo ID for the sole purpose of identification and verification. I authorize the staff to perform any necessary services needed during diagnosis and treatment. I authorize the release of any medical information necessary to process and to secure payment of benefits. I authorize payment directly to New Smyrna Beach Chiropractic Clinic, PLC/ Dr. Amanda Prokop, D.C. of the "Health Benefits", "Medical Reimbursement" from a Third Party Payer and/or "Government Benefits" otherwise payable to me. I understand this office only accepts assignment when insurance pays directly. Should collection of past due amount become necessary, I will become responsible for all charges, fees, and attorney fees. I authorize the use of this signature on all insurance submissions and I certify my sole purpose of entering this office is for healthcare.

_____ ____/____/____
Signature of Patient or Parent/Guardian Date

Consent to Treat a Minor:

I (we) being the parents, guardian, or custodian of the minor being _____, Age_____, do hereby authorize, request, and direct this office, its doctors and staff to perform examinations, diagnostic X-rays, laboratory tests, and any treatment that in their judgement is deemed advisable or is required while said minor child is under care of this office's doctors and staff until legal age. All charges for service and care given to said minor will be charged directly to me (us) and I (we) will be personally responsible for payment of them. I (we) hereby authorize the doctor to release all information necessary to secure payments of benefits. I authorized the use of this signature on all insurance submissions.

_____ ____/____/____
Signature of Patient or Parent/Guardian Date

I have completed the above information to the best of my knowledge. I authorize New Smyrna Beach Chiropractic Clinic, PLC to release any information concerning my health and health care services to my insurance companies. I hereby assign all medical benefits to which I am entitled, private insurance, Medicare, and any other insurance program to New Smyrna Beach Chiropractic Clinic, PLC and I direct that payment be made directly New Smyrna Beach Chiropractic Clinic 665 N. Dixie Freeway New Smyrna Beach, FL 32168. A photocopy of this assignment is to be considered as valid as original. This assignment will remain in effect until revoked by me in writing. I understand I am financially responsible for all charges, whether or not paid/covered by said insurance, and that I will be responsible for any amounts uncollected by New Smyrna Beach Chiropractic Clinic, PLC.

_____ ____/____/____
Signature of Patient or Parent/Guardian Date

New Smyrna Beach Chiropractic Clinic, PLC