

WORKER'S COMPENSATION CASE HISTORY

Please fill in this questionnaire **COMPLETELY**. If a section does not apply to you, simply cross it out. This confidential history will be part of your permanent records. **Please initial the bottom of each page.**

CHIEF COMPLAINT

FOR OFFICE USE ONLY

Please be sure to fill in each area completely. Mark the area(s) on your body where you feel the described sensation(s). **Use the appropriate symbol(s).** Mark areas of radiating pain, and include all affected areas. You may draw on the face as well.
Note diagram on the left is front and on right is the back.

Aches ^^^^ Numbness o o o o

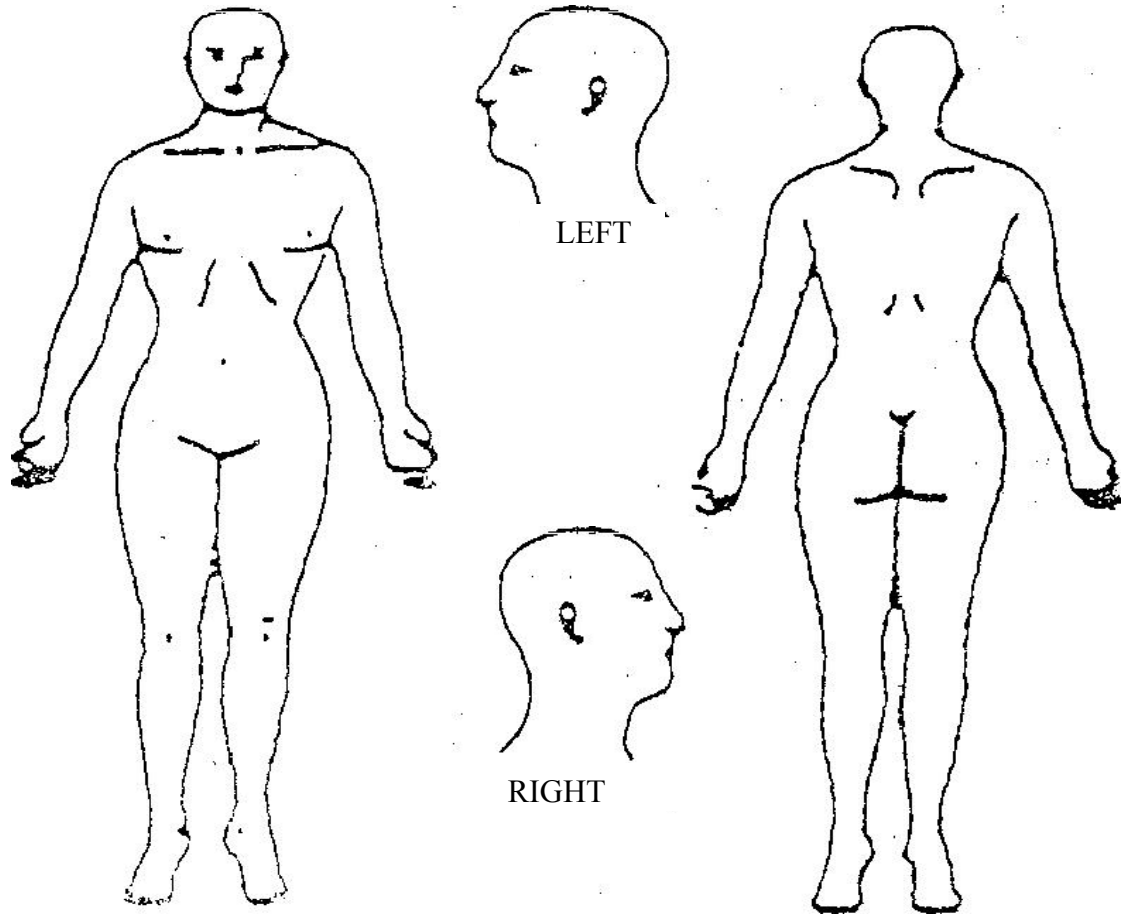
Throbbing TTTTT

Electrical EEEE

Pins/Needles ●●●●

Cramping CCCCC

Burning xxxx Sharp ////



FRONT

BACK

Place Patient Id Sticker Here

What are your major complaints in order of intensity?

What are your major complaints in order of intensity? (#1 most bothersome)	Complaint #1	Complaint #2	Complaint #3
Circle How often is your pain	No pain Occasional Intermittent Constant	No pain Occasional Intermittent Constant	No pain Occasional Intermittent Constant
List for your complaint which movement makes each area worse			
List for your complaint which movement makes each area better			
When during your day are your symptoms worse?			
When during your day are your symptoms better?			
Is this condition _____ (please circle)	Improved Mildly improved Unchanged Mildly Worse Getting Worse	Improved Mildly improved Unchanged Mildly Worse Getting Worse	Improved Mildly improved Unchanged Mildly Worse Getting Worse
On a scale of one-to-ten, how bad are your symptoms now ? (With 1 meaning 'no pain', and 10 meaning 'worst possible pain')			
On a scale of one-to-ten, how bad are your symptoms most of the time ? (With 1 meaning 'no pain', and 10 meaning 'worst possible pain')			
On a scale of one-to-ten, how bad have they been in the past ? (With 1 meaning 'no pain', and 10 meaning 'worst possible pain')			

HISTORY OF PRESENT ILLNESS

What do you think caused this condition? _____

What was the time/date/address did your injury occur? _____

Did you notify your employer of this injury? Yes No

Do you have other injuries or illnesses that affect your employment? If yes, please list: _____

In your work do you favor one part of your body more than others? Explain: _____

If disabled, (as worker/ student/ homemaker), date last worked? _____

If disabled, have you tried to return to work? Full time Part time No Yes: What day? _____

Have you received disability income related to this condition? Yes, receive now Yes, in the past No, never

Have you had this or similar conditions in the past? If yes, please explain. _____

How long have you had this condition? _____

Please describe your problem in your own words, including dates when possible. **(Please be as complete as possible.)**

LEGAL REPRESENTATION

Do you have an attorney yet? Yes No

Who is the attorney handling your injury case?

Name: _____ Phone Number: _____

Address: _____

FUNCTIONAL INFORMATION

Has pain interfered with your social life, hobbies or sexual ability? Please draw a line to the match ability level of change.

Social Life	No Change
Hobbies	Minimal Change
Sexual Ability	Considerable Change
	Completely Prevents

Does pain frequently awaken you? Yes No

If yes, about how many times would you wake up per night? _____

Before you pain how many times would you wake up per night? _____

Sleep position: Back Stomach Right side Left side

In a typical workday, your job requires that you: (8 hrs total)

Sit ___ hrs

Walk ___ hrs

Stand ___ hrs

Bend ___ hrs

At any one time, how many hours can you:

Sit ___ hrs

Walk ___ hrs

Stand ___ hrs

Bend ___ hrs

Is this condition interfering with: (Please Circle) Work, Sleep or other Daily Routines such as reading, housecleaning, driving, sitting, dressing, etc? Discuss what areas of your body you have more problems with due to each activity.

How many pounds can you carry?	Never	Sometimes	Often	Continuously
Up to 5 pounds	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
6 to 10 pounds	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
11 to 20 pounds	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
21 to 25 pounds	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
26 to 50 pounds	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
51 to 100 pounds	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

How many pounds can you lift?	Never	Sometimes	Often	Continuously
Up to 5 pounds	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
6 to 10 pounds	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
11 to 20 pounds	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
21 to 25 pounds	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
26 to 50 pounds	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
51 to 100 pounds	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Can you use your hands for:	Right hand	Left hand
Simple grasping.....	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
Pushing and pulling arm controls.....	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
Fine manipulation.....	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
Repetitive movements (pushing).....	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
Repetitive movements (pulling)	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No

How far can you walk? Less than one block 1-3 blocks 4-6 blocks A mile or more As far as I want to

Are you able to:	Never	Sometimes	Often	Continuously
Bend ...	<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	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Get on knees	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Are you performing an exercise program? When? How often? What type? _____

PREVIOUS TREATMENT

PREVIOUS TREATMENT & RESULTS	When ?	Have not had treatment	Significant Benefit	Some Benefit	No Help	Worsened Condition
Physical Therapy						
Chiropractic Manipulation						
Heating pads, ultrasound, whirlpool, massage, etc						
Nerve blocks/ Spinal injections						
Other: _____						

If applicable, what have you been told is your diagnosis/ problem? _____

By whom? _____

Who is your primary care provider?

Doctor _____ Clinic Name/Address _____

Last seen _____ Condition _____

Would you like us to refer you to a primary care provider or to a specialist for another condition you have? Yes / No

If yes what condition? _____

What other doctors have you seen in the last 3 years? Please give address if possible.

Doctor	Clinic Name/Address	Last seen	Condition

Other Treatments. Please describe: _____

DIAGNOSTIC TESTS

Please tell us what tests have been performed in evaluating your condition.

TEST	Date/ Year	Ordering Physician	Location Performed
X-rays			
CT scan/MRI			
EMG/NCV (Nerve tests)			
Bone Scan/Fluoroscopy			
Other(please list): _____			

PAST INJURY HISTORY

Have you had any prior on-the-job injuries? Yes No Explain: _____

Have you had any automobile accident injuries? Yes No Explain: _____

ASSOCIATED FACTORS CONTRIBUTING TO SPINAL COMPLAINTS

Is there pain, numbness, or tingling with prolonged standing, walking or climbing stairs in your knees, calves, shins ankles, feet or toes? Yes No

Do you experience aching or cramping in your feet? Yes No

If you wear anything other than your favorite shoes, do you experience these types of symptoms? Yes No

Do you avoid activity due to your pain in your feet or lower extremities? Yes No

Do you have to elevate your feet to get comfortable? Yes No

Are you: flat footed? Yes No have high arches? Yes No normal arches? Yes No

Do you currently wear custom-made orthotics in your shoes? Yes No Have you before? Yes No

PREVIOUS HOSPITALIZATIONS/ INJURIES/SURGERIES

When?	Condition?	Operation (if any):

MEDICATIONS

Please list all the medication that you have been taking recently.

Name of Medication	Dosage	How often
Please list medications you are allergic to:		Type of reaction

REVIEW OF SYSTEMS

Please review the following list of medical problems and mark any that apply to you now or in the past

GENERAL NOW PAST

- Weakness
- Fatigue
- Night Sweats
- Fever
- Chills

SKIN

- Color Changes
- Nail Changes
- Hair Changes
- Moles
- Rashes

HEAD

- Migraine
- Headaches
- Injuries

EARS

- Earache
- Deafness
- Ringing
- Discharge
- Hearing Aid
- Room Spins

NOSE

- Sinus Problems
- Decreased Smell
- Discharge
- Obstruction

BLOOD

- Leukemia
- Hemophilia
- Anemia
- Low Blood Iron
- Easy Bruising
- Easy Bleeding
- Swollen Nodes
- Painful Nodes
- Red Spots On Skin
- Blood Disease

NEUROLOGIC

- Seizures/Epilepsy
- Vertigo
- Dizziness
- Hand Trembling
- Loss of Sensation
- Incoordination
- Loss of Facial Sense
- Weak Grip
- Paralysis
- Difficulty w/ Speech
- Numbness/Tingling
- Brain Aneurysm
- Brain Hemorrhage
- Multiple Sclerosis

ENDOCRINE NOW PAST

- Thyroid Problems
- Hepatitis
- Jaundice
- Weight Loss
- Weight Gain
- Heat Intolerance
- Cold Intolerance
- Gall Stones
- Diabetes Type 1
- Diabetes Type 2
- Steroid Use

THROAT

- Soreness
- Hoarseness
- Pain
- Trouble Swallowing

NECK

- Lumps
- Stiff Neck
- Soreness

BREASTS

- Breast Changes
- Discharge
- Lumps
- Pain
- Bleeding

LUNGS

- Bronchitis
- Emphazema
- Chronic Cough
- Blood w/ Cough
- Short of Breath
- Wheezing

HEART

- Mitral Valve
- Prolapse
- Pacemaker
- Fainting Spells
- Heart Attack
- Shortness of Breath
- Murmur
- Palpitations
- Rapid Heartbeat
- Swollen Extremities
- Hypertension
- Cold Extremities
- Chest Pain/Pressure
- Blood Clots
- Blue Extremities
- Rheumatic Fever
- Angina w/o exertion
- Angina w/ exertion
- Phlebitis
- Stroke/TIA
- Embolism

MUSCULOSKELETAL

- Muscle Pain
- Muscle Weakness
- Muscle Cramps
- Muscle Twitching
- Joint Stiffness
- Joint Pain
- Arm Weakness
- Hand/Wrist Weakness
- Leg Weakness
- Ankle/Foot Weakness
- Arthritis _____
- Deformities _____

GASTROINTESTINAL

- Abdominal Pain
- Nausea
- Heartburn
- Constipation
- Diarrhea
- Irregular Bowel Habits
- Bloody Stools
- Black Stools
- Hemorrhoids
- Parasites
- Hiatal Hernia
- Ulcerative Colitis
- Colostomy
- Vomiting Blood

GENITOURINARY

- Gonorrhea
- Discharge
- Prostate Problems
- Urgency
- Incontinence
- Impotence
- Back Pain
- Sexual Problems
- Frequent Voiding
- Dribbling
- Burning
- Cloudy Urine
- Syphilis
- Bladder Trouble
- Kidney Stones
- Blood In Urine
- Kidney Infections
- Dialysis

OTHERS

- Cancer
- Tumor
- Gout
- Polio
- HIV/AIDS
- Scoliosis

FAMILY HISTORY

Relative	Age if Living	Age at Death	Cause of Death	State of Health	Illness
Father	_____	_____	_____	_____	_____
Mother	_____	_____	_____	_____	_____
Brother (s)	_____	_____	_____	_____	_____
Sister (s)	_____	_____	_____	_____	_____

► Do you have a family history of spinal/physical problems? (i.e. neck pain, back pain, herniated disc, degenerated disc, sciatica, etc...)

Relation: _____ Condition: _____

RESULTS OF TREATMENT

What are the results you hope for: **(Check all that are apply)**

- Pain reduction Increased recreation Improved emotional well-being
 Return to work Elimination of drugs Better daily function

What other activities would you like for us to help you get back to? _____

What do you hope will be the results of this evaluation: **(Check all that are applicable)**

- Medical diagnosis (discover the cause of the pain) Recommendation for treatment
 Recommendation for rehabilitation Determine the existence of a disability

Recommendation for surgery

Other, describe _____

^If you were treated at another office and were dissatisfied with your care, how can we improve on your experience

with us? _____

REFERRAL INFORMATION

Who can we thank for referring you?

Patient: _____ Physician: _____ Attorney: _____

Advertisement: _____ Other: _____

CURRENT TREATMENT INTERESTS

Are you interested in: **(Check all that apply)**

- | | |
|---|---|
| <input type="checkbox"/> DRS Low Back Treatment | <input type="checkbox"/> MCU Neck Pain Therapy |
| <input type="checkbox"/> Chiropractic with Occupational or Physical Therapy | <input type="checkbox"/> Massage Therapy |
| <input type="checkbox"/> Aquatic/Pool Therapy | <input type="checkbox"/> Home Exercise Program |
| <input type="checkbox"/> Orthotics (Custom Insoles) | <input type="checkbox"/> Free Spinal Health Care Workshop Classes |

FUTURE TREATMENT INTERESTS

Are you interested in: **(Check all that apply)**

- | | |
|---|--|
| <input type="checkbox"/> Acupuncture | <input type="checkbox"/> Weight loss programs |
| <input type="checkbox"/> Nutritional programs | <input type="checkbox"/> Ergonomic workstation evaluation/training |
| <input type="checkbox"/> Spa Services | <input type="checkbox"/> Anti-Aging Programs |

RELEASE OF INFORMATION:

The physician(s) may disclose all or part of the patient's record to any person or corporation which is or may be liable under a contract to the physician(s) or the patient or to a family member or employer of the patient for all part or part of the physician(s) charges, including but not limited to, insurance companies, workers' compensation carriers, welfare funds, or the patient's employer.

As a courtesy, we may send your primary care physician reports about your treatment with our office. By signing below, I authorize my records to be sent to my primary care physician and the release of any medical or other information necessary to process my claims. Our office may photograph you on your first visit for identification purposes. Your photograph may be sent to your insurance company with your medical records. Any other use will require your consent.

CONSENT FOR TREATMENT:

I voluntarily consent to the rendering of care, including treatment and performance of diagnostic procedures. I understand that I am under the care and supervision of the attending physician and it is the responsibility of the staff to carry out the instructions of such physician (s).

I understand that rehabilitation medicine occasionally aggravates an existing condition and that this may be possible in respect to my condition. I understand treatments rendered by Better Health Pain & Wellness Centers, LLC are intended to aid in the reduction of my pain and to allow as full a recovery as possible and are not intended to aggravate an existing condition or cause a new one to occur.

I have carefully completed and reviewed this form to the best of my knowledge. **Date:** _____

X

Signature of Patient, Parent or Guardian

Relationship to patient (if not self)