Krieser Chiropractic
*Family 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. Is it Ok to leave a message on the preferred number* ❒*Yes* ❒*No*

❒Home Phone: _____ ❒Work Phone: _____

❒Cell Phone: _____ ❒e-mail address:_____

*Would you like to receive appointment reminders?* ❒ NO ❒YES Preferred Method: ❒Phone call ❒ Text ❒ E-mail

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** (❒):

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

**Continued on back...**

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

| | | |
|---|---|---|
| ❍ ❒ AIDS/HIV | ❍ ❒ Heart Disease | ❍ ❒ None |
| ❍ ❒ Cancer | ❍ ❒ Diabetes | ❍ ❒ Unknown |
| ❍ ❒ High Blood Pressure | ❍ ❒ Stroke | ❍ ❒ 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: _____/_____/_____

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**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 | ❒ | ❒ | ❒ | ❒ |
| Squat | ❒ | ❒ | ❒ | ❒ |
| Crawl | ❒ | ❒ | ❒ | ❒ |
| Climb | ❒ | ❒ | ❒ | ❒ |
| Reach above head | ❒ | ❒ | ❒ | ❒ |
| Kneel | ❒ | ❒ | ❒ | ❒ |
| Balancing | ❒ | ❒ | ❒ | ❒ |
| Pushing/pulling | ❒ | ❒ | ❒ | ❒ |
| Lifting | ❒ | ❒ | ❒ | ❒ |
| Typing | ❒ | ❒ | ❒ | ❒ |

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

_____

_____

**PLEASE LIST YOUR CURRENT AREAS OF COMPLAINT:**
(chief complaint)

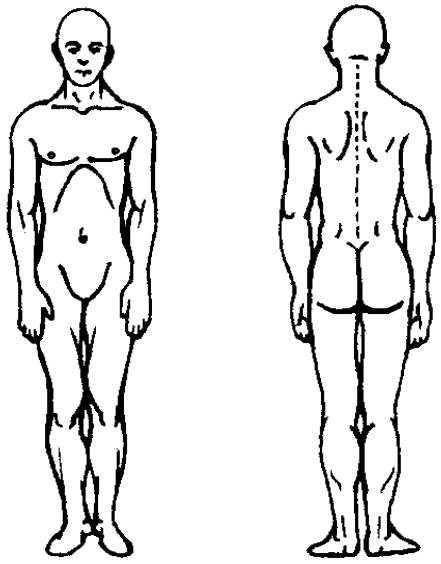
1) _____ 2) _____ 3) _____ 4) _____

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(List dosage if known): ❒ 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:** _____