



INTERNAL USE ONLY

___ CASE TYPE

___ COVERAGE TYPE

___ CONDITION TAB

___ CLAIM#

___ BATCH CLAIM ONLY

___ TERM OTHER COVERAGE

WORKERS COMPENSATION INTAKE FORM

making your health a priority

1 ACCIDENT INFORMATION

FIRST NAME _____ LAST NAME _____

DATE OF INJURY _____ TIME _____ AM PM LOCATION _____

Please describe the circumstances of the accident in detail:

Where did you feel pain immediately after the accident? _____

Did you return to work? YES NO If so, date returned: _____

Did you consult any other doctors? YES NO Doctor's Name: _____

Diagnosis | Treatment _____

Have you ever injured this area before? YES NO If yes, when? _____

Did you lose time from work? YES NO Doctor(s) consulted: _____

Do any other diseases/accidents affect your employment? YES NO

If yes, explain: _____

At work do you favor any part of your body? YES NO If yes, explain: _____

Do you have a history of absenteeism caused from accidents on the job? YES NO

Have you ever had a Workers Compensation claim before? YES NO

Before the injury, were you capable of working on an equal basis with others your age? YES NO

Are your work activities restricted as a result of this accident? YES NO

Since this injury are your symptoms: IMPROVING GETTING WORSE STAYING THE SAME

2 EMPLOYMENT INFO

EMPLOYER/OCCUPATION _____ HR CONTACT _____

ADDRESS _____

CITY _____ STATE _____ ZIP _____

PHONE _____

3 INSURANCE INFORMATION

WORKERS COMPENSATION COMPANY _____ CASE WORKER'S NAME _____

ADDRESS _____

CLAIM# _____ PHONE _____

Do you have an attorney that has advised you in this case? YES NO

If yes, attorney's name & address _____

New Beginnings Chiropractic has my permission to share information with appropriate parties in order to process claims.

PATIENT NAME (PRINT) _____

PATIENT SIGNATURE _____

DATE _____



ADULT

PATIENT INFORMATION

INSURANCE INFORMATION: Please present your insurance card(s) at time of service. If you have primary AND secondary insurance please inform the front desk, so there is no discrepancy with your claims.

1 PATIENT DEMOGRAPHICS

FIRST NAME _____ LAST NAME _____

ADDRESS _____

CITY _____ STATE _____ ZIP _____

HOME PHONE _____ CELL PHONE _____ GENDER M F

EMAIL _____ *This will be used to email receipts, for future newsletter mailings or massage specials only. It will not be solicited.*

BIRTH DATE MM|DD|YYYY _____ AGE _____ IS YOUR VISIT TODAY DUE TO A: CAR ACCIDENT

WORKERS
COMPENSATION

STATUS SINGLE MARRIED DIVORCED OTHER _____

HOW DID YOU HEAR ABOUT OUR OFFICE? GOOGLE/ OTHER _____

EXISTING PATIENT _____ ANOTHER PROVIDER _____

2 EMERGENCY CONTACT

FIRST NAME _____ LAST NAME _____

RELATIONSHIP TO PATIENT _____ PHONE _____

YOUR PRIMARY DOCTOR _____ PHONE _____

3 EMPLOYMENT INFO

EMPLOYMENT STATUS FULL-TIME SELF-EMPLOYED STUDENT
 PART-TIME UNEMPLOYED RETIRED

EMPLOYER _____ OCCUPATION _____ WORK PHONE _____

ADDRESS _____

CITY _____ STATE _____ ZIP _____

You may be asked to sign a Patient Authorization to Release Information, as we would want to request information from other providers that have participated in your care. This will help insure that we have all information concerning your condition.

4 INSURANCE INFORMATION

PATIENT NAME ON INSURANCE CARD (PRINT) _____

DATE POLICY ACTIVE _____

NAME OF INSURANCE CARRIER _____

Do you have insurance? Yes No

POLICY NUMBER _____

GROUP NUMBER _____

1. Describe your symptoms presently: _____

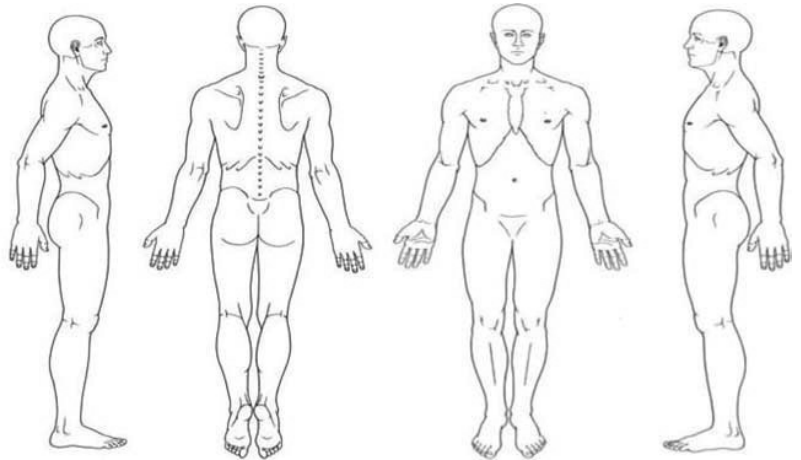
When & how did your symptoms start? _____

What makes it better/worse? _____

2. How often do you experience your symptoms?

- Constantly (76-100% of the day)
- Frequently (51-75% of the day)
- Occasionally (26-50% of the day)
- Intermittently (0-25% of the day)

Indicate where you have pain or other symptoms



3. What describes the nature of your symptoms?

- Sharp Shooting Radiating
- Dull ache Burning
- Numb Tingling

4. What describes the nature of your symptoms?

- Getting Better
- Not Changing
- Getting Worse

5. During the past 4 weeks:

Indicate the average intensity of your symptoms

NONE 0 1 2 3 4 5 6 7 8 9 10 UNBEARABLE

How much has pain interfered with your normal schedule? (Including work and home)

- All of the time Most of the time Some of the time A little of the time None of the time

How much of the time has your condition interfered with your social activities?

- All of the time Most of the time Some of the time A little of the time None of the time

6. In general would you say your overall health is right now.

- Excellent Very Good Good Fair Poor

7. Who have you seen for your symptoms? Chiropractor Medical Doctor Physical Therapist Other

What treatment did you receive and when? _____

What tests have you had for your symptoms? Xrays DATE _____ CT Scan DATE _____

MRI DATE _____ Other DATE _____

8. Have you had similar symptoms in the past? Yes No

If you have received treatment in the past for the same or similar symptoms, who did you see? This Office Medical Doctor Other

Chiropractor Physical Therapist

9. Is your pain: worse in morning worse at night worse with cough/sneeze disrupting sleep

Have you ever been to a chiropractor before? Yes No

If YES, when was your last adjustment: DATE _____ Were your goals met with this chiro? Yes No

PATIENT SIGNATURE _____

DATE _____

What Activities of Daily Living does your current condition effect (self-care, driving, stairs etc)? _____

What type of regular exercise do you perform? None _____

What is your height and weight? Height FEET INCHES Weight lbs

For each of the conditions listed below, place a check in the Past column if you have had the condition in the past. If you presently have a condition listed below, place a check in the Present column.

PAST	PRESENT		PAST	PRESENT		PAST	PRESENT	
<input type="radio"/>	<input type="radio"/>	Headaches	<input type="radio"/>	<input type="radio"/>	High Blood Pressure	<input type="radio"/>	<input type="radio"/>	Diabetes
<input type="radio"/>	<input type="radio"/>	Neck Pain	<input type="radio"/>	<input type="radio"/>	Heart Attack	<input type="radio"/>	<input type="radio"/>	Excessive Thirst
<input type="radio"/>	<input type="radio"/>	Upper Back Pain	<input type="radio"/>	<input type="radio"/>	Chest Pains	<input type="radio"/>	<input type="radio"/>	Frequent Urination
<input type="radio"/>	<input type="radio"/>	Mid Back Pain	<input type="radio"/>	<input type="radio"/>	Stroke	<input type="radio"/>	<input type="radio"/>	Smoking/Use Tobacco
<input type="radio"/>	<input type="radio"/>	Low Back Pain	<input type="radio"/>	<input type="radio"/>	Angina	<input type="radio"/>	<input type="radio"/>	Drug/Alcohol Dependence
<input type="radio"/>	<input type="radio"/>	Shoulder Pain	<input type="radio"/>	<input type="radio"/>	Kidney Stones	<input type="radio"/>	<input type="radio"/>	Depression
<input type="radio"/>	<input type="radio"/>	Elbow/Upper Arm Pain	<input type="radio"/>	<input type="radio"/>	Kidney Disorders	<input type="radio"/>	<input type="radio"/>	Systemic Lupus
<input type="radio"/>	<input type="radio"/>	Wrist Pain	<input type="radio"/>	<input type="radio"/>	Bladder Infection	<input type="radio"/>	<input type="radio"/>	Epilepsy
<input type="radio"/>	<input type="radio"/>	Hand Pain	<input type="radio"/>	<input type="radio"/>	Painful Urination	<input type="radio"/>	<input type="radio"/>	Dermatitis/Eczema/Rash
<input type="radio"/>	<input type="radio"/>	Hip/Upper Leg Pain	<input type="radio"/>	<input type="radio"/>	Loss of Bladder Control	<input type="radio"/>	<input type="radio"/>	Digestive Issues
<input type="radio"/>	<input type="radio"/>	Knee/Lower Leg Pain	<input type="radio"/>	<input type="radio"/>	Prostate Problems			
<input type="radio"/>	<input type="radio"/>	Ankle/Foot Pain	<input type="radio"/>	<input type="radio"/>	Abnormal Weight Gain/Loss			Females Only
<input type="radio"/>	<input type="radio"/>	Jaw Pain	<input type="radio"/>	<input type="radio"/>	Loss of Appetite	<input type="radio"/>	<input type="radio"/>	Birth Control Pills
<input type="radio"/>	<input type="radio"/>	Joint Swelling/Stiffness	<input type="radio"/>	<input type="radio"/>	Abdominal Pain	<input type="radio"/>	<input type="radio"/>	Hormonal Replacement
<input type="radio"/>	<input type="radio"/>	Arthritis	<input type="radio"/>	<input type="radio"/>	Ulcer	<input type="radio"/>	<input type="radio"/>	Pregnancy/How many? _____
<input type="radio"/>	<input type="radio"/>	Rheumatoid Arthritis	<input type="radio"/>	<input type="radio"/>	Hepatitis			
<input type="radio"/>	<input type="radio"/>	General Fatigue	<input type="radio"/>	<input type="radio"/>	Liver/Gall Bladder Disorder			Other Health Issues list
<input type="radio"/>	<input type="radio"/>	Muscular In-coordination	<input type="radio"/>	<input type="radio"/>	Cancer			below:
<input type="radio"/>	<input type="radio"/>	Visual Disturbances	<input type="radio"/>	<input type="radio"/>	Tumor	<input type="radio"/>	<input type="radio"/>	_____
<input type="radio"/>	<input type="radio"/>	Dizziness	<input type="radio"/>	<input type="radio"/>	Asthma	<input type="radio"/>	<input type="radio"/>	_____
			<input type="radio"/>	<input type="radio"/>	Chronic Sinusitis			

Do you have any **allergies?** (to food/medication/seasonal)? _____

Indicate if any immediate family member has had any of the following:

Rheumatoid Arthritis Heart Problems Diabetes Cancer Lupus Other _____

List ALL prescriptions, over-the-counter medications, and nutritional supplements you are taking:

List ALL surgeries/hospitalization/conditions/car accidents/sports injuries (even if you got no treatments for them)

PATIENT SIGNATURE _____

DATE _____

Doctor's Additional Comments

DOCTOR SIGNATURE _____

DATE _____



***PREFERRED METHOD OF CONTACT FOR APPOINTMENT REMINDERS:**

TEXT

EMAIL

BOTH

making your health a priority

FINANCIAL POLICY

1. Please verify your chiropractic benefits with your health insurance company. When our staff calls on your benefits they only give us an outline of benefits, not a guarantee of payment. All benefits are subject to the terms and exclusions of your policy.
2. Your insurance will make payments for any authorized and/or covered services. You are required to pay for services and materials that your insurance does not cover.
3. If your insurance requires a referral from another provider, we will require information of the referral to process your insurance with in-network benefits. Until this information is provided to us, we require you to pay all co-pays, deductibles and/or co-insurance relating to out-of-network benefits. Any over payments to your account will be reimbursed to you after insurance pays their portion.
4. If your insurance carrier has not paid your claim within sixty days of submission, you agree to take an active part in the recovery of your claim. If your insurance carrier has not paid your claim within ninety days of submission, you accept full responsibility for payment of any outstanding balance. If your account becomes delinquent and consequently gets forwarded to a collections agency, you accept full responsibility of all charges.
5. I hereby authorize payment to be made directly to New Beginnings Chiropractic LLC for all benefits which may be payable under a Healthcare plan or from any other collateral sources. I authorize utilization of this application or copies thereof for the purpose of processing claims and effecting payments, and further acknowledge that this assignment of benefits does not in any way relieve me of payment liability and that I will remain financially responsible to New Beginnings LLC for any and all services I receive at this office.

I have read and understand and agree to abide by the information stated above as it applies to my coverage.

PATIENT NAME (PRINT)

PATIENT SIGNATURE

DATE

INFORMED CONSENT TO CHIROPRACTIC TREATMENT & HIPAA NOTICE

I hereby request and consent to the performance of chiropractic procedures, including a comprehensive exam, diagnostic testing, physical therapy techniques, massage or manual therapy, adjustments or manipulation, and acupuncture on me which are recommended by the doctors at New Beginnings Chiropractic, and/or other licensed doctor of chiropractic who now or in the future render treatment to me while employed by or associated with New Beginnings Chiropractic. I have had an opportunity to discuss with the physician and/or with other office personnel the nature and purpose of chiropractic adjustments and other procedures. I understand that results are not guaranteed. I understand and am informed that, as in the practice of medicine and all healthcare, the practice of chiropractic carries some risks to treatment; including, but not limited to: fractures, muscle sprain/strain, disc injuries, strokes (CVA), dislocations, and sprains. I do not expect the physician to be able to anticipate and explain all risks and complications. Further, I wish to rely on the physician to exercise judgment during the course of the procedure which the physician feels are in my best interests at the time, based upon the facts then known.

I have read, or have had read to me, the above consent. I have also had an opportunity to ask questions about its contents, and by signing below, I agree to the treatment recommended by my physician. I intend this consent form to cover the entire course of treatment for my present condition(s) and for any condition(s) for which I seek treatment at this facility.

PATIENT NAME (PRINT)

PATIENT SIGNATURE

DATE

I consent to the use or disclosure of my protected health information by New Beginnings Chiropractic for the purpose of analyzing, diagnosing or providing treatment to me, obtaining payment for my health care bills or to conduct health care operations of New Beginnings Chiropractic. I understand that analysis, diagnosis or treatment of me by New Beginnings Chiropractic may be conditioned upon my consent as evidenced by my signature below. I understand I have the right to request a restriction as to how my protected health information is used or disclosed to carry out treatment payment or healthcare operations of this practice. New Beginnings Chiropractic is not required to agree to the restrictions that I may request. However, if New Beginnings agrees to a restriction that I request, the restriction is binding on New Beginnings Chiropractic. I have the right to revoke this consent, in writing, at any time, except to the extent that New Beginnings Chiropractic has taken action in reliance on the consent.

My protected health information means health information, including my demographic information, collected from me and created or received by my physician, another health care provider, and health plan, my employer or a health care clearinghouse. This protected health information relates to my past, present or future physical or mental health or condition and identifies me, or there is a reasonable basis to believe the information may identify me. A full copy of HIPAA policies are available upon request.

PATIENT NAME (PRINT)

PATIENT SIGNATURE

DATE

OSWESTRY LOW BACK DISABILITY QUESTIONNAIRE

Instructions: this questionnaire has been designed to give us information as to how your back pain has affected your ability to manage everyday life. Please answer every section and mark in each section only the ONE box which applies to you at this time. We realize you may consider 2 of the statements in any section may relate to you, but please mark the box which most closely describes your current condition.

1. PAIN INTENSITY

- I can tolerate the pain I have without having to use pain killers
- The pain is bad but I manage without taking pain killers
- Pain killers give complete relief from pain
- Pain killers give moderate relief from pain
- Pain killers give very little relief from pain
- Pain killers have no effect on the pain and I do not use them

2. PERSONAL CARE (e.g. Washing, Dressing)

- I can look after myself normally without causing extra pain
- I can look after myself normally but it causes extra pain
- It is painful to look after myself and I am slow and careful
- I need some help but manage most of my personal care
- I need help every day in most aspects of self care
- I don't get dressed, I was with difficulty and stay in bed

3. LIFTING

- I can lift heavy weights without extra pain
- I can lift heavy weights but it gives extra pain
- Pain prevents me from lifting heavy weights off the floor, but I can manage if they are conveniently positioned, i.e. on a table
- Pain prevents me from lifting heavy weights, but I can manage light to medium weights if they are conveniently positioned
- I can lift very light weights
- I cannot lift or carry anything at all

4. WALKING

- Pain does not prevent me walking any distance
- Pain prevents me walking more than one mile
- Pain prevents me walking more than ½ mile
- Pain prevents me walking more than ¼ mile
- I can only walk using a stick or crutches
- I am in bed most of the time and have to crawl to the toilet

5. SITTING

- I can sit in any chair as long as I like
- I can only sit in my favorite chair as long as I like
- Pain prevents me from sitting more than one hour
- Pain prevents me from sitting more than ½ hour
- Pain prevents me from sitting more than 10 minutes
- Pain prevents me from sitting at all

6. STANDING

- I can stand as long as I want without extra pain
- I can stand as long as I want but it gives me extra pain
- Pain prevents me from standing for more than one hour
- Pain prevents me from standing for more than 30 minutes
- Pain prevents me from standing for more than 10 minutes
- Pain prevents me from standing at all

7. SLEEPING

- Pain does not prevent me from sleeping well
- I can sleep well only by using medication
- Even when I take medication, I have less than 6 hrs sleep
- Even when I take medication, I have less than 4 hrs sleep
- Even when I take medication, I have less than 2 hrs sleep
- Pain prevents me from sleeping at all

8. SOCIAL LIFE

- My social life is normal and gives me no extra pain
- My social life is normal but increases the degree of pain
- Pain has no significant effect on my social life apart from limiting my more energetic interests, i.e. dancing, etc.
- Pain has restricted my social life and I do not go out as often
- Pain has restricted my social life to my home
- I have no social life because of pain

9. TRAVELLING

- I can travel anywhere without extra pain
- I can travel anywhere but it gives me extra pain
- Pain is bad, but I manage journeys over 2 hours
- Pain restricts me to journeys of less than 1 hour
- Pain restricts me to short necessary journeys under 30 minutes
- Pain prevents me from traveling except to the doctor or hospital

10. EMPLOYMENT/ HOME MAKING

- My normal homemaking/ job activities do not cause pain.
- My normal homemaking/ job activities increase my pain, but I can still perform all that is required of me.
- I can perform most of my homemaking/ job duties, but pain prevents me from performing more physically stressful activities (e.g. lifting, vacuuming)
- Pain prevents me from doing anything but light duties.
- Pain prevents me from doing even light duties.
- Pain prevents me from performing any job or homemaking chores.

Neck Index

ACN Group, Inc. Form NI-100

ACN Group, Inc. Use Only rev 3/27/2003

Patient Name _____ **Date** _____

This questionnaire will give your provider information about how your neck condition affects your everyday life. Please answer every section by marking the one statement that applies to you. If two or more statements in one section apply, please mark the one statement that most closely describes your problem.

Pain Intensity

- ⓪ I have no pain at the moment.
- ① The pain is very mild at the moment.
- ② The pain comes and goes and is moderate.
- ③ The pain is fairly severe at the moment.
- ④ The pain is very severe at the moment.
- ⑤ The pain is the worst imaginable at the moment.

Sleeping

- ⓪ I have no trouble sleeping.
- ① My sleep is slightly disturbed (less than 1 hour sleepless).
- ② My sleep is mildly disturbed (1-2 hours sleepless).
- ③ My sleep is moderately disturbed (2-3 hours sleepless).
- ④ My sleep is greatly disturbed (3-5 hours sleepless).
- ⑤ My sleep is completely disturbed (5-7 hours sleepless).

Reading

- ⓪ I can read as much as I want with no neck pain.
- ① I can read as much as I want with slight neck pain.
- ② I can read as much as I want with moderate neck pain.
- ③ I cannot read as much as I want because of moderate neck pain.
- ④ I can hardly read at all because of severe neck pain.
- ⑤ I cannot read at all because of neck pain.

Concentration

- ⓪ I can concentrate fully when I want with no difficulty.
- ① I can concentrate fully when I want with slight difficulty.
- ② I have a fair degree of difficulty concentrating when I want.
- ③ I have a lot of difficulty concentrating when I want.
- ④ I have a great deal of difficulty concentrating when I want.
- ⑤ I cannot concentrate at all.

Work

- ⓪ I can do as much work as I want.
- ① I can only do my usual work but no more.
- ② I can only do most of my usual work but no more.
- ③ I cannot do my usual work.
- ④ I can hardly do any work at all.
- ⑤ I cannot do any work at all.

Personal Care

- ⓪ I can look after myself normally without causing extra pain.
- ① I can look after myself normally but it causes extra pain.
- ② It is painful to look after myself and I am slow and careful.
- ③ I need some help but I manage most of my personal care.
- ④ I need help every day in most aspects of self care.
- ⑤ I do not get dressed, I wash with difficulty and stay in bed.

Lifting

- ⓪ I can lift heavy weights without extra pain.
- ① I can lift heavy weights but it causes extra pain.
- ② Pain prevents me from lifting heavy weights off the floor, but I can manage if they are conveniently positioned (e.g., on a table).
- ③ Pain prevents me from lifting heavy weights off the floor, but I can manage light to medium weights if they are conveniently positioned.
- ④ I can only lift very light weights.
- ⑤ I cannot lift or carry anything at all.

Driving

- ⓪ I can drive my car without any neck pain.
- ① I can drive my car as long as I want with slight neck pain.
- ② I can drive my car as long as I want with moderate neck pain.
- ③ I cannot drive my car as long as I want because of moderate neck pain.
- ④ I can hardly drive at all because of severe neck pain.
- ⑤ I cannot drive my car at all because of neck pain.

Recreation

- ⓪ I am able to engage in all my recreation activities without neck pain.
- ① I am able to engage in all my usual recreation activities with some neck pain.
- ② I am able to engage in most but not all my usual recreation activities because of neck pain.
- ③ I am only able to engage in a few of my usual recreation activities because of neck pain.
- ④ I can hardly do any recreation activities because of neck pain.
- ⑤ I cannot do any recreation activities at all.

Headaches

- ⓪ I have no headaches at all.
- ① I have slight headaches which come infrequently.
- ② I have moderate headaches which come infrequently.
- ③ I have moderate headaches which come frequently.
- ④ I have severe headaches which come frequently.
- ⑤ I have headaches almost all the time.

Neck
Index
Score