ULERY CHIROPRACTIC

SPINE, SPORT & REHAB

Todd Ulery, DC, CCSP
Certified Chiropractic Sports Physician

109 Crossroads Road, Suite 206
Scottdale, PA 15683
724-887-4661
www.ulerychiropractic.com

WORK ACCIDENT PATIENT INFORMATION & CONDITION

PERSONAL INFORMATION

TODAY'S DATE ________________ ☐ MARRIED ☐ SINGLE ☐ SEPARATED ☐ DIVORCED ☐ WIDOWED

NAME ______________________________ EMAIL ______________________

BIRTH DATE ____________ AGE _____ GENDER M / F SOCIAL SECURITY NUMBER ______________

ADDRESS ______________________ CITY ______________ STATE______ ZIP ________

HOME PHONE ______________ CELL PHONE ______________ WORK PHONE ______________

ARE YOU A STUDENT ☐NO ☐ YES ☐FULL-TIME ☐PART-TIME SCHOOL NAME ______________

SPOUSE NAME ______________ SPOUSE DATE OF BIRTH __________SPOUSE PHONE ______________

SPOUSE OCCUPATION ______________ SPOUSE'S EMPLOYER ______________

EMERGENCY CONTACT NAME & RELATIONSHIP ______________________ PHONE ______________

HOW DID YOU LEARN ABOUT US ______________________________

EMPLOYMENT INFORMATION

OCCUPATION ______________ ☐FULL TIME ☐ PART TIME

EMPLOYER ______________________ EMPLOYER PHONE ______________

EMPLOYER ADDRESS ______________________STATE_____ ZIP__________

INSURANCE INFORMATION

WORKER'S COMP INSURANCE______________________ CLAIM #______________

CLAIM REP NAME ______________________ CLAIM REP PHONE ______________

MEDICAL INFORMATION

PRIMARY CARE PHYSICIAN ______________________ PHONE ______________

ADDRESS ______________________ STATE __________ ZIP ________

BASIC INFORMATION ABOUT THE ACCIDENT

DATE ACCIDENT OCCURRED OR STARTED______________ TIME OF DAY ACCIDENT OCCURRED OR STARTED _____:_____AM/PM

DESCRIBE HOW THE ACCIDENT TOOK PLACE ____

____

____

DESCRIBE THE CONDITION OR SYMPTOMS CAUSED BY THE ACCIDENT____

____

____

WORK-ACCIDENT SPECIFIC INFORMATION

CHECK ALL THAT APPLY

☐ DID THE ACCIDENT OCCUR ON THE PREMISES OF THE FACILITY WHERE YOU NORMALLY WORK (YOUR LOCAL WORK ADDRESS)?

☐ DID THE ACCIDENT OCCUR DURING YOUR NORMAL WORKING HOURS?

☐ DID YOU REPORT THE ACCIDENT TO YOUR EMPLOYER?

☐ IS YOUR EMPLOYER COVERED BY WORKER'S COMPENSATION INSURANCE UNDER STATE LAW?

☐ HAS YOUR EMPLOYER PREPARED AN INITIAL WRITTEN REPORT?

☐ DOES YOUR EMPLOYER'S REPORT DESCRIBE THE CONDITION OR SYMPTOMS YOU ARE EXPERIENCING?

☐ HAS A CLAIM NUMBER BEEN ISSUED FOR THIS ACCIDENT?

☐ HAVE YOU RECEIVED ANY WRITTEN DENIAL OF LIABILITY FROM EITHER YOUR EMPLOYER OR WORKER'S INSURANCE COMP PAYER?

ADDITIONAL INFORMATION RELATED TO THE CONDITION

DESCRIBE YOUR PAIN ☐ BURNING ☐ SHARP

☐DULL ☐ ACHE ☐NUMB/TINGLING

RATE YOUR PAIN

NO PAIN--1--2—3—4--5—6—7—8—9--10--SEVERE PAIN

IS THE PAIN ☐CONSTANT or does it ☐COME and GO

DOES THE PAIN INTERFERE WITH YOUR

☐WORK ☐SLEEEP

☐DAILY ROUTINE ☐RECREATION

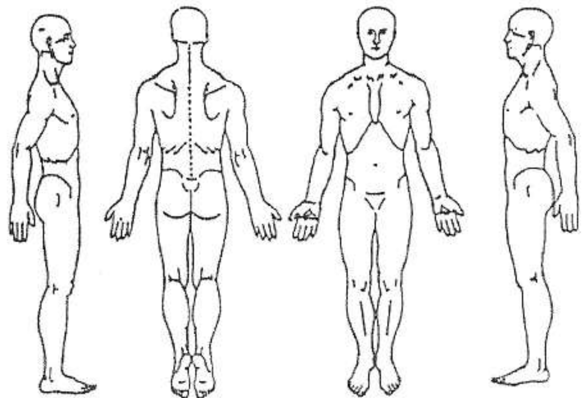
ARE ANY OF THE FOLLOWING PAINFUL TO PERFORM

☐SITTING ☐STANDING ☐WALKING

☐BENDING ☐LYING DOWN

PLEASE MARK – XXXXXX FOR PAIN

OOOOO FOR NUMBNESS



WHAT CAUSED YOUR PAIN ____________________

WHAT AGGRAVATES YOUR PAIN____________________

WHAT RELIEVES YOUR PAIN ____________________

HAVE YOU EVER HAD THE SAME OR SIMILAR CONDITION IN THE PAST ☐ NO ☐ YES -- DATE ________

IF YES PLEASE DESCRIBE ____________________

HAVE YOU MISSED WORK OR SCHOOL AS A RESULT OF YOUR INJURIES ☐ NO ☐ YES

PLEASE LIST ANY OTHER HEALTHCARE PROVIDERS YOU'VE SEEN FOR THIS CONDITION AND WHEN YOU LAST SAW THEM

NAME	TYPE OF PRACTICE:	DATE OF LAST VISIT:

ARE YOU CURRENTLY EXPERIENCING ANY OF THE FOLLOWING SYMPTOMS

☐HEADACHE	☐CLUMSINESS	☐TINGLING LEGS/FEET	☐NERVOUSNESS	☐NUMBNESS LEGS/FEET
☐LOSS OF MEMORY	☐SLEEPING PROBLEMS	☐CONSTIPATION	☐FAINTING	☐SHARP SHOOTING PAIN
☐HANDS COLD	☐BUZZING IN EARS	☐SHORTNESS OF BREATH	☐PAIN ARMS/HANDS	☐NECK PAIN
☐NUMBNESS ARMS/HANDS	☐TENSION	☐CHEST/RIB PAIN	☐DIFFICULTY SWALLOWING	☐EARS RING
☐COLD SWEATS	☐LOSS OF SMELL	☐LOSS OF STRENGTH LEGS	☐HEAD SEEMS TOO HEAVY	☐BACK PAIN
☐IRRITABILITY	☐BURNING MUSCLE PAIN	☐DIARRHEA	☐TINGLING ARMS/HANDS	☐LOSS OF BALANCE
☐LOSS OF STRENGTH ARMS/HANDS	☐LIGHT BOTHERS EYES	☐NECK STIFFNESS	☐NAUSEA	☐FATIGUE
☐DIZZINESS	☐FEET COLD	☐FACE FLUSHED	☐FEVER	☐JAW PAIN

HAVE YOU EXPERIENCED ANY CHANGE TO

☐EYES (SIGHT) ☐EARS (HEARING) ☐NOSE (SMELL) ☐MOUTH (TASTE) ☐BLADDER ☐BOWELS ☐SLEEP ☐EMOTION ☐APPETITE

PLEASE EXPLAIN ____________________

DO YOU SMOKE ☐ NO ☐ YES -- # OF PACKS______ HOW OFTEN________

DO YOU DRINK ALCOHOL ☐ NO ☐ YES -- # OF DRINKS______ HOW OFTEN________

MEDICAL HISTORY

HAVE YOU BEEN IN OUR OFFICE BEFORE ☐ NO ☐YES

LIST ANY PREVIOUS ACCIDENTS OR INJURIES (WORK, AUTO OR PERSONAL)

1. ______________________________ DATE ____________
2. ______________________________ DATE ____________
3. ______________________________ DATE ____________

SURGERIES / HOSPITALIZATIONS AND DATES

1. ______________________________ DATE ____________
2. ______________________________ DATE ____________
3. ______________________________ DATE ____________

ALLERGIES ______________________________

CURRENT MEDICATIONS AND REASON TAKING ______________________________

____

PLEASE INDICATE IF YOU HAVE EVER HAD OR IF YOU NOW HAVE ANY OF THE FOLOWING MEDICAL CONDITIONS

☐AIDS/HIV	☐CHEMICAL DEPENDENCY	☐KIDNEY DISEASE	☐PROSTHESIS
☐ANEMIA	☐DIABETES	☐LIVER DISEASE	☐RHEUMATOID ARTHRITIS
☐ANOREXIA	☐EPILEPSY	☐MIGRAINE HEADACHES	☐STROKE
☐ARTHRITIS	☐FRACTURES ________	☐MULTIPLE SCLEROSIS	☐THYROID PROBLEMS
☐ASTHMA	☐HEART DISEASE	☐OSTEOPOROSIS	☐TUMORS/GROWTH
☐BLEEDING DISORDER	☐HEPATITIS	☐PARKINSON'S DISEASE	☐OTHER ________
☐BREAST LUMP	☐HERPES	☐PINCHED NERVE	________
☐BULIMIA	☐HIGH BLOOD PRESSURE	☐POLIO	________
☐CANCER ________	☐HIGH CHOLESTEROL	☐PROSTATE PROBLEMS	

ARE YOU PREGNANT OR ANY POSSIBILTY YOU MAY BE PREGNANT ☐ YES ☐ NO ☐ UNCERTAIN

I HAVE READ, UNDERSTOOD, AND AGREE TO THE FOREGOING. THE INFORMATION WHICH I HAVE PROVIDED IS TRUE AND COMPLETE TO THE BEST OF MY KNOWLEDGE.

PATIENT SIGNATURE ______________________________ DATE ____________

ULERY CHIROPRACTIC
SPINE, SPORT & REHAB
Todd Ulery, DC, CCSP
Certified Chiropractic Sports Physician

109 Crossroads Road, Suite 206
Scottdale, PA 15683
724-887-4661
www.ulerychiropractic.com

PATIENT AUTHORIZATION TO USE AND DISCLOSE HEALTH INFORMATION

I, ______________________ HEREBY AUTHORIZE ULERY CHIROPRACTIC TO USE AND DISCLOSE MY HEALTH INFORMATION IN THE MANNER DESCRIBED BELOW.

1. RELEASE OF EXAMINATION AND TEST RESULTS TO PHYSCIANS, HOSPITALS, AND HEALTH CARE AGENCIES INVOLVED IN MY CARE.
2. I AUTHORIZE ULERY CHIROPRACTIC TO PROVIDE ME COPIES OF TEST RESULTS UPON MY REQUEST AND WILL ASSUME RESPONSIBILTY FOR SAFEGUARDING THIS HEALTHCARE INFORMATION FROM IMPROPER DISCLOSURE
3. I AUTHORIZE ULERY CHIROPRACTIC TO DISCLOSE MY HEALTH CARE INFORMATION AND/OR BILLING INFORMATION TO THE FOLLOWING PERSON WHO IS INVOLVED WITH MY CARE:

   ____

   ____

4. I AUTHORIZE ULERY CHIROPRACTIC TO RECEIVE HEALTH CARE INFORMATION FROM ANY PHYSICIAN OR HEALTH CARE AGENCY DIRECTLY INVOLVED IN MY CARE. THIS APPLIES TO VERBAL, WRITTEN AND ELECTRONIC SUBMISSIONS.
5. THIS AUTHORIZATION IS IN EFFECT UNTIL I REVOKE IT AND I UNDERSTAND THAT I MAY REVOKE THIS AUTHORIZATION AT ANY TIME BY NOTIFYING ULERY CHIROPRACTIC IN WRITING. I AM AWARE THAT MY REVOCATION S NOT EFFECTIVE TO THE EXTENT OF THE PERSONS THAT I HAVE AUTHORIZED TO USE/OR DISCLOSE MY HEALTH INFORMATION HAVE ACTED IN RELIANCE UPON THIS AUTHORIZATION.

______________________________ ______________________

PATIENT SIGNATURE DATE

IF THIS AUTHORIZATION IS SIGNED BY A PATIENT'S PERSONAL REPRESENTATIVE ON BEHALF OF THIS PATIENT, PLEASE COMPLETE THE FOLLOWING:

______________________________ ______________________

NAME OF PERSONAL REPRESENTATIVE RELATIONSHIP TO PATIENT

*NOTE THAT THIS FORM MAY BE USED TO DOCUMENT THE FOLLOWING TYPES OF PERSONAL REPRESENTATIVE RELATIONSHIPS: 1) MAKING APPOINTMENTS FOR HEALTH CARE SERVICES 2) DISCUSSION WITH HEALTH CARE PROVIDERS ABOUT ROUTINE TESTS AND TREATMENT (DO NOT REQUIRE INFORMED CONSENT) 3) ACCESS TO MEDICAL RECORDS.

*NOTE THAT THIS FORM ALSO SERVES AS AN ACKNOWLEDGEMENT THAT THE PATIENT HAS RECEIVED OR BEEN MADE AWARE OF ULERY CHIROPRACTIC'S NOTICE OF PRIVACY PRACTICE FOR PROTECTED HEALTH INFORMATION.

ULERY CHIROPRACTIC

SPINE, SPORT & REHAB
Todd Ulery, DC, CCSP
Certified Chiropractic Sports Physician

109 Crossroads Road, Suite 206
Scottdale, PA 15683
724-887-4661
www.ulerychiropractic.com

RELEASE OF RESPONSIBILITY

ALL INSURANCE RECIPIENTS

IN THE EVENT OF NON –PAYMENT BY AN INSURANCE CARIIER (HEALTH, AUTO or WORKERS COMP), I TAKE FULL RESPONSIBILITY FOR PAYMENT OF ALL TREATMENT RENDERD BY ULERY CHIROPRACTIC.

BY MY SIGNATURE, I ACKNOWLEDGE THAT IF MY INSURANCE CARRIER DENIES PAYMENT I AGREE TO BE PERSONALLY AND FULLY REPSONSIBLE FOR PAYMENT AND THAT I AM ALSO RESPONSIBLE FOR ANY CHARGES OR BALANCES NOT COVERED BY MY INSURANCE CARRIER.

MEDICARE RECIPIENTS

IN ACCORDANCE WITH THE MEDICARE ACT, SECTION 1842 (1), THIS NOTICE IS TO ADVISE YOU THAT MEDICARE WILL ONLY PAY FOR SERVICES THAT IT DETERMINES TO BE REASONABLE AND NECESSARY UNDER SECTION 1852 (1) OF THE MEDICARE ACT. IF MEDICARE DETERMINES THAT A PARTICULAR SERVICE, ALTHOUGH NORMALLY COVERED, IS NOT REASONABLE AND NECESSARY UNDER MEDICARE PROGRAM STANDARDS, MEDICARE WILL DENY PAYMENT FOR THAT SERVICE.

BY MY SIGNATURE, NOTIFICATION BY MY DOCTOR THAT HE BELIEVES IN MY CASE MEDICARE IS LIKELY TO DENY PAYMENT FOR THE SERVICES RENDERED FOR THE REASON STATED ABOVE. IF MEDICARE DENIES PAYMENT I AGREE TO BE PERSONALLY RESPONSIBLE FOR PAYMENT AND THAT I AM ALSO RESPONSIBLE FOR ANY CHARGES OR BALANCES NOT COVERED BY MY INSURANCE CARRIER.

_______________________________ _______________________
PATIENT SIGNATURE DATE

_______________________________ _______________________
WITNESS SIGNATURE DATE

IN OUR OFFICE WE SPECIALIZE IN TREATING THE NEURO-MUSCULOSKELETAL SYSTEM. WE UTILIZE X-RAYS TO HELP INSURE AN ACCURATE DIAGNOSIS AND PROPER TREATMENT PLAN. MANUAL ADJUSTMENTS, ELECTRICAL MUSCLE STIMULATION, ULTRASOUND, CRYOTHERAPY (ICE), MOIST HEAT, INTERSEGMENTAL TRACTION, REHABILITATIVE EXERCISES, AND DIOWAVE LASER ARE UTILIZED IN THIS OFFICE AS PART OF YOUR TOTAL HEALTH CARE.
IF DR. ULERY FEELS THAT YOUR CONDITION CANNOT BE TREATED CHIROPRACTICALLY, A PROPER REFERRAL WILL BE MADE IMMEDIATELY. THEREFORE, WE MUST BE INFORMED OF ANY NEW OR EXISTING PROBLEMS THAT YOU MAY BE HAVING.

I AM FULLY AWARE OF DR. ULERY'S RECOMMENDATIONS FOR CARE AND I AM AUTHORIZING TREATMENT THEREOF.

_______________________________ _______________________
PATIENT SIGNATURE DATE

_______________________________ _______________________
WITNESS SIGNATURE DATE