WORKERS COMPENSATION HISTORY

Patient Name: _____

Employers Name: _____ Telephone Number: _____

Address: _____ City: _____ State: _____ Zip: _____

Injury Description

Date present injury was received: _____ Time of injury: _____ Date/time injury was reported: _____

Who saw the accident? **Name**_____ **Title** _____

Who reported the accident? **Name** _____ **Title** _____

Who was the accident reported to? **Name** _____ **Title** _____

How did the injury occur (be specific)? _____

_____

_____

_____

Present Work History

What is the job classification/name of your normal job? _____

Please describe your normal job _____

How long have you been at your present job? _____

Average work week: Hours/day: _____ Days/week: _____

Were you performing your normal job at the time of injury? **Yes** **No**

Have you lost any time from work as a result of this work injury? **Yes** **No**

If yes, please give dates of time lost: _____

Have you gone back to work: **Yes** **No**

If yes, what status of work have you returned to? **Modified** **Regular** When did you return (date)? _____

Please list any restrictions you have been placed on: _____

If you are presently back to work, please list work activities that are painful or difficult:

_____

Are there any problems you have with a fellow employee, supervisor, or management that need to be discussed? **Yes** **No**

If off work, do you want to return to your normal job? **Yes** **No**

Doctors seen/Hospital visits

Have you gone to the hospital or seen any doctors/physicians for this injury? **Yes No**

DOCTOR #1:

Name: _____ Date of first visit: _____

Were you examined? **Yes No** Did you receive (circle) **X-rays MRI CT scan**? Did you receive Treatment: **Yes No**

If you received treatment:

What type of treatment did you receive? _____

What benefits did you receive from treatment? _____

What was the date of your last treatment? _____

DOCTOR #2:

Name: _____ Date of first visit: _____

Were you examined? **Yes No** Did you receive (circle) **X-rays MRI CT scan**? Did you receive Treatment: **Yes No**

If you received treatment:

What type of treatment did you receive? _____

What benefits did you receive from treatment? _____

What was the date of your last treatment? _____

Prior Similar Symptoms

Just prior to your work injury, did you have any physical complaints that are the same or similar to the current complaints caused by present work injury? **Yes No**

If yes, please describe: _____

Have you retained legal counsel (attorney) for this injury? **Yes No**

If yes, give name and address: _____

The above information is accurate and has been completed to the best of my knowledge:

_____ _____

Patient Signature Date

Ohio | Bureau of Workers' Compensation

First Report of an Injury, Occupational Disease or Death

This form can be completed and submitted online at **ohiobwc.com**

Report your injury by completing all three sections of this form

1. Complete as much of all three sections of this form as possible to reduce the time necessary in determining the claim. If this form is completed by the injured worker at the first visit to a medical provider, the injured worker may give the FROI to the provider to complete the treatment information section.The provider can then submit the FROI to the MCO.
2. Deliver, mail or fax the completed document to your employer or your employer's managed care organization (MCO).
3. If you do not know your employer's MCO, contact BWC at **1-800-OHIOBWC** and follow the prompts, or use the MCO on BWC's Web site at **ohiobwc.com.**
4. If you are unable to determine your MCO, mail or fax this form to the BWC customer service office closest to your home. For information on your local customer service office, please visit **ohiobwc.com**, or call **1-800-OHIOBWC**.

Injured workers employed by a self-insuring employer

- Complete this form and give to your employer.
- Your employer should be able to tell you if he or she is a self-insuring employer.
- If your employer is self-insuring and you file this information with BWC, processing delays may occur.

For assistance in completing this form, call your BWC customer service office Monday through Friday, 8 a.m. – 5 p.m.

Cambridge
61501 Southgate Road
Cambridge, OH 43725
Phone: 740-435-4200
Fax: 866-281-9351

Canton
400 Third St., SE
Canton, OH 44702-1102
Phone: 330-438-0638
Toll free: 800-713-0991
Fax: 866-281-9352

Cleveland
615 Superior Ave. W.
Cleveland, OH 44113-1889
Phone: 216-787-3050
Toll free: 800-821-7075
Fax: 866-336-8345

Columbus
30 W. Spring St.
Columbus, OH 43215-2256
Phone: 614-728-5416
Fax: 866-336-8352

Dayton
3401 Park Center Drive
Dayton, OH 45413-0910
Phone: 937-264-5000
Fax: 866-281-9356

Garfield Heights
4800 E. 131 St., Suite A
Garfield Heights, OH 44105
Phone: 216-584-0100
Toll free: 800-224-6446
Fax: 866-457-0590

Governor's Hill
8650 Governor's Hill Drive
Cincinnati, OH 45249
Phone: 513-583-4400
Fax: 866-281-9357

Hamilton
1 Renaissance Center
345 High St.
Hamilton, OH 45011
Phone: 513-785-4500
Fax: 866-336-8343

Lima
2025 E. Fourth St.
Lima, OH 45804-4101
Phone: 419-227-3127
Toll free: 888-419-3127
Fax: 866-336-8346

Logan
P.O. Box 630
1225 W. Hunter St.
Logan, OH 43138-0630
Phone: 740-385-5607
Toll free: 800-385-5607
Fax: 866-336-8348

Mansfield
240 Tappan Drive, N.
Mansfield, OH 44906-8051
Phone: 419-747-4090
Fax: 866-336-8350

Portsmouth
1005 Fourth St.
Portsmouth, OH 45662-1307
Phone: 740-353-2187
Fax: 866-336-8353

Toledo
P.O. Box 794
1 Government Center, Suite 1136
Toledo, OH 43697-0794
Phone: 419-245-2700
Fax: 866-457-0594

Youngstown
242 Federal Plaza, W., Suite 200
Youngstown, OH 44501-1877
Phone: 330-797-5500
Toll free: 800-551-6446
Fax: 866-457-0596

Completion instructions
(continued)

Injured worker and injury/disease/death info.

Last name, first name, middle initial | Social Security number | Marital status ☐ Single ☐ Married ☐ Divorced ☐ Separated ☐ Widowed | Date of birth

Home mailing address (1) | Sex ☐ Male ☐ Female | Number of dependents

City | State | 9-digit ZIP code | Country if different from USA | Department name (2)

Wage rate $_____ Per: (3) ☐ Hour ☐ Month ☐ Week ☐ Year ☐ Other_____ | What days of the week do you usually work? (4) ☐ Sun ☐ Mon ☐ Tues ☐ Wed ☐ Thur ☐ Fri ☐ Sat | Regular work hours From ____ To ____ (4)

Have you been offered or do you expect to receive payment or wages for this claim from anyone other than the Ohio Bureau of Workers' Compensation? ☐ YES ☐ NO If yes, please explain. (5) | Occupation or job title (6)

Employer name (7)

Mailing address (number and street, city or town, state, ZIP code and county)

Location, if different from mailing address

Was place of accident or exposure on employer's premises? ☐ Yes ☐ No
If no, give accident location, street address, city, state and ZIP code.

Date of injury/disease (8) | Time of injury _____ ☐ a.m. ☐ p.m. | If fatal, give date of death | Time employee began work _____ ☐ a.m. ☐ p.m. | Date last worked (9) | Date returned to work (10)

Date hired | State where hired (11) | Date employer notified (12) | State where supervised (13)

Description of accident (Describe the sequence of events that directly injured the employee, or caused the disease or death) (14) | Type of injury/disease and part(s) of body affected (for example: sprain of lower left back, etc.) (15)

Benefit application release of information – I am applying for a claim under the Ohio Bureau of Workers' Compensation Act for work-related injuries that I did not inflict. I affirm that I elect to receive compensation and benefits under Ohio's workers' compensation laws for my claim, and I waive and release my right to file for and receive compensation and benefits under the laws of any other state for this claim. I request payment for compensation and/or medical benefits as allowable, and authorize direct payment to my medical providers. I permit and authorize any provider who attends, treats or examines me, the Ohio State Board of Pharmacy, the Ohio Department of Job and Family Services and the Ohio Rehabilitation Services Commission to release medical, psychological, psychiatric, pharmaceutical, vocational and social information. I understand this may include personally identifying information that is casually or historically related to my physical or mental injuries relevant to issues necessary for the administration of my claim to BWC, the Industrial Commission of Ohio, the employer in this claim, the employer's managed care organization and any authorized representatives. My previous or future BWC claims may affect decisions made in this claim. Proper administration of the present claim may require BWC to share claims information with the employers of record (or their authorized representatives) and/or my authorized representative for any and all such previous or future claims. The released claims information may include any record maintained in my claim files.

Injured worker signature (16) | Date | E-mail address | Telephone number ( ) | Work number ( )

Injured worker and injury/disease/death info.

(1) Home address: Enter the home address where the injured worker lives. Include the apartment number, if applicable.
- If the post office does not deliver mail to the home address, list the mailing address instead of the home address.

(2) Department name: Enter the injured worker's department or area name where he/she normally reports for work.

(3) Wage rate: Enter the injured worker's rate of pay, and then select how often it is received. (If the pay rate being reported is not hourly, report the gross amount.)
- If eight or more days of work will be missed, BWC needs wage information for the 52 weeks prior to the date of injury. Submit wage information using employer payroll reports, wage statement (BWC form C-94-A), W-2s, etc.

(4) What days of the week do you usually work? What are your regular work hours: Enter the days and hours the injured worker normally works.
- If the days worked vary from week to week, list the number of hours worked in an average week.

(5) Wages: If you received wages during disability, please explain.

(6) Occupation or job title: Enter the injured worker's type of occupation or actual job title at the time of injury, occupational disease or death.

(7) Employer name: Enter the name of the injured worker's employer at the time of the injury, occupational disease or death.

(8) Date of injury/disease: Enter the date injured worker was injured. OR
If the injured worker contracted an occupational disease, determine which of the following happened most recently:
- The occupational disease was diagnosed by a medical provider;
- The first medical treatment;
- The injured worker first quit work, due to the occupational disease.

Enter this as the date of occupational disease.

(9) Date last worked: Enter the last day worked as a result of this injury, occupational disease or death.

(10) Date returned to work: Enter the date the injured worker returned to work after the injury or occupational disease.

(11) State where hired: Enter the state where the injured worker was hired by the employer listed on this application.

(12) Date employer notified: Enter the date the employer was notified of the injury, occupational disease or death.

(13) State where supervised: Enter the state where the injured worker was supervised by the employer listed on this application.

(14) Description of accident: Describe in detail the events that caused the injury, occupational disease or death. Attach additional sheets, if necessary.

(15) Type of injury/disease and part of body affected: Describe the nature of the injury, occupational disease or death.
Indicate the part(s) of body injured, affected or that caused the death.
Examples:
- Laceration of first toe, left foot;
- Sprain of lower right back; etc.

(16) Injured worker signature (injured workers only): Please read the Benefit application/medical release information before signing and dating this form.

Instructions continued on last page

Ohio | Bureau of Workers' Compensation

First Report of an Injury, Occupational Disease or Death

By signing this form, I:

- **Elect to only receive compensation and/or benefits that are provided for in this claim under Ohio workers' compensation laws;**
- **Waive and release my right to receive compensation and benefits under the workers' compensation laws of another state for the injury or occupational disease, or death resulting from an injury or occupational disease, for which I am filing this claim;**
- **Agree that I have not and will not file a claim in another state for the injury or occupational disease or death resulting from an injury or occupational disease for which I am filing this claim;**
- **Confirm that I have not received compensation and/or benefits under the workers' compensation laws of another state for this claim, and that I will notify BWC immediately upon receiving any compensation or benefits from any source for this claim.**

WARNING:
Any person who obtains compensation from BWC or self-insuring employers by knowingly misrepresenting or concealing facts, making false statements or accepting compensation to which he or she is not entitled, is subject to felony criminal prosecution for fraud.
(R.C. 2913.48)

Injured worker and injury/disease/death info.

Last name, first name, middle initial		Social Security number	Marital status ☐ Single ☐ Married ☐ Divorced ☐ Separated ☐ Widowed	Date of birth
Home mailing address		Sex ☐ Male ☐ Female		Number of dependents
City	State / 9-digit ZIP code	Country if different from USA		Department name
Wage rate ☐ Hour ☐ Month ☐ Week $ _____ Per: ☐ Year ☐ Other _____		What days of the week do you usually work? ☐ Sun ☐ Mon ☐ Tues ☐ Wed ☐ Thur ☐ Fri ☐ Sat		Regular work hours From _____ To _____
Have you been offered or do you expect to receive payment or wages for this claim from anyone other than the Ohio Bureau of Workers' Compensation? ☐ Yes ☐ No If yes, please explain.				Occupation or job title

Employer name

Mailing address (number and street, city or town, state, ZIP code and county)

Location, if different from mailing address

Was the place of accident or exposure on employer's premises? ☐ Yes ☐ No
(If no, give accident location, street address, city, state and ZIP code)

Date of injury/disease	Time of injury _____ ☐ a.m. ☐ p.m.	If fatal, give date of death	Time employee began work _____ ☐ a.m. ☐ p.m.	Date last worked	Date returned to work
Date hired	State where hired		Date employer notified	State where supervised	

Description of accident (Describe the sequence of events that directly injured the employee, or caused the disease or death.)	Type of injury/disease and part(s) of body affected (For example: sprain of lower left back)

Benefit application release of information – I am applying for a claim under the Ohio Bureau of Workers' Compensation Act for work-related injuries that I did not inflict. I affirm that I elect to receive compensation and benefits under Ohio's workers' compensation laws for my claim, and I waive and release my right to file for and receive compensation and benefits under the laws of any other state for this claim. I request payment for compensation and/or medical benefits as allowable, and authorize direct payment to my medical providers. I permit and authorize any provider who attends, treats or examines me, the Ohio State Board of Pharmacy, the Ohio Department of Job and Family Services and the Ohio Rehabilitation Services Commission to release medical, psychological, psychiatric, pharmaceutical, vocational and social information. I understand this may include personally identifying information that is casually or historically related to my physical or mental injuries relevant to issues necessary for the administration of my claim to BWC, the Industrial Commission of Ohio, the employer in this claim, the employer's managed care organization and any authorized representatives. My previous or future BWC claims may affect decisions made in this claim. Proper administration of the present claim may require BWC to share claims information with the employers of record (or their authorized representatives) and/or my authorized representative for any and all such previous or future claims. The released claims information may include any record maintained in my claim files.

Injured worker signature	Date	E-mail address	Telephone number	Work number ( )

Treatment info.

Health-care provider name	Telephone number ( )	Fax number ( )	Initial treatment date
Street address	City	State	9-digit ZIP code

Diagnosis(es): Include ICD code(s)

Will the incident cause the injured worker to miss eight or more days of work? ☐ Yes ☐ No	Is the injury causally related to the industrial incident? ☐ Yes ☐ No	
E code	11-digit BWC provider number	Date
Health-care provider signature		

Employer info.

Employer policy number	Check if ☐ Employer is self-insuring ☐ Injured worker is owner/partner/member of firm			
Telephone number ( )	Fax number ( )	E-mail address	Federal ID number	Manual number

Was employee treated in an emergency room? ☐ Yes ☐ No	Was employee hospitalized overnight as an inpatient? ☐ Yes ☐ No

If treatment was given away from work site, provide the facility name, street address, city, state and ZIP code

☐ **Certification -** The employer certifies that the facts in this application are correct and valid.

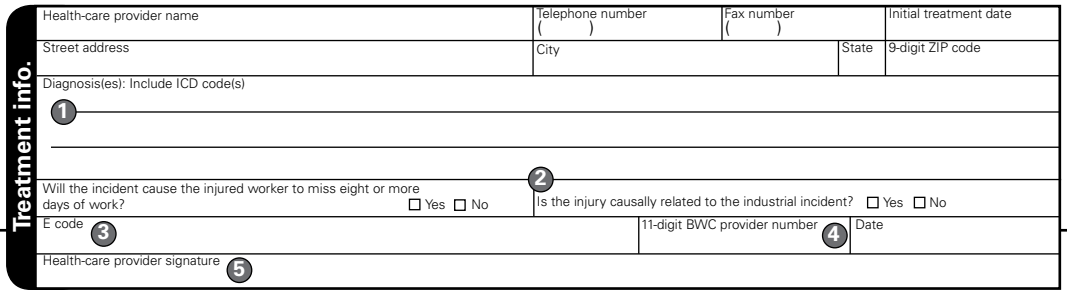
☐ **Rejection -** The employer rejects the validity of this claim for the reason(s) listed below:

For self-insuring employers only

☐ **Clarification -** The employer clarifies and allows the claim for the condition(s) below:
☐ **Medical only** ☐ **Lost time**

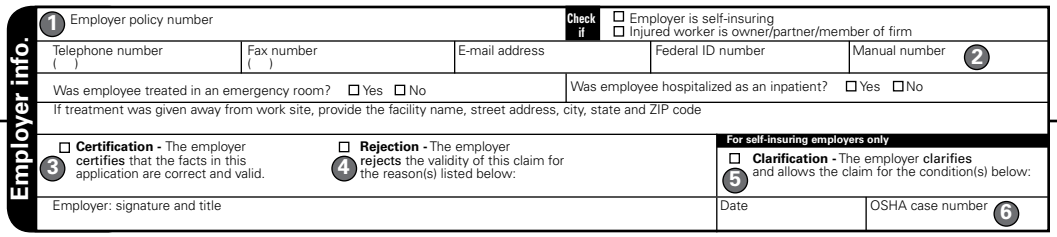
Employer signature and title	Date	OSHA case number

Completion instructions
(continued)



Treatment info.

1. Indicate the diagnosis and ICD codes for conditions being treated as a result of the injury.
2. Indicate the treating provider's medical opinion that the injury sustained is causally related to the industrial incident, that the injury could result from the method (manner) of the accident, as described by the injured worker. It must be clear that the diagnosis in all probability occurred as a result of the injury.
3. Providing a valid E code will enable us to determine the claim more quickly and efficiently.
4. Enter the physician's or health-care provider's 11-digit BWC-assigned provider number.
5. Signature of the health-care provider completing this form.



Employer info.

1. Enter the employer's BWC-assigned policy number, which is located on the BWC certificate of coverage.
2. Enter the four-digit code that indicates the injured worker's job classification, located on the semiannual payroll report.
   - If you do not know the injured worker's manual number, call **1-800-OHIOBWC** and follow the prompts.
3. If certification is selected and the claim is allowed, it will promptly be paid. Employers certifying a claim waive both the notice of receipt and notice of first order of compensation.
4. If rejection is selected, use the space provided to list the reasons for rejection. Attach additional sheets, if necessary.
5. Self-insuring employers that choose to clarify certification may use the space provided. Attach additional sheet, if necessary.
6. If this is an OSHA-reportable injury, include the case number assigned by the employer. This form meets OSHA 301 requirements and may be used in lieu of the OSHA 301 when reporting recordable injuries and illnesses to the federal government.

Note:
If your employee misses eight or more days of work, BWC will need wage information for the 52 weeks prior to the date of injury. Submit wage information using employer payroll reports, wage statement (BWC form C-94-A), W-2s, etc.

BWC
Better Workers' Compensation
Built with *you* in mind.

Notice to Change Physician of Record

The physician selected must be BWC certified or the injured worker will be responsible for payment.

INSTRUCTIONS TO THE INJURED WORKER:
- Please complete all of PART I of the form.
- Sign in the space provided and submit all copies to your MCO to record your change of physician.

PART I

Injured worker's name	Date of injury	Claim number

Address	Phone number ( )

City	State	9-digit ZIP Code

Please change my physician of record for the above listed claim as follows:

From physician:	Provider number

Address	Phone number ( )

City	State	9-digit ZIP Code

To physician:	Provider number

Address	Phone number ( )

City	State	9-digit ZIP Code

Reason for change:

☐ Physician moved ☐ Physician no longer practicing ☐ I moved ☐ Physician is not a BWC certified provider

☐ Physician terminated patient-provider relationship
Please explain: _____

☐ Dissatisfied with physician's treatment
Please explain: _____

☐ Other, please explain: _____

Have you been treated by the new physician for the condition(s) allowed in your claim? ☐ Yes ☐ No **If yes give date of first treatment** _____

Injured worker's signature	Date

INSTRUCTIONS TO THE MCO:
- MCO to complete PART II.
- MCO must notify BWC via EDI (148) of change of physician within 24 hours of notification by the injured worker.
- Return signed copies per distribution listed below.

PART II

Your request for change of physician has been received and recorded. Only medical services and items related to the treatment of the allowed conditions and in accordance with the MCO medical management guidelines, may be billed to the MCO or the Self-Insured employer.

The allowed conditions for this workers' compensation claim, with corresponding ICD-9-CM codes are as follows: _____

MCO name	Phone number ( )

MCO case manager	Date

Distribution: White–MCO Claim file • Yellow–Injured worker • Pink–Requested physician • Goldenrod–Former physician

RED FLAG QUESTIONNAIRE

NAME _____ DATE _____ AGE _____

Please check the appropriate response. If "yes", please explain. If you are not sure, check the "?" box.

NO	YES	?	
☐	☐	☐	Do you have a past history of cancer?
☐	☐	☐	Have you had any unexplained weight loss?
☐	☐	☐	Does your pain improve with rest?
☐	☐	☐	Are you over 50 years old?
☐	☐	☐	Failure to respond to a course of conservative care (4-6 weeks)?
☐	☐	☐	Have you had spinal pain greater than 4 weeks?

NO	YES	?	
☐	☐	☐	Prolonged use of corticosteroids (such as organ transplant Rx)?
☐	☐	☐	Intravenous drug use?
☐	☐	☐	Current or recent urinary tract, respiratory tract or other infection?
☐	☐	☐	Immunosuppression medication &/or condition?

NO	YES	?	
☐	☐	☐	History of significant trauma?
☐	☐	☐	Minor trauma in person >50 years old?
☐	☐	☐	Do you have osteoporosis (weak bones)?
☐	☐	☐	Are you over 70 years old?
☐	☐	☐	Any history of prolonged use of corticosteroids?

NO	YES	?	
☐	☐	☐	Acute onset urinary retention or overflow incontinence (wet underwear)
☐	☐	☐	Loss of anal sphincter tone or fecal incontinence (bowel accidents)
☐	☐	☐	Saddle anesthesia (numbness in the groin region)
☐	☐	☐	Global or progressive muscle weakness in the legs (legs give out)

COMMENTS:_____
_____
_____
_____
_____
_____

Long Chiropractic Office
4978 Northcutt Place, Dayton, OH 45414
7244 Far Hills Ave. Centerville, OH 45459
(937) 278-7246 (p) ~ (937) 278-5640 (f)

Terms of Acceptance

The goal of our office is to enable patients to gain control of their health. To attain this we believe communication is the key. Please read the following and if you have any questions please feel free to ask one of our staff members.

Informed Consent:

The chiropractic adjustment, clinical procedures, physical therapy procedures, and rehabilitation exercises are usually beneficial and seldom cause any problems. In rare cases, underlying physical defects, deformities or pathologies may render the patient susceptible to injury, such as fractures, muscular strain, ligamentous sprain, intervertebral disc injury, nerve injury, or stroke. The doctor, of course, will not give any treatment or care if he determines such care may be contra-indicated. It is the responsibility of the patient to disclose any known latent pathological defects, illnesses or deformities which would otherwise not come to the attention of the chiropractic physician. The chiropractic doctor provides a specialized health care service and is available to work with other types of providers in your health care regimen. I understand that if I am accepted as a patient by Long Chiropractic Office, I am granting authorization to proceed with treatment that Dr. Long deems necessary. Furthermore, any additional questions I may have regarding chiropractic treatment will be answered upon my request.

Women Only:

To the best of my knowledge I **am / am NOT** pregnant and (**give my permission / don't give permission**) to x-ray me for diagnostic interpretation.
(Circle one above) *(Circle one above)*

Consent to Evaluate and Treat a Minor:

I, _____ being the parent or legal guardian of _____, have read and fully understand the above terms of acceptance and hereby grant permission for my child to receive chiropractic care.

Communications:

To whom may we communicate your healthcare information?

Spouse: _____

Children: _____

Others: _____

No one: [ ]

May we leave messages regarding your personal healthcare information on any answering device?
(i.e. home answering machines or voicemails) Yes [ ] No [ ]

Acknowledgement

I have read and fully understand the above statements. I have read the Notice of Privacy Practices Form (HIPAA) and have been provided an opportunity to discuss my right to privacy. Upon request I will be given a copy.

Print Name: _____

Signature: _____ Date: _____

WELCOME

PATIENT INFORMATION

Date _____

SS/HIC/Patient ID # _____

Patient Name _____
Last Name

_____
First Name Middle Initial

Address _____

City _____

State _____ Zip _____

E-mail _____

Sex ☐ M ☐ F Age _____

Birthdate _____

☐ Married ☐ Widowed ☐ Single ☐ Minor

☐ Separated ☐ Divorced ☐ Partnered for _____ years

Occupation _____

Patient Employer/School _____

Employer/School Address _____

_____

Employer/School Phone (____) _____

Spouse's Name _____

Birthdate _____

SS# _____

Spouse's Employer _____

Whom may we thank for referring you? _____

INSURANCE

Who is responsible for this account? _____

Relationship to Patient _____

Insurance Co. _____

Group # _____

Is patient covered by additional insurance? ☐ Yes ☐ No

Subscriber's Name _____

Birthdate _____ SS# _____

Relationship to Patient _____

Insurance Co. _____

Group # _____

ASSIGNMENT AND RELEASE

I certify that I, and/or my dependent(s), have insurance coverage with

_____ and assign directly to
Name of Insurance Company(ies)

Dr. _____ all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I authorize the use of my signature on all insurance submissions.

The above-named doctor may use my health care information and may disclose such information to the above-named Insurance Company(ies) and their agents for the purpose of obtaining payment for services and determining insurance benefits or the benefits payable for related services. This consent will end when my current treatment plan is completed or one year from the date signed below.

_____
Signature of Patient, Parent, Guardian or Personal Representative

_____
Please print name of Patient, Parent, Guardian or Personal Representative

_____ _____
Date Relationship to Patient

PHONE NUMBERS

Home Phone (____) _____

Cell Phone (____) _____

Best time and place to reach you _____

IN CASE OF EMERGENCY, CONTACT

Name _____

Relationship _____

Home Phone (____) _____

Work Phone (____) _____

ACCIDENT INFORMATION

Is condition due to an accident? ☐ Yes ☐ No

Date _____

Type of accident ☐ Auto ☐ Work ☐ Home ☐ Other

To whom have you made a report of your accident?
☐ Auto Insurance ☐ Employer ☐ Worker Comp. ☐ Other

Attorney Name (if applicable)

_____

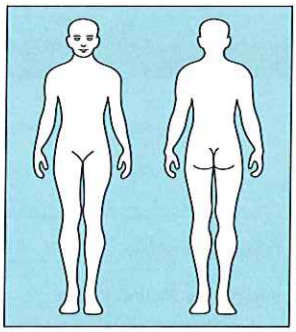
PATIENT CONDITION

Reason for Visit _____

When did your symptoms appear? _____

Is this condition getting progressively worse? ☐ Yes ☐ No ☐ Unknown

Mark an X on the picture where you continue to have pain, numbness, or tingling.



Rate the severity of your pain on a scale from 1 (least pain) to 10 (severe pain) _____

Type of pain: ☐ Sharp ☐ Dull ☐ Throbbing ☐ Numbness ☐ Aching ☐ Shooting
☐ Burning ☐ Tingling ☐ Cramps ☐ Stiffness ☐ Swelling ☐ Other

How often do you have this pain? _____

Is it constant or does it come and go? _____

Does it interfere with your ☐ Work ☐ Sleep ☐ Daily Routine ☐ Recreation

Activities or movements that are painful to perform ☐ Sitting ☐ Standing ☐ Walking ☐ Bending ☐ Lying Down

HEALTH HISTORY

What treatment have you already received for your condition? ☐ Medications ☐ Surgery ☐ Physical Therapy

☐ Chiropractic Services ☐ None ☐ Other _____

Name and address of other doctor(s) who have treated you for your condition _____

Date of Last: Physical Exam_____ Spinal X-Ray_____ Blood Test_____

Spinal Exam_____ Chest X-Ray_____ Urine Test_____

Dental X-Ray_____ MRI, CT-Scan, Bone Scan _____

Place a mark on "Yes" or "No" to indicate if you have had any of the following:

AIDS/HIV	☐ Yes ☐ No	Diabetes	☐ Yes ☐ No	Liver Disease	☐ Yes ☐ No	Rheumatic Fever	☐ Yes ☐ No
Alcoholism	☐ Yes ☐ No	Emphysema	☐ Yes ☐ No	Measles	☐ Yes ☐ No	Scarlet Fever	☐ Yes ☐ No
Allergy Shots	☐ Yes ☐ No	Epilepsy	☐ Yes ☐ No	Migraine Headaches	☐ Yes ☐ No	Sexually Transmitted Disease	☐ Yes ☐ No
Anemia	☐ Yes ☐ No	Fractures	☐ Yes ☐ No	Miscarriage	☐ Yes ☐ No		
Anorexia	☐ Yes ☐ No	Glaucoma	☐ Yes ☐ No	Mononucleosis	☐ Yes ☐ No	Stroke	☐ Yes ☐ No
Appendicitis	☐ Yes ☐ No	Goiter	☐ Yes ☐ No	Multiple Sclerosis	☐ Yes ☐ No	Suicide Attempt	☐ Yes ☐ No
Arthritis	☐ Yes ☐ No	Gonorrhea	☐ Yes ☐ No	Mumps	☐ Yes ☐ No	Thyroid Problems	☐ Yes ☐ No
Asthma	☐ Yes ☐ No	Gout	☐ Yes ☐ No	Osteoporosis	☐ Yes ☐ No	Tonsillitis	☐ Yes ☐ No
Bleeding Disorders	☐ Yes ☐ No	Heart Disease	☐ Yes ☐ No	Pacemaker	☐ Yes ☐ No	Tuberculosis	☐ Yes ☐ No
Breast Lump	☐ Yes ☐ No	Hepatitis	☐ Yes ☐ No	Parkinson's Disease	☐ Yes ☐ No	Tumors, Growths	☐ Yes ☐ No
Bronchitis	☐ Yes ☐ No	Hernia	☐ Yes ☐ No	Pinched Nerve	☐ Yes ☐ No	Typhoid Fever	☐ Yes ☐ No
Bulimia	☐ Yes ☐ No	Herniated Disk	☐ Yes ☐ No	Pneumonia	☐ Yes ☐ No	Ulcers	☐ Yes ☐ No
Cancer	☐ Yes ☐ No	Herpes	☐ Yes ☐ No	Polio	☐ Yes ☐ No	Vaginal Infections	☐ Yes ☐ No
Cataracts	☐ Yes ☐ No	High Blood Pressure	☐ Yes ☐ No	Prostate Problem	☐ Yes ☐ No	Whooping Cough	☐ Yes ☐ No
Chemical Dependency	☐ Yes ☐ No	High Cholesterol	☐ Yes ☐ No	Prosthesis	☐ Yes ☐ No	Other _____	
Chicken Pox	☐ Yes ☐ No	Kidney Disease	☐ Yes ☐ No	Psychiatric Care	☐ Yes ☐ No		
				Rheumatoid Arthritis	☐ Yes ☐ No		

EXERCISE

☐ None
☐ Moderate
☐ Daily
☐ Heavy

WORK ACTIVITY

☐ Sitting
☐ Standing
☐ Light Labor
☐ Heavy Labor

HABITS

☐ Smoking Packs/Day _____
☐ Alcohol Drinks/Week _____
☐ Coffee/Caffeine Drinks Cups/Day _____
☐ High Stress Level Reason _____

Are you pregnant? ☐ Yes ☐ No Due Date_____

Injuries/Surgeries you have had	Description	Date
Falls		
Head Injuries		
Broken Bones		
Dislocations		
Surgeries		

MEDICATIONS

_____
_____
_____
Pharmacy Name_____
Pharmacy Phone (____)_____

ALLERGIES

VITAMINS/HERBS/MINERALS