Hulsebus Machesney Park Chiropractic Clinic
1010 Harlem Road
Machesney Park, IL 61115
Phone (815) 654-1044

Workers Comp. History

Today's Date: _____

Name: _____ Date of Birth: ___/___/_____ Age: _____

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

Home Phone #: _____ Cell #: _____ Email: _____

Social Security #: _____

Marital Status: _____ Spouse's Name: _____ Phone #: _____

How were you referred to this office?

_____

Name of Compensation Carrier: _____ _____ Phone#: _____

Address of Carrier: _____ City: _____ State: ____ _ Zip: _____

Employer's Name: _____ Phone#: _____Claim #: _____

Employer's Address: _____ City: _____ State: ____ _ Zip: _____

1. Type of Business: _____ Your Occupation: _____
2. Date Injured: _____ Hour: _____AM/PM Last Date Worked: _____ Are you off Work? ( ) Yes ( ) No
3. Previous Worker's compensation injury? ( ) Yes ( ) No
4. Accident reported to employer? ( ) Yes ( ) No Name of person accident reported to: _____
5. Injured at: _____ _City: _____ State: _____ Zip: _____
6. Length of time worked there prior to accident:_____
7. Type of work being done at time of injury: _____ _____ _____
8. In your own words, please describe accident: _____ _____ _____
9. What are your present complaints or symptoms: _____ _____
10. Have you been treated by another doctor for this accident? ( ) Yes ( ) No
    If yes, please list names and address: _____

_____

How long were you treated by this doctor?

_____

11. Are you: ( ) Improved ( ) Unchanged ( ) Getting worse
12. What types of medicines are you taking?

_____

_____

Do these medicines help? ( ) Yes ( ) No ( ) Don't know

13. Have you had physical therapy? ( ) Yes ( ) No
    If yes, how often? ( ) Daily ( ) Every other day ( ) Several times a week ( ) Weekly ( ) Every other week ( ) Monthly ( ) Other:

    _____

    Does the physical therapy help? ( ) Yes ( ) No ( ) Don't know
14. Prior to the accident, have you ever had any physical complaints similar to what you have now? ( ) Yes ( ) No ( ) Don't know
    If yes, please describe:

    _____

    _____

    _____

    _____

    Were these similar complaints result of previous accident(s)? ( ) Yes ( ) No
    If yes, please describe details of accident(s):

    _____

    _____

    _____
15. Have you had any other serious accidents which required medical care? ( ) Yes ( ) No
    If yes, please describe:

    _____

    _____

    _____
16. Have you had any serious illnesses that required hospitalization? ( ) Yes ( ) No
    If yes, please describe:

    _____

    _____

    _____
17. Have you returned to work since this accident? ( ) Yes ( ) No

    If you have returned to work since your accident, please fill out the information below:

Date	Employer	Occupation	Light Duty or Regular Duty	Full Time or Part Time

Current Medicare Complaints

Back Pain:

1. Currently, I have pain in my: ( ) Low back ( ) Mid back ( ) Upper back
2. My pain began: ( ) Gradually ( ) Suddenly
3. I have pain: ( ) Sometimes ( ) All of the time
4. My pain goes into my: ( ) Right leg ( ) Left leg ( ) Both
5. I have tingling and/or numbness in my: ( ) Right leg ( ) Left leg ( ) Both
6. My pain is worse when I:

Cough or sneeze	( ) Yes	( ) No
Sit	( ) Yes	( ) No
Bend	( ) Yes	( ) No
Walk	( ) Yes	( ) No
Lift	( ) Yes	( ) No
Push	( ) Yes	( ) No
Pull	( ) Yes	( ) No

7. My back is worse with sexual activity: ( ) Yes ( ) No
8. My pain wakes me up during the night: ( ) Yes ( ) No
9. Changed in the weather affect my pain: ( ) Yes ( ) No

Neck Pain:

1. My neck pain began: ( ) Gradually ( ) Suddenly
2. I have pain: ( ) Sometimes ( ) All of the time
3. My pain goes into my: ( ) Right Arm ( ) Left Arm ( ) Both
4. I have tingling and/or numbness in my: ( ) Right Arm ( ) Left Arm ( ) Both
5. My pain is wore when I:

Cough or sneeze	( ) Yes	( ) No
Bend forward	( ) Yes	( ) No
Lift	( ) Yes	( ) No
Pull	( ) Yes	( ) No
Turn my head	( ) Yes	( ) No

6. My pain wakes me during the night: ( ) Yes ( ) No
7. Changes in the weather affect my pain: ( ) Yes ( ) No
8. I have neck stiffness: ( ) Yes ( ) No
9. I have headaches: ( ) Yes ( ) No
10. If I do get headache, they occur: ( ) Sometimes ( ) All of the time

Other Pain:

Please describe ay medical complaints which you are experiencing and were not previously coved on this questionnaire, or list any additional comments you h to make regarding your condition.

_____
_____
_____
_____
_____

(In terms of an 8-hour workday, “occasionally” means 33%, “frequently” means 34% to 66%, and “continuously” means 67% to 100% of the day)

1. In a typical 8-hour work day, I: (Circle # 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
2. On the job, I perform the following activities:

	Not at all	Occasionally	Frequently	Continuously
Bend/Stoop	( )	( )	( )	( )
Squat	( )	( )	( )	( )
Crawl	( )	( )	( )	( )
Climb	( )	( )	( )	( )
Reach Above Shoulder Level	( )	( )	( )	( )
Crouch	( )	( )	( )	( )
Kneel	( )	( )	( )	( )
Balancing	( )	( )	( )	( )
Pushing / Pulling	( )	( )	( )	( )

3. On the job, I lift:

	Not at all	Occasionally	Frequently	Continuously
Up to 10 pounds	( )	( )	( )	( )
11 to 24 pounds	( )	( )	( )	( )
25 to 34 pounds	( )	( )	( )	( )
35 to 50 pounds	( )	( )	( )	( )
51 to 74 pounds	( )	( )	( )	( )
75 to 100 pounds	( )	( )	( )	( )

4. Do you have to bend over while doing any lifting? ( ) Yes ( ) No
5. Are your feet used for repetitive movements, such as operating foot controls? ( ) Yes ( ) No
6. Do you use your hands for repetitive actions such as:

	Simple grasping	Firm grasping	Fine manipulating
Right Hand	( )	( )	( )
Left Hand	( )	( )	( )

7. Are you required to work on unprotected heights? ( ) Yes ( ) No
   Describe:
   _____
   _____
   ____
   _____
   ____
8. Are you required to be around moving machinery? ( ) Yes ( ) No
   Describe:
   _____
   _____
   ____
   _____
   ____
9. Are you exposed to marked changes in temperature and humidity? ( ) Yes ( ) No
   Describe:
   _____
   _____
   ____
   _____
   ____
10. Are you required to drive automotive equipment? ( ) Yes ( ) No
    Describe:
    _____

_____
____
_____
____

11. Are you exposed to dust, fumes and/or gases? ( ) Yes ( ) No
    Describe:
    _____
    _____
    ____
    _____
    ____

12. Please list any additional comments:
    _____
    _____
    ____
    _____
    ____

Health & Lifestyle

Do you exercise? ( ) Yes ( ) No How often? _____ day (s)/week;
Other:_____

What activities? ( ) Walking ( ) Running/Jogging ( ) Weight training ( ) Cycling ( ) Yoga ( ) Pilates ( )Swimming ( ) Other: _____

Do you smoke? ( ) Yes ( ) No How much? / How often? _____

Do you drink alcohol? ( ) Yes ( ) No How much? / How often? _____

Do you drink coffee? ( ) Yes ( ) No How much? / How often?
_____

Do you take any supplements (i.e. vitamins, minerals, herbs)? ( ) Yes ( ) No

If yes, please list: _____

Other

Please list any health conditions not mentioned:

_____
_____

Please list any medications (include name, dose, what condition, and how long you've been taking it):

_____
_____
_____

Please list any surgeries (include type of surgery and date it was performed):

_____
_____
_____
_____

Pregnancy Release

This is to certify that to the best of my knowledge I am not pregnant and the above doctor and his associates have my permission to perform an x-ray evaluation. I have been advised that x-rays can be hazardous to an unborn child.

Date of last menstrual cycle: ___/___/_____
Patient's Signature: _____ Date: _____

Authorization of Care

I authorize and agree to allow the following doctor and/or his designated staff to work with my spine or the spine of the charge I represent through the use of spinal adjustments and rehabilitative exercise for the sole purpose of postural and structural restoration of normal bio-mechanical and neurological function.

I understand that I am responsible for all fees incurred for the services provided, and agree to ensure full payment of all charges.

The doctor and/or his staff will not be held responsible for any health conditions or diagnoses which pre-existing, given by another healthcare practitioner, or are related to the spinal structural conditions diagnosed at this clinic.

I also clearly understand that if I do not follow the doctors and/or his staff's specific recommendations at this clinic that I will not receive the full benefit from these programs; and that if I terminate care prematurely that all fees incurred will be due and payable at that time.

Patient's Signature: _____ Date: _____
Patient's Name Printed: _____ Date: _____

If the patient is legal charge limited capacity requiring guardianship for treatment, please complete the following:
Date Guardianship Awarded: _____ County, State of Guardianship_____

I hereby authorize the doctor to administer care as deemed necessary to my charge as appointed to by the courts.
Guardian's Signature: _____ Date: _____

In Case of Emergency

Name: _____ Relationship: _____
Phone #: _____