

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:

- Currently, I have pain in my: () Low back () Mid back () Upper back
- My pain began: () Gradually () Suddenly
- I have pain: () Sometimes () All of the time
- My pain goes into my: () Right leg () Left leg () Both
- I have tingling and/or numbness in my: () Right leg () Left leg () Both
- 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
- My back is worse with sexual activity: () Yes () No
- My pain wakes me up during the night: () Yes () No
- Changed in the weather affect my pain: () Yes () No

Neck Pain:

- My neck pain began: () Gradually () Suddenly
- I have pain: () Sometimes () All of the time
- My pain goes into my: () Right Arm () Left Arm () Both
- I have tingling and/or numbness in my: () Right Arm () Left Arm () Both
- 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
- My pain wakes me during the night: () Yes () No
- Changes in the weather affect my pain: () Yes () No
- I have neck stiffness: () Yes () No
- I have headaches: () Yes () No
- If I do get headache, they occur: () Sometimes () All of the time

Other Pain:

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

Job Description

(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) per week

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) or Prescription Medications? Yes / No

If yes, please list: _____

Are you allergic to any Medications? Yes / No If yes, please list: _____

Height: _____ Weight: _____ Blood Pressure: _____/_____

Other

Please list any health conditions not mentioned: _____

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. Yes / No

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 #: _____