



Milton Chiropractic & Rehabilitation, Inc.



BAY STATE PHYSICAL THERAPY

Workers Compensation Intake Form

File Number (Office Use) _____

Patient Information:

Today's Date _____

Name _____

I prefer to be called _____

Address _____

Sex **Male** **Female**

Occupation _____

Employer _____

Address _____

If minor, name of parent or guardian _____

Who should we contact in case of an emergency? _____

Relation _____

Address _____

Attorney _____

Primary Care Physician _____

» Is He/She within Harvard Vanguard Medical Group **YES** **NO**

How did you hear about our office? _____

Have you ever been to a chiropractor/physical therapist before? **YES** **NO** Who? _____

Worker's Compensation Insurance Information:

Employer Name _____

Phone # _____

Work Compensation Insurance Co _____

Phone #: _____

Adjuster Name _____

Phone # _____

Claim # _____

Accident Information:

Date _____ Time _____ AM PM

Briefly describe the accident _____

Was your accident directly related to your work? **YES** **NO**

Were there witnesses? **YES** **NO**

Did you report the accident to your employer? **YES** **NO**

Please give the address where the accident occurred (if other than employer's address) _____

What recommendations did your employer make just after your accident? _____

Has this type of accident happened to you before? **YES** **NO**

To the best of your knowledge, has this accident happened in your workplace before? **YES** **NO**

Patient Signature: _____ **Date:** _____



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Post-Accident Information:

Please describe your **PAIN(S)** and its **LOCATION** _____

When did the(se) symptom(s) begin **IMMEDIATELY** **LATER, SAME DAY** **DIFFERENT DATE**

____/____/____

Has your condition **IMPROVED** **WORSENERD** or **STAYED SAME** since the accident?

Have you seen any other doctor(s) since the accident? **YES** **NO** Name _____

When did you go? **IMMEDIATELY** **NEXT DAY** **2 DAYS PLUS**

How did you get there? **AMBULANCE** **PRIVATE TRANSPORTATION**

Name of hospital and/or attending doctor: _____

Was he/she a: **D.C.** **M.D.** **D.O.** **D.D.S.**

Please describe any treatment you received _____

Were X-Rays done? **YES** **NO** An MRI? **YES** **NO** CAT scan? **YES** **NO**

Was medication prescribed? **YES** **NO** If yes, what? _____

Job-Related Information

Have you missed any work since the accident? **YES** **NO** Date(s) _____

Is your condition affecting your **WORK** **SLEEP** or **DAILY ROUTINE**? Please explain _____

How many hours are in your normal workday? _____

Please indicate your daily job duties and any activities that you are asked to perform:

STANDING

OPERATING EQUIPMENT

DRIVING

SITTING

TWISTING

WORK W/ARMS ABOVE HEAD

WALKING

CRAWLING

TYPING

LIFTING

BENDING

STOOPING

While in recovery, are there any light duty tasks you could request? **YES** **NO?** Please describe _____

Patient Signature _____ **DOB** _____ **Date** _____



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Health History

Please list all medications you are currently taking for this or any other health condition:

Please list any medical conditions that you currently have or have ever had: _____

Please list anything that you may be allergic to: _____

Please list previous surgeries/treatments with dates: _____

Please list any past serious accidents with dates: _____

Is there anything else about your family health history that you feel is important to share? _____

Do you: Take supplements or vitamins? **YES** **NO** Exercise? **YES** **NO**

Are you on a special diet? **YES** **NO** Since: ____ / ____ / ____

Do you smoke? **YES** **NO** How much? _____ How long? _____
Former Smoker, but have quit _____ Years Since last Smoked _____

Are you wearing: **HEEL LIFTS** **SOLE LIFTS** **INNER SOLES** **ARCH SUPPORTS ?**

For Women: Are you taking birth control? **YES** **NO**
Are you pregnant? **YES** **NO** Due Date ____ / ____ / ____

Tests:

Test	Have you had this test?	Date performed	Did you bring copy today?
X-ray	Y or N		Y or N
MRI	Y or N		Y or N
CT Scan	Y or N		Y or N
Bone Scan	Y or N		Y or N
EMG	Y or N		Y or N
Other:	Y or N		Y or N

Patient Signature _____ DOB _____ Date _____



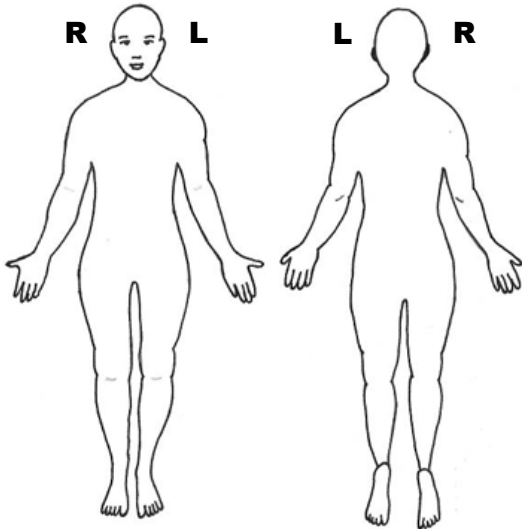
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Please mark these drawings to show the location of your **CURRENT** symptoms and the type of symptoms you are experiencing.

Sharp Pain: /////
Achy Pain: ^^^^
Burning Pain: XXXXX
Numbness: 0000



Circle the number corresponding with the intensity of your symptoms. A "0" = No Pain where as a "10" = most severe pain imaginable.

Location: _____ 1 2 3 4 5 6 7 8 9 10

Location: _____ 1 2 3 4 5 6 7 8 9 10

Location: _____ 1 2 3 4 5 6 7 8 9 10

Location: _____ 1 2 3 4 5 6 7 8 9 10

Please Answer "YES" or "NO" As It Pertains to Your Health

CONSTITUTIONAL

Weight Loss Y N
 Fatigue Y N
 Fever Y N

EYES

Glasses/Contacts Y N
 Eye Pain Y N
 Double Vision Y N
 Cataracts Y N

CARDIOVASCULAR

Murmur Y N
 Chest Pain Y N
 Palpitations Y N
 Fainting/Spells Y N
 Short of Breath Y N
 Difficulty Lying Flat Y N
 Swelling in Ankles Y N

ENDOCRINE

Loss of Hair Y N
 Heat Intolerance Y N
 Cold Intolerance Y N

PSYCHIATRIC

Anxiety Y N
 Depression Y N
 Mood Swings Y N
 Difficulty Sleeping Y N

RESPIRATORY

Cough Y N
 Coughing Blood Y N
 Wheezing Y N
 Chills Y N

GASTROINTEST

Heartburn/Reflux Y N
 Nausea/Vomiting Y N
 Constipation Y N
 Change Bowel Mvts Y N
 Diarrhea Y N
 Jaundice Y N
 Abdominal Pain Y N
 Black/Bloody Bowel Mvts Y N

GENITOURINARY

Burning/Frequency Y N
 Nighttime Y N
 Blood in Urine Y N
 Erectile Dysfunction Y N
 Bladder Leakage Y N
 Abnormal Leakage Y N

ALLERGIC

Hives/Eczema Y N
 Hay Fever Y N

HEMATOLOGY/LYMPH

Bruise Easily Y N
 Gums Bleed Easily Y N
 Enlarged Glands Y N

MUSCLE/BONE

Joint Pain/Swelling Y N
 Stiffness Y N
 Muscle Pain Y N
 Bone Pain Y N

SKIN

Rashes/Sores Y N
 Lesions Y N
 Itching/Burning Y N

NEUROLOGICAL

Loss of Strength Y N
 Numbness Y N
 Headaches Y N
 Tremors Y N
 Memory Loss Y N

FEMALES ONLY

Age Onset of Periods _____
 Periods Regular? Yes _____ No _____
 Age Onset of Menopause _____
 Number of Pregnancies _____

Patient Signature: _____ **DOB** _____ **DATE** _____



**Milton Chiropractic
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BAY STATE
PHYSICAL THERAPY

Acknowledgement of Office Policies

The following are Milton Chiropractic and Bay State Physical Therapy's policies. Please read carefully **AND INITIAL** beside each section before signing the bottom, and be sure to ask any questions you might have before signing the document.

Appointment Scheduling. We at Milton Chiropractic and Bay State Physical Therapy are glad to accept insurance assignment on your behalf in handling payment for the care you receive. However, in order to help ensure that your insurance company pays for the care you receive here, it is important that you adhere to the recommended care program. This means that if you miss several appointments without notifying our office (emergencies considered), you may be dismissed from care and your file may be closed. _____

Consent for Treatment. I, the undersigned, give Milton Chiropractic and/or Bay State Physical Therapy my permission to evaluate (including x-rays if needed) and treat my injury as deemed reasonable and necessary. I further understand that with any diagnostic or therapeutic procedure there is always risk of injury or worsening of my condition on rare occasions (ie. increased pain, muscle spasm, rib injury, etc). Risk of such injury or complications from chiropractic treatments and physical therapy treatments are substantially lower than that associated with many medical procedures or medications given for the same symptoms. I further understand that **no guarantee or promise** has been made to me concerning the results of treatment. _____

Assignment of Payment. I hereby **authorize** my insurance company and/or my attorney to pay direct to Milton Chiropractic & Rehabilitation and Bay State Physical Therapy any monies due on my account for professional services rendered. _____

Acknowledgement and Understanding. It is further understood that I, the undersigned, **agree to pay the full amount** of the charges should my condition be such that it is not covered by my policy, or if, for any reason, the insurance company and/or my attorney refused to pay my balance at this office. _____

Private Health Insurance. I understand that I am responsible for whatever fees my insurance company does not pay on my claim. (Typically, this includes deductibles and/or co-payments). _____

Authorization to Release Information. I understand that Milton Chiropractic / Bay State Physical Therapy may use or disclose my personal health information for the purposes of carrying out treatment, obtaining payment, evaluating the quality of services provided and any administrative operations related to treatment or payments. I understand that I have the right to restrict how my personal health information is used and disclosed for treatment, payment and administrative operation if I notify the practice. I also understand that Milton Chiropractic / Bay State Physical Therapy will consider requests for restriction on a case by case basis, but does not have to agree to requests for restrictions. _____

Patient Requests for Records. I **authorize** the release of all medical, hospital, or surgical records pertinent to my care, including but not limited to, exams, special tests, x-rays, or lab results to this office. _____

Ownership. I understand that Milton Chiropractic, Bay State Physical Therapy, Optimal Weight Loss and Massage Works! are all owned and operated by the same entity. I understand I have the option to seek any/all of the same services these clinics provide elsewhere. _____

I certify that I have read and understand all appointment and office policies listed above.

Name(print) _____ Signature _____ DOB _____ Date _____