

WORKER'S COMPENSATION INTAKE FORM

PATIENT INFORMATION	
Name:	WCB #:
Name Preferred to be called:	Home Phone #:
Date of Birth:	Cell Phone #:
Social Security #:	Work Phone #:
Mailing Address:	Email Address:
City, State, Zip:	Referred to us by:
EMPLOYER INFORMATION	
Employer Name:	W#
Employer Address:	
Employer Phone Number:	Contact Person:
Positional/Title at time of injury:	Date of Injury:
INSURANCE CARRIER INFORMATION	
Worker's Compensation Carrier: :	Carrier Case #:
Worker's Compensation Carrier Address:	
Carrier Phone #:	Carrier Fax #:
Carrier Contact Person/Adjustor:	
Contact Person Phone Number:	
IN CASE OF EMERGENCY	
Please Contact:	Home Phone #:
Relationship to patient:	Alternate Phone #:
The above information is true to the best of my knowledge. I authorize that my insurance benefits be paid directly to the doctor. I understand that I am financially responsible for any balance. I also authorize Wiles Chiropractic or my insurance company to release any information required to process my claims.	
Patient/Guardian:	Date:

Patient Health Questionnaire - PHQ

ACN Group of California - Form PHQ-202

ACN Group, Inc. Use Only rev 7/18/05

Patient Name _____ Date _____

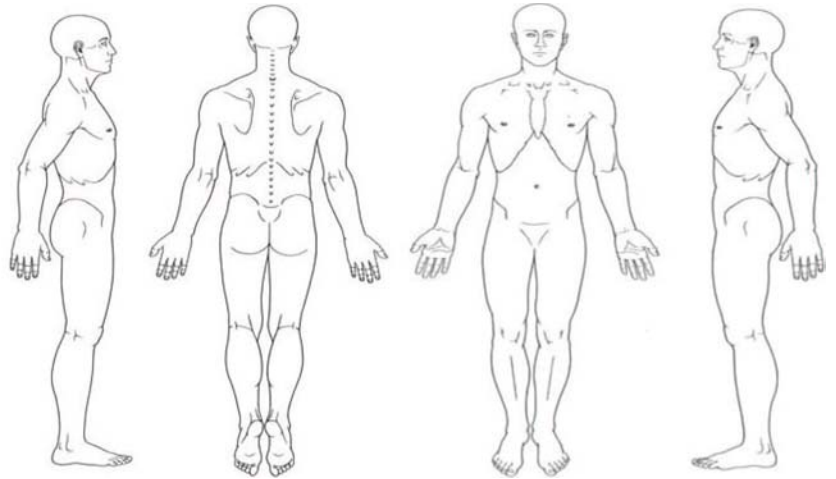
1. Describe your symptoms

a. When did your symptoms start?

b. How did your symptoms begin?

2. How often do you experience your symptoms? Indicate where you have pain or other symptoms

- ① Constantly (76-100% of the day)
- ② Frequently (51-75% of the day)
- ③ Occasionally (26-50% of the day)
- ④ Intermittently (0-25% of the day)



3. What describes the nature of your symptoms?

- ① Sharp
- ② Dull ache
- ③ Numb
- ④ Shooting
- ⑤ Burning
- ⑥ Tingling

4. How are your symptoms changing?

- ① Getting Better
- ② Not Changing
- ③ Getting Worse

5. During the past 4 weeks:

a. Indicate the average intensity of your symptoms

None ① ② ③ ④ ⑤ ⑥ ⑦ ⑧ ⑨ ⑩ Unbearable

b. How much has pain interfered with your normal work (including both work outside the home, and housework)

① Not at all ② A little bit ③ Moderately ④ Quite a bit ⑤ Extremely

6. During the past 4 weeks how much of the time has your condition interfered with your social activities?

(like visiting with friends, relatives, etc)

① All of the time ② Most of the time ③ Some of the time ④ A little of the time ⑤ None of the time

7. In general would you say your overall health right now is...

① Excellent ② Very Good ③ Good ④ Fair ⑤ Poor

8. Who have you seen for your symptoms?

- ① No One
- ② Chiropractor
- ③ Medical Doctor
- ④ Physical Therapist
- ⑤ Other

a. What treatment did you receive and when?

b. What tests have you had for your symptoms and when were they performed?

- ① Xrays date: _____
- ② MRI date: _____
- ③ CT Scan date: _____
- ④ Other date: _____

9. Have you had similar symptoms in the past?

- ① Yes
- ② No

a. If you have received treatment in the past for the same or similar symptoms, who did you see?

- ① This Office
- ② Chiropractor
- ③ Medical Doctor
- ④ Physical Therapist
- ⑤ Other

10. What is your occupation?

- ① Professional/Executive
- ② White Collar/Secretarial
- ③ Tradesperson
- ④ Laborer
- ⑤ Homemaker
- ⑥ FT Student
- ⑦ Retired
- ⑧ Other

a. If you are not retired, a homemaker, or a student, what is your current work status?

- ① Full-time
- ② Part-time
- ③ Self-employed
- ④ Unemployed
- ⑤ Off work
- ⑥ Other

Patient Signature _____ Date _____

Patient Name: _____

Past Medical History

Have you ever been diagnosed as having or have you suffered from any of the following? (Check all that apply)

<input type="checkbox"/>	High or Low Blood Pressure	<input type="checkbox"/>	Heart Attack	<input type="checkbox"/>	Circulatory Problems
<input type="checkbox"/>	Atherosclerotic Disease	<input type="checkbox"/>	Pace Maker	<input type="checkbox"/>	Stroke
<input type="checkbox"/>	Broken or Fractured Bones	<input type="checkbox"/>	Osteoarthritis	<input type="checkbox"/>	Rheumatoid Arthritis
<input type="checkbox"/>	Joint Dislocations	<input type="checkbox"/>	Multiple Sclerosis	<input type="checkbox"/>	Muscular Dystrophy
<input type="checkbox"/>	Fibromyalgia	<input type="checkbox"/>	Gout	<input type="checkbox"/>	Carpal Tunnel (R / L)
<input type="checkbox"/>	Tennis Elbow (R / L)	<input type="checkbox"/>	Back/Neck Problems	<input type="checkbox"/>	Diabetes
<input type="checkbox"/>	Seizures/Convulsions	<input type="checkbox"/>	Epilepsy	<input type="checkbox"/>	Fainting
<input type="checkbox"/>	Asthma	<input type="checkbox"/>	Emphysema	<input type="checkbox"/>	Ulcers
<input type="checkbox"/>	Cancer	<input type="checkbox"/>	Congenital Disease	<input type="checkbox"/>	
Other: _____					

Exercise		Work Activity		Stress Level		Habits			
<input type="checkbox"/>	None	<input type="checkbox"/>	Sitting	<input type="checkbox"/>	Low	<input type="checkbox"/>	Smoking	<input type="checkbox"/>	Packs a day
<input type="checkbox"/>	1-2 x Week	<input type="checkbox"/>	Standing	<input type="checkbox"/>	Medium	<input type="checkbox"/>	Alcohol	<input type="checkbox"/>	Drinks a week
<input type="checkbox"/>	3-4 x Week	<input type="checkbox"/>	Light Labor	<input type="checkbox"/>	High	<input type="checkbox"/>	Coffee/Soda	<input type="checkbox"/>	Cups a week
<input type="checkbox"/>	5+ x Week	<input type="checkbox"/>	Heavy Labor	<input type="checkbox"/>		<input type="checkbox"/>		<input type="checkbox"/>	
What types of exercise do you perform?: _____									
What things cause stress in your life?: _____									

Are you taking any seizure medication? YES NO If yes, list name: _____

Are you taking any medications that might affect your lungs, heart, consciousness or general well being while participating in therapy? YES NO If yes, list name: _____

List all medications you are currently taking: _____

List all surgeries in the past two years (including dates): _____

Are you pregnant: YES NO If yes, what week? _____

Have you had any injuries related to work? YES NO If yes, list the injury and date: _____

Have you had any Auto Accidents? YES NO If yes, list the injury and date: _____

Have you had Physical Therapy or Massage Therapy before? YES NO If yes, where: _____

Signature of Patient, Parent, Guardian, Personal Representative

Date

Current Complaint:

Have you been able to work since the injury? (Circle) YES - NO

How many days have you missed? _____

If you have had any of the following symptoms since your injury please check:

Arm/Shoulder pain	Feet/Toe Numbness	Neck Pain
Back Pain	Hand/Finger Numbness	Stiff Neck
Back Stiffness	Headaches	Shortness of Breath
Chest Pain	Irritability	Difficulty Sleeping
Dizziness	Jaw Problems	Upset Stomach
Ear Buzzing	Leg Pain	Tension
Ear Ringing	Memory Loss	Blurred Vision
Fatigue	Nausea	

Is this condition getting progressively worse? (Circle) YES - NO - DON'T KNOW

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

Type of pain you're currently experiencing:

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: (circle one) WORK - SLEEP - DAILY ROUTINE - RECREATION

Movements that are painful to perform: (circle one) SITTING - STANDING - WALKING - BENDING - LYING DOWN

To the best of my knowledge, the abo

ve information is complete and correct. I understand that it is my responsibility to inform my doctor if I, or my minor child, ever have a change in health.

Signature of Patient, Parent, Guardian or Personal Representative

Date

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

Relationship to Patient

SYMPTOMS FROM ACCIDENT

Did you experience bleeding, cuts or bruises? Yes No

If bleeding or cuts, where? _____ If bruises, where? _____

Please describe how you felt: PLEASE BE SPECIFIC

Immediately after the accident: _____

Later that Day / Night: _____

The next day(s): _____

Check symptoms that have been apparent since the accident/injury:

Nervousness	Loss of balance	Sleeping Trouble	Headache	Fainting
↑ Neck Pain/Stiffness	Loss of smell	Toe Numbness	Anxiety	Seizures
Ringing/buzzing ears	Loss of taste	Finger Numbness	Cold Hands	Cold Feet
Low Back Pain	Loss of memory	Blurred Vision	Chest Pain	Constipation
Eyes- light sensitive	Pins/Needles – Arms	Diarrhea	Fatigue	Depression
Pain behind eyes	Pins/Needles – Legs	Dizziness	Confusion	Disoriented
Shortness of breath	Double Vision	Forgetfulness	Tension	Cold Sweats
Heads seems heavy	Mid back Pain	Face Flushed	Irritability	Fever
Visual Disturbance	Other			

MECHANISM OF INJURY:

Please explain the mechanism of the injury (only fill in the sections that apply to you)

FALL

Yes No Did you hit anything when you fell? If yes, what? _____

Yes No Were you carrying anything when you fell? If yes, what? _____

How much did it weigh? _____ lbs

Yes No Did you twist when you fell? If so, to which side? Left Right

Yes No Was the area lighted?

Describe the condition of the area (slippery, graveled, etc) _____

What part of the body did you fall on? _____

How far did you fall ? (In feet) _____

What did you land on? _____

LIFT/PULL

How much did the object weigh? _____ lbs

Yes No Did you fall after the injury? If yes, how far? _____

Yes No Did you hit anything when you fell? If yes, what? _____

Yes No Were you twisting when you were lifting/pulling? If yes, to which side? Left Right

How far off the ground did you have the object before the pain started? _____

Yes No Did you drop the object when the pain started?

Yes No Did it land on you? Where? _____

Did you lift your Legs Back Other _____

BEND

Yes No Were you lifting when you bent over? If yes, how much did the object weigh? _____ lbs

How far did you bend over? _____

Yes No Did you fall when the pain started? How far? _____

Yes No Were you twisting when you bent forward? Toward which side? Left Right

Yes No Did you land on anything? If so, what? _____

WORK STATUS HISTORY:

Yes No Have you lost time from work as a result of this new injury? If yes, give dates: _____

Yes No Have you gone back to work? When? _____

If yes, status of work: Modified Regular

List restrictions that you have been placed on: _____

If you have gone back to work, list the activities that are:

PAINFUL _____

DIFFICULT _____

Yes No If you are currently on disability (time loss), do you want to go back to work doing your regular job? If no, why not? _____

Yes No Are there any problems you have with a fellow employee, supervisor, or manager that needs to be discussed? If yes, please explain: _____

Instructions for the Use
of the HIPAA-compliant Authorization Form to
Release Health Information Needed for Litigation

This form is the product of a collaborative process between the New York State Office of Court Administration, representatives of the medical provider community in New York, and the bench and bar, designed to produce a standard official form that complies with the privacy requirements of the federal Health Insurance Portability and Accountability Act (“HIPAA”) and its implementing regulations, to be used to authorize the release of health information needed for litigation in New York State courts. It can, however, be used more broadly than this and be used before litigation has been commenced, or whenever counsel would find it useful.

The goal was to produce a standard HIPAA-compliant official form to obviate the current disputes which often take place as to whether health information requests made in the course of litigation meet the requirements of the HIPAA Privacy Rule. It should be noted, though, that the form is optional. This form may be filled out on line and downloaded to be signed by hand, or downloaded and filled out entirely on paper.

When filing out Item 11, which requests the date or event when the authorization will expire, the person filling out the form may designate an event such as “at the conclusion of my court case” or provide a specific date amount of time, such as “3 years from this date”.

If a patient seeks to authorize the release of his or her entire medical record, but only from a certain date, the first two boxes in section 9(a) should both be checked, and the relevant date inserted on the first line containing the first box.

Patient Health Information Consent Form

HIPAA

We want you to know how your Patient Health Information (PHI) is going to be used in this office and your rights concerning those records. Before we will begin any health care operations we must require you to read and sign this consent form stating that you understand and agree with how your records will be used. If you would like to have a more detailed account of our policies and procedures concerning the privacy of your Patient Health Information we encourage you to read the HIPAA NOTICE that is available to you at the front desk before signing this consent.

1. The patient understands and agrees to allow this chiropractic office to use their Patient Health Information (PHI) for the purpose of treatment, payment, healthcare operations, and coordination of care. As an example, the patient agrees to allow this chiropractic office to submit requested PHI to the Health Insurance Company (or companies) provided to us by the patient for the purpose of payment. Be assured that this office will limit the release of all PHI to the minimum needed for what the insurance companies require for payment.
2. The patient has a right to examine and obtain a copy of his or her own health records at any time and request corrections. The patient may request to know what disclosures have been made and submit in writing any further restrictions on the use of their PHI. Our office is not obligated to agree to those restrictions.
3. A patient’s written consent need only be obtained one time for all subsequent care given the patient in this office.
4. The patient may provide a written request to revoke consent at any time during care. This would not affect the use of those records for the care given prior to the written request to revoke consent but would apply to any care given after the request has been presented.
5. For your security and right to privacy, all staff has been trained in the area of patient record privacy and a privacy official has been designated to enforce those procedures in our office. We have taken all precautions that are known by this office to assure that your records are not readily available to those that do not need them.
6. Patients have the right to file a formal complaint with our privacy official about any possible violations of these policies and procedures.
7. If the patient refuses to sign this consent for the purpose of treatment, payment and health care operations, the chiropractic physician has the right to refuse to give care.

I have read and understand how my Patient Health Information will be used and I agree to these policies and procedures.

Patient Signature

Date

PATIENT REFERRAL BOARD PERMISSION FORM

We believe in recognizing our patients who are kind enough to refer family and friends. One method we use is the placement of your name in public view in our reception area. However, we are required to have your permission before displaying your name. Please read and sign in the appropriate box below.

I HEREBY AUTHORIZE and give permission to Wiles Chiropractic to display my name in public View on the office referral board.

OR

I DO NOT AUTHORIZE and give permission to Wiles Chiropractic To display my name in public view On the office referral board.

Patient Signature

Patient Signature

Date

Date

Patient Name: _____ Date: _____

Assignment of Benefits Form

Financial Responsibility

All professional services rendered are charged to the patient and are due at the time of service, unless other arrangements have been made in advance with our office. Necessary forms will be completed to file for insurance carrier payments.

Assignment of Benefits

I hereby assign all benefits, to include major medical benefits to which I am entitled. I hereby authorize and direct my insurance carrier(s), including Medicare, private insurance and any other health/medical plan, to issue payment check(s) directly to Dr. Joseph A. Wiles for chiropractic services rendered to myself and/or my dependents regardless of my insurance benefits, if any. I understand that I am responsible for any amount not covered by insurance.

Authorization to Release Information

I hereby authorize Dr. Joseph A. Wiles to: (1) release any information necessary to insurance carriers regarding my illness and treatments; (2) process insurance claims generated in the course of examination or treatment; and (3) allow a photocopy of my signature to be used to process insurance claims for the period of lifetime. This order will remain in effect until revoked by me in writing.

I have requested chiropractic services from Dr. Joseph A. Wiles on behalf of myself and/or my dependents, and understand that by making this request, I become fully financially responsible for any and all charges incurred in the course of the treatment authorized.

I further understand that fees are due and payable on the date that services are rendered and agree to pay all such charges incurred in full immediately upon presentation of the appropriate statement. A photocopy of this assignment is to be considered as valid as the original.

Patient/Responsible Party Signature

Date

Witness

Date

Patient Health Information Consent Form

We want you to know how your Patient Health Information (**PHI**) is going to be used in this office and your rights concerning those records. Before we will begin any health care operations we must require you to read and sign this consent form stating that you understand and agree with how your records will be used. If you would like to have a more detailed account of our policies and procedures concerning the privacy of your Patient Health Information we encourage you to read the HIPAA NOTICE that is available to you at the front desk before signing this consent.

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5. For your security and right to privacy, all staff has been trained in the area of patient record privacy and a privacy official has been designated to enforce those procedures in our office. We have taken all precautions that are known by this office to assure that your records are not readily available to those who do not need them.
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7. If the patient refuses to sign this consent for the purpose of treatment, payment and health care operations, the chiropractic physician has the right to refuse to give care.

I have read and understand how my Patient Health Information will be used and I agree to these policies and procedures.

Name of Patient

Date