DR _________ *NP*___ *X-ray #*________

Mantonya Chiropractic Center LLC

New Patient Information Form - Work Injury

(Please Print and complete all areas)

Name____**Today'sDate**_____________
Legal First *Middle* *Last*

Mailing Address____

City____ **State**_________ **Zip**_______________ **Birth Date**____________ **Age**_____

SS#_____________________________________ **Sex: ( )Male ( )Female Marital Status: S M W D Partner**

- **Language:** _____English _____ Spanish _____ Indian _____ Japanese _____ Chinese _____ Korean _____ French
  _____ German _____ Russian_____ Italian_____ Ukrainian Other_______________
- **Race**: _____ White/Caucasian _____American Indian/ Alaska Native _____ Asian _____Native Hawaiian/Other Pacific Islander
  _____ Black/ African American _____ Decline to Answer Other____________________
- **Ethnicity:** _____ Hispanic or Latino _____Not Hispanic or Latino _____ Decline to Answer

Home Phone: ____________________________________ **Work Phone**:____

Cell Phone: ____________________________________ **Cell Carrier**____

Please check your contact preference: _____Hm phone _____ Wk phone _____ Cell _____Email _____ Postal Mail

Email hm: ____ **Email wk**: ____

Emergency Contact:___________________________ **Phone Number**: ______________________ Relationship _____________

Name of Partner/Spouse (*or parent if minor*)____

Spouse's (*or parent if minor*) **Employer**____

Person Responsible For Account ___ **Self** ___ **Other:** ____

Their Address *(if different than yours)*____

Were you referred by: ___**Family Doctor** ___ **Attorney** ___ **Our Patient(s)...their name)**____________________________

If you were not referred, how did you pick us? ___**Sign** ___ **Google Search** ___ **our Website** ___ **Location** ___ **Reputation**

___ **doctor** ___ **Insurance** ___ **Phone Book Other:**__________________________

We will make a copy of your insurance card(s). However, please complete the following information.

Family Physician Name____

Do you have Health Insurance? □Yes □No

Primary Insurance Company Name_________________ **ID#**___________ **Grp#**_______

Whose name is it under? ___Self ___Other(their name):______________ **Their Birthday**__________

Do you have a secondary insurance coverage? □ Y □N If yes, please complete the following:

Secondary Insurance Company Name_________________ **ID#**___________ **Grp#** _______

Whose name is it under? ___Self ___Other(their name):______________ **Their Birthday**__________

Fees are payable the day of service unless arrangements are made otherwise.

Have you ever been to a Chiropractor before? □Yes □No
If yes, where? ________________________
When was your last adjustment? ________________

Female Patients: Are you pregnant? □Yes □No

Health History

Are you seeing anyone else for other problems or health conditions? Yes No
Please list the problem/s, date problem/s began, and Provider/s treating you for the condition/s:

____

____

____

Past Health History

Have you…

	Yes	No	If yes, include date & provider seen
...been diagnosed with Diabetes?	□	□	______________________
Type I____ or Type II_____			
…been treated for hypertension?	□	□	______________________

Do you smoke? □Never □Former Smoker □Current/Every Day Smoker □Current Some Day Smoker

Medications
What medications are you currently taking? Include vitamins, herbs, minerals…

List Date Started, Brand Name, Generic Name, Strength, Dosage, Frequency, Duration, Quantity, Refills Available, Prescribed by

Please be as specific as possible. Check here if None _______.
____
____
____
____
____

Do you have allergies? □ Food □ Environmental □ Medication □ None

List Type of Allergy and Reaction
____
____
____

Welcome to our office! Rest assured we will do everything in our power to help you.
If we can't help you, we will tell you and get you to the right place that can.

WORKER'S COMPENSATION INJURY QUESTIONNAIRE

Name____ **Date**______________
First *Middle* *Last*

Employer's Business Name at time of Accident_______________________________

Employer's Phone_______________Employer's Address_________________________

Occupation____
❑ Yes ❑ No Previous Worker's Compensation Injury? Impairment Rating______________

Length of time at this job prior to injury__________________________________
Date of injury______________ Time of injury______________ Last Date Worked______________

Please explain what you were doing at the time you were injured and how the accident happened (lifting, bending, walking, carrying, standing, etc.) Try to be as specific and thorough as possible.
____
____

When did the pain begin?(Please be specific)______________________________

Where did you first feel it?(Please be specific)____________________________

Was the pain intense at first or did it gradually worsen?_____________________

REPORT ACCIDENT/ACCIDENT OBSERVER

What date did you report this injury on?__________________________________

Who did you report this injury to?______________________Position?______________

Did anyone else observe accident/injury? ❑ Yes ❑ No If yes, Name____________________
Position____________________

SYMPTOMS FROM ACCIDENT

Did you experience bleeding cuts or bruises? ❑ Yes ❑ No
If bleeding 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 become apparent since the accident/injury:

❑ Nervousness	❑ Loss of balance	❑ Sleeping trouble	❑ Headache
❑ NeckPain/Stiffnes	❑ Loss of smell	❑ Toe Numbness	❑ Fainting
❑ Mid Back Pain	❑ Loss of taste	❑ Finger Numbness	❑ Anxiety
❑ Low Back Pain	❑ Loss of memory	❑ Cold Hands	❑ Seizures
❑ Eyes sensitive to light	❑ Pins & Needles – Arms	❑ Cold Feet	❑ Visualdisturbance
❑ Pain behind eyes	❑ Pins & Needles – Legs	❑ Chest Pain	❑ Forgetfulness
❑ Dizziness	❑ Shortness of breath	❑ Constipation	❑ Blurred Vision
❑ Cold sweats	❑ Head seems too heavy	❑ Diarrhea	❑ Double Vision
❑ Face flushed	❑ Irritability	❑ Fatigue	❑ Confused
❑ Ringing/Buzzing Ears	❑ Depression	❑ Tension	❑ Disoriented
❑ Fever	❑ Other______________		

MECHANISM OF INJURY:

Please explain the mechanism of the injury *(only fill in those 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 with your ❑ Legs ❑ Back ❑ Other____

BEND:

❑ Yes ❑ No Were you lifting when you were bent over? If yes, how much did the object weigh? ________________lbs.

How far were you bent 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, please give dates: ____

❑ Yes ❑ No Have you gone back to work? When______________________________________

If yes, status of work: ❑ Modified ❑ Regular

List restrictions you have been placed on___________________________________

If you have gone back to work, list 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__________________________________ ____

FIRST DOCTOR/HOSPITAL/CLINIC:

❑ Yes ❑ No Were you hospitalized as a result of this accident? If yes, where____________________

Doctor 1 Name___________________________________ Date of First Visit____________________________

❑ Yes ❑ No Were you examined? ❑ Yes ❑ No Were X-rays taken?

What diagnosis did the doctor give you?____

❑ Yes ❑ No Were you given treatment? If yes, what type?__________________________________
What benefits did you receive from this treatment?_______________________________
____
Date of last treatment?____

❑ Yes ❑ No Did the doctor refer you to another health professional? If yes, to whom and for what?
____

❑ Yes ❑ No Did you follow the doctor's recommendation? If no, why not?_____________________
____

SECOND DOCTOR/CLINIC:
Doctor 2 Name: ____________________________________ Date of First Visit__________________________

❑ Yes ❑ No Were you examined? ❑ Yes ❑ No Were X-rays taken?

What diagnosis did the doctor give you?____

❑ Yes ❑ No Were you given treatment? If yes, what type?__________________________________
What benefits did you receive from this treatment?_______________________________
____
Date of last treatment?____

PRIOR SIMILAR SYMPTOMS:
❑ Yes ❑ No Did you have any physical complaints just before the accident? If yes, please describe in detail____
____

❑ Yes ❑ No Have you ever had any prior injuries, accidents, diseases or treatment to the area of your body now affected? If yes, what part was previously injured?__________________
Date previously injured?____
Describe previous injury____

❑ Yes ❑ No Were you treated? By whom?____
Date treatment began__________________ Date treatment ended__________________
The last date you felt pain or problems from that previous injury____________________

JOB DESCRIPTION

In terms of an 8-hour workday: ***Occasionally***=33%, ***Frequently***=34% to 66%, ***Continuously***=67% to 100%

In a typical 8-hour workday, I (circle the number of hours of 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

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	❑	❑	❑	❑
Pulling/Pushing	❑	❑	❑	❑

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	❑	❑	❑	❑

❑ Yes ❑ No Are you required to bend over while doing any lifting?

❑ Yes ❑ No Are your feet used in repetitive movements, such as operating foot controls?

Do you use your hands for repetitive actions such as:

	Simple Grasping	Firm Grasping	Fine Manipulating
Right Hand	❑ Yes ❑ No	❑ Yes ❑ No	❑ Yes ❑ No
Left Hand	❑ Yes ❑ No	❑ Yes ❑ No	❑ Yes ❑ No

❑ Yes ❑ No Are you required to work at unprotected heights? If yes, please describe_____________
____

❑ Yes ❑ No Are you required to be around moving machinery? If yes, please describe____________
____

❑ Yes ❑ No Are you exposed to marked changes in temperature and humidity? If yes, please describe____

❑ Yes ❑ No Are you required to drive automotive equipment? If yes, please describe_____________
____

❑ Yes ❑ No Are you exposed to dust, flames, and/or gases? If yes, please describe______________
____

Please list any additional comments____
____

Patient's Signature____**Date**_____________

Mantonya Chiropractic Center LLC

Notice of Privacy Practices

Patient Health Information Consent Form

____
Patients name

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 the 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 who 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.

Other uses include:
Appointment reminder messages, Sign-in log, Newsletters/Emails/Postcards, Chart Holders, Open Therapy Bay

***Other uses as permitted/required by law**
***We do not sell patient names/info for any purposes**

*** In the event that we would need to communicate your healthcare information, to whom may we do so?**
Spouse______________________________ Children_________________________________ Others _________________________
No One _____

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

_____________________________________ _______________________________________ _____________
Print Name Signature patient or parent/guardian Date

____
Witness