WORKERS COMPENSATION

DATE: _____/_____/_____

NAME: _____HOME PHONE: _____

ADDRESS: _____CELL PHONE: _____

CITY: _____STATE:_____ZIP:_____WORK PHONE: _____

DATE OF BIRTH: _____/_____/_____ AGE: _____ SS#_____

SPOUSE NAME: _____DOB:_____/_____/_____ SS#_____

EMERGENCY CONTACT: _____ PHONE #:_____

Email: _____ **Height: _____Weight: _____**

Race: □Asian □Black □Hispanic □White □Other □Refuse to Answer

Ethnicity: □Latino □Non-Latino □Refuse to Answer **Language:** □English □Spanish □Other: _____

PHYSICIAN INFORMATION

REFFERRED BY: _____PHONE: _____

CARDIOLOGIST: _____PHONE:_____

INSURANCE INFORMATION

PRIMARY INSURANCE: _____ID#_____

SECONDARY INSURANCE: _____ ID#_____

PHARMACY INFORMATION

NAME: _____Town & Street: _____ PHONE: _____

Provide a 10 year history on the following:

1. Are your symptoms due to an injury at work? ☐No ☐Yes

Where did injury take place (address would be helpful)?_____

Briefly describe how you got hurt?: _____

What parts of the body were hurt and do you currently feel pain?:_____

When did you first notice any symptoms (Date of injury if known)?_____

2. Have you received treatment for similar symptoms before visiting this office? ☐No ☐Yes

If yes, please provide name and addresses and dates:

PRIMARY DOCTOR: _____Phone:_____

Address: _____Fax:_____

Additional info: _____

Chiropractor's name:_____Phone:_____

Address: _____Fax:_____

Treatment received: _____

Pain Management Doctor name:_____Phone:_____

Address: _____Fax:_____

Treatment received: _____

Physical Therapist Name: _____Phone:_____

Address: _____Fax:_____

Treatment received: _____

3. Have you ever filed a workers compensation claim in the past? Please explain:_____

Have you ever been involved in motor vehicle accident? ☐No ☐Yes Explain:_____

4. Work History

Current Employer: _____

Occupational Description: _____

5. Do you have a second job? ☐No ☐Yes if yes, please describe:

_____

6. What do you like to do for fun? (Recreational activities) Describe: _____

Do you currently participate in any athletic sporting activities? Explain:_____

7. Have you had previous Imaging studies?

TESTS AND RADIOLOGICAL STUDIES: (Please indicate the Year and Results):

	YEAR	**RESULTS**
X-rays:	_____	_____
CAT Scan:	_____	_____
MRI:	_____	_____
EMG:	_____	_____

8. Have you had any **Surgeries**? ☐No ☐Yes—If yes, list operations, date, doctor/hospital:

Surgery: Date/Doctor/Hospital:_____

Surgery: Date/Doctor/Hospital:_____

9. Please check the following illnesses you have had or have now:

☐Arthritis _____	☐ Diabetes (Insulin?) _____	☐ Eyes _____	☐ Ear/Nose/Throat _____
☐ Epilepsy _____	☐ Heart Disease _____	☐ Psychiatric _____	☐ Bleeding/Clotting _____
☐Hypertension _____	☐ Cancer _____	☐ Headaches _____	☐ Lungs _____
☐ Stroke _____	☐ Anemia _____	☐ Bowel Dysfunction _____	☐ Bladder Dysfunction _____
☐ Tuberculosis _____	☐ Asthma/COPD _____	☐ Balance/Dizziness _____	☐ Numbness/Tingling _____
☐ Depression _____	☐vascular disease _____	☐ Blackouts/Fainting _____	☐ Stomach ulcers _____
☐ Osteoarthritis _____	☐ Rheumatoid Arthritis _____	☐ Lyme _____	☐ Fibromyalgia _____
☐ HIV/AIDS _____	☐ Hepatitis Type _____	☐ others (specify) _____	

10. Allergies to medicine or other product (latex, tape, peanuts, etc.)? ☐No ☐Yes—if yes, please explain:

_____

11. Alcohol? ☐No ☐Yes **How often?** _____

Other Substance abuse? ☐No ☐Yes **Please describe:** _____

12. Smoker? ☐Yes ☐ **Non-Smoker** ☐ **Quit Smoking: How long ago?** _____

Please circle one: Everyday / Not everyday. How many per day? _____

How soon after waking up do you smoke your first cigarette? _____

13. CURRENT AND PREVIOUS PAIN MEDICATION RESULTS:

MEDICATION	DOSE / FREQUENCY	PAIN RELIEF?	ANY SIDE EFFECTS?	CURRENTLY TAKING?
_____	_____mg_____/day	Yes / No /Some	_____	Yes / No
_____	_____mg_____/day	Yes / No /Some	_____	Yes / No
_____	_____mg_____/day	Yes / No /Some	_____	Yes / No
_____	_____mg_____/day	Yes / No /Some	_____	Yes / No

Please list all other **Current Medications** (including herbal, vitamins and over the counter medications).

Name of Medicine	Dose	Name of Medicine	Dose
_____	_____	_____	_____
_____	_____	_____	_____

14. DESCRIBE YOUR PAIN:

___Aching ___Burning ___Dull ___Pressure ___Sharp
___Shooting ___Throbbing ___Tightness ___Other (Specify):_____

15. CIRCLE THE LETTER THAT BEST DESCRIBES THE TIMING OF YOUR PAIN.

A. Constant –same intensity all the time
B. Constant – the intensity varies
C. Intermittent with short periods without pain

16. INTERFERENCE WITH YOUR DAILY LIFE:

___No interference ___Minimal Interference
___Considerable Interference ___Total Interference

17. DOES THE PAIN INTERFERE WITH YOUR SLEEP: ___No ___Yes If Yes, regularly? ___No ___Yes

SINCE YOUR PAIN BEGAN, HAS IT: ___Increased ___Decreased ___Stayed the same

HOW LONG HAVE YOU HAD THIS PAIN: _____ weeks / months / years

DOES YOUR PAIN SPREAD (RADIATE OR TRAVEL): ___No ___Yes (Where?)_____

IS THIS THE RESULT OF (circle): ACCIDENT / INJURY / SURGERY / ILLNESS
(Describe) _____

18. ITEMS THAT INCREASE YOUR PAIN:

___Coughing ___Driving ___Having Sex ___Lying down ___Repetitive Movement
___Sitting ___Sneezing ___Standing ___Time of Day (_____)
___Stress ___Walking ___Weather ___Other (Specify) _____

19. ITEMS THAT DECREASE YOUR PAIN:

___Applying Cold ___Applying Heat ___Changing Position ___Lying Down ___Massage
___Medications ___Physical Activity ___Rest ___ Time of Day (_____)
___Sitting Down ___Standing ___Walking Around ___Other (Specify) _____

20. CHECK HOW OFTEN YOU USE THE FOLLOWING DEVICES:

CANE	___Never	___Sometimes	___Often	___Usually
WALKER	___Never	___Sometimes	___Often	___Usually
WHEELCHAIR	___Never	___Sometimes	___Often	___Usually
BRACE	___Never	___Sometimes	___Often	___Usually
NECK COLLAR	___Never	___Sometimes	___Often	___Usually

21. ANY OF THE FOLLOWING ASSOCIATED WITH THE PAIN:

___Numbness ___Tingling ___Weakness ___Loss of bowel or Bladder Control _____Radiating
___Muscle Spasm and Tightness ___Headache ___Other (Specify _____

22. PREVIOUS PAIN TREATMENT / THERAPY (check which apply):

	DATE/HOW LONG?	DID IT HELP?	DURATION OF PAIN RELIEF?
___Acupuncture	_____	Yes / No	_____ days / weeks / months / years
___Massage	_____	Yes / No	_____ days / weeks / months / years
___Chiropractic	_____	Yes / No	_____ days / weeks / months / years
___Heat / Cold Application	_____	Yes / No	_____ days / weeks / months / years
___Nerve Blocks or injections	_____	Yes / No	_____ days / weeks / months / years
___Physical Therapy	_____	Yes / No	_____ days / weeks / months / years
___Electrical Stimulation (TENS)	_____	Yes / No	_____ days / weeks / months / years
___Psychotherapy	_____	Yes / No	_____ days / weeks / months / years
___Biofeedback/Hypnosis	_____	Yes / No	_____ days / weeks / months / years
___Traction	_____	Yes / No	_____ days / weeks / months / years
___Ultrasound Therapy	_____	Yes / No	_____ days / weeks / months / years
___Home Exercise/Stretching	_____	Yes /No	_____ days / weeks / months / years

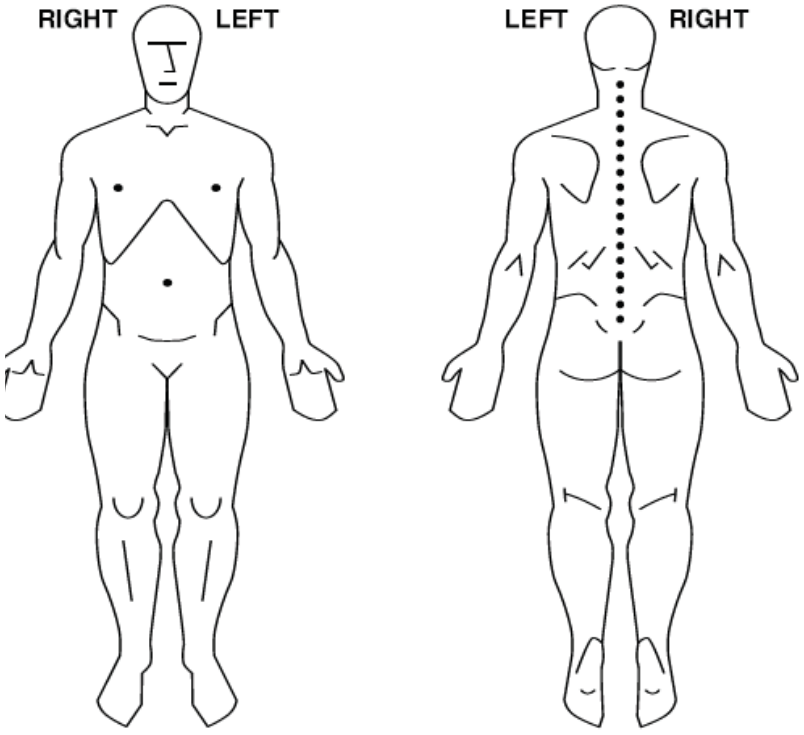
Pain diagram

No pain ***Worst***

|----------|----------|

0 1 2 3 4 5 6 7 8 9 1

Mark where your pain is TODAY



Mark the location of your pain on the body

XXX	where you have pain
OOO	where you have numbness
ZZZ	where you have weakness

Patient Signature:_____Date:_____

University Spine Center

NOTICE OF PRIVACY PRACTICES

This notice describes how medical information about you may be used and disclosed and how you can get access to this information. Please review it carefully. If you have any questions about this notice, please contact our privacy contact.

This Notice of Privacy Practices advises you about the way we may use and disclose medical information about you. It also describes your rights and certain obligations we have regarding the use and disclosure of your protected health information. We are required to abide by the terms of this notice and may change the terms at any time. Upon you request we will provide you with any revision made to this notice.

Uses and disclosures of Protected Health Information
Your protected health information may be used and disclosed for your ongoing treatment, our ongoing healthcare operations or to secure payment of services.

Treatment
The provision, coordination or management of healthcare and related services among providers or with third party.

Healthcare Operations
Necessary disclosures to run our practice and monitor quality of care including staff performance, evaluation of practice enhancements, and staff education.

Payment
Necessary disclosure to secure reimbursement from you, your insurance company, or other third party payer for services rendered. In addition, PHI may be disclosed to obtain prior approval from your insurance company to assure payment for services yet to be rendered.

Appointment Confirmation
We will continue our practice of telephone confirmation of all appointments.

Individuals Involved In Your Ongoing Care
Upon you verbal authorization we will disclose your information about you to your designated care givers, other family members, or other individuals.

Case Management for Workers' Compensation/PIP/Disability
We may release PHI for your workers' compensation, auto related or other liability claim, or your claim for disability benefits or similar programs that provide benefits for injuries or illness. This may include claims adjusters, nurse case managers and may be telephonic.

As Required By Law
We will disclose medical information about you when required to do so by federal, state, or local law. This may include activities by the government to monitor the healthcare system and compliance with civil rights laws, audits, inspection and licensor. We may disclose PHI for matters involving public health risks including disease exposure, child abuse or neglect or other domestic abuse, neglect or violence. If you are involved in a lawsuit we may disclose PHI in response to a subpoena or other court order. PHI may be disclosed to other legal authority pursuant to law enforcement.

Other Uses and Disclosures of Your PHI
Other disclosures of you PHI will be made only upon written authorization and payment of allowable fee. You may obtain an authorization form from our office. You may revoke this authorization at any time in writing. You understand that we are unable to take back any disclosures that have already been made with your prior permission.

Methods of Disclosure
We will respond to your request by mailing copies of your records via US Postal Service. We will not disclose any PHI through e-mail. Under limited circumstances at our discretion your medical records may be faxed.

Your Rights Regarding Your Protected Health Information
Right to Inspect
You have the right to inspect a copy of your PHI including medical and billing information which is used to make decisions about you. You must submit your request in writing. We may charge a fee as permitted by state law for the costs of copying and mailing. We will not fax your medical information to you. We may deny your request under limited circumstances.

Right to Amend
If you feel the medical information we have is incorrect or incomplete, you may ask us to amend it. We will provide an amendment form which you must complete. You must provide a reason which must support your request. In the absence of a reason we will deny your request.

Rights to an Accounting of Disclosure
We will keep an accounting of all disclosures we made about you. You may request this list in writing and must state a time period no longer than six years and may not include dates before April 14, 2003.

Right to Request Restrictions
You have the right to request a restriction on the medical information we disclose for treatment, payment, operations or your care givers and other involved persons. *We are not required to agree with your request.* We will comply with your request unless the information is needed for emergency treatment. Your request for limitations must be made in writing and must include what information you want limited and to whom you want these limits to apply.

Changes to this Notice
We reserve the right to change this notice and apply the changes to information we already have about you or may receive in the future. We will post a copy of the current notice in the office. The effective date will appear in the upper right hand corner. We will offer you a copy of the current notice.

Complaints
If you believe that your rights have been violated, you may file a complaint with our office. Your complaint must be made in writing and addressed to Doranne Moncavage, University Spine Center. No complaints will be acknowledged by phone.

Acknowledgment of Receipt of Privacy Notice

Our notice of Privacy Practices provides information about how we may use and disclose protected health information about you. You have the right to review our notice and ask questions about our privacy practices. The terms of this notice may change. Upon request a copy of our revised notice will be made available to you. By signing this for you acknowledge that you have received our Notice of Privacy Practices.

Name of Patient: _____Date: _____

✖ Signature of Patient/ Guardian: _____

Please release any information to the following people:

_____ _____

_____ _____

NOTICE TO PATIENTS

INSURANCE PARTICIPATION AND REFERRALS

Please be advised that it is the patient's responsibility to advise the practice of any insurance coverage changes or termination of coverage. It is not the responsibility of the practice to know your personal insurance coverage, participation, and/or any out of pocket expenses you may incur. If you have questions or concerns you are advised to notify your insurance company Members Services Department, or Human Resource Department at your place of employment.

Please note that if your plan requires a referral, it is the patient's responsibility to obtain one and it must be presented at the time of service. If you do not have one, then you will have to reschedule your appointment until you are able to obtain a referral.

LITIGATION MATTERS

In order to be fair to all patients, the physician cannot agree to act as an expert witness for any litigation matters. While we will agree to render assistance, such as providing patient records pertinent to the case, we cannot agree to testify in court on your behalf as an expert witness. The imposition on the medical practice is unfair to the other patients as well as to the staff. The doctors' schedule does not permit time for the dictation of narrative reports.

The physician will agree, for a fee, to appear on a videotaped deposition to be performed in our office at the physician's convenience, so that his testimony can be presented on your behalf based on the agreement not to testify. Payment for such services will be coordinated with your attorney and must be paid in advance.

University Spine Center will not wait for payment of services rendered until the case is settled. We will not accept a lien. Payment is due at the time of service.

Please acknowledge by signing and dating below that you have received and reviewed the above policy. A copy of this document will be forwarded to your attorney if and when the need arises.

_____ _____

Patient / Guardian signature **Date**