INNOVATIVE Health
Chiropractic • Laser Therapy
Functional Medicine
2114 Schofield Avenue, Weston, WI 54476

WORKER'S COMPENSATION HISTORY

If you have any questions on the form, please call us at 715-355-4224.

Legal Name (*First, Middle, Last*):		Today's Date:
Street Address:		Home Phone: ☐ Preferred
City / State / Zip:		Cell Phone: ☐ Preferred
Social Security #:	Birthdate:	Work Phone: ☐ Preferred
Driver's license #:	Email:	
Ethnicity: ☐ Non-Hispanic ☐ Hispanic	Sex: ☐ Male ☐ Female	

Race: ☐ White/Caucasian ☐ African American/Black ☐ Hispanic ☐ Asian ☐ American Indian ☐ Alaska Native ☐ Native Hawaiian ☐ Other Pacific Islander ☐ Other: ____________

Emergency Contact:	Emergency Contact's Phone:
Primary Medical Doctor:	Medical Doctor Clinic & City:
Marital Status: ☐ Single ☐ Married ☐ Divorced ☐ Widowed	Spouse's Name:
Spouse's Phone:	Spouse's Employer:

EMPLOYER INFORMATION

Employer Name:	Employer Phone:
Street Address:	HR Contact Name:
City / State / Zip:	Patient's Occupation:

CHIEF COMPLAINT

Use the symbols from the top box on the left to indicate the location and type of pain you are having.

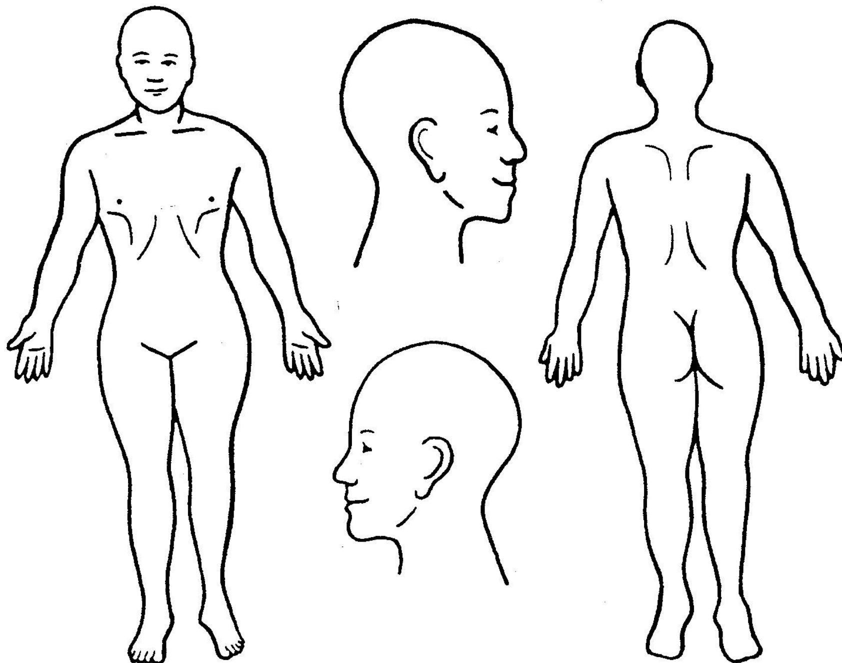
XXX	Burning
(((	Aching
000	Pins & Needles
- - -	Numbness
: : :	Sharp Pains

Pain is:

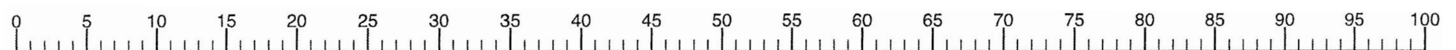
____ Constant
____ Comes & Goes

____ Getting Better
____ Getting Worse
____ Staying Same

Better		Worse
____	Morning	_____
____	Midday	_____
____	Evening	_____



Rate your pain on the scale below. If there is more than one area of pain, please indicate the pain level (0 to 100) next to each area as appropriate.



NO PAIN INTOLERABLE

SYMPTOMS

What are your symptoms:

What were you doing at the time you were injured? How did the injury happen?

Please describe how you felt: Immediately after the injury:

Later that day:

The next day(s):

Please mark any of the following activities which you find to be painful or difficult.

____ Lying on back	____ Dressing Self	____ Lifting	____ Bending Forward	____ Twist/Turn Left/Right
____ Lying on side	____ Stooping	____ Gripping	____ Standing (1 hour+)	____ Sitting/Driving/Riding
____ Lying on stomach	____ Pushing/Pulling	____ Kneeling	____ Get In/Out of Car	____ Using Computer
____ Turning over in bed	____ Reaching	____ Walking	____ Sexual Activity	____ Going Up/Down Stairs
____ Balancing	____ Climbing			

____ Cough / Sneeze / Grunt - If painful, where? ____

Please mark any symptoms that have become apparent since the accident/injury.

____ Nervousness	____ Face flushed	____ Depression	____ Pins/needles, arms	____ Visual changes
____ Neck pain/stiffness	____ Ringing in ears	____ Cold hands	____ Pins/needles, legs	____ Forgetfulness
____ Mid back pain	____ Loss of balance	____ Cold feet	____ Toe numbness	____ Blurred vision
____ Low back pain	____ Loss of smell	____ Chest pain	____ Finger numbness	____ Double vision
____ Eye sensitivity	____ Loss of memory	____ Constipation	____ Headache	____ Confused
____ Pain behind eyes	____ Short of breath	____ Diarrhea	____ Fainting	____ Disoriented
____ Dizziness	____ Head feels heavy	____ Fatigue	____ Anxiety	Other: ___________________
____ Cold sweats	____ Irritability	____ Tension	____ Seizures	_________________________

☐ Yes ☐ No Does the pain interfere with your sleep? # of times you wake up:_____ Sleep position: _________ # of pillows: ______

☐ Yes ☐ No Does heat affect the pain? If so, how?

☐ Yes ☐ No Does cold affect the pain? If so, how?

☐ Yes ☐ No Do you wear a heel lift? If so, which side?

☐ Yes ☐ No Do you have any congenital (birth) factors which relate to the problem? If so, please describe

What Makes the Condition Better?	**What Makes the Condition Worse?**
Head, Neck:	Head, Neck:
Mid Back:	Mid Back:
Low Back:	Low Back:
Shoulder, Arm, Hand:	Shoulder, Arm, Hand:
Hip, Leg, Foot:	Hip, Leg, Foot:

PRIOR SIMILAR SYMPTOMS

☐ Yes ☐ No Did you have any physical complaints just before the accident? If yes, describe in detail:

☐ Yes ☐ No Have you had any prior symptoms, injuries, accidents, diseases, or treatment to the area of your body now affected?

If yes, which body part? When (date)?

Describe:

☐ Yes ☐ No Were you treated? If yes, by whom?

Date treatment began: Date treatment ended:

The last date you felt pain/had problems from that condition:

WORKPLACE REPORTING

Date of Injury: | Time of Injury:

Last date worked: | Date injury was reported:

Who did you report injury to? | What is his/her position?

Did anyone observe injury? ☐ No ☐ Yes If Yes, who?

Length of time at this job prior to injury: Previous Workers Comp Injury? ☐ No ☐ Yes If Yes, date:

MECHANISM OF INJURY *Only complete the section(s) that apply to your injury.*

☐ **FALL** Did you hit anything when you fell? ☐ Yes ☐ No If yes, what?

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

☐ Yes ☐ No Did it land on you? | How much did it weigh?

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

What part of your body did you fall on? | How far did you fall? (in feet)

What did you land on? | Was the area well lit? ☐ Yes ☐ No

Describe the condition of the area: (slippery, gravel, wet, etc…)

☐ **LIFT / PULL** At the time of the injury were you ☐ Lifting ☐ Pulling ☐ Both

What were you lifting/pulling? | How much did the object weigh?

☐ Yes ☐ No Did you fall after the injury? If yes, how far (in feet)?

☐ 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

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

☐ Yes ☐ No Did it land on you? If yes, where?

How far off of the ground did you have the item before the pain started?

Did you lift with your ☐ Legs ☐ Back ☐ Other (describe):

☐ **BEND** Were you lifting when you were bent over? ☐ Yes ☐ No | How far were you bent over?

If yes, what were you lifting? | If yes, how much did the object weigh?

☐ Yes ☐ No Were you twisting when you were bent forward? If yes, to which side? ☐ Left ☐ Right

☐ Yes ☐ No Did you fall when the pain started? If yes, how far (in feet)?

☐ Yes ☐ No Did you land on anything? If yes, what?

FIRST DOCTOR / HOSPITAL / CLINIC

Did you seek medical attention after the accident? ☐ No ☐ Yes

If yes, how did you get there? ☐ Ambulance ☐ Police ☐ Someone else drove me ☐ Drove myself

Doctor / Hospital / Clinic: | Date of first visit: | Date of last visit:

Were you examined? ☐ No ☐ Yes | Were X-rays taken? ☐ No ☐ Yes

What diagnosis were you given?

Were you treated? ☐ No ☐ Yes If yes, describe:

What benefits did you receive from the treatment?

Did you follow the doctor's recommendations? ☐ No ☐ Yes If no, why not?

Were you referred to another provider? ☐ No ☐ Yes If yes, to whom? for what?

Did you see the referred provider? ☐ No ☐ Yes If no, why not?

SECOND DOCTOR / HOSPITAL / CLINIC

Doctor / Hospital / Clinic: | Date of first visit: | Date of last visit:

Were you examined? ☐ No ☐ Yes | Were X-rays taken? ☐ No ☐ Yes

Were you treated? ☐ No ☐ Yes If yes, describe:

What benefits did you receive from the treatment?

JOB DESCRIPTION

In a typical 8-hour work day, how many hours do you spend: Sitting: Standing: Walking:

On the job, how many hours do you spend:	NOT AT ALL	OCCASIONALLY (1-2 hours)	FREQUENTLY (3-5 hours)	CONTINUOUSLY (6-8 hours)
Bending / Stooping				
Squatting				
Crawling				
Climbing				
Reaching above shoulder level				
Crouching				
Kneeling				
Balancing				
Pulling / Pushing				

On the job, how much weight do you lift:	NOT AT ALL	OCCASIONALLY (1-2 hours)	FREQUENTLY (3-5 hours)	CONTINUOUSLY (6-8 hours)
Up to 10 pounds				
11-24 pounds				
25-34 pounds				
35-50 pounds				
51-74 pounds				
75-100 pounds				

☐ Yes ☐ No Are you required to work at unprotected heights? If yes, describe:

☐ Yes ☐ No Are you required to work around moving machinery? If yes, describe:

☐ Yes ☐ No Are you exposed to marked changes in temperature and humidity? If yes, describe:

☐ Yes ☐ No Are you required to drive automotive equipment? If yes, describe:

☐ Yes ☐ No Are you exposed to dust, fumes, and/or gases? If yes, describe:

Please list any additional comments related to your job description/duties:

WORK STATUS

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

☐ Yes ☐ No Have you gone back to work? If yes, when?

If yes, check one: ☐ Modified Duty ☐ Regular Duty

If modified duty, list restrictions:

If regular duty, list any activities you find painful or difficult:

WORK STATUS CONT'D

☐ Yes ☐ No Are you on disability?

☐ Yes ☐ No If on disability, do you want to go back to work doing your regular job? If no, why not?

☐ Yes ☐ No Are there any problems with a co-worker, supervisor, or manager that need to be discussed?
If yes, please explain:

SOCIAL HEALTH HISTORY

Recreational Activities / Hobbies:

Do you commute to work? ☐ No ☐ Yes If Yes, how far?

Do you exercise? ☐ No ☐ Yes If Yes, in what way? How often per week?

Do you consume Caffeine (Coffee, Tea, Soda, Energy Drinks)? ☐ No ☐ Yes If Yes, how much per day?

Do you consume Alcohol (Beer, Wine, Mixed Drinks)? ☐ No ☐ Yes If Yes, how much per week?

Smoking Status *(If 13 years old or older):* ☐ Never ☐ Former (___ Packs/day or ___ Cigarettes/day from Age ____ to Age _____)
☐ Smoker—Some days (NOT daily) ☐ Smoker—Daily (____ Packs/day or ____ Cigarettes/day for ______ Years)

MEDICAL HISTORY

FEMALES: Are you pregnant? ☐ No ☐ Yes If Yes, Due Date:

Have you ever seen a chiropractor? ☐ No ☐ Yes If Yes, Doctor's Name: Clinic:

List major problems, illnesses, injuries, hospitalizations, accidents, or surgeries: ☐ None

Date	Condition(s)	Treating Doctor	Results
			☐ Full Recovery ☐ Complications
			☐ Full Recovery ☐ Complications
			☐ Full Recovery ☐ Complications
			☐ Full Recovery ☐ Complications

List current prescriptions, over-the-counter medications, and supplements: ☐ None

Name	Dosage *(mg, mL, …)*	Form *(Tablets, Caps…)*	How Often *(times per day, wk, mo)*	Duration *Chronic*	*As Needed*	*Unknown*
			x's per			
			x's per			
			x's per			
			x's per			
			x's per			

List allergies ☐ None

Drugs, Medications (ADR):	Foods:
Environmental:	Other: (latex, animals...)

Additional Comments:

I certify that the above statements are true and complete to the best of my knowledge. I authorize the doctor to examine and treat my condition through the use of chiropractic care, and I give authority for these procedures to be performed.

Patient Signature: ____ Date: ______________

Parent/Guardian/Legal Representative:______________________________ Date: ______________

D.C. / C.A. Signature: ____ Date: ______________

Staff Initials:

INFORMED CONSENT

While chiropractic care is remarkably safe, like any health care treatment, it does have some risks. It is your right as a patient to be informed of the potential risks of care so that you are fully informed in consenting to treatment.

The nature of the chiropractic adjustment - The primary treatment used by Doctors of Chiropractic is called spinal manipulative therapy. Your doctor may use his/her hands or a mechanical instrument upon your body in such a way as to move your joints. This may cause an audible "pop" or "click," much as you have experienced when you "crack" your knuckles. You may feel a sense of movement.

Analysis / Examination / Treatment - As a part of the analysis, examination, and treatment, a variety of tests and therapies may be used in your care including: spinal manipulative therapy, range of motion testing, muscle strength testing, ultrasound, radiographic studies (x-rays), palpation, orthopedic testing, postural analysis, basic neurological testing, hot/cold therapy, vital signs, EMS, ultrasound, spinal decompression therapy, and/or high intensity laser therapy.

The material risks inherent in chiropractic adjustment - As with any healthcare procedure, there are certain complications which may arise during chiropractic manipulation and therapy. These complications include but are not limited to: fractures, disc injuries, dislocations, muscle strain, cervical myelopathy, costovertebral strains and separations, and burns. Some types of manipulation of the neck have been associated with injuries to the arteries in the neck leading to or contributing to serious complications including stroke. Some patients will feel some stiffness and soreness following the first few days of treatment. Your doctor will make every reasonable effort during the examination to screen for contraindications to care; however, if you have a condition that would otherwise not come to our attention, it is your responsibility to inform the doctor.

The probability of those risks occurring - Fractures are rare occurrences and generally result from some underlying weakness of the bone which your doctor will check for during the taking of your history and during examination and x-ray. Stroke has been the subject of tremendous disagreement. The incidences of stroke are exceedingly rare and are estimated to occur between one in one million and one in five million cervical adjustments. *Statistically speaking, the risk of stroke from unknown causes in the general population actually exceeds the risk of stroke following a chiropractic adjustment*. The other complications are also generally described as rare.

Results - As with any health care option, we cannot guarantee any particular results from our chiropractic treatment. If during the course of care, we encounter non-chiropractic or unusual findings, we will advise you of those findings and recommend that you seek the services of another qualified health care provider.

The availability and nature of other treatment options - Other treatment options for your condition may include: self-administered, over-the-counter analgesics and rest; medical care and prescription drugs such as anti-inflammatory, muscle relaxants and pain-killers; hospitalization; surgery. There are risks and benefits with each of these options, and you may wish to discuss these risks and benefits with your primary medical physician.

The risks and dangers attendant to remaining untreated - Remaining untreated may allow the formation of adhesions and reduce mobility which may set up a pain reaction further reducing mobility. Over time, this process may complicate treatment making it more difficult and less effective the longer it is postponed.

❖ **PREGNANCY RELEASE –** This is to certify that, to the best of my knowledge, I am not pregnant. I give my permission to perform x-ray evaluation with the understanding that x-ray can be hazardous to an unborn child. ______________

(Patient Initials)

Having carefully read the above, I hereby give my informed consent to have the doctors of Innovative Health administer chiropractic care.

______________________	______________________
Patient Name (printed)	Date
X ______________________	X ______________________
Patient Signature	Parent/Guardian/Legal Representative Signature