Welcome To Our Clinic

WORKER'S COMPENSATION INFORMATION FORM

Your Name: ______________________ **Today's Date:** ____________

Address: ______________________ **City:** ____________ **Zip Code:**

Social Security #: ___--___--___ **Home Phone:** ( ) ____________ **Work Phone:**( ) ____________

Marital Status: **S** o **M** o **D** o **W** o Male Female **E-mail address:**

Date of Birth: ___/___/______ **Age:** ____________

Please Indicate Your doctor of Preference: o____________________

Your Insurance Company: ______________________ **Spouse Name:** ____________

Policy/Group #: ______________________ **Who Referred You To Our Office?:**

Your Employer: ______________________ **City:** ____________

Your Occupation: ____________ **Job Type:** Office-oriented o Manual o Travel o Homemaker o

Job Requirements: Lifting o Bending o Stooping o Telephone Cradling o Typewriting/Data Entry o Prolonged Sitting o Prolonged Standing o Lifting Children o (Ages:)

Your Primary Care Physician: **Name:** ______________________ **Phone:** ____________

Which of the following statements best describes your attitude towards health and health care (check the statement that best describes you):

o I seek medical attention only when absolutely necessary.

o My primary health goal is to be symptom free. I take care of symptoms when they are relatively minor.

o I am inclined to prevent future health problems via lifestyle choices such as exercise, nutrition, and other "health habits".

Tell Us What Is Bothering You

In order to give the doctor a clear understanding of your case, we would like to answer a few simple questions. Please be as specific as possible on both the body diagrams and questions. If you are unsure about any part of this form, please feel free to ask the staff, or especially, the doctor.

What health problem brings you to our office? ______________________

Is it due to a recent accident or injury? o Yes o No o Unknown

If "Yes", was it o Work o Auto o Other (describe):

Date of Accident: ____________ **Time:** ____________ o a.m. o p.m.

Have your injuries been reported? o Yes o No **If "yes", to whom?:**

Have you seen other doctors and been treated as a result of this condition/accident? o Yes o No

If "yes", please list names and specialties: ______________________

What did the other doctor(s)/specialist(s) do? o Examination o Injections o X-rays o Traction o Physiotherapy (how long?): o Other

What is you main area of chief complaint? (i.e., neck pain, headaches, low back pain, arm/leg pain):

____

Exact date problem began (if you have had this problem a long time, give date you finally felt you needed to get care):

____

How long has it been since you really felt good? ______________________

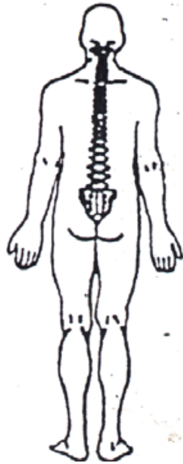
How long have you been under the care of a physician? ______________________

Are you still under a doctor's care? o Yes o No

Please mark the appropriate area of your chief complaint on the following diagrams. If you are experiencing radiating pain, please mark the areas the pain is going to.

BACK

LEFT



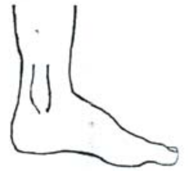
RIGHT

FRONT

LEFT

HEAD

FOOT



Check any of the following terms which describe your pain o Sharp o Stabbing o Dull Ache o Knawing oOther:_______ o Deep

Intensity of Pain / Frequency of Pain 0-10 (10 highest) ___________ Frequency: (# times/wk): _______________

Check the following symptoms which apply to your condition:

o Headache
o Insomnia
o Diarrhea
o Chest pain
o Eye strain
o Pallor
o Shortness of breath
o Nausea or vomiting
o Sinus trouble
o Extreme nervousness
o Difficulty in prolonged sitting
o Head and shoulders feel tired

o Neck pain
o Tension
o Fainting
o Dizziness
o Pain behind eyes
o Palpitations
o Leg problems
o Hands cold
o Extreme fatigue
o Digestive disorders
o Head seems too heavy

o Constipation
o Double vision
o Tremors
o Pain in joints
o Feet cold
o Excessive sweat
o Muscle jerking
o Depression
o Irritability
o Anxiety

o Back pain or stiffness in: (>>>) o Upper o Mid o Lower

o Pain radiating into: o Arms o Buttock o Legs o Feet

o Restriction of motion: o Neck R/L o Shoulders R/L o Arms R/L

o Numbness/Tingling in: o Neck R/L o Shoulders R/L o Arms R/L o Hips R/L o Fingers R/L o Legs R/L o Feet R/L

o Pins & Needles in: o Neck R/L o Shoulders R/L o Arms R/L o Hips R/L o Fingers R/L o Legs R/L o Feet R/L

Any other condition not specified: ____

What factors aggravate your complaint (make it worse):

o Sitting for long periods of time o Standing for long periods of time o Walking o Driving
o Lifting o Light o Moderate o Heavy o Repeated
o Twisting o Light o Moderate o Heavy o Repeated
o Standing o Light o Moderate o Heavy o Repeated
o Other activities (please list):

Check any of the following that have helped you get relief from your complaint:

o Ice o Heat o Stretches/Exercise o Rest o Massage

o Medication (list):
o Other (specify):

Does your pain seem to be worse at any of the following times of day?

o Worse in morning o Worse in afternoon o Worse in evening
o Wakes me up at night o Worse only with activity
o Constant, no relief o Other (specify):

Are there any activities you cannot do because of your condition?

o Work (how long) o Clean House o Drive o Lift things o Play sport/activity
o Other (specify):

Does your pain seem to be getting: o Better o Worse o Same

Have you ever had the same or similar condition? o Yes o No

Other health problems that concern you: ______________________

HISTORY:

Auto Accident: ______________________

Serious Fall: ______________________

Hospitalizations: ______________________

Surgeries: ______________________

Emotional Upsets: ______________________

Recent Dr. Visits: ______________________

Date of Last: Physical Exam Spinal X-Ray Spinal Exam
Chest X-Ray Blood Test Dental X-Ray
Urine Test

Do you take: o Nerve pills o Muscle relaxers o Pain killers o "Pep" pills
o Tranquilizers o Insulin o Birth control o Other: ____________

Do you now take vitamins and/or minerals?: o Yes o No If yes, list: ______________________

Habits (please give amount):

o Tobacco _____ (packs/day) o Alcohol ______ (drinks/day)
o Caffeine (coffee/tea/cola) ______ (drinks/day) o Non-job exercise _____ (hrs/wk)
o Sleep _____ (hrs/night) o Do you sleep on your: o Back o Side o Stomach
o Do you use a bedboard? o Yes o No Is your bed comfortable? o Yes o No

Do you wear: o Heel lifts o Sole lifts o Inner soles o Arch supports o Back brace o Prescribed orthotics

Mark the following diseases you have had:

o AIDS/HIV o Heart Disease o Rheumatoid Arthritis o Anemia
o Hepatitus o A o B o C o Rheumatic fever o Cancer/Tumors o Maliara
o Small pox o Chicken Pox o Measles o Tuberculosis
o Diabetes o Multiple Sclerosis o Typhoid Fever o Diptheria
o Mumps o Whooping Cough o Eczema o Pneumonia
o Polio o Epiliepsy o Other: ____________

Are you aware of any diseases that run in your family? o Yes o No If yes, describe: ______________________

Do any family members have similar health problems? o Yes o No (If yes, please describe):

FOR WOMEN ONLY:

Date of your last normal period: ____________________ **Interval between periods:** _______ **days**

First period at age: ___________ **Date of last visit to gynecologist:** ______________________

Is there any chance you may be pregnant? o Yes o No

WOMEN ***CONTINUED***

Check all that apply:

o Irregular cycles	o Excessive flow	o Congested breasts, lumps in breasts
o Premenstrual tension	o Other menstrual symptoms	
o Pain or bleeding during	o Vaginal discharge	
o Cramps or backache	o Menopausal symptoms	

Worker's Compensation

The Colorado Worker's Compensation Act requires employers (except for certain specifically exempted employers) to pay for treatment of injuries received by an employee while on the job. This law includes chiropractic, medical services and treatment.

Most employers utilize the State Compensation Insurance Fund to pay for necessary treatment as well as for wages lost because of injury. Some employers who use private insurance companies require you to see a company doctor first for on-the-job injuries. If you are unhappy with the company doctor's treatment, you can request that you be allowed to see the doctor of your choice.

It is necessary that the accompanying authorization be signed and returned to us on your next visit. If it is not (or if your employer uses a private insurance carrier who refuses to financially compensate this office for professional services rendered), then you will be expected to make other financial arrangements. If proper authorization is supplied to our office, we will bill the insurance company for payment of services you receive.

We hope this serves as an explanation of our procedures. If you need additional help or information, please contact our office and discuss it with us.

The best doctor/patient relationship is when there is complete understanding of treatment and financial responsibilities between the doctor and the patient.

I acknowledge that I have read and understand the above policy.

____ ____________________
Signature of Patient   Date

____
Witness

Authorization To Release Information

I hereby authorize Lifetime Health & Wellness/Westminster to release any information you deem appropriate concerning my physical condition to any insurance company, attorney or adjuster in order to process any claim for reimbursement of charges incurred by me as a result of professional services rendered by Lifetime Health & Wellness/Westminster.; and I hereby release you of any consequences thereof.

Date: ________________________ **Signed:** ____________________________________

Authorization To Pay Physician/Lien

I hereby authorize my attorney and/or insurance company to pay by check made out and mailed directly to Lifetime Health & Wellness/Westminster any monies due, and otherwise payable to me, the same to be deducted from any settlement made on my behalf for professional services rendered. Further, I agree to pay Lifetime Health & Wellness the difference, if any, between the total amount of charges and the amount paid by the attorney and/or insurance carrier.

I hereby state and agree that a photocopy of this document will be deemed as valid and binding on all parties involved as the original copy.

Date: ________________________ **Signed:** ____________________________________

Authorization For Treatment of Work Injury

TO: **Dr. Randy B. Snyder**
Dr. James J. Hoven, Jr.
Dr. Kevin R. Bates
Dr. James T. Turnbull Jr.

8155 W 94th Avenue
Broomfield, CO 80021

4100 E. Mississippi Suite 310
Glendale, CO 80246

FROM: ___________________________

Please render necessary care to: ____
For injuries received while at work. This employer will file the necessary insurance forms with our insurance carrier within 10 days.

Place Injury Occurred: ____

Date of Injury: ____

Reported To: ____

Position of Person Reported To: ____

Name of Employer: ____

Address of Employer: ____

Employer Telephone Number: ____

Contact ______________________________ for further information, if necessary.

I hereby authorize the above treatment on the employer's behalf:

Signature: ____

Position: ____

Date: ____

Name of Compensation Insurance Carrier: ____

Address of Insurance Carrier: ____

Phone Number of Insurance Carrier: ____