Workers' Compensation Questionnaire

Please answer all questions completely

Dear Patient: This information is considered confidential. We need this information because we care enough to want to know, and your answers will help us determine if chiropractic can help you. If we do not sincerely believe your condition will respond satisfactorily, we will not accept your case. In order for us to understand your condition properly, please be as neat and accurate as possible while completing this form. Thank you.

Name _____ Sex _____ Marital Status _____ Date of Birth _____ Home Phone _____

Address _____ City _____ State _____ Zip _____

Occupation _____ Who referred you to our office? _____
(Indicate if child, student, housewife, unemployed, retired)

Social Sec. # _____ Business Phone _____ Company Name _____ Location _____

Spouse's First Name _____ Spouse's Soc. Sec. # _____ Spouse's Employer _____ Location _____

Please explain in detail how your accident happened _____

Have you retained an attorney? ☐ Yes ☐ No Litigation? ☐ Yes ☐ No ☐ Maybe

If so, name and address _____

Give time and date present injury occurred _____ ☐ AM ☐ PM _____ 19_____

Where did you feel pain immediately after the accident? _____

Did you return to work? ☐ Yes ☐ No If so, date returned to work _____

Did you consult any other doctor? ☐ Yes ☐ No

If so, give doctor's name _____ ☐ D.C., ☐ M.D., ☐ D.O., ☐ D.D.S.

Doctor's diagnosis _____

What treatments did you receive? _____

Have you ever injured this area before? ☐ Yes ☐ No If so, when? _____

If injured before, did you lose time from work? ☐ Yes ☐ No

If you lost time from work with injuries prior to this injury, give name of doctor or doctors consulted _____

Do any other diseases or accidents affect your employment? ☐ Yes ☐ No If so, explain _____

In your work do you have to favor any part of your body? ☐ Yes ☐ No If so, explain _____

Do you have a history of absenteeism caused from accidents on the job? ☐ Yes ☐ No

Have you ever had a Workmen's Compensation claim before? ☐ Yes ☐ No

Before the injury were you capable of working on an equal basis with others your age? ☐ Yes ☐ No

Are your work activities restricted as a result of this accident? ☐ Yes ☐ No

Since this injury are your symptoms ☐ improving? ☐ getting worse? ☐ the same?

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HEALTH QUESTIONNAIRE:

Please indicate for each of the questions below your experience by use of the following codes: 1-never had; 2-previously had; 3-presently have.

MUSCULO-SKELETAL SYSTEM

_____ Low back problems
_____ Pain between shoulders
_____ Neck problems
_____ Arm problems
_____ Leg problems
_____ Swollen joints
_____ Painful joints
_____ Stiff joints
_____ Sore muscles
_____ Weak muscles
_____ Walking problems
_____ Ruptures
_____ Broken bones

GENITO-URINARY SYSTEM

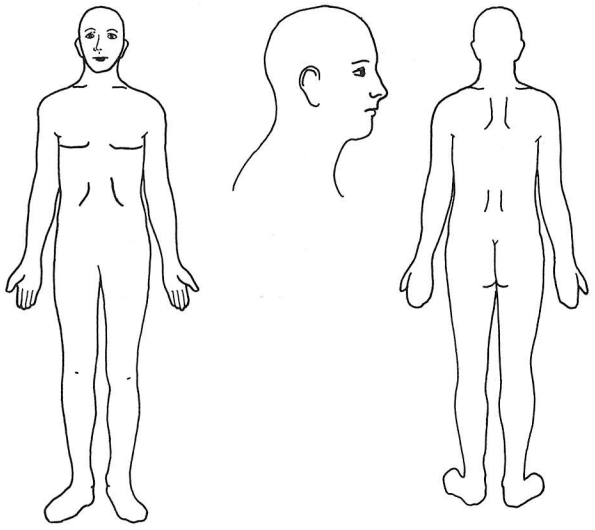
_____ Bladder trouble
_____ Excessive urination
_____ Scanty urination
_____ Painful urination
_____ Discolored urine

FEMALE

_____ Vaginal discharge
_____ Vaginal bleeding
_____ Vaginal pain
_____ Breast pain
_____ Lumps on breast

Are you pregnant?
_____ Yes _____ No

Please mark your areas of pain on the figures below.



GASTRO-INTESTINAL SYSTEM

_____ Poor appetite
_____ Excessive hunger
_____ Difficult chewing
_____ Difficult swallowing
_____ Excessive thirst
_____ Nausea
_____ Vomiting food
_____ Vomiting blood
_____ Abdominal pain
_____ Diarrhea
_____ Constipation
_____ Black stool
_____ Bloody stool
_____ Hemorrhoids
_____ Liver trouble
_____ Gall bladder problems
_____ Weight trouble

NERVOUS SYSTEM

_____ Numbness
_____ Loss of feeling
_____ Paralysis
_____ Dizziness
_____ Fainting
_____ Headaches
_____ Muscle jerking
_____ Convulsions
_____ Forgetfulness
_____ Confusion
_____ Depression

CARDIO-VASCULAR-RESPIRATORY SYSTEM

_____ Chest pain
_____ Pain over heart
_____ Difficult breathing
_____ Persistent cough
_____ Coughing phlegm
_____ Coughing blood
_____ Rapid heartbeat
_____ Blood pressure problems
_____ Heart problems
_____ Lung problems
_____ Varicose veins

EYE, EAR, NOSE, AND THROAT

_____ Eye strain
_____ Eye inflammation
_____ Vision problems
_____ Ear pain
_____ Ear noises
_____ Hearing loss
_____ Ear discharge
_____ Nose pain
_____ Nose bleeding
_____ Nose discharge
_____ Difficult breathing thru nose
_____ Sore gums
_____ Dental problems
_____ Sore mouth
_____ Sore throat
_____ Hoarseness
_____ Difficult speech

_____
Patient's Signature

DO NOT WRITE BELOW THIS LINE

Patient accepted? ☐ Yes ☐ No Doctor's Signature _____

Health Care Chiropractic Centre **Dr. Steven B. Goldstein** **215 Atlantic Avenue Suite A**
516-887-1001 **Lynbrook, New York 11563**

TERMS OF ACCEPTANCE/CONSENT TO TREATMENT

When a patient seeks Chiropractic health care and we accept a patient for such care, it is essential for both to be working towards the same objective. Chiropractic has only one goal. It is important that each patient understands both the objective and the method that will be used to attain it. This will prevent any confusion or disappointment.

- **Adjustment**: An adjustment is the specific application of forces to facilitate the body's correction of the vertebral subluxation. Our Chiropractic method of correction is by specific adjustments of the spine.
- **Health**: A state of optimal physical, mental and social well-being; not merely the absence of disease or infirmity.
- **Subluxation**: A misalignment of one or more of the 26 vertebrae in the spinal column which is caused by an alteration of nervous system function and interference with the transmission of mental impulses, resulting in a lessening of the body's innate ability to express its maximum health potential.

We do not offer to diagnose or treat any disease or condition other than subluxation. However, if during the course of a Chiropractic neurological examination, we encounter Non-Chiropractic or unusual findings, we will advise you. If you desire advice, diagnosis or treatment for those findings, we will recommend that you seek the services of another health care provider.

Regardless of what the disease is called, we do not offer to treat it. Nor do we offer advice regarding treatment prescribed by others. OUR ONLY PRACTICE OBJECTIVE is to find and remove vertebral subluxations. Our only method is specific adjusting to correct neurological subluxations.

I hereby consent to and authorize the administration of all diagnostic and Chiropractic treatments that may be considered advisable or necessary in the judgment of Health Care Chiropractic Centre. I also certify that no guarantee or assurance has been made to the results that may be obtained. I understand and agree that health and accident insurance policies are an arrangement between an insurance carrier me. Furthermore, I understand that while Health Care Chiropractic Centre may prepare necessary reports and forms to assist me in making collections from the insurance company, all services rendered to me are charged directly to me and I am personally responsible for payment. In addition, all co-pays and any other form of financial patient responsibilities are due at the time of service.

I have read, understand, and agree to Health Care Chiropractic Centre's Terms of Acceptance/Consent to Treatment.

Signature (parent/guardian, when applicable): _____

Date: _____

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HIPPA 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. This Notice of Privacy Practices describes how Health Care Chiropractic Centre may use and disclose your Protected Health Information (PHI) to carry out treatment, payment or health care operations and for other purposes that are permitted or required by law. It also describes your right to access and control your PHI that may identify you and that relates to your past, present, or future physical or mental health or condition and related health care services.

USES AND DISCLOSURES OF PROTECTED HEALTH INFORMATION

Your PHI may be used and disclosed by your doctor, office staff, and others outside of our office that are involved in your care and treatment for the purpose of providing health care services to you, to pay your health care bills, to support the operation of Health Care Chiropractic Centre, and other use required by law.

TREATMENT: Health Care Chiropractic Centre will use an disclose your PHI to provide, coordinate, or manage your health care and any related services. This includes the coordination or management of your health care with a third party. For example, Health Care Chiropractic Centre would disclose your PHI, as necessary, to a physician to whom you have been referred to ensure that the physician has the necessary information to diagnose or treat you.

PAYMENT: Your PHI will be used, as needed, to obtain payment from your insurance company for your health care services.

HEALTHCARE OPERATIONS: Health Care Chiropractic Centre may use or disclose, as needed, your protected health information in order to support the business activities of Health Care Chiropractic Centre. The staff at the office may use a sign-in sheet at the registration desk where you will be asked to sign your name, may call you by name in the waiting room when the doctor is ready to see you, may use or disclose your PHI as necessary to contact you to remind you of your appointment by leaving a voicemail message on the contact numbers listed on your intake form.

- ✓ **I give Health Care Chiropractic Centre permission to use my address, phone number, and clinical records to contact me with appointment reminders, missed appointment notification, birthday cards, holiday-related cards, newsletters, information about treatment alternatives, or other health-related information.**
- ✓ **If Health Care Chiropractic Centre contacts me by phone, I give them permission to leave a message on my voicemail or answering machine.**
- ✓ **Health Care Chiropractic Centre may also contact me via text message or e-mail for appointment reminders or missed appointments. I may also request to opt-out of receiving text messages and e-mails.**

Other permitted and required uses and disclosures will be made only with your consent, authorization, or opportunity to object unless required by law.

You may revoke this authorization at any time, in writing, except to the extent that your doctor has taken an action in reliance on the use or disclosure indicated in the authorization.

You have the right to request to receive confidential communications from us by alternative means or at an alternative location. You have the right to obtain a paper copy of this notice from us, upon request, even if you have agreed to accept this notice In an alternative medium, such as electronically.

You may have the right to have your doctor amend your PHI. If we deny your request for amendment, you have the right to file a statement of disagreement with us and we may prepare a rebuttal to your statement and will provide you with a copy of such rebuttal.

You have the right to receive an accounting of certain disclosures we have made, if any, of your PHI. We reserve the right to change the terms of this notice and will inform you of any changes. You then have the right to object or withdraw as provided in this notice.

COMPLAINTS

If you believe that Health Care Chiropractic Centre has violated your privacy rights, you may file a complaint with Dr. Steven B. Goldstein at Health Care Chiropractic Centre, 215 Atlantic Avenue Suite A, Lynbrook, NY 11563.

I have read, understand, and agree to Health Care Chiropractic Centre's Notice of Privacy Practice.

Signature (parent/guardian, when applicable): _____

Date: _____