

Worker's Compensation Intake Form

Patient Information

Date: _____ Date of Birth: ___/___/___
 Name: _____ Social Security: ___-__-___
 Address: _____
 Street City State Zip
 Email Address: _____
 Home Phone: _____ Cell Phone: _____
 Gender: _____ Height: _____" Weight: _____ lbs
 Marital Status: _____ Number of Children: _____
 Employer: _____ Occupation: _____ Work Phone: _____
 Employer Address: _____
 Street City State Zip
 Attorney: _____ Phone: _____
 Emergency Contact: _____ Relation: _____
 Emergency Contact Phone Number: _____
 If under 18 years, name of Parent or Guardian: _____
 PCP Name: _____ Phone: _____
 How did you hear about our office? Website Gym member Walk in Yellow pages
 Friend/Formal patient _____ Doctor _____
 Other _____

Accident Information

Date: _____ Time: _____ AM PM Was it reported? YES NO
 Please explain in detail how the accident occurred: _____

 Please list symptoms felt immediately after the accident: _____

 Where were you taken after the accident? _____
 If hospital, how were you taken? AMBULANCE PRIVATE VEHICLE OTHER
 Were X-Rays done? YES NO An MRI? YES NO CAT scan? YES NO
 Have you seen any other doctor(s) since the accident? YES Name _____ NO
 Have you missed any work since the accident? YES NO Date(s) _____
 Did you ever experience similar symptoms prior to the accident? YES NO
 Has your condition IMPROVED WORSENEED or STAYED SAME since the accident?
 Please share any other information that might be important to your diagnosis and
 treatment: _____

Signature (Parent/Guardian of Minor): _____ **Date:** ___/___/___



Milton Chiropractic & Rehabilitation INCORPORATED

Acknowledgement of Office Policies

The following are Bay State Physical Therapy and Milton Chiropractic & Rehabilitation's policies governing appointment scheduling, payment terms, and information releases. **Please read carefully** and be sure to ask questions you might have before signing the document.

Appointment Scheduling: We at Bay State Physical Therapy and Milton Chiropractic & Rehabilitation are glad to accept insurance assignment on your behalf in handling your personal injury or worker's compensation claim. However, in order to help ensure that your insurance company pays for the care you receive here, it is important that you adhere to the recommended care program. We require a 24 hour cancellation notice for all appointments. If you miss three (3) appointments in a three (3) week period without notifying Bay State (emergencies considered), you may be dismissed from care and your file may be closed.

Consent for Treatment: I, the undersigned, give Bay State Physical Therapy and/or Milton Chiropractic & Rehabilitation my permission to evaluate and treat my injury. I further understand that in the course of recommended treatment, condition may worsen on rare occasions. I further understand that no guarantee or promise has been made to me concerning the results of treatment. I further understand that the gym and/or pool areas are common areas accessed by patients, gym members and guests and as a result there may be incidental contact with personal health information.

Assignment of Payment: I hereby authorize my insurance company and/or my attorney to pay direct to Bay State Physical Therapy and/or Milton Chiropractic & Rehabilitation any monies due on my account for professional services rendered.

Acknowledgment and Understanding: It is further understood that I, the undersigned, agree to pay the full amount of the charges should my condition be such that it is not covered by my policy, or if, for any reason, the insurance company and/or my attorney refused to pay my balance at this office.

Private Health Insurance: I understand that I am responsible for whatever fees my insurance company does not pay on my claim. (Typically, this includes deductibles and/or co-payments).

Authorization to Release Information: I have read and fully understand Bay State Physical Therapy and/or Milton Chiropractic & Rehabilitation's Notice of Information Practices. I understand that Bay State Physical Therapy and/or Milton Chiropractic & Rehabilitation may use or disclose my personal health information for the purposes of carrying out treatment, obtaining payment, evaluating the quality of services provided and any administrative operations related to treatment or payments, understand that I have the right to restrict how my personal health information is used and disclosed for treatment, payment and administrative operation if I notify the practice. I also understand that Bay State Physical Therapy and/or Milton Chiropractic & Rehabilitation will consider requests for restriction on a case by case basis, but does not have to agree to requests for restrictions.

Patient Requests for Records: I instruct the release of all medical, hospital, or surgical records pertinent to my case, including but not limited to exams, special test, x-rays, or lab results to this office.

Ownership: I understand that Milton Chiropractic, Bay State Physical Therapy, Optimal Weight Loss, and Massage Works! Are all owned and operated by the same entity. I understand I have the option to seek any/all of the same services these clinics provide elsewhere.

I certify that I have read and understand all appointment and office policies listed above.

Patient Signature (Parent/Guardian of Minor): _____ Date: _____

Name (Please Print): _____ DOB: _____

Designate Individuals Authorization Form

I hereby authorize one or all of the designated parties listed below to request and receive the release of any protected health information regarding my treatment, payment or administrative operations related to treatment and payment. I understand that the identity of designated parties must be verified before the release of any information.

Please give the name(s) of the individual(s) who you will allow to receive any part(s) of your health record.

Authorized Designees:

Name: _____ Relationship: _____

Name: _____ Relationship: _____

Name: _____ Relationship: _____

Name: _____ Relationship: _____

_____ DOB: _____
Patient Name

_____ Date: _____
Patient Signature (Parent/Guardian of Minor)

Medical History Form

Name: _____ DOB: ___/___/___ Today's Date: ___/___/___

Occupation: _____ Gender: _____ PCP: _____

Referring Physician (MD): _____ Next appointment w/ referring MD: ___/___/___

Please answer the following questions:

What injury or condition brings you here today? _____

When did you first notice your condition (date of onset)? _____

How did this injury occur? _____

Is your condition due to a motor vehicle accident? Yes No If yes, date of accident? _____

Have you had any falls in the past 12 months? Yes No If yes, how many times? _____

Did the fall(s) result in injury? Yes No If yes, please describe: _____

Please describe above: _____

Are you seeing (or have you been seen by) any other specialists for your current condition (e.g.: doctor, psychologist, chiropractor, physical therapist etc.)? Please list:

Have you been treated by another physical therapist/chiropractor in the past for this or any other condition?

Yes No

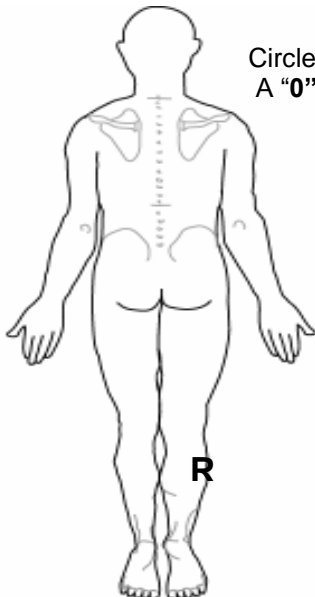
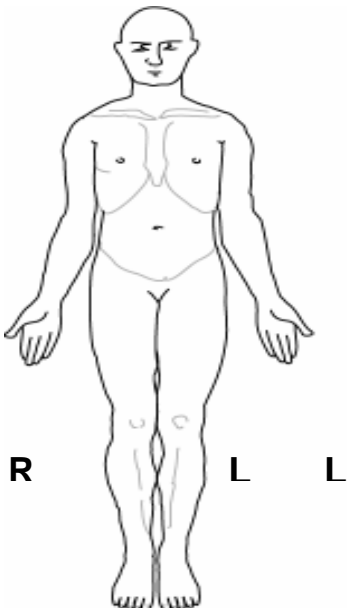
If Yes, by whom/when? _____

What tests have you had for this condition? X-ray MRI CT scan Other: _____

Please mark where you have symptoms on the picture below.

Sharp Pain: // // // // Achy Pain: ~ ~ ~ ~ Burning Pain: X X X X X Numbness: 0 0 0 0

Circle the number corresponding with the intensity of your symptoms.
 A "0" = No Pain where as a "10" = most severe pain imaginable.



Location: _____ 0 1 2 3 4 5 6 7 8 9 10

Location: _____ 0 1 2 3 4 5 6 7 8 9 10

Location: _____ 0 1 2 3 4 5 6 7 8 9 10

Location: _____ 0 1 2 3 4 5 6 7 8 9 10

Since this condition began your symptoms have: decreased not changed increased

Your symptoms are worse in the: morning afternoon night same all day

What are your goals for treatment? _____

Please list past surgeries/conditions/hospitalizations (or you may attach a separate list):

_____/_____/_____
 _____/_____/_____

Please list all medications, dosage, frequency and route (or you may attach a separate list):

Name: _____ Dosage: _____ Frequency: _____ Route: _____
 Name: _____ Dosage: _____ Frequency: _____ Route: _____
 Name: _____ Dosage: _____ Frequency: _____ Route: _____

Have you ever been diagnosed and/or treated for any of the following conditions (circle all that apply):

CONSTITUTIONAL

Weight Loss
 Fatigue
 Fever

EYES

Glasses/Contacts
 Eye Pain
 Double Vision
 Cataracts

CARDIOVASCULAR

Murmur
 Chest Pain
 Palpitations
 Fainting/Spells
 Short of Breath
 Difficulty Lying Flat
 Swelling in Ankles
 Pacemaker/Defibrillator

ENDOCRINE

Loss of Hair
 Heat Intolerance
 Cold Intolerance
 Diabetes Type I or II

ALLERGIC

Hives/Eczema
 Hay Fever

PSYCHIATRIC

Anxiety
 Depression
 Mood Swings
 Difficulty Sleeping

RESPIRATORY

Cough
 Coughing Blood
 Wheezing
 Chills

GASTROINTEST

Heartburn/Reflux
 Nausea/Vomiting
 Constipation
 Change Bowel Mvts
 Diarrhea
 Jaundice
 Abdominal Pain
 Black/Bloody Bowel Mvts

GENITOURINARY

Burning/Frequency
 Nighttime
 Blood in Urine
 Erectile Dysfunction
 Bladder Leakage
 Abnormal Leakage

HEMATOLOGY/LYMPH

Bruise Easily
 Gums Bleed Easily
 Enlarged Glands

MUSCLE/BONE

Joint Pain/Swelling
 Stiffness
 Muscle Pain
 Bone Pain

SKIN

Rashes/Sores
 Lesions
 Itching/Burning

NEUROLOGICAL

Loss of Strength
 Numbness
 Headaches

Tremors
 Memory Loss

CANCER

Date of diagnosis: _____
 Location: _____
 Status: _____

FEMALES ONLY

Age Onset of Periods _____
 Periods Regular? Yes/No
 Age Onset of Menopause _____
 Number of Pregnancies _____

Please list any allergies that you have (For example: medications, latex, food, bee stings): _____

Is there any additional information? _____

The above information is true to the best of my knowledge:

Signature (Parent/Guardian of Minor): _____ **DOB:** ___/___/___ **Date:** ___/___/___