



"Dedicated to helping you live a healthy, productive and long life"
DR. RICHARD M. NOVAK
 Certified in Whiplash & Spinal Trauma
 Loomis Digestive Health Specialist
 Fellowship International Academy
 of Medical Acupuncture
 Certified Golf Specialist

WORK INJURY INFORMATION

Patient Name: _____ Date: _____
 Address: _____
 City: _____ State: _____ Zip Code: _____
 S.S.#: _____ Date of Birth: _____ Age: _____ Sex: M F
 Marital Status: S/M/D/W Children: _____
 Home Telephone: _____ Work Telephone: _____
 Occupation: _____
 Employer's Name and Address: _____
 Emergency Name and Phone #: _____ Relationship: _____
 Name of M.D.: _____ Date of last physical: _____

PRIMARY HEALTH INSURANCE INFORMATION:

Name of Insured: _____
 Name of Primary Insurance Company: _____
 Address: _____ Phone: _____
 City: _____ State: _____ Zip Code: _____
 Employee ID #: _____ Policy #: _____
 Group Name: _____ Group #: _____

Your attorney's name: _____ Phone: _____
 Address: _____
 City: _____ State: _____ Zip Code: _____
 Have you filled a incident report at work? YES NO Date filled out: _____
 Name of person you reported this accident to: _____
 Their position: _____ (Ex. Supervisor, Manager, etc...)

EMPLOYER'S WORK INSURANCE INFORMATION:

Name of Work Comp. Carrier: _____ Phone: _____
 Address: _____
 City: _____ State: _____ Zip Code: _____
 Adjuster's Name: _____ Phone: _____
 Policy #: _____ Claim #: _____

Miscellaneous information: _____

Signed: _____ **Today's Date:** _____

GUARANTOR OF PAYMENT



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WORK INJURY STATEMENT

Patient Name: _____

EMPLOYMENT INFORMATION:

Occupation: _____

Duties: _____

How long with this employer? _____

Is patient on disability? YES NO Authorized by: _____

Detail of work lost due to accident: _____

ACCIDENT INFORMATION: Auto Other: _____

Date of Injury: _____ Time of Injury: _____ am/pm

Location of Accident: _____

Describe how accident occurred: _____

INJURIES AND MEDICAL INFORMATION:

Nature of Injuries: _____

Was first aid administered at the scene of the accident? YES NO

By whom: () Bystanders () Police () Emergency Medical Staff

Did you go to the hospital? YES NO

If yes, what is the name and city of the hospital? _____

How did you get to the hospital? _____

What diagnostic tests were performed at the hospital? (Ex. X-Rays, MRI, CT Scan, etc.)

What did the hospital do for your injuries? _____

How long did you stay at the hospital? _____

Have you seen any other doctor for this accident? YES NO

If yes, what is the doctor's name? _____

Signed: _____ Today's Date: _____

GUARANTOR OF PAYMENT

PERSONAL HISTORY

What is the most you ever weighed? _____ When? _____

Do you smoke? YES NO How much do you smoke? _____ packs/day _____ packs/week
How long have you been a smoker? _____ Have you been a smoker in the past? YES NO
How long have you stopped smoking? _____

Do you drink alcoholic beverages? YES NO
How much do you drink? _____ drinks/day _____ drinks/week _____ drinks/month
How long have you been drinking alcoholic beverages? _____ months _____ years

How many children did you give birth to? _____ What are their ages? _____

Do you commute to work? YES NO if yes, how long is the commute? _____
What means of transportation? (Ex. Bus, drive car, carpool, walk, etc...) _____

Do you presently exercise on a regular basis? YES NO If yes, complete below:

Activity	Duration	Frequency
_____	_____	_____
_____	_____	_____
_____	_____	_____

List exercise activity prior to your problem:

Activity	Duration	Frequency
_____	_____	_____
_____	_____	_____
_____	_____	_____

Any known food allergies? _____

What did you eat and drink yesterday:

Breakfast: _____

Lunch: _____

Dinner: _____

Snacks: _____

Do you crave certain foods: _____

Does any food you eat cause any discomfort: _____

8oz. Glasses per day

Water/day = _____ Soda/day = _____ Tea/day = _____ Other: _____

Your last bowel movement was: _____

How often do you have a bowel movement: 1x/day 2x/day 3x/day Other: _____

PERSONAL HISTORY

Do you have, or have had, any of the following?

Problem	NO	YES	When	What
Surgery				
Surgery				
Surgery				
Cancer				
Broken Bone				
Broken Bone				
Scoliosis				
Heart Problems				
High Blood Pressure				
Stroke				
Diabetes				
Rheumatic Fever				
Rheumatoid Arthritis				
Gout				
Lupus				
Psoriasis				
Multiple Sclerosis				
Lung Problems				
Other				
Other				
Other				

FAMILY HISTORY

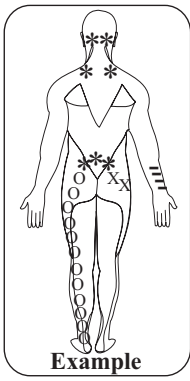
Do any of your BLOOD FAMILY have, or have had, any of the following?

Problem	NO	YES	When	What
Chronic Back Pain				
Chronic Neck Pain				
Spine Surgery				
Cancer				
Heart Problems				
High Blood Pressure				
Stroke				
Diabetes				
Rheumatic Fever				
Rheumatoid Arthritis				
Gout				
Lupus				
Psoriasis				
Multiple Sclerosis				
Lung Problems				
Scoliosis				
Other				
Other				
Other				
Other				
Other				

PAIN CHART

Date: _____ 200__

Signature: _____



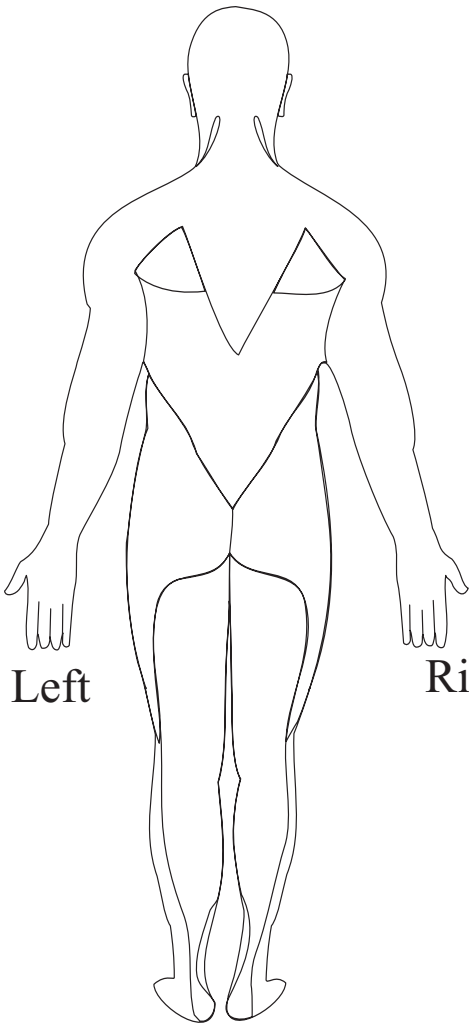
SHOW AREA(S) OF PAIN OR UNUSUAL FEELING

Mark the areas on this body where you feel the described sensations.

Use the **appropriate symbols** (See box below)

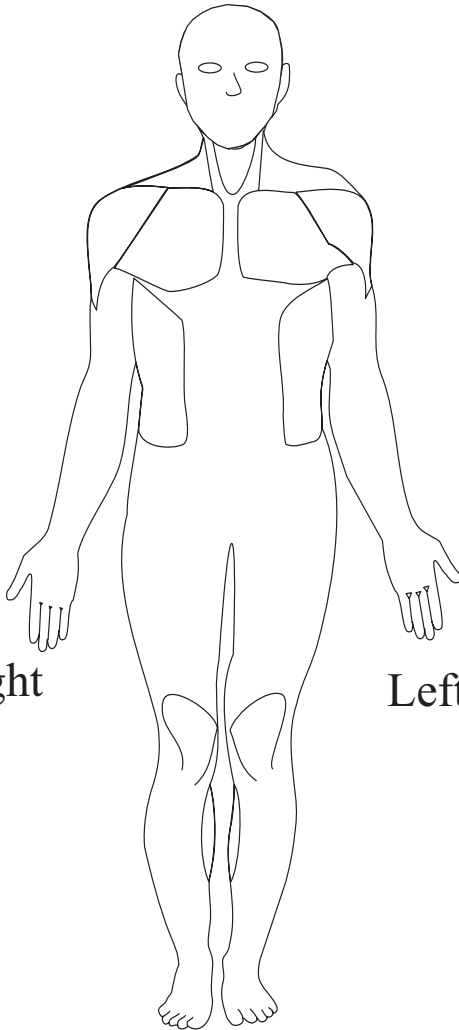
Mark areas of **radiation** (Ex. down leg, down arm, into hip, etc.) Include **all** affected areas.

Numbsness -----	Pins & Needles OOOOO	Burning XXXX	Aching *****	Stabbing /////
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Left

Right



Left

Neck-Shoulder-Arm-Pain

On a scale of zero to ten, I rate my discomfort as follows:



Mid Back Pain

On a scale of zero to ten, I rate my discomfort as follows:



Low Back and Leg Pain

On a scale of zero to ten, I rate my discomfort as follows:



Best You Have Felt This Week **Worst Pain This Week**

0 ————— 10 0 ————— 10

Average Pain This Week

0 ————— 10

Please complete back side of this page

Symptom Questionnaire

What is your Chief/Primary Complaint? _____

How did this condition develop? _____

Overexertion / Strenuous Position / Auto Accident / Work Accident / Fall / Trauma

ONSET: When was the first time (date) you were aware of the problem? _____

PROV: What makes the problem worse? _____
Coughing/Sneezing / Lifting / Bending / Prolonged Sitting / Driving / Standing / Walking

PALL: What relieves the problem? _____
Rest / Movement/Exercise / Sitting / Standing / Lying / Ice / Heat / Drugs-Aspirin / Tylenol /
Ibuprofen / Drugs-Other: _____

QUALITY: How would you describe the pain or problem? _____
Sharp / Stabbing / Dull / Aching / Burning / Throbbing / Pins & Needles / Numbness

RADIATES: Does this or refer into another part of your body? Left Side of / Right Side of
Head / Neck / Shoulder / Arm / Hand / Back / Hip / Leg & Thigh / Calf / Foot _____

TIME: Is there any certain time of day that you notice the pain being worse?

Morning / Afternoon / Evening / Bedtime / Wakes me up at night / At Work / After Work

How long does the pain/problem last? _____
Brief / Intermittent / Occasional / Frequent / Constant

Have you ever had the same or similar problem before? YES NO If yes, when?
Please explain: _____

Have you seen another doctor for this problem before? NO (YES Dr. _____)
Recommendations or prescriptions? _____
Please list any other medication you are currently taking. _____

Please list any vitamin or herbal supplements you are currently taking. _____

Have you ever been treated by a chiropractor before? NO (YES Dr. _____)
Did the chiropractor adjust your Neck (Y / N), Mid Back (Y / N), Low Back (Y / N)? _____

How many times have you ever had any significant accidents (automobile or other)
or falls? _____ As a child and/or adolescent: _____ As an adult: _____