Workman's Compensation Injury Form

Name: ______________________________ Date: ____/____/____

Date of Birth: ____/____/____ (age ___) M / F Social Security Number _____/__/______

Address ______________________________ State ___________ Zip Code ________

Phone Number: (___)-___-_____ Cell: (___)-___-_____ E-Mail: ______________________

Emergency Contact Person: ______________________ Contact Number: (___)-_____-_____

Marital Status: S M D W Who can we thank for referring you? ______________

Employer: ________________________ Occupation: ______________________

Address: ________________________ Phone Number: ______________________

Have you reported your injury? Y / N Supervisor Name: ______________________

Are you taking any medication? Please Circle

Nerve Pill Pain Meds Muscle Relaxer Stimulant Blood Thinner Insulin Aspirin

Other: __________________ Do you smoke? Y / N Are you pregnant? Y / N

Date of Injury: ___/___/___ Time of Injury: ____ am/pm Date of 1st Treatment: ___/___/___

Primary Complaint: ____________________ Secondary Complaint: ________________

Any complaints BEFORE the accident? Y / N If yes, list them ______________________

Describe Accident: (Please be specific) ____

____

Feeling felt during the accident was: ________________ Immediately after: ______________

Later that day: ________________________ Next day: ____________________

*641 Latton Lane * Portage, WI 53901 * 608-742-1300 * www.blauchiropractic.com*

Injuries Involving Lifting (Please be specific)
From where were you lifting the object? ______________________________

How many pounds was the object you were lifting? __________

What position were you in while lifting the object? ______________________________

Injuries Involving Falling (Please be specific)
Where at work did you fall? ______________________________

What part of your body did you fall on? ______________________________

What other areas were injured as a result of your fall? ______________________________

Other Work Related Injuries
Other type of accident if not from lifting or falling? Y / N If yes, explain (Please be specific)

____

____

Job Analysis
What are your job duties or activities you perform while at work? ______________________________

____

How many pounds do you regularly lift at your job? ______________________________

Are your hands subject to repetitive movement? Y / N Such as? ______________________________

Are you working now ? Y / N Last Day Worked _____/_____/_____

Please circle: Regular or Light Duty Full or Part Time

In a typical work day how many hours do you: Sit _____ Stand _____ Walk _____ Lift _____

How many hours is your typical work day? ________________

By signing below I, ______________________________ understand the above information and guarantee this form was completed correctly to the best of my knowledge and understand it is my responsibility to inform Blau Family Chiropractic of any changes in my medical status.

I authorize Blau Family Chiropractic to perform any necessary services needed during diagnosis and treatment. I also authorize Blau Family Chiropractic to release any information requested and required to process insurance claims, this includes releasing records to lawyers.

______________________________ ________________
Signature Date

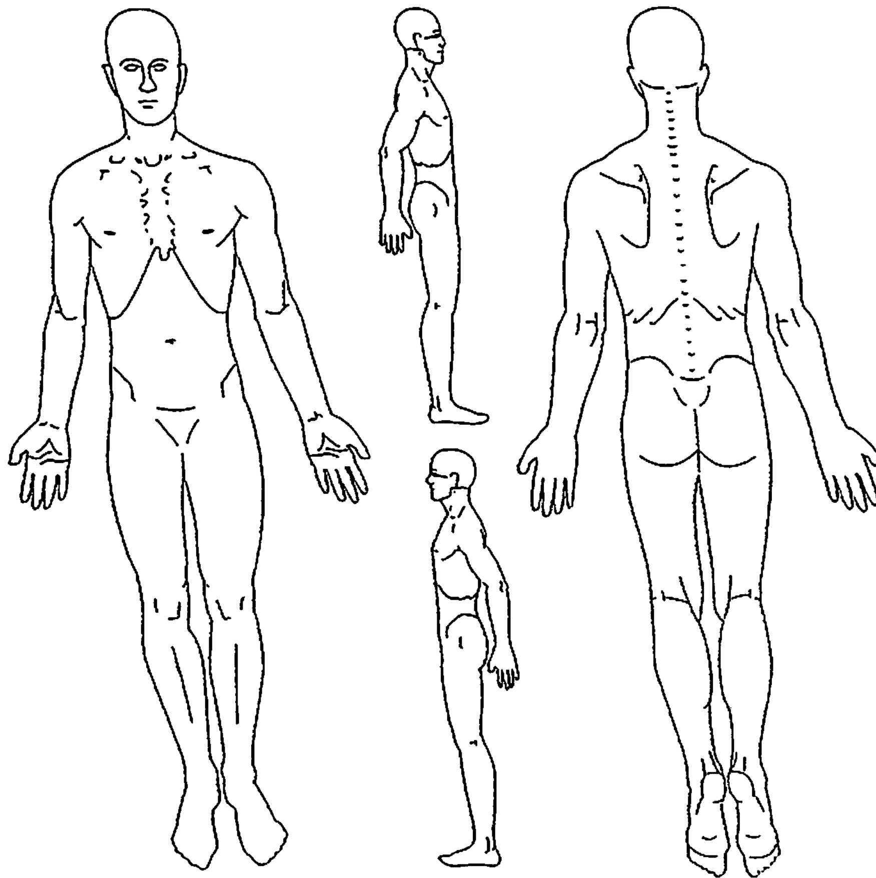
Blau Family
CHIROPRACTIC

Location of your discomfort

Name ______________________________ Date: ________________

Please locate the area of discomfort on the image below by using the letters shown:

D = Dull S = Stabbing B = Burning T = Tingling
N = Numbness C = Cramping A = Aching SH = Shooting
TH = Throbbing



Frequency of discomfort: Continuous Intermittent Occasional Frequent

Pain (choose one) decreases / stays the same / increases with movement.

Intensity: Please Circle

1(no pain) 2 3 4 5 6 7 8 9 10 (unbearable)

Amount of time in discomfort: Please Circle

10% 20% 30% 40% 50% 60% 70% 80% 90% 100%

Oswestry Disability Questionnaire

This questionnaire has been designed to give us information as to how your back or leg pain is affecting your ability to manage in everyday life. Please answer by checking **one box in each section** for the statement which best applies to you. We realize you may consider that multiple statements in a section apply but please just select the statement **which most clearly describes your problem.**

Name: ____________________________ Date: _____________

Section 1: Pain Intensity

- ◌ I have no pain at the moment
- ◌ The pain is very mild at the moment
- ◌ The pain is moderate at the moment
- ◌ The pain is fairly severe at the moment
- ◌ The pain is very severe at the moment
- ◌ The pain is the worst imaginable at the moment

Section 2: Personal Care (Washing, Dressing, etc.)

- ◌ I can look after myself normally without causing extra pain
- ◌ I can look after myself normally but it causes extra pain
- ◌ It is painful to look after myself and I am slow and careful
- ◌ I need some help but can manage most of my personal care
- ◌ I need help every day in most aspects of self-care
- ◌ I do not get dressed, wash with difficulty and stay in bed

Section 3: Lifting

- ◌ I can lift heavy weights without extra pain
- ◌ I can lift heavy weights but it gives me extra pain
- ◌ Pain prevents me lifting heavy weights off the floor but I can manage if they are conveniently placed (example - on a table)
- ◌ Pain prevents me lifting heavy weights but I can manage light to medium weights if they are conveniently positioned
- ◌ I can only lift very light weights
- ◌ I cannot lift or carry anything

Section 4: Walking

- ◌ Pain does not prevent me walking any distance
- ◌ Pain prevents me from walking more than one mile
- ◌ Pain prevents me from walking more than 1/2 mile
- ◌ Pain prevents me from walking more than 1/4 mile
- ◌ I can only walk using a stick or crutches
- ◌ I am in bed most of the time

Section 5: Sitting

- ◌ I can sit in any chair as long as I like
- ◌ I can only sit in my favorite chair as long as I like
- ◌ Pain prevents me sitting more than one hour
- ◌ Pain prevents me from sitting more than 30 minutes
- ◌ Pain prevents me from sitting more than 10 minutes
- ◌ Pain prevents me from sitting at all

Section 6: Standing

- ◌ I can stand as long as I want without extra pain
- ◌ I can stand as long as I want but it gives me extra pain
- ◌ Pain prevents me from standing for more than 1 hour
- ◌ Pain prevents me from standing for more than 30 minutes
- ◌ Pain prevents me from standing for more than 10 minutes
- ◌ Pain prevents me from standing at all

Section 7: Sleeping

- ◌ My sleep is never disturbed by pain
- ◌ My sleep is occasionally disturbed by pain
- ◌ Because of pain I have less than 6 hours sleep
- ◌ Because of pain I have less than 4 hours sleep
- ◌ Because of pain I have less than 2 hours sleep
- ◌ Pain prevents me from sleeping at all

Section 8: Social Life

- ◌ My social life is normal and gives me no extra pain
- ◌ My social life is normal but increases the degree of pain
- ◌ Pain has no significant effect on my social life apart from limiting my more energetic interests (example - sports)
- ◌ Pain has restricted my social life and I do not go out as often
- ◌ Pain has restricted my social life to my home
- ◌ I have no social life because of pain

Section 9: Traveling

- I can travel anywhere without pain
- I can travel anywhere but it gives me extra pain
- Pain is bad but I manage journeys over two hours
- Pain restricts me to journeys of less than one hour
- Pain restricts me to short necessary journeys less than 30 minutes
- Pain prevents me from travelling except to receive treatment

Section 10: Employment/Homemaking

- My normal homemaking/job activities do not cause pain
- My normal homemaking/job activities increase my pain, but I can still perform all that is required of me
- I can perform most of my homemaking/job activities, but pain prevents me from performing more physically stressful activities (example - lifting, vacuuming)
- Pain prevents me from doing anything but light duties
- Pain prevents me from doing even light duties
- Pain prevents me from performing any job or homemaking chores

Source:
Fritz JM, Irrgang JJ. A comparison of a modified Oswestry Low Back Pain Disability Questionnaire and the Quebec Back Pain Disability Scale. *Physical Therapy.* 2001;81:776-788.
Modified by Fritz & Irrgang with permission of The Chartered Society of Physiotherapy, from Fairbanks JCT, Couper J, Davies JB, et al. The Oswestry Low Back Pain Disability Questionnaire. *Physiotherapy.* 1980;66:271-273.

Form prepared for the VWA/TAC Outcome Measurement Seminar 2004

TERMS OF ACCEPTANCE

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 understand both the objective and the method that will be able 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 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.

Vertebral Subluxation: A misalignment of one or more of the 24 vertebra in the spinal column which causes alteration of nerve function and interference to 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 vertebral subluxation. However, if during the course of a chiropractic spinal evaluation, 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 a health care provider who specializes in that area.
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 eliminate a major interference to the expression of the body's innate wisdom. Our only method is specific adjusting to correct vertebral subluxations.

I, ________________________________ have read and fully understand the above statements.
(print name)

All questions regarding the doctor's objectives pertaining to my care in this office have been answered to my complete satisfaction.
I therefore accept chiropractic care on this basis.

____ ________________________
(signature) (date)

INFORMED CONSENT TO CHIROPRACTIC TREATMENT

The State of Wisconsin requires that every patient be informed of the risks of treatment and the alternatives to treatment prior to the beginning of treatment. The following is Blau Family Chiropractic's informed consent. We intend this consent form to cover the entire course of treatment for your present condition, and for any future conditions for which you seek treatment at this office.

The nature of chiropractic treatment: The doctor will use his/her hands or a mechanical device in order to adjust your joints. You may hear a "click or pop," similar to when a joint is "cracked," and you may feel movement of the joint. Various ancillary procedures, such as hot or cold packs, light therapy, electric muscle stimulation, therapeutic ultrasound, or traction, as well as exercise instruction.

Possible risks and probability: There are inherent risks in any and all treatment delivered by any health care provider, ranging from taking a single aspirin to complicated brain surgery. Chiropractic is no exception. Although we take every precaution, there are indeed some slight risks to chiropractic adjustment. The risk is very minor to almost nonexistent in any treatment of extremities. The risks involved in treatment to the spine excluding the neck are several. A list from the least to the most serious would include: muscular strain (rare), ligamenous sprain (rare), fractures (rare), and injury to intervertebral discs, nerves, or spinal cord (very rare). The risks involved in the treatment of the neck would include any on the proceeding list but also include the remote possibility of cervebrovascular injury, or stroke (very very rare chances are one in one million to one in ten million.) A minority of patients may notice stiffness or soreness after the first few days of treatment (common). The ancillary physical therapy procedures could produce skin irritation, burns, or other minor complications (rare).

Other treatment options that could be considered may include the following:

Over the counter analgesics: The risks of these medications include irritation to stomach, liver, kidneys, and other side effects in a significant number of cases.

Medical Care: Typically anti-inflammatory drugs, tranquilizers, and analgesics. Risks of these drugs include numerous undesirable effects, usually more serious than those listed above, and the patient dependence in a significant number of cases.

Surgery: In conjunction with medical care adds the risks of adverse reaction to anesthesia (which includes death) as well as an extended convalescent period in a significant number of cases.

Risks of remaining untreated

Delay of treatment allows formation of adhesions, scar tissue and other degenerative changes. These changes can further reduce skeletal mobility and include chronic pain cycles. It is probable that delay of treatment will complicate the condition, and make future rehabilitation more difficult.

Concerns or Questions

Please ask your Doctor of Chiropractic. Be assured Blau Family Chiropractic has gone to great lengths to make your health and safety our top priority. We will be glad to explain any concern about treatment. We will only recommend treatment for you that we would feel comfortable having performed on ourselves.

I have read the above explanation of Chiropractic Treatment. I also had the opportunity to ask questions and have them answered to my satisfaction. I have fully evaluated the risks and benefits of undergoing treatment, I have freely decided to undergo treatment, and hereby give my full consent to treatment.

____
Date

________________________ ________________________
Signature of Patient or Parent Printed Patient Name

Notice of Information Practices

Protecting the privacy of your personal health information is important to us. This notice describes how information about you may be used and disclosed and how you can get access to this information. Please review it carefully.

Disclosure of your protected health information without authorization is strictly limited to defined situations that include emergency care, quality assurance activities, public health, research, and law enforcement activities. Any other disclosures for the purposes of treatment, payment, or practice operations will be made only after obtaining your consent. You may request restrictions on disclosures.

Disclosures of protected health information are limited to the minimum necessary for the purpose of the disclosure. This provision does not apply to the transfer of medical records for treatment.

You may inspect and receive copies of your records within 30 days of a request to do so. There may be a reasonable cost-based fee for photocopying, postage and preparation.

You may request changes to your records. Our practice has the right to accept or deny your request.

We maintain a history of protected health information disclosures that is accessible to you.

In the future, we may contact you for appointment reminders, missed appointments, announcements, and to inform you about our practice and its staff.

Our practice is required to abide by this notice. We have the right to change this notice in the future. Any revisions will be prominently displayed in a clearly visible location in our office.

You may file a complaint about privacy violations by contacting our Office Manager.

Name ____

Phone ________________________

The effective date of this Notice of Information Practices is 10/02/2006.

Thank you.
Blau Family Chiropractic
641 Latton Lane Suite A
Portage, WI 53901