CHIROPRACTIC CENTER OF ANNAPOLIS

108 Old Solomons Island Rd., Bldg. 2
Annapolis, MD 21401 (410) 266-5054
Dr. William J. Boro

WORKERS' COMPENSATION - PATIENT HISTORY - WC/PHF

Name_____ Date_____ File# _____Occupation _____

Describe your job _____ Have you reported this injury to your employer? □ **Y** □ **N**

Was there a witness to your injury? □ **Y** □ **N** What is the witness's name? _____

Whom did your report injury to? _____ What is their position? _____ Date of Injury _____

Time of Injury _____ Did injury involve □ machinery □ operating a motor vehicle?

What were you doing at the time you were injured? _____

And, how did the accident/injury happen (lifting, bending, walking, carrying, standing, etc)? _____

_____

Describe the environmental conditions which may have contributed to your present injury (darkness, faulty equipment, slippery floor, limited space). Distinguish natural hazards from hazards created by other employees. _____

_____

Have you lost any time from work as a result of this injury? □ **Y** □ **N** If yes give dates:_____

Have you gone back to work? □ **Y** □ **N** If yes, when _____ What status of work □ regular □ modified

Please list what restrictions you have been placed on:_____

Did you have any physical complaints JUST BEFORE THIS ACCIDENT? □ **Y** □ **N** If yes, please describe in detail:

_____

Have you ever had any PRIOR injuries, accidents, diseases, or treatment to the same area of your body? □ **Y** □ **N**

If yes, state what part of your body was PREVIOUSLY injured: _____

WHEN did pain begin? And WHERE did you first feel it? Was the pain intense at first, or did the pain gradually worsen? Please be specific. _____

Check Symptoms You Have Noticed Since Accident: (Check any symptoms which are constant.)

□ Headache	□ Numbness in toes	□ Numbness in Fingers	□ Nervousness	□ Eyes Sensitive to Light
□ Irritability	□ Stomach Upset	□ Shortness of Breath	□ Fainting	□ Pins & Needles in Arms
□ Feet Cold	□ Fatigue	□ Low Back Pain	□ Mid Back Pain	□ Neck Pain
□ Dizziness	□ Ears Ring	□ Loss of Smell	□ Constipation	□ Pins & Needles in Legs
□ Neck Stiff	□ Loss of Taste	□ Loss of Balance	□ Tension	□ Diarrhea
□ Fever	□ Muscles Jerking	□ Memory Loss	□ Cold Sweats	□ Head Seems too Heavy
□ Depression	□ Chest Pain	□ Sleeping Problems	□ Nausea	

□ Other: _____

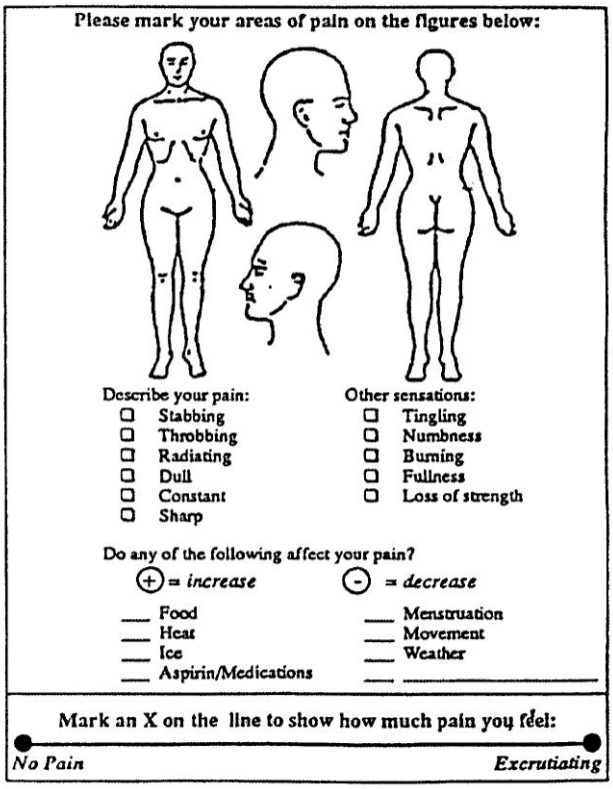
If you are currently on disability (time loss) do you want to go back to work doing your regular work duties? □ **Y** □ **N**
If no, state why _____
Do you feel your present condition is: □ temporary □ permanent □ do not know
Do you have an attorney? □ **Y** □ **N** Name: _____
Telephone Number:_____
Address: _____
_____

	Before	After
Do/Did you have any discomfort, pain, or restrictions while working or lifting?	□ **Y** □ **N**	□ **Y** □ **N**
Were/are you able to do almost any physical work activity?	□ **Y** □ **N**	□ **Y** □ **N**
Were/are you able to do almost any mental work activity?	□ **Y** □ **N**	□ **Y** □ **N**
Were/are you limited in your lifting in some body positions?	□ **Y** □ **N**	□ **Y** □ **N**

What kind of labor do you feel you can perform?
□ hard □ moderate □ light □ sitting □ full time □ part time
□ not able to work at all □ can work but it hurts □ feels better when I work

Symptoms are □ constant □ improving □ getting worse □ same

Are worse in □ AM □ Midday □ PM
□ wake me up at night □ increase with physical activity
□ interfere with daily routine
□ unaware of symptoms when I'm active



Indicate your ability to perform the following activities using these codes: More than one letter may be used.

U-unable P-painful D-difficult L-limited N-normal

_____Coughing or Sneezing	_____Climbing	_____Lying on back
_____Getting in or out of car	_____Kneeling	_____Lying flat on stomach
_____Lying on side with knees bent	_____Stooping	_____Bending over
_____Turning over in bed	_____Gripping	_____Sleeping
_____Walking short distances	_____Pushing	_____Sexual activity
_____Standing for more than 1 hour	_____Pulling	_____Dressing self
_____Sitting at a table	_____Reaching	_____Lifting _____lbs.
_____Balancing		

Were you hospitalized as a result of this accident? □ **Y** □ **N** If yes, where_____

FIRST DOCTOR/HOSPITAL SEEN:

Doctor's name _____ _____ Date of first visit _____ Were you □ examined □ x-rayed

Doctor's address _____

Did you receive treatment? □ **Y** □ **N** If so, what kind of treatment?_____

What benefits did you receive from treatment? _____

Date of last treatment _____

SECOND DOCTOR/CLINIC SEEN:

Doctor's name _____ _____ Date of first visit _____ Were you □ examined □ x-rayed

Doctor's address _____

Did you receive treatment? □ **Y** □ **N** If so, what kind of treatment?_____

What benefits did you receive from treatment? _____

Date of last treatment _____

Is there anything else you think we should know? _____

CHIROPRACTIC CENTER OF ANNAPOLIS

108 Old Solomons Island Rd., Bldg. 2
Annapolis, MD 21401 (410) 266-5054

Dr. William J. Boro | Dr. Mary X. Psaromatis

New Patient History Form

Patient Name:_____ Date: _____

Please list your complaints in order of severity *How and when did your problem begin?*

1. _____ 1. _____
2. _____ 2. _____
3. _____ 3. _____
4. _____ 4. _____

Please list below any treatment or diagnosis you have received for these conditions:

Who, When or Where seen *Type of Treatment or Diagnosis*

1. _____ 1. _____
2. _____ 2. _____
3. _____ 3. _____
4. _____ 4. _____

Have you had this or similar conditions in the past? □Yes □No
Is this condition getting progressively worse? □Yes □No
Is this condition interfering with your:
□Work □Sleep □Daily Routine
How would you classify your condition?
□Minor □Fairly severe and getting worse
□Involved □Serious, want cause and correction
If you have ever received treatment or have been hospitalized for a health condition in the last 10 years, list below:

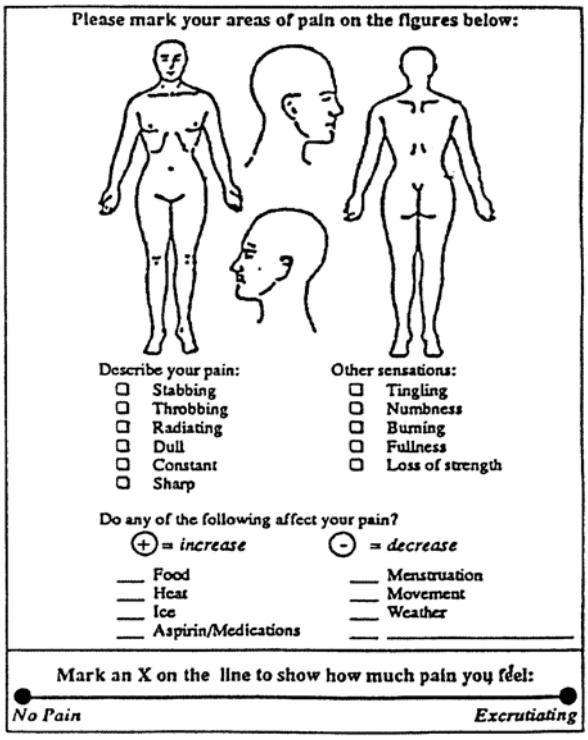
Date	Reason

Have you ever been in an auto accident? □Never
□Past year □Past 5 years □Over 5 years
Describe: _____
When did you last have:

Spinal X-ray:	□Never	□0-6 months	□6-18 months	□Longer
Spinal Exam:	□Never	□0-6 months	□6-18 months	□Longer
Physical Exam	□Never	□0-6 months	□6-18 months	□Longer
Dental Exam:	□Never	□0-6 months	□6-18 months	□Longer

Are you interested in recommendations regarding:
□diet □nutritional support □exercise instruction
□blood work/hair analysis/other lab work □allergy evaluation
□orthotics for your shoes

What type of service do you desire?
□Temporary Relief
□General Stabilization (medium care)
□Specific Correction or stabilization if possible(optimum health care)



Please complete other side

List any drugs you now take:

_____
_____
_____
_____
_____

Drug Allergies _____

Indicate with a check if you wear:

□Heel Lifts □Inner Soles
□Arch Supports □High Heels

Age of your mattress_____
□Comfortable □Uncomfortable

Indicate ability to perform the following activities:

Painful	Difficult	Unable	
□	□	□	Coughing or sneezing
□	□	□	Getting in & out of car
□	□	□	Turning over in bed
□	□	□	Walking short distances
□	□	□	Standing more than 1 hour
□	□	□	Sitting at a table
□	□	□	Bending over forward
□	□	□	Straightening up
□	□	□	Kneeling
□	□	□	Dressing self
□	□	□	Sleeping
□	□	□	Stooping
□	□	□	Gripping
□	□	□	Pushing
□	□	□	Reaching
□	□	□	Sexual activity

Have you ever suffered from:

	Now	Past	Ongoing
Back pain	□	□	□
Neck pain	□	□	□
Ulcer	□	□	□
Reproductive problems	□	□	□
Arthritis	□	□	□
Headaches	□	□	□
Heart problems	□	□	□
Diabetes	□	□	□
Frequent colds	□	□	□
Constipation/diarrhea	□	□	□
Asthma	□	□	□
Hemorrhoids	□	□	□
Urinary tract infections	□	□	□
Impotency	□	□	□
Ear infections	□	□	□
Gall bladder	□	□	□

DAILY HABITS	None	Light	Medium	Heavy
Alcohol	□	□ 1-2 oz	□ 3-5 oz	□ >5 oz
Appetite	□	□	□	□
Artificial Sweetener	□	□	□	□
Caffeine/Sodas	□	□ 1-2 cups	□ 3-6 cups	□ 7 cups
Exercise	□	□	□	□
Minerals, herbs or Vitamins	□	□	□	□
Salty Foods	□	□	□	□
Sugary Products	□	□	□	□
Tobacco	□	□ 1/2 pack	□ 1/2-1 pack	□ >1pack
Water	□	□ 1-10 oz	□ 10-30 oz	□ >30 oz

If any of these diseases run in your family, please circle who was affected:

Diabetes	Grandfather	Grandmother	Father	Mother
Heart Disease	Grandfather	Grandmother	Father	Mother
High Blood Pressure	Grandfather	Grandmother	Father	Mother
Arthritis	Grandfather	Grandmother	Father	Mother
Cancer	Grandfather	Grandmother	Father	Mother
	Grandfather	Grandmother	Father	Mother
	Grandfather	Grandmother	Father	Mother

Are you or do you think you may be pregnant? □yes □no
Have you missed days of work due to your problem? □yes □no
Does pain wake you at night? □yes □no
Is the pain worse in the AM or PM? □AM □PM
□no difference

Indicate how many hours of your day are spent:
Standing _____ Sitting _____
Walking _____ Sleeping_____

The nature of the procedure, possible alternative methods of treatment, the risks involved, and possible complications have been fully explained to me by my chiropractor. No guarantee or assurance has been given by anyone as to the results that may be obtained.

Patient Signature _____

□Accepted for care
□Referred to
_____
□Request records from:
□AAGH □Dr. O'Brien
□Other_____
□Further tests required:
□Blood □Urine □X-Ray
□Other _____