WORKERS COMPENSATION HISTORY

GENERAL INFORMATION			
PATIENT NAME:			DATE:
ADDRESS:		CITY:	STATE/ZIP CODE:
HOME PHONE NUMBER:		CELL PHONE NUMBER:	
WORK PHONE:		CELL PHONE:	
SOCIAL SECURITY NUMBER:	DATE OF BIRTH:	AGE:	GENDER:

EMPLOYER INFORMATION			
EMPLOYER NAME:		SUPERVISOR NAME:	
EMPLOYER ADDRESS:		CITY:	STATE/ZIP CODE:
WORK PHONE:		OCCUPATION:	

COMPENSATION CARRIER INFORMATION			
COMPENSATION CARRIER NAME:		COMPENSATION CARRIER PHONE:	
COMPENSATION CARRIER ADDRESS:		CITY	STATE/ZIP
CLAIM NUMBER:			

ACCIDENT/INJURY DETAILS	
DATE OF INJURY:	TIME OF INJURY (A.M. OR P.M.):
EXPLAIN THE DETAILS OF THE ACCIDENT:	
ARE YOU OFF WORK? ❑ YES ❑ NO	IF YES, DATE YOU LEFT WORK:
HAVE YOU RETURNED TO WORK SINCE THE ACCIDENT? ❑ YES ❑ NO	IF YES, DATE YOU RETURNED TO WORK:
HAVE YOU BEEN TREATED BY ANY OTHER DOCTORS FOR THIS CONDITION? ❑ YES ❑ NO	IF YES, LIST THE DOCTOR(S) NAMES & PHONE NUMBERS:
HAVE YOU HAD ANY PREVIOUS WORKERS COMPENSTATION INJURIES? ❑ YES ❑ NO	DATE(S) OF PREVIOUS WORKERS COMPENSATION INJURIES:
PRIOR TO THE ACCIDENT, HAD YOU HAD SIMILAR COMPLAINTS TO THE ONES YOU ARE EXPERINCING NOW? ❑ YES ❑ NO	
IF YES, PLEASE DESCRIBE:	

SIGNATURE	
PATIENT SIGNATURE:	DATE:

Build and Balance Chiropractic
12203 Aberdeen St #100
Blaine, MN 55449

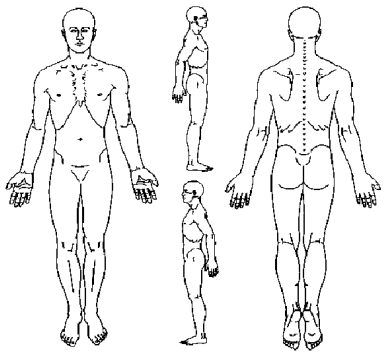
SYMPTOMS

INSTRUCTIONS: *Check (✓) any/all symptoms noted after the accident.*

- ❑ HEADACHE
- ❑ NECK PAIN
- ❑ NECK STIFFNESS
- ❑ SLEEPING PROBLEMS
- ❑ BACK PAIN
- ❑ NERVOUSNESS
- ❑ TENSION
- ❑ IRRITABILITY
- ❑ CHEST PAIN
- ❑ DIARRHEA
- ❑ CONSTIPATION
- ❑ FEVER
- ❑ DIZZINESS
- ❑ HEAD SEEMS HEAVY
- ❑ PINS & NEEDLES IN ARMS
- ❑ PINS & NEEDLES IN LEGS
- ❑ NUMBNESS IN FINGERS
- ❑ NUMBNESS IN TOES
- ❑ SHORTNESS OF BREATH
- ❑ FATIGUE
- ❑ DEPRESSION
- ❑ FEET FEEL COLD
- ❑ HANDS FEEL COLD
- ❑ COLD SWEATS
- ❑ LIGHT BOTHERS EYES
- ❑ LOSS OF MEMORY
- ❑ EARS RING
- ❑ FACE FLUSHED
- ❑ BUZZING IN EARS
- ❑ LOSS OF BALANCE
- ❑ FAINTING
- ❑ LOSS OF SMELL
- ❑ LOSS OF TASTE
- ❑ UPSET STOMACH
- ❑ OTHER: _____
- ❑ OTHER: _____

INTRUCTIONS: *Please mark the area and type of pain on the drawings using the codes listed below:*

N=Numbness P=Pain A=Ache T=Tingling S=Stiffness/Soreness



COMMENTS:

PLEASE PROVIDE ANY OTHER PERTINENT INFORMATION YOU THINK WE SHOULD KNOW:

DOCTOR ONLY

DOCTOR COMMENTS:

LUMBAR ROM	CERVICAL ROM
90 FLEXION	65 FLEXION
30 EXTENTION	50 EXTENSION
20 R L FLEX	45 R L FLEX
20 L L FLEX	45 L L FLEX
30 R ROTATION	80 R ROTATION

SIGNATURE

PATIENT SIGNATURE:

DATE:

AUTHORIZATION FOR CARE

I hereby authorize the Doctor to work with my condition through the use of adjustments to my spine, as he or she deems appropriate. I clearly understand and agree that all services rendered me are charged directly to me and that I am personally responsible for payment. I agree that I am responsible for all bills incurred at this office. The Doctor will not be held responsible for any pre-existing medically diagnosed conditions nor for any medical diagnosis. I also understand that if I suspend or terminate my care, any fees for professional services rendered me will become immediately due and payable.

I hereby authorize assignment of my insurance rights and benefits (if applicable) directly to the provider for services rendered. I understand and agree that health and accident insurance policies are an arrangement between an insurance carrier and myself. I understand that the Doctor's Office will prepare any necessary reports and forms to assist me in collecting from the insurance company and that any amount authorized to be paid directly to the Doctor's Office will be credited to my account on receipt.

Ownership of X-ray Films: *It is understood and agreed that the payments to the Doctor for X-rays is for examination of X-rays only. The X-ray negative will remain the property of the office. They are kept on file where they may be seen at any time while I am a patient at this office.*

SIGNATURE:	DATE:
GUARDIAN OR SPOUSE AUTHORIZING CARE SIGNATURE:	DATE:

WHO SHOULD RECEIVE BILLS FOR PAYMENT ON YOUR ACCOUNT?

❑ PATIENT ❑ SPOUSE ❑ PARENT ❑ WORKERS COMP ❑ AUTO INSURANCE ❑ MEDICARE ❑ HEALTH INSURANCE

TERMS OF ACCEPTANCE

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

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 to the spine.

Health is a state of optimal physical, mental and social well being, not merely the absence of disease.

Vertebral Subluxation is a misalignment of one or more of the joints of the body. This can cause pain or alteration of nerve function and interference of the transmission of nerve impulses, lessening the body's innate ability to maintain maximal health.

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 subluxation.

I have read and fully understand the above statement. Any 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:
Print Name:	DATE: