VAN DRISSE CHIROPRACTIC CENTER
WORKERS' COMPENSATION QUESTIONNAIRE

Please answer all questions completely.

Dear Patient,

This information is considered confidential. We need this information because we care enough to want to know, and your answers will help us determine if chiropractic can help you. If we do not sincerely believe you condition will respond satisfactorily, we will not accept your case. In order for us to understand your condition properly, please be as neat and accurate as possible while completing this form. Thank you.

Patient Information

Name _____ Today's Date _____/_____/_____

Address _____ City/State/Zip _____

Home Tel (____) _____ Sex _____ Date of Birth _____/_____/_____ Marital Status S/M/D/W

Social Security #_____-_____-_____ Occupation _____

Who referred you to our office? _____

Employer

Employer Name _____ Employer Tel (____) _____

Employer Address _____ City/State/Zip _____

Contact person _____

Accident Information/Details

Please explain in detail how your accident happened. _____

_____

Time and date present injury occurred _____ am/pm

Where did you feel pain immediately after the accident? _____

Did you return to work? YES NO

If so, date returned to work _____

If injured before, did you lose time from work? YES NO

Before this injury, were you capable of working on an equal basis with others your age?

Have you tried any home remedies for your condition such as aspirin, heating pad, ice packs, etc.?

_____

What aggravates your condition? _____

(For example: walking, sitting, bending, etc.)

Is there any position that you can get into that makes your condition better? _____

_____

Does your condition interfere with your work? YES NO

If so, please explain how? _____

Since this injury are your symptoms:

Getting better Worse About the same

VAN DRISSE CHIROPRACTIC CENTER
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Please answer all questions completely.

List all medications you are taking _____

_____

List any other comments relative to this accident _____

_____

Have you retained an attorney? YES NO
Is it in litigation? YES NO Maybe
If so, please give name and address _____

Did you consult another doctor? YES NO
If so, please give doctors name _____ D.C. / M.D. / D.O. / D.D.S

Doctor's diagnosis _____

What treatments did you receive? _____

Do any other diseases or accidents affect your employment? YES NO
If so, please explain _____

If you lost time from work with injuries prior to this injury, please give name of doctor consulted. _____

_____

In your line of work do you have to favor any part of your body? YES NO
If so, please explain _____

Do you have a history of absenteeism caused from accidents on the job? YES NO

Have you ever had a Workmen's Compensation claim before? YES NO

List all previous surgeries_____

_____

List secondary complaints not directly related to this accident_____

_____

Other comments_____

_____

_____

Patient Signature_____ Date _____

1) Indicate with a **mark** on this line, the level of pain you are now experiencing:

No Pain |----------| **Maximum Pain**
0 1 2 3 4 5 6 7 8 9 10

2) Listed below are **5 types** of pain. **Select the type** (or types) of pain that you are experiencing.
3) Mark the body figures (**draw below**) to indicate where on you body the pain is being felt.
Be sure to **use** the corresponding **symbols** for each type of pain.
4) Please **draw your face** on the figure below.

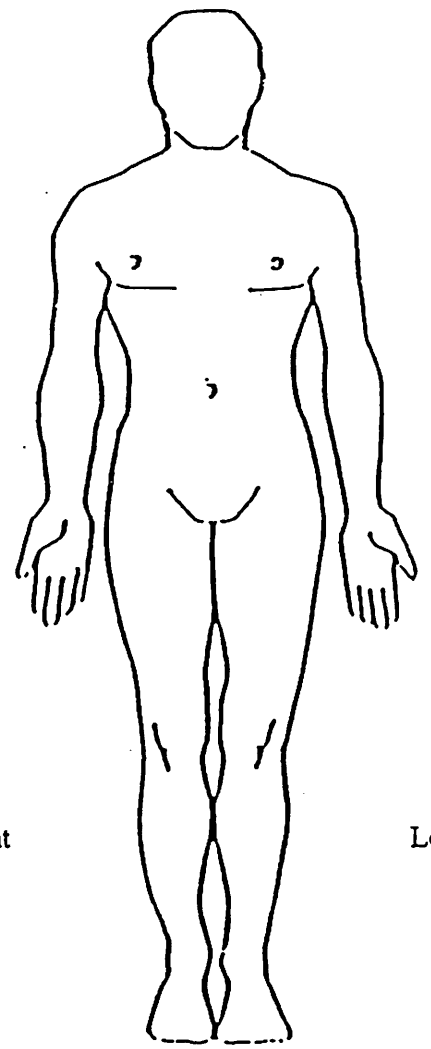
Numbness XXXXX XXXXXXXXXX XXXXX

Stabbing SSSSS SSSSSSSSS SSSSS

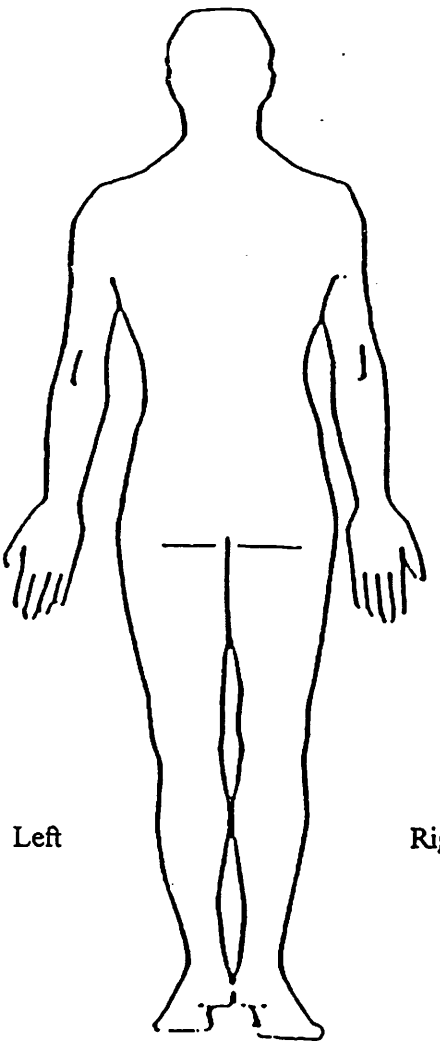
Ache //////////
//////////////////
//////////

Pins and Needles OOOOO OOOOOOOOOO OOOOO

Burning +++++ ++++++++++ +++++



Right Left



Left Right

Van Drisse Chiropractic Center * 502 George Street * DePere, WI 54115 * (920) 337-0103

Van Drisse Chiropractic Center

502 George Street
De Pere, WI 54115

Electronic Health Records Intake Form

In compliance with Medicare requirements for the government EHR incentive program

Are you currently taking any medications? (Please include regularly used over the counter medications)

Medication Name	Dosage and Frequency (i.e. 5mg once a day, etc.)

Do you have any medication allergies?

Medication Name	Reaction	Onset Date	Additional Comments

Patient Signature: _____ Date:_____

For office use only

Height: _____ Weight:_____ Blood Pressure:_____/_____

Neck Index

ACN Group, Inc. Form NI-100

ACN Group, Inc. Use Only rev 3/27/2003

Patient Name _____ **Date** _____

This questionnaire will give your provider information about how your neck condition affects your everyday life. Please answer every section by marking the one statement that applies to you. If two or more statements in one section apply, please mark the one statement that most closely describes your problem.

Pain Intensity

⓪ I have no pain at the moment.
① The pain is very mild at the moment.
② The pain comes and goes and is moderate.
③ The pain is fairly severe at the moment.
④ The pain is very severe at the moment.
⑤ The pain is the worst imaginable at the moment.

Sleeping

⓪ I have no trouble sleeping.
① My sleep is slightly disturbed (less than 1 hour sleepless).
② My sleep is mildly disturbed (1-2 hours sleepless).
③ My sleep is moderately disturbed (2-3 hours sleepless).
④ My sleep is greatly disturbed (3-5 hours sleepless).
⑤ My sleep is completely disturbed (5-7 hours sleepless).

Reading

⓪ I can read as much as I want with no neck pain.
① I can read as much as I want with slight neck pain.
② I can read as much as I want with moderate neck pain.
③ I cannot read as much as I want because of moderate neck pain.
④ I can hardly read at all because of severe neck pain.
⑤ I cannot read at all because of neck pain.

Concentration

⓪ I can concentrate fully when I want with no difficulty.
① I can concentrate fully when I want with slight difficulty.
② I have a fair degree of difficulty concentrating when I want.
③ I have a lot of difficulty concentrating when I want.
④ I have a great deal of difficulty concentrating when I want.
⑤ I cannot concentrate at all.

Work

⓪ I can do as much work as I want.
① I can only do my usual work but no more.
② I can only do most of my usual work but no more.
③ I cannot do my usual work.
④ I can hardly do any work at all.
⑤ I cannot do any work at all.

Personal Care

⓪ I can look after myself normally without causing extra pain.
① I can look after myself normally but it causes extra pain.
② It is painful to look after myself and I am slow and careful.
③ I need some help but I manage most of my personal care.
④ I need help every day in most aspects of self care.
⑤ I do not get dressed, I wash with difficulty and stay in bed.

Lifting

⓪ I can lift heavy weights without extra pain.
① I can lift heavy weights but it causes extra pain.
② Pain prevents me from lifting heavy weights off the floor, but I can manage if they are conveniently positioned (e.g., on a table).
③ Pain prevents me from lifting heavy weights off the floor, but I can manage light to medium weights if they are conveniently positioned.
④ I can only lift very light weights.
⑤ I cannot lift or carry anything at all.

Driving

⓪ I can drive my car without any neck pain.
① I can drive my car as long as I want with slight neck pain.
② I can drive my car as long as I want with moderate neck pain.
③ I cannot drive my car as long as I want because of moderate neck pain.
④ I can hardly drive at all because of severe neck pain.
⑤ I cannot drive my car at all because of neck pain.

Recreation

⓪ I am able to engage in all my recreation activities without neck pain.
① I am able to engage in all my usual recreation activities with some neck pain.
② I am able to engage in most but not all my usual recreation activities because of neck pain.
③ I am only able to engage in a few of my usual recreation activities because of neck pain.
④ I can hardly do any recreation activities because of neck pain.
⑤ I cannot do any recreation activities at all.

Headaches

⓪ I have no headaches at all.
① I have slight headaches which come infrequently.
② I have moderate headaches which come infrequently.
③ I have moderate headaches which come frequently.
④ I have severe headaches which come frequently.
⑤ I have headaches almost all the time.

Index Score = [Sum of all statements selected / (# of sections with a statement selected x 5)] x 100

Neck Index Score _____

Back Index

ACN Group, Inc. Form BI-100

ACN Group, Inc. Use Only rev 3/27/2003

Patient Name _____ **Date** _____

This questionnaire will give your provider information about how your back condition affects your everyday life. Please answer every section by marking the one statement that applies to you. If two or more statements in one section apply, please mark the one statement that most closely describes your problem.

Pain Intensity

⓪ The pain comes and goes and is very mild.
① The pain is mild and does not vary much.
② The pain comes and goes and is moderate.
③ The pain is moderate and does not vary much.
④ The pain comes and goes and is very severe.
⑤ The pain is very severe and does not vary much.

Sleeping

⓪ I get no pain in bed.
① I get pain in bed but it does not prevent me from sleeping well.
② Because of pain my normal sleep is reduced by less than 25%.
③ Because of pain my normal sleep is reduced by less than 50%.
④ Because of pain my normal sleep is reduced by less than 75%.
⑤ Pain prevents me from sleeping at all.

Sitting

⓪ I can sit in any chair as long as I like.
① I can only sit in my favorite chair as long as I like.
② Pain prevents me from sitting more than 1 hour.
③ Pain prevents me from sitting more than 1/2 hour.
④ Pain prevents me from sitting more than 10 minutes.
⑤ I avoid sitting because it increases pain immediately.

Standing

⓪ I can stand as long as I want without pain.
① I have some pain while standing but it does not increase with time.
② I cannot stand for longer than 1 hour without increasing pain.
③ I cannot stand for longer than 1/2 hour without increasing pain.
④ I cannot stand for longer than 10 minutes without increasing pain.
⑤ I avoid standing because it increases pain immediately.

Walking

⓪ I have no pain while walking.
① I have some pain while walking but it doesn't increase with distance.
② I cannot walk more than 1 mile without increasing pain.
③ I cannot walk more than 1/2 mile without increasing pain.
④ I cannot walk more than 1/4 mile without increasing pain.
⑤ I cannot walk at all without increasing pain.

Personal Care

⓪ I do not have to change my way of washing or dressing in order to avoid pain.
① I do not normally change my way of washing or dressing even though it causes some pain.
② Washing and dressing increases the pain but I manage not to change my way of doing it.
③ Washing and dressing increases the pain and I find it necessary to change my way of doing it.
④ Because of the pain I am unable to do some washing and dressing without help.
⑤ Because of the pain I am unable to do any washing and dressing without help.

Lifting

⓪ I can lift heavy weights without extra pain.
① I can lift heavy weights but it causes extra pain.
② Pain prevents me from lifting heavy weights off the floor.
③ Pain prevents me from lifting heavy weights off the floor, but I can manage if they are conveniently positioned (e.g., on a table).
④ Pain prevents me from lifting heavy weights off the floor, but I can manage light to medium weights if they are conveniently positioned.
⑤ I can only lift very light weights.

Traveling

⓪ I get no pain while traveling.
① I get some pain while traveling but none of my usual forms of travel make it worse.
② I get extra pain while traveling but it does not cause me to seek alternate forms of travel.
③ I get extra pain while traveling which causes me to seek alternate forms of travel.
④ Pain restricts all forms of travel except that done while lying down.
⑤ Pain restricts all forms of travel.

Social Life

⓪ My social life is normal and gives me no extra pain.
① My social life is normal but increases the degree of pain.
② Pain has no significant affect on my social life apart from limiting my more energetic interests (e.g., dancing, etc).
③ Pain has restricted my social life and I do not go out very often.
④ Pain has restricted my social life to my home.
⑤ I have hardly any social life because of the pain.

Changing degree of pain

⓪ My pain is rapidly getting better.
① My pain fluctuates but overall is definitely getting better.
② My pain seems to be getting better but improvement is slow.
③ My pain is neither getting better or worse.
④ My pain is gradually worsening.
⑤ My pain is rapidly worsening.

Index Score = [Sum of all statements selected / (# of sections with a statement selected x 5)] x 100

Back Index Score _____

VAN DRISSE CHIROPRACTIC CENTER
502 George Street – De Pere WI, 54115

Workers' Compensation Claim Information

Name: _____

Date: _____

Required

Date of Injury: _____

Insurance Company: _____

Contact name for
claim information: _____

Title/Relation to Case: _____

Contact Number: _____

Claim # _____

Claim Address _____

_____

_____