WORKER COMPENSATION HISTORY FORM

Patient Information

Patient Name:____ Sex: Male Female

Date of Birth:_______________ Age:______ Social Security #:_____________________________ Marital Status: __________

Address:____ City, State, Zip:____________________________________

Phone: Cell #:__________________________ Home #:_________________________Work #:_________________________

Primary Phone #: ❍Cell ❍Home ❍Work Email:____

Occupation:________________________________ Employer:__________________________________#Hours/Week_______

Employer Address, City, State:____

Employer Phone:____________________________________ Contact Name:_______________________________________

Injury reported to employer? No Yes Name of person reported to:____

How did you hear about our office?____

Emergency Contact:________________________________ Phone:_____________________Relationship:________________

Do you have a Primary Care Physician? No Yes Name & location:____

Worker Compensation Carrier

Worker Compensation Carrier:____

Carrier Address:____

Carrier Phone #:_____________________________________Coverage Verified by:___________________________________

Adjuster's Name::_______________________________________Claim #:____

Date of Injury:_______________ Time of Injury:________ am pm Describe the accident in your own words:

____

____

____

Have you lost time from work due to this injury? No Yes #Hours________ # Days__________ Other__________________

Any previous Worker Compensation Injuries? No Yes List dates:____

If yes, describe areas of injury for previous worker compensation injuries:____

Tests you've had since the injury? None X-rays MRI CT scan Other____

Other Physicians who have treated since accident: None ____

Any other treatment since the accident?:____

Chief Complaints from this injury:____

Rate the severity of symptoms on a scale from 1 (least) to 10 (severe) at **Rest**:__________ with **Activity**:______________

Do your symptoms radiate? No Yes Where:____

Do you notice your symptoms during (circle): work sleep daily routine recreation sitting standing walking bending

Quality of Symptoms: Sharp Dull Burning Tingling Cramping Aching ____

HEALTH HISTORY:

Vitamins/Supplements:____

Smoking: No Yes Packs/Day________ Exercise: Type/Frequency:____

Coffee/Caffeine: No Yes Cups/Day_________ Soda: No Yes Cans/Week________ Alcohol: No Yes Drinks/Week_________

Stress Level: Low Moderate High____

Work Activity Involves (circle): Sitting Standing Light Labor Heavy Labor Traveling Other:____________________________

Are you Right or Left Handed? Right Left **Females: Are you pregnant?** No Not Sure Yes Due Date:____________

List all past **Injuries or Accidents** (Year):____

____

Medical History

Existing or Relevant Previous Conditions

Allergies	◯ Yes ◯ No	Dizzy Spells	◯ Yes ◯ No	MRSA (skin infection staph)	◯ Yes ◯ No
Anemia	◯ Yes ◯ No	Emphysema/Bronchitis	◯ Yes ◯ No	Multiple Sclerosis	◯ Yes ◯ No
Anxiety	◯ Yes ◯ No	Fibromyalgia	◯ Yes ◯ No	Muscular Disease	◯ Yes ◯ No
Arthritis	◯ Yes ◯ No	Fractures	◯ Yes ◯ No	Osteoporosis	◯ Yes ◯ No
Asthma	◯ Yes ◯ No	Gallbladder Problems	◯ Yes ◯ No	Parkinson's	◯ Yes ◯ No
Autoimmune Disorder	◯ Yes ◯ No	Headaches	◯ Yes ◯ No	Rheumatoid Arthritis	◯ Yes ◯ No
Cancer	◯ Yes ◯ No	Hearing Impairment	◯ Yes ◯ No	Seizures	◯ Yes ◯ No
Cardiac Conditions	◯ Yes ◯ No	Hepatitis	◯ Yes ◯ No	Smoking	◯ Yes ◯ No
Cardiac Pacemaker	◯ Yes ◯ No	High/Low blood pressure	◯ Yes ◯ No	Speech Problems	◯ Yes ◯ No
Chemical Dependency	◯ Yes ◯ No	High Cholestero	◯ Yes ◯ No	Strokes	◯ Yes ◯ No
Circulation Problems	◯ Yes ◯ No	HIV/AIDS	◯ Yes ◯ No	Thyroid Disease	◯ Yes ◯ No
Currently Pregnant	◯ Yes ◯ No	Incontinence	◯ Yes ◯ No	Tuberculosis	◯ Yes ◯ No
Depression	◯ Yes ◯ No	Kidney Problems	◯ Yes ◯ No	Vision Problems	◯ Yes ◯ No
Diabetes	◯ Yes ◯ No	Metal Implants	◯ Yes ◯ No		

Describe any other conditions

If "Yes" to any of the above, please **explain** and **give approximate dates**.
Describe any **other conditions not listed above**.

Fall History

Injury as a result of a fall in the past year? ◯ No ◯ Yes ____

Two or more falls in the last year? ◯ No ◯ Yes____

Surgical History **Month / Day / Year**

Body Region:_________________Surgery Type:___________________Date:___________________________

Body Region:_________________Surgery Type:___________________Date:___________________________

Body Region:_________________Surgery Type:___________________Date:___________________________

Body Region:_________________Surgery Type:___________________Date:___________________________

Current Medications ◯ currently not taking any medications

Drug:_______________Dosage:_______Frequency:__________Route:__________Reason Taking:______________

Drug:_______________Dosage:_______Frequency:__________Route:__________Reason Taking:______________

Drug:_______________Dosage:_______Frequency:__________Route:__________Reason Taking:______________

Review of Systems: Have you experienced any of the following in the **last few months?**

Please circle and detail below. If you have no complaint in a category please circle "NONE".

General: Fever Chills Swollen glands Loss of memory Weakness Aches/pains Weight loss/gain Cancer NONE

Headaches: Tension Migraines Premenstrual Other Frequency:___________________ NONE

Eyes: Glasses/contacts Double vision Blurry vision Eye pain Glaucoma cataracts NONE

Ear/Nose/Throat: ear pain hearing loss ringing in ears nosebleeds sinus problems tooth pain hoarseness NONE

Skin: Rashes Changing moles Change in skin Other lesions Itchy skin Eczema Numbness NONE

Cardio: Irregular beat/palpitations Chest pain High blood pressure Pacemaker Heart attack date:_______ NONE

Lungs: Cough Cough up blood Wheezing Asthma Shortness of breath Sleep apnea NONE

GI: Poor appetite Indigestion/heartburn Nausea Vomiting blood Abdominal pain/cramps Constipation

Diarrhea Change in bowel habits Rectal bleeding Liver disease Hepatitis Irritable bowel NONE

GU/GYN: Urinate at night more than once Blood in urine Burning or pain when urinating

Problems passing urine Problems controlling urine Incontinence Menstrual problems NONE

Neuro: Weakness in extremity R L______________ Tingling or numbness Radiating pain Balance problems

Sciatica dizziness Fainting spells Speech problems Seizures Stroke Head injury Concussion NONE

Musculoskeletal: Joint pain Swelling Muscle spasms Back or neck pain Sprain/strain fracture NONE

Hemo: Bleed or bruise easily Varicose veins Blood clots Lymph node pain/enlargement NONE

Endocrine: Constant thirst Always cold Always warm Very sluggish or tired Hot flashes NONE

Family History:

Is there a history of any of the following conditions in your family?

Diabetes Heart Attack Stroke Cancer Kidney Problems Arthritis Scoliosis Migraines Thyroid Disease

High Blood Pressure High Cholesterol Other Inherited Diseases:____

____

CONSENT FOR DISCLOSURE OF INFORMATION:
Our clinic has always been very protective and respectful of your personal information. Under the HIPAA Privacy Act we have adopted additional guidelines to ensure the proper use, confidentiality and disclosure of your health information.

⇨ I give the clinic permission to leave a message on my voice mail / answering machine. ◯ No ◯ Yes
Note: This statement applies to phone calls outside our usual appointment reminder calls.

⇨ I give the clinic permission to discuss my medical condition with another person. ◯ No ◯ Yes
If yes, please specify names. Parents: _________________________________ Spouse:_______________________________
Other:____

AUTHORIZATION: I clearly understand that services rendered to me are charged directly to me and that I am personally responsible for payment in the event that my claim for Worker Compensation benefits is denied. I understand that filing for Worker Compensation benefits does not relieve me from my responsibility for the payment of all charges.

X____ **Date:**____________________
Signature of Patient, Parent or Guardian if under 18 years old

Consent for Treatment:

I hereby give consent to the healthcare providers of Wellspring Health Center, PLLC / Sports & Family Wellness, PLLC to render such care and treatment as might be required by my condition. Such care may include, but is not limited to consultations, examinations, digital x-rays, rehabilitative physical therapy, medical treatment, massage, wellness or maintenance care.

X____ Date:_____________________________

Signature of Patient, Parent or Guardian if under 18 years old

HIPAA Privacy Policies: Consent for Use and Disclosure of Health Information

I acknowledge that I have been made aware of the clinic's privacy policies and may request a copy at any time. The policies are available in our reception area and on our website at www.wellspringhopkins.com.

X____ Date:_____________________________

Signature of Patient, Parent or Guardian if under 18 years old

Payment Policy

We will file claims with contracted and approved insurance plans as a courtesy. The clinic has the right to not accept non-contracted insurance plans at its discretion and in these cases; charges for services rendered are to be paid at the time of service, unless other arrangements have been made in advance. I understand that if I have not listed any insurance plan that I am responsible for the full amount of the visit unless other arrangements have been made in advance. Please note that affordable payment options and financial hardship plans are available if needed.

I understand that I am financially responsible for all charges whether or not paid by insurance, unless other arrangements have been made in advance. Any unpaid patient balance will accrue a 1 ½% monthly billing charge after 90 days. Any collection fees, attorney fees, or returned check fees are the responsibility of the adult person(s) named on the account.

Assignment of Insurance Benefits

I certify that I or my dependents have insurance through the insurance company information that I have provided and assign directly to Wellspring Health Center, PLLC / Sports & Family Wellness, PLLC all insurance benefits, if any, otherwise payable to me for services rendered. I authorize the use of this signature on all insurance submissions.

In the event that my insurance company forwards payment directly to me, instead of Wellspring Health Center, PLLC / Sports & Family Wellness PLLC, I will immediately deliver said payment to Wellspring Health Center, PLLC / Sports & Family Wellness, PLLC.

I also verify that all the information contained on the history forms is true and correct to the best of my knowledge and belief. I authorize Wellspring Health Center, PLLC / Sports & Family Wellness, PLLC to release my complete records to its business management company and/or to my insurance carrier(s) and or agents to secure payment of benefits; I also authorize Wellspring Health Center, PLLC / Sports & Family Wellness, PLLC designation of representation for insurance claims appeals.

Release of Records

I authorize the release of my complete records to or from other physicians or medical facilities that may be pertinent and necessary to my care and treatment.

Print Patient Name:____

X____ **Date:**____________________

Signature of Patient, Parent or Guardian if under 18 years old