WORKMEN'S COMPENSATION QUESTIONAIRE

Dear Patient. Please complete this questionnaire. Your answers will help us determine if chiropractic can help you.
If we do not sincerely believe your condition will respond satisfactorily, we will not accept your case.
Thank you.

Name _____ Sex ___ Martial Status ___ Date of Birth _____ Home Phone _____

Address _____ City _____ State _____ Zip _____

Social Sec. #_____ **Cell Phone Number** _____ **Cell Carrier** _____

Who referred you to our office? _____ **Email Address** _____

Occupation _____ Work Number _____ Employers Name: _____

Work Name &Address: _____

Workers Comp INSURANCE CARRIER _____

Please explain how your accident happened in detail _____

_____

Address/location where injury occurred _____

Have you retained an attorney? ☐ Yes ☐ No Litigation? ☐ Yes ☐ No ☐Maybe

If so, name and address _____

Give the time and date present injury occurred _____ AM PM _____ 20_____

Explain where you felt pain immediately after the accident _____

Did you miss time from work? ☐ Yes ☐ No If yes, first date you missed work _____

Did you return to work? ☐ Yes ☐ No If yes, date returned to work _____

Did you consult any other doctor? ☐ Yes ☐No If yes, doctors name _____D.C., M.D., D.O., D.D.S.

Doctor's diagnosis _____What treatments did you receive? _____

Have you ever injured this area before? ☐ Yes ☐ No If yes, when? _____

If injured before; did you lose time from work? ☐ Yes ☐ No

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

_____

Do any other diseases or accidents affect your employment? ☐ Yes ☐ No If yes, explain _____

In your work do you have to favor any part of your body? ☐ Yes ☐ No If yes, explain _____

Do you have a history of absenteeism caused from accidents on the job? ☐ Yes ☐ No

Have you ever had a Workman's Compensation claim before? ☐ Yes ☐ No

Before the injury were you capable of working on an equal basis with others your age? ☐ Yes ☐ No

Are your work activities restricted as a result of this accident? ☐ Yes ☐ No

Since this injury are your symptoms: ☐ Improving? ☐ Getting worse? ☐ The same?

HEALTH QUESTIONAIRE

Please indicate for each of the questions below your experience by use of the following codes:

1-never had; **2**-previously had; **3**-presently have.

MUSCULO-SKELETAL SYSTEM

___ Lower back problems
___ Pain between shoulders
___ Neck problems
___ Arm problems
___ Leg problems
___ Swollen joints
___ Painful joint
___ Stiff joints
___ Sore muscles
___ Weak muscles
___ Walking problems
___ Ruptures
___ Broken bones

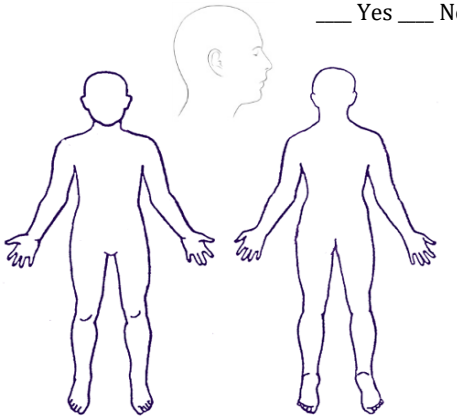
GENITO-URINARY SYSTEM

___ Bladder trouble
___ Excessive urination
___ Scanty urination
___ Painful urination
___ Discolored urine

FEMALE

___ Vaginal discharge
___ Vaginal bleeding
___ Vaginal pain
___ Breast pain
___ Lumps on breast

Are you pregnant?
___ Yes ___ No



GASTRO-INTESTINAL SYSTEM

___ Poor appetite
___ Excessive hunger
___ Difficult chewing
___ Difficult swallowing
___ Excessive thirst
___ Nausea
___ Vomiting food
___ Vomiting blood
___ Abdominal pain
___ Diarrhea
___ Constipation
___ Black stool
___ Bloody stool
___ Hemorrhoids
___ Liver trouble
___ Gall bladder problems
___ Weight trouble

NERVOUS SYSTEM

___ Numbness
___ Loss of feeling
___ Paralysis
___ Dizziness
___ Fainting
___ Headaches
___ Muscle jerking
___ Convulsions
___ Forgetfulness
___ Confusion
___ Depression

CARDIO-VASCULAR RESPIRATORY

___ Chest pain
___ Pain over heart
___ Difficulty breathing
___ Persistent cough
___ Coughing blood
___ Rapid heartbeat
___ Blood pressure problems
___ Heart problems
___ Lung problems
___ Varicose veins

EYE, EAR, NOSE, AND THROAT

___ Eye strain
___ Eye inflammation
___ Vision problems
___ Ear pain
___ Ear noises
___ Ear discharge
___ Hearing loss
___ Nose pain
___ Nose bleeding
___ Nose discharge
___ Difficult breathing via nose
___ Sore gums
___ Dental problems
___ Sore mouth
___ Sore throat
___ Hoarseness
___ Difficult speech

Vitals

Height: _____ Weight: _____

Please check one of the Following Below:

Never a Smoker____ Current Smoker____ Every day Smoker____ Former Smoker____ Sometimes_____

Medication

Please list any **medications** and the **dosage** you are currently using:

_____

Allergies

Please List what you allergies that you may have: _____

Surgery

Have you had any surgeries? If so what were they? When? _____

Family History

Please list what kind of illnesses run in your family: _____

Social History

Smoking ___ Alcohol ___ Caffeine ___ Drug use ___ Exercise___ Other ___

Patient Signature _____ **Date:** _____

Dr. George M. Rizos

Chiropractor

390 Merrick Avenue
East Meadow, NY 11554
(516) 489-2212

3089 Lawson Blvd
Oceanside, NY 11572
(516) 766-1717

NOTICE OF PRIVACY PRACTICES PATIENT ACKNOWLEDGEMENT

Patient Name: _____

Date of Birth: _____

I have received this practice's Notice of Private Practices written in plain language. The notice provides in detail the uses and disclosures of my protected health information that may be made by this practice, my individual rights, how I may exercise these rights, and the practice's legal duties with respect to my information.

I understand that this practice reserves the right to change the terms of its Notice of Private Practices, and to make changes regarding all protected health information resident at, or controlled by this practice. I understand I can obtain this practice's current Notice of Privacy Practices on request.

Signature: _____

Relationship to patient (if other than self): _____

Date: _____

Dr. George M. Rizos

Chiropractor

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Dear _____
(Please print your name)

Effective 01/01/2015, due to the high demand for appointments with Dr. Rizos and the massage therapist our office will be charging a **$25.00** fee for the following:

- ***Failure to show up for your scheduled appointment.***
- ***Failure to give 24 hours' notice for a cancelled appointment.***
- ***Failure to give 24 hours' notice when rescheduling an appointment.***

We do understand that emergencies occur and will be taken into consideration. Please remember that the massage therapist's time is very valuable and when you do not keep a scheduled appointment you are delaying your own treatment and preventing another patient from receiving their treatment as well.

Thank you

The Staff

Patient Signature: _____ Date: _____