PATIENT REGISTRATION
WORKERS' COMPENSATION

Today's Date:

PATIENT INFORMATION

Name:

Name Preferred to Be Called:

Date of Birth:

Social Security #:

Mailing Address:

City, State, Zip:

Marital Status:
☐ Single ☐ Married ☐ Divorced ☐ Separated ☐ Widowed

Home Phone #:

Cell Phone #:

Work Phone #: Ext:

Email Address:

Referred To Us By:

PRIMARY CARE PHYSICIAN

Primary Care Physician:

Street Address:

City, State, Zip:

Clinic Name:

Phone #:

Fax #:

INJURY INFORMATION

Date of Injury:

Injured Areas of the Body:

Carrier Case # (if known)

WCB Case # (if known)

Patient's Employer:

Employer Address:

City, State, Zip:

Employer's Phone #: Ext.

Disability Status:
(Please Circle One) ☐Working ☐Not Working

INSURANCE INFORMATION

Primary Insurance:

Policy Holder:

Policy Holder's Birthday:

Policy #:

ATTORNEY INFORMATION

Attorney Name:

Attorney Address:

City, State, Zip:

Attorney Phone #: Fax #:

IN CASE OF EMERGENCY

Please Contact:

Relationship to Patient:

Home Phone #:

Alternate Phone #:

Assignment & Release *- By signing below, I authorize Chester Chiropractic Office to release medical records required by my insurance company(s) to obtain precertification or payment. I authorize my insurance company(s) to pay benefits directly to Chester Chiropractic Office and I agree that a reproduced copy of this authorization will be as valid as the original. I understand that I am responsible for any amount not covered by my insurance, or any amount for a patient for which I am the guarantor. I agree that I will be responsible for any collection agency or attorney fees incurred due to non-payment on this account. I understand that by signing below, I am giving written consent for the use and disclosure of protected health information for treatment, payment, and health care operations.*

Patient / Guardian Date

Donald Littlejohn, DC ~ Chester Chiropractic Office ~ 7 Academy Avenue, Chester NY 10918
Phone (845) 469-7575 ~ Fax (845) 469-9328 ~ Emergency (845) 987-2840

PATIENT HEALTH HISTORY

If you are presently troubled by a particular condition or have ever had a listed condition in the past, please check it in the Yes column. The information you provide concerning past and present conditions assist your doctor in more thoroughly understanding your state of health. This questionnaire is completely confidential and will not be released without your specific consent

Yes	No		Yes	No	
___	___	Neck Pain (723.1)	___	___	Aortic Aneurysm (441.5)
___	___	Shoulder Pain (719.41)	___	___	High Blood Pressure (401.9)
___	___	Pain in ☐ Upper Arm or ☐ Elbow (719.42)	___	___	Angina (413.9)
___	___	Hand Pain (719.44)	___	___	Heart Attack (411.0)
___	___	Wrist Pain (719.43)	___	___	Stroke (436.9)
___	___	Upper Back Pain (724.1)	___	___	Asthma (439.9)
___	___	Low Back Pain (724.2)	___	___	Cancer ☐ Past (V10) ☐ Present (199.1)
___	___	Pain in ☐ Upper Leg or ☐ Hip (719.45)	___	___	Tumor (229.9)
___	___	Pain in ☐ Lower Leg or ☐ Knee (729.5)	___	___	Prostate Problems (601.9)
___	___	Pain in ☐ Ankle or ☐ Foot (719.47)	___	___	Blood Disorder (790.6)
___	___	Jaw Pain (526.9)	___	___	Emphysema (Chronic Lung Disorders) (492.8)
___	___	Joint ☐ Swelling (719.0) / ☐ Stiffness (719.5)	___	___	Arthritis (716.9)
___	___	Fainting (780.2)	___	___	Rheumatoid Arthritis (714.0)
___	___	Visual Disturbances (728.9)	___	___	Diabetes ☐ Type I (250.01) ☐ Type II (250.00)
___	___	Convulsions (780.3)	___	___	Epilepsy (349.5)
___	___	Dizziness (780.4)	___	___	Ulcer (556.9)
___	___	Headache (784.0)	___	___	☐ Liver (573.9) / ☐ Gallbladder Problems (575.9)
___	___	Muscular Incoordination (781.3)	___	___	Kidney Stones (592.0)
___	___	Tinnitus (Ear Noises) (388.30)	___	___	Hepatitis (573.3)
___	___	Rapid Heart Beat (785.0)	___	___	Bladder Infection (595.9)
___	___	Chest Pain (786.50)	___	___	Kidney Disorders (V11.03)
___	___	Loss of Appetite (783.0)	___	___	Colitis (558.9)
___	___	Irritable Colon (564.1)	___	___	Abnormal Weight ☐ Gain (783.1) / ☐ Loss (783.2)
___	___	Excessive Thirst (783.5)	___	___	HIV (V08) /AIDS (042)
___	___	Chronic Cough (786.2)	___	___	Anorexia (307.1)
___	___	Chronic Sinusitis (473.9)	___	___	Systemic Lupus (710.0)
___	___	General Fatigue (780.7)	___	___	Other _____
___	___	Irregular Menstrual (626.4)			
___	___	Profuse Menstrual (611.72)	**Yes**	**No**	
___	___	Breast ☐ Soreness / ☐ Lumps (611.72)	___	___	Tobacco ☐ Present (305.1) ☐ Past (V15.82)
___	___	Endometriosis (617.9)	___	___	Alcohol If Yes, Frequency: _____
___	___	PMS (625.4)	___	___	☐ Drug / ☐ Alcohol Dependence (V11.3/303.99)
___	___	Loss of Bladder Control (788.30)	___	___	☐ Coffee / ☐ Tea / ☐ Caffeinated Soft Drinks
___	___	Painful Urination (788.1)			Servings per Day: _____
___	___	Frequent Urination (788.41)	___	___	Hospitalization / Surgeries: _____
___	___	Abdominal Pain (789.0)			_____
___	___	☐ Constipation / ☐ Irregular Bowel Habits (564.0)	___	___	Prior Accidents/Injuries: _____
___	___	Difficulty Swallowing (787.2)			_____
___	___	☐ Heartburn / ☐ Indigestion (787.1)	___	___	Current Medications (Rx, OTC, Vitamins):
___	___	☐ Dermatitis / ☐ Eczema / ☐ Rash (692.9)			_____
___	___	Depression (311.9)			_____

Yes	No	
___	___	Do You Have A Permanent Disability Rating?

Area of the Body Affected: _____

Date Rating Received: _____

Rating Percentage: _____

Please List Any Known Allergies: _____

_____

_____

Weight _____ lbs **Height** _____ Ft _____ In

Immediate Family Medical History

___ Cancer (V16)	___ Chronic Back Problems (V17.89)
___ Heart Problems (V17.4)	___ Chronic Headaches (V19.8)
___ Lung Problems (V17.6)	___ High Blood Pressure (V17.49)
___ Diabetes (V18.0)	___ Rheumatoid Arthritis (V17.7)
___ Epilepsy (V17.2)	___ Other Condition(s): _____
___ Lupus (V19.8)	_____

For Women

Yes	No	
___	___	Are You On Any Form Of Birth Control?
___	___	Are You Nursing?
___	___	Are You Or Could You Be Pregnant?
		If Yes, How Far Along? _____
		If No, Last Period? _____

_____ _____

Patient Signature Date

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PATIENT HEALTH QUESTIONNAIRE

Patient Name: _____

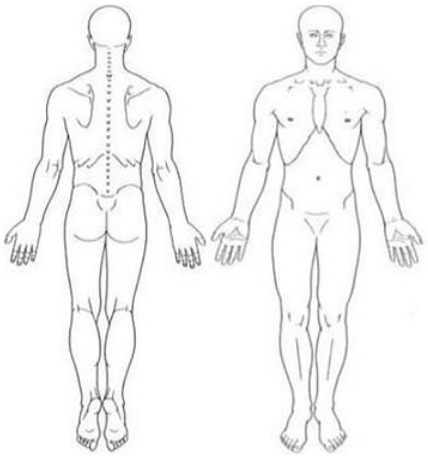
1. What is the reason for your visit today? _____

a. Approximately when did this current episode start? _____

b. What brought on this current episode? _____

c. Is this episode a worsening of a prior injury? ○ No ○ Yes, it was: ○Work-related ○Auto Accident ○Other

2. Location: Where does it hurt?



3. Nature of Symptoms

- ○ Numbness
- ○ Tingling
- ○ Stiffness
- ○ Dull
- ○ Aching
- ○ Cramps
- ○ Nagging
- ○ Sharp
- ○ Burning
- ○ Shooting
- ○ Throbbing
- ○ Stabbing
- ○ _____
- ○ _____

4. Intensity of Symptoms:

	None					Mild		Moderate			Severe
Currently:	⓪	①	②	③	④	⑤	⑥	⑦	⑧	⑨	⑩
At its worst:	⓪	①	②	③	④	⑤	⑥	⑦	⑧	⑨	⑩
At its best:	⓪	①	②	③	④	⑤	⑥	⑦	⑧	⑨	⑩

5. Duration: How often do you experience symptoms?

- ○ Constantly (76-100% of the day)
- ○ Frequently (51-75% of the day)
- ○ Occasionally (56-50% of the day)
- ○ Intermittently (0-25% of the day)

6. Aggravating or Relieving Factors:

What makes your symptoms worse? _____

What makes your symptoms better? _____

7. Prior Treatment: What have you done to relieve the symptoms?

○ Chiropractic	○ Acupuncture	○ Prescription Meds: _____
○ Physical Therapy	○ Massage	○ Over-the-Counter Meds: _____
○ Surgery	○ _____	○ Homeopathic Remedies: _____

8. Activities of Daily Living: How much does this condition interfere with your life and ability to function?

	None	Mild	Moderate	Severe		None	Mild	Moderate	Severe
Sitting	○	○	○	○	Using a computer	○	○	○	○
Rising out of chair	○	○	○	○	Getting in/out of car	○	○	○	○
Standing	○	○	○	○	Driving/Riding in a car	○	○	○	○
Walking	○	○	○	○	Looking over shoulder	○	○	○	○
Lying down	○	○	○	○	Exercising	○	○	○	○
Bending over	○	○	○	○	Caring for family	○	○	○	○
Climbing stairs	○	○	○	○	Showering or bathing	○	○	○	○
Lifting objects	○	○	○	○	Dressing myself	○	○	○	○
Reaching overhead	○	○	○	○	Social life	○	○	○	○
Shopping	○	○	○	○	Getting to sleep	○	○	○	○
Household chores	○	○	○	○	Staying asleep	○	○	○	○
Yard Work	○	○	○	○	Concentrating	○	○	○	○

9. What is your current work status?

○ Working – Full Duty	○ Unemployed.....last date worked _____/_____/_____
○ Working – Modified Duty	○ Retired.....last date worked _____/_____/_____

10. What is your current occupation?

○ Homemaker ○ Full-Time Student ○ Retired ○ _____

11. Current: Height ____ feet ____ inches **Weight** _____ pounds **Smoking Status:** _____

12. Additional Comments: _____

_____

Patient Signature _____ **Date** _____

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Employee Claim

C-3

State of New York - Workers' Compensation Board

Fill out this form to apply for workers' compensation benefits because of a work injury or work-related illness. Type or print neatly. This form may also be filled out on-line at www.wcb.state.ny.us.

WCB Case Number (if you know it): _____

A. YOUR INFORMATION (Employee)

1. Name: _____ (First / MI / Last) 2. Date of Birth: _____/_____/_____

3. Mailing address: _____ (Number and Street/PO Box / City / State / Zip Code)

4. Social Security Number: ___-___-_____ 5. Phone Number: (____)_____ 6. Gender: ☐ Male ☐ Female

7. Do you speak English? ☐ Yes ☐ No If no, what language do you speak? _____

B. YOUR EMPLOYER(S)

1. Employer when injured: _____ 2. Phone Number: (____)_____

3. Your work address: _____ (Number and Street / City / State / Zip Code)

4. Date you were hired: _____/_____/_____ 5. Your supervisor's name: _____

6. List names/addresses of any other employer(s) at the time of your injury/illness: _____

7. Did you lose time from work at the other employment(s) as a result of your injury/illness? ☐ Yes ☐ No

C. YOUR JOB on the date of the injury or illness

1. What was your job title or description? _____

2. What types of activities did you normally perform at work? _____

3. Was your job? (check one) ☐ Full Time ☐ Part Time ☐ Seasonal ☐ Volunteer ☐ Other: _____

4. What was your gross pay (before taxes) per pay period? _____ 5. How often were you paid? _____

6. Did you receive lodging or tips in addition to your pay? ☐ Yes ☐ No If yes, describe: _____

D. YOUR INJURY OR ILLNESS

1. Date of injury or date of onset of illness: _____/_____/_____ 2. Time of injury: _____ ☐ AM ☐ PM

3. Where did the injury/illness happen? (e.g., 1 Main Street, Pottersville, at the front door) _____

4. Was this your usual work location? ☐ Yes ☐ No If no, why were you at this location? _____

5. What were you doing when you were injured or became ill? (e.g., unloading a truck, typing a report) _____

6. How did the injury/illness happen? (e.g., I tripped over a pipe and fell on the floor) _____

7. Explain fully the nature of your injury/illness; list body parts affected (e.g., twisted left ankle and cut to forehead): _____

YOUR NAME: _____ DATE OF INJURY/ILLNESS: _____/_____/_____
First MI Last

D. YOUR INJURY OR ILLNESS *continued*

8. Was an object (e.g., forklift, hammer, acid) involved in the injury/illness? ☐ Yes ☐ No If yes, what? _____

9. Was the injury the result of the use or operation of a licensed motor vehicle? ☐ Yes ☐ No
   If yes, ☐ your vehicle ☐ employer's vehicle ☐ other vehicle License plate number (if known): _____
   If your vehicle was involved, give name and address of your motor vehicle insurance carrier: _____

10. Have you given your employer (or supervisor) notice of injury/illness? ☐ Yes ☐ No
    If yes, notice was given to: _____ ☐ orally ☐ in writing Date notice given: _____/_____/_____

11. Did anyone see your injury happen? ☐ Yes ☐ No ☐ Unknown If yes, list names: _____

E. RETURN TO WORK

1. Did you stop work because of your injury/illness? ☐ Yes, on what date? _____/_____/_____ ☐ No, skip to Section F.
2. Have you returned to work? ☐ Yes ☐ No If yes, on what date? _____/_____/_____ ☐ regular duty ☐ limited duty
3. If you have returned to work, who are you working for now? ☐ Same employer ☐ New employer ☐ Self employed
4. What is your gross pay (before taxes) per pay period? _____ How often are you paid? _____

F. MEDICAL TREATMENT FOR THIS INJURY OR ILLNESS

1. What was the date of your first treatment? _____/_____/_____ ☐ None received (skip to question F-5)
2. Were you treated on site? ☐ Yes ☐ No
3. Where did you receive your first off site medical treatment for your injury/illness? ☐ none received ☐ Emergency Room ☐ Doctor's office ☐ Clinic/Hospital/Urgent Care ☐ Hospital Stay over 24 hours
   Name and address where you were first treated: _____
   _____ Phone Number: (_____)_____
4. Are you still being treated for this injury/illness? ☐ Yes ☐ No
   Give the name and address of the doctor(s) treating you for this injury/illness: _____
   _____ Phone Number: (_____)_____
5. Do you remember having another injury to the same body part or a similar illness? ☐ Yes ☐ No
   If yes, were you treated by a doctor? ☐ Yes ☐ No If yes, provide the names and addresses of the doctor(s) who treated you and COMPLETE AND FILE FORM C-3.3 TOGETHER WITH THIS FORM:
   _____
   _____
   _____
6. Was the previous injury/illness work related? ☐ Yes ☐ No
   If yes, were you working for the same employer that you work for now? ☐ Yes ☐ No

I am hereby making a claim for benefits under the Workers' Compensation Law. My signature affirms that the information I am providing is true and accurate to the best of my knowledge and belief.

Any person who knowingly and with INTENT TO DEFRAUD presents, causes to be presented, or prepares with knowledge or belief that it will be presented to, or by an insurer, or self-insurer, any information containing any FALSE MATERIAL STATEMENT or conceals any material fact, SHALL BE GUILTY OF A CRIME and subject to substantial FINES AND IMPRISONMENT.

Employee's Signature: _____ Print Name: _____ Date: _____/_____/_____

On behalf of Employee: _____ Print Name: _____ Date: _____/_____/_____

An individual may sign on behalf of the employee only if he or she is legally authorized to do so and the employee is a minor, mentally incompetent or incapacitated.

I certify to the best of my knowledge, information and belief, formed after an inquiry reasonable under the circumstances, that the allegations and other factual matters asserted above have evidentiary support, or are likely to have evidentiary support after a reasonable opportunity for further investigations or discovery.

Signature of Attorney/Representative (if any): _____ Date: _____/_____/_____

Print Name: _____ Title: _____

ID No., if any: R _____ If Licensed Representative, License No.: _____ Expiration Date: _____/_____/_____

Limited Release of Health Information (HIPAA)

C-3.3

State of New York - Workers' Compensation Board

WCB Case No. *(if you know it):*_____

To Claimant: If you received treatment for a *previous* injury to the same body part or for an illness similar to the one described in your current Claim, fill out this form. This form allows the health care providers you list below to release health care information about your previous injury/illness to your employer's workers' compensation insurer. The federal HIPAA law (Health Insurance Portability and Accountability Act of 1996) says you have a right to get a copy of this form. If you do not understand this form, talk to your legal representative. If you do not have a legal representative, the Advocate for Injured Workers at the Workers' Compensation Board can help you. Call: 800-580-6665.

To Health Care Provider: A **copy** of this HIPAA-compliant release allows you to disclose health information. If you send records to the employer's workers' compensation insurer in response to this release, also mail copies to the Claimant's legal representative. (If no legal representative is listed below, send copies to the Claimant.) Health care providers who release records must follow New York state law and HIPAA.

This release is:

- **Voluntary.** Your health care provider(s) must give you the same care, payment terms, and benefits, whether you sign this form or not.
- **Limited.** It gives your health care provider(s) permission to release only those health records that are related to the previous illness/condition you describe below.
- **Temporary.** It ends when your current claim for compensation is established or disallowed and all appeals are exhausted.
- **Revocable.** You can cancel this release at any time. To cancel, send a letter to the health care provider(s) listed on this form. Also, send a copy of your letter to your employer's workers' compensation insurer and the Workers' Compensation Board. *Note: You may not cancel this release with respect to medical records already provided.*
- **For records only.** It gives your health care provider(s) listed on this form permission to send copies of your health care records to your employer's workers' compensation insurer.

This form does NOT allow your health care provider(s) to release the following types of information:

- **HIV-related information**
- **Psychotherapy notes**
- **Alcohol/Drug treatment**
- **Mental Health treatment** (unless you check below)
- **Verbal information** (your health care providers may not discuss your health care information with anyone)

Any medical records released will become part of your workers' compensation file and are confidential under the Workers' Compensation Law.

A. YOUR INFORMATION (Claimant)

1. Name:_____ 2. Social Security Number:_____-_____-_____
3. Mailing Address: _____
4. Date of Birth: _____/_____/_____ 5. Date of the current injury/illness: _____/_____/_____
6. Current injury/illness, including all body parts injured:_____

_____

7. Your legal representative's name and address (if any):_____

_____

☐ *Check here if you allow your health care provider(s) to release **mental health care** information.*

B. YOUR HEALTH CARE PROVIDER(S)

(List all health care providers who treated you for a *previous* injury to the same body part or similar illness. If more than 2 providers attach their contact information to this form.)

1. Provider:_____ 2. Phone Number: (_____)_____
3. Mailing Address: _____
4. Other provider (if any):_____ 5. Phone Number: (_____)_____
6. Mailing Address:_____

C. READ AND SIGN BELOW.

I hereby request that the health care provider(s) listed above give my employer's workers' compensation insurer copies of all health records related to any previous injury/illness, to all body parts, described above.

_____

Claimant's signature (ink only -- use blue ballpoint pen, if possible.) Date

If the claimant is unable to sign, the person signing on his/her behalf must fill out and sign below:

_____

Your name | Relationship to Claimant | Signature (ink only -- use blue ballpoint pen, if possible.) | Date

Versión en español al reverso de la forma.