Bailey Chiropractic

9500 Brooktree Rd. Suite 305, Wexford, PA 15090
724 – 934 – 0899

PATIENT INFORMATION

Date_____

☐Mr. ☐Mrs. ☐ Ms. _____
(First) (Initial) (Last) (Nickname)

Address _____

City_____ State_____ Zip_____ Birthday_____ Age:_____ ☐ Male ☐ Female

Employer _____Occupation _____

Address _____ City_____ State_____ Zip_____

Insurance Company_____

Is patient covered by **Spouse's** insurance? ☐ No ☐ Yes Is patient covered by additional insurance? ☐ No ☐ Yes

Subscriber Name _____ Birthday_____
(First) (Initial) (Last)

Employer_____ Insurance Company_____

Please present insurance card(s) so we can put a copy in your file.

CONTACT INFORMATION

Best way to reach you ☐ Home ☐ Cell ☐ Work ☐ Email **Home phone** _____

Cell phone _____Work phone _____ Ext _____ Email_____

In Case of Emergency

Name_____ Relationship_____ Home Phone _____ Cell_____

How did you hear about our office? ☐ Advertisement ☐ Friend ☐ Family Member ☐ Doctor ☐ Other _____

Is your present pain due to an injury? ☐ No ☐ Yes ☐ On the job ☐ Auto Accident ☐ Other_____

Has the accident been reported? ☐ No ☐ Yes ☐ To Employer ☐ Workmen's s Compensation ☐Auto Carrier

☐ Other_____

Have you had any surgeries? ☐ No ☐ Yes If yes please list below

Surgery	Date
Surgery	Date
Surgery	Date

X-Ray Exam ☐ No ☐ Yes When _____	MRI ☐ No ☐ Yes When _____	CAT SCAN ☐ No ☐ Yes When _____

PLEASE LIST ANY ACCIDENTS OR FALLS		DATES
Auto	☐ No ☐ Yes	
Sports or Other	☐ No ☐ Yes	
Other	☐ No ☐ Yes	
Broken Bones or dislocations (fractures)	☐ No ☐ Yes	
Have you ever had any spinal taps or spinal injections?	☐ No ☐ Yes	
Were you ever knocked unconscious or had a lapse of memory?	☐ No ☐ Yes	
Have you ever had a lapse of memory?	☐ No ☐ Yes	
Are you presently taking any medications - prescribed or patent?	☐ No ☐ Yes	If yes list below
What medications?		

Bailey Chiropractic

9005 Brooktree Rd, Suite 305, Wexford, PA 15090
724 – 934 – 0899

WORKMAN'S COMP QUESTIONNAIRE

Name			Date	
Name of employer at time of accident				
Date of accident	Length of time worked there prior to accident			
Type of work being done at time of injury				
In your own words, please describe accident				
Have you been treated by another doctor for this accident?			☐ No	☐ Yes
Doctor's name				
Address				
City	State		Zip	
What type of treatment did you receive?				
Have you	☐ improved	☐ unchanged	☐ gotten worse	
What types of medicines are you taking for this condition?				
Do these medicines help?		☐ No	☐ Yes	☐ Don't Know
Have you had physical therapy?	☐ No	☐ Yes	If yes indicate below how often	
☐ Daily	☐ Every other day	☐ Several times a week	☐ Weekly	☐ Every other week	☐ Other
Does the physical therapy help?				
Prior to this accident, have you ever had any physical complaints similar to what you have now?		☐ No	☐ Yes	☐ Don't Know
If yes, describe				
Were these similar complaints the result of a previous accident(s)?			☐ No	☐ Yes
If yes, please provide details of accidents(s)				
Have you returned to work since your accident?	☐ No	☐ Yes	If yes, please fill out information below	
Date returned to work	Employer			
Type of work you are now doing				
	☐ Light Duty	☐ Reg. Duty	☐ Full-Time	☐ Part-Time
Current medical complaints				
Have you had any other serious accidents which required medical care?			☐ No	☐ Yes
Describe				
Have you had any serious Illnesses that required hospitalization?			☐ No	☐ Yes
Describe				
Have you had any surgeries?			☐ No	☐ Yes
Type surgery			Date	
Type surgery			Date	
Would you like to have information about the benefits of supplements?			☐ No	☐ Yes
Do you want information on how Chiropractic treatment can help allergies/migraines			☐ No	☐ Yes

Bailey Chiropractic

JOB DESCRIPTION

In a typical 8-hour workday, I ---- Circle # of hours for each activity									
Sit	1	2	3	4	5	6	7	8	hours
Stand	1	2	3	4	5	6	7	8	hours
Walk	1	2	3	4	5	6	7	8	hours

In terms of an 8 hour work day	Occasionally means 33% of the day	Frequently means 34% to 66%	Continuously means 67% or more
On the Job, I perform the following activities	Occasionally	Frequently	Continuously
Bend / stoop	☐	☐	☐
Squat	☐	☐	☐
Crawl	☐	☐	☐
Climb	☐	☐	☐
Reach above shoulder level	☐	☐	☐
Crouch	☐	☐	☐
Kneel	☐	☐	☐
Balancing	☐	☐	☐
Pushing / Pulling	☐	☐	☐

On the job, I lift:	Not At All	Occasionally	Frequently	Continuously
Up to 10 pounds	☐	☐	☐	☐
11 to 24 pounds	☐	☐	☐	☐
25 to 34 pounds	☐	☐	☐	☐
35 to 50 pounds	☐	☐	☐	☐
51 to 74 pounds	☐	☐	☐	☐
75 to 100 pounds	☐	☐	☐	☐

Do you have to bend over while doing any lifting?	No	Yes
Are your feet used for repetitive movements, such as in operating foot controls?	No	Yes

Do you use your hands for repetitive actions such as	Simple Grasping	Firm Grasping	Fine Manipulating
Right hand	☐	☐	☐
Left hand	☐	☐	☐
Both hands	☐	☐	☐

			Please Describe
Are you required to work on unprotected heights?	☐ No	☐ Yes	
Are you required to be around moving machinery?	☐ No	☐ Yes	
Are you exposed to marked changes in temperature and humidity?	☐ No	☐ Yes	
Are you required to drive automotive equipment?	☐ No	☐ Yes	
Are you exposed to dust, fumes and / or gases?	☐ No	☐ Yes	

Please list any additional comments

Signature Date

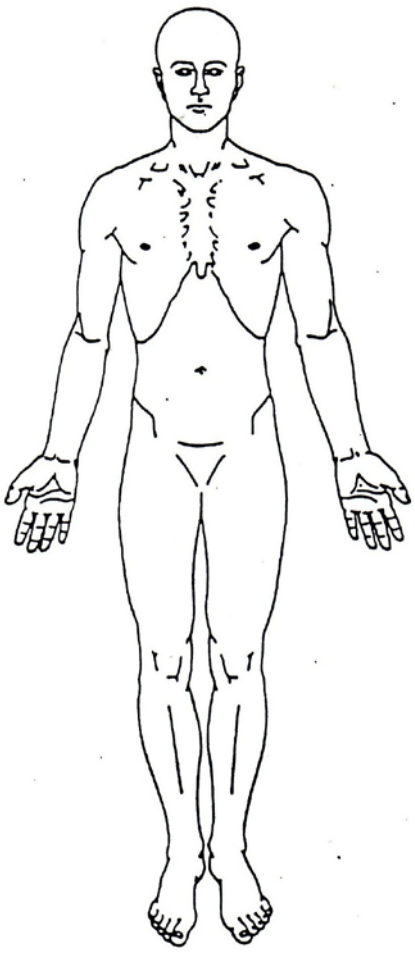
Bailey Chiropractic

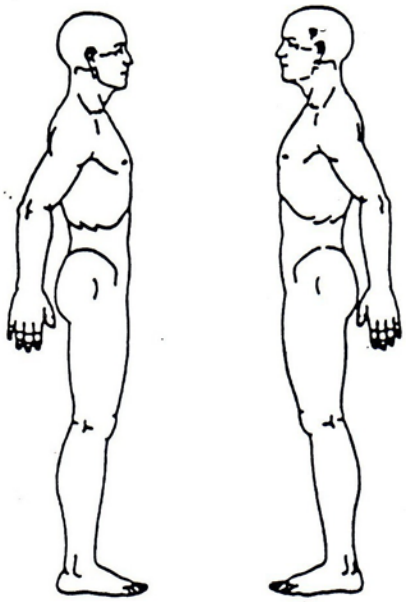
DIAGRAM OF PATIENT'S DISCOMFORT

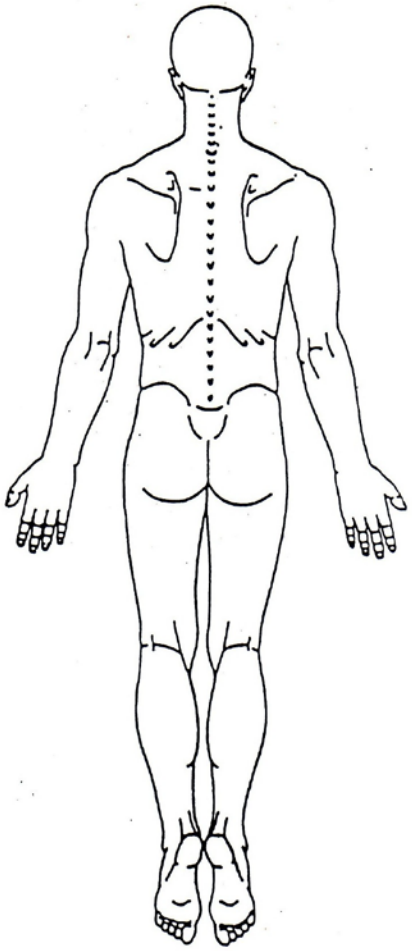
Name		Date
Habits		
☐ Smoke - packs /day	☐ Coffee - Cups/day	☐Alcohol - Amount/day
Exercise		
☐ None ☐ Moderate ☐ Daily	Type of Exercise?	
Do you currently take any vitamins and or supplements?		☐ Yes ☐ No
☐ Over the counter	☐ From my doctor	☐ I send away for them
Please list type you take		

LIST PRESENT COMPLAINTS WITH RATINGS OF 1 - 10 (10 being unbearable Pain)										
1	**1**	**2**	**3**	**4**	**5**	**6**	**7**	**8**	**9**	**10**
2	**1**	**2**	**3**	**4**	**5**	**6**	**7**	**8**	**9**	**10**
3	**1**	**2**	**3**	**4**	**5**	**6**	**7**	**8**	**9**	**10**

Use these figures to mark your pain







Mark with
A for Ache
B for Burning sensations
M for pain with Movement
N for Numbness
P for Pins & needles
S for Sharp/Stabbing pain
T for Tingling sensations
O for Other

Bailey Chiropractic

9500 Brooktree Rd. Suite 305, Wexford, PA 15090
724 – 934 – 0899

BACK AND NECK PAIN

BACK PAIN

Currently, I have pain in my			☐ low back	☐ mid back	☐ upper back		
My pain began			☐ gradually	☐ suddenly			
I have pain			☐ sometimes	☐ all of the time			
My pain goes into my			☐ right leg	☐ left leg	☐ both		
I have tingling and/or numbness In my			☐ right leg	☐ left leg	☐ both		
My pain is worse when I:							
cough/sneeze	☐ No	☐ Yes	walk	☐ No	☐ Yes		
sit	☐ No	☐ Yes	lift	☐ No	☐ Yes		
bend	☐ No	☐ Yes	push	☐ No	☐ Yes		
use a computer	☐ No	☐ Yes	pull	☐ No	☐ Yes		
My back is worse with sexual activity				☐ No	☐ Yes		
My pain wakes me up during the night				☐ No	☐ Yes		
Changes in the weather affect my pain				☐ No	☐ Yes		

NECK PAIN

My neck pain began			☐ gradually	☐ suddenly			
I have pain			☐ sometimes	☐ all of the time			
My pain goes into my			☐ right arm	☐ left arm	☐ both		
I have tingling and / or numbness in my			☐ right arm	☐ left arm	☐ both		
My pain is worse when I:			cough/sneeze	☐ No	☐ Yes		
lift	☐ No	☐ Yes	bend forward	☐ No	☐ Yes		
push	☐ No	☐ Yes	turn my head	☐ No	☐ Yes		
pull	☐ No	☐ Yes	use a computer	☐ No	☐ Yes		
My pain wakes me up during the night				☐ No	☐ Yes		
Changes In the weather affect my pain				☐ No	☐ Yes		
I have neck stiffness				☐ No	☐ Yes		
I have headaches				☐ No	☐ Yes		
If I do get headaches, they occur		☐ sometimes		☐ all of the time			

OTHER PAIN

Please describe any current medical complaints which you are experiencing and were not previously covered on this questionnaire, or list any additional comments you wish to make regarding your condition

Bailey Chiropractic

9500 Brooktree Rd. Suite 305, Wexford, PA 15090
724 – 934 – 0899

HIPAA PATIENT PRIVACY FORM

IN ORDER TO BE COMPLIANT WITH HIPAA REGULATIONS WE REQUEST THAT EACH PATIENT COMPLETE THIS FORM. THIS FORM WILL BECOME A PERMANENT PART OF YOUR MEDICAL RECORDS. THE HIPAA PRIVACY RULES GIVE INDIVIDUALS THE RIGHT TO REQUEST A RESTRICTION ON USES AND DISCLOSURES OF THEIR PROTECTED HEALTH INFORMATION. IN LAYMANS TERMS, WE ARE ASKING FOR YOUR PERMISSION TO SEND ANY PERTANANT HEALTH INFORMATION TO ANOTHER PHYSICIAN, HOSPITAL, LAB, INSURANCE COMPANY OR ANY OTHER ENTITY THAT REQUESTS YOUR INFORMATION FOR REASONS OF CONDUCTING BUSINESS WITH REGARDS TO YOUR CARE. THE TYPES OF INFORMATION THAT ARE TYPICALLY SENT TO ANOTHER ENTITY INCLUDE: MEDICAL RECORDS, LABORATORY OR PATHOLOGY REPORTS, MEDICATIONS LIST, CONSULTATION NOTES, SURGERY NOTES AND PHOTOS AND INSURANCE INFORMATION.

I understand that I have the right to revoke this authorization at any time and that I must put that request in writing and present it to the Privacy Officer at this office I understand that the revocation will not apply to the information that has already been released or to information that is required by law or by my insurance company.

I understand that authorizing the disclosure of this health information is voluntary. I can refuse to sign this authorization and my treatment will not be altered. I understand that I may view or receive a copy of the information to be used or disclosed.

OUR OFFICE IS COMMITED TO PROTECTING YOUR PRIVACY.
PLEASE LET US KNOW HOW WE CAN CONTACT YOU.

CHECK ALL THAT APPLY

☐ HOME TELEPHONE: _____

☐ YES, YOU ARE PERMITTED TO LEAVE A MESSAGE WITH DETAILED INFORMATION ON MY MACHINE.

☐ YES, YOU ARE PERMITTED TO LEAVE A MESSAGE WITH ANOTHER ADULT.

OR

☐ N0, DO NOT LEAVE A MESSAGE ON MY MACHINE OR WITH ANOTHER ADULT.

☐ If necessary may we call you at work? If yes, list number_____

Signature of patient_____ Date _____/____/_____
or legal proxy

Bailey Chiropractic

9500 Brooktree Rd. Suite 305, Wexford, PA 15080, (412) 934-0899

MEDICAL REPORTS AND DOCTOR'S LIEN

I do hereby authorize Ted E. Bailey, D. C. to furnish you, my attorney, with a full report of his examination, diagnosis, treatment, prognosis, etc. of myself in regard to the accident in which I was recently involved.

I hereby authorize and direct you, my attorney, to pay directly to said doctor such sums as may be due and owing him for medical service rendered me both by reason of this accident and by reason of any other bills that are due his office and to withhold such sums from any settlement, judgment of verdict as may be necessary to adequately protect such doctor. And I hereby further give a Lien on my case to said doctor against any and all proceeds of my settlement, judgment or verdict which may be paid to you, my attorney, or myself, as the result of the injuries for which I have been treated or injuries in connection therewith.

I agree never to rescind this document and that a rescission will not be honored by my attorney. I hereby instruct that in the event another attorney is substituted in this matter, the new attorney honor this lien as inherent to the settlement and enforceable upon the case as if it were executed by him.

I fully understand that I am directly and fully responsible to said doctor for all medical bills submitted by him for service rendered me and that this agreement is made solely for said doctor's additional protection and in consideration of his awaiting payment. And I further understand that such payment is not contingent on any settlement, judgment or verdict by which I may eventually recover said fee.

This Notice of Doctor's Lien is executed by me subject to any conditions or criteria which appear in Act 6 of 1990 to the extent that Act modifies or affects the rights of the respective parties otherwise set forth herein.

Please acknowledge this letter by signing below and returning to the doctor's office. I have been advised that if my attorney does not wish to cooperate in protecting the doctor's interest, the doctor will not await payment but will require me to make payments on a current basis.

Patients Signature_____ Date_____

The undersigned being attorney of record for the above patient does hereby agree to observe all the terms of the above and agrees to withhold such sums from any settlement, judgment or verdict as may be necessary to adequately protect said doctor above-named.

Attorney's Signature_____Date_____

Please sign and return. Please Copy for your records.