# NEW PATIENT INFORMATION

Name _____ Today's Date_____

Date of Birth_____ Age ____ Sex: □ Male □ Female

Social Security # _____ Marital Status _____ Number of Children _____

Your Address _____

Email _____ Home # _____ Work # _____

Cell # _____ Cell Provider (Verizon, T-Mobile,etc) _____

**(Providing your cell provider allows us to send you appointment text reminders)**

Spouse Name _____ Spouse Date of Birth_____

Emergency Contact _____ Relationship _____ Phone _____

Employer _____ Occupation (job title) _____

Type of work: □ Office/clerical □ Light Labor □ Moderate Labor □ Heavy Labor

Employer's Address _____

Name of person from your work that we contact about this injury: _____

Employer's Phone: _____

Who is responsible for payment of this account _____

Have you ever received chiropractic care before? □ YES □ NO

If yes, how long ago?_____ For what?_____

Date of work accident / injury:_____ Time of Day when accident occurred. _____

Address / Location where you were injured: _____

## Continue with work injury paperwork on next page



ROMNEY CHIROPRACIC 24255 104th Ave SE Kent WA 98030 PH 253-277-4672

Mark the boxes below if you have had any of these symptoms **at any point following the work accident:**

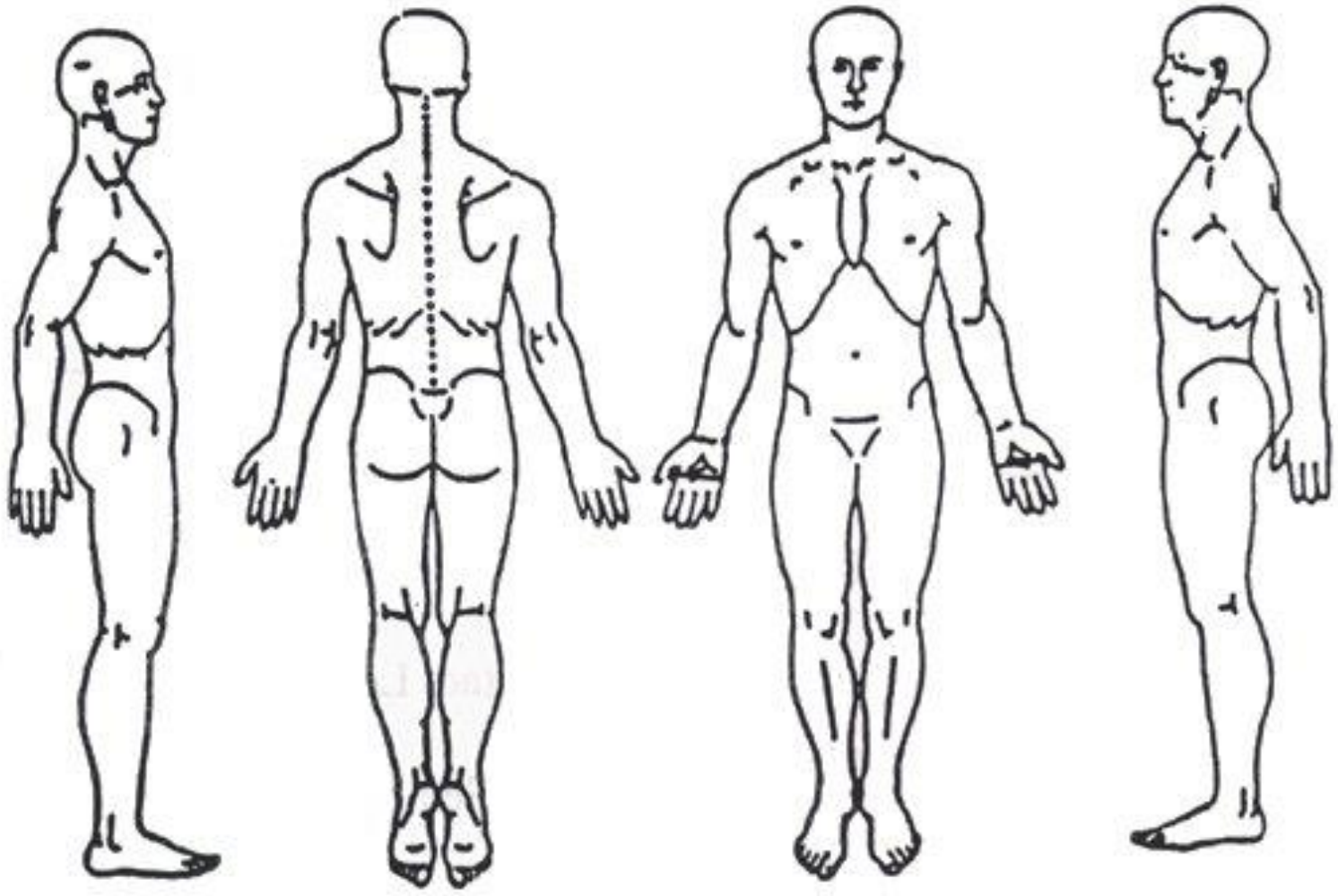
| 1. | Doctor's Notes | 3. |
|---|---|---|
| □ Headache | □ Daily □ ____x/week<br>D 1 2 3 4<br>F 1 2 3 4 | □ Nervousness<br>□ Anxiety |
| □ Neck Discomfort / Stiffness | □ Daily □ ____x/week<br>D 1 2 3 4<br>F 1 2 3 4 | □ Dizziness<br>□ Light Headed<br>□ Room Spinning<br>□ Ear Ringing |
| □ Shoulder Discomfort / Stiffness | □ Daily □ ____x/week<br>D 1 2 3 4<br>F 1 2 3 4 | □ Difficulty Finding Comfortable Sleep Position<br>□ Trouble Staying Asleep<br>□ Trouble Falling Asleep |
| □ Arm / Hand discomfort | □ Daily □ ____x/week<br>D 1 2 3 4<br>F 1 2 3 4 | □ Fatigue<br>□ Tiredness<br>□ Irritability |
| □ Arm / Hand Numbness and/or Tingling | □ Daily □ ____x/week<br>D 1 2 3 4<br>F 1 2 3 4 | □ Nausea<br>□ Vomiting |
| □ Chest / Rib Discomfort | □ Daily □ ____x/week<br>D 1 2 3 4<br>F 1 2 3 4 | □ Blurred Vision<br>□ Double Vision |
| □ Upper Back Discomfort / Stiffness | □ Daily □ ____x/week<br>D 1 2 3 4<br>F 1 2 3 4 | □ Stuttering Speech<br>□ Slurring Speech |
| □ Mid Back Discomfort / Stiffness | □ Daily □ ____x/week<br>D 1 2 3 4<br>F 1 2 3 4 | □ Change in Smell<br>□ Change in Taste |
| □ Low Back Discomfort / Stiffness | □ Daily □ ____x/week<br>D 1 2 3 4<br>F 1 2 3 4 | □ Problems with coordination<br>□ Poor Balance<br>□ Dropping Things |
| □ Hip Discomfort | □ Daily □ ____x/week<br>D 1 2 3 4<br>F 1 2 3 4 | □ Light Sensitivity<br>□ Noise Sensitivity |
| □ Leg / Foot discomfort | □ Daily □ ____x/week<br>D 1 2 3 4<br>F 1 2 3 4 | □ Increased Depression<br>□ Increased Emotions |
| □ Leg / Foot Numbness and/or Tingling | □ Daily □ ____x/week<br>D 1 2 3 4<br>F 1 2 3 4 | □ Problems Finding the "right word",<br>□ Difficulty with Math<br>□ Difficulty Concentrating<br>□ Difficulty with Names and Places |
| □ Jaw Discomfort | □ Daily □ ____x/week<br>D 1 2 3 4<br>F 1 2 3 4 | □ Other |

**Frequency (F1= 25%, F2= 50%, F3= 75%, F4=Constant) - Severity (D1= slight, D2=mild, D3=moderate, D4=severe).**

# BODY DIAGRAM

**Please use the following symbols to mark the areas on the image below where you feel any described sensations**

Dull Pain: NNN  Stabbing/Cutting Pain: /// /// ///  Burning: XXX  Numbness: = = =  Tingling: :::::  Cramping: SSS



**In the 3 months (90 days) before the injury, did you have any neck or back pain?  □ Yes  □ No**

**If yes, describe:**_____



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**Please describe and/or draw, to the best of your knowledge, what happened during this work accident:**

The injury was: □ Sudden □ Gradual □ Progressive

Did you report this to your employer? □ Yes □ No If so, to whom? _____

Did you continue to work immediately following the injury? □ YES □ No

Describe your routine job duties: _____

Do you feel you could perform your usual job right now? □ YES □ NO

If no, what job duties are you unable to perform? _____

Have you had to change the way you perform your job duties: □ YES □ NO

If yes, explain: _____

Have you experienced this problem, condition, or injury before? □ YES □ NO, When_____

**How often does your job require you to do the following:**

| Phone _____hrs/day | Sitting _____hrs/day | Standing _____hrs/day | Computer _____hrs/day | Driving _____hrs/day |
|---|---|---|---|---|
| Push / Pull | □ Never □ Once in a while □ Often □ Frequently □ Almost all the time | | | |
| Reach Overhead | □ Never □ Once in a while □ Often □ Frequently □ Almost all the time | | | |
| Grasping | □ Never □ Once in a while □ Often □ Frequently □ Almost all the time | | | |
| Twisting / Bending | □ Never □ Once in a while □ Often □ Frequently □ Almost all the time | | | |
| Squatting / Kneeling | □ Never □ Once in a while □ Often □ Frequently □ Almost all the time | | | |
| Walking | □ Never □ Once in a while □ Often □ Frequently □ Almost all the time | | | |
| Climbing / Ladders | □ Never □ Once in a while □ Often □ Frequently □ Almost all the time | | | |
| Lifting _____ Lbs | □ Never □ Once in a while □ Often □ Frequently □ Almost all the time | | | |

# TREATMENT FOLLOWING THE WORK INJURY

**Are you currently taking medications prescribed or over the counter for your injury? □ Yes □ No**

**If yes, describe**:_____

**Did you go to the Emergency Department (ER) or Urgent Care:** □ YES □ NO

Location: _____

Medications prescribed: _____

X-ray? □ Neck □ Mid Back □ Lower Back □ Chest □ Arm/Leg. _____

CT Scan or MRI? □ YES □ NO Describe_____

Lab Work? □ YES □ NO Describe_____

Referral? □ None □ Chiropractic Doctor □ Physical Therapist □ Massage □ Primary MD □ Specialist

**List any other healthcare providers, clinics, or therapists you have seen for this injury? □ None**

| Name of provider/clinic | Special Tests (x-ray, MRI, etc) | Start Date & Stop Date | Type of Treatment and Medications prescribed | Results |
|---|---|---|---|---|
| | | | | |
| | | | | |
| | | | | |
| | | | | |

# PERSONAL HABITS & MEDICAL HISTORY

Do you drink alcohol? □ Yes □ No If yes, daily average _____

Do you drink coffee or tea? □ Yes □ No If yes, daily average _____

Do you drink soda/energy drinks? □ Yes □ No If yes, daily average _____

Have you smoked or used tobacco? □ Yes □ No If yes, how many years? _____ daily average now _____

How many hours of sleep per night? _____ How many hours of exercise per week? _____

How many vegetable servings daily? _____ How much water do you drink per day? _____

Name of primary care doctor / Clinic _____City _____

Current health problems: □ None _____

Current medications not related to the work injury: □ None _____

What is your height? _____ What is your weight? _____ Are you pregnant? □ Yes □ No

Previous Auto Accident? □ No □ Yes, _____

Fracture/broken bone? □ No □ Yes, _____

Surgery or Joint Replacement? □ No □ Yes, _____

Work Injury? □ No □ Yes, _____

Sports / Other Injury? □ No □ Yes _____

In the last month, check if you have you had? □ unexpected weight loss □ viral / bacterial infection □ fever

□ difficulty with bowel movements □ difficulty with urination □ the "worst headache of your life"

□ **I have not had any of these things in the last month**

Do any family members (blood relatives) have these conditions? □ Diabetes □ Cancer □ Stroke

□ Heart Disease □ High BP □ Bleeding Disorder □ Neck/Low Back Pain □ Other, _____

If you have experienced any of the following conditions in the past mark a **"P"** in the box. If you are currently experiencing any of the following conditions please mark a **"C"**. (check all that apply)

| | | | | | | | |
|---|---|---|---|---|---|---|---|
| | Heart attack | | Prostate trouble | | Arthritis | | Gall bladder trouble |
| | Diabetes | | Glaucoma | | Fainting spells | | Kidney stones |
| | Difficulty with urination | | Bloody stools | | AIDS | | Asthma |
| | Stroke | | Anemia | | Constipation | | Menstrual cramping |
| | Cancer | | Ulcers | | Diverticulosis | | Shortness of breath |
| | Unexpected weight loss | | Loss of memory | | Chest pain | | Sudden weight loss |
| | Gout | | Diarrhea | | General fatigue | | Loss of hearing |
| | Nausea | | Muscle cramping | | Soreness in joints | | Epilepsy |
| | Ears ringing | | Headache | | Migraine | | Concussion |
| | Dizziness | | Tuberculosis | | Syphilis | | |
| | Other | | | | | | |

**PATIENT SIGNATURE:** _____ **DATE:** _____