

Today's Date: \_\_\_/\_\_\_/\_\_\_

## Welcome To Physicians Sports and Injury Center, LLC

Name \_\_\_\_\_  
Last First MI

### Nature of Complaint

\_\_\_\_\_  
\_\_\_\_\_

### Cause of Condition

What caused your symptoms?  Auto Accident  Work Accident  Other/Unknown: \_\_\_\_\_

### Personal Information

Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Home Phone (\_\_\_\_) \_\_\_\_\_ Cell Phone (\_\_\_\_) \_\_\_\_\_ Email: \_\_\_\_\_

Birth Date: \_\_\_/\_\_\_/\_\_\_ Social Security: \_\_\_\_\_-\_\_\_\_\_-\_\_\_\_\_ Age: \_\_\_\_\_

Gender:  Male  Female Race: \_\_\_\_\_ Ethnicity: \_\_\_\_\_

Marital Status:  Single  Married  Divorced  Widowed  Separated

Occupation: \_\_\_\_\_ May we call you at work?  Yes  No Work Phone (\_\_\_\_) \_\_\_\_\_

Emergency Contact: \_\_\_\_\_ Relationship to patient: \_\_\_\_\_

Phone number: Home: (\_\_\_\_) \_\_\_\_\_ Work: (\_\_\_\_) \_\_\_\_\_ Cell: (\_\_\_\_) \_\_\_\_\_

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### Financial Information

#### Cash (cash/check/credit card)

Check here if you will settle your payments privately rather than through a third party.

**Major Medical/Medicare** WE WILL NEED A COPY OF YOUR INSURANCE CARD.

**Auto Injury Insurance Medpay** WE WILL NEED A COPY OF THE POLICE REPORT.

This information should reflect your personal Medpay policy

Were you the:  Driver  Passenger  Other \_\_\_\_\_

Owner of the vehicle: \_\_\_\_\_

Relationship to patient:  Self  Spouse  Child  Other \_\_\_\_\_

Insured's Address \_\_\_\_\_ Insured's SSN \_\_\_\_\_-\_\_\_\_\_-\_\_\_\_\_

Name of Insurance Carrier \_\_\_\_\_ ID \_\_\_\_\_ Claim \_\_\_\_\_ Phone \_\_\_\_\_

Is an attorney representing you?  Yes  No Attorney's name \_\_\_\_\_ Law Firm \_\_\_\_\_

Phone \_\_\_\_\_ Fax \_\_\_\_\_ Address \_\_\_\_\_

# ***FINANCIAL AGREEMENT***

We would like to take a moment to welcome you to our office and assure you that you will receive the very best of care available for your condition. In order to familiarize you with the financial policy of this office we would like to explain how your medical bills will be handled.

## **Explanation of Insurance Coverage**

Many insurance policies do cover chiropractic care but this office makes no representation that yours does. Insurance policies may vary greatly in terms of deductible and percentage of coverage for chiropractic care. Because of the variance from one insurance policy to another, we require that you, the patient, be personally responsible for the payment of your deductibles, as well as any unpaid balances in this office. We will do our best to verify your insurance coverage, and will bill your insurance in a timely manner as a courtesy to you.

## **Assignment of Benefits**

Attached is an "Assignment of Benefits" form which we would like you to sign. This form directs your insurance company to send payments directly to this office. If your insurance carrier sends payment to you for services incurred in this office, you agree to send or bring those payments to this office upon receipt. If you pay for your visits in full the assignment need not be signed and the payments will be sent directly to you from the insurance.

## **Release of Information**

If your insurance company requires medical reports or records to document your treatment or progress, your signature below authorizes this office to release the medical information necessary to process your claim.

## **Voluntary Termination of Care**

If you suspend or terminate your care at any time, your portion of all charges for professional services is immediately due and payable to this office. All services rendered by this office are charged directly to you, and you, ultimately will be personally responsible for payment regardless of your insurance coverage.

We hope this answers any questions you might have concerning the financial policy of this office. Once again we welcome your to our office, and will be glad to answer any further questions that you might have.

## **Authorization to Communicate**

I give PSIC permission to communicate with me (including emails). I understand I am not required to sign this agreement to receive treatment. I can choose to opt-out of this agreement at any time.

**I have read and agree to the above.**

\_\_\_\_\_  
**Signature**

\_\_\_\_\_  
**Date**

## **Authorization to Treat a Minor**

I hereby request and authorize Physicians Sports and Injury Center, LLC physicians to perform diagnostic tests and render chiropractic adjustments and other treatment to MY MINOR SON/DAUGHTER<sup>1</sup>. This authorization also extends to all other providers and office staff members.

\_\_\_\_\_  
**Signature of Parent/Guardian**

\_\_\_\_\_  
**DATE OF BIRTH**

As of the date, I have the legal right to select and authorize health care services for the minor child named above.

(If applicable) Under the terms and conditions of my divorce, separation or other legal authorization, the consent of a spouse / former spouse or other parent is not required. If my authority to so select and authorize this care should be revoked or modified in any way, I will immediately notify this office.

## *Office Financial Policy*

It is our policy that following a preliminary exam, any services which are rendered by this office on the initial visit shall be paid for at that time, unless other arrangements have been made in writing. Our office is pleased to accept your insurance assignment, as soon as your exact coverage is verified by the responsible party. However, it must be fully understood that the contract is between you and your insurance company, and you are fully responsible for any and all amounts not paid by your insurance.

Our office policy is as follows:

1. Since by taking your insurance assignment, we have to await payment, this courtesy may be withdrawn if warranted.
2. Insurance payments should be made every 30 days. The maximum time limit we extend is 60 days, then fees must be paid in full by the patient.
3. You are required to sign the "Authorization to Pay Physician" section of Welcome to Our Clinic form and any other documents required by your insurance company.
4. Our office WILL NOT guarantee that your insurance company will pay. At the beginning of your healthcare, we will make every attempt to receive verification of your policy coverage. However, if for any reason your claim is denied, you are responsible for the total amount due this office.
5. This office will not enter into a dispute with your insurance company over your claim. This includes Workmen's Comp and Personal Injury cases. This is your responsibility and obligation. We will, however, assist you in any way that we can.
6. You the patient must keep current with your insurance co-payment.
7. We reserve the right to charge a 50% finance charge to all accounts over 90 days old that require additional collection attention.
8. In the event you do not meet your financial obligation for services provided in this office, we will have no choice but to send your account to collections. We will make every attempt to work with you in the event of financial hardship. However if collections become necessary then you agree to be responsible for any and all fees required by our office to collect payment.
9. If the insurance company sends you payment for our services, it is your responsibility and obligation to bring to us payment in full.
10. A Cancellation Fee of \$35 may be assessed if you do not provide us with 24 hours notice of your cancellation.

I have fully read, and agree to this financial policy as written:

Signed: \_\_\_\_\_

Date: \_\_\_\_\_

Witness: \_\_\_\_\_

**PATIENT CONSENT  
FOR USE AND/OR DISCLOSURE OF  
PROTECTED HEALTH INFORMATION  
TO CARRY OUT TREATMENT, PAYMENT  
AND HEALTHCARE OPERATIONS**

\_\_\_\_\_, hereby states that by signing this Consent, I acknowledge and agree as follows:

1. The Practice’s Privacy Notice has been provided to me prior to my signing this Consent. The Privacy Notice includes a complete description of the uses and/or disclosures of my protected health information (“PHI”) necessary for the Practice to provide treatment to me, and also necessary for the Practice to obtain payment for that treatment and to carry out its health care operations. The Practice explained to me that the Privacy Notice will be available to me in the future at my request. The Practice has further explained my right to obtain a copy of the Privacy Notice prior to signing this Consent, and has encouraged me to read the Privacy Notice carefully prior to my signing this Consent.
2. The Practice reserves the right to change its privacy practices that are described in its Privacy Notice, in accordance with applicable law.
3. I understand that, and consent to, the following appointment reminders that will be used by the Practice: a) a postcard mailed to me at the address provided by me; and b) telephoning my home and leaving a message on my answering machine or with the individual answering the phone.
4. The Practice may use and/or disclose my PHI (which includes information about my health or condition and the treatment provided to me) in order for the Practice to treat me and obtain payment for that treatment, and as necessary for the Practice to conduct its specific health care operations.
5. I understand that I have a right to request that the Practice restrict how my PHI is used and/or disclosed to carry out treatment, payment and/or health care operations. However, the Practice is not required to agree to any restrictions that I have requested. If the Practice agrees to a requested restriction, then the restriction is binding on the Practice.
6. I understand that this Consent is valid for seven years. I further understand that I have the right to revoke this Consent, in writing, at any time for all *future* transactions, with the understanding that any such revocation shall not apply to the extent that the Practice has already taken action in reliance on this consent.
7. I understand that if I revoke this consent at any time, the Practice has the right to refuse to treat me.
8. I understand that if I do not sign this Consent evidencing my consent to the uses and disclosures described to me above and contained in the Privacy Notice, then the Practice will not treat me.

**I have read and understand the foregoing notice, and all of my questions have been answered to my full satisfaction in a way that I can understand.**

\_\_\_\_\_  
Name of Individual (Printed)

\_\_\_\_\_  
Signature of Individual

\_\_\_\_\_  
Signature of Legal Representative

\_\_\_\_\_  
Relationship  
(e.g., Attorney-In-Fact, Guardian, Parent if a  
minor):

Date Signed \_\_\_\_/\_\_\_\_/\_\_\_\_

Witness: \_\_\_\_\_

**PRACTICE'S REQUIREMENTS**

1. The Practice:

- (a) Is required by federal law to maintain the privacy of your PHI and to provide you with this Privacy Notice detailing the Practice's legal duties and privacy practices with respect to your PHI.
- (b) Is required by State law to maintain a higher level of confidentiality with respect to certain portions of your medical information that is provided for under federal law. In particular, the Practice is required to comply with the following State statutes: 'Not applicable at this time'
- (c) Is required to abide by the terms of this Privacy Notice.
- (d) Reserves the right to change the terms of this Privacy Notice and to make the new Privacy Notice provisions effective for all of your PHI that it maintains.
- (e) Will distribute any revised Privacy Notice to you prior to implementation.
- (f) Will not retaliate against you for filing a complaint.

**EFFECTIVE DATE**

This Notice is in effect as of January 1, 2009.

\_\_\_\_\_  
Name of Individual (Printed)

\_\_\_\_\_  
Signature of Individual

\_\_\_\_\_  
Signature of Legal Representative

\_\_\_\_\_  
Relationship  
(e.g., Attorney-In-Fact, Guardian, Parent if a minor)

Date Signed \_\_\_\_/\_\_\_\_/\_\_\_\_

Witness:\_\_\_\_\_

# QUADRUPLE VISUAL ANALOGUE SCALE

Please list your **PRIMARY** symptom (i.e. neck pain) \_\_\_\_\_

**Instructions:** Please circle the number that best describes the question being asked for the primary symptom listed above

**1. What is your pain RIGHT NOW?**

No Pain \_\_\_\_\_ worst possible pain  
0 1 2 3 4 5 6 7 8 9 10

**2. What is your TYPICAL or AVERAGE pain?**

No Pain \_\_\_\_\_ worst possible pain  
0 1 2 3 4 5 6 7 8 9 10

**3. What is your pain level AT ITS BEST (how close to "0" does your pain get at its best)?**

No Pain \_\_\_\_\_ worst possible pain  
0 1 2 3 4 5 6 7 8 9 10

**4. What is your pain level AT ITS WORST (how close to "10" does your pain get at its worst)?**

No Pain \_\_\_\_\_ worst possible pain  
0 1 2 3 4 5 6 7 8 9 10

DOCTOR SIGNATURE: \_\_\_\_\_

PATIENT SIGNATURE: \_\_\_\_\_

# CONFIDENTIAL PATIENT HEALTH RECORD

Name: \_\_\_\_\_ Date: \_\_\_\_/\_\_\_\_/\_\_\_\_

Current Age: \_\_\_\_\_ Gender:  Male  Female

## HEALTH HISTORY

Please describe the reason for your visit:

How long have you had this problem? \_\_\_\_\_

Have you ever had this problem before?  Yes  No If Yes, how many times? \_\_\_\_\_

What do you think caused this problem?

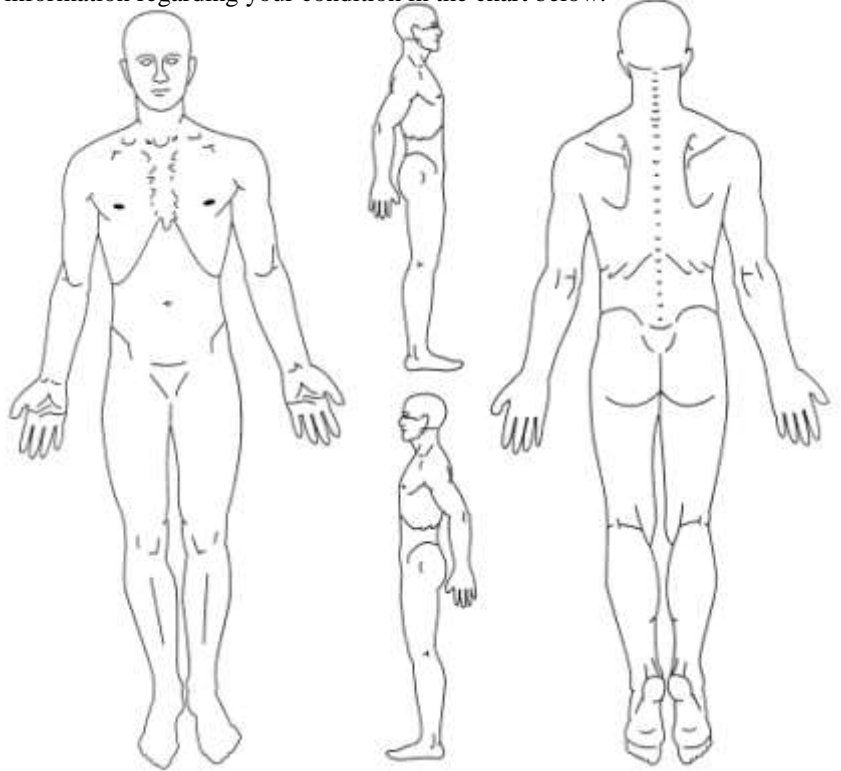
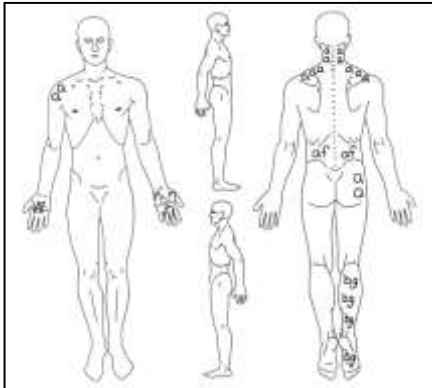
## PAIN DIAGRAM

Report here the symptoms you feel at the present time. Mark the body area(s) with the type of symptoms, using the symbols in the key below. Then please fill in the additional information regarding your condition in the chart below.

### SYMPTOM SYMBOLS

- Aching = a
- Burning = b
- Numbness = n
- Sharp = s
- Stiffness = f
- Tingling = g
- Weakness = w

### Example



	Side: Left Side (L) Right Side (R) or Both (B)	Pain Type: Aching (a), Burning (b) Numbness (n), Sharp (s) Stiff (f), Tingling (g) Weakness (w)	Pain Rating: Choose 0 (no pain) to 10 (intolerable pain)	Pain Frequency: Constantly (C) (76-100% of the time) Frequently (F) (51-75% of the time) Occasionally (O) (26-50% of the time) Intermittently (I) (1-25% of the time)	What aggravates the pain? Lifting, walking, etc. Include time of day as appropriate: Morning, Mid-day, Evening, At night while sleeping	What relieves the pain? Lying down, heat, ice, etc. Include time of day as appropriate: Morning, Mid-day, Evening, At night while sleeping
<b>REGION</b>						
<i>Low Back</i>	<i>L</i>	<i>a, b</i>	<i>8</i>	<i>C</i>	<i>Bending forward, cough</i>	<i>Lying down, Ibuprofen</i>

DOCTOR SIGNATURE: \_\_\_\_\_

PATIENT SIGNATURE: \_\_\_\_\_

## SECONDARY COMPLAINT

Please describe the secondary complaint:

How long have you had this problem? \_\_\_\_\_

Have you ever had this problem before?  Yes  No If Yes, how many times? \_\_\_\_\_

What do you think caused this problem?

## THIRD COMPLAINT

Please describe the third complaint:

How long have you had this problem? \_\_\_\_\_

Have you ever had this problem before?  Yes  No If Yes, how many times? \_\_\_\_\_

What do you think caused this problem?

## FOURTH COMPLAINT

Please describe the fourth complaint:

How long have you had this problem? \_\_\_\_\_

Have you ever had this problem before?  Yes  No If Yes, how many times? \_\_\_\_\_

What do you think caused this problem?

DOCTOR SIGNATURE: \_\_\_\_\_

PATIENT SIGNATURE: \_\_\_\_\_

# PERSONAL HEALTH HISTORY

PLACE A "C" NEXT TO ALL SYMPTOMS/PROBLEMS YOU HAVE CURRENTLY  
AND PLACE A "P" NEXT TO ALL SYMPTOMS/PROBLEMS YOU HAVE HAD IN A PAST

I have not had, nor do I presently have, any of the following symptoms.

- |  |  |   |   |  |
|--|--|---|---|--|
| <input type="checkbox"/> Burning, tingling, or numbness into the shoulders, arms, or hands (upper extremities)<br><input type="checkbox"/> Burning, tingling, or numbness into the hips, legs, or feet (lower extremities)<br><input type="checkbox"/> Recent loss or blurring of vision<br><input type="checkbox"/> Cancer:<br>Type(s): _____<br>Date diagnosed: ___/___/___<br><input type="checkbox"/> Diabetes:<br>___ Type I<br>___ Type II (adult onset)   | <input type="checkbox"/> Condition aggravated by coughing, sneezing, or grunting<br><input type="checkbox"/> Loss of sexual function<br><input type="checkbox"/> Recent onset of:<br>___ Urinary retention<br>___ Increased urinary frequency<br>___ Inability to control bladder<br><input type="checkbox"/> Constant pain unrelated to movement<br><input type="checkbox"/> Night pain unrelated to movement<br><input type="checkbox"/> Unexplained weight loss greater than 10 lbs.<br><input type="checkbox"/> History of malaise/generalized weakness<br><input type="checkbox"/> History of fever or chills | <input type="checkbox"/> Osteoporosis<br><input type="checkbox"/> Bacterial infection<br>Date it began: ___/___/___<br><input type="checkbox"/> Abdominal pain<br><input type="checkbox"/> Blood in urine<br><input type="checkbox"/> Rectal bleeding<br><input type="checkbox"/> Hemorrhoids<br><input type="checkbox"/> Urethral discharge<br><input type="checkbox"/> Prolonged steroid use<br><input type="checkbox"/> IV drug abuse  |   |  |
| <input type="checkbox"/> Abdominal pain<br><input type="checkbox"/> Allergies<br>Type: _____<br>_____<br>_____<br><input type="checkbox"/> Angina<br><input type="checkbox"/> Back pain<br><input type="checkbox"/> Blurred vision<br><input type="checkbox"/> Chemical dependency<br><input type="checkbox"/> Chest pain<br><input type="checkbox"/> Chronic back problems<br><input type="checkbox"/> Cold feet  | <input type="checkbox"/> Cold sweats<br><input type="checkbox"/> Constipation<br><input type="checkbox"/> Depression<br><input type="checkbox"/> Dermatitis<br><input type="checkbox"/> Digestive problems<br><input type="checkbox"/> Dizziness<br><input type="checkbox"/> Fainting<br><input type="checkbox"/> Fatigue<br><input type="checkbox"/> Hair loss<br><input type="checkbox"/> Headaches<br><input type="checkbox"/> Heart attacks<br><input type="checkbox"/> Hormone replacement<br><input type="checkbox"/> Jaw problems   | <input type="checkbox"/> Joint swelling<br><input type="checkbox"/> Kidney stones<br><input type="checkbox"/> Loss of smell<br><input type="checkbox"/> Loss of memory<br><input type="checkbox"/> Loss of taste<br><input type="checkbox"/> Menstrual cramps<br><input type="checkbox"/> Migraines<br><input type="checkbox"/> Miscarriage<br><input type="checkbox"/> Muscular incoordination<br><input type="checkbox"/> Nausea<br><input type="checkbox"/> Nervousness<br><input type="checkbox"/> Painful urination<br><input type="checkbox"/> Pinched nerve  |   |  |
| <input type="checkbox"/> Alcoholism<br><input type="checkbox"/> Anemia<br><input type="checkbox"/> Anorexia<br><input type="checkbox"/> Appendicitis<br><input type="checkbox"/> Arteriosclerosis<br><input type="checkbox"/> Arthritis<br><input type="checkbox"/> Asthma<br><input type="checkbox"/> Bleeding disorders<br><input type="checkbox"/> Blindness<br><input type="checkbox"/> Bulimia<br><input type="checkbox"/> Cancer<br><input type="checkbox"/> Cataracts<br><input type="checkbox"/> Chicken Pox | <input type="checkbox"/> Chronic lung disease<br>___ Bronchitis<br>___ Emphysema<br><input type="checkbox"/> Congestive heart failure<br><input type="checkbox"/> Connective tissue disease<br>Type: _____<br>Date diagnosed: ___/___/___<br><input type="checkbox"/> Deafness or reduced hearing<br><input type="checkbox"/> Drug/alcohol dependency<br><input type="checkbox"/> Epilepsy<br><input type="checkbox"/> Fibromyalgia<br><input type="checkbox"/> Fractures<br><input type="checkbox"/> Gall Bladder Problems<br><input type="checkbox"/> Glaucoma<br><input type="checkbox"/> Goiter                | <input type="checkbox"/> Gout<br><input type="checkbox"/> Heart Disease<br><input type="checkbox"/> Hepatitis<br><input type="checkbox"/> Hernia<br><input type="checkbox"/> Herniated disc<br><input type="checkbox"/> Herpes<br><input type="checkbox"/> High Blood Pressure<br><input type="checkbox"/> High Cholesterol<br><input type="checkbox"/> HIV/AIDS<br><input type="checkbox"/> Hypertension<br><input type="checkbox"/> Kidney Disease<br><input type="checkbox"/> Liver Disease<br><input type="checkbox"/> Low Blood Pressure<br><input type="checkbox"/> Low Blood Sugar<br><input type="checkbox"/> Measles | <input type="checkbox"/> Menopause<br><input type="checkbox"/> Mononucleosis<br><input type="checkbox"/> Multiple Sclerosis<br><input type="checkbox"/> Mumps<br><input type="checkbox"/> Pacemaker<br><input type="checkbox"/> Parkinson's Disease<br><input type="checkbox"/> Pneumonia<br><input type="checkbox"/> Polio<br><input type="checkbox"/> Pregnancy<br><input type="checkbox"/> Prostate Disease<br><input type="checkbox"/> Prosthesis<br><input type="checkbox"/> Psychiatric Care<br><input type="checkbox"/> Psoriasis<br><input type="checkbox"/> Rheumatic fever<br><input type="checkbox"/> Rheumatoid arthritis | <input type="checkbox"/> Scarlet fever<br><input type="checkbox"/> Sciatica<br><input type="checkbox"/> Scoliosis<br><input type="checkbox"/> Sinus problems<br><input type="checkbox"/> SLE (Lupus)<br><input type="checkbox"/> Spinal Disc Disorder<br><input type="checkbox"/> STDs (venereal, etc.)<br><input type="checkbox"/> Stroke<br><input type="checkbox"/> Tendonitis<br><input type="checkbox"/> Thyroid Disorder<br><input type="checkbox"/> Tumor(s)<br><input type="checkbox"/> Visual disturbances<br><input type="checkbox"/> Whooping cough |

**Please tell us about any major injuries, hospitalizations, serious illnesses or surgeries:**

Year	Reason	Hospital	Outcome

List your prescribed medications, over-the-counter medications, herbs, vitamins and inhalers:

Product	Reason	Dosage (Example: 500mg)	Frequency (Example: 2x/day)	Is it helping?

DOCTOR SIGNATURE: \_\_\_\_\_

PATIENT SIGNATURE: \_\_\_\_\_

Please provide details of any known allergies. (eg., latex, medications, foods)

Allergy	Reaction

## HEALTH HABITS

**EXERCISE:** How often do you exercise?  Never  Rarely  Occasionally  Moderately  Regularly

Type of exercise: \_\_\_\_\_

If you exercise, what is the intensity?  Light  Moderate  Strenuous

**INTERESTS/HOBBIES:** What interests, hobbies, or activities do you enjoy? \_\_\_\_\_

**HABITS:** Do you drink alcohol?  Never  Once a week  Several times a week  Once daily  Several times per day

Tobacco Use:

Cigarettes:  Never  Used in the past  Less than 1/2 pack/day  1/2 pack/day  1 pack/day  2 packs/day  More than 2 packs/day

Chewing tobacco:  Never  Used in the past  Occasionally  Often

Cigars:  Never  Used in the past  Occasionally  Often

For how many years have you used tobacco products? \_\_\_\_\_

If you have quit smoking, when did you quit? \_\_\_\_\_ months ago / years ago (please circle one)

**DIET/NUTRITION:** Are you dieting currently?  Yes  No Is this a physician prescribed medical diet?  Yes  No

How many meals do you eat on average every day? \_\_\_\_\_

Do you drink water daily?  0-2 glasses  2-4 glasses  4-6 glasses  6-8 glasses  8-10 glasses

Do you drink beverages containing caffeine?  Never  Once a week  Several times/week  Once daily  Several times per day

Do you eat refined sugar?  Never  Once a week  Several times per week  Once daily  Several times per day

Do you consume dairy products?  Never  Once a week  Several times per week  Once daily  Several times per day

Do you eat wheat products?  Never  Once a week  Several times per week  Once daily  Several times per day

### SLEEP PATTERNS:

Does your complaint disrupt your sleep?  Yes  No

How do you rate your quality of sleep?: \_\_\_\_\_ Perfect 1 2 3 4 5 6 7 8 9 10 Terrible

What position do you sleep in? \_\_\_\_\_

Do you sleep with a pillow?  Yes  No If Yes, how many? \_\_\_\_\_

**STRESS FACTORS:** Please rate your stress management strategies: \_\_\_\_\_ Perfect 1 2 3 4 5 6 7 8 9 10 Terrible

Please rate your daily stress level : \_\_\_\_\_ None 1 2 3 4 5 6 7 8 9 10 Terrible

**PREGANANCY/CHILDREN:** # of Pregnancies \_\_\_\_\_ # Birth Children \_\_\_\_\_

DOCTOR SIGNATURE: \_\_\_\_\_

PATIENT SIGNATURE: \_\_\_\_\_

Please check the boxes below to indicate how this condition has affected the following aspects of your life:

	Severely	Moderately	Mildly	Not at all
Quality of work				
Ability to do household chores				
Social life				
Family life				
Recreational activities				
Quality of sleep				

Has this condition affected your life in any other way?  Yes  No If Yes, how: \_\_\_\_\_

## FAMILY HEALTH HISTORY

Please help us to identify your potential health risks by placing a check in any column that applies to you or your blood relatives.

Condition / Body System	Self	Grandparent	Parent	Sibling	Child	None
Aids / HIV						
Arthritis						
Bleeding disorders						
Cancer						
Endocrine / glandular (diabetes, thyroid)						
Hepatitis						
Immune						
Stroke / TIA						
Circulatory Problems (blood vessels, heart)						
Ear, Nose, Throat						
Heart Problems						
High blood pressure						
Neurological (brain, nerves)						
Gastrointestinal (stomach, intestines)						
Muscle / Joint / Bone						
Genitourinary (urinary, kidney, prostate)						
Psychological						
Respiratory (lung, breathing)						
Skin						

## WORK STATUS

Has this condition caused you to miss work?  Yes  No (IF "NO" PLEASE SKIP THIS SECTION)

Date you were first off work \_\_\_/\_\_\_/\_\_\_ Returned to work?  Yes  Limited hours only  No Date of return: \_\_\_\_\_

(Ex: MD, chiropractor, neurologist)

Returned to work with recommendation from \_\_\_\_\_.  Returned without recommendation

Can you perform your usual work duties?  Yes  No Is alternative work available to you?  Yes  No

Has a physician placed you on work restriction/disability? (IF NO, PLEASE SKIP THIS SECTION)

Yes, TOTAL restriction/disability  Yes, PARTIAL restriction

By whom? (List doctor's name and specialty) \_\_\_\_\_

Please list your work restrictions \_\_\_\_\_

Return to regular work duties: Exact Date: \_\_\_/\_\_\_/\_\_\_ Approx. Date: \_\_\_/\_\_\_/\_\_\_

Date for return to regular work is unknown.

DOCTOR SIGNATURE: \_\_\_\_\_

PATIENT SIGNATURE: \_\_\_\_\_