Kent-East Chiropractic Clinic
10830 SE Kent-Kangley Rd, Ste 101, Kent, WA 98030 253.854.3040

# LABOR AND INDUSTRY HISTORY FORM

Please Print Date: _____

Name: (L)_____(F)_____(M)_____

Address_____ Apt # _____

City_____ State_____ Zip Code_____

Home / Cell:_____ Cell / Work:_____

Birth Date:_____Sex: M [ ] F [ ] Social Security #:_____

Email Address:_____

Current Employer:_____ Occupation:_____

Claim #:_____Claims Manager:_____

## DESCRIPTION OF THE ACCIDENT

Employer at the time of accident:_____ Employer Phone:_____

Employer Address:_____

What is the name of your company's insurance carrier?:_____

Date of injury:_____Place injury occurred:_____

Name of employer at the time of accident:_____

Employers address:_____

Occupation at time of accident:_____How long prior to accident:_____

Type of work being done at time of injury:_____

In your own words please describe the accident:_____

_____

Was your employer notified? Yes [ ] No [ ] If yes, when?_____

Was an injury report filed? Yes [ ] No [ ] _____

## CURRENT AREAS OF COMPLAINT (WHAT HURTS)

_____

_____

_____

Did you have any physical complaints before the accident? Yes [ ] No [ ], I was healthy

If yes, please describe:_____

_____

MEDICAL TREATMENT RESULTING FROM THE ACCIDENT

Did you receive emergency care at the accident site? Yes [ ] No [ ]

Did you go to the hospital? Yes [ ] No [ ] If yes, when?_____

Name of hospital:_____

How did you get to the hospital?_____

What did the hospital do for your injuries?_____

Were you scheduled for follow up care?_____

What bleeding cuts did you sustain during the accident?_____

What bruised did you sustain during the accident?_____

Have you been examined or treated by a doctor since the accident? If yes, who/when/where?

_____

_____

_____

What medications are you currently taking?_____

Do these medications help? Yes [ ] No [ ] Unsure [ ]

TIME LOSS / ACTIVITY RESTRICTIONS

Have you lost any time from work as a result of the accident? Yes [ ] No [ ]

If yes, last day worked?_____ Have you been released for work? Yes [ ] No [ ]

If yes, were you released with restrictions? Describe:_____

_____

Are you still on restricted work release? Yes [ ] No [ ]

Disability? None [ ] Temporary disability _____ days or Total disability_____

days

Are you currently being compensated for time lost from work? Yes [ ] No [ ]

If yes, what type of compensation are you receiving? _____

_____

Do you notice any activity restrictions as a result of the accident? Yes [ ] No [ ]

If yes, please describe in detail: _____

_____

PAST MEDICAL HISTORY

Hospitalization: None [ ] Yes: _____

_____

Surgery/Operations: None [ ] Yes: _____

_____

Serious Illness: None [ ] Yes: _____

_____

Allergies: None [ ] Yes: _____

_____

Fractures: None [ ] Yes: _____

_____

Work related injury: None [ ] Yes: _____

_____

Automobile Accidents: None [ ] Yes: _____

_____

Sports related injuries: None [ ] Yes: _____

_____

Prior Treatment by a Chiropractor: None [ ] Yes: _____

_____

Prior History of Current Complaints: None [ ] Yes: _____

_____

Please check any of the following diagnosed conditions (conditions your doctor treated you for or told you that you had) that you had in the past or currently have. If you were diagnosed with a condition that does not appear in the following list please indicate under OTHER.

Stroke [ ] Multiple Sclerosis [ ] Epilepsy [ ] Low Blood Pressure [ ] Arthritis [ ]

Heart Disease [ ] Hernia [ ] High Blood Pressure [ ] Asthma [ ] Diabetes [ ]

Gout [ ] Hypothyroid [ ] Cancer [ ] Tuberculosis [ ] Polio [ ] Hyperthyroid [ ]

Other: _____

_____

## PERSONAL AND SOCIAL HISTORY

Marital Status: M [ ] W [ ] D [ ] S [ ] Spouse's Name_____

Children: None [ ] How many?_____

Do you currently smoke? Yes [ ] No [ ]

If yes, how much?_____How long?_____

If no, have you ever smoked? Yes [ ] No [ ]

How much?_____When did you quit?_____

Military service? Yes [ ] No [ ]

If yes, did you sustain any injuries in the performance of your duties? Yes [ ] No [ ]

Please list injuries sustained in performance of your duties:_____

_____

_____

## FAMILY MEDICAL HISTORY

| | Arthritis | Cancer | Strokes | Diabetes | Epilepsy | Heart Disease | Multiple Sclerosis | High Blood Pressure | Other: |
|---|---|---|---|---|---|---|---|---|---|
| Mother | | | | | | | | | |
| Father | | | | | | | | | |
| Sister | | | | | | | | | |
| Brother | | | | | | | | | |

All first visit charges are payable in full when the services are rendered.

The fee paid for the x-rays is for analysis only. The film itself remains property of this office.

I understand and agree that health and accident insurance policies are an agreement between the insurance company and me. Furthermore, I understand Kent-East Chiropractic will prepare any necessary reports and/or forms to assist me in making collections from the insurance company and that any amount authorized to be paid directly to Kent-East Chiropractic will be credited to my account upon receipt. However, I clearly understand and agree that I am personally responsible for payment. Also, if applicable, I authorize Kent-East Chiropractic to provide any care that is medically necessary to my dependent (listed above as patient).

Patient's Signature_____ Date_____

Guardian's Signature_____ Date_____

In case of emergency, please notify (nearest relative not living with you):_____

Relationship_____ Phone number & Address_____

_____

PLEASE CONTINUE ON TO NEXT PAGE AND COMPLETE THE

JOB ASSESMENT QUESTIONNAIRE PRIOR TO INJURY

THANK YOU

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FOR OFFICE USE ONLY:

Prior patient account number:_____

Account numbers for others involved in case:_____

Adjuster contacted: Yes [ ] No [ ] Claim allowed: Yes [ ] No [ ] $MAX:_____

Attorney contacted: Yes [ ] No [ ]

*Patient briefed on office and billing procedures regarding case: Yes [ ] No [ ] Initials:*_____

Special Instructions or Limitations:_____

_____

_____

_____

Completed By: _____ Date: _____

# JOB ASSESSMENT QUESTIONNAIRE PRIOR TO INJURY

Name:_____ Claim#:_____ Social Security #:_____

Note: In terms of a 8 hour workday, Occasionally = 1% to 33% (0 – 2.6 hours); Frequently = 34% to 66% (2.7 – 5.3 hours); Continuously = 65% to 100% (5.4 - 8 hours).

1. During an 8 hour day, I could do: (Circle full capacity for each activity)

| | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|
| A. Sit | 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | (hours) |
| B. Stand | 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | (hours) |
| C. Walk | 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | (hours) |

Total At One Time

| | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|
| A. Sit | 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | (hours) |
| B. Stand | 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | (hours) |
| C. Walk | 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | (hours) |

| | Never | Occasionally | Frequently | Continuously |
|---|---|---|---|---|
| 2. I was able to: | | | | |
| A. Bend/Stoop | [ ] | [ ] | [ ] | [ ] |
| B. Squat, Crouch | [ ] | [ ] | [ ] | [ ] |
| C. Crawl | [ ] | [ ] | [ ] | [ ] |
| D. Climb | [ ] | [ ] | [ ] | [ ] |
| E. Kneel | [ ] | [ ] | [ ] | [ ] |
| F. Balance | [ ] | [ ] | [ ] | [ ] |
| G. Push/Pull | [ ] | [ ] | [ ] | [ ] |
| 3. I could carry: | | | | |
| A. Up to 10 lbs. | [ ] | [ ] | [ ] | [ ] |
| B. 11 to 20 lbs. | [ ] | [ ] | [ ] | [ ] |
| C. 21 to 34 lbs. | [ ] | [ ] | [ ] | [ ] |
| D. 35 to 50 lbs. | [ ] | [ ] | [ ] | [ ] |
| E. 51 to 74 lbs. | [ ] | [ ] | [ ] | [ ] |
| F. 75lbs. to 100 lbs. | [ ] | [ ] | [ ] | [ ] |
| 4. I could lift: | | | | |
| A. Up to 10 lbs. | [ ] | [ ] | [ ] | [ ] |
| B. 11 to 20 lbs. | [ ] | [ ] | [ ] | [ ] |
| C. 21 to 34 lbs. | [ ] | [ ] | [ ] | [ ] |
| D. 35 to 50 lbs. | [ ] | [ ] | [ ] | [ ] |

E. 51 to 74 lbs. [ ] [ ] [ ] [ ]

F. 75lbs. to 100 lbs. [ ] [ ] [ ] [ ]

5. I could use feet for repetitive movements as in operating foot controls:

Right: Yes [ ] No [ ] Left: Yes [ ] No [ ] Both: Yes [ ] No [ ]

6. I had restriction of activities involving: YES NO

A. Unprotected heights [ ] [ ]

B. Being around moving machinery [ ] [ ]

C. Exposure to marked changes in temp. [ ] [ ]

D. Driving automotive equipment [ ] [ ]

E. Exposure to dust, fumes, gases [ ] [ ]

Never Occasionally Frequently Continuously

7. I could:

A. Use right are for repetitive reaching to the:

1) Front [ ] [ ] [ ] [ ]

2) Sides [ ] [ ] [ ] [ ]

3) Above shoulder[ ] [ ] [ ] [ ]

B. Use right arm for any reaching to the:

1) Front [ ] [ ] [ ] [ ]

2) Sides [ ] [ ] [ ] [ ]

3) Above shoulder [ ] [ ] [ ] [ ]

C. Use left arm for repetitive reaching to the:

1) Front [ ] [ ] [ ] [ ]

2) Sides [ ] [ ] [ ] [ ]

3) Above shoulder [ ] [ ] [ ] [ ]

D. Use left arm for any reaching to the:

1) Front [ ] [ ] [ ] [ ]

2) Sides [ ] [ ] [ ] [ ]

3) Above shoulder [ ] [ ] [ ] [ ]

E. Use right wrist for repetitive twisting activities:

[ ] [ ] [ ] [ ]

F. Use right arm of any twisting activities:

[ ] [ ] [ ] [ ]

G. Use left wrist for repetitive twisting activities:

[ ] [ ] [ ] [ ]

H. Use left arm of any twisting activities:

[ ] [ ] [ ] [ ]

I. Use fingers for fine finger activities to include:

[ ] [ ] [ ] [ ]

J. Use right hand for any repetitive grasping:

[ ] [ ] [ ] [ ]

K. Use left hand for any repetitive grasping:

[ ] [ ] [ ] [ ]

# FUNCTIONAL RATING INDEX

**In order to properly assess your condition, we must understand how much your neck and/or back problems have affected your ability to manage everyday activities. For each item below, please circle the number which most closely describes your condition right now.**

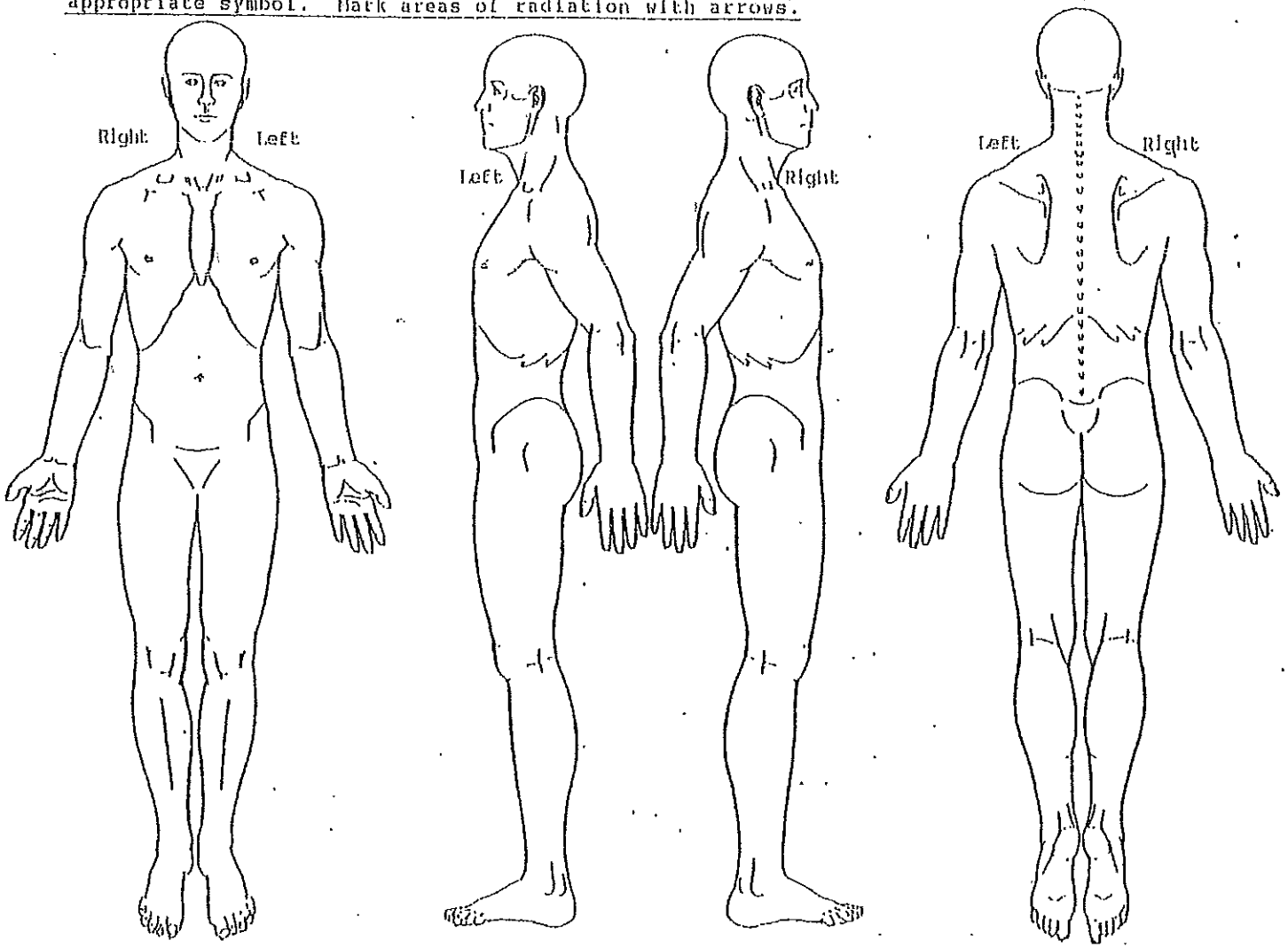
| | | | | | | |
|---|---|---|---|---|---|---|
| 1. | Pain Intensity: | 0<br>None | 1<br>Mild | 2<br>Moderate | 3<br>Severe | 4<br>Worst possible pain |
| 2. | Frequency of Pain: | 0<br>None | 1<br>Occasional 25% of the day | 2<br>Intermittent 50% of the day | 3<br>Frequent 75% of the day | 4<br>Constant 100% of the day |
| 3. | Sleeping: | 0<br>Perfect Sleep | 1<br>Mildly Disturbed Sleep | 2<br>Moderate Disturbed Sleep | 3<br>Greatly Disturbed Sleep | 4<br>Totally Disturbed Sleep |
| 4. | Personal Care: (Washing, Dressing, etc) | 0<br>No Pain No restrictions | 1<br>Mild Pain No restrictions | 2<br>Moderate Pain, need to go slow | 3<br>Need some assistance | 4<br>Severe need 100% assistance |
| 5. | Travel, Driving or riding: | 0<br>No Pain on Long Trips | 1<br>Mild Pain on Long Trips | 2<br>Moderate Pain on Long Trips | 3<br>Moderate Pain on Short Trips | 4<br>Severe Pain on Short Trips |
| 6. | Work: | 0<br>Can do usual work plus extra work | 1<br>Can do usual work, no extra work | 2<br>Can do 50% of usual work | 3<br>Can do 25% of usual work | 4<br>Cannot Work |
| 7. | Recreation: | 0<br>Can do all activities | 1<br>Can do most activities | 2<br>Can do some activities | 3<br>a few activities activities | 4<br>Cannot do any activities |
| 8. | Lifting: | 0<br>No Pain with heavy weight | 1<br>Increased pain w/heavy weight | 2<br>Increased pain w/moderate wt. | 3<br>Increased pain w/light weight | 4<br>Increased pain w/any weight |
| 9. | Walking: | 0<br>No pain any distance | 1<br>Increased pain after 1 mile | 2<br>Increased pain after ½ mile | 3<br>Increased pain after ¼ mile | 4<br>Increased pain all walking |
| 10. | Standing: | 0<br>No pain after several hours | 1<br>Increased pain after several hrs | 2<br>Increased pain after 1 hour | 3<br>Increased pain after ½ hour | 4<br>Increased pain any standing |

Print Patient Name: _____

Patient Signature: _____ Date: _____

| ACHE | BURNING | NUMBNESS | PINS & NEEDLES | STABBING |
|---|---|---|---|---|
| ZZZ | BBB | XXXX | = = = | //// |
| ZZZ | BBB | XX | = = = | /// |

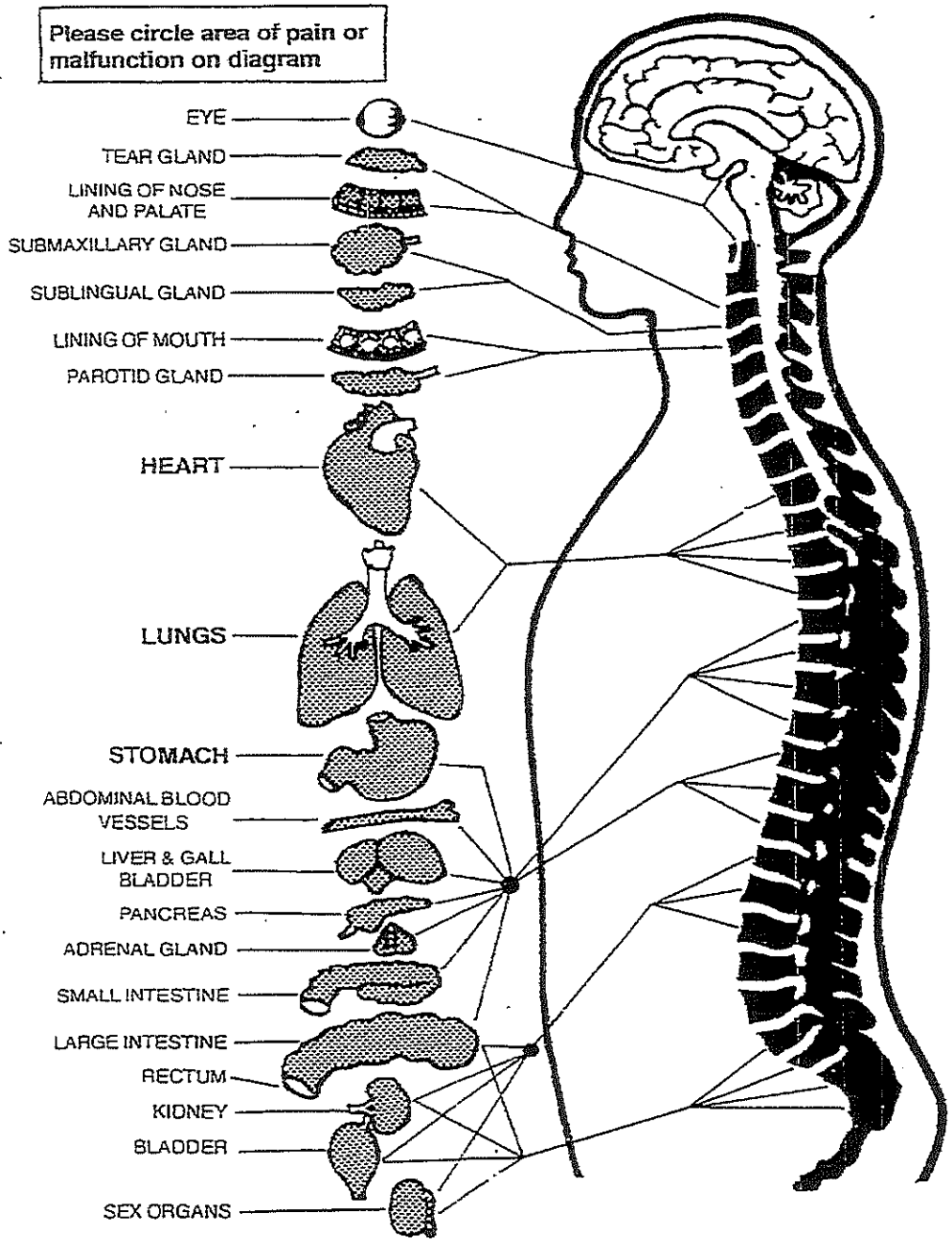
Mark the areas on your body where you feel the described sensations. Please use the appropriate symbol. Mark areas of radiation with arrows.




Name _____ Date _____

# CHIROPRACTIC
# HEALTH QUESTIONNAIRE

Please circle area of pain or malfunction on diagram




*Are you now or have you suffered from any of the following. Check appropriate box.*

| Past | Present | No | |
|---|---|---|---|
| | | | Eye disorders |
| | | | Loss of Taste |
| | | | Headaches |
| | | | Nervousness |
| | | | Trouble Sleeping |
| | | | Dizziness |
| | | | Loss of Smell |
| | | | Sinus Trouble |
| | | | Ear Disorders |
| | | | Frequent Sore Throats |
| | | | Asthma |
| | | | Hay Fever/Allergies |
| | | | Persistant Cough |
| | | | Stomach Problems |
| | | | Rheumatic Fever |
| | | | Tuberculosis |
| | | | Heart Disease |
| | | | High Blood Pressure |
| | | | Diabetes |
| | | | Poor Digestion |
| | | | Nausea |
| | | | Vomiting |
| | | | Constipation |
| | | | Diarrhea |
| | | | Abdominal Pain |
| | | | Hemorroids |
| | | | Urinary Disorders |
| | | | Bed Wetting |
| | | | Menstrual Disorders |
| | | | Sex Problems |
| | | | Tension |
| | | | Irritability |
| | | | Fatigue |
| | | | Sleeping Problems |

## Symptoms related to the Autonomic Nervous System

Chiropractic deals with the relationship between your spine and nervous system

The Nervous System's function is to control and co-ordinate all the other organs and structures. Pinched or irritated nerves may interfere with this function and thus cause a wide variety of symptoms.

Name:

Date:

# *Kent-East Chiropractic*

## I want the following care, Doctor.

Thank you for taking the time to participate in this survey. For me to help you, I believe that communication and understanding are vital. It is important that you take a moment to read the following statements to help me understand your philosophy of life. This is not a judgement statement; it is rather an attempt to clarify. **Your health is your responsibility**. I am committed to serve you to the best of my ability regardless of the level you choose. This understanding will allow care to be directed to the level you desire.

**Please circle the number of the appropriate statement below.**
If none of these statements describe you, please write your own on the lines provided.

1. I appreciate good health. I understand the benefits of natural health care. ***I am interested in information*** concerning a scientifically validated system to improve my health, prevent future disease, and enhance my well being.

2. I appreciate good health. ***I don't really understand*** the benefits of natural health care. I may be interested in a scientifically validated system to improve my health and prevent future disease.

3. I appreciate good health. ***I am primarily symptom oriented.*** I prefer to focus on my health only after awareness that something is wrong. I prefer to use natural, non-toxic, non-abrasive procedures first.

4. I am ***symptom oriented and here to eliminate my pain only***. The drug(s) that I am taking are: A prescription, B over the counter and (a) are no longer effective or (b) didn't work this time.

5. Other

_____

_____

_____

_____ _____ _____

Name Signature Date