WORKER'S COMP HISTORY FORM

Please write legibly and answer each question

Patient Name: _____ Date of Accident: _____

1. Name of employer at time of accident: _____
2. Length of time worked there prior to accident: _____
3. Type of work being done at time of injury: _____
_____
4. In your own words, please describe accident: _____
_____
_____
5. Have you been treated by another doctor for this accident? ( ) Yes ( ) No
If yes, please list doctor's name and address: _____
_____
What type of treatment did you receive? _____
How long were you treated by this doctor? _____
6. Are you: ( ) improved ( ) unchanged ( ) getting worse
7. What types of medicines are you taking? _____
_____
Do these medicines help? ( ) Yes ( ) No ( ) Don't know
8. Have you had physical therapy? ( ) Yes ( ) No
If yes, how often? ( ) Daily ( ) Every other day ( ) Several times a week ( ) Weekly
( ) Every other week ( ) Monthly ( ) Other _____
Does the physical therapy help? ( ) Yes ( ) No ( ) Don't know
9. Prior to this accident, have you ever had any of the physical complaints similar to what you have now?
( ) Yes ( ) No ( ) Don't know
If yes, describe: _____
_____
_____
Were these similar complaints the results of a previous accident(s)? ( ) Yes ( ) No ( ) Not Applicable
If yes, please provide details of accident(s): _____
_____
_____
10. Have you had any other serious accident which required medical care? ( ) Yes ( ) No
If yes, please describe: _____
_____
_____
11. Have you had any serious illnesses that required hospitalization? ( ) Yes ( ) No
If yes, please describe: _____
_____
_____
12. Have you had any surgeries? ( ) Yes ( ) No
If yes, please list type of surgery and date:_____
_____
_____
13. Have you had any nervous or mental illnesses? ( ) Yes ( ) No
Have you had any psychiatric care? ( ) Yes ( ) No
14. Have you received a medical discharge from the Armed Forces? ( ) Yes ( ) No

15. Have you returned to work since this accident? ( ) Yes ( ) No

If you have returned to work since your accident, please fill out the information below.

Date Returned	Employer	Occupation	Light/Reg. duty	Part/full time

CURRENT MEDICAL COMPLAINTS

Back Pain:

1. Currently I have pain in my:……	( ) low back	( ) mid back	( ) upper back	
2. My pain began:……	( ) gradually	( ) suddenly		
3. I have pain:……	( ) sometimes	( ) all of the time		
4. My pain goes into my:……	( ) right leg	( ) left leg	( ) both	( ) neither
5. I have tingling/numbness in my:…..	( ) right leg	( ) left leg	( ) both	( ) neither
6. My pain is worse when I:				
Cough or sneeze……..		( ) Yes	( ) No	
Sit……..		( ) Yes	( ) No	
Bend……		( ) Yes	( ) No	
Walk……		( ) Yes	( ) No	
Lift……..		( ) Yes	( ) No	
Push……..		( ) Yes	( ) No	
Pull……		( ) Yes	( ) No	
7. My back is worse with sexual activity……		( ) Yes	( ) No	
8. My pain wakes me during the night……		( ) Yes	( ) No	
9. Changes in the weather affect my pain……		( ) Yes	( ) No	

Neck Pain: (*complete only if applicable*)

1. My pain began:……	( ) gradually	( ) suddenly		
2. I have pain:……	( ) sometimes	( ) all of the time		
3. My pain goes into my:……	( ) right arm	( ) left arm	( ) both	( ) neither
4. I have tingling/numbness in my:…..	( ) right arm	( ) left arm	( ) both	( ) neither
5. My pain is worse when I:				
Cough or sneeze……..		( ) Yes	( ) No	
Bend forward……		( ) Yes	( ) No	
Lift……..		( ) Yes	( ) No	
Push……..		( ) Yes	( ) No	
Pull……		( ) Yes	( ) No	
Turn my head……		( ) Yes	( ) No	
6. My pain wakes me up during the night……		( ) Yes	( ) No	
7. Changes in the weather affect my pain……		( ) Yes	( ) No	
8. I have neck stiffness……		( ) Yes	( ) No	
9. I have headaches……..		( ) Yes	( ) No	
10. 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:

_____

_____

_____

Job Description: (In terms of an 8-hour workday, "occasionally" means 33%, "frequently" means 34% to 66%, and "continuously" means 67% to 100% of the day.)

1. In a typical 8-hour workday, I: (circle # of hours per 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

2. On the job, I perform the following activities:

	NOT AT ALL	OCCASIONALLY	FREQUENTLY	CONTINUOUSLY
Bend/stoop	( )	( )	( )	( )
Squat	( )	( )	( )	( )
Crawl	( )	( )	( )	( )
Climb	( )	( )	( )	( )
Reach above shoulder level	( )	( )	( )	( )
Crouch	( )	( )	( )	( )
Kneel	( )	( )	( )	( )
Balancing	( )	( )	( )	( )
Pushing/pulling	( )	( )	( )	( )

3. On the job, I lift:

	NOT AT ALL	OCCASIONALLY	FREQUENTLY	CONTINUOUSLY
Up to 10 lbs.	( )	( )	( )	( )
11 to 24 lbs.	( )	( )	( )	( )
25 to 34 lbs.	( )	( )	( )	( )
35 to 60 lbs.	( )	( )	( )	( )
61 to 74 lbs.	( )	( )	( )	( )
75 to 100 lbs.	( )	( )	( )	( )

4. Do you have to bend over while doing any lifting? ( ) Yes ( ) No

5. Are your feet used for repetitive movements, such as operating controls? ( ) Yes ( ) No

6. Do you use your hands for repetitive actions, such as:

	SIMPLE GRASPING	FIRM GRASPING	FINE MANIPUATION
Right hand	( ) Yes ( ) No	( ) Yes ( ) No	( ) Yes ( ) No
Left hand	( ) Yes ( ) No	( ) Yes ( ) No	( ) Yes ( ) No

7. Are you required to work on unprotected heights: ( ) Yes ( ) No

If yes, please describe: _____

_____

8. Are you required to be around moving machinery: ( ) Yes ( ) No

If yes, please describe: _____

_____

9. Are you exposed to marked change in temperature and humidity? ( ) Yes ( ) No

If yes, please describe: _____

_____

10. Are you required to drive automotive equipment? ( ) Yes ( ) No

If yes, please describe: _____

_____

11. Are you exposed to dust, fumes and/or gases? ( ) Yes ( ) No

If yes, please describe: _____

_____

12. Please list any additional comments not previously addressed: _____

_____

_____

Signature: _____ Date: _____

DOCTOR'S LIEN
NATURAL CARE WELLNESS CENTER

Dr. Scott Ferreira **Dr. Jody Ferreira**
6 Seeley Lane
Eliot, ME 03903
Phone: 207-439-9242
Fax: 207-438-0246

I, THE UNDERSIGNED, HERBY AUTHORIZE _____
(NAME OF PAYING PARTY)
TO PAY MY CLAIMS DIRECTLY TO **NATURAL CARE WELLNESS CENTER (DR. SCOTT FERREIRA)** FOR SERVICES RENDERED FOR CHIROPRACTIC, MASSGE, AND/OR OTHER THERAPIES PROVIDED TO ME AT THIS OFFICE DUE TO A PERSONAL INJURY OR WORKMAN'S COMPENSATION CASE.

I UNDERSTAND THAT I WILL BE RESPONSIBLE FOR ANY PAYMENTS NOT COVERED OR AUTHORIZED BY THE INSURANCE COMPANY HANDLING MY CASE. FURTHERMORE, IN THE EVENT THAT THE INSURANCE COMPANY SENDS THE PAYMENTS TO ME INSTEAD OF **NATURAL CARE WELLNSS CENTER** FOR THE ABOVE SERVICES RENDERED, I WILL MAKE A PROMPT PAYMENT WITHIN 30 DAYS OF RECEIVING THE INSURANCE REIMBURSEMENT TO **NATURAL CARE WELLNESS CENTER (send to the address above)**.

CLAIM#: _____

POLICY #: _____

DATE OF ACCIDENT: _____

PATIENT NAME (print): _____

SIGNATURE: _____

TODAY'S DATE: _____

BACK INDEX

Patient Name: _____ **Date:** _____

This questionnaire will give your provider information about how your back condition affects your everyday life. Please answer every section by marking the one statement that applies to you. If two or more statements in one section apply, please fill in the one statement that most closely describes your problem.

Pain Intensity
⓪ The pain comes and goes and is very mild.
① The pain is mild and does not vary much.
② The pain comes and goes and is moderate.
③ The pain is moderate and does not vary much.
④ The pain comes and goes and is very severe.
⑤ The pain is very severe and does not vary much.

Sleeping
⓪ I get no pain in bed .
① I get pain in bed but it does not prevent me from sleeping well.
② Because of pain, my normal sleep is reduced by less than 25%.
③ Because of pain, my normal sleep is reduced by less than 50%.
④ Because of pain, my normal sleep is reduced by less than 75%.
⑤ Pain prevents me from sleeping at all.

Sitting
⓪ I can sit in any chair as long as I like.
① I can only sit in my favorite chair as long as I like.
② Pain prevents me from sitting more than 1 hour.
③ Pain prevents me from sitting more than ½ hour.
④ Pain prevents me from sitting more than 10 minutes.
⑤ I avoid sitting because it increases pain immediately.

Standing
⓪ I can stand as long as I want without pain.
① I have some pain with standing but it does not increase with time.
② I cannot stand for longer than 1 hour without increasing pain.
③ I cannot stand for longer than ½ hour without increasing pain.
④ I cannot stand for longer than 10 minutes without increasing pain.
⑤ I avoid standing because it increases pain immediately.

Walking
⓪ I have no pain while walking.
① I have some pain while walking but it does not increase with distance.
② I cannot walk more than 1 mile without increasing pain.
③ I cannot walk more than ½ mile without increasing pain.
④ I cannot walk more than ¼ mile without increasing pain.
⑤ I cannot walk at all without increasing pain.

Personal Care
⓪ I do not have to change my way of washing/dressing to avoid pain.
① I do not normally change my way of washing/dressing even though it causes some pain.
② Washing/dressing increase the pain but I manage not to change my way of doing it.
③ Washing/dressing increases the pain and I find it necessary to change my way of doing it.
④ Because of the pain I am unable to do some washing/dressing without help.
⑤ Because of the pain I am unable to do any washing/dressing without help.

Lifting
⓪ I can lift heavy weights without extra pain.
① I can lift heavy weights but it causes extra pain.
② Pain prevents me from lifting heavy weights off the floor.
③ Pain prevents me from lifting heavy weights off the floor, but I can manage if they are conveniently positioned (e.g., on a table).
④ Pain prevents me from lifting heavy weights off the floor, but I can manage light to medium weights if they are conveniently positioned.
⑤ I can only lift very light weights.

Traveling
⓪ I get no pain while traveling.
① I get some pain while traveling but none of my usual forms of travel make it worse.
② I get extra pain while traveling but it does not cause me to seek alternate forms of travel.
③ I get extra pain while traveling, which causes me to seek alternate forms of travel.
④ Pain restricts all forms of travel except that done while lying down.
⑤ Pain restricts all forms of travel.

Social Life
⓪ My social life is normal and I get no extra pain.
① My social life is normal but increases the degree of pain.
② Pain has no significant affect on my social life apart from limiting my more energetic interests (e.g., dancing, etc.)
③ Pain has restricted my social life and I do not go out very often.
④ Pain has restricted my social life to my home.
⑤ I have hardly any social life because of the pain.

Changing degree of pain
⓪ My pain is rapidly getting better.
① My pain fluctuates but overall is definitely getting better.
② My pain seems to be getting better but improvement is slow.
③ My pain is neither getting better or worse.
④ My pain is gradually worsening.
⑤ My pain is rapidly worsening.

Index Score = [Sum of all statements selected/# of sections with a statement selected x 5)] x 100

Back Index Score

NECK INDEX

Patient Name: _____ **Date:** _____

This questionnaire will give your provider information about how your neck condition affects your everyday life. Please answer every section by marking the one statement that applies to you. If two or more statements in one section apply, please fill in the one statement that most closely describes your problem.

Pain Intensity
⓪ I have no pain at the moment.
① The pain is very mild at the moment.
② The pain comes and goes and is moderate.
③ The pain is fairly severe at the moment.
④ The pain is very severe at the moment.
⑤ The pain is the worse imaginable at the moment.

Personal Care
⓪ I can look after myself normally without causing extra pain.
① I can look after myself normally but it causes extra pain.
② It is painful to look after myself and I am slow and careful.
③ I need some help but I manage most of my personal care.
④ I need help every day in most aspects of self care.
⑤ I do not get dresses, I wash with difficulty and stay in bed.

Sleeping
⓪ I have no trouble sleeping .
① My sleep is slightly disturbed (less than 1 hour sleepless)
② My sleep is mildly disturbed (1-2 hours sleepless).
③ My sleep is moderately disturbed (2-3 hours sleepless).
④ My sleep is greatly disturbed (3-5 hours sleepless)
⑤ My sleep is completely disturbed (5-7 hours sleepless)

Lifting
⓪ I can lift heavy weights without extra pain.
① I can lift heavy weights but it causes extra pain.
② Pain prevents me from lifting heavy weights off the floor, but I can manage if they conveniently positioned (e.g., on a table).
③ Pain prevents me from lifting heavy weights off the floor, but I can manage light to medium weights if they are conveniently positioned.
④ I can only lift very light weights.
⑤ I cannot lift or carry anything at all.

Reading
⓪ I can read as much as I want with no neck pain.
① I can read as much as I want with slight neck pain.
② I can read as much as I want with moderate neck pain.
③ I cannot read as much as I want because of moderate neck pain.
④ I can hardly read at all because of severe neck pain.
⑤ I cannot read at all because of neck pain.

Driving
⓪ I can drive my car without any neck pain.
① I can drive my car as long as I want without slight neck pain.
② I can drive my car as long as I want with moderate neck pain.
③ I cannot drive my car as long as I want because of moderate neck pain.
④ I can hardly drive at all because of severe neck pain.
⑤ I cannot drive my car at all because of neck pain.

Concentration
⓪ I can concentrate fully when I want with no difficulty.
① I can concentrate fully when I want with slight difficulty.
② I have a fair degree of difficulty concentrating when I want.
③ I have a lot of difficulty concentrating when I want.
④ I have a great deal of difficulty concentrating when I want.
⑤ I cannot concentrate at all.

Recreation
⓪ I am able to engage in all my recreation activities without neck pain.
① I am able to engage in all my usual recreation activities with some neck pain.
② I am able to engage in most but not all my usual recreation activities because of pain
③ I am only able to engage in a few of my usual recreation activities because of neck pain.
④ I can hardly do any recreation activities because of neck pain.
⑤ I cannot do any recreation activities at all.

Work
⓪ I can do as much work as I want.
① I can only do my usual work but no more.
② I can only do most of my usual work but no more.
③ I cannot do my usual work.
④ I can hardly do any work at all.
⑤ I cannot do any work at all.

Headaches
⓪ I have no headaches at all.
① I have slight headaches which come infrequently.
② I have moderate headaches which come infrequently.
③ I have moderate headaches which come frequently.
④ I have severe headaches which come frequently.
⑤ I have headaches almost all the time.

Index Score = [Sum of all statements selected/# of sections with a statement selected x 5)] x 100

Neck Index Score