UPLAND
SPINE & REHABILITATION
CHIROPRACTIC CENTER

CONFIDENTIAL PATIENT INFORMATION

Patient Name _____ Date _____/_____/_____
(First, Middle, Last)

Gender M/F Date of Birth _____/_____/_____ Current Age _____ SSN# _____

_____
Address City/State/Zip

Phone (_____)_____-_____ (_____)_____-_____ (_____)_____-_____
Home Cell Other

Email _____ Best reached by EMAIL/PHONE/TEXT

WORKERS COMPENSATION INFORMATION

Date and time of accident / / ___ AM ___ PM
Was your accident directly related to your work YES/NO
Briefly describe the events that occurred just before and during your accident
Give the address where the accident occurred (if other than employer's address)
Was anyone else present during your accident YES/NO
Did you report your accident to your employed? YES/NO
What recommendations did your employer make just after your accident? _____

_____

_____

Has this type of accident happened before? YES/NO
To the best of your knowledge, has this accident occurred in your workplace before? YES/NO
In general
Is your job physically stressful? YES/NO
Is your job mentally stressful YES/NO
Is your workplace noisy? YES/NO
Have you changed jobs in the last year? YES/NO

AFTER INJURY

Did the accident render you unconscious? YES/NO
Please describe how you felt immediately after the accident _____
_____
Have you gone to a hospital or seen any other doctor? YES/NO
Name of doctor _____
When did you go to the hospital? ___ Just after the accident ___ The next day ___ 2+ days ___Other _____
How did you get there? ___ Ambulance ___ Private transportation
Name of hospital and/or attending doctor _____
Was he/she a ___ MD ___ DO ___ DC ___ DDS
Describe the type of treatment you received _____
Were X-Rays taken? YES/NO
Was medication prescribed? YES/NO _____
Have you been able to work since the injury? YES/NO
Are your work activities restricted as a result of this injury? YES/NO
Indicate the symptoms that are a result of this accident

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___ Dizziness ___ Memory loss ___ Headaches ___ Blurred vision ___ Buzzing in ear ___ Ears ringing
___ Difficulty Sleeping ___ Irritability ___ Fatigue ___ Tension ___ Neck pain ___ Neck stiffness ___ Jaw problems
___ Arm/shoulder pain ___ Numb hands/fingers ___ Chest pain ___ Shortness of breath ___ Stomach upset
___ Nausea ___ Back pain ___ Lower back pain ___ Back stiffness ___ Leg pain ___ Numb feet/toes
Is your condition getting worse? ___ YES ___NO ___CONSTANT ___ COMES AND GOES

Level of comfort while performing the following activities

	Comfortable	Uncomfortable	Painful
Lying on back			
Lying on side			
Lying on stomach			
Sitting			
Standing			
Walking			
Running			
Sports			
Working			
Lifting			
Bending			
Kneeling			
Reaching			
Other _____			

Have you retained an attorney? YES/NO
If yes, whom? _____
Attorney phone number

RECOVERY

How many hours are in your normal workday? _____
Please indicate your daily job duties and any activities which you are occasionally asked to perform
___ Standing ___ Sitting ___ Walking ___ Lifting ___ Driving ___ Twisting ___ Crawling ___ Bending
___ Operating equipment ___ Work with arms above head ___ Typing ___ Stooping
What positions can you work with a minimum physical effort and for how long? _____
Prior to injury were you capable of working on an equal basis with others your age? YES/NO N/A
Do you work with others who can help you with any heavy lifting? YES/NO N/A
Is there any light duty work you could request while in recovery? YES/NO N/A

Upland Spine & Rehab invites you to discuss with us any questions regarding our services. The best services are based on a friendly, mutual understanding between provider and patient.
Our policy requires payment in full for all services rendered at time of visit, unless arrangements have been made. If accounts are not paid within 90 days of the date of service and no financial arrangements have been made, you will be responsible for legal fees, collection agency fees, interest charges and any other expenses incurred in collecting the account.
I authorize the staff at Upland Spine & Rehab to perform any necessary services needed during diagnosis and treatment. I also authorize the provider to release any information required to process insurance claims.
I understand it is my responsibility to inform this office of any changes to the information I have provided.

_____

Patient (Parent/Legal Guardian) Name Patient (Parent/Legal Guardian) Signature Date