BEECHER CHIROPRACTIC CLINIC
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Confidential New Patient Information
For PIP & Workman's Compensation Claims

The following information is needed for our files so we can better serve you as a patient. Please print and fill out all portions of this form. All information is confidential.

Patient Data:

Name: _____ Patient's Employer: _____

Address: _____ Business Address: _____

City: _____ State: _____ Zip: _____ City: _____ State: _____ Zip: _____

Hm Phone: _____ Cell: _____ WK Phone: _____ Occupation: _____

SSN: _____ SEX: __ M __ F Policy Holder's Employer (If different from above): _____

Birthdate: _____ Age: _____ # of Children: _____ WK Phone: _____ Occupation: _____

Marital Status: __ Single __ Married __ Divorced __ Widowed Emergency Contact _____: _____

Relationship: _____ Ph #: _____

Attorney Information:

Attorney Name: _____ Case Manager: _____

Address: _____ Case Mgr Ph #: _____ Ext: _____

City: _____ State: _____ Zip: _____ Fax #: _____ Type of Case: _____

Attorney Ph #: _____ Ext: _____ TWCC #: _____

Insurance Information: (YOUR PIP INSURANCE INFORMATION)

Ins. Carrier Name: _____ Adjuster: _____

Address: _____ Ph #: _____ Ext: _____

City: _____ State: _____ Zip: _____ Fax #: _____

Claim #: _____ Policy #: _____

(THE OTHER PARTY'S INSURANCE INFO)

Ins. Carrier Name: _____ Adjuster: _____

Address: _____ Ph #: _____ Ext: _____

City: _____ State: _____ Zip: _____ Fax #: _____

Claim #: _____ Policy #: _____

Policy Holder Name: _____ Policy Holder Ph #: _____

Injury Info:

Date of Accident: _____ Hour of Accident: _____ __AM __PM

Type of Accident: __ Work Related __ Auto Accident __ Other Explain: _____

Briefly describe symptoms: _____

_____

List any/or all doctors seen for this condition: _____

_____

PLEASE CONTINUE ON BACK OF THIS FORM

Confidential New Patient Information
For PIP or Workman's Compensation Claims, Page 2

HEALTH HISTORY

__CANCER __MUSCULAR DYSTROPHY __POLIO __EPILEPSY __ASTHMA
__ANEMIA __MULTIPLE SCLEROSIS __DIABETES __HEPATITIS __DIZZINESS
__CONCUSSION __TUBERCULOSIS __NERVOUSNESS __ ARTHRITIS __BACKACHES
__OTHER If other, please list: _____

Date of last physical exam: _____ With Doctor: _____ Ph#: _____

Describe & date of any operations you've had: _____

Are you allergic to any medication: __ No __ Yes What kind: _____

Are you taking any medication: __ No __ Yes What kind: _____

(FEMALE PATIENTS) Are you pregnant: __ No __ Yes Date of last menstrual: _____

Present Complaint:

__Headache __Pin & Needles in arms/legs __Extreme fatigue __Neck stiffness __Loss of taste
__Chest pain __Head seems to heavy __Shortness of breath __Neuritis __Loss of smell
__Fainting __Neck motion restricted __Eyes loss of focus __Anxiety __Feet/hand cold
__ Dizziness __Digestive disorders __Nausea/Vomiting __Palpitation __Loss of memory
__ Diarrhea __Upper back pain/stiffness __Face flushed __Face pale __Double vision
__ Insomnia __Mid back pain/stiffness __Eyes loss of focus __Eye strain __Constipation
__Tremors __Lower back pain/stiffness __Pain behind eyes __Neck pain __Cramping
__Tension __Ears buzzing/ringing __Sinus trouble __Excessive perspiration __Irritability
__Swelling __Equilibrium problems __Mental dullness __Extreme nervousness __Depression
__Eyes sensitive to light __ Head & shoulders feel tired & heavy __Numbness in fingers, arm, legs
__Difficulty in prolonged car riding __Neck, mid-back, low-back pain & stiffness upon rising.
__ Difficulty in excessive: __Standing __Walking __Riding __Bending __Other _____

Traffic Accident:

What kind of vehicle was involved in accident: __ Truck __Car __SUV __Motorcycle __ Other _____

Were you a: __Driver __Passenger __ Pedestrian If a passenger, indicate location in car: _____

Was your vehicle moving when the accident occurred: __ No __ Yes MPH: _____

Did your vehicle hit other vehicle/s: __ No __ Yes Where: _____

Did other vehicle/s hit your vehicle: __ No __ Yes Where: _____

Was accident reported to police department: __ No __ Yes

Where traffic citations issued: __No __Yes Whom: _____

Describe accident including cause/s and surrounding circumstances: _____

_____

_____

PLEASE CONTINUE ON NEXT PAGE

Confidential New Patient Information
For PIP or Workman's Compensation Claims, Page 3

Work Related Accident Info: (Answer only if Filing Workman's Comp)

Employer: _____ Was Accident Reported to Supervisor/Employer: __ No __ Yes

Type of Business: _____ Has a Worker's Compensation claim been filed: __ No __ Yes

Was any equipment, machinery, and/or objects related to accident: __ No __ Yes What Kind: _____

Do you currently have a treating Doctor for your WC Case? __ No __ Yes If Yes please fill in Current Treating Doctor Information:

Doctor Name: _____ Phone #: _____ Fax#: _____

Address: _____ City: _____ State: _____ Zip: _____

I understand that the information provided on this form have been answered accurately to the best of my knowledge. And that providing incorrect information can be dangerous to my (my child's) health. It is my responsibility to inform the doctor's office of any changes to my (my child's) medical status. I also understand and agree that health and accident insurance policies are an arrangement between the insurance carrier and myself. Furthermore, I understand that this office will prepare any necessary reports and forms to assist me in making collections from the insurance company and that any amounts authorized to be paid directly to this office will be credited to my account upon receipt. I permit this office to endorse co-issued remittances for the conveyance of credit to my account if necessary. However, I clearly understand and agree that all services rendered me are charged directly to me, and that I am personally responsible for payment, unless otherwise noted at beginning of treatment. I also understand that if I suspend or terminate my care and treatment, any fees for professional services rendered me will be immediately due and payable.

_____ _____

SIGNATURE OF PATIENT OR LEGAL GUARDIAN (IF MINOR) DATE

AUTHORIZATION FOR CHIROPRACTIC TREATMENT

I, THE UNDERSIGNED, A PATIENT IN THIS OFFICE HEREBY AUTHORIZE DR. WARD BEECHER (AND WHOMEVER HE MAY DESIGNATE AS HIS ASSISTANTS) TO ADMINISTER SUCH TREATMENT AS IS NECESSARY, AND TO PERFORM THE FOLLOWING THERAPY AND MANIPULATION AND SUCH ADDITIONAL THERAPEUTICALLY NECESSARY ON THE BASIS OF FINDINGS DURING THE COURSE OF SAID TREATMENT.

I HEREBY CERTIFY THAT I HAVE READ AND FULLY UNDERSTAND THE ABOVE AUTHORIZATION FOR CHIROPRACTIC TREATMENTS, THE REASONS WHY THE ABOVE NAMED TREATMENT IS CONSIDERED NECESSARY, ITS ADVANTAGES AND POSSIBLE COMPLICATIONS, IF ANY, AS WELL AS POSSIBLE ALTERNATIVE MODES OF TREATMENT, WHICH WERE EXPLAINED TO ME BY DR. BEECHER. I ALSO CERTIFY THAT NO GUARANTEE OR ASSURANCE HAS BEEN MADE TO THE RESULTS THAT MAY BE OBTAINED.

_____ _____

SIGNATURE OF PATIENT OR LEGAL GUARDIAN (IF MINOR) DATE

CONSENT TO TREATMENT OF CHILD

I HEARBY AUTHORIZE DR. BEECHER AND ASSISTANTS TO ADMINISTER TREATMENT TO MY SON/DAUGHTER.

_____ _____

SIGNATURE OF LEGAL GUARDIAN DATE

HIPPA COMPLIANCE/PRIVATE PRACTICE LAWS

BY SIGNING I HEARBY STATE THAT I AM AWARE OF THE PRATICE PRIVACY NOTICE AND THAT THE PROVACY NOTICE IS LOCATED AT MY DISPOSAL IN THE OFFICE AND I CAN REQUEST IT FOR REVIEW AT ANY TIME. I HEREBRY AGREE TO ALL GUIDELINES AS IS NECESSARY FOR THE PRACTICE TO CONDUCT ITS HEALTH CARE OPERATIONS.

_____ _____

SIGNATURE OF PATIENT OR LEGAL GUARDIAN DATE

PLEASE COMPLETE THE QUESTIONAIRE ON THE FOLLOWING PAGE.

HEALTH STATUS QUESTIONAIRE (HSQ-12)

Name: _____ Date: _____ Date of Injury: _____

Please circle the number which best describes your health from time of injury or when pain began, unless otherwise specified:

1. In general, would you say your health is:

Excellent.....1
Very Good 2
Good.....3
Fair.....4
Poor.....5

The following items are about activities you might do during a typical day. Does your health now limit you in these activities? If so, how much?

	Yes, Limited A lot	Yes, Limited A little	No, Not Limited At All
2. Lifting or carrying groceries.....	1	2	3
3. Climbing several flights of stairs.....	1	2	3
4. Walking several blocks.....	1	2	3

5. Since the time of injury or when your pain began, how much difficulty did you have doing your work or other regular daily activities as a result of your physical health?

None at all... 1
A little bit.....2
Moderately 3
Quite a bit... 4
Couldn't do any work 5

6. During the past 4 weeks, or when your pain began or injury occurred, to what extent have you accomplished less than you would like in your work or other daily activities as a result of emotional problems (such as feeling depressed or anxious)?

None at all.....1
A little bit.....2
Moderately.....3
Quite a bit.....4
Extremely.....5

7. During the past 4 weeks, or when your pain began or injury occurred, to what extent has your physical health or emotional problems interfered with your normal social activities with family, friends, neighbors, or groups?

None.....1
Very Mild.....2
Mild.....3
Moderate.....4
Severe.....5

8. How much bodily pain have you had since the time of injury or when your pain began?

None.....1
Very Mild.....2
Mild.....3
Moderate.....4
Severe.....5
Very Severe.....6

These questions are about how you feel and how things have been with you during the past 4 weeks or from the start of your pain or injury. For each question, please give the one answer that comes closest to the way you have been feeling.

PLEASE CONTINUE ON FOLLOWING PAGE.

HEALTH STATUS QUESTIONAIRE, PAGE 2

How much of the time during the past 4 weeks…

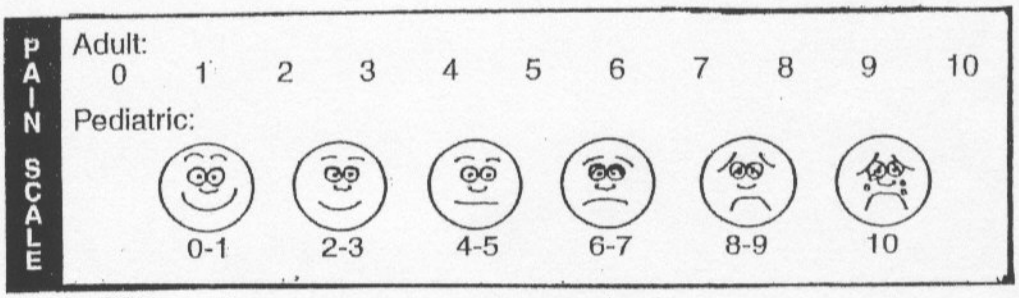
	All of the Time	Most of the time	A Good bit of the time	Some of the time	Little of the time	None of the time
9. Have you felt peaceful & calm?	1	2	3	4	5	6
10. Did you have a lot of energy?	1	2	3	4	5	6
11. Have you felt downhearted or blue?	1	2	3	4	5	6
12. Have you been a happy person?	1	2	3	4	5	6

Please answer YES or NO for each question by circling 1 or 2 on each line.

	Yes	No
13. In the past year, have you had 2 weeks or more during which you felt sad blue, or depressed; or when you lost all interest or pleasure in things that you usually cared about or enjoyed?	1	2
14. Have you had 2 yrs or more in your life when you felt depressed or sad most of days, even if you felt okay sometimes?	1	2
15. Have you felt depressed or sad much of the time in the past year?	1	2

PLEASE MARK AN "X" IN THE BOX THAT BEST DESCRIBES YOUR LEVEL OF PAIN FOR THE TIME SPECIFIED.

	No Pain	0	1	2	3	4	5	6	7	8	9	10	Unbearable
A. Right Now:													
B. Average Pain:													
C. At Best:													
D. At Worst:													



PAIN DRAWING

Please be sure to mark the area on your body where you feel the described sensation, using the appropriate markings. You may use all the areas on the body including the face and feet.

Numbness ------ **Pins & Needles** 0000 **Burning Pain** XXXX **Stabbing Pain** ////// **Aching Pain** ((((((