Adirondack Family Chiropractic, P.C.

148 Margaret Street, P.O. Box 3046, Plattsburgh, NY 12901
Phone (518)561-6004, Fax (518)561-0357

6018 Sentinel Road, Lake Placid, NY 12946
Phone (518)523-8222, Fax (518) 523-8220

Dr. Carolyn F. Clauss Dr. Joseph J. Clauss

Workers Compensation/ No Fault History

Patient Name: _____ Phone #:_____

Address: _____City:_____ State: _____ Zip: _____

DOB: _____ Age: _____ Sex: M / F SSN: _____

Employer's Name: _____ Phone: _____

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

Your Occupation: _____ Type of Business: _____

Date of Injury/ Accident: _____ Time: _____AM/PM State: _____

Are you still working? ☐Yes ☐No

(If Yes) ☐Full Duty ☐With Restrictions (If No) Date last worked: _____

In your own words, please fully describe the injury/ accident: _____

_____

_____

Has another doctor for this accident treated you? ☐Yes ☐No

If yes please give the doctors name: _____

Is this doctor still treating you? ☐Yes ☐No Are you: ☐ improving ☐Unchanged ☐Worse

Are you taking any medications? ☐Yes ☐No Do they help? ☐Yes ☐No

Prior to this accident, have you had any of the physical complaints similar to what you have now? ☐Yes ☐No

If yes please describe: _____

_____

Were these complaints the results of a previous accident? ☐Yes ☐No

If yes please provide details of previous accident(s)? _____

_____

Have you had any problems with nerves or mental illness? ☐Yes ☐No

If yes have you had Psychiatric care? ☐Yes ☐No

Have you received a medical discharged from the armed forces? ☐Yes ☐No

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Medical Complaints Pertaining to Injury/ Accident Only

Back Pain:

Currently I have pain in my:	☐N/A	☐Low Back	☐Mid Back	☐Upper Back
My pain began:	☐N/A	☐Gradually	☐Suddenly	
I have pain:	☐N/A	☐Sometimes	☐All of the time	
My pain goes into my:	☐N/A	☐ Right leg	☐Left Leg	☐Both
I have tingling and/or Numbness in my:	☐N/A	☐Right Leg	☐Left Leg	☐Both

My Pain is worse when I:

Cough	☐N/A	☐Yes	☐No
Sit:	☐N/A	☐Yes	☐No
Bend:	☐N/A	☐Yes	☐No
Walk:	☐N/A	☐Yes	☐No
Lift:	☐N/A	☐Yes	☐No
Push Pull:	☐N/A	☐Yes	☐No
Sneeze:	☐N/A	☐Yes	☐No

My Back is worse with:

Sexual Activity: ☐N/A ☐Yes ☐No

Neck Pain:

My neck pain began:	☐N/A	☐Gradually	☐Suddenly	
I have pain:	☐N/A	☐Sometimes	☐All of the time	
My pain goes into my:	☐N/A	☐ Right arm	☐Left arm	☐Both
I have tingling and/or Numbness in my:	☐N/A	☐Right arm	☐Left arm	☐Both

My Pain is worse when I:

Cough	☐N/A	☐Yes	☐No
Bend Forward:	☐N/A	☐Yes	☐No
Walk:	☐N/A	☐Yes	☐No
Lift:	☐N/A	☐Yes	☐No
Push Pull:	☐N/A	☐Yes	☐No

Turn my Head: ☐N/A ☐Yes ☐No

I have neck Stiffness ☐N/A ☐Yes ☐No

I have Headaches: ☐N/A ☐Yes ☐No

If I have Headaches, they occur: ☐N/A ☐Sometimes ☐All of the time

Does your pain wake you during the night? ☐N/A ☐Yes ☐No

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Job Description:

In a Typical 8-Hour work day, I: (circle numbers of hours for each 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

In terms of an 8 hour work day	"Occasionally"	Means	33%	Of the day
	"Frequently"	Means	34% to 66%	Of the day
	"Continuously"	Means	67% to 100%	Of the day

On the job, I perform the following activities:

	Not at all	Occasionally	Frequently	Continuously
Bend/ Stop	☐	☐	☐	☐
Squat	☐	☐	☐	☐
Crawl	☐	☐	☐	☐
Climb	☐	☐	☐	☐
Reach above Shoulder Level	☐	☐	☐	☐
Crouch	☐	☐	☐	☐
Kneel	☐	☐	☐	☐
Balancing	☐	☐	☐	☐
Pushing/ Pulling	☐	☐	☐	☐
On the Job I Lift:				
Up to 10 pounds	☐	☐	☐	☐
11 to 24 pounds	☐	☐	☐	☐
25 to 34 pounds	☐	☐	☐	☐
35 to 50 pounds	☐	☐	☐	☐
51 to 74 pounds	☐	☐	☐	☐
75 to 100 pounds	☐	☐	☐	☐

Do you have to bend over while doing any lifting? ☐N/A ☐Yes ☐No

Are your feet used for repetitive movements, such as in operating foot controls? ☐N/A ☐Yes ☐No

Do you use your hands for repetitive action, such as:

	Simple grasping	Firm Grasping	Fine Manipulation
Right hand:	☐Yes ☐No	☐Yes ☐No	☐Yes ☐No
Left hand:	☐Yes ☐No	☐Yes ☐No	☐Yes ☐No

Are you required to work on unprotected heights? ☐Yes ☐No

Describe: _____

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Are you required to be around moving machinery? ☐Yes ☐No
Describe: _____

Are you exposed to marked changes in temperature and humidity? ☐Yes ☐No
Describe: _____

Are you required to drive automotive equipment? ☐Yes ☐No
Describe: _____

Are you exposed to dust, fumes and/or gases? ☐Yes ☐No
Describe: _____

Please list any additional comments related to your condition: _____
_____
_____

If you receive any information pertaining to your Workers Compensation/No-Fault accident (for example: letters, phone calls, e-mails, etc.) you will need to bring it to the attention of this office!!!

This section is for Workers Compensation Only!!!
After completing this section please sign and date the bottom of the page

Name of compensation carrier: _____ Phone: _____

Address of Carrier: _____ City:_____ State:_____ ZIP:_____

Was this accident reported to your employer? ☐Yes ☐No

*****Attention all Workers' Compensation patients*****

If any correspondence concerning your Workers' Compensation condition is needed for any of the following reasons:

- Court Hearing
- Independent Medical Exams
- Travel Dates ($6 charge)
- Attorney request for records
- Disability Forms
- Special letters ($5-$10 charge)

This office request at least 5 business day's notification to meet your request.

Signature: _____ **Date:** _____

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This section is for No-Fault Only!!!
After completing this section please sign the bottom.

Vehicle Information:
Make & Model of the vehicle: _____
Whose Name is the vehicle insured to? _____
Insurance agent's name: _____ Phone: _____

*****Attention all No–Fault patients! *****

It is the responsibility of the patient to notify the appropriate insurance company immediately following an accident. After we have verified the No-Fault benefits we will be happy to submit on the patients behalf. However, at all times, the patient remains responsible for the account balance.

*****Please note that New York State is a No-Fault State*****

All medical benefits are paid through the insurance policy of the owner of the vehicle you are riding in at the time of the accident

*****Workers' Compensation and No-Fault patients please read then sign and date*****

Assignment of release of information statements.

I herby authorize and direct the above named, having treated me, to release to government agencies, insurance carriers, or others who are financially liable for my chiropractic care, all information needed to substantiate payment for such care and to permit representative thereof to examine and make copies of all records relating to such care and treatment.

Signature:_____ Date:_____

Assignment to Adirondack Family Chiropractic.

I herby assign, transfer, and set over to the above named sufficient monies and/or benefits to which I may be entitled from governmental agencies, insurance carriers, or others who are financially liable for my chiropractic care to cover the costs of the care treatment rendered to myself of my dependent said office.

Signature:_____ Date:_____