Dr. Williams *Chiropractic Office*

WORKERS' COMPENSATION CASE HISTORY

PLEASE PRINT

First Name: ______________________________ **M.I.:** _____ **Last Name:** __________________________________

Occupation And Specific Job Title: ____

____

Employer Name: ____

Address: ____

City: __________________________ **State:** _________ **Zip Code:** __________ **Phone #:** (_____)- __________

Nature Of Business: ____

Do You Have An Attorney? __________ **If Yes, Please Give This Office Her/His Name, Address, Phone Number**

____

____

Date Of Accident/Injury: _______________ **Time Of Accident/Injury:** ________ **A.M.** _______ **P.M.** _______

Date Last Worked: ____________________ **Are You Able To Perform Your Job Duties:** ____________________

Accident/Injury Occurred At: ____

Address: ____ **City:** ____________________________

State: ______________ **County:** ____

Were You Conscious? ________ **Did You Receive Medical Attention At The Accident/Injury Scene?** __________

Did You Go To A Medical Facility/Physician For Treatment After The Accident/Injury? ____________________

If Yes, Where: ____

____

Where Do You Feel Pain? ____

____

____

Is Your Pain: Getting Worse ________________ **Same** _________________ **Improving** _________________

Please Describe In Your Own Words How Your Accident/Injury Occurred

____

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____

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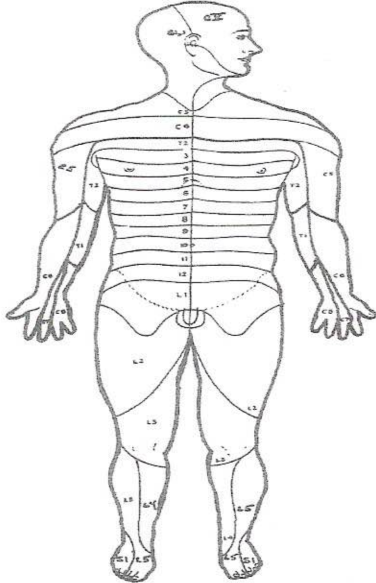
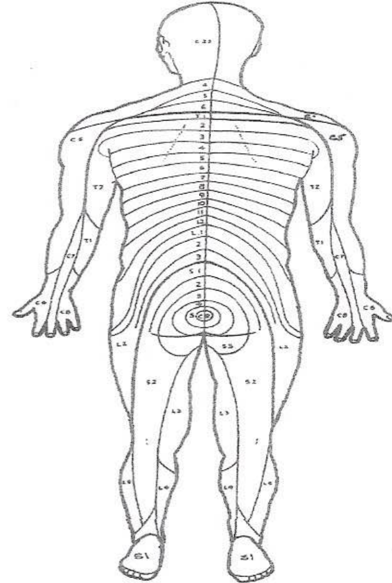
Dr. Williams *Chiropractic Office*

Please Mark Area(s) & Type of Pain On The Drawings Using The Letters Listed Below

A-Ache N-Numbness P-Pain S-Soreness ST–Stiffness T-Tingling





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Dr. Williams *Chiropractic Office* Financial Policy

The State of California requires that before this office can provide any chiropractic services to you under the workers' compensation system, this chiropractic office must verify your work accident/injury with your employer and/or your employer's workers' compensation insurance company.

As a *Workers' Compensation* patient, your employer or your employer's workers' compensation insurance company will pay for all pre-approved chiropractic services rendered by this office.

Any person who makes or causes to be made any knowingly false or fraudulent material statement or material representation for the purpose of obtaining or denying workers' compensation benefits or payments is guilty of a felony.

Date _____/_____/_______ ***Signature*** ______________________________

STATE OF CALIFORNIA

DOCTOR'S FIRST REPORT OF OCCUPATIONAL INJURY OR ILLNESS

Within 5 days of your initial examination, for every occupational injury or illness, send two copies fo this report to the **employer's workers' compensation insurance carrier** or the **self-insured employer**. Failure to file a timely doctor's report may result in assessment of a civil penalty. In the case of diagnosed or suspected pesticide poisoning, send a copy of this report to Division of Labor Statistics and Research, P.O. Box 420603, San Francisco, CA 94142-0603, and notify your local health officer by telephone within 24 hours.

	PLEASE DO NOT USE THIS COLUMN
1. **INSURER NAME AND ADDRESS**	
2. **EMPLOYER NAME**	Case No.
3. Address: No. and Street / City / Zip	Industry
4. Nature of business (e.g., food manufacturing, building construction, retailer of women's clothes)	County
5. **PATIENT NAME** (first name, middle initial, last name) / 6. Sex ☐ Male ☐ Female / 7. Date of Birth Mo. Day Yr.	Age
8. Address: No. and Street / City / Zip / 9. Telephone Number	Hazard
10. Occupation (Specific job title) / 11. Social Security Number	Disease
12. Injured at: No. and Street / City / County	Hospitalization
13. Date and hour of injury or onset of illness Mo. Day Yr. Hour ________ a.m. ________ p.m. / 14. Date last worked Mo. Day Yr.	Occupation
15. Date and hour of first examination or treatment Mo. Day Yr. Hour ________ a.m. ________ p.m. / 16. Have you (or your office) previously treated patient? ☐ Yes ☐ No	Return Date Code

Patient please complete this portion, if able to do so. Otherwise, doctor please complete immediately. Inability or failure of a patient to complete this portion shall not affect his/her rights to workers' compensation under the California Labor Code.

17. DESCRIBE HOW THE ACCIDENT OR EXPOSURE HAPPENED (Give specific object, machinery or chemical. Use reverse side if more space is required.)

18. **SUBJECTIVE COMPLAINTS** (Describe fully. Use reverse side if more space is required.)

19. **OBJECTIVE FINDINGS** (Use reverse side if more space is required.)
   A. Physical examination

   B. X-ray and laboratory results (State if none or pending.)

20. **DIAGNOSIS** (if occupational illness, specify etiologic agent and duration of exposure.) Chemical or toxic compounds involved?? ☐ Yes ☐ No

ICD-9 Code ___ ___ ___ . ___ ___

21. Are your findings and diagnosis consistent with patient's account of injury or onset of illness? ☐ Yes ☐ No
   If " no ", please explain.

22. Is there any other current condition that will impede or delay patient's recovery? ☐ Yes ☐ No
   If " yes ", please explain

23. **TREATMENT RENDERED** (Use reverse side if more space is required.)

24. If further treatment required, specify treatment plan/estimated duration.

25. If hospitalization as inpatient, give hospital name and location. Date admitted Mo. Day Yr. Estimated stay

26. **WORK STATUS**-- Is patient able to perform usual work? ☐ Yes ☐ No
   If "no", date when patient can return to: Regular work ________________
   Modified work ________________ Specify restrictions ________________

Doctor's Signature ________________ CA License Number ________________
Doctor Name and Degree (please type)________________ IRS Number ________________
Address________________ Telephone Number________________

FORM 5021 (REV 4)
1992
C-111

Any person who makes or causes to be made any knowingly false or fraudulent material statement or material representation for the purpose of obtaining or denying workers' compensation benefits or payments is guilty of a felony

WC-1

Dr. Williams *Chiropractic Office*
(909) 592-2823

PAIN QUESTIONNAIRE

DATE: ______/______/__________ **NAME:** ____

AREA(S) OF PAIN: ____

1. **Please Indicate Your Usual Level Of Pain During The Past Week!**

   No Pain = 0 1 2 3 4 5 6 7 8 9 10 = Worst Pain Possible

2. **Does Pain, Numbness, Tingling Or Weakness Extend Into Your Back- Arm(s) – Legs?**

   No Pain = 0 1 2 3 4 5 6 7 8 9 10 = Worst Pain Possible

3. **How Would You Rate Your General Health?**

   Good = 0 1 2 3 4 5 6 7 8 9 10 = Not Good At All

4. **If You Had To Spend The Rest Of Your Life With Your Condition As It Is Right Now – How Would You Feel About It?**

   Very Happy = 0 1 2 3 4 5 6 7 8 9 10 = Not Very Happy

5. **How Anxious – Tense – Uptight – Irritable – Fearful – Difficult In Concentrating – Relaxing – Have You Been Feeling During The Past Week?**

   No Tension = 0 1 2 3 4 5 6 7 8 9 10 = Very Tense

6. **How Much Have You Been Able To Control - Reduce – Help – Your Pain – On Your Own During The Past Week?**

   Very Controlled = 0 1 2 3 4 5 6 7 8 9 10 = No Control

7. **Please Indicate How Depressed – Down in The Dumps – Sad – Downhearted – In Low Spirits – Pessimistic Feelings I Have Been Feeling In The Past Week?**

   No Depression = 0 1 2 3 4 5 6 7 8 9 10 = Very Depressed

8. **How Certain Are You That You Will Be Doing Normal Activities Or Working Without Pain In Six (6) Months?**

   Very Certain = 0 1 2 3 4 5 6 7 8 9 10 = Not Certain

9. **Can You State "I Can Do Light Work For An Hour"**

   I Can = 0 1 2 3 4 5 6 7 8 9 10 = No I Cannot

10. **Can You State I Can Sleep At Night."**

    I Sleep All Night = 0 1 2 3 4 5 6 7 8 9 10 = I Cannot Sleep At Night

11. **An Increase In Pain Is An Indication That I Should Stop What I Am Doing Until The Pain Decreases Or Goes Away!**

    No Increase In Pain = 0 1 2 3 4 5 6 7 8 9 10 = I Have A Increase In Pain

12. **Physical Activity Makes My Pain Worse!**

    No = 0 1 2 3 4 5 6 7 8 9 10 = Yes Physical Activity Makes My Pain Worse

13. **I Should Not Do My Normal Activities Including Work With My Present Pain!**

    Able To Do My Normal Activities = 0 1 2 3 4 5 6 7 8 9 10 = Not Able To Do My Normal Activities

Dr. Williams *Chiropractic Office*

PLEASE CHECK ALL PRESENT SYMPTOMS

Please Circle Right or Left

DATE _____/_____/_______ **NAME** ____

PRINT FIRST PRINT MIDDLE PRINT LAST

HEAD

_____ HEADACHES
_____ SINUS
_____ MIGRAINE HEADACHE
_____ HEADACHE ON TOP OF HEAD
_____ HEADACHE ON BACK OF HEAD
_____ HEADACHE ON FOREHEAD
_____ HEADACHE ON SIDE OF HEAD
_____ HEAD FEELS HEAVY
_____ LIGHT HEADEDNESS
_____ DIZZINESS
_____ RINGING IN EARS

NECK

_____ PAIN IN NECK
_____ NECK PAIN WITH MOVEMENT
_____ MUSCLE SPASMS

SHOULDERS

_____ PAIN IN RIGHT SHOULDER
_____ PAIN IN LEFT SHOULDER
_____ PAIN ACROSS SHOULDERS
_____ UNABLE TO MOVE SHOULDER
_____ MUSCLE SPASMS IN SHOULDER

ARMS & HANDS

_____ PAIN IN UPPER RIGHT OR LEFT ARM
_____ PAIN IN RIGHT OR LEFT ELBOW
_____ PAIN IN RIGHT OR LEFT FOREARM
_____ PAIN IN RIGHT OR LEFT HAND
_____ NUMBNESS IN RIGHT OR LEFT EXTREMITY

MID - BACK

_____ MID BACK PAIN
_____ DULL PAIN
_____ SHARP PAIN

ABDOMEN

_____ STOMACH PAIN
_____ GAS
_____ CONSTIPATION
_____ DIARRHEA
_____ NAUSEA
_____ HEMORRHOIDS

LOWER BACK

_____ LOW BACK PAIN
_____ LOW BACK PAIN UPON MOVEMENT
_____ MUSCLE SPASMS

LEGS & FEET

_____ PAIN IN UPPER RIGHT OR LEFT LEG
_____ PAIN IN RIGHT OR LEFT KNEE
_____ PAIN IN RIGHT OR LEFT LEG
_____ PAIN IN RIGHT OR LEFT ANKLE
_____ PAIN IN RIGHT OR LEFT FOOT

CHEST

_____ CHEST PAIN
_____ RADIATING CHEST PAIN
_____ SHORTNESS OF BREATH
_____ BREAST PAIN RIGHT OR LEFT

NOTES

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