



ELANCO CHIROPRACTIC, INC.

1907 Division Highway • Ephrata, PA 17522

Office: 717-355-5000 • Fax: 717-354-8587

www.elancochiropractic.com

Building Healthy Living

Confidential Case History: Workers Compensation/Injury Related:

Today's Date: _____ How did you hear about our office? _____

First Name: _____ MI. _____ Last Name: _____

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

Home Phone: _____ - _____ - _____ Cell phone: _____ - _____ - _____

Male/Female Date of Birth ____/____/____ Age: _____ Email: _____

Marital Status: S / M / D / W No. of Children: _____ Occupation: _____

Employer: _____

Work Phone: _____ - _____ - _____ Employed: Work Full /Part Time, Student Full/Part Time

Spouse: _____ Spouse Occupation: _____ Spouse Cell phone: _____ - _____ - _____

In addition to your spouse, whom should we contact in case of an emergency?

Name: _____ Relationship: _____

Phone: _____ - _____ - _____ Address: _____

MAJOR MEDICAL INSURANCE:

Insurance Company Name: _____

Address: _____

City: _____ State: _____ Zip Code: _____

Policy #: _____ Group #: _____

Phone: _____ - _____ - _____

ATTORNEY:

Name: _____

Address: _____ City: _____

State _____ Zip Code: _____ Phone: _____ - _____ - _____

Please put the appropriate symbol (X) or (O) on the line for any of the following symptoms
NOW have (X) OR **HAD** previously (O)

<p> <input type="checkbox"/> Neck Pain <input type="checkbox"/> Neck Stiffness <input type="checkbox"/> Neck Grating <input type="checkbox"/> Neck Tension <input type="checkbox"/> Mid-back Pain <input type="checkbox"/> Mid-back Stiffness <input type="checkbox"/> Mid-back Grating <input type="checkbox"/> Mid-back Tension <input type="checkbox"/> Low back Pain <input type="checkbox"/> Low back Stiffness <input type="checkbox"/> Low back Grating <input type="checkbox"/> Low back Tension </p> <p><u>Pain in:</u></p> <p> <input type="checkbox"/> Shoulders <input type="checkbox"/> Arms <input type="checkbox"/> Hands <input type="checkbox"/> Hips <input type="checkbox"/> Legs <input type="checkbox"/> Feet </p> <p><u>Numbness in:</u></p> <p> <input type="checkbox"/> Shoulders <input type="checkbox"/> Arms <input type="checkbox"/> Hands <input type="checkbox"/> Hips <input type="checkbox"/> Legs <input type="checkbox"/> Feet </p> <p><u>Other Conditions:</u></p> <p>_____</p> <p>_____</p> <p>_____</p> <p>Do you have any heart conditions? YES / NO Explain:</p> <p>_____</p> <p>_____</p> <p>_____</p> <p>Do you any have lung conditions? YES / NO: Explain: _____</p>	<p> <input type="checkbox"/> Painful Tailbone <input type="checkbox"/> Sciatica <input type="checkbox"/> Painful Joints <input type="checkbox"/> Swollen Joints <input type="checkbox"/> Bursitis <input type="checkbox"/> Hernia <input type="checkbox"/> Pinched Nerves <input type="checkbox"/> Headaches <input type="checkbox"/> Migraines <input type="checkbox"/> Dizziness <input type="checkbox"/> Fainting <input type="checkbox"/> Fatigue <input type="checkbox"/> Anxiety <input type="checkbox"/> Depression <input type="checkbox"/> Bad moods and Behavior <input type="checkbox"/> Tremors <input type="checkbox"/> Insomnia <input type="checkbox"/> Sweats <input type="checkbox"/> Chills <input type="checkbox"/> Belching <input type="checkbox"/> Excessive Gas <input type="checkbox"/> Colon Trouble <input type="checkbox"/> Constipation <input type="checkbox"/> Diarrhea <input type="checkbox"/> Indigestion <input type="checkbox"/> Hemorrhoids <input type="checkbox"/> Nausea <input type="checkbox"/> Gall Bladder Trouble <input type="checkbox"/> Liver Trouble <input type="checkbox"/> Vomiting <input type="checkbox"/> Stomachaches <input type="checkbox"/> Asthma <input type="checkbox"/> Allergies <input type="checkbox"/> Sinus Problems <input type="checkbox"/> Tonsillitis <input type="checkbox"/> Eye Pain <input type="checkbox"/> Ringing in the Ears <input type="checkbox"/> High Blood Pressure <input type="checkbox"/> Low Blood Pressure <input type="checkbox"/> Chest Pains <input type="checkbox"/> Poor Circulation </p>	<p> <input type="checkbox"/> Chronic Cough <input type="checkbox"/> Difficulty Breathing <input type="checkbox"/> Bedwetting <input type="checkbox"/> Blood in Urine <input type="checkbox"/> Frequent Urination <input type="checkbox"/> Painful Urination <input type="checkbox"/> Kidney trouble <input type="checkbox"/> Prostate Trouble <input type="checkbox"/> Menstrual Cramps <input type="checkbox"/> Excessive Flow <input type="checkbox"/> Irregular Cycle <input type="checkbox"/> Pregnancy <input type="checkbox"/> Menopausal Symptoms <input type="checkbox"/> Lumps in Breast </p> <p><u>Conditions:</u></p> <p> <input type="checkbox"/> Alcoholism <input type="checkbox"/> Anemia <input type="checkbox"/> Arteriosclerosis <input type="checkbox"/> Arthritis <input type="checkbox"/> Cancer, Type: _____ _____ _____ <input type="checkbox"/> Diabetes <input type="checkbox"/> Drug Abuse <input type="checkbox"/> Epilepsy <input type="checkbox"/> Heart Disease <input type="checkbox"/> Miscarriage <input type="checkbox"/> Polio <input type="checkbox"/> Stroke <input type="checkbox"/> T.B. <input type="checkbox"/> Ulcers <input type="checkbox"/> Mental Disorders <input type="checkbox"/> Moles (color and/or size change) </p> <p>_____</p> <p>_____</p> <p>_____</p> <p>Other: _____</p> <p>_____</p> <p>_____</p> <p>_____</p>
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Current Medications (If possible please provide list): _____

PAST MEDICAL HISTORY:

Surgeries and Dates: _____

Serious Illnesses and Dates: _____

Fractures and Dates: _____

Worker's Compensation Injuries and Dates: _____

Auto Accidents, Dates, Injuries and Treatment: _____

Sports or Other Injuries, Dates and Treatment: _____

FAMILY HISTORY

<u>Relative</u>	<u>Age if Living</u>	<u>Age at Death</u>	<u>Cause of Death</u>	<u>State of Health</u>	<u>Illnesses</u>
Father	_____	_____	_____	_____	_____
Mother	_____	_____	_____	_____	_____
Brother(s)	_____	_____	_____	_____	_____
Sister(s)	_____	_____	_____	_____	_____
Maternal Grandfather	_____	_____	_____	_____	_____
Maternal Grandmother	_____	_____	_____	_____	_____
Paternal Grandfather	_____	_____	_____	_____	_____
Paternal Grandmother	_____	_____	_____	_____	_____

Social History: Smoke: () None Pack/Day _____ Years _____
 Alcohol: () Never () Social () Light () Moderate

What is your **Height:** _____ **Weight:** _____ **Shoe size:** _____ **Dominant Hand:** Right / Left

Date of Injury: ____/____/____

Did you report this injury in writing to your employer? Yes / No

History of Onset (Injury): _____

Please List Major Complaints:

1. _____

(rate your pain) Good- 0 1 2 3 4 5 6 7 8 9 10 -Bad

occasional intermittent frequent constant

THIS COMPLAINT AFFECTS: (Circle all that apply)

Work, Sleep, Driving, Hobbies, Bending, Eating, Grooming, Family Life, Lifting (light-medium-heavy)

2. _____

(rate your pain) Good- 0 1 2 3 4 5 6 7 8 9 10 -Bad

occasional intermittent frequent constant

THIS COMPLAINT AFFECTS: (Circle all that apply)

Work, Sleep, Driving, Hobbies, Bending, Eating, Grooming, Family Life, Lifting (light-medium-heavy)

3. _____

(rate your pain) Good- 0 1 2 3 4 5 6 7 8 9 10 -Bad

occasional intermittent frequent constant

THIS COMPLAINT AFFECTS: (Circle all that apply)

Work, Sleep, Driving, Hobbies, Bending, Eating, Grooming, Family Life, Lifting (light-medium-heavy)

4. _____

(rate your pain) Good- 0 1 2 3 4 5 6 7 8 9 10 -Bad

occasional intermittent frequent constant

THIS COMPLAINT AFFECTS: (Circle all that apply)

Work, Sleep, Driving, Hobbies, Bending, Eating, Grooming, Family Life, Lifting (light-medium-heavy)

5. _____

(rate your pain) Good- 0 1 2 3 4 5 6 7 8 9 10 -Bad

occasional intermittent frequent constant

THIS COMPLAINT AFFECTS: (Circle all that apply)

Work, Sleep, Driving, Hobbies, Bending, Eating, Grooming, Family Life, Lifting (light-medium-heavy)

Have you been under Chiropractic care before? Yes / No

If yes please describe: _____

Doctor's Name: _____ Date of Last Treatment: ____/____/____

Name of Practice: _____ Phone: _____ - _____ - _____

Have you ever had the same or similar condition in the past:

3 Months - Yes / No 6 Months - Yes / No 1 Year - Yes / No

If yes please describe: _____

Is there anything you can do to relieve the problem? Yes / No

If yes please describe: _____

Have you been treated for any other health condition in the past year? Yes / No

If yes please describe: _____

Name of Primary Care Physician: _____

Primary Care Physician Phone: _____ - _____ - _____

Hospital/Practice location: _____

WOMEN ONLY

Are you pregnant, or is there any possibility that you may be pregnant?

YES / NO

Signature: _____

Authorization and Release:

I authorize payment of insurance benefits directly to ELANCO Chiropractic and Rehabilitation Center, Inc and or the Owner/President of ELANCO Chiropractic Dr. Gary J. Greve. I understand and agree to allow this chiropractic office to use their Patient Health Information (PHI) for the purpose of treatment, payment, Healthcare operations and coordination of care. I understand that I am responsible for all cost of chiropractic care, regardless of insurance coverage. I also understand that if I suspend or terminate my schedule of care as determined by my treating doctors, any fees for professional services rendered will be immediately due and payable. I understand that interest is charged on overdue accounts at the annual rate of 18%.

Patient's/Guardians Signature _____ DATE: ____/____/____

Workers Compensation Injuries Form

Injuries involving Lifting:

From where were you lifting the object?

- Ground level
- Below ground level
- A surface about 1 to 2 feet off the ground
- A surface about 2 to 3 feet off the ground
- A surface about 3 to 5 feet off the ground
- A surface above 5 feet off the ground
- Other: _____

How many pounds was the object you were lifting?

- 1 to 5 pounds 5 to 10 pounds 10 to 20 pounds 20 to 40 pounds
- 40 to 60 pounds 60 to 80 pounds 80 to 100 pounds over 100 pounds
- Other: _____

What position were you in while lifting the object?

- Back was in an upright/straight position
- Position was bent over at the waist
- Position was twisted to the left side
- Position was twisted to the right side
- Other: _____

What type of pain did you feel immediately after the injury?

- A gripping pain A sharp pain A dull pain an achy pain
- A popping feeling Other: _____

Injuries involving Falling:

Where at work did you fall?

- Onto the ground while walking
- Onto the ground while running
- From a surface 1 to 3 feet off the ground
- From a surface 3 to 6 feet off the ground
- From a surface 6 to 9 feet off the ground
- From a surface higher than 9 feet off the ground
- Other: _____

What part of your body did you land on?

What type of surface did you land on?

- Hard
- Soft
- Flat
- Irregular

What other areas were injured as a result of your fall?

Selection: _____ (choose from list below)

- | | | | |
|-------------------|--------------------|---------------|------------------------|
| (A) Head | (F) Right Shoulder | (K) Right arm | (P) Right Hand |
| (B) Neck | (G) Left shoulder | (L) Left arm | (Q) Left Hand (I) Back |
| (C) Right buttock | (H) Tail bone | (M) Left hip | (R) Left Leg |
| (D) Left buttock | (I) Right hip | (N) Right leg | (S) Right knee |
| (E) Right knee | (J) Right foot | (O) Left knee | (T) Left foot |

Other work related injuries: _____

Other type of accident (if not caused by lifting or a fall)?

-
- Raised up from bending over
 - Twisted at the waist
 - Suffered a wrist injury from repetitive use
 - Suffered a wrist injury from pulling

Job Analysis:

What regular activities do you perform at your job?

- Bending and stooping Crawling Reaching above the shoulders
- Squatting Climbing Crouching
- Kneeling Maintaining an awkward posture
- Pushing and pulling Balancing

How much do you regularly lift at your job?

	Not at all	Occasionally	Frequently	Continuously
<input type="checkbox"/> 1 to 10 pounds	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> 11 to 24 pounds	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> 25 to 34 pounds	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> 35 to 50 pounds	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> 51 to 74 pounds	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> 75 to 100 pounds	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Over 100 pounds	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Are you required to regularly bend over while lifting at your job?

- Yes
- No

Are your hands subject to repetitive movements? Yes / No

If Yes, Such as?

- Light grasping with the left hand Firm grasping with the right hand
- Light grasping with both hands Firm grasping with the left hand
- Light grasping with the right hand Firm grasping with both hands
- Typing Using a computer mouse

Do you have to bend over while doing any lifting?

- Yes No

How many hours are you required to regularly perform each of the following activities at your job?

Sitting _____ hrs

Standing _____ hrs

Walking _____ hrs

Lifting _____ hrs

Check below if applicable:

- Did you report this injury in writing at work?
- Have you seen another health care provider since the accident?

Have you been treated by another doctor for this accident/Injury?

- 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? _____

Are you:

Improved Unchanged Getting worse

What type of medications are you taking for this injury?

Medications Help?

Yes NO Don't Know

Length of time worked there prior to accident: _____

Have you returned to work since you had the accident/Injury?

Yes No

Other: _____

Neck Pain:

- 1) My neck pain began: gradually suddenly
- 2) I have pain: sometimes all of the time
- 3) My pain goes into my: right arm left arm both
- 4) I have tingling and/or numbness in my: right arm left arm both

5) My pain is worse when I:

- | | | | | | |
|------------------------|------------------------------|-----------------------------|---------------------|------------------------------|-----------------------------|
| cough or sneeze | <input type="checkbox"/> Yes | <input type="checkbox"/> No | bend forward | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| lift | <input type="checkbox"/> Yes | <input type="checkbox"/> No | push | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| pull | <input type="checkbox"/> Yes | <input type="checkbox"/> No | turn my head | <input type="checkbox"/> Yes | <input type="checkbox"/> 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

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

5) I have tingling and/or numbness in my: right leg left leg both

6) My pain is worse when I:

- | | | | | | |
|------------------------|------------------------------|-----------------------------|-------------|------------------------------|-----------------------------|
| cough or sneeze | <input type="checkbox"/> Yes | <input type="checkbox"/> No | sit | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| bend | <input type="checkbox"/> Yes | <input type="checkbox"/> No | walk | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| lift | <input type="checkbox"/> Yes | <input type="checkbox"/> No | push | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| pull | <input type="checkbox"/> Yes | <input type="checkbox"/> No | | | |

7) My back pain is worse with sexual activity: Yes No

8) My pain wakes me up during the night: Yes No

9) Changes in the weather affect my pain: Yes No

Pain Drawing

Use the appropriate symbols shown below to mark the areas on your body where you feel these described sensations. Include ALL areas affected by your pain, and mark the type and area.

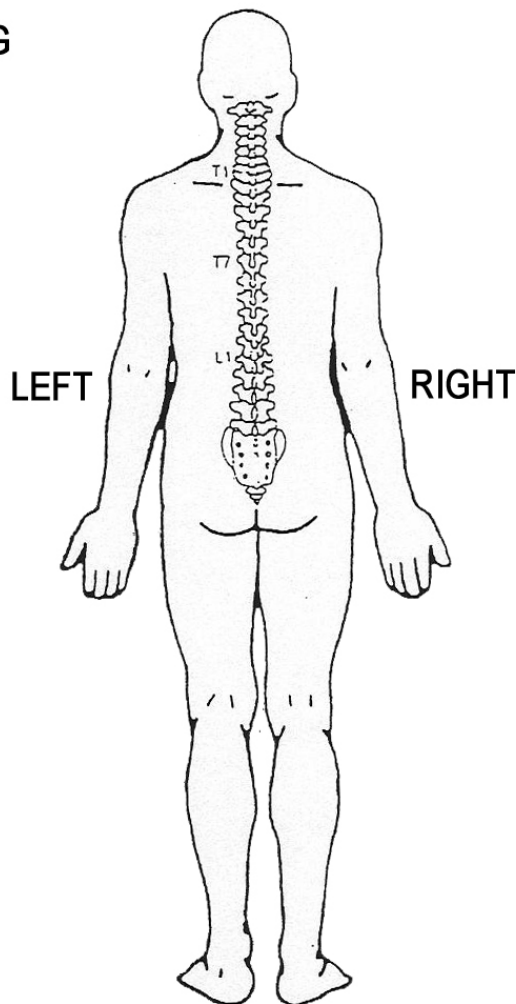
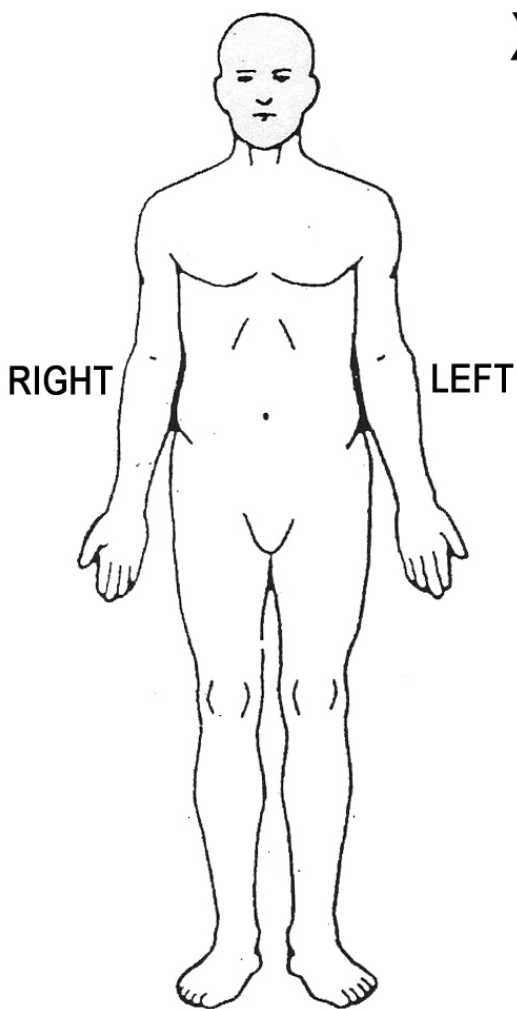
= PINS AND NEEDLES

O NUMBNESS

/ STABBING

X BURNING

^ ACHING



Signature: _____

Date: _____