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: _____

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: _____-_____-_____

Patient Name: _____ Date: _____

How did you hear about our office?

Please check all that apply

- ☐ Doctor : Name? _____
- ☐ Presentation
- ☐ Expo : Name? _____
- ☐ Postcard/letter
- ☐ Newsletter
- ☐ Newspaper
- ☐ Hometown Values Mag.
- ☐ Phonebook
- ☐ Internet Search
- ☐ ELANCO Website
- ☐ Facebook
- ☐ Staff : Name? _____
- ☐ Patient : Name? _____
- ☐ Care Enough to Share Card

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

___Neck Pain
___Neck Stiffness
___Neck Grating
___Neck Tension
___Mid-back Pain
___Mid-back Stiffness
___Mid-back Grating
___Mid-back Tension
___Low back Pain
___Low back Stiffness
___Low back Grating
___Low back Tension

Pain in:
___Shoulders
___Arms
___Hands
___Hips
___Legs
___Feet

Numbness in:
___Shoulders
___Arms
___Hands
___Hips
___Legs
___Feet

Other Conditions:
_____
_____
_____
_____

Do you have any heart conditions?
YES / NO Explain:
_____
_____
_____
_____

Do you any have lung conditions?
YES / NO:
Explain:_____

___Painful Tailbone
___Sciatica
___Painful Joints
___Swollen Joints
___Bursitis
___Hernia
___Pinched Nerves
___Headaches
___Migraines
___Dizziness
___Fainting
___Fatigue
___Anxiety
___Depression
___Bad moods and Behavior
___Tremors
___Insomnia
___Sweats
___Chills
___Belching
___Excessive Gas
___Colon Trouble
___Constipation
___Diarrhea
___Indigestion
___Hemorrhoids
___Nausea
___Gall Bladder Trouble
___Liver Trouble
___Vomiting
___Stomachaches
___Asthma
___Allergies
___Sinus Problems
___Tonsillitis
___Eye Pain
___Ringing in the Ears
___High Blood Pressure
___Low Blood Pressure
___Chest Pains
___ Poor Circulation

___Chronic Cough
___Difficulty Breathing
___Bedwetting
___Blood in Urine
___Frequent Urination
___Painful Urination
___Kidney trouble
___Prostate Trouble
___Menstrual Cramps
___Excessive Flow
___Irregular Cycle
___Pregnancy
___Menopausal Symptoms
___Lumps in Breast

Conditions:
___Alcoholism
___Anemia
___Arteriosclerosis
___Arthritis
___Cancer, Type:_____
_____
_____
___Diabetes
___Drug Abuse
___Epilepsy
___Heart Disease
___Miscarriage
___Polio
___Stroke
___T.B.
___Ulcers
___Mental Disorders
___Moles (color and/or size change)
_____
_____

Other: _____
_____
_____
_____
_____

Current Medications (If possible please provide list): _____

_____

PAST MEDICAL HISTORY:

Surgeries and Dates:_____

_____

Serious Ilnesses 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

Relative	Age if Living	Age at Death	Cause of Death	State of Health	Illnesses
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 Each Major Complaints: (ex: neck, back, shoulder, etc.)

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)

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**
( ) 1 to 10 pounds	( )	( )	( )	( )
( ) 11 to 24 pounds	( )	( )	( )	( )
( ) 25 to 34 pounds	( )	( )	( )	( )
( ) 35 to 50 pounds	( )	( )	( )	( )
( ) 51 to 74 pounds	( )	( )	( )	( )
( ) 75 to 100 pounds	( )	( )	( )	( )
( ) Over 100 pounds	( )	( )	( )	( )

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: _____

_____

_____

<u>Neck Pain:</u>

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	**( ) Yes ( ) No**	**bend forward**	**( ) Yes ( ) No**
lift	**( ) Yes ( ) No**	**push**	**( ) Yes ( ) No**
pull	**( ) Yes ( ) No**	**turn my head**	**( ) Yes ( ) 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**

<u>Back Pain:</u>

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	**( ) Yes ( ) No**	**sit**	**( ) Yes ( ) No**
bend	**( ) Yes ( ) No**	**walk**	**( ) Yes ( ) No**
lift	**( ) Yes ( ) No**	**push**	**( ) Yes ( ) No**
pull	**( ) Yes ( ) No**		

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

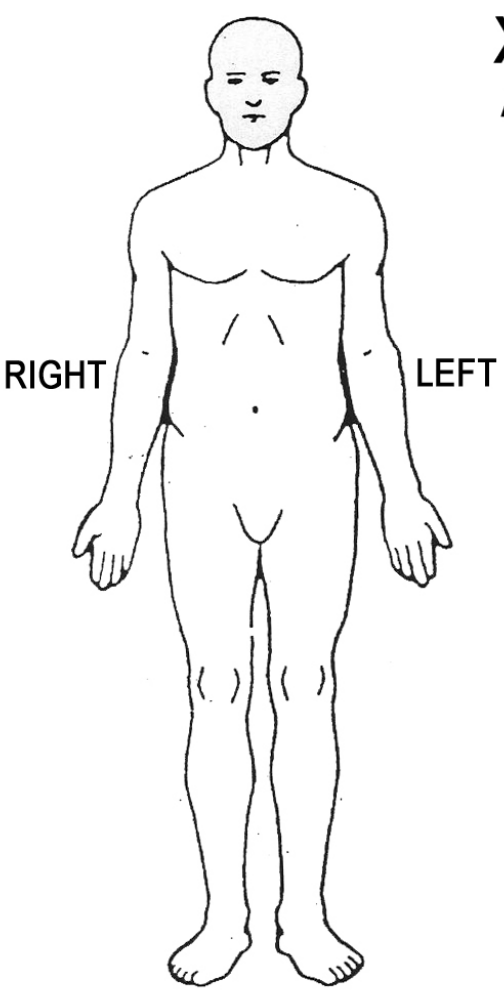
8) My pain wakes me up during the night: **( ) Yes ( ) No**

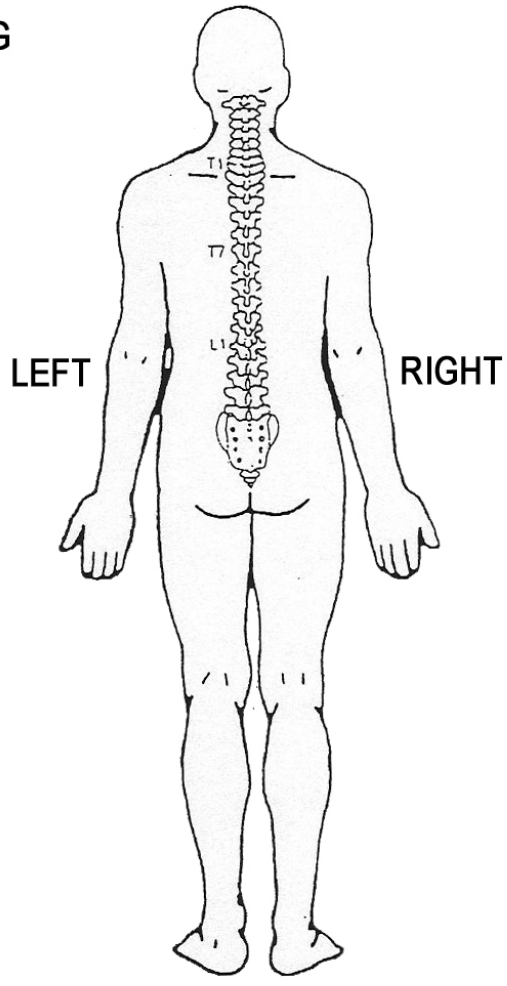
9) Changes in the weather affect my pain: **( ) Yes ( ) No**

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: _____