



Lakes Chiropractic



Worker Compensation Information

Patient Information

Name _____ Date _____
 Address _____ Home Phone() _____
 City _____ State _____ Zip _____
 Date of Birth ___/___/___ Age ___ Sex M F Social Security# _____

Employer

Employer Name _____
 Employer Address _____
 Employer Phone _____ Contact Person _____

Worker Compensation Carrier (for office use)

Worker Compensation Carrier _____
 Carrier Address _____
 Carrier Phone Number _____ Coverage verified by _____
 Adjuster's Name _____ Claim Number _____

Injury Prevention

Date of Injury _____ Time _____ AM PM
 Place of Injury _____
 Accident reported to employer? __Yes__No Name of person you reported accident
 to _____
 Give full description of how accident happened _____

Have you lost time from work? __Yes__No How much? _____
 Other doctors seen for this condition?
 Doctor's Name _____ Diagnosis _____
 Were x-rays taken? __Yes__No Other tests? __Yes__No
 If yes, by whom? Please list test(s) and result(s) _____

Any previous Worker Compensation injuries? __Yes__No Date(s) of previous injuries _____
 Describe previous Worker Compensation injuries _____

Authorization

I clearly understand and agree that all services rendered to me are charged directly to me and that I am personally responsible for payment in the event that my claim for Workers Compensation benefits is denied.

Patient's Signature _____ Date _____

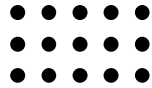
Draw in your face.

Show area(s) of pain or unusual feeling.

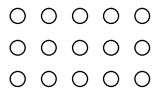
Mark the areas on this body where you feel the described sensations. Use the appropriate symbols.

Mark areas of radiation. Include all affected areas.

Numbness



Pins & Needles



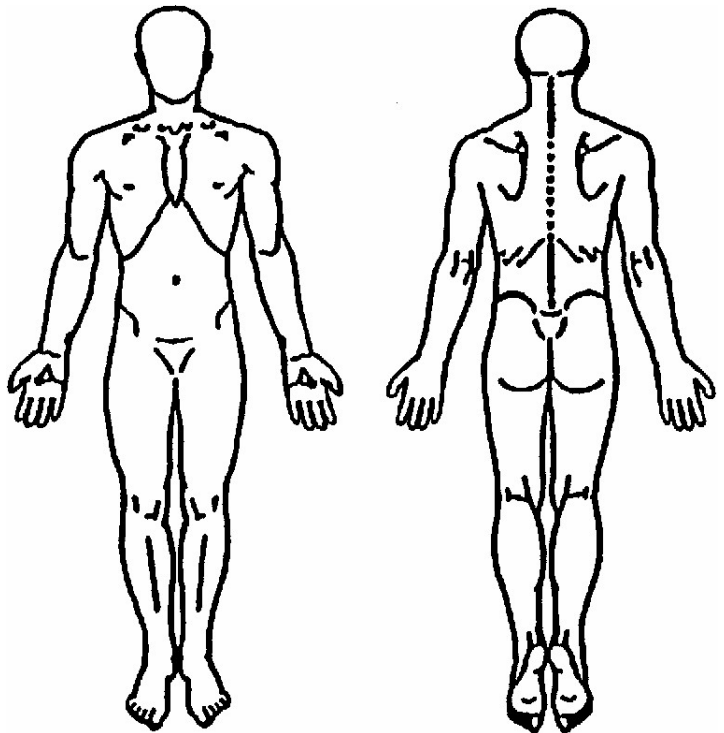
Burning



Aching



Stabbing



AUTHORIZATION FOR CARE

I hereby authorize Lakes Chiropractic and its doctors to administer care as they deem necessary. I authorize the doctors to take x-rays, perform an exam and administer treatment. I clearly understand and agree that I am personally responsible for payment of any fees not covered by my insurance.

Signature: _____ Date: _____

TERMS OF ACCEPTANCE

When a patient seeks chiropractic health care and we accept a patient for such care, it is essential for both parties to be working towards the same objective. Chiropractic care has only one goal; which is to obtain optimal health. It is important that each patient understands the objective and the method that will be used to attain it. This will prevent any confusion or disappointment.

Adjustment: An adjustment is the specific application of manual forces to facilitate the body's correcting of vertebral subluxation. Our chiropractic method of correction is by specific adjustments of the spine.

Health: A state of optimal physical, mental and social well being, not merely the absence of disease or infirmity.

Vertebral subluxation: A misalignment of one or more on the 24 vertebra in the spinal column which causes alteration of nerve function and interference to the transmission of mental impulses, resulting in lessening of the body's innate ability to express its maximum health potential.

We do not offer to diagnose or treat any disease or condition other than vertebral subluxation. However, if during the course of a chiropractic spinal exam, we encounter non-chiropractic or unusual findings, we will advise you. If you desire advice, diagnosis or treatment of any findings we will recommend that you seek the services of a health care provider who specializes in that area.

Regardless of what the disease is called, we do not offer to treat it, nor do we offer advice regarding treatment prescribed by other. **OUR ONLY PRACTICE OBJECTIVE** is to eliminate a major interference to the expression of the body's innate wisdom. Our only method is specific manual manipulation of the spine to correct vertebral subluxation.

I, _____, have read and fully understand the above statements. All questions regarding the doctor's objectives pertaining to my care in this office have been answered to my complete satisfaction. Therefore I accept chiropractic care on this basis.

Signature

Date