FRED C. NELSON, D.C., C.C.S.P.
RUSS C. REDD, D.C.

10405-F Ligon Mill Road Wake Forest, NC 27587 (919) 556-2014

Welcome

to our office!

To insure your first visit with us is a pleasant one, here are the procedures you can expect during the next 50 minutes with us.

Paperwork
Complete this brief questionnaire to help us get to know you. The doctor will use this information to helps formulate the recommendations for your care.

Patient Education
To acquaint you with our office and explain how we help our patients regain their health.

Consultation
You'll meet the doctor who will review your health history and determine if yours is a chiropractic case.

Examination
Standard physical, orthopedic, neurological, and chiropractic tests will be performed to determine the cause(s) of your problem.

X-ray Exam
Necessary views may be taken to visualize the location of any spinal problems, reveal any pathologies, and make your chiropractic care more precise.

Correlation
Before proper care can be rendered the Doctor will study your examination findings.

Adjunctive Procedures
The doctor may suggest the application of ice, heat, or the use of some other procedure to help reduce inflammation and make you more comfortable.

Next Visit
Your first visit is complete. Plan to spend about 45 minutes on your next visit to receive the Doctor's report of findings and chiropractic care.

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WORKER'S COMPENSATION INTAKE FORM

PLEASE PRINT THE FOLLOWING INFORMATION: **DATE:** ______________________

FULL, LEGAL NAME: ____ GENDER: _________

BIRTHDATE: ________________ AGE: _______ SOCIAL SECURITY NUMBER: __________________

PHONE: (H) _______________________ (W) _____________________ OTHER: ___________________

ADDRESS: ____

CITY: ____ STATE: _________ ZIP CODE: ______________

MARITAL STATUS (Circle one): MARRIED SINGLE DIVORCED OTHER CHILDERN (#): _____

SPOUSE'S NAME (IF APPLICABLE): ____

EMPLOYER: _________________________________ OCCUPATION/JOB TITLE: _________________

EMPLOYER ADDRESS: ____

CITY: ____________________________________ STATE: ____________ ZIP CODE: ______________

Have you ever applied for Worker's Compensation benefits before this injury (Circle one): YES NO

DATE: _______What was the time lost from work? _______ Have you fully recovered (Circle one)? YES NO

If NO, explain: ____

How long have you been at your present job? ____

When was the injury sustained? DATE: _________________________ TIME: ________________ AM/PM

Describe in your own words, how and where the accident/injury happened: ____________________________

____

____

____

Was pain felt immediately (Circle one): YES NO If YES, where: _______________________________

If NO, when did symptoms begin? _______________ Describe: ___________________________________

Did you return to work following the injury (Circle one): YES NO When? ______________________

Did condition gradually worsen with the continuation of work duties (Circle one): YES NO

Explain: ____

Have you missed ANY time from work due to the injury (Circle one)? YES NO If YES, how much? ______

When the injury occurred, were you performing a normal job duty (Circle one)? YES NO

Did anyone witness the accident (Circle one)? YES NO NAME: ______________________________

Did you report the accident to your Employer on the Industrial Commission's FORM 18 (Circle one): YES NO

Date reported: ________________ Name of Employer that you reported injury to: ________________________

Title: ______________________________ Direct Phone Number: ____________________________________

Did Employer refer you to a specific Physician of Facility for medical treatment (Circle one)? YES NO

If YES, list name of Physician and/or Facility: ____

Did you seek medical attention with the recommended Physician of Facility (Circle one)? YES NO

If YES, when? _________________ List treatment and recommendations given: ________________________

List any past surgeries/medical history: __________________________ Medications: ____________________

Were you satisfied with the Physician of Facility that Employer recommended for care (Circle one): YES NO

If NO, describe: ____

Has your Employer been informed of your visit to our office (Circle one)? YES NO When: _____________

Has your Employer authorized your chiropractic treatment in our office (Circle one)? YES NO

Have you retained an Attorney (Circle one)? YES NO NAME: __________________ PHONE: __________

What are your current symptoms and chief complaints? ____

____

What actions aggravate your symptoms? ____

What actions relieve your symptoms? ____

Since injury occurred, is condition (Circle one): IMPROVED WORSE SAME CONSTANT COME & GO

JOB DUTIES

Do you pick up or lift (Circle one)? YES NO If you lift, how much? __________ How often? __________

When working, do you mostly (Circle one): SIT STAND WALK DRIVE/RIDE KNEEL

In your job, do you push or pull (Circle one): YES NO If YES, give specifics: _________________________

List any other details or specifics about job description and duties: ____________________________________

____

JOB CONDITIONS

Type of building: _________________________________ Workstation:_______________________________

Type of floor (Circle one): ROUGH SMOOTH WOOD CONCRETE STEEL CARPET

Average work week: Hours: ___________________ Days: ______________________

Do work related injuries seem to occur often at your place of employment (Circle one)? YES NO

Could improvements be made to decrease rates of injury (Circle one)? YES NO Explain: _______________

____

PATIENT'S NAME: ____ DATE: _________________

SIGNATURE: ____ DATE: _________________