Bartz Chiropractic
1316 SW 4th Terrace, Suite 102
Cape Coral, FL 33991

Compensation History

Date _____

Name_____
First **Middle** **Last**

Address_____

City_____**State**_____**Zip**_____

Soc Sec #_____**Home Phone**_____

Birthdate_____ **Age**_____ **Gender: M F**

Marital Status: M S W D **Number of Children**_____

EMPLOYER INFORMATION

Name_____

Address_____

_____

Work Phone_____

EMPLOYER'S COMPENSATION CARRIER NAME AND ADDRESS

_____
_____
_____

INJURY INFORMATION

Date of Accident: _____ Location where happened: _____

In your own words, please describe how accident happened: _____
_____
_____
_____
_____

In your own words, please describe injury received: _____
_____
_____
_____
_____

Was accident reported to employer?: _____Yes _____No

Length of time worked there prior to accident: _____

Type of work being done at time injury: _____

Have you been treated by another doctor (MD or DC) for this accident? _____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 types of medicines are you taking? _____
_____

Do these medicines help? ( )Yes ( ) No ( ) Don't know

Have you had physical therapy? ( )Yes ( ) No If yes, how often?
_____

Prior to this accident, have you ever had any of the physical complaints similar to what you have now?
( ) Yes ( ) No ( ) Don't know If yes, describe: _____
_____

Have you had any other serious accidents which required medical care? ( ) Yes ( ) No
Describe: _____

Have you had any serious illnesses that required hospitalization? ( ) Yes ( ) No
Describe: _____

Have you had any surgeries? ( ) Yes ( ) No
If yes, list type of surgery and date: _____
_____

Have you returned to work since this accident? ( ) Yes ( ) No If no, please give disability date: __/__/___
*If you have returned to work since your accident, please fill out the information below:

DATE	EMPLOYER	OCCUPATION	LIGHT DUTY REG. DUTY	FULL-TIME PART-TIME

Current Medical Complaints

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 ( ) neither
5. I have tingling and/or numbness in my: .....( ) right leg ( ) left leg ( ) both ( ) neither
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

Neck Pain: Complete only if applicable

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

Other Pain:

Please describe any current medical complaints which you are experiencing and were not previously covered on this questionnaire, or list any additional comments you wish to make regarding your condition._____

_____

_____

Job Description: *(In terms of an 8 hour workday, "occasionally" means 33%, "frequently" means 34% to 66% and "continuously" means 67% to 100% of the day.)*

1. In a typical 8-hour workday, I: (Circle # of hours / activity)

Sit:	1	2	3	4	5	6	7	8	hours
Stand:	1	2	3	4	5	6	7	8	hours
Walk:	1	2	3	4	5	6	7	8	hours

2. On the job, I perform the following activities:

	NOT AT ALL	OCCASIONALLY	FREQUENTLY	CONTINUOUSLY
Bend/stoop	( )	( )	( )	( )
Squat	( )	( )	( )	( )
Crawl	( )	( )	( )	( )
Climb	( )	( )	( )	( )
Reach above shoulder level	( )	( )	( )	( )
Crouch	( )	( )	( )	( )
Kneel	( )	( )	( )	( )
Balancing	( )	( )	( )	( )
Pushing/ Pulling	( )	( )	( )	( )

3. On the job, I lift:

	NOT AT ALL	OCCASIONALLY	FREQUENTLY	CONTINUOUSLY
Up to 10 pounds	( )	( )	( )	( )
11 to 24 pounds	( )	( )	( )	( )
25 to 34 pounds	( )	( )	( )	( )
35 to 50 pounds	( )	( )	( )	( )
51 to 74 pounds	( )	( )	( )	( )
75 to 100 pounds	( )	( )	( )	( )

4. Do you have to bend over while doing any lifting? ( ) Yes ( ) No

5. Are your feet used for repetitive movements, such as in operating foot controls? ( ) Yes ( ) No

6. Do you use your hands for repetitive actions, such as:

	SIMPLE GRASPING	FIRM GRASPING	FINE MANIPULATION
Right Hand	( ) Yes ( ) No	( ) Yes ( ) No	( ) Yes ( ) No
Left Hand	( ) Yes ( ) No	( ) Yes ( ) No	( ) Yes ( ) No

7. Are you required to be around moving machinery? ( ) Yes ( ) No
   Describe: _____
   _____
   _____

9. Are you required to drive automotive equipment? ( ) Yes ( ) No
   Describe: _____
   _____
   _____

10. Are you exposed to dust, fumes and/or gasses? ( ) Yes ( ) No
    Describe: _____
    _____
    _____

11. Please list any additional comments: _____
    _____
    _____
    _____

Work Injury – I was injured in the course of employment and am eligible to have my expenses covered under workman's compensation. Please read Financial Arrangements below and sign and date.

Assignment Authorization, Power of Attorney and Agreement

In that the office is waiting for the payment of some or all of its fees, I agree to provide the office with information and forms regarding any potential source of fee payment, to assist in any way I can, and,

1. I hereby assign to this office my rights to received payments from negligent parties or from insurance companies. Payments should be payable to and mailed to:

Bartz Chiropractic, LLC
Daniel J. Bartz, D.C.
1316 SW 4th Terrace, Suite 102
Cape Coral, FL 33991

If my policy prohibits assignments, then check should be payable to me and sent to the above address
2. I understand that if this office receives more than their fees, the office will pay any credit balances to me, the PATIENT.
3. I authorize the office to release any information to any insurance company, adjustor, or attorney that will assist in the payment of a claim.
4. I appoint this office as attorney-in-fact to correspond in my behalf with insurance companies, to negotiate any settlement and to cash any settlement draft or check. Counsel, insurance companies and negligent parties be advised that, no settlement can be effectuated without the agreement of this office or the office's release of this specific provision
5. I fully understand and agree that insurance policies are an arrangement between an insurance carrier and myself. I will be responsible for any expenses not paid by insurance.
6. A photocopy of this form shall be valid as the original.

Signature _____ Date _____