Workers Compensation Form

Healing Arts Center of Lenexa

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Lenexa, KS 66219
Tel. (913) 894-4428 * Fax (913) 894-4427
www.healingartscenterlenexa.com

Today's Date: _____

Patient's Name: _____ **Date of Birth:** _____

Brief Description of Accident:

_____

_____

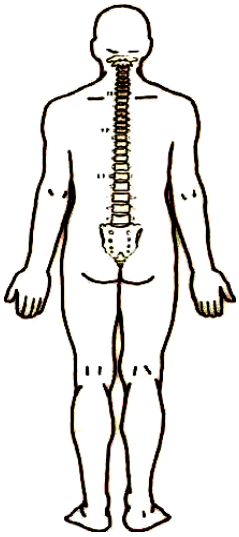
_____

Date & Location of Accident:

_____

Select region of pain and circle the number indicating the pain's severity

Burning • Stabbing • Sharp • Constant



EXAMPLE: NECK _____ Sharp

1 2 3 4 5 6 (7) 8 9 10

NECK _____

1 2 3 4 5 6 7 8 9 10

MID BACK _____

1 2 3 4 5 6 7 8 9 10

LOW BACK _____

1 2 3 4 5 6 7 8 9 10

HIPS _____

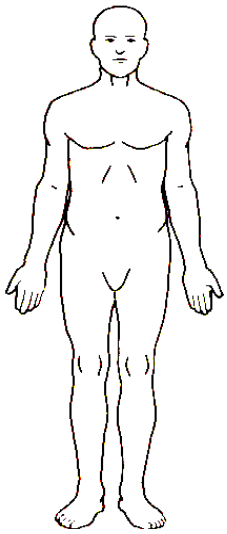
1 2 3 4 5 6 7 8 9 10

ARMS _____

1 2 3 4 5 6 7 8 9 10

LEGS _____

1 2 3 4 5 6 7 8 9 10



Please draw on the figures where you have any of the following:

A= Ache **SF**= Stiffness **SH**= Sharp **S**= Soreness **N**= Numbness **P**= Pain **C**= Constant **XX**= Other

When did you feel pain after the accident? Immediately Later that day Next day

Where did you feel pain after the accident? _____

Where were you taken after the accident? _____

Are your work activities restricted now? Yes No

Since the injury, are your symptoms: Improving Getting worse Same

Patient Name:_____ **Date of Birth:**_____

Please identify how any of your current conditions is affecting your ability to carry out activities that may be routinely part of your life.

Walking	□ No Effect	□ Painful (can do)	□ Painful (limited)	□ Unable to perform
Standing	□ No Effect	□ Painful (can do)	□ Painful (limited)	□ Unable to perform
Running	□ No Effect	□ Painful (can do)	□ Painful (limited)	□ Unable to perform
Pushing	□ No Effect	□ Painful (can do)	□ Painful (limited)	□ Unable to perform
Reading	□ No Effect	□ Painful (can do)	□ Painful (limited)	□ Unable to perform
Gardening	□ No Effect	□ Painful (can do)	□ Painful (limited)	□ Unable to perform
Dancing	□ No Effect	□ Painful (can do)	□ Painful (limited)	□ Unable to perform
Shoveling	□ No Effect	□ Painful (can do)	□ Painful (limited)	□ Unable to perform
Sleeping	□ No Effect	□ Painful (can do)	□ Painful (limited)	□ Unable to perform
Doing Chores	□ No Effect	□ Painful (can do)	□ Painful (limited)	□ Unable to perform
Rolling Over	□ No Effect	□ Painful (can do)	□ Painful (limited)	□ Unable to perform
Watching T.V.	□ No Effect	□ Painful (can do)	□ Painful (limited)	□ Unable to perform
Playing Sports	□ No Effect	□ Painful (can do)	□ Painful (limited)	□ Unable to perform
Sitting	□ No Effect	□ Painful (can do)	□ Painful (limited)	□ Unable to perform
Sitting to Standing	□ No Effect	□ Painful (can do)	□ Painful (limited)	□ Unable to perform
Computer Work	□ No Effect	□ Painful (can do)	□ Painful (limited)	□ Unable to perform
Sexual Activity	□ No Effect	□ Painful (can do)	□ Painful (limited)	□ Unable to perform
Bending	□ No Effect	□ Painful (can do)	□ Painful (limited)	□ Unable to perform
Lifting	□ No Effect	□ Painful (can do)	□ Painful (limited)	□ Unable to perform
Carrying	□ No Effect	□ Painful (can do)	□ Painful (limited)	□ Unable to perform
Dressing	□ No Effect	□ Painful (can do)	□ Painful (limited)	□ Unable to perform
Working	□ No Effect	□ Painful (can do)	□ Painful (limited)	□ Unable to perform
Driving	□ No Effect	□ Painful (can do)	□ Painful (limited)	□ Unable to perform
Climbing	□ No Effect	□ Painful (can do)	□ Painful (limited)	□ Unable to perform
Concentrating	□ No Effect	□ Painful (can do)	□ Painful (limited)	□ Unable to perform
Recreation	□ No Effect	□ Painful (can do)	□ Painful (limited)	□ Unable to perform

Was any doctor consulted after the accident occurred? Yes No

If yes, please provide the following:

Name: _____

Phone: _____

Doctor's Diagnosis: _____

Was any treatment given? What type? _____

How often and long did you see this doctor? _____

Have you ever had any complaints in the involved area before? Yes No

If yes, what were the complaints?

_____

Before the injury, were you capable of working on an equal basis with others your age?

Yes No

Patient Name:_____ **Date of Birth:**_____

Employer Name: _____

Employer Address: _____

Authorizing Supervisor's Name: _____

Phone Number: _____ **Extension:** _____

Fax Number: _____

E-Mail: _____ @ _____

Insurance Carrier: _____

Claim #: _____

Insurance Address: _____

Phone Number: _____ **Contact Name:** _____

CONSENT FOR TREATMENT

I hereby request and consent to the performances of chiropractic adjustments and other chiropractic procedures. This includes various modes of physical therapy and diagnostic x-rays on the named patient, for whom I am legally responsible, by the doctor of chiropractic named below and/or other licensed doctors of chiropractic who now or in the future work at the Healing Arts Center of Lenexa. I have had an opportunity to discuss the nature and purpose of chiropractic adjustments and other procedures with the doctor of chiropractic named below and/or with other clinic personnel. I understand that results are not guaranteed. I understand that in the practice of chiropractic, as in the presence of medicine, there are some risks. I do not expect the doctor to be able to anticipate and explain all risk and complications. I wish to rely upon the doctor to exercise judgement during the course of the procedure, which the doctor feels at the time is in the patient's best interest, based upon the facts then known to him or her. I have also had the opportunity to ask questions about is content, and by signing below I agree to the above named procedures. I intend this consent form to cover the entire course of treatment for the present condition and for any future condition(s) for which I seek treatment.

Dated: _____

Patient's Name: _____

Patient's Signature: _____

Eugene Lockrow, DC **Brenda Casey, DC** **Mike Hamilton, DC** **Emilio John, DC**
Nicholas Lockrow, DC **Colton Bartels, DC** **Blain Kingsbury, DC, RTP, BCIM**
Katherine Kubovy, DC, DABCI