



ATLANTIC CHIROPRACTIC

PHONE: 302-422-3100 * ACA-DE.COM * FAX: 302-422-2900

Workers Compensation - New Condition Intake

Title: ☐ Dr. ☐ Mr. ☐ Mrs. ☐ Ms. ☐ Miss (check one) **Sex:** ☐ Male ☐ Female **Date:** _____/_____/_____

First Name: _____ **Middle Initial:** _____ **Last Name:** _____

Date of Birth: _____/_____/_____ **Age:** _____ **Email:** _____

Address: _____

City: _____ **State:** _____ **Zip Code:** _____

Mobile/Home Phone: (_____) _____-_____

Primary Medical Provider: _____ **Practice/Facility:** _____ **City:** _____

Orthopedist / Neurologist: _____ **Practice/Facility:** _____ **Date seen:** _____

[Please notify the front desk if you have had any imaging related to this complaint.]

Patient Employer Data:

Employment Status: ☐ Employed (☐ FT/ ☐ PT) ☐ Student ☐ Retired ☐ Homemaker ☐ Unemployed

Employer Name: _____

Address Line: _____ **City:** _____ **State:** _____

Job Title/Position: _____ **Physical work duties:** _____

Marital Status: ☐ Single ☐ Married ☐ Other _____ **Is your spouse a patient in the clinic?** ☐ Yes ☐ No

Spouse Data:

First Name: _____ **Middle:** _____ **Last Name:** _____

Phone: (_____) _____-_____

Emergency Contact:

Contact Name: _____ **Relationship:** _____

Phone: (_____) _____-_____

For Office Use Only: (Staff: _____)

Height: _____ **Weight:** _____ **BP:** _____ **Pulse:** _____

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PHONE: 302-422-3100 FAX: 302-422-2900

Date of Injury / Accident: _____ **Location (What State?):** _____

- Patient Employer: _____ Was employer notified? ☐ Yes ☐ No
- Do you have an attorney? ☐ Yes ☐ No If yes, who? _____

(Staff use only)

Describe how you were injured (REQUIRED TO FILE A WORK CLAIM):

After the Injury:

- Immediately after the injury, did you experience (circle area(s) and select left and/or right side):
 - Headaches • Neck Pain (☐L / ☐R) • Mid Back Pain (☐L / ☐R)
 - Low Back Pain (☐L / ☐R) • Shoulder/Arm Pain (☐L / ☐R) • Hip/Leg Pain (☐L / ☐R)
 - Other: _____

- What are your current complaints? (circle area(s) and select left and/or right side):
 - Headaches • Neck Pain (☐L / ☐R) • Mid Back Pain (☐L / ☐R)
 - Low Back Pain (☐L / ☐R) • Shoulder/Arm Pain (☐L / ☐R) • Hip/Leg Pain (☐L / ☐R)
 - Other: _____

- Self Assessment as of today: % improved (list for separate areas)

Area _____ % Improved: _____

Area _____ % Improved: _____

Area _____ % Improved: _____

Area _____ % Improved: _____

- Any prior history of similar complaints? ☐ Yes ☐ No

If yes, please describe episodes with dates: _____

- Where did you go after the injury? ☐ Home ☐ Work ☐ Hospital ☐ Other: _____

Emergency Department: (If you went to the hospital/urgent care center)

- Which Hospital / Urgent Care Center: _____
- Mode of Transportation: _____
- Tests done at the hospital? ☐ Xrays ☐ MRI ☐ CT Scan ☐ Lab Work ☐ Other: _____
- Areas Imaged: _____
- Results: _____

- Medication Prescribed: _____
- Other Treatments: _____

- Follow-Up Instructions: _____

Current Area(s) of Complaint:

Please Circle:	Left/Right	Please grade your pain on a scale of 0-10: [0= No Pain, 10= Extreme Pain]											Choose how frequent the pain is present:			
		0	1	2	3	4	5	6	7	8	9	10	Occasional (0 – 25%)	Intermittent (26 – 50%)	Frequent (51 – 75%)	Constant (76 – 100%)
Neck	L / R	0	1	2	3	4	5	6	7	8	9	10	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Upper Back	L / R	0	1	2	3	4	5	6	7	8	9	10	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Mid Back	L / R	0	1	2	3	4	5	6	7	8	9	10	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Low Back	L / R	0	1	2	3	4	5	6	7	8	9	10	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
_____	L / R	0	1	2	3	4	5	6	7	8	9	10	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
(Other)																

(Staff use only)

**** Please mark where your pain/symptoms are: ****



Do you have any pain / symptoms that extend into arms / legs? ☐ Yes ☐ No

Explain: _____

Are symptoms worse in the morning / afternoon / evening / night? ☐ Yes ☐ No

Explain: _____

Circle the quality of your symptoms:

- | | | |
|----------------|------------------|-----------------------|
| • Sharp | • Dull | • Throbbing |
| • Achiness | • Discomfort | • Dizziness |
| • Headache | • Losing balance | • Loss of flexibility |
| • Muscle spasm | • Numbness | • Unsteadiness |
| • Stiffness | • Swelling | • Tenderness |
| • Tightness | • Tingling | • Weakness |

Other symptoms: _____

Circle the activities that aggravate your condition:

- | | | |
|-----------|------------|------------|
| • Driving | • Walking | • Working |
| • Bending | • Sports | • Sleeping |
| • Sitting | • Standing | • Twisting |
| • Lifting | | |

Other aggravating factors: _____

Circle activities that relieve your condition:

- Rest
- Heat
- Pain meds
- PT
- Movement
- Dry Needling
- Elevation
- Stretch
- Chiropractic
- Ice
- NSAIDs
- Massage
- Acupuncture

Other relieving factors: _____

Can you go to sleep without problems? ☐ Yes ☐ No

Do you wake up because of pain? ☐ Yes ☐ No

If yes, where is the pain that wakes you up? _____

Family History:

Cancer: _____	Parent	Sibling	Grandparent
High Blood pressure:	Parent	Sibling	Grandparent
Heart attack:	Parent	Sibling	Grandparent
Diabetes:	Parent	Sibling	Grandparent
Stroke:	Parent	Sibling	Grandparent
Osteoarthritis:	Parent	Sibling	Grandparent
Other: _____	Parent	Sibling	Grandparent

Medical History:

Have you seen other providers for THIS injury? ☐ Yes ☐ No

If yes, what specialty? ☐ Chiropractic ☐ Medical ☐ Physical Therapy ☐ Other: _____

Please list all providers (Name and Facility/Practice): _____

Have you ever had chiropractic care before for any reason? ☐ Yes ☐ No

If yes, where? _____

Prior Imaging (X-rays, MRIs, etc.):

- **Imaging related to THIS condition:** _____
- **All other imaging in last 2 years:** _____

Medical Conditions/Procedures you have had or are currently being treated for:

☐ High Blood Pressure ☐ Diabetes ☐ Stroke / TIA ☐ Vascular Conditions ☐ Pain Management
☐ Spine Surgery ☐ Other: _____

Do you have a pacemaker? ☐ Yes ☐ No

Prior Hospitalizations (other than surgeries): _____

Medications:

- **Medications for THIS condition:** _____
- **All other medications:** _____

Supplements: _____

Allergies: _____

Prior Trauma (falls, fractures, injuries): _____

Prior Auto Accidents or Work Injuries: _____

Surgeries (including spinal surgeries):

- Surgeries related to THIS complaint: _____
- All other surgeries (list surgery and year performed): _____

Female only:

Date of last menstrual cycle: _____ Currently pregnant? Yes No Unsure

Have you had children? ☐ Yes ☐ No If yes, how many? _____

Social Information:

Do you currently smoke? ☐ Yes ☐ No If yes, how long: _____ Packs/Day: _____

If no, have you ever smoked? ☐ Yes ☐ No

How many alcoholic beverages do you consume per week? _____

Medical/Recreation Marijuana use? ☐ Yes ☐ No Frequency: _____

How many days per week do you exercise? _____

Type of exercise: _____

Review of Systems:

Constitutional Now Past Never

Fever: ☐ ☐ ☐

Poor appetite: ☐ ☐ ☐

Weakness: ☐ ☐ ☐

Weight loss/gain: ☐ ☐ ☐

Eyes

Blurred vision: ☐ ☐ ☐

Change in vision: ☐ ☐ ☐

Glasses: ☐ ☐ ☐

Ear/Nose/Throat/Mouth

Difficulty hearing: ☐ ☐ ☐

Earache: ☐ ☐ ☐

Ear infection: ☐ ☐ ☐

Sinus problem: ☐ ☐ ☐

Sore throat: ☐ ☐ ☐

Cardiovascular

Chest pain: ☐ ☐ ☐

Irregular heartbeat: ☐ ☐ ☐

Swelling of legs: ☐ ☐ ☐

Respiratory Now Past Never

Blood in sputum: ☐ ☐ ☐

Frequent cough: ☐ ☐ ☐

Shortness of breath: ☐ ☐ ☐

Wheezing: ☐ ☐ ☐

Gastrointestinal

Abdominal pain: ☐ ☐ ☐

Blood in stool: ☐ ☐ ☐

Constipation: ☐ ☐ ☐

Diarrhea: ☐ ☐ ☐

Nausea/Vomiting: ☐ ☐ ☐

Genitourinary

Blood in urine: ☐ ☐ ☐

Painful urination: ☐ ☐ ☐

Urinary frequency: ☐ ☐ ☐

Musculoskeletal

Stiffness: ☐ ☐ ☐

Joint pain: ☐ ☐ ☐

Balance problems: ☐ ☐ ☐

Osteoporosis: ☐ ☐ ☐

Skin Now Past Never

Change in color: ☐ ☐ ☐

Lump / growth: ☐ ☐ ☐

Skin rash: ☐ ☐ ☐

Neurological

Dizzy spells: ☐ ☐ ☐

Headaches: ☐ ☐ ☐

Migraines: ☐ ☐ ☐

Numbness/tingling: ☐ ☐ ☐

Seizures: ☐ ☐ ☐

Slurred speech: ☐ ☐ ☐

Stroke: ☐ ☐ ☐

Weakness: ☐ ☐ ☐

Psychiatric

Depression: ☐ ☐ ☐

Memory loss/forgetful: ☐ ☐ ☐

Hematologic/Lymphatic

Anemia: ☐ ☐ ☐

Clotting problems: ☐ ☐ ☐

Easy bruising/bleed: ☐ ☐ ☐

**** Patient Signature:** _____ **Date:** _____

Authorization, Consent and Release

I consent and authorize the providers of Atlantic Chiropractic Associates, P.A. to examine and/or treat me / my child/legal dependent, if patient is a minor, today and during future office visits.

I authorize the release of any information, including the diagnosis and records of any treatment or examination rendered to me / my dependent during the period of such care to third party payers and/or other health practitioners.

I authorize and request my insurance company to pay benefits directly to Atlantic Chiropractic Associates, P.A., for the services rendered. I understand that my insurance carrier may pay less than the actual bill for services. I agree to be responsible for payment of all co-pays, deductibles, and any other subscriber liabilities at the time that services are rendered, as are allowable.

Signature of Patient or Parent/Guardian of Minor Patient

Date

Please list below any family/friend whom we may inform about your care, treatment, medical condition, and payment:

_____ Name	_____ Relationship	_____ Phone
_____ Name	_____ Relationship	_____ Phone

Financial Policy

We are dedicated to providing you with the best possible care and service and regard your understanding of our financial policies as an essential element of your care and treatment. To assist you, we have the following financial policy. If you have any questions, please feel free to discuss them with our staff. Unless other arrangements have been made in advance by either yourself or your health coverage carrier, **full payment is due at the time of service.** For your convenience, most credit cards and Care Credit are accepted.

Your Insurance

We have made prior arrangements with many insurers and health care plans. We will bill those plans with whom we have an agreement and will collect any required co-payment at the time of service. The co-payment will be collected when you arrive for your appointment. In the event that your health coverage plan determines a service to be "not covered," **you will be responsible for the complete charge.** In that event, we will bill you and payment is due upon receipt of that statement.

If you have insurance coverage with a plan with which we do not participate, **payment is expected at the time that services are rendered.** We will provide you with a receipt from our office for you to submit to your insurance carrier. Your insurance company should then send the payment directly to you.

Missed Appointments

Please call us as early as possible if you know you will need to reschedule your appointment. More than three (3) "no show" appointments without a valid reason may result in discharge from our practice.

I have read and understand the financial policy of the practice; and, I agree to be bound by its terms. I also understand and agree that such terms may be amended from time to time by the practice.

Acknowledgment of Privacy Practices

Our practice is committed to protecting privacy and confidentiality. With my consent, Atlantic Chiropractic Associates, P.A., may use and disclose Protected Health Information (PHI) about me or my dependent to perform treatment, payment and healthcare operations (TPO). Please refer to Notice of Privacy Practices of Atlantic Chiropractic Associates, P.A. for a complete description of such uses and disclosures. I acknowledge that a copy of said Notice of Privacy Practices was offered to me.

Signature of Patient or Parent/Guardian of Minor Patient

Patient Name: _____
Patient #: _____ **Date:** _____

Dr. Andrew Riddle
Dr. Lauren Hitchens
Dr. Gary Morgan
Dr. Cliff Renyo
Dr. Crystal Crate
Dr. Meg Van de Loo



Phone: (302) 422-3100
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ACA-DE.com

AUTHORIZATION TO OBTAIN PROTECTED HEALTH INFORMATION FOR USE AND DISCLOSURE

Patient Name: _____ DOB: _____

I hereby authorize (Full name of Physician and/or Facility): _____

to release my individually identifiable Protected Health Information (PHI) to Atlantic Chiropractic Associates, P.A. (ACA) at 509 Lakeview Avenue., Milford, DE 19963 to use and disclose for the specific purpose of **diagnosis, treatment, and payment**. I understand that my PHI may be redisclosed by any person or entity receiving my PHI from ACA. I voluntarily sign this authorization and I understand that my health care will not be affected if I do not sign this form.

THE FOLLOWING PHI IS TO BE RELEASED: (PATIENT OR PATIENT REPRESENTATIVE MUST CHECK ONE BOX FOR EACH ITEM):

Yes	No	Items Requested	Yes	No	Items Requested	Yes	No	Items Requested
<input type="checkbox"/>	<input type="checkbox"/>	Physician Notes	<input type="checkbox"/>	<input type="checkbox"/>	CT Scans	<input type="checkbox"/>	<input type="checkbox"/>	All Medical Records on file
<input type="checkbox"/>	<input type="checkbox"/>	X-Ray Reports	<input type="checkbox"/>	<input type="checkbox"/>	Lab Results	<input type="checkbox"/>	<input type="checkbox"/>	Other: _____
<input type="checkbox"/>	<input type="checkbox"/>	MRI Scans	<input type="checkbox"/>	<input type="checkbox"/>	Claims/Billing Information			

The authorization will expire on (date no more than one year in advance): _____

I understand that I have the right to receive a copy of this authorization. I also understand that I may revoke or modify this authorization at any time by notifying ACA in writing. I understand that my revocation or modification of this authorization will not affect any actions taken by ACA in reliance on this authorization before ACA receives my request for revocation or modification. I must sign and date my written request and send it to the following address:

Medical Records Department
Atlantic Chiropractic Associates, P.A.
509 Lakeview Avenue
Milford, DE 19963

Signature of Patient or Patient Representative: _____ Date: _____

If you are signing as the patient's representative, print your name: _____

Please indicate your relationship to the patient:

- ☐ Parent, guardian or caregiver of a minor patient.
☐ Guardian or conservator of an incompetent patient.
☐ Beneficiary or personal representative of a deceased patient.

Other: _____ (Specify Relationship)