



**ALTERNATIVE HEALTH & PAIN CENTER**  
*"Dedicated to helping you live a healthy, productive and long life"*  
**DR. RICHARD M. NOVAK**  
 Certified in Whiplash & Spinal Trauma

# WORK INJURY INFORMATION

Patient Name: \_\_\_\_\_  
 Address: \_\_\_\_\_  
 City: \_\_\_\_\_ State: \_\_\_\_\_ Zip Code: \_\_\_\_\_  
 S.S.#: \_\_\_\_\_ Date of Birth: \_\_\_\_\_ Age: \_\_\_\_\_ Sex: M F  
 Marital Status: S/M/D/W Children: \_\_\_\_\_ Cell Phone: \_\_\_\_\_  
 Home Phone: \_\_\_\_\_ Work Phone: \_\_\_\_\_  
 Occupation: \_\_\_\_\_  
 Employer's Name and Address: \_\_\_\_\_  
 Emergency Name and Phone #: \_\_\_\_\_ Relationship: \_\_\_\_\_  
 Name of M.D.: \_\_\_\_\_ Date of last physical: \_\_\_\_\_

## PRIMARY HEALTH INSURANCE INFORMATION:

Name of Insured: \_\_\_\_\_  
 Name of Primary Insurance Company: \_\_\_\_\_  
 Address: \_\_\_\_\_ Phone: \_\_\_\_\_  
 City: \_\_\_\_\_ State: \_\_\_\_\_ Zip Code: \_\_\_\_\_  
 Employee ID #: \_\_\_\_\_ Policy #: \_\_\_\_\_  
 Group Name: \_\_\_\_\_ Group #: \_\_\_\_\_

Your attorney's name: \_\_\_\_\_ Phone: \_\_\_\_\_  
 Address: \_\_\_\_\_  
 City: \_\_\_\_\_ State: \_\_\_\_\_ Zip Code: \_\_\_\_\_  
 Have you filled a incident report at work? YES NO Date filled out: \_\_\_\_\_  
 Name of person you reported this accident to: \_\_\_\_\_  
 Their position: \_\_\_\_\_ (Ex. Supervisor, Manager, etc...)

## EMPLOYER'S WORK INSURANCE INFORMATION:

Name of Work Comp. Carrier: \_\_\_\_\_ Phone: \_\_\_\_\_  
 Address: \_\_\_\_\_  
 City: \_\_\_\_\_ State: \_\_\_\_\_ Zip Code: \_\_\_\_\_  
 Adjuster's Name: \_\_\_\_\_ Phone: \_\_\_\_\_  
 Policy #: \_\_\_\_\_ Claim #: \_\_\_\_\_

Miscellaneous information: \_\_\_\_\_

**Signed:** \_\_\_\_\_ **Today's Date:** \_\_\_\_\_  
 GUARANTOR OF PAYMENT



# WORK INJURY STATEMENT

*"Dedicated to helping you live a healthy, productive and long life"*  
**DR. RICHARD M. NOVAK**  
Certified in Whiplash & Spinal Trauma

Patient Name: \_\_\_\_\_

## EMPLOYMENT INFORMATION:

Occupation: \_\_\_\_\_

Duties: \_\_\_\_\_

How long with this employer? \_\_\_\_\_

Is patient on disability? YES NO Authorized by: \_\_\_\_\_

Detail of work lost due to accident: \_\_\_\_\_

**ACCIDENT INFORMATION:** Auto Other: \_\_\_\_\_

Date of Injury: \_\_\_\_\_ Time of Injury: \_\_\_\_\_ AM/PM

Location of Accident: \_\_\_\_\_

Describe how accident occurred: \_\_\_\_\_

## INJURIES AND MEDICAL INFORMATION:

Nature of Injuries: \_\_\_\_\_

Was first aid administered at the scene of the accident? YES NO

By whom: ( ) Bystanders ( ) Police ( ) Emergency Medical Staff

Did you go to the hospital? YES NO

If yes, what is the name and city of the hospital? \_\_\_\_\_

How did you get to the hospital? \_\_\_\_\_

What diagnostic tests were performed at the hospital? (Ex. X-Rays, MRI, CT Scan, etc.)

What did the hospital do for your injuries? \_\_\_\_\_

How long did you stay at the hospital? \_\_\_\_\_

Have you seen any other doctor for this accident? YES NO

If yes, what is the doctor's name? \_\_\_\_\_

Signed: \_\_\_\_\_ Today's Date: \_\_\_\_\_

GUARANTOR OF PAYMENT



# PERSONAL HISTORY

What is the most you ever weighed? \_\_\_\_\_ When? \_\_\_\_\_

Do you smoke? YES NO How much do you smoke? \_\_\_\_\_ packs/day \_\_\_\_\_ packs/week  
How long have you been a smoker? \_\_\_\_\_ Have you been a smoker in the past? YES NO  
How long have you stopped smoking? \_\_\_\_\_

Do you drink alcoholic beverages? YES NO  
How much do you drink? \_\_\_\_\_ drinks/day \_\_\_\_\_ drinks/week \_\_\_\_\_ drinks/month  
How long have you been drinking alcoholic beverages? \_\_\_\_\_ months \_\_\_\_\_ years

How many children did you give birth to? \_\_\_\_\_ What are their ages? \_\_\_\_\_

Do you commute to work? YES NO if yes, how long is the commute? \_\_\_\_\_  
What means of transportation? (Ex. Bus, drive car, carpool, walk, etc...) \_\_\_\_\_

Do you presently exercise on a regular basis? YES NO If yes, complete below:

Activity	Duration	Frequency
_____	_____	_____
_____	_____	_____
_____	_____	_____

List exercise activity prior to your problem:

Activity	Duration	Frequency
_____	_____	_____
_____	_____	_____
_____	_____	_____

Any known food allergies? \_\_\_\_\_

What did you eat and drink yesterday:

Breakfast: \_\_\_\_\_

Lunch: \_\_\_\_\_

Dinner: \_\_\_\_\_

Snacks: \_\_\_\_\_

Do you crave certain foods: \_\_\_\_\_

Does any food you eat cause any discomfort: \_\_\_\_\_

8oz. Glasses per day

Water/day = \_\_\_\_\_ Soda/day = \_\_\_\_\_ Tea/day = \_\_\_\_\_ Other: \_\_\_\_\_

Your last bowel movement was: \_\_\_\_\_

How often do you have a bowel movement: 1x/day 2x/day 3x/day Other: \_\_\_\_\_

# PERSONAL HISTORY

Do you have, or have had, any of the following?

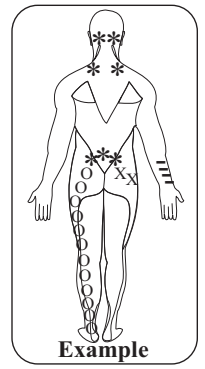
Problem	NO	YES	When	What
Surgery				
Surgery				
Surgery				
Cancer				
Broken Bone				
Broken Bone				
Scoliosis				
Heart Problems				
High Blood Pressure				
Stroke				
Diabetes				
Rheumatic Fever				
Rheumatoid Arthritis				
Gout				
Lupus				
Psoriasis				
Multiple Sclerosis				
Lung Problems				
Other				
Other				
Other				

# FAMILY HISTORY

Do any of your BLOOD FAMILY have, or have had, any of the following?

Problem	NO	YES	When	What
Chronic Back Pain				
Chronic Neck Pain				
Spine Surgery				
Cancer				
Heart Problems				
High Blood Pressure				
Stroke				
Diabetes				
Rheumatic Fever				
Rheumatoid Arthritis				
Gout				
Lupus				
Psoriasis				
Multiple Sclerosis				
Lung Problems				
Scoliosis				
Other				
Other				
Other				
Other				
Other				

# PAIN CHART



**Date:** \_\_\_\_\_

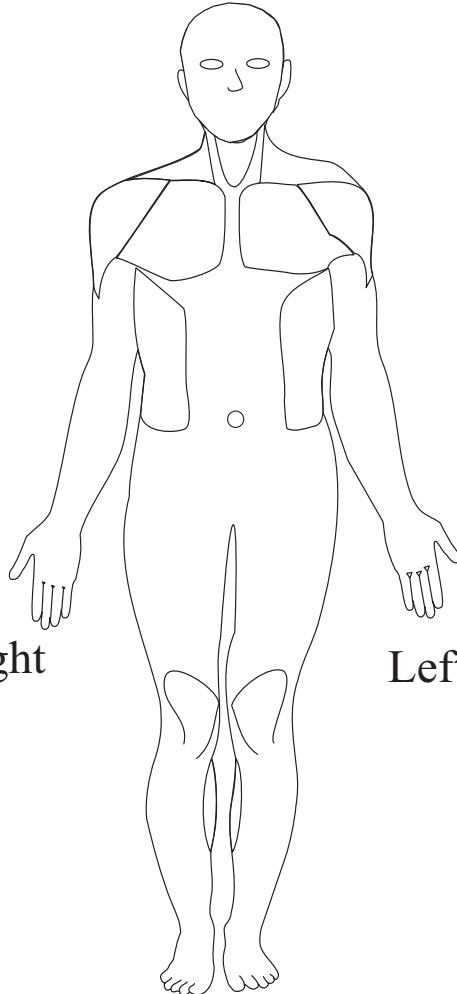
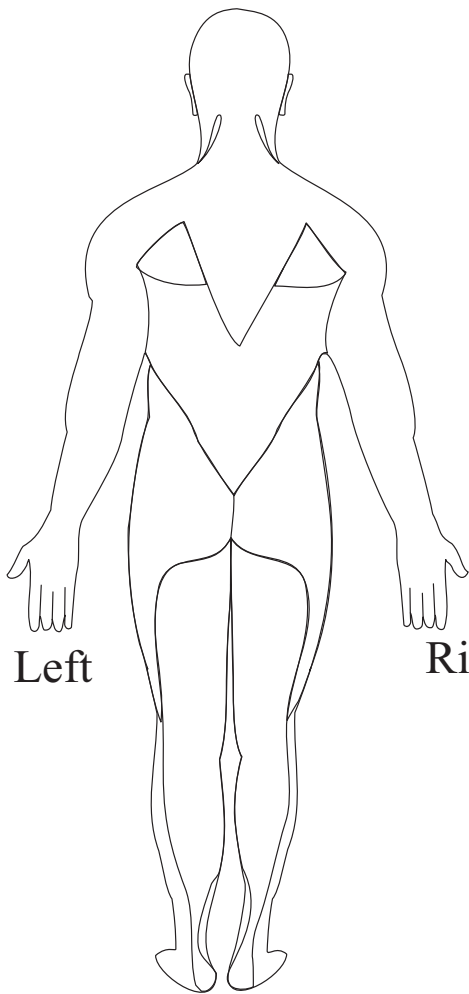
**Signature:** \_\_\_\_\_

**SHOW AREA(S) OF PAIN OR UNUSUAL FEELING**

Mark the areas on this body where you feel the described sensations.  
 Use the appropriate symbols (See box below)

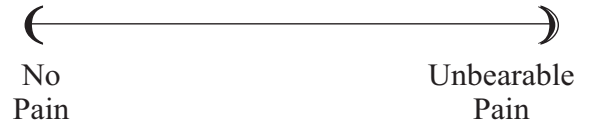
Mark areas of radiation (Ex. down leg, down arm, into hip, etc.) Include all affected areas.

<b>Numbness</b> -----	<b>Pins &amp; Needles</b> OOOOO	<b>Burning</b> XXXXX	<b>Aching</b> *****	<b>Cramping</b> CCCCC	<b>Stabbing</b> /////
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**Neck-Shoulder-Arm-Pain**

I rate my discomfort as follows:



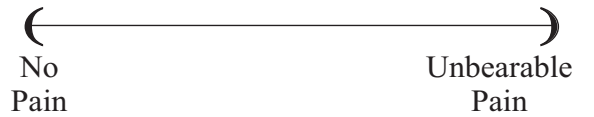
**Mid Back Pain**

I rate my discomfort as follows:



**Low Back and Leg Pain**

I rate my discomfort as follows:



**Best You Have Felt This Week**      **Worst Pain This Week**

← No Pain      Unbearable Pain      No Pain      Unbearable Pain →

**Average Pain This Week**

← No Pain      Unbearable Pain →

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# Symptom Questionnaire

What is your Chief/Primary Complaint? \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

How did this condition develop? \_\_\_\_\_  
\_\_\_\_\_  
Overexertion / Strenuous Position / Auto Accident / Work Accident / Fall / Trauma

**ONSET:** When was the first time (date) you were aware of the problem? \_\_\_\_\_

**PROV:** What makes the problem worse? \_\_\_\_\_  
Coughing/Sneezing / Lifting / Bending / Prolonged Sitting / Driving / Standing / Walking

**PALL:** What relieves the problem? \_\_\_\_\_  
Rest / Movement/Exercise / Sitting / Standing / Lying / Ice / Heat / Drugs-Aspirin / Tylenol /  
Ibuprofen / Drugs-Other: \_\_\_\_\_

**QUALITY:** How would you describe the pain or problem? \_\_\_\_\_  
Sharp / Stabbing / Dull / Aching / Burning / Throbbing / Pins & Needles / Numbness

**RADIATES:** Does this refer into another part of your body? Left Side of / Right Side of  
Head / Neck / Shoulder / Arm / Hand / Back / Hip / Leg & Thigh / Calf / Foot \_\_\_\_\_

**TIME:** Is there any certain time of day that you notice the pain being worse?  
\_\_\_\_\_  
Morning / Afternoon / Evening / Bedtime / Wakes me up at night / At Work / After Work

How long does the pain/problem last? \_\_\_\_\_  
Brief / Intermittent / Occasional / Frequent / Constant

Have you ever had the same or similar problem before? YES NO If yes, when?  
Please explain: \_\_\_\_\_

Have you seen another doctor for this problem before? NO (YES Dr. \_\_\_\_\_ )  
Recommendations or prescriptions? \_\_\_\_\_  
Please list any other medication you are currently taking. \_\_\_\_\_

Please list any vitamin or herbal supplements you are currently taking. \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Have you ever been treated by a chiropractor before? NO (YES Dr. \_\_\_\_\_ )  
Did the chiropractor adjust your Neck (Y / N), Mid Back (Y / N), Low Back (Y / N)? \_\_\_\_\_  
\_\_\_\_\_

Please list any significant accidents (automobile or other) or falls? \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_