

## WORK / COMP HISTORY

Patient \_\_\_\_\_ Phone ( ) \_\_\_\_\_

Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Age \_\_\_\_\_ Birthdate \_\_\_\_\_ Sex \_\_\_\_\_ S/S# \_\_\_\_\_

Name of Compensation Carrier: \_\_\_\_\_ Phone ( ) \_\_\_\_\_

Address of Carrier: \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Employer's Name: \_\_\_\_\_ Phone ( ) \_\_\_\_\_

Employer's Address: \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

1. Type of Business \_\_\_\_\_ Your Occupation \_\_\_\_\_

2. Date Injured \_\_\_\_\_ Hour \_\_\_\_\_ AM/PM Last Date Worked \_\_\_\_\_ Are you off work? ( ) Yes ( ) No

3. Previous Workers' Compensation Injury? ( ) Yes ( ) No

4. Accident reported to employer? ( ) Yes ( ) No Name of person reported accident to \_\_\_\_\_

5. Injured at: \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

6. Length of time worked there prior to accident: \_\_\_\_\_

7. Type of work being done at time of injury: \_\_\_\_\_

8. In your own words, please describe accident: \_\_\_\_\_

9. Have you been treated by another doctor 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? \_\_\_\_\_

10. Are you: ( ) improved ( ) unchanged ( ) getting worse

11. What types of medicines are you taking? \_\_\_\_\_

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

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

( ) Daily ( ) Every other day ( ) Several times a week ( ) Weekly ( ) Every other week

( ) Monthly ( ) Other \_\_\_\_\_

Does the physical therapy help? ( ) Yes ( ) No ( ) Don't know

13. 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: \_\_\_\_\_

Were these similar complaints the results of a previous accident(s)? ( ) Yes ( ) No

Please provide details of accident(s): \_\_\_\_\_

14. Have you had any other serious accidents which required medical care? ( ) Yes ( ) No

Describe: \_\_\_\_\_

15. Have you had any serious illnesses that required hospitalization? ( ) Yes ( ) No

Describe: \_\_\_\_\_

\_\_\_\_\_

16. Have you had any surgeries? ( ) Yes ( ) No

If yes, list type of surgery and date: \_\_\_\_\_

\_\_\_\_\_

17. Have you had any nervous or mental illnesses? ( ) Yes ( ) No

Have you had psychiatric care? ( ) Yes ( ) No

18. Have you received a medical discharge from the Armed Forces? ( ) Yes ( ) No

19. Have you returned to work since this accident? ( ) Yes ( ) No

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
- 5. I have tingling and/or numbness in my: ( ) right leg ( ) left leg ( ) both
- 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 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:**

- 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 described 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.

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**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 hand for repetitive actions, such as:

	SIMPLE GRASPING	FIRM GRASPING	FINE MANIPULATING
Right hand	( ) Yes ( ) No	( ) Yes ( ) No	( ) Yes ( ) No
Left hand	( ) Yes ( ) No	( ) Yes ( ) No	( ) Yes ( ) No

7. Are you required to work on unprotected heights? ( ) Yes ( ) No

Describe: \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

8. Are you required to be around moving machinery? ( ) Yes ( ) No

Describe: \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

9. Are you exposed to marked changes in temperature and humidity? ( ) Yes ( ) No

Describe: \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

10. Are you required to drive automotive equipment? ( ) Yes ( ) No

Describe: \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

11. Are you exposed to dust, fumes and/or gases? ( ) Yes ( ) No

Describe: \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

12. Please list any additional comments: \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

**COMMONWEALTH OF KENTUCKY  
DEPARTMENT OF WORKERS' CLAIMS**

Claim No. \_\_\_\_\_

**NOTICE OF DESIGNATED PHYSICIAN**

EMPLOYEE:

\_\_\_\_\_  
Name

\_\_\_\_\_  
Street Address

\_\_\_\_\_  
City, State, Zip

\_\_\_\_\_  
Date of Birth

\_\_\_\_\_  
Social Security Number

( ) \_\_\_\_\_  
Telephone Number

EMPLOYER AT TIME OF INJURY OR LAST EXPOSURE:

\_\_\_\_\_  
Name

\_\_\_\_\_  
Street Address

\_\_\_\_\_  
City, State, Zip

NATURE OF INJURY OR OCCUPATIONAL DISEASE: \_\_\_\_\_  
\_\_\_\_\_

DATE OF INJURY OR LAST EXPOSURE: \_\_\_\_\_

FIRST DESIGNATED PHYSICIAN:

\_\_\_\_\_  
Name

\_\_\_\_\_  
Street Address

\_\_\_\_\_  
City, State, Zip

( ) \_\_\_\_\_  
Telephone Number

Accepted by: \_\_\_\_\_

**MEDICAL INFORMATION RELEASE:** I hereby waive any privilege I may have to restrict the release of information or written material reasonably related to the work-related injury/disease for which I have sought treatment, and I consent to the release of this information or written material to the medical payment obligor, my employer, Special Fund, Uninsured Employers' Fund, or attorneys representing me or any of the parties named above.

\_\_\_\_\_  
Date

\_\_\_\_\_  
Employee Signature

MEDICAL PAYMENT OBLIGOR:

\_\_\_\_\_  
Name Of Obligor

\_\_\_\_\_  
Representative

\_\_\_\_\_  
Street Address

\_\_\_\_\_  
City, State, Zip

( ) \_\_\_\_\_  
Telephone Number

**This form identifies the designated physician and must be returned to the medical payment obligor within ten (10) days after treatment begins. An identification card will be provided to the employee, and that card should be presented when medical treatment is required.**

Notice: The Workers' Compensation Act requires the employer to pay for the medical services reasonably necessary for cure and relief from the effects of a workplace injury or disease.

The employee may choose the physician (including chiropractors, etc.) who treats him as "designated physician." The designated physician is responsible for the coordination of the employee's medical care and may refer the patient to consulting or treating physicians as required. Except in an emergency, all treatment must be performed by or on referral from the designated physician. The employee may not change his designated physician more than once without the medical payment obligor's consent.

Inquiries shall be made to the listed representative of the medical payment obligor.

This form is not advance authorization from the workers' compensation medical payment obligor for medical services.

# Neck Pain and Disability Index (Vernon-Mior)

Patient Name: \_\_\_\_\_ File # \_\_\_\_\_ Date: \_\_\_\_\_

This questionnaire has been designed to give the doctor information as to how your neck pain has affected your ability to manage in everyday life. Please answer every section and mark in each section only the ONE box which applies to you. We realize you may consider that two of the statements in any one section relate to you, but please just mark the box which most closely describes your problem.

## SECTION 1 – PAIN INTENSITY

- I have no pain at the moment.
- The pain is very mild at the moment.
- The pain is moderate at the moment.
- The pain is fairly severe at the moment.
- The pain is very severe at the moment.
- The pain is the worst imaginable at the moment.

## SECTION 2 – PERSONAL CARE (Washing, Dressing, etc)

- I can look after myself normally without causing extra pain.
- I can look after myself normally but it causes extra pain.
- It is painful to look after myself and I am slow and careful.
- I need some help but manage most of my personal care.
- I need help every day in most aspects of self care.
- I do not get dressed; I wash with difficulty and stay in bed.

## SECTION 3 – LIFTING

- I can lift heavy weights without extra pain.
- I can lift heavy weights but it gives extra pain.
- Pain prevents me from lifting heavy weights off the floor, but I can manage if they are conveniently positioned, for example on a table.
- Pain prevents me from lifting heavy weights but I can manage light to medium weights if they are conveniently positioned.
- I can lift very light weights.
- I cannot lift or carry anything at all.

## SECTION 4 – READING

- I can read as much as I want to with no pain in my neck.
- I can read as much as I want to with slight pain in my neck.
- I can read as much as I want to with moderate pain in my neck.
- I can't read as much as I want because of moderate pain in my neck.
- I can hardly read at all because of severe pain in my neck.
- I cannot read at all.

## SECTION 5 – HEADACHES

- I have no headaches at all.
- I have slight headaches which come infrequently.
- I have moderate headaches which come infrequently.
- I have moderate headaches which come frequently.
- I have severe headaches which come frequently.
- I have headaches almost all the time.

## SECTION 6 - CONCENTRATION

- I can concentrate fully when I want to with no difficulty.
- I can concentrate fully when I want to with slight difficulty.
- I have a fair degree of difficulty in concentrating when I want to.
- I have a lot of difficulty in concentrating when I want to.
- I have a great deal of difficulty in concentrating when I want to.
- I cannot concentrate at all.

## SECTION 7 – WORK

- I can do as much work as I want to.
- I can only do my usual work, but no more.
- I can do most of my usual work, but no more.
- I cannot do my usual work.
- I can hardly do any work at all.
- I can't do any work at all.

## SECTION 8 – DRIVING

- I can drive my car without any neck pain.
- I can drive my car as long as I want with slight pain in my neck.
- I can drive my car as long as I want with moderate pain in my neck.
- I can't drive my car as long as I want because of moderate pain in my neck.
- I can hardly drive at all because of severe pain in my neck.
- I can't drive my car at all.

## SECTION 9 – SLEEPING

- I have no trouble sleeping.
- My sleep is slightly disturbed (less than 1 hr. sleepless).
- My sleep is mildly disturbed (1-2 hrs. sleepless).
- My sleep is moderately disturbed (2-3 hrs. sleepless).
- My sleep is greatly disturbed (3-5 hrs. sleepless).
- My sleep is completely disturbed (5-7 hrs. sleepless).

## SECTION 10 – RECREATION

- I am able to engage in all my recreation activities with no neck pain at all.
- I am able to engage in all my recreation activities, with some pain in my neck.
- I am able to engage in most, but not all of my usual recreation activities because of pain in my neck.
- I am able to engage in a few of my usual recreation activities because of pain in my neck.
- I can hardly do any recreation activities because of pain in my neck.
- I can't do any recreation activities at all.

Pain Severity Scale: Rate the Severity of your pain by checking one box of the following scale.

No Pain

0	1	2	3	4	5	6	7	8	9	10
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Excruciating Pain

Patient Signature \_\_\_\_\_

## Low Back Pain and Disability Questionnaire (Revised Oswestry)

Patient Name: \_\_\_\_\_ File # \_\_\_\_\_ Date: \_\_\_\_\_

This questionnaire has been designed to give the doctor information as to how your back pain has affected your ability to manage everyday life. Please answer every section and mark in each section only the ONE box which applies to you. We realize you may consider that two of the statements in any one section relate to you, but please just mark the box which most closely describes your problem.

### SECTION 1 – PAIN INTENSITY

- The pain comes and goes and is very mild.
- The pain is mild and does not vary much.
- The pain comes and goes and is moderate.
- The pain is moderate and does not vary much.
- The pain comes and goes and is very severe.
- The pain is severe and does not vary much.

### SECTION 2 – PERSONAL CARE

- I would not have to change my way of washing or dressing in order to avoid pain.
- I do not normally change my way of washing or dressing even though it causes some pain.
- Washing and dressing increase the pain but I manage not to change my way of doing it.
- Washing and dressing increase the pain and I find it necessary to change my way of doing it.
- Because of the pain I am unable to do some washing and dressing without help.
- Because of the pain I am unable to do any washing and dressing without help.

### SECTION 3 – LIFTING

- I can lift heavy weights without extra pain.
- I can lift heavy weights but it causes extra pain.
- Pain prevents me from lifting heavy weights off the floor.
- Pain prevents me from lifting heavy weights off the floor, but I manage if they are conveniently positioned (e.g. on a table).
- Pain prevents me from lifting heavy weights but I can manage light to medium weights if they are conveniently positioned.
- I can only lift very light weights at the most.

### SECTION 4 – WALKING

- I have no pain on walking.
- I have some pain on walking but it does not increase with distance.
- I cannot walk more than one mile without increasing pain.
- I cannot walk more than ½ mile without increasing pain.
- I cannot walk more than ¼ mile without increasing pain.
- I cannot walk at all without increasing pain.

### SECTION 5 – SITTING

- I can sit in any chair as long as I like.
- I can only sit in my favorite chair as long as I like.
- Pain prevents me from sitting more than one hour.
- Pain prevents me from sitting more than half hour.
- Pain prevents me from sitting more than 10 minutes.
- I avoid sitting because it increases pain straight away.

### SECTION 6 - STANDING

- I can stand as long as I want without pain.
- I have some pain on standing but it does not increase with time.
- I cannot stand for longer than one hour without increasing pain.
- I cannot stand for longer than ½ hour without increasing pain.
- I cannot stand for longer than 10 minutes without increasing pain.
- I avoid standing because it increases the pain straight away.

### SECTION 7 – SLEEPING

- I get not pain in bed.
- I get pain in bed but it does not prevent me from sleeping well.
- Because of pain my normal night's sleep is reduced by less than ¼.
- Because of pain my normal night's sleep is reduced by less than ½.
- Because of pain my normal night's sleep is reduced by less than ¾.
- Pain prevents me from sleeping at all.

### SECTION 8 – SOCIAL LIFE

- My social life is normal and gives me no pain.
- My social life is normal but increases the degree of pain.
- Pain has no significant effect on my social life apart from limiting my more energetic interests, e.g. dancing, etc.
- Pain has restricted my social life and I do not go out very often.
- Pain has restricted my social life to my home.
- I have hardly any social life because of the pain.

### SECTION 9 – TRAVELLING

- I get no pain whilst travelling.
- I get some pain whilst travelling but none of my usual forms of travel make it any worse.
- I get extra pain whilst travelling but it does not compel me to seek alternative forms of travel.
- I get extra pain whilst travelling which compels me to seek alternative forms of travel.
- Pain restricts all forms of travel.
- Pain prevents all forms of travel except that done lying down.

### SECTION 10 – CHANGING DEGREE OF PAIN

- My pain is rapidly getting better.
- My pain fluctuates but overall is definitely getting better.
- My pain seems to be getting better but improvement is slow at present.
- My pain is neither getting better nor worse.
- My pain is gradually worsening.
- My pain is rapidly worsening.

Pain Severity Scale: Rate the Severity of your pain by checking one box of the following scale.

No Pain

0	1	2	3	4	5	6	7	8	9	10
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Excruciating Pain

Patient Signature \_\_\_\_\_



**ASSIGNMENT OF MEDICAL BENEFITS &  
INFORMED CONSENT**

I understand that **my doctor is submitting my x-rays to Midwest Radiology Consultants for radiological evaluation.** I also understand that the fee for such services will be submitted to my insurance company, workers' compensation carrier, or my attorney.

**I authorize my insurance company to pay directly to Midwest Radiology Consultants for services rendered.**

In the event my insurance company, attorney, or workman's compensation carrier does not reimburse for the fee in full, or if I do not have insurance coverage, **I agree that I am directly responsible for the charges or any unpaid portion.** Returned checks for insufficient funds will be assessed a \$20.00 service charge. *Accounts delinquent by 90 days from the time of my 1<sup>st</sup> billing statement may be placed with a legal collection agency. I am fully responsible for all collection costs unless prior payment arrangements have been made with Midwest Radiology Consultants.*

I understand that Dr. Doran L. Nicholson is not a participating provider in my insurance plan and that his services may not be covered by my insurance. *I also understand that this service is not covered by Medicare or Medicaid.*

**In the event that my insurance company sends payment directly to me, I agree to promptly remit such payments to Midwest Radiology Consultants.**

**Patient Signature:**

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(Patient, Parent or Guardian)

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

**MIDWEST RADIOLOGY CONSULTANTS**  
706 NE Langsford Rd.  
Lee's Summit, MO 64063  
Phone: 816 525-2822  
800-454-2822  
Doran L. Nicholson, D.C., D.A.C.B.R.

**MIDWEST  
RADIOLOGY  
CONSULTANTS**

706 N.E. LANGSFORD RD. (P.O. BOX 1122)  
LEE'S SUMMIT, MO 64063  
PHONE: 816 525-2822 FAX: 816 525-4540

**Doctor Information:**

**Maysville Family Chiropractic  
Dr. Rita Goldman  
1335 Southgate Plaza  
Maysville, KY 41056**

**Results Requested:**  Phone: 606-564-4213

Fax: 606-564-4406

E-Mail \_\_\_\_\_

**Trauma? Y  N  Explain:**

**Malignancy? Y  N  Explain:**

**Areas of Concern:**

**Payment:**  Payment Enclosed  Bill Patient  Insurance  Work Comp  PI  Auto Accident

(Date of Accident: \_\_\_/\_\_\_/\_\_\_)

**CONFIDENTIAL**

PATIENT INFORMATION		INSURED PARTY
Name:		Name:
Street:		Street:
City/State/Zip:		City/State/Zip:
Phone:	M <input type="checkbox"/> F <input type="checkbox"/>	Phone:
Soc. Sec. #	Date of Birth:	Relation to insured: <input type="checkbox"/> Self <input type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Other

INSURANCE INFORMATION		SECONDARY INSURANCE	
Company & Adjustor Name:		Company & Adjustor Name:	
Street:		Street:	
City/State/Zip:		City/State/Zip:	
Phone #	Claim #	Phone #	
Group #	Policy / ID #	Claim #	Group#

ATTORNEY INFORMATION		WORKER'S COMPENSATION CARRIER	
Name		Company Name:	
Street:		Street:	
City/State/Zip:		City/State/Zip:	
Phone:		Phone	Claim#