HADAYA CHIROPRACTIC INC.
KINAN HADAYA, D.C, D.A.A.P.M.
Diplomate, American Academy of Pain Management
Qualified Medical Evaluator, State of California

615 West Ave Q, Suite E
Palmdale CA, 93551
Ph: 661-947-2455 Fax: 661-947-2770

WORKERS' COMPENSATION PATIENT QUESTIONNAIRE

Dear Patient/Injured Worker:

It is important in a workers' compensation case to establish a complete and accurate base of personal and historical information. This information often becomes a critical part of the decision-making process in coming to final determinations or conclusions about your case. Therefore, your help and cooperation in answering this questionnaire as completely and accurately as possible is necessary and appreciated. This is important to the people involved in handling your case and ultimately, for you to receive appropriate and fair compensation.

PLEASE REVIEW AND COMPLETE THIS PATIENT QUESTIONNAIRE. DOING THIS, WILL SIGNFICANTLY REDUCE YOUR TIME IN THE OFFICE. THE AMOUNT OF TIME, WHICH HAS BEEN SCHEDULED FOR YOUR APPOINTMENT, DOES TAKE INTO CONSIDERATION THAT THIS HAS BEEN DONE.

THANK YOU!

PHYSICIAN USE ONLY:

EVALUATION DATE: _____
EVALUATION BEGAN: _____ AM _____ PM _____
EVALUATION ENDED: _____ AM _____ PM _____

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Patient Name _____
Address _____ City _____ Zip Code _____
Birth Date _____/_____/_____ Age _____ SSN ____-_____-_____
Sex: M F Home Phone _____ Cell Phone _____
Marital Status: Single Married Divorced
Emergency Contact Name _____ Relation _____ Phone _____

Employer _____
Employer's Address _____
Occupation _____ Full Time or Part Time (Circle One)

Insurance company _____ Adjuster Name _____
Phone _____ Fax _____
Insurance address _____
Claim # _____

Attorney Information:
Office Name_____ Attorneys/Case Manager Name _____
Address _____
Phone _____

Information About Your Work Injury:
Date of Injury _____ Time _____
Date you reported your injury to your employer/supervisor _____
Name of person you reported your injury _____
Where did your injury occur? (Address, description of location) _____
Please describe how your injury occurred: _____
_____
_____
Please list the injured body parts, as a result of your work injury _____
_____
What are your present complaints and symptoms? _____
_____
Do you smoke? _____
Describe all past illnesses, surgeries, &/or accidents and dates they occurred. _____
_____

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Have you been treated by any other doctors? _____ If yes, who, where and why? _____
Have you ever been under chiropractic care before? _____ If yes, why? _____
Who and where is your previous chiropractor? _____
When was your last adjustment? _____ Were you satisfied with him/her? _____
If not, why _____

Name of spouse _____ # of children _____ Boys _____ Girls _____
Does someone take care of you? _____
Are your parents alive? _____ Has anyone in your family died from anything other than old age? _____
If yes, who, when, and from what? _____
Do you or a family member have any illnesses or physical and/or mental impairments? Please give name, age, illness or impairment and relationship. _____
_____

Please list all activities that you cannot do because of your condition. _____
_____
Were you hospitalized? _____ What were the dates of hospitalization? _____

List the vitamins and medications you now take: _____
_____
_____

List when and why you were x-rayed: _____
_____

For women, Are you pregnant? _____ If yes, due date? _____

To the best of my knowledge, all information above is accurate and true. I authorize my insurance carrier(s), trustees, executors, accountant, custodian &/or attorney to make payment directly to Hadaya Chiropractic, Inc. for services rendered to me/my family by Hadaya Chiropractic, Inc.. I agree to pay any balance left unpaid. I authorize Hadaya Chiropractic, Inc. to send bill/claims &/or reports for services rendered directly to my insurance carrier &/or attorney and to release to my insurance carrier &/or attorney any information needed to process my claim. I acknowledge that I am completely and fully responsible for paying all fees that I or my family incur with Hadaya Chiropractic, Inc. If I have financial difficulties/hardships, I shall pay Hadaya Chiropractic, Inc. according to the terms of any agreement that I make with Hadaya Chiropractic, Inc.. The authorization serves as a Doctors Lien, directing my attorney to withhold from any settlement, judgment, or verdict which may be paid to my attorney or me whenever sum is needed to protect Hadaya Chiropractic, Inc., and to pay Hadaya Chiropractic, Inc. directly from those proceeds. If Hadaya Chiropractic, Inc. has to resort to collection proceedings against me, I agree to pay all collection costs including the fees of collection agents, attorneys, and court cost, in addition to paying all fees due Hadaya Chiropractic, Inc. for services rendered by Hadaya Chiropractic, Inc. to &/or for me or my family.

Date _____ Patients Signature _____

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REVIEW OF SYSTEMS

Please review each area, if you are not having any difficulties, please check "**No Problems**".

If you are experiencing any of the symptoms listed, **PLEASE CIRCLE THE ONES THAT APPLY**, or explain any that may not be listed. If you have any questions about this, please ask one of the medical assistants or Dr. Hadaya.

Const. (Health in General) ☐ No Problems, lack of energy, unexplained weight gain or weight loss, loss of appetite, fever, night sweats, pain in jaw when eating, scalp tenderness, prior diagnosis of cancer, Other: _____

Ears, Nose, Mouth & Throat ☐ No Problems, difficulty with hearing, sinus problems, runny nose, post-nasal drip, ringing in ears, mouth sores, loose teeth, ear pain, nosebleeds, sore throat, facial pain or numbness, Other: _____

C-V (Heart & Blood Vessels) ☐ No Problems, irregular heartbeat, racing heart, chest pains, swelling feet or legs, pain in legs with walking, Other: _____

Res. (Lungs & Breathing) ☐ No Problems, shortness of breath, night sweats, prolonged cough, wheezing, sputum production, prior tuberculosis, pleurisy, oxygen at home, coughing up blood, abnormal chest x-ray, Other: _____

GI (Stomach & Intestines) ☐ No Problems, heartburn, constipation, intolerance to certain foods, diarrhea, abdominal pain, difficulty swallowing, nausea, vomiting, blood in stools, unexplained change in bowel habits, incontinence, Other: _____

GU (Kidney & Bladder) ☐ No Problems, painful urination, frequent urination, urgency, prostate problems, bladder problems, impotence. Other: _____

MS (Muscle, Bones, Joints) ☐ No Problems, joint pain, aching muscles, shoulder pain, swelling of joints, joint deformities, back pain, Other: _____

Integ. (Skin, Hair, & Breast) ☐ No Problems, persistent rash, itching, new skin lesion, change in existing skin lesion, hair loss or increase, breast changes, Other: _____

Neurologic (Brain & Nerves) ☐ No Problems, frequent headaches, double vision, weakness, change in sensation, problems with walking or balance, dizziness, tremor, loss of consciousness, uncontrolled motions, episodes of visual loss, Other: _____

Psychiatric (Mood & Thinking) ☐ No Problems, insomnia, irritability, depression, anxiety, recurrent bad thoughts, mood swings, hallucinations, compulsion, Other: _____

Endocrinologic (Glands) ☐ No Problems, intolerance to heat or cold, menstrual irregularities, frequent hunger/urination/thirst, changes in sex drive, Other: _____

Hematologic (Blood/Lymph) ☐ No Problems, easy bleeding, easy bruising, anemia, abnormal blood, test, leukemia, unexplained swollen areas, Other: _____

Allergic /Immunologic ☐ No Problems, seasonal allergies, hay fever symptoms, itching, frequent infections, exposure to HIV, Other: _____

Patient Signature _____ Date _____

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HIPAA COMPLIANCE

Health Insurance Portability and Accountability Act
AUTHORIZATION FOR RELEASE OF INFORMATION

The Health Insurance Portability & Accountability Act of 1996 (HIPAA) requires all health care records and other individually identifiable health information (protected health information) used or disclosed to us in any form, whether electronically, on paper or orally, be kept confidential. This federal law gives you, the patient significant new rights to understand and control how your health information is used. HIPAA provides penalties for covered entities that misuse personal information. As required by HIPAA, we have prepared this explanation of how we are required to maintain the privacy of your health information and how we may use and disclose your health information.

By signing this form, you are authorizing the release of you/or your dependents' healthcare information by a healthcare provider, insurer, insurance support organization, health plan, or your insurance agent for the purpose of complete medical treatment.

You are entitled to a copy of this Authorization after you sign it.

PATIENT SIGNATURE_____ TODAY'S DATE _____

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Informed Consent for Chiropractic Care

The Doctor of Chiropractic evaluates the patient using standard examination and testing procedures. A chiropractic adjustment involves the application of a quick, precise force directed over a very short distance to a specific Vertebra or bone. There are a number of different techniques that may be used to deliver the adjustment, some of which utilize specially designed equipment. Adjustments are usually performed by hand but may also be performed by hand-guided instruments. In addition to adjustments, other treatments used by chiropractors include physical therapy modalities (heat, ice, ultrasound, soft-tissue manipulation), nutritional recommendations and rehabilitative procedures.

Chiropractic treatments are one of the safest interventions available to the public demonstrated through various clinical trials and indirectly reflected by the low malpractice insurance paid by Chiropractors. While there are risks involved with treatment, these are seldom great enough to contraindicate care. Referral for further diagnosis or management to a medical physician or other health care provider will be suggested based on history and examination findings.
Listed below are summaries of both common and rare side-effects/ complications associated with Chiropractic care:
Common:

- Reactions most commonly reported are local soreness/ discomfort (53%), headaches (12%), tiredness (11%), radiating discomfort (10%) , dizziness, the vast majority of which resolve within 48 hours

Rare:

- Fractures or joint injuries in isolated cases with underlying physical side defects, deformities or pathologies
- Physiotherapy burns due to some therapies
- Disc herniations
- Cauda Equina Syndrome (1 case per 100 million adjustments)
- Compromise of the vertebrobasilar artery (i.e. stroke) (range: 1 case per 400,000 to 1 million cervical spine adjustments [manipulations]). This associated risk is also found with consulting a medical doctor for patients under the age of 45 and is higher for those older than 45 when seeing a medical doctor.

Please indicate to your doctor if you have headache or neck pain that is the worst you have ever felt.

I understand that there are beneficial effects associated with these treatment procedures including decreased pain, improved mobility and function, and reduced muscle spasm. I also understand that my condition may worsen and referral maybe necessary if a course of chiropractic care does not help or improve my condition.
Reasonable alternatives to these procedures have been explained to me including prescription medications, over-the-counter medications, possible surgery, and non-treatment. Listed below are summaries of concern with the associated alternative procedures.

- Long-term use or overuse of medication carries some risk of dependency with the use of pain medication the risk of gastrointestinal bleeding among other risks.
- Surgical risks may include unsuccessful outcome, complications such as infection, pain, reactions to anesthesia, and prolonged recovery.
- Potential risks of refusing or neglecting care may result in increased pain, restricted motion, increased inflammation, and worsening of my condition.

Neck and back pain generally improve in time, however, recurrence is common. Remaining active and positive improve your chances of recovery.

Patient Consent Signature_____ Date_____

Reset Form | Print Form

STATE OF CALIFORNIA
DIVISION OF WORKERS' COMPENSATION
WORKERS' COMPENSATION APPEALS BOARD
NOTICE AND REQUEST FOR ALLOWANCE OF LIEN

Date Of Original Lien: _____ ☐ Original Lien ☐ Amended Lien
MM/DD/YYYY

_____
Case No.

(Choose only one)

☐ a specific injury on _____
(DATE OF INJURY: MM/DD/YYYY)

☐ a cumulative injury which began on _____ and ended on _____
(START DATE: MM/DD/YYYY) (END DATE: MM/DD/YYYY)

_____ _____
SSN (Numbers Only) (DATE OF BIRTH: MM/DD/YYYY)

Injured Worker:

_____ ___
First Name MI

_____
Last Name

_____
Address/PO Box (Please leave blank spaces between numbers, names or words)

_____ _____ _____
City State Zip Code

Attorney/Representative for Injured Worker:

_____
Name

_____
Address/PO Box (Please leave blank spaces between numbers , names or words)

_____ _____ _____
City State Zip Code

Lien Claimant (Completion of this section is required):

_____
Name of Organization filing lien (for individual lien claimants, leave blank)

_____
First Name of Individual filing lien(organizational lien claimants, leave blank)

_____
Last Name of Individual filing lien(organizational lien claimants, leave blank)

_____
Address/PO Box (Please leave blank spaces between numbers, names or words)

_____ _____ _____
City State Zip Code

_____
Phone

Lien Claimant's Attorney/Representative, if any

☐ Law Firm/Attorney ☐ Non-Attorney Representative ☐ Lien Claimant not represented

Lien Claimant Law Firm/Representative

First Name

Last Name

Address/PO Box (Please leave blank spaces between numbers, names or words)

City State Zip Code

Phone

Employer

Name

Address/PO Box (Please leave blank spaces between numbers, names or words)

City State Zip Code

Insurance Carrier or Claims Administrator

Name

Address/PO Box (Please leave blank spaces between numbers, names or words)

City State Zip Code

Employer or Claims Administrator Attorney/Representative (if known)

Name

Address/PO Box (Please leave blank spaces between numbers, names or words)

City State Zip Code

The lien claimant hereby requests the Workers' Compensation Appeals Board to determine and allow as a lien the sum of $ _____ against any amount now due or which may hereafter become payable as
Total Lien Amount
compensation to the above-named employee on account of the above-claimed injury.

This request and claim for lien is for (mark appropriate box):

- ☐ A reasonable attorney's fee for legal services pertaining to any claim for compensation either before the appeals board or before any of the appellate courts, and the reasonable disbursements in connection therewith. (Labor Code § 4903 (a).)
- ☐ The reasonable expense incurred by or on behalf of the injured employee, as provided by Labor Code § 4600. (Labor Code § 4903 (b).)
- ☐ Reasonable expense incurred by or on behalf of the injured employee for medical-legal expenses. (Labor Code § 4903 (b).)
- ☐ The reasonable value of the living expenses of an injured employee or of his or her dependents, subsequent to the injury. (Labor Code § 4903 (c).)
- ☐ The reasonable burial expenses of the deceased employee. (Labor Code § 4903 (d).)
- ☐ The reasonable living expenses of the spouse or minor children of the injured employee, or both, subsequent to the date of the injury, where the employee has deserted or is neglecting his or her family. (Labor Code § 4903 (e).)
- ☐ The reasonable fee for interpreter's services performed on _____ 20 ___ . (Labor Code § 4600 (f).)
- ☐ The amount of indemnification granted by the California Victims of Crime Program. (Labor Code § 4903 (i).)
- ☐ The amount of compensation, including expenses of medical treatment, and recoverable costs that have been paid by the Asbestos Workers' Account. (Labor Code § 4903 (j).)
- ☐ Other Lien(s): Specify nature and statutory basis.

NOTE: ITEMIZED STATEMENT JUSTIFYING THE LIEN MUST BE ATTACHED

- ☐ A copy of the lien claim and supporting documents was served by mail or delivered to each of the above-named parties.

(Signature of Attorney/Representative for Lien Claimant)	(Signature of Lien Claimant)	Date (MM/DD/YYYY)

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PATIENT'S AUTHORIZATION FOR RELEASE OF INFORMATION

As part of your care this office obtains a considerable amount of information about you. We take it very seriously that this information MUST be kept strictly confidential. For this reason, only you can authorize the release of this information. Without your authorization, absolutely NO information will be released to anyone under any circumstances, unless there is a court order forcing the release of that information.

Each of the following authorizations pertains to the Chiropractic office of Kinan Hadaya, DC and the members of his Chiropractic office staff.

(PLEASE INITIAL EACH ITEM & SIGN BELOW)

1. _____I authorize the release of information and discussion of my case/treatment with an attorney, health care provider and/or Insurance Company.
2. _____I authorize the release of my information to any health care provider that is involved in my care, treatment, and/or therapy.
3. _____I authorize Kinan Hadaya, DC and his staff to contact me by telephone at the number provided and/or by email at _____ to discuss my appointments, treatment information, and/or other details related to my therapy, treatment, and/or care in his office. This includes but is not limited to financial issues (Insurance, balance due, etc) related to my care as well as anything related to the treatment that has or will be provided to me.
4. _____I authorize the leaving of messages about my appointments and treatment on my voicemail/answering machine.

5. _____ I authorize the submission of my diagnostics studies (including but not limited to X-ray, CT scan, MRI, Sonogram, Blood Test, Doppler, etc.) to an independent health care provider and/or diagnostics evaluation service for the purpose of obtaining a second opinion and/or more in-depth evaluation of my condition.

   The above authorizations are valid until I rescind them with written notice and a photocopy of these authorizations is to be considered as valid as the original.

Patient Signature: _____ Date: _____

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LATE ARRIVAL/RE-SCHEDULE APPOINTMENT POLICY

* **LATE ARRIVAL** If you arrive late for your appointment, we reserve the right to reschedule the appointment. We allow up to a 10-minute grace period. Late arrivals will cause a delay in seeing patients who are on time. If you find you are running late, we recommend you call our office to determine if we can hold your appointment time.

* **RE-SCHEDULING** We require at least 24 hours' notice for re-scheduling any appointment. You must contact our office via phone or text at 661-947-2455. If you must re-schedule, we will offer you the next available appointment time, which may possibly be a few weeks out.

** Any patient arriving within the 10-minute grace period will still keep their appointment but will have to cut into their service time.

*** Any patient arriving after the 10-minute grace period from their scheduled appointment will forfeit the session resulting in an automatic cancellation.

In the event of excessive tardiness, we reserve the right to refuse further service as this action affects our business and prevents willing clients from utilizing that time slot.

We know things come up and emergencies happen, we simply ask that you be mindful of our time. We are here to help you relief stress, not give you more stress.

Patient Consent Signature_____ Date_____