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 very important to the people involved in handling your case and for you to receive appropriate and fair compensation.

PLEASE, REVIEW AND COMPLETE THIS PATIENT QUESTIONNAIRE. DOING THIS, WILL SIGNIFICANTLY 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 VERY MUCH!

PHYSICIAN USE ONLY:

Evaluation Date: ____________

Evaluation Began: ____________ A.M. ____ P.M. ____

Evaluation Ended: ____________ A.M. ____ P.M. ____

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ADVANCED CHIROPRACTIC HEALTH

WELCOME TO OUR OFFICE! ! THANK YOU FOR GIVING US THE PRIVILEGE OF HELPING YOU.

IF YOU NEED MORE SPACE, WRITE ON THE BACK OF THIS PAGE

YOUR FULL LEGAL NAME________________ NICK NAME________

WHO/WHAT REFERRED YOU TO OUR OFFICE?________________

ADDRESS________________

CITY________________ STATE________ ZIP________

DRIVER LICENSE #________________ ISSUED BY STATE OF________ DATE OF BIRTH________

SEX______ MARITAL STATUS______ SOCIAL SECURITY #________ E-MAIL ADDRESS________

PHONES: HOME________ WORK________ CELL________ FAX NUMBER________

OCCUPATION________ *FULL OR PART TIME*________ *EMPLOYER*________

EMPLOYER'S ADDRESS________________

WHAT IS YOUR PROBLEM OR COMPLAINT?________________

WHEN DID IT START________IS THIS THE FIRST TIME________IF NO, WHEN WAS THE FIRST TIME________IS THIS *PROBLEM DUE TO EITHER A WORK OR CAR ACCIDENT?*________ DO YOU SMOKE?________

HOW DID IT START THIS TIME AND THE FIRST TIME (PLEASE DESCRIBE IN DETAIL)________________

WHAT OTHER PROBLEMS AND/OR COMPLAINTS HAVE YOU HAD IN THE PAST________________

DESCRIBE ALL PAST ILLNESSES, SURGERIES, &/OR ACCIDENTS AND THE DATES THEY OCCURED________________

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?________DOES THE CAREGIVER CARE FOR ANYONE ELSE?________HOW MANY OTHERS?________

ARE YOUR PARENTS ALIVE?________HAS ANYONE IN YOUR FAMILY DIED FROM ANYTHING OTHER THAN OLD AGE?________IF YES, WHO, WHEN AND FROM WHAT?________________

DOES ANYONE ELSE IN YOUR FAMILY SUFFER WITH THE SAME PROBLEMS THAT YOU HAVE?________IF YES, WHO, WHAT PROBLEM AND WHAT IS RELATIONSHIP TO YOU?________________

WHAT ILLNESSES AND WHAT PHYSICAL AND/OR MENTAL IMPAIRMENTS DO ANY OF YOUR RELATIVES SUFFER FROM? PLEASE GIVE NAME, AGE, ILLNESS OR IMPAIRMENT AND RELATIONSHIP________________

PLEASE LIST ALL ACTIVITIES THAT YOU CAN NOT DO AS A RESULT OF YOUR CONDITION________________

DUE TO YOUR ACCIDENT OR ILLNESS, WERE YOU TOTALLY DISABLED?________FROM WHEN TO WHEN________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________

INSURANCE COMPANY________________ PHONE #________ FAX #________

INSURANCE ADDRESS________________ IDENTIFICATION #________ POLICY #________ GROUP#________

IF ANYONE ELSE IS LEGALLY/FINANCIALLY RESPONSIBLE FOR YOU, GIVE THEIR NAME AND ADDRESS________________

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 ADVANCED CHIROPRACTIC HEALTHfor services rendered to me/my family by ADVANCED CHIROPRACTIC HEALTH. I agree to pay any balance left unpaid. I authorizeADVANCED CHIROPRACTIC HEALTH to send bills/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 ADVANCED CHIROPRACTIC HEALTH. If I have financial difficulties/hardships, I* shall pay ADVANCED CHIROPRACTIC HEALTH according to the terms of any agreement that I make with ADVANCED CHIROPRACTIC HEALTH. This authorization serves as a Doctor's Lien, directing my attorney to withhold from any settlement, judgment, or verdict which may be paid to my attorney or me whatever sum is needed to protect ADVANCED CHIROPRACTIC HEALTH, and to pay ADVANCED CHIROPRACTIC HEALTH directly from those proceeds. If ADVANCED CHIROPRACTIC HEALTH has to resort to collection proceedings against me, I agree to pay all collection costs including the fees of collection agents, attorneys, and court costs, in addition to paying all fees due ADVANCED CHIROPRACTIC HEALTH for services rendered by ADVANCED CHIROPRACTIC *HEALTH to &/or for me or my family. I authorize ADVANCED CHIROPRACTIC HEALTH and staff to call me on the telephone to discuse appointments, treatment information, and/or any other details related to my/my family's therapy and treatment.* ADVANCED CHIROPRACTIC HEALTH and staff may leave messages about appointments on my answering machine. If I am unavailable or incapacitated, I authorize ADVANCED CHIROPRACTIC HEALTH and/or staff to discuss my case with my spouse, parents, adult children, and/or other health care providers. ADVANCED CHIROPRACTIC HEALTH is authorized to release any and all information requested to any other health care provider involved in my care and treatment.

TODAY'S DATE________________ YOUR SIGNATURE________________

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WORK ACCIDENT INFORMATION FORM - IF YOU NEED MORE SPACE, WRITE ON THE BACK OF THIS PAGE

NAME________________________________AGE IN YEARS________DATE OF BIRTH__________________SEX__________

MARITAL STATUS____________________HOME PHONE____________________ WORK PHONE______________

ADDRESS____

E-MAIL ADDRESS____

ACCIDENT DATE__________TIME_________ WHERE DID ITHAPPEN?_____________________________

EMPLOYER ____ EMPLOYER'S PHONE NUMBER_______________

GIVE A DETAILED DESCRIPTION OF HOW THIS ACCIDENTINJURY HAPPENED. TYPE OF INJURY: [] LIFTING [] FALL [] OTHER

____

WHAT PARTS OF YOUR BODY WERE HURT?____

HAVE YOU *EVER* HURT THESE PARTS OF YOUR BODY BEFORE?__________IF YES, HOW AND WHEN________________

____

WHERE DO YOU NOW FEEL PAIN? ____

WHAT SYMPTOMS/PROBLEMS BEGAN WHEN YOU GOT HURT?_____________________________________

WHAT SYMPTOMS/PROBLEMS DO YOU FEEL RIGHT NOW?____

HAVE YOU *EVER* HAD THESE SYMPTOMS/PROBLEMS BEFORE THE ACCIDENT?__________________________

IF YES, WHEN AND FROM WHAT?____

WHERE WERE YOU WHEN YOU GOT HURT?________________ WERE YOU HURT DURING NORMAL WORK HOURS?______

SINCE THE INJURY, HAVE YOU DEVELOPED OTHER SYMPTOMS__________ IF YES, DESCRIBE THEM______________

____

HOW SOON AFTER THE INJURY DID THE OTHER SYMPTOMS DEVELOP?________________[] MINUTES [] HOURS [] DAYS

****

LIFTING INJURY: WHAT WAS YOUR POSTURE?______________________ HOW MUCH DID THE OBJECT WEIGH?________LBS.

WHAT WAS THE POSITION AND HEIGHT OF THE OBJECT LIFTED? ___________________________________

****

FALLING INJURY: FROM WHAT HEIGHT DID YOU FALL? ____________ WHAT DID YOU LAND ON?__________________

WHICH PART OF YOUR BODY GOT THE IMPACT?____

WHAT ELSE GOT HURT?_________________________________ WAS A WORK INJURY REPORT FILED?____________

****

DID YOU LOSE CONSCIOUSNESS?__________ WERE YOU GIVEN EMERGENCY CARE AT SCENE?________________

IMMEDIATELY AFTER THE ACCIDENT WHERE DID YOU GO OR WHERE WERE YOU TAKEN? ____________________

WHAT WERE YOU DOING JUST BEFORE YOU WERE INJURED? __________________________________

WHAT ACTIVITIES ARE REQUIRED FOR YOU TO DO YOUR JOB? [] BENDING [] LIFTING [] CRAWLING [] CLIMBING [] DRIVING [] PULLING [] PUSHING [] REACHING [] KNEELING [] RUNNING [] WALKING [] SITTING [] SQUATTING [] STANDING [] GRASPING [] TYPING [] OTHER - DESCRIBE IN DETAIL ______________________________

____

LIST ALL THE DOCTORS THAT YOU HAVE BEEN EXAMINED OR TREATEDY BY SINCE THIS ACCIDENT. INCLUDEDOCTOR'S NAME, ADDRESS, TREATMENT YOU WERE GIVEN, REASON FOR TREATMENT, AND WHAT EFFECT DID THE TREATMENT HAD ON YOU? USE BACK OF THIS PAGE IF YOU NEED MORE SPACE.

____

DID YOU MISS WORK DUE TO THIS ACCIDENT?_______WHAT IS THE FIRST DATE YOU MISSED _________ HAVE YOU RETURNED TO WORK_______ ON WHAT DATE_________ BETWEEN THESE DATES DID YOU DO ANY WORK? ______ IF YES, ON WHAT DATES____________________ WAS ANYONE ELSE INJURED WITH YOU?_______________ WHO AND WHAT RELATIONSHIP DOES THAT PERSON(S) HAVE TO YOU?____

HAS THAT PERSON(S) BEEN TREATED DUE TO THIS ACCIDENT? ______DID YOU REPORT THIS TO YOUR INSURANCE? ______

IS THERE ANYTHING YOU CAN NOT DO AS A RESULT OF THIS ACCIDENT? PLEASE BE SPECIFIC ABOUT WHAT YOU CAN NOT DO. ____

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 for services rendered to me/my family by . I agree to pay any balance left unpaid. I authorize to send bills/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 . If I have financial difficulties/hardships, I shall pay according to the terms of any agreement that I make with . This authorization serves as a Doctor's Lien, directing my attorney to withhold from any settlement, judgment, or verdict which may be paid to my attorney or me whatever sum is needed to protect , and to pay directly from those proceeds. If has to resort to collection proceedings against me, I agree to pay all collection costs including the fees of collection agents, attorneys, and court costs, in addition to paying all fees due for services rendered by to &/or for me or my family. I authorize and staff to call me on the telephone to discuss appointments, treatment information, and/or any other details related to my/my family's therapy and treatment. and staff may leave messages about appointments on my answering machine. If I am unavailable or incapacitated, I authorize and/or staff to discuss my case with my spouse, parents, adult children, and/or other health care providers. is authorized to release any and all information requested to any other health care provider involved in my care and treatment.

TODAY'S DATE___________YOUR SIGNATURE____

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PATIENT'S AUTHORIZATIONS FOR RELEASE OF INFORMATION

As part of your care in this office a considerable amount of information is recorded 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. Please fill in your name and identification information, read each item, check the appropriate box, cross out the phrase that does not apply, initial at the end of each item, date and sign at the bottom.

My name is ____________________________
My date of birth is______________________
My current address is____
My phone numbers are: HOME ________ WORK ______ CELL_____________
Each of the following authorizations pertains to the Chropractic office of and the members of his Chiropractic office staff. ______________________________ *PLEASE INITIAL AFTER EACH ITEM*

1. **I [] authorize [] do NOT authorize the release of information to my insurance company.**
2. **I [] authorize [] do NOT authorize the writing of my name on the office message/birthday board.**
3. **I [] authorize [] do NOT authorize the release of my information to any other health care provider that is involved in my care, treatment, and/or therapy.**
4. **I [] do NOT authorize the discussion of my case/care with anyone except for those authorizations given in items 1, 3, 9, and 10. *If this is checked DO NOT fill in any information in items 5 and 8!***
5. **I [] authorize the discussion of my case/care with ONLY the following persons:**
   my spouse whose name is ____
   my parents whose names & phone numbers are ______________________________
   my adult children whose name(s) & phone number(s) is/are ______________________
   my sibling(s) whose name(s) & phone number(s) is/are _________________________
   my friend(s) whose name(s) & phone number(s) is/are __________________________
   ____

6 **I [] authorize [] do NOT authorize the leaving of messages about my appointments and treatment on my voice mail/answering machine.**

7 **I [] authorize [] do NOT authorize and his staff to contact me by telephone at the numbers listed above and by email at ______________@______________________to discuss my appointments, treatment information, and/or other details related to my therapy, treatment, and/or care in his/her 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.**

8. **If I am not available, and his staff [] are [] are NOT authorized to speak with the relative(s) and/or friend(s) noted in item 5 above about all the items listed in item 7 above.**

9. **I [] authorize [] do NOT authorize the discussion of my case/treatment with an attorney and/or health care provider that represents me or my insurance company.**

10. **I [] authorize [] do NOT authorize the submission of my diagnostic studies (including but not limited to x-ray, CT scan, MRI, sonogram, blood tests, Doppler, etc.) to an independent health care provider and/or diagnostic 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.
Today's Date is ____________ Signature of Patient______________________________
Signature of Parent or Guardian if patient is under 18 years ____________________
Please print name of parent or guardian_____________________________________

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ADVANCED CHIROPRACTIC HEALTH CENTER
KINAN HADAYA, DC
Diplomate, American Academy of Pain Management
Qualified Medical Evaluator, State of California

615 W. Ave Q, Suite E
Palmdale, CA 93551
(P) 661-947-2455 (F) 661-947-2770

18500 Via Princessa, Suite 3
Canyon Country, CA 91387
(P) 661-252-2225 (F) 661-252-2239

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____________________

Patient Name/ Parent or Guardian ________________________________ Date____________________

STATE OF CALIFORNIA
DEPARTMENT OF INDUSTRIAL RELATIONS

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

ID OR CASE NO.

(Print or type names and addresses; include ZIP Codes)

Injured Worker	Address
Date of Claimed Injury	Social Security Number / Date of Birth
Attorney for Injured Worker	Address
Employer	Address
Insurance Carrier or, if Self-Insured, Certificate Name	Address Where Claim Administered
Adjusting Agency, if Agency Administered	
Attorney for Employer/Carrier	Address
Lien Claimant	Address and Telephone No.
Attorney for Lien Claimant	Address and Telephone No.

The lien claimant hereby requests the Workers' Compensation Appeals Board to determine and allow as a lien the sum of ______________________ Dollars ($ ________) against any amount now due or which may hereafter become payable as compensation to the above named worker on account of the above claimed injury.

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

☐ The reasonable expense incurred by or on behalf of said worker for medical treatment to cure or relieve from the effects of said injury; or

☐ The reasonable medical expense incurred to prove a contested claim; or

☐ The reasonable value of living expenses of said worker or of his or her dependents, subsequent to the injury, or

☐ The reasonable living expenses of the spouse or minor children, or both of said worker, subsequent to the date of injury, where such worker has deserted or is neglecting his or her family; or

☐ The reasonable fee for interpreter's services performed on ____________

NOTE: ITEMIZED STATEMENT JUSTIFYING THE LIEN MUST BE ATTACHED

FOR INJURIES OCCURRING ON OR AFTER JANUARY 1, 1990, FOR WHICH THE LIEN CLAIMANT DOES NOT HAVE A WCAB IDENTIFICATION NUMBER, the lien claimant declares under penalty of perjury that:

☐ a copy of the original completed Employee's Claim for Workers' Compensation Benefits (DWC Form 1) is attached, or

☐ the lien claimant does not have a copy of the claim form, but made the following efforts to secure one:

* We are obtaining a copy from

☐ 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 for Lien Claimant ____________ Signature of Lien Claimant ____________ Date ____________

EMPLOYEE'S CONSENT TO ALLOWANCE OF LIEN

I consent to the requested allowance of a lien against my compensation.

Signature of Attorney for Injured Worker ____________ Signature of Injured Worker ____________

DWC WCAB Form 6 (Rev 2/91)

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
661-947-2455 Fax: 661-947-2770

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/ PARENT OR LEGAL GUARDIAN

______________________________ TODAY'S DATE __________

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KINAN HADAYA, DC
Diplomate, American Academy of Pain Management
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At Advanced Chiropractic Health Center, we understand your time is valuable which is why we try to be as flexible as possible for each and every single one of our patient's. We do our best effort to confirm appointments ahead of time, but we do however want all our patient's to know, that you're ultimately responsible for your appointments scheduled.

In an effort to effectively control our schedule, a new policy will be taking effect starting on January 4, 2016. For every missed appointment, there will be a $25 inconvenience fee. For every appointment, there will be a 15 minute grace period in case patient is running late. In order to avoid these fees, please advise our office about your rescheduled appointment or cancellation, at least 24 hours ahead of time. If you are having transportation issues, please advise our office in advanced to better manage your appointments. Reason being is we dedicate our scheduled time to all of our patient's well-being, and by missing an appointment we lose time that could have been used effectively to help another patient on their road to recovery.

By signing below, you understand our new policy, and please note that on your next scheduled appointment, your fee will be collected before treatment is rendered. Thank you for your understanding and cooperation with this matter.

Patient Name______________________________ Date____________

Signature_________________________________ Date____________

Name of Guardian/Legal Representative______________________________