Physicians Plus Spine & Rehab Center
1106 Pulaski Highway
Bear, Delaware 19701
Tel. 302-300-1111

Sean P. Feeney, M.S., D.C., CMUA
Specializing in Auto & Work Related Injuries

Work Related Injury

File #

Name:_____ **Date:**_____
Address:_____ **City:**_____ **State:**_____ **Zip:**_____
DOB:_____ **Age** _____ **Social Security #**_____
Home #:_____ **Work #:**_____ **Cell #:**_____ **E-mail:**_____
Handedness **Right / Left**

Primary Care Physician:_____
Referred to United Spine Centre:_____

Date of Injury:_____ **Time:** _____
or
Period of time over which your injury occurred:_____

Name of Insurance Company Responsible for the Payment of Your Injuries:_____
Address: _____ **City:**_____ **State:**_____**Zip:**_____
Claim#:_____ **Claim Agent:** _____ **Ph#**_____

Very Important (for your protection)
❑ **Yes** ❑ **No**
I have completed and turned in all of the paperwork, forms, etc. required by the Insurance Company in order to initiate payment on my medical bills. You should be fully aware that it is your responsibility to complete the necessary paperwork as mandated by the Insurance Carrier that is responsible for the payment of all medical expenses that you may have already accrued from other treatment(s) or shall accrue from this or any subsequent treatment(s).
If this paperwork is not completed (in a timely manner) the Insurance Company will not initiate the payment of your benefits and may choose to deny payment on your entire claim, regardless of the party at fault.
We are here to help you simplify this process by answering any questions to the best of our ability. Please do not hesitate to ask for assistance.

❒ **Yes** ❒ **No** Do you have any Private Health Insurance (this is for your protection in case of the denial of your claim)?

Name of Private Insurance:_____
ID#: _____
*** Please Note, this information is for your protection in case there is an emergency**
*** Please provide a copy of your private insurance card**

❒ **Yes** ❒ **No** Do you have an attorney to assist you?
If yes, Name of Law Firm:_____
Name of Attorney:_____
Address: _____City:_____
State:_____ Zip:_____

Employer:_____ Phone:_____
Occupation:_____ Job: Position_____
Employer Address:_____City:_____State:_____Zip:_____
How long have you been employed by your present employer?_____

❒ **Yes** ❒ **No** Did your injuries occur from a single incident.
If yes, what date?_____ Approx Time?(if known)_____

❒ **Yes** ❒ **No** Did your injuries occur over a period of time?
If yes, approximately what was the time phrase of occurance? _____

❒ **Yes** ❒ **No** Were you performing your normal job duties when injured?

❒ **Yes** ❒ **No** Did your injuries occur on your jobsite?
If no to above question, where did your injury occur? _____
_____

Injury Details

Briefly describe how you injured yourself:_____
_____
_____
What were your immediate symptoms?_____
_____
_____

❒ **Yes** ❒ **No** Did anyone witness your injuries?
❒ **Yes** ❒ **No** Did you report your injuries to your supervisor?
❒ **Yes** ❒ **No** Did you report your injuries to someone other that your supervisor?
Name of the person you reported your injuries to:_____
Name of the contact person (if needed) to discuss your condition:_____
Telephone #:_____

❒ **Yes** ❒ **No** Were you given any specific recommendations after reporting your injuries?
If yes, please briefly describe_____
_____
_____

❒ **Yes** ❒ **No** ❒ **Don't Recall** After your injury, did you lose consciousness?
If yes, please describe_____
❒ **Yes** ❒ **No** Did you sustain any cuts, lacerations or bruises?
If yes, please describe_____
❒ **Yes** ❒ **No** Have your symptoms changed since you originally got injured?
If yes, please describe_____
❒ **Yes** ❒ **No** ❒ **Don't Recall** Did your feet/ankles get twisted or jammed into the floorboard?

❒ **Yes** ❒ **No** Did your body strike anything else within the vehicle? If yes, please describe_____
_____

❒ Yes ❒ No Did you go to your company's employee health center?
If yes, what treatment was conducted?_____
_____

❒ Yes ❒ No Were you given any specific recommendations or placed on any restrictions from employee health? _____
If yes, what were they?_____

❒ Yes ❒ No Did you see a company physician?

❒ Yes ❒ No If yes, was any treatment conducted?
If treatment was rendered at employee health, please briefly describe_____
_____
_____

❒ Yes ❒ No Were you taken to the Emergency Room immediately after the accident? (If yes, how were you transported) ❒ Ambulance ❒Drove Self ❒ Driven by another ❒ Medi-Vac

❒ Yes ❒ No Did you go to the Emergency Room later in the day or at all? If you went to the Emergency Room, which one? _____

If you went to the Emergency Room, did you (check all that apply)
❒ get examined ❒ have x-rays ❒ have a Cat Scan ❒ have an EKG
❒ get stitches ❒ get casted ❒ get admitted to the hospital
❒ other:_____

❒ Yes ❒ No Were you prescribed any medications? If yes, which ones?_____
_____

Follow-up Treatment

❒ Yes ❒ No Have you seen your family physician? If yes, what medications/treatments were prescribed?_____

❒ Yes ❒ No Was physical therapy prescribed?
If yes, where?_____
For how long?_____
Approximate times per week?_____

❒ Yes ❒ No Have you been referred to any specialist (i.e. Neurosurgeon, Neurologist, Orthopedic Surgeon, Physiatrist, etc.)
If yes, please list:
1. _____
2. _____
3. _____
4. _____
5. _____

❒ Yes ❒ No Due to your injuries, have you had any of the following tests?

LOCATION

❒ X-Rays_____
❒ MRI_____
❒ Cat Scan_____
❒ EMG_____
❒ Other_____
_____

AUTHORIZATION AND RELEASE: I authorize payment of insurance benefits directly to the Physicians Plus. I authorize physician to release all information necessary to communicate with personal physicians and other healthcare providers and payors and to secure the payment of benefits. In the unanticipated event that the expenses for my treatment are not covered by my Insurance Carrier (or Private Insurance) I am responsible for payment of professional services.

I understand and agree to allow Physicians Plus to use my Patient Health Information for the purposes of treatment, payment, healthcare operations, and coordination of care. I understand that my medical records are privileged and confidential information and that my records will be utilized by this office strictly within the parameters of my legal rights concerning said records.

I am aware that there is a more detailed account of all policies and procedures concerning the privacy of my Patient Health Information. We encourage you to read the HIPAA NOTICE that is available to you desk for you to read in its entirety at the front, before signing this notice. If there is anyone you do not want to receive your medical records, please inform our office.

_____ _____

Patient Signature **Date**

_____ _____

Guardian's Signature Authorizing Care **Date**

Present complaints due to accident:

❒ Yes	❒ No	Headaches	❒ Yes	❒ No	Cramp of muscles in left leg
❒ Yes	❒ No	Dizziness	❒ Yes	❒ No	Cramping of muscles in right leg
❒ Yes	❒ No	Light sensitivity	❒ Yes	❒ No	Left knee pain
❒ Yes	❒ No	Nausea with headaches	❒ Yes	❒ No	Right knee pain
❒ Yes	❒ No	Jaw pain	❒ Yes	❒ No	Left foot and/or ankle pain
❒ Yes	❒ No	Facial pain	❒ Yes	❒ No	Right foot and/or ankle pain
❒ Yes	❒ No	Heaviness of head	❒ Yes	❒ No	Anxiety
❒ Yes	❒ No	Neck pain and/or stiffness	❒ Yes	❒ No	Tension
❒ Yes	❒ No	Numb, tingling and/or weak down left arm	❒ Yes	❒ No	Insomnia
❒ Yes	❒ No	Numb, tingling and/or weak down right arm	❒ Yes	❒ No	Depression
❒ Yes	❒ No	Left shoulder pain	❒ Yes	❒ No	Difficulty with concentration
❒ Yes	❒ No	Right shoulder pain	❒ Yes	❒ No	Irritability
❒ Yes	❒ No	Cramping of muscles in left arm	❒ Yes	❒ No	Loss of taste
❒ Yes	❒ No	Cramping of muscles of right arm	❒ Yes	❒ No	Loss of smell
❒ Yes	❒ No	Mid back pain and/or stiffness	❒ Yes	❒ No	Vision change
❒ Yes	❒ No	Pain into rib cage	❒ Yes	❒ No	Memory loss
❒ Yes	❒ No	Sternal pain	❒ Yes	❒ No	Fatigue
❒ Yes	❒ No	Low back pain and/or stiffness	❒ Yes	❒ No	Mental dullness
❒ Yes	❒ No	Numb, tingling and/or weak down left leg	❒ Yes	❒ No	Ringing or buzzing in ears
❒ Yes	❒ No	Numb, tingling and/or weak down right leg			

Notes:

Present Medications

Injury Related	Prior to Injury

As a result of your injuries, are any of the following conditions difficult or impossible to perform? Check all that apply.

❒ **Yes** ❒ **No** ❒ **Not Applicable** Heavy lifting (50 lbs. and above from ground level)
❒ **Yes** ❒ **No** ❒ **Not Applicable** Moderate lifting (25 lbs. to 49 lbs. from ground level)
❒ **Yes** ❒ **No** ❒ **Not Applicable** Light lifting (Less than 25 lbs. from ground level)
❒ **Yes** ❒ **No** ❒ **Not Applicable** Bending
❒ **Yes** ❒ **No** ❒ **Not Applicable** Twisting
❒ **Yes** ❒ **No** ❒ **Not Applicable** Standing
❒ **Yes** ❒ **No** ❒ **Not Applicable** Sitting
❒ **Yes** ❒ **No** ❒ **Not Applicable** Sleeping
❒ **Yes** ❒ **No** ❒ **Not Applicable** Gripping
❒ **Yes** ❒ **No** ❒ **Not Applicable** Pushing
❒ **Yes** ❒ **No** ❒ **Not Applicable** Pulling
❒ **Yes** ❒ **No** ❒ **Not Applicable** Reaching
❒ **Yes** ❒ **No** ❒ **Not Applicable** Housework
❒ **Yes** ❒ **No** ❒ **Not Applicable** Dressing self (i.e. putting shoes on)
❒ **Yes** ❒ **No** ❒ **Not Applicable** Bathing/ Showering
❒ **Yes** ❒ **No** ❒ **Not Applicable** Brush teeth in morning
❒ **Yes** ❒ **No** ❒ **Not Applicable** Shaving
❒ **Yes** ❒ **No** ❒ **Not Applicable** Caring for children
❒ **Yes** ❒ **No** ❒ **Not Applicable** Sexual Activities

❒ **Yes** ❒ **No** Is there anything that makes you feel better? (i.e.: medication, exercise, heat/ice, rest)
(if yes , please explain) _____
_____

Past Medical History

❒ **Yes** ❒ **No** 1. Did you have any of your current complaints prior to the accident?
(if yes, please explain)_____
_____
_____

❒ **Yes** ❒ **No** 2. Have you ever had an auto and/or work comp claim(s) in the past? (if yes,
please list them and approx. dates): _____
_____
_____

❒ **Yes** ❒ **No** 3. Have you ever been given an impairment rating or been listed with permanent
injuries?_____

❒ **Yes** ❒ **No** 4. Have you had any other major injuries in the past? (i.e., Auto accidents, falls,
traumas etc. If yes, please explain) _____
_____

(Do you have any of the following disorders?)

❒ **Yes** ❒ **No** Allergies
❒ **Yes** ❒ **No** Anemia
❒ **Yes** ❒ **No** Asthma
❒ **Yes** ❒ **No** Cancer
❒ **Yes** ❒ **No** Chronic Obstructive Pulmonary Disease
❒ **Yes** ❒ **No** Diabetes
❒ **Yes** ❒ **No** Depression/Anxiety
❒ **Yes** ❒ **No** Emphysema
❒ **Yes** ❒ **No** Gastrointestinal problems (i.e. Colitis, Chron's Disease)
❒ **Yes** ❒ **No** Heart Disease
❒ **Yes** ❒ **No** Hepatitis / Cirrhosis
❒ **Yes** ❒ **No** High Blood Pressure
❒ **Yes** ❒ **No** High Cholesterol
❒ **Yes** ❒ **No** HIV / AID's
❒ **Yes** ❒ **No** Stroke
❒ **Yes** ❒ **No** Thyroid Disease
❒ **Yes** ❒ **No** Ulcers (peptic or gastric)
❒ **Yes** ❒ **No** Other Medical Conditions (if yes, please describe): _____
_____

<u>Surgical History:</u> (List surgeries (other than surgeries due to this accident) and approximate dates)

1. _____
2. _____
3. _____
4. _____
5. _____

Social History

1. Martial Status: _____ Number of Children:_____

2. Education Status (check all that apply):
- ❒ Grade School
- ❒ High School
- ❒ GED
- ❒ Some College
- ❒ Associates Degree
- ❒ Specialty Degree (PTA, Dental Hygienist, Chiropractic Tech, MRI Tech)
- ❒ 4 Year Degree
- ❒ Graduate Degree
- ❒ Doctorate (PhD, EdD, etc)
- ❒ Professional Degree (MD, DO, DC, DDS, DVM, DPMETC)
- ❒ Professional Health Care Degree (RN, PT, ATC, PA, CNP, etc.)

Job Description and Work History

Employer: _____
Job Title: _____
❒ **Yes** ❒ **No** Does your job require lifting? If yes, what is the maximum amount you are required to lift? _____

Place a ✓ next to all that apply to your job requirements:

- ❒ Lifting (max weight)
- ❒ Bending
- ❒ Twisting
- ❒ Gripping
- ❒ Repetitive Use of arms
- ❒ Pushing
- ❒ Pulling
- ❒ Reaching
- ❒ Overhead Activity
- ❒ Repetitive use of legs

Others: _____

What is the average number of hours you are required to sit per day? _____
What is the average number of hours you are required to stand per day? _____
What is the average number of hours you are required to work per week? _____

❒ **Yes** ❒ **No** Do you smoke tobacco? (if yes how much do you smoke) _____ packs per week.
❒ **Yes** ❒ **No** Do you chew tobacco? (if yes, On Rare Occasions _____ Moderate _____ Heavy _____).

❒ **Yes** ❒ **No** Do you consume alcohol?

a. Never _____
b. Very Rarely _____
c. Lightly_____ (average 1 drink or less per day)
d. Moderately _____ (average 2-3 drinks per day)
e. Heavily _____ (average 4 or more drinks per day)

Scale: 1 Drink = 12 oz. of Beer
5 oz. of Wine
1 oz. of Hard Liquor

❒ **Yes** ❒ **No** Have you ever been addicted to alcohol, prescription drugs, or street drugs?

Recreational Activities

List some of the hobbies or recreational activities you enjoyed prior to your injury. Place an **X** by those activities you can no longer perform/enjoy because of your injury (i.e., hiking, dancing, playing with and/or lifting children, jogging, aerobics, working out, going out with friends, etc.).

1._____ 4._____

2._____ 5. _____

3._____ 6._____

Disability and/or Job Restrictions:

❒ **Yes** ❒ **No** Are you currently on disability due to your injuries (i.e. not working at all)?
If yes, what is the name of the Doctor who placed you on disability?
_____
If yes, dates of disability: _____

❒ **Yes** ❒ **No** Where you previously disabled do to your injuries?
If yes, what is the name of the Doctor who placed you on disability?
_____
If yes, dates of disability: _____

❒ **Yes** ❒ **No** Do you currently have any job restrictions?
If yes, what is the name of the Doctor who gave you restrictions?
_____
Please describe your restrictions:_____
_____
_____

Patient request for Patient Records

Date: _____

To: _____

Patient Name: _____

I hereby authorize the release of my Medical Records and request that they be transferred to:

Physicians Plus Spine & Rehab Center
1106 Pulaski Highway
Bear, DE 19701

Patient Signature:_____

Social Security :_____

Medical Information Release Form
(HIPAA Release Form)

Name: _____ Date of Birth: _____/____/_____

Release of Information

[ ] I authorize the release of information including the diagnosis, records; examination rendered to me and claims information. This information may be released
to:

[ ] Spouse_____
[ ] Child(ren)_____
[ ] Other_____
[ ] Information is not to be released to anyone.

This ***Release of Information*** will remain in effect until terminated by me in writing.

Messages

Please call [ ] my home [ ] my work [ ] my cell
Number:_____
If unable to reach me:
[ ] you may leave a detailed message
[ ] please leave a message asking me to return your call
[ ] _____
The best time to reach me is (*day*)_____ between (*time*)_____

Signed: _____ Date:____/____/_____

Witness:_____ Date: ___/____/_____

PREGNANCY WAIVER

I hereby acknowledge that Physicians Plus has informed me prior to being x-rayed of the advisability of risk and the probable consequences of receiving x-rays during pregnancy. I have stated on my own that I was not pregnant at the time and do hereby release and hold harmless from any legal action or responsibility caused by the use of this procedure.

_____

Printed Name of Patient

_____

Signature of Patient/Authorized Representative of Patient

_____

Witness

Date: _____