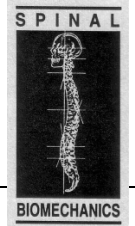


Bailey Chiropractic

11279 Perry Highway, Wexford, PA 15090
724 - 934 - 0899



WORKMEN'S COMPENSATION

PATIENT INFORMATION

Please present your insurance card(s) so we can put a copy in your file.

Date _____	Patient # _____
<input type="checkbox"/> Mr. <input type="checkbox"/> Mrs. <input type="checkbox"/> Ms. _____ <div style="display: flex; justify-content: space-between; font-size: small;"> (First) (Initial) (Last) (Nickname) </div>	
Address _____	
City _____ State _____ Zip _____ Birthday _____ Age: _____ <input type="checkbox"/> Male <input type="checkbox"/> Female	
Employer _____ Occupation _____	
Address _____ City _____ State _____ Zip _____	
Insurance Company _____	
Is patient covered by Spouse's insurance? <input type="checkbox"/> No <input type="checkbox"/> Yes Is patient covered by additional insurance? <input type="checkbox"/> No <input type="checkbox"/> Yes	
Subscriber Name _____ Birthday _____ <div style="display: flex; justify-content: space-between; font-size: small;"> (First) (Initial) (Last) </div>	
Employer _____ Insurance Company _____	

Please present insurance card(s) so we can put a copy in your file.

CONTACT INFORMATION

Best way to reach you Home Cell Work Email **Home phone** _____

Cell phone _____ Work phone _____ Ext _____ Email _____

In Case of Emergency

Name _____ Relationship _____ Home Phone _____ Cell _____

If someone referred you to Dr. Bailey's office would you please tell us their name & address so we can send them a coupon to thank them.

Name _____ Ad Friend Relative Neighbor Doctor

Address _____ City _____ State _____ ZIP _____

Is your present pain due to an injury? No Yes On the job Auto Accident Other _____

Has the accident been reported? No Yes To Employer Workmen's s Compensation Auto Carrier Other _____

Have you had any surgeries? If yes, please list ----

Surgery _____ Date _____

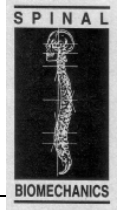
Surgery _____ Date _____

X-Ray Exam No Yes Date _____ MRI No Yes Date _____ CAT SCAN No Yes Date _____

PLEASE LIST ANY ACCIDENTS OR FALLS		DATES
Auto	<input type="checkbox"/> No <input type="checkbox"/> Yes	
Sports or Other	<input type="checkbox"/> No <input type="checkbox"/> Yes	
Other	<input type="checkbox"/> No <input type="checkbox"/> Yes	
Broken Bones or dislocations (fractures)	<input type="checkbox"/> No <input type="checkbox"/> Yes	
Have you ever had any spinal taps or spinal injections?	<input type="checkbox"/> No <input type="checkbox"/> Yes	
Were you ever knocked unconscious or had a lapse of memory?	<input type="checkbox"/> No <input type="checkbox"/> Yes	
Have you ever had a lapse of memory?	<input type="checkbox"/> No <input type="checkbox"/> Yes	
Are you presently taking any medications - prescribed or patent?	<input type="checkbox"/> No <input type="checkbox"/> Yes	If yes list below
What medications?		

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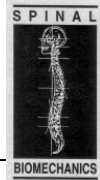
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WORKMAN'S COMP QUESTIONNAIRE

Name		Date	
Name of employer at time of accident			
Date of accident		Length of time worked there prior to accident	
Type of work being done at time of injury			
In your own words, please describe accident			
Have you been treated by another doctor for this accident?			<input type="checkbox"/> No <input type="checkbox"/> Yes
Doctor's name			
Address			
City		State	Zip
What type of treatment did you receive?			
Have you		<input type="checkbox"/> improved	<input type="checkbox"/> unchanged <input type="checkbox"/> gotten worse
What types of medicines are you taking for this condition?			
Do these medicines help?		<input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> Don't Know
Have you had physical therapy?		<input type="checkbox"/> No <input type="checkbox"/> Yes	If yes indicate below how often
<input type="checkbox"/> Daily	<input type="checkbox"/> Every other day	<input type="checkbox"/> Several times a week	
Does the physical therapy help?			
Prior to this accident, have you ever had any physical complaints similar to what you have now?		<input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> Don't Know
If yes, describe			
Were these similar complaints the result of a previous accident(s)?			<input type="checkbox"/> No <input type="checkbox"/> Yes
If yes, please provide details of accidents(s)			
Have you returned to work since your accident?		<input type="checkbox"/> No <input type="checkbox"/> Yes	If yes, please fill out information below
Date returned to work		Employer	
Type of work you are now doing			
<input type="checkbox"/> Light Duty		<input type="checkbox"/> Reg. Duty	<input type="checkbox"/> Full-Time <input type="checkbox"/> Part-Time
Current medical complaints			
Have you had any other serious accidents which required medical care?			<input type="checkbox"/> No <input type="checkbox"/> Yes
Describe			
Have you had any serious illnesses that required hospitalization?			<input type="checkbox"/> No <input type="checkbox"/> Yes
Describe			
Have you had any surgeries?			<input type="checkbox"/> No <input type="checkbox"/> Yes
Type surgery		Date	
Type surgery		Date	
Would you like to have information about the benefits of supplements?			<input type="checkbox"/> No <input type="checkbox"/> Yes
Do you want information on how Chiropractic treatment can help allergies/migraines			<input type="checkbox"/> No <input type="checkbox"/> Yes

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JOB DESCRIPTION

In a typical 8-hour workday, I ---- Circle # of hours for each 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
In terms of an 8 hour work day				Occasionally means 33% of the day	Frequently means 34% to 66%	Continuously means 67% or more			
On the Job, I perform the following activities				Occasionally	Frequently	Continuously			
Bend / stoop				<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>			
Squat				<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>			
Crawl				<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>			
Climb				<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>			
Reach above shoulder level				<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>			
Crouch				<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>			
Kneel				<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>			
Balancing				<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>			
Pushing / Pulling				<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>			
On the job, I lift:	Not At All			Occasionally	Frequently	Continuously			
Up to 10 pounds	<input type="checkbox"/>	<input type="checkbox"/>			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		
11 to 24 pounds	<input type="checkbox"/>	<input type="checkbox"/>			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		
25 to 34 pounds	<input type="checkbox"/>	<input type="checkbox"/>			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		
35 to 50 pounds	<input type="checkbox"/>	<input type="checkbox"/>			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		
51 to 74 pounds	<input type="checkbox"/>	<input type="checkbox"/>			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		
75 to 100 pounds	<input type="checkbox"/>	<input type="checkbox"/>			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		
Do you have to bend over while doing any lifting?								No	Yes
Are your feet used for repetitive movements, such as in operating foot controls?								No	Yes
Do you use your hands for repetitive actions such as				Simple Grasping	Firm Grasping	Fine Manipulating			
Right hand				<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>			
Left hand				<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>			
Both hands				<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>			
				Please Describe					
Are you required to work on unprotected heights?				<input type="checkbox"/> No	<input type="checkbox"/> Yes				
Are you required to be around moving machinery?				<input type="checkbox"/> No	<input type="checkbox"/> Yes				
Are you exposed to marked changes in temperature and humidity?				<input type="checkbox"/> No	<input type="checkbox"/> Yes				
Are you required to drive automotive equipment?				<input type="checkbox"/> No	<input type="checkbox"/> Yes				
Are you exposed to dust, fumes and / or gases?				<input type="checkbox"/> No	<input type="checkbox"/> Yes				
Please list any additional comments									

Signature _____

Date _____

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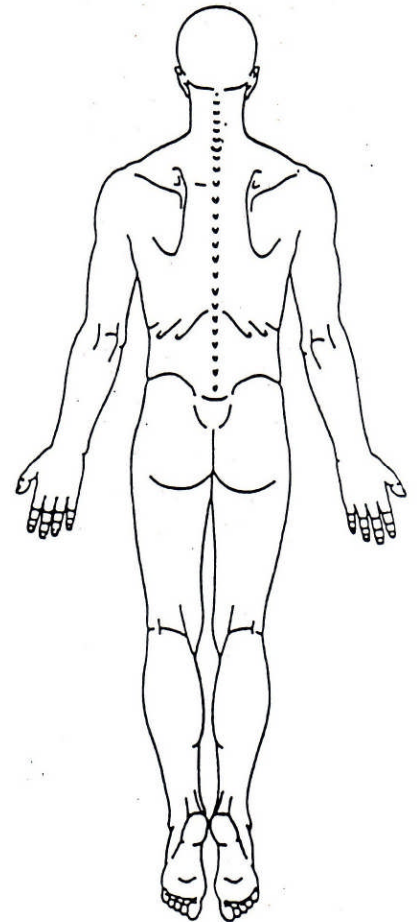
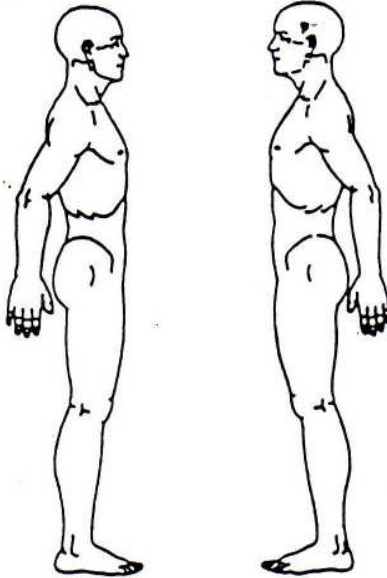
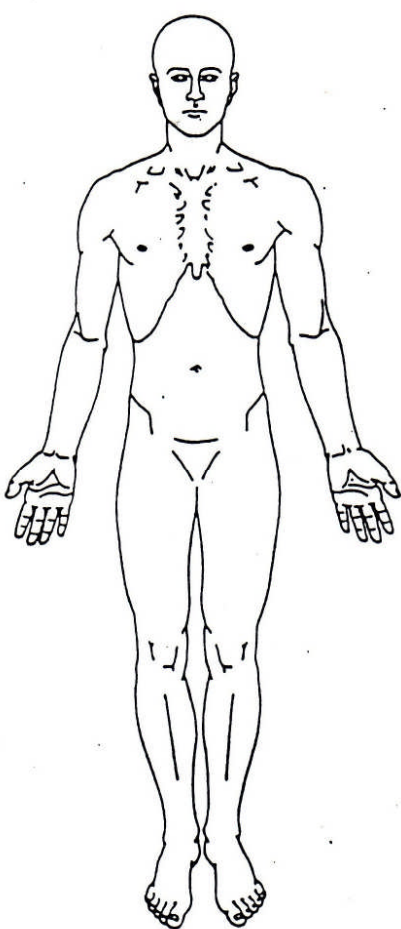
DIAGRAM OF PATIENT'S DISCOMFORT

Name		Date
Habits		
<input type="checkbox"/> Smoke - packs /day	<input type="checkbox"/> Coffee - Cups/day	<input type="checkbox"/> Alcohol - Amount/day
Exercise		
<input type="checkbox"/> None <input type="checkbox"/> Moderate <input type="checkbox"/> Daily	Type of Exercise?	
Do you currently take any vitamins and or supplements?		
<input type="checkbox"/> Over the counter	<input type="checkbox"/> From my doctor	<input type="checkbox"/> Yes <input type="checkbox"/> No
<input type="checkbox"/> I send away for them		
Please list type you take		

LIST PRESENT COMPLAINTS WITH RATINGS OF 1 - 10 (10 being unbearable Pain)

1	1	2	3	4	5	6	7	8	9	10
2	1	2	3	4	5	6	7	8	9	10
3	1	2	3	4	5	6	7	8	9	10

Use these figures to mark your pain



Mark with
A for Ache
B for Burning sensations
M for pain with Movement
N for Numbness
P for Pins & needles
S for Sharp/Stabbing pain
T for Tingling sensations
O for Other

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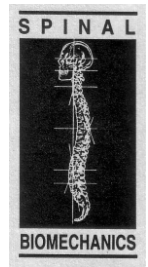
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BACK AND NECK PAIN

BACK PAIN					
Currently, I have pain in my		<input type="checkbox"/> low back	<input type="checkbox"/> mid back	<input type="checkbox"/> upper back	
My pain began		<input type="checkbox"/> gradually	<input type="checkbox"/> suddenly		
I have pain		<input type="checkbox"/> sometimes	<input type="checkbox"/> all of the time		
My pain goes into my		<input type="checkbox"/> right leg	<input type="checkbox"/> left leg	<input type="checkbox"/> both	
I have tingling and/or numbness In my		<input type="checkbox"/> right leg	<input type="checkbox"/> left leg	<input type="checkbox"/> both	
My pain is worse when I:					
cough/sneeze	<input type="checkbox"/> No	<input type="checkbox"/> Yes	walk	<input type="checkbox"/> No	<input type="checkbox"/> Yes
sit	<input type="checkbox"/> No	<input type="checkbox"/> Yes	lift	<input type="checkbox"/> No	<input type="checkbox"/> Yes
bend	<input type="checkbox"/> No	<input type="checkbox"/> Yes	push	<input type="checkbox"/> No	<input type="checkbox"/> Yes
use a computer	<input type="checkbox"/> No	<input type="checkbox"/> Yes	pull	<input type="checkbox"/> No	<input type="checkbox"/> Yes
My back is worse with sexual activity				<input type="checkbox"/> No	<input type="checkbox"/> Yes
My pain wakes me up during the night				<input type="checkbox"/> No	<input type="checkbox"/> Yes
Changes in the weather affect my pain				<input type="checkbox"/> No	<input type="checkbox"/> Yes
NECK PAIN					
My neck pain began		<input type="checkbox"/> gradually	<input type="checkbox"/> suddenly		
I have pain		<input type="checkbox"/> sometimes	<input type="checkbox"/> all of the time		
My pain goes into my		<input type="checkbox"/> right arm	<input type="checkbox"/> left arm	<input type="checkbox"/> both	
I have tingling and / or numbness in my		<input type="checkbox"/> right arm	<input type="checkbox"/> left arm	<input type="checkbox"/> both	
My pain is worse when I:					
lift		<input type="checkbox"/> No	<input type="checkbox"/> Yes	cough/sneeze	<input type="checkbox"/> No <input type="checkbox"/> Yes
push		<input type="checkbox"/> No	<input type="checkbox"/> Yes	bend forward	<input type="checkbox"/> No <input type="checkbox"/> Yes
pull		<input type="checkbox"/> No	<input type="checkbox"/> Yes	turn my head	<input type="checkbox"/> No <input type="checkbox"/> Yes
				use a computer	<input type="checkbox"/> No <input type="checkbox"/> Yes
My pain wakes me up during the night				<input type="checkbox"/> No	<input type="checkbox"/> Yes
Changes In the weather affect my pain				<input type="checkbox"/> No	<input type="checkbox"/> Yes
I have neck stiffness				<input type="checkbox"/> No	<input type="checkbox"/> Yes
I have headaches				<input type="checkbox"/> No	<input type="checkbox"/> Yes
If I do get headaches, they occur		<input type="checkbox"/> sometimes		<input type="checkbox"/> all of the time	
OTHER PAIN					
Please describe 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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HIPAA PATIENT PRIVACY FORM

IN ORDER TO BE COMPLIANT WITH HIPAA REGULATIONS WE REQUEST THAT EACH PATIENT COMPLETE THIS FORM. THIS FORM WILL BECOME A PERMANENT PART OF YOUR MEDICAL RECORDS. THE HIPAA PRIVACY RULES GIVE INDIVIDUALS THE RIGHT TO REQUEST A RESTRICTION ON USES AND DISCLOSURES OF THEIR PROTECTED HEALTH INFORMATION. IN LAYMANS TERMS, WE ARE ASKING FOR YOUR PERMISSION TO SEND ANY PERTANANT HEALTH INFORMATION TO ANOTHER PHYSICIAN, HOSPITAL, LAB, INSURANCE COMPANY OR ANY OTHER ENTITY THAT REQUESTS YOUR INFORMATION FOR REASONS OF CONDUCTING BUSINESS WITH REGARDS TO YOUR CARE. THE TYPES OF INFORMATION THAT ARE TYPICALLY SENT TO ANOTHER ENTITY INCLUDE: MEDICAL RECORDS, LABORATORY OR PATHOLOGY REPORTS, MEDICATIONS LIST, CONSULTATION NOTES, SURGERY NOTES AND PHOTOS AND INSURANCE INFORMATION.

I understand that I have the right to revoke this authorization at any time and that I must put that request in writing and present it to the Privacy Officer at this office I understand that the revocation will not apply to the information that has already been released or to information that is required by law or by my insurance company.

I understand that authorizing the disclosure of this health information is voluntary. I can refuse to sign this authorization and my treatment will not be altered. I understand that I may view or receive a copy of the information to be used or disclosed.

OUR OFFICE IS COMMITED TO PROTECTING YOUR PRIVACY.
PLEASE LET US KNOW HOW WE CAN CONTACT YOU.

CHECK ALL THAT APPLY

- HOME TELEPHONE: _____
- YES, YOU ARE PERMITTED TO LEAVE A MESSAGE WITH DETAILED INFORMATION ON MY MACHINE.
- YES, YOU ARE PERMITTED TO LEAVE A MESSAGE WITH ANOTHER ADULT.

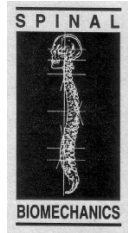
OR

- NO, DO NOT LEAVE A MESSAGE ON MY MACHINE OR WITH ANOTHER ADULT.
- If necessary may we call you at work? If yes, list number _____

Signature of patient _____ Date ____/____/____
or legal proxy

Bailey Chiropractic

11279 Perry Highway, Wexford, PA 15080, (412) 934-0899



MEDICAL REPORTS AND DOCTOR'S LIEN

I do hereby authorize Ted E. Bailey, D. C. to furnish you, my attorney, with a full report of his examination, diagnosis, treatment, prognosis, etc. of myself in regard to the accident in which I was recently involved.

I hereby authorize and direct you, my attorney, to pay directly to said doctor such sums as may be due and owing him for medical service rendered me both by reason of this accident and by reason of any other bills that are due his office and to withhold such sums from any settlement, judgment or verdict as may be necessary to adequately protect such doctor. And I hereby further give a Lien on my case to said doctor against any and all proceeds of my settlement, judgment or verdict which may be paid to you, my attorney, or myself, as the result of the injuries for which I have been treated or injuries in connection therewith.

I agree never to rescind this document and that a rescission will not be honored by my attorney. I hereby instruct that in the event another attorney is substituted in this matter, the new attorney honor this lien as inherent to the settlement and enforceable upon the case as if it were executed by him.

I fully understand that I am directly and fully responsible to said doctor for all medical bills submitted by him for service rendered me and that this agreement is made solely for said doctor's additional protection and in consideration of his awaiting payment. And I further understand that such payment is not contingent on any settlement, judgment or verdict by which I may eventually recover said fee.

This Notice of Doctor's Lien is executed by me subject to any conditions or criteria which appear in Act 6 of 1990 to the extent that Act modifies or affects the rights of the respective parties otherwise set forth herein.

Please acknowledge this letter by signing below and returning to the doctor's office. I have been advised that if my attorney does not wish to cooperate in protecting the doctor's interest, the doctor will not await payment but will require me to make payments on a current basis.

Patients Signature _____ Date _____

The undersigned being attorney of record for the above patient does hereby agree to observe all the terms of the above and agrees to withhold such sums from any settlement, judgment or verdict as may be necessary to adequately protect said doctor above-named.

Attorney's Signature _____ Date _____

Please sign and return. Please Copy for your records.