Donnermeyer Chiropractic – WORKERS' COMPENSATION

First name: _____ middle: _____ Last: _____

TODAYS date: _____ Cell Carrier: _____ Cell #: _____

Employer _____ **Accident** Date _____

Employer's Phone Number: _____

Contact for WC Claims _____

Full-Time Employed Part-Time Employed Volunteer Not Employed

Date Of Birth: _____ **Referred by:** _____

Have You Seen Any Other Doctors or Chiropractors for **This** Injury? _____ If Yes, Please List Doctors' Names and Phone Numbers: _____

_____

Briefly Give Details of How the Accident Occurred: _____

_____

_____

Briefly Describe Your **Symptoms** Since Your Accident: _____

_____

_____

Have You Filed a Workers' Compensation Claim?	Yes	No	
Have You Reported This Injury to Your Employer?	Yes	No	
Were You Treated When the Injury Happened?	Yes	No	
Have You Missed Work Since This Injury Occurred?	Yes	No	
Does Your Job Require Frequent Lifting?	Yes	No	_____ lbs.
Have You Missed Work Due to Prior Injuries?	Yes	No	

WC Insurance Carrier: _____

Insurance Carrier's Address: _____

_____

Insurance Carrier's Phone Number: _____

Contact at work: and phone# : _____

WC Claim Number: _____

Specific Instructions/Notes: _____

_____

DONNERMEYER CHIROPRACTIC – CPI

First Name _____Middle:_____ Last:_____ Date:_____
Home address:_____ apt#:_____ City:_____ State:____ Zip_____
Home phone#:_____ Cell phone#: _____Carrier_____
E-Mail address: _____ sex: M F Date of Birth:_____ age:_____
Height: _____ Weight:_____ # of children_____ Marital Status: M S W D Spouse's Name:_____
Emergency Contact _____ Phone # of Emergency Contact _____ _____
Employer: _____ Occupation: _____ Work Phone# _____

Your :_ Physician _____Referred by:_____

List the Problems you want us to address:

1. _____
2. _____
3. _____

When did the primary problem start? Approximate Date: _____
Did it come on: Instantly Over several minutes Over several hours Other _____
Briefly describe what activity you were doing: _____

_____

_____

_____

What positions or activities make it better? Lifting Sitting Standing Walking Other _____
What positions or activities make it worse? Lifting Sitting Standing Walking Other _____
Have you had problems in this area of your body before? _____ If yes, describe briefly: _____

_____

_____

_____

What other doctors, therapists, or chiropractors have you seen in the past?

_____

_____

Do you exercise regularly? (Briefly describe how often, how long, what type…)

_____

_____

Have any of the following tests been done?

Test	Approx. Date	Where was the test done?	Results
X-Rays			
MRI			
CAT Scan			
Mylegram			
EMG			
Other			

Have you had any of these treatments previously?

	Helped A Lot	Helped A Little	No Effect	Made Worse	How often do you do this?
Chiropractic Manipulation	☐	☐	☐	☐	_____
Massage	☐	☐	☐	☐	_____
Electrical Stimulation	☐	☐	☐	☐	_____
Traction	☐	☐	☐	☐	_____
Injection	☐	☐	☐	☐	_____
Other Treatments	☐	☐	☐	☐	_____

Please list prescription or over-the-counter medications you routinely take:

Name of Medication	What is it for?	Dose and Frequency	When did you start?

Have you been hospitalized or had any surgery in the past 5 years? _____ If yes, briefly describe when and what for:

_____

_____

Do any of the following diseases run in your family? (Grandparents, parents, siblings, children)

☐ Diabetes ☐ Cancer ☐ Heart Disease ☐ Stroke ☐ Depression

Circle any/all that you have had in the last 3 months:

Accidental bowel movements
Bloody or black stools
Constipation
Diarrhea
Problems with bowel movements
Accidental urination
Burning, foul smelling, cloudy, or bloody urine
Inability to urinate
Problems with urination
Urge to urinate more frequently than usual
Chest pain or tightness
Coughing or coughing up blood
Difficulty talking or swallowing
Fevers or chills
Nausea and/or vomiting
Shortness of breath
Stomach or belly pain
Depression
Frequent headaches
Loss of vision or double vision
Difficulty sleeping
If yes, how long does it take to fall asleep? _____
How many times a night do you awaken? _____
Problems with sexual function
Unexpected weight loss of more than 10 lbs.
Difficulty walking
Leg cramps when walking or at night
Loss of balance/falling
Numbness or tingling in arms, forearms, or hands
Numbness or tingling in thighs, legs, or feet
Poor coordination
Swelling in feet or ankles
Weakness in thighs, legs, or feet
If you are female:
Is there any chance you could be pregnant now?
Yes No
Are your symptoms worsened near your period?
Yes No

Any known allergies:-List all:_____

_____

_____

Demographic: preferred Language:_____ Race:_____

Ethnicity: circle one Hispanic/Latina or NOT Hispanic/Latino Do you smoke? No. yes

Donnermeyer Chiropractic
CONSENT FORM

INFORMED CONSENT TO CHIROPRACTIC ADJUSTMENTS AND CARE

Doctor Initials	Patient Initials	
___	___	I have been informed that it is not uncommon that patients have some increased discomfort after an adjustment. If that happens, I will apply ice to the area and rest it. If I am concerned about this discomfort or develop any new symptoms, I can call the number listed above to speak with the doc during normal business hours. If I am out of town or unable to contact the doctor, I can present myself to an emergency room or other health care facility.
___	___	If any tests were performed outside of this office (laboratory or other diagnostic procedures) I understand that the doctor will notify me of the results at my next scheduled appointment.
___	___	I hereby request and consent to the performance of chiropractic adjustments and other chiropractic procedures, including various modes of physical therapy and, if necessary, diagnostic x-rays, on me by the Doctor of Chiropractic named below and/or anyone working in this clinic authorized by the Doctor of Chiropractic.
___	___	I further understand and am informed that, as in all health care, in the practice of chiropractic there are some very slight risks to treatment, including, but not limited to, muscle strains and sprains, disc injuries, and strokes. I do not expect the doctor to be able to anticipate and explain all risks and complications. I wish to rely on the doctor to exercise judgment during the course of the procedure which the doctor feels at the time, based upon the facts then known, is in my best interests.
___	___	I have read the above consent, with the doctor, as indicated by our initials. I have also had an opportunity to ask questions about its content, and by signing below I agree to the above named procedures. I intend this consent form to cover the entire course of treatment for my present condition and for any future conditions for which I seek treatment.

To be completed by the patient:

Print Patient's Name	Signature of Patient (or parent/guardian)	Date Signed

Doctor's Signature:_____

Dr Brad Donnermeyer

DONNERMEYER CHIROPRACTIC L.L.C.

873 N Casaloma Dr Appleton, WI 54913-8606 FUNCTIONAL RATING

NAME:_____ DATE:_____Phone#:_____

In order to properly assess your condition we must understand how much your problems have affected your ability to manage everyday activities. For each item below, please circle the number which most closely describes your condition right now.

1. Pain Intensity

0----------1----------2----------3----------4

No pain | Mild pain | Moderate Pain | Severe Pain | Worst Possible Pain

2. Sleeping

0----------1----------2----------3----------4

Perfect Sleep | Mildly Disturbed Sleep | Moderately Disturbed Sleep | Greatly Disturbed Sleep | Totally Disturbed Sleep

3. Personal Care (Washing, dressing, etc.)

0----------1----------2----------3----------4

No Pain; No Restrictions | Mild Pain; No Restrictions | Moderate Pain; Need To Go Slowly | Moderate Pain; Need Some Assistance | Severe Pain Need 100% Assist

4. Travel (driving, etc.)

0----------1----------2----------3----------4

No Pain On Long Trips | Mild Pain On Long Trips | Moderate Pain On Long Trips | Moderate Pain On short Trips | Severe Pain On Short Trips

5. Work

0----------1----------2----------3----------4

Can Do Usual Work Plus Unlimited Extra Work | Can do usual work No Extra Work | Can Do 50% Of Usual Work | Can Do 25% Of Usual Work | Can Not Work

6. Recreation

0----------1----------2----------3----------4

Can Do All Activities | Can Do Most Activities | Can Do Some Activities | Can Do A Few Activities | Can Not Do Any Activities

7. Frequency Of Pain

0----------1----------2----------3----------4

No Pain | Occasional Pain 25% Of The Day | Intermittent Pain 50% Of The Day | Frequent Pain 75% Of The Day | Constant Pain 100% Of The Day

8. Lifting

0----------1----------2----------3----------4

No Pain With Heavy Weight | Increased Pain With Heavy Weight | Increased Pain With Moderate Weight | Increased Pain With Light Weight | Increased Pain With Any Weight

9. Walking

0----------1----------2----------3----------4

No Pain Any Distance | Increased Pain After 1 Mile | Increased Pain After ½ Mile | Increased Pain After ¾ Mile | Increased Pain With All Walking

10. Standing

0----------1----------2----------3----------4

No Pain After Several Hours | Increased Pain After Several Hours | Increased Pain After 1 Hour | Increased Pain After ½ Hour | Increased Pain With Any Standing

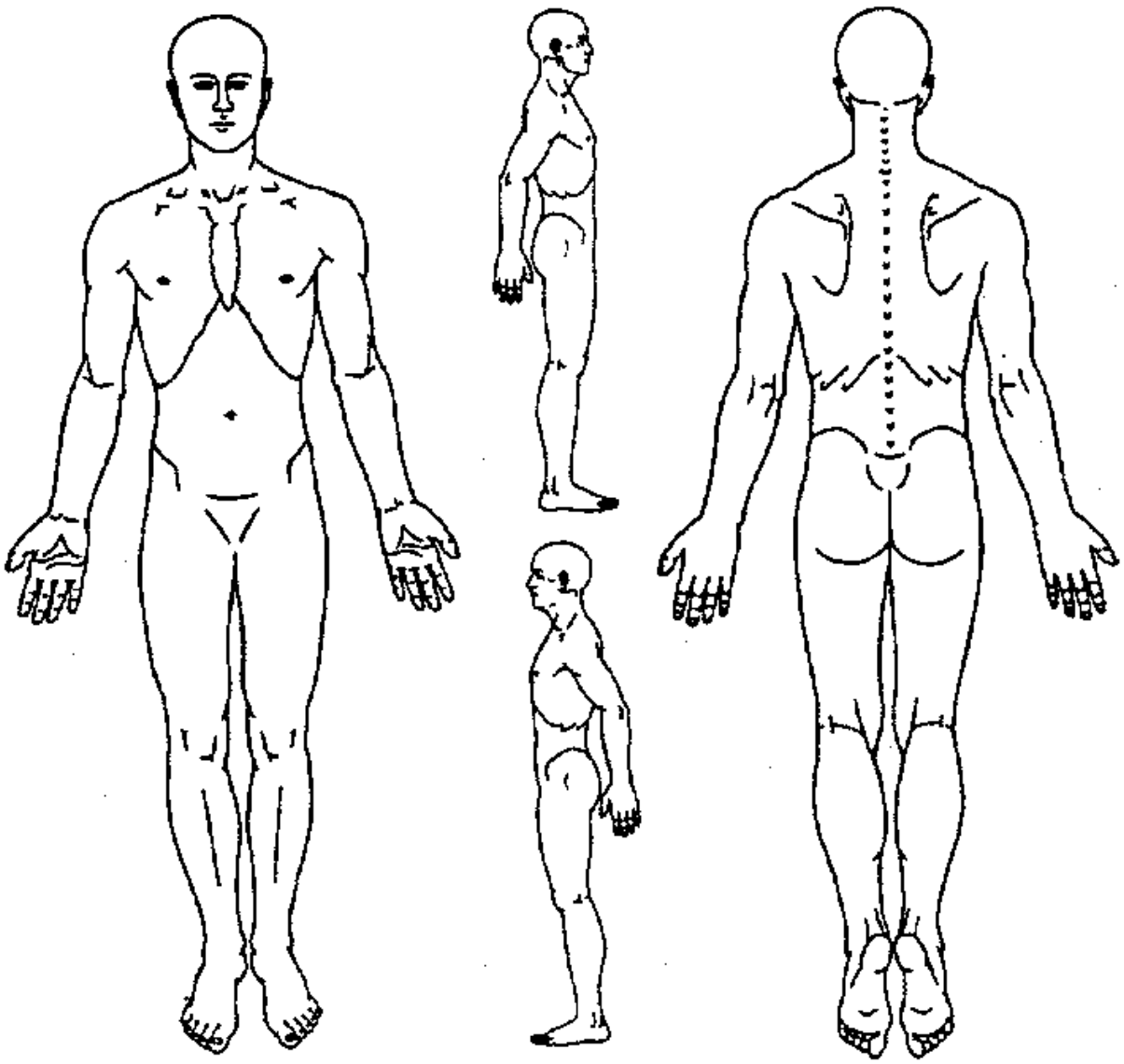
Score:_____

Name:_____ Date:_____

PAIN DIAGRAM

On the diagrams below mark where you are experiencing pain, right now. Use the letters below to indicate the type and location of your sensations.

Key: **A** – ACHE **B** – BURNING **N** – NUMBNESS
P – PINS & NEEDLES **S** – STABBING **O** - OTHER



PAIN SCALE

Rate the severity of your pain by checking one box on the following scale.

No Pain — Worst Possible Pain

0	1	2	3	4	5	6	7	8	9	10

Donnermeyer Chiropractic
873 N Casaloma Drive
Appleton WI 54913
Phone: 920-734-2400
fax: 920-734-2100

Dr Bradley Donnermeyer, D.C.

WORKER'S COMPENSATION AUTHORIZATION

DATE_____
EMPLOYEE NAME _____
EMPLOYER _____
Claim Number_____
DATE OF ACCIDENT _____
INSURANCE CARRIER _____
ADDRESS _____
_____
PHONE NUMBER _____
CLAIM Number:_____
SPECIFIC INSTRUCTIONS: _____
_____
_____

The above patient has reported to our office for examination and chiropractic treatment due to injuries sustained while on the job. **Please sign and return** this authorization for treatment to our office **AND submit a copy of the completed EMPLOYEE'S INJURY REPORT. Thank you.**

Thank you for your assistance.

_____ _____
Employer's Signature Date

Donnermeyer Chiropractic – FINANCIAL POLICY

The following is the financial policy adopted by our office. Please feel free to ask about any portion you do not understand.

Insurance Information: Your insurance policy is a contract between you and your insurance carrier. Our professional services are rendered to you not your insurance company. We will, as a courtesy to you, bill your insurance company for you. However, you will be responsible for all charges not paid/covered or refunded to your insurance company. If your insurance policy does not provide chiropractic coverage or you do not want to use your insurance policy, you will be required to pay by cash, check or debit/credit card at each visit. Supplies are not covered and will not be billed to your insurance company.
Co-pays are to be paid same day as service. If you have a deductible, we will bill your insurance and wait for payment till we hear from them. We send out statements once a month and accept payment in full.

Cash Patients: We ask that cash patients pay in full at each visit.
Medicare Patients. We do accept assignment on Medicare claims. Medicare covers only a portion of the Chiropractic adjustment. They do not cover any exams, x-rays or any therapies in our office. If you have a secondary Medicare plan, usually Medicare will send those out for you.
Medicare Supplement Plans also cover the adjustment only, usually with a co-pay. Co-pays are to be paid at time of service.
Personal Injury/Auto Patients: We will work with your Auto insurance and attorneys, but please remember that you are responsible for your bill. We can't work with 3rd party insurance. We will bill your health insurance only after your Med Pay is exhausted.
Worker's Comp patients: We will bill your worker's comp carrier. Please make sure you report your injury at work. We will need you to get a billing address , claim number and phone number for your case as soon as you can. If your claim is denied, we will bill your health insurance, but remember you are responsible for your entire balance.
Nutritional Patients
Payments are to be paid in full same day as service. We do not bill your insurance.
Supplements and Supplies: It is our policy that any supply or supplements may <u>not</u> be returned opened or not after leaving the office. Sorry for any inconvenience this may cause.

Missed Appointments: We realize that everyone can forget an appointment once in awhile, which is why we will not charge you for your first missed appointment. However, to avoid this becoming a habit, you will be charged $20.00 for your second missed appointment and for everyone thereafter. We also require a 4 hour window if you need to cancel and reschedule. You will be charged $20.00 if you cancel later than this.

Signature:_____ Date: _____
Print Name:_____
Print any underage Children's names: _____
_____

Donnermeyer Chiropractic LLC

873 N Casaloma Drive, Appleton WI 54913 Phone#: 920-734-2400

HIPPA Compliance Patient Consent Form

Our notice of Privacy Practices provides information about how we may use or disclose protected health information.

The notice contains a patient's rights section describing your rights under the law. You ascertain that by your signature that you have reviewed our notice before signing this consent. The terms of this notice may change, if so, you will be notified at your next visit to update your signature/date.

You have the right to restrict how your protected health information is used and disclosed for treatment, payment or healthcare operations. We are not required to agree with this restriction, but if we do, we shall honor this agreement. The HIPPA (Health Insurance Portability and Accountability Act of 1996) law allows for the use of the information for treatment, payment, or healthcare operations.

By signing this form, you consent to our use and disclosure of your healthcare information. YOU have the right to revoke this consent in writing, signed by you. However, such a revocation will not be retroactive.

By signing this form, I understand that:

+protected health information may be disclosed or used for treatment, payment or healthcare operations

+the practice reserves the right to change the privacy policy as allowed by law.

+The practice has the right to revoke this consent in writing at any time and all full disclosures will then cease.

+the practice may condition receipt of treatment upon execution of this consent.

May we phone, email or sent a text to you to confirm appointments? Yes No

May we leave a message on your answering machine at home or on your cell phone? Yes No

May we discuss your medical condition with any member of your family? Yes NO

If yes, please name the members allowed: _____

This Consent was signed by: Please print name:_____

Signature_____date:_____

Witness: _____date: _____