Dr Robert C Slater BA: Bachelor of Arts, MSc: Master of Science, DC: Doctor of Chiropractic, CME: Federally Certified Medical Examiner, DACO: National Diplomate of Orthopedic: Healing Hands Wellness: 631 South Cleveland Ave, St Paul MN 55116, ph: 651-699-3366; Fx: 651-699-5780: email: ezekarnak99@gmail.com

Patient's Information: Back or Limb Pain Per Recent Onset or Ongoing Condition or Injury

The purpose of this questionnaire is to help us understand both your specific work injury and general health status. If you need assistance in filling out any question, please ask at the front desk for help. This form is considered part of your medical record.

Name:_____ Date:_____

Address:_____ Date of Injury:_____

City:_____ State:_____ Zip Code:_____ Time of Injury:_____: am/pm

PH: _____ Cell: _____ Social Security #:_____

Age:_____ Sex:_____ Driver License #:_____ Date of Birth:_____

Referring physician:_____: Family physician:_____

Date of last general health check-up:_____: Occupation:_____

Emergency Contact:_____ Relationship:_____

How did you hear of our office?_____ Last Day of Work:_____

Employer and Employment Information

Name of employer:_____ PH: _____

Address of employer:_____ City:_____ State____

Zip code: _____ Occupation:_____ Type of work you do:_____

How long at your present employment: _____ Your immediate supervisor:_____

Last date your worked due to this injury:_____: Date returned to work after injury:_____

Have you had an surgery for this injury:_____: If yes: type of surgery: Date: _____

Are you currently taking any prescriptions for: anti-inflammation: (y) (n); muscle relaxers: (y) (n)

Pain medication: (y) (n); or any non-prescription medications: (y) (n)

Work Injury: ☐Yes ☐No If Yes explain_____

Car Accident: ☐Yes ☐No If Yes explain_____

Worker's Comp Insurance Carrier Information

Insurance Name :_____ Address:_____

PH:_____ Claim #:_____ Adjuster Name:_____

Mechanic of Your Injury / Accident

Please explain in detail how your accident occurred:_____

_____

Did you report your accident to your employer? ☐Yes ☐No

Name of your supervisor who you reported to:_____

Were you lifting something? ☐Yes ☐No If yes, How many pounds?_____

Did you slip? ☐Yes ☐No

Have you worked after the accident? ☐Yes ☐No If Yes, Doing what?_____

Have you seen any other doctor related to this accident? ☐Yes ☐No

If yes, doctor's Info: Name:_____ PH#:_____

Your First visit to this doctor's office:_____ Your last visit to this doctor's office:_____

Have you had any other worker related injury/ claim before? ☐Yes ☐No

If Yes, Approximate Date:_____ please explain your previous injury _____

_____

For the area of injury: have you had a X ray: (y) (n); CT Scan: (y) (n); MRI: (y) (n); EMG/NCV: (y) (n);

Current Injury Related Complaints

Currently I have my pain in:_____

My pain began: ☐ gradually ☐suddenly:
I have pain: ☐ sometimes ☐all of the time
My pain is: ☐sharp ☐dull ☐burning ☐achy ☐ stabbing ☐ numbness ☐ pins/needles
My pain is worse when I: ☐sit ☐bend ☐walk ☐lift ☐push ☐other _____
My pain severity is: ☐mild ☐slight ☐moderate ☐severe

Please mark all the symptoms you have noticed since the injury

☐Neck pain	☐Mid Back Pain	☐Low Back Pain	☐Nervousness
☐Neck Stiffness	☐Chest Pain	☐Buttock Pain	☐Depression

☐Headaches ☐Breathing Problem ☐Leg Pain ☐Stomach upset

Medicine Doseage:[.....], Dates start (Fecha de inicio)..... **Date Finish**: [Fecha final].....: Side Effects: [efectos secundarios].....

Please Mark All The Symptoms You Have Noticed Since The Injury

☐Dizziness ☐Tension ☐Leg/Feet Numbness ☐Memory Loss
☐Arm/Hand Numbness ☐Ringing/Buzzing in ears ☐Loss of Balance ☐Face Flushed
☐Cold Hands ☐ Other_____

Have You Ever Suffered From Any Of These Past Conditions?

Heart Problems/High Blood Pressure: ☐Yes ☐No If Yes explain_____

Blood Clot/Stroke: ☐Yes ☐No If Yes explain_____

Diabetes: ☐Yes ☐No If Yes explain_____

Infectious/Sexually Transmissible Disease: ☐Yes ☐No If Yes explain_____

Epilepsy/Seizures/Dizziness: ☐Yes ☐No If Yes explain_____

Cancer/chemo/radiation: ☐Yes ☐No If Yes explain_____

Osteoporosis/arthritis: ☐Yes ☐No If Yes explain_____

Fractures: ☐Yes ☐No If Yes explain_____

Joint Replacement/Pins/metal Implants: ☐Yes ☐No If Yes explain_____

Bowel/bladder Incontinence: ☐Yes ☐No If Yes explain_____

Smoke/Bronchitis/Emphysema: ☐Yes ☐No If Yes explain_____

For Women Only:

Pelvic Inflammatory Disease: ☐Yes ☐No If Yes explain_____

Irregular menstrual Cycles: ☐Yes ☐No If Yes explain_____

Complicated Pregnancy Deliveries: ☐Yes ☐No If Yes explain_____

Endometriosis: ☐Yes ☐No If Yes explain_____

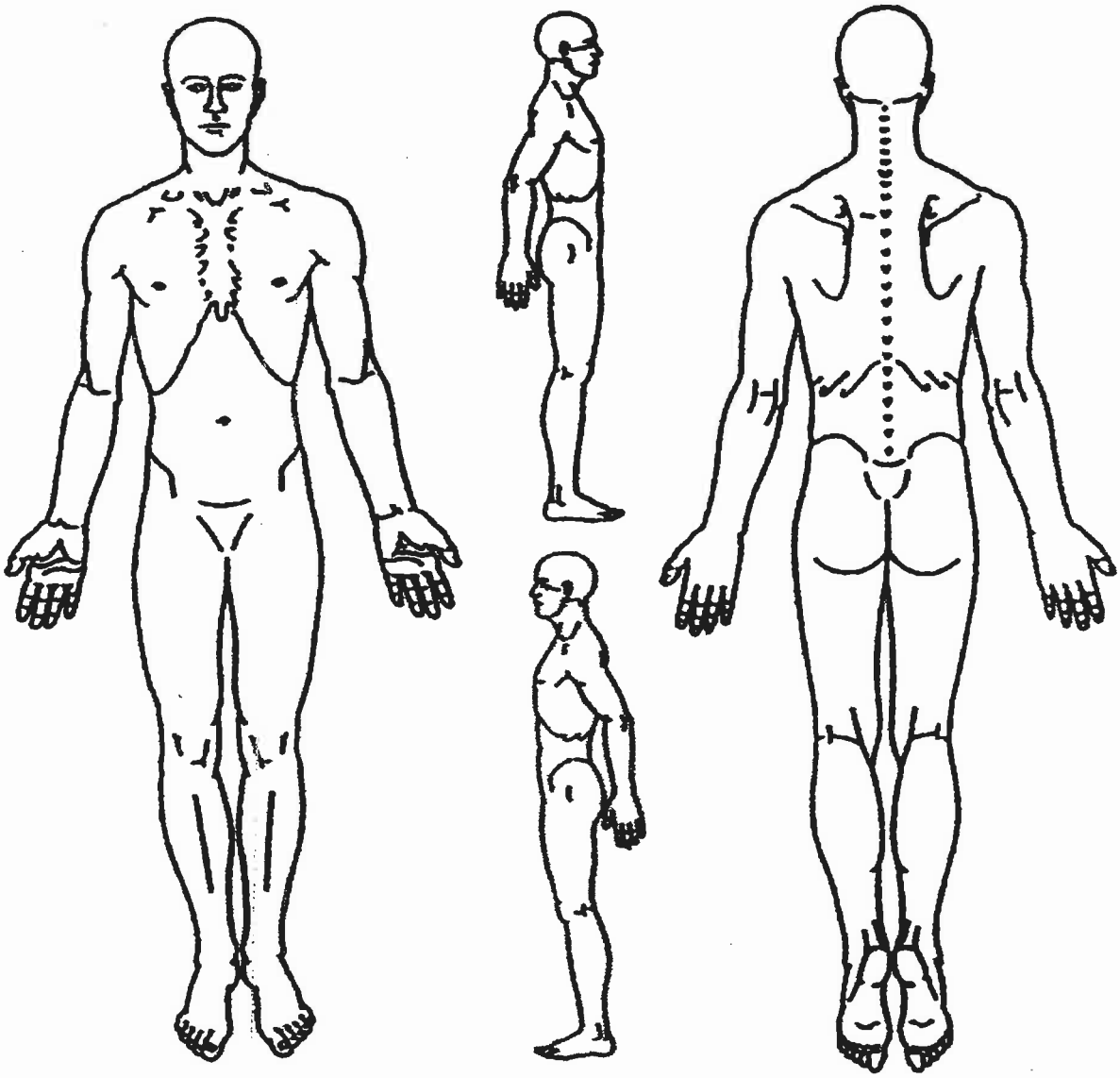
Are you now pregnant: ☐Yes ☐No

Patient's Signature:_____**:Date:**_____

Use the letters listed below to indicate the type and location of your pain and sensations:

KEY

A = ACHE
B = BURNING
S = STABBING
N = NUMBNESS
P = PINS & NEEDLES
O = OTHER



PLEASE INDICATE THE LEVEL OF PAIN YOU ARE EXPERIENCING

NO PAIN SEVERE PAIN

0 1 2 3 4 5 6 7 8 9 10

Patient Signature _____ Date _____