Work Cover Intake

Name: ______________________________ Date: ______________________

Address: ______________________________ Age: ________ Marital Status: ________

Occupation: ____

Claim number: ____________________ Case Worker: __________________ Phone: ______________________

Time and Date of accident ____

Location of accident ____

What were you doing at the time you were injured? (lifting, walking, carrying, standing, stopping, etc) ___________

____

____

____

Medical attention / X-rays / hospitalization required ____

____

Symptoms immediately after the accident ____

____

Symptoms 1-2 days after the accident ____

____

Symptoms 1-2 weeks after the accident ____

____

Have you missed work? ____

Have you missed any leisure activities? ____

Have you seen another doctor or health care provider for this injury? Yes / No If yes, whom? ________________

____

Who rendered your first treatment? ____

Have you had any previous work cover accidents or a similar disability? Yes / No When? __________________

If Yes, state how you were injured, how long you were off work, what treatments you received, and what problems, if any, you have as a result of the injuries: ____________________ ________________________________

____

____

____

____

____

____

____

Have the injuries prevented you from carrying out any of the following:
□ Daily home activities □ Employment □ Schooling □ Sports or recreation
□ Other ____

Do you think your injury will:
□ Get better soon □ Get better slowly □ Never get better □ Don't know

Have you ever been diagnosed as having:

Stroke / TIA.. □ **YES** □ **NO**
Cancer .... □ **YES** □ **NO**
High blood pressure / cholesterol.. □ **YES** □ **NO**
Diabetes.. □ **YES** □ **NO**
Other serious illness / hospitalization... □ **YES** □ **NO**

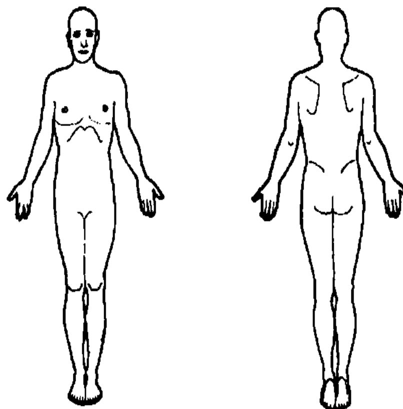
At present, or recently, have you experienced episodes of:

Pain waking you at night .... □ **YES** □ **NO**
Bowel, bladder, or sexual dysfunction .... □ **YES** □ **NO**
Pain with straining, coughing, or sneezing .... □ **YES** □ **NO**
Abnormal loss of weight (recently) .... □ **YES** □ **NO**

Visual Analogue Scale for Pain

No Pain 0____10 worst imaginable pain.
(Place a vertical mark on the line at the point which best represents your current level of pain)

Indicate the location of your pain by shading in the appropriate area



FINANCIAL POLICY

I understand that Quest Chiropractic does not hold accounts and that I am personally responsible for the Full payment of all fees incurred. Date: ____________________ Patient Signature:_________________________

PATIENT INFORMATION AND CONSENT FORM

All practitioners who manipulate the spine are required to warn patients of material risks associated with those procedures. In very rare circumstances, some treatments of the neck may damage a blood vessel and give rise to stroke or stroke-like symptoms (estimated at between 1 in 2 million to 1 in 5.85 million neck manipulations. Haldeman, et al. Spine vol 24-8 1999). Other very slight risks include strain/injury to a ligament or disc in the neck (less than 1 in 139,000) or the low back (1 in 62,000). [Dvorak study in Principles and Practice of Chiropractic, Haldeman. 2nd Ed.]
Chiropractic adjustments (manipulations) of the spine are internationally recognised as being safer in dealing with neck and low back pain than medication and other alternatives. (A Risk Assessment of Cervical Manipulation, JMPT, 1995. Manga Report, Ontario Ministry of Health, 1993.)
The procedures to be used in your case will be described after which you will be asked if you have any questions. After speaking with the chiropractor we request that you sign below as **your consent to proceed is required for both examination and treatment procedures**.
Please note there may be a considerable degree of variation in individual patient response.

Patient's signature___________________________ Print name here_________________________________

Chiropractor's signature___________________________ □ Discussed Date _________________________

The Impact of Event Scale (IES) **Name:** **Date:**

Below is a list of comments made by people after stressful life events. Using the following scale, please indicate below how frequently each of these comments was true for you **DURING THE PAST SEVEN DAYS**.

Comments	**Not at all**	**Rarely**	**Sometimes**	**Often**
1. I thought about it when I didn't mean to.				
2. I avoided letting myself get upset when I thought about it or was reminded of it.				
3. I tried to remove it from memory.				
4. I had trouble falling asleep or staying asleep because of pictures or thoughts about it that came into my mind.				
5. I had waves of strong feelings about it.				
6. I had dreams about it.				
7. I stayed away from reminders of it.				
8. I felt as if it hadn't happened or wasn't real.				
9. I tried not to talk about it.				
10. Pictures about it popped into my mind.				
11. Other things kept making me think about it.				
12. I was aware that I still had a lot of feelings about it, but I didn't deal with them.				
13. I tried not to think about it.				
14. Any reminder brought back feelings about it.				
15. My feelings about it were kind of numb.				

K10 **Name:** **Date:**

Please tick the answer that is correct for you:	**All of the time (score 5)**	**Most of the time (score 4)**	**Some of the time (score 3)**	**A little of the time (score 2)**	**None of the time (score 1)**
In the past four weeks, about how often did you feel tired out for no good reason?					
In the past four weeks, about how often did you feel nervous?					
In the past four weeks, about how often did you feel so nervous that nothing could calm you down?					
In the past four weeks, about how often did you feel hopeless?					
In the past four weeks, about how often did you feel restless or fidgety?					
In the past four weeks, about how often did you feel so restless you could not sit still?					
In the past four weeks, about how often did you feel depressed?					
In the past four weeks, about how often did you feel that everything was an effort?					
In the past four weeks, about how often did you feel so sad that nothing could cheer you up?					
In the past four weeks, about how often did you feel worthless?					

Neck Disability Index **Name:** **Date:**

This questionnaire has been designed to give your health professional information as to how neck pain has affected your ability to manage in everyday life. Please answer every section and mark in each section only the ONE box that applies to you. We realise you may consider that two of the statements in any one section relate to you, but please just mark the box which most closely describes your problem.

Section 1 – Pain intensity
- ☐ I have no pain at the moment.
- ☐ The pain is very mild at the moment.
- ☐ The pain is moderate at the moment.
- ☐ The pain is fairly severe at the moment.
- ☐ The pain is very severe at the moment.
- ☐ The pain is the worst imaginable at the moment.

Section 2 – Personal care (washing, dressing etc)
- ☐ I can look after myself normally without causing extra pain.
- ☐ I can look after myself normally but it causes extra pain.
- ☐ It is painful to look after myself and I am slow and careful.
- ☐ I need some help but manage most of my personal care.
- ☐ I need help every day in most aspects of self-care.
- ☐ I do not get dressed, I wash with difficulty and stay in bed.

Section 3 – Lifting
- ☐ I can lift heavy weights without extra pain.
- ☐ I can lift heavy weights but it gives extra pain.
- ☐ Pain prevents me from lifting heavy weights off the floor, but I can manage if they are conveniently positioned, for example on a table.
- ☐ Pain prevents me from lifting heavy weights, but I can manage light to medium weights if they are conveniently positioned.
- ☐ I can lift very light weights.
- ☐ I cannot lift or carry anything at all.

Section 4 – Reading
- ☐ I can read as much as I want to with no pain in my neck.
- ☐ I can read as much as I want to with slight pain in my neck.
- ☐ I can read as much as I want with moderate pain in my neck.
- ☐ I cannot read as much as I want because of moderate pain in my neck.
- ☐ I can hardly read at all because of severe pain in my neck.
- ☐ I cannot read at all.

Section 5 – Headaches
- ☐ I have no headaches at all.
- ☐ I have slight headaches which come infrequently.
- ☐ I have moderate headaches which come infrequently.
- ☐ I have moderate headaches which come frequently.
- ☐ I have severe headaches which come frequently
- ☐ I have headaches almost all the time.

Section 6 – Concentration
- ☐ I can concentrate fully when I want to with no difficulty.
- ☐ I can concentrate fully when I want to with slight difficulty.
- ☐ I have a fair degree of difficulty in concentrating when I want to.
- ☐ I have a lot of difficulty in concentrating when I want to.
- ☐ I have a great deal of difficulty in concentrating when I want to.
- ☐ I cannot concentrate at all.

Section 7 – Work
- ☐ I can do as much work as I want to.
- ☐ I can only do my usual work, but no more.
- ☐ I can do most of my usual work, but no more.
- ☐ I cannot do my usual work.
- ☐ I can hardly do any work at all.
- ☐ I cannot do any work at all.

Section 8 – Driving
- ☐ I can drive my car without any neck pain.
- ☐ I can drive my car as long as I want with slight pain in my neck.
- ☐ I can drive my car as long as I want with moderate pain in my neck.
- ☐ I cannot drive my car as long as I want because of moderate pain in my neck.
- ☐ I can hardly drive at all because of severe pain in my neck.
- ☐ I cannot drive my car at all.

Section 9 – Sleeping
- ☐ I have no trouble sleeping.
- ☐ My sleep is slightly disturbed (less than 1 hr sleepless).
- ☐ My sleep is mildly disturbed (1-2 hrs sleepless).
- ☐ My sleep is moderately disturbed (2-3 hrs sleepless).
- ☐ My sleep is greatly disturbed (3-5 hrs sleepless).
- ☐ My sleep is completely disturbed (5-7 hrs sleepless).

Section 10 – Recreation
- ☐ I am able to engage in all my recreation activities with no neck pain at all.
- ☐ I am able to engage in all my recreation activities, with some pain in my neck.
- ☐ I am able to engage in most, but not all of my usual recreation activities because of pain in my neck.
- ☐ I am able to engage in a few of my usual recreation activities because of pain in my neck.
- ☐ I can hardly do any recreation activities because of pain in my neck.
- ☐ I cannot do any recreation activities at all.

OSWESTRY - Low back pain disability questionnaire   Name: Date:

This questionnaire has been designed to give your doctor information as to how your back pain has affected your ability to manage in every day life. Please answer every question by placing a mark in the **one** box that best describes your condition today. We realize you may feel that two of the statements may describe your condition, but **please mark only the box which most closely describes your current condition**.

Pain Intensity
☐ I can tolerate the pain I have without having to use pain medication.
☐ The pain is bad but I can manage without having to take pain medication.
☐ Pain medication provides me complete relief from pain.
☐ Pain medication provides me with moderate relief from pain.
☐ Pain medication provides me with little relief from pain.
☐ Pain medication has no affect on my pain.

Personal Care (Washing, Dressing etc.)
☐ I can take care of myself normally without causing increased pain.
☐ I can take care of myself normally but it increases my pain.
☐ It is painful to take care of myself and I am slow and careful.
☐ I need help but I am able to manage most of my personal care
☐ I need help every day in most aspects of my care.
☐ I do not get dressed, wash with difficulty and stay in bed.

Lifting
☐ I can lift heavy weights without increased pain.
☐ I can lift heavy weights but it causes increased pain.
☐ Pain prevents me from lifting heavy weights off the floor, but I can manage if the weights are conveniently positioned (ex. on a table).
☐ Pain prevents me from lifting heavy weights, but I can manage light to medium weights if they are conveniently positioned.
☐ I can lift only very light weights.
☐ I can not lift or carry anything at all.

Walking
☐ Pain does not prevent me from walking any distance.
☐ Pain prevents me from walking more than 1 mile.
☐ Pain prevents me from walking more than ½ mile
☐ Pain prevents me from walking more than ¼ mile.
☐ I can only walk with crutches or a cane.
☐ I am in bed most of the time and have to crawl to the toilet.

Sitting
☐ I can sit in any chair as long as I like.
☐ I can only sit in my favorite chair as long as I like.
☐ Pain prevents me from sitting for more than 1 hour.
☐ Pain prevents me from sitting for more than ½ hour.
☐ Pain prevents me from sitting for more than 10 minutes.
☐ Pain prevents me from sitting at all.

Standing
☐ I can stand as long as I want without increased pain.
☐ I can stand as long as I want but increases my pain.
☐ Pain prevents me from standing more than 1 hour.
☐ Pain prevents me from standing more than ½ hour.
☐ Pain prevents me from standing more than 10 minutes.
☐ Pain prevents me from standing at all.

Sleeping
☐ Pain does not prevent me from sleeping well.
☐ I can sleep well only by using pain medication.
☐ Even when I take pain medication, I sleep less than 6 hours.
☐ Even when I take pain medication, I sleep less than 4 hours.
☐ Evens when I take pain medication, I sleep less than 2 hours.
☐ Pain prevents me from sleeping at all.

Social Life
☐ My social life is normal and does not increase my pain.
☐ My social life is normal, but it increases my level of pain.
☐ Pain prevents me from participating in more energetic activities (ex. sports, dancing etc.)
☐ Pain prevents me from going out very often.
☐ Pain has restricted my social life to my home.
☐ I have hardly any social life because of my pain.

Traveling
☐ I can travel anywhere without increased pain.
☐ I can travel anywhere but it increases my pain.
☐ My pain restricts travel over 2 hours.
☐ My pain restricts my travel over 1 hour.
☐ My pain restricts my travel to short necessary journeys under ½ hour.
☐ My pain prevents all travel except for visits to the doctor/therapist or hospital.

Employment/Homemaking
☐ My normal homemaking/job activities do not cause pain.
☐ My normal homemaking/job activities increase my pain, but I can still perform all that is required of me.
☐ I can perform most of my homemaking/job duties, but pain prevents me from performing more physically stressful activities (ex. lifting, vacuuming)
☐ Pain prevents me from doing anything but light duties.
☐ Pan prevents me from doing even light duties.
☐ Pain prevents me from performing any job or homemaking chores.

CSQ **Name:** **Date:**

Please rate the frequency of their use of each coping strategy on the scale, from (0) 'Never' through (3) 'Sometimes' to (6) 'Always'.

1) It's terrible and I feel it's never going to get any better.

0 1 2 3 4 5 6
Never sometimes always

2) It's awful and I feel that it overwhelms me.

0 1 2 3 4 5 6
Never sometimes always

3) I feel my life isn't worth living.

0 1 2 3 4 5 6
Never sometimes always

4) I worry all the time about whether it will end.

0 1 2 3 4 5 6
Never sometimes always

5) I feel I can't stand it anymore.

0 1 2 3 4 5 6
Never sometimes always

6) I feel like I can't go on.

0 1 2 3 4 5 6
Never sometimes always

The Self-Efficacy Scale **Name:** **Date:**

Please rate how confident you are to perform each of the activities listed in below in spite of pain, where 0 = not at all confident and 10 = very confident.

1. Taking out the trash ______________________
2. Concentrating on a project _________________
3. Going shopping___________________________
4. Playing cards_____________________________
5. Shoveling ________________________________
6. Driving the car ___________________________
7. Eating in a restaurant _____________________
8. Watching television ______________________
9. Visiting friends __________________________
10. Working on the car ______________________
11. Raking leaves ___________________________
12. Writing a letter _________________________
13. Doing a load of laundry ___________________
14. Working on a house repair ________________
15. Going to a movie ________________________
16. Washing the car _________________________
17. Riding a bicycle _________________________
18. Going on vacation ________________________
19. Going to a park _________________________
20. Visiting relatives ________________________

Work Cover Symptom Checklist Date:

For each symptom, check YES (if present) or NO (if not present), and rate severity on a scale of 0 to 10 where indicated 0 is "No Pain" and 10 is "Pain as bad as it could be."

Neck or shoulder pain ☐ **YES** ☐ **NO**
(No Pain) 0 1 2 3 4 5 6 7 8 9 10 (Pain as bad as it could be)

Upper or Mid-back pain ☐ **YES** ☐ **NO**
(No Pain) 0 1 2 3 4 5 6 7 8 9 10 (Pain as bad as it could be)

Low back pain ☐ **YES** ☐ **NO**
(No Pain) 0 1 2 3 4 5 6 7 8 9 10 (Pain as bad as it could be)

Headache ☐ **YES** ☐ **NO**
(No Pain) 0 1 2 3 4 5 6 7 8 9 10 (Pain as bad as it could be)

Pain in Arm(s) ☐ **YES** ☐ **NO**
(No Pain) 0 1 2 3 4 5 6 7 8 9 10 (Pain as bad as it could be)

Pain in Hand(s) ☐ **YES** ☐ **NO**
(No Pain) 0 1 2 3 4 5 6 7 8 9 10 (Pain as bad as it could be)

Pain in Face of Jaw ☐ **YES** ☐ **NO**
(No Pain) 0 1 2 3 4 5 6 7 8 9 10 (Pain as bad as it could be)

Pain in Leg(s) ☐ **YES** ☐ **NO**
(No Pain) 0 1 2 3 4 5 6 7 8 9 10 (Pain as bad as it could be)

Pain in Foot/Feet ☐ **YES** ☐ **NO**
(No Pain) 0 1 2 3 4 5 6 7 8 9 10 (Pain as bad as it could be)

Pain in Abdomen or Chest ☐ **YES** ☐ **NO**
(No Pain) 0 1 2 3 4 5 6 7 8 9 10 (Pain as bad as it could be)

Feeling of numbness, tingling in arms or hands**.................** ☐ **YES** ☐ **NO**
Feeling of numbness, tingling in legs or feet**......................** ☐ **YES** ☐ **NO**
Dizziness or unsteadiness**..** ☐ **YES** ☐ **NO**
Vision problems**..** ☐ **YES** ☐ **NO**
Hearing problems **...** ☐ **YES** ☐ **NO**
Anxiety or worry**..** ☐ **YES** ☐ **NO**
Nausea or vomiting**...** ☐ **YES** ☐ **NO**
Difficulty swallowing**...** ☐ **YES** ☐ **NO**
Problems concentrating or with memory **...........................** ☐ **YES** ☐ **NO**
Loss of consciousness **..** ☐ **YES** ☐ **NO**