

PHYSICIAN'S REPORT

INITIAL Employee: Sections 1 & 2/Physician: Sections 3 & 4
 PROGRESS Physician: Sections 1 & 4
 TREATMENT PLAN Employee: Sections 1 & 2/Physician: Sections 3 & 4

AWCB Case Number

SECTION 1	1. Employee's Name (Last, First, Middle Initial)		2. Insurer Claim Number		3. Injury Date										
	4. Address				5. Sex <input type="checkbox"/> Male <input type="checkbox"/> Female		8. Social Security Number								
	City		State		Zip Code		Telephone		7. Birthdate						
	8. Employer				9. Insurer										
	10. Address				11. Address										
City		State		Zip Code		Telephone		City		State		Zip Code		Telephone	
SECTION 2	12. Date Last Worked		13. Was Body Part Injured Before? <input type="checkbox"/> No <input type="checkbox"/> Yes If yes, when and describe:												
	14. Describe Injury and Tell How it Happened:														
	15. Have You Seen any Other Doctor for this Injury? <input type="checkbox"/> No <input type="checkbox"/> Yes If yes, list name and address:								16. Hospitalized as Inpatient? <input type="checkbox"/> No <input type="checkbox"/> Yes Name of Hospital:						
	17. YOUR First Treatment Date:			18. Describe Complaints:											
	19. Fully Describe Findings on First Examination (Specify Right or Left):														
SECTION 3	20. Diagnosis														
	21. X-Rays? <input type="checkbox"/> No <input type="checkbox"/> Yes X-Ray Diagnosis:														
	22. Is Condition Work Related? <input type="checkbox"/> No <input type="checkbox"/> Yes Explain: <input type="checkbox"/> Undetermined (Explain):														
	23. Treatment Date(s) Since Last Report:				24. Next Treatment Date:				25. Estimate Length of Further Treatment Days Weeks Months						
	26. Medically Stable? <input type="checkbox"/> No <input type="checkbox"/> Yes		27. Date of Medical Stability		28. Injury May Permanently Preclude Return to Job at Time of Injury <input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> Undetermined				29. Will Injury Result in Permanent Impairment? <input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> Undetermined						
30. Impairment Rating:						31. Factors on Which Rating is Based:									
SECTION 4	32. Released for Work		<input type="checkbox"/> No Estimate Length of Disability: <input type="checkbox"/> 1-3 Days <input type="checkbox"/> 4-7 Days <input type="checkbox"/> 8-14 Days <input type="checkbox"/> 15-21 Days <input type="checkbox"/> 22-28 Days <input type="checkbox"/> More: ____ Weeks ____ Months												
	<input type="checkbox"/> Yes		Regular Work (date):				Modified Work (date):				Give Limitations:				
	33. If the number of treatments will exceed Board's frequency standards, state the objectives, modalities, frequency of treatment, and reasons for frequency of treatments. Continue treatment plan on reverse if necessary. GIVE EMPLOYEE AND EMPLOYER/INSURER A COPY OF THIS REPORT.														
	34. Describe Treatment (and/or Attach Chart Notes):														
	35. If Case Referred to Another Physician, State Name and Address:								36. IRS I.D. Number						
37. Physician's Name and Degree (Print or Type)						38. Physician's Signature			39. Report Date						
40. Address				City				State		Zip Code		41. Telephone			

Chiropractic Registration and History

Patient Information

Date _____

SS/HIC/Patient ID # _____

Patient Name _____
Last Name _____
First Name _____ Middle Initial _____

Address _____

City _____

State _____ Zip _____

E-mail _____

Sex M F Age _____

Birthdate _____

Married Widowed Single Minor

Separated Divorced Partnered for _____ years

Occupation _____

Patient Employer/School _____

Employer/School Address _____

Employer/School Phone (____) _____

Spouse's Name _____

Birthdate _____

SS# _____

Spouse's Employer _____

Whom may we thank for referring you? _____

Phone Numbers

Home Phone (____) _____ Cell Phone (____) _____

Best time and place to reach you _____

IN CASE OF EMERGENCY, CONTACT

Name _____ Relationship _____

Home Phone (____) _____ Work Phone (____) _____

Patient Condition

Reason for Visit _____

When did your symptoms appear? _____

Is this condition getting progressively worse? Yes No Unknown

Mark an X on the picture where you continue to have pain, numbness, or tingling.

Rate the severity of your pain on a scale from 1 (least pain) to 10 (severe pain) _____

Type of pain: Sharp Dull Throbbing Numbness Aching Shooting

Burning Tingling Cramps Stiffness Swelling Other

How often do you have this pain? _____

Is it constant or does it come and go? _____

Does it interfere with your Work Sleep Daily Routine Recreation

Activities or movements that are painful to perform Sitting Standing Walking Bending Lying Down

Insurance

Who is responsible for this account? _____

Relationship to Patient _____

Insurance Co. _____

Group # _____

Is patient covered by additional insurance? Yes No

Subscriber's Name _____

Birthdate _____ SS# _____

Relationship to Patient _____

Insurance Co. _____

Group # _____

ASSIGNMENT AND RELEASE

I certify that I, and/or my dependent(s), have insurance coverage with _____ and assign directly to _____

Name of Insurance Company(ies)

Dr. _____ all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I authorize the use of my signature on all insurance submissions.

The above-named doctor may use my health care information and may disclose such information to the above-named Insurance Company(ies) and their agents for the purpose of obtaining payment for services and determining insurance benefits or the benefits payable for related services. This consent will end when my current treatment plan is completed or one year from the date signed below.

Signature of Patient, Parent, Guardian or Personal Representative

Please print name of Patient, Parent, Guardian or Personal Representative

Date

Relationship to Patient

Accident Information

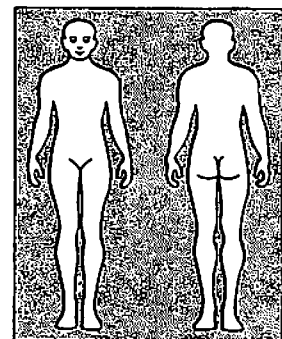
Is condition due to an accident? Yes No Date _____

Type of accident Auto Work Home Other

To whom have you made a report of your accident?

Auto Insurance Employer Worker Comp. Other

Attorney Name (if applicable) _____



Health History

What treatment have you already received for your condition? Medications Surgery Physical Therapy

Chiropractic Services None Other _____

Name and address of other doctor(s) who have treated you for your condition _____

Date of Last: **Physical Exam** **Spinal X-Ray** **Blood Test**

Spinal Exam **Chest X-Ray** **Urine Test**

Dental X-Ray **MRI, CT-Scan, Bone Scan**

Place a mark on "Yes" or "No" to indicate if you have had any of the following:

AIDS/HIV	<input type="checkbox"/> Yes <input type="checkbox"/> No	Diabetes	<input type="checkbox"/> Yes <input type="checkbox"/> No	Liver Disease	<input type="checkbox"/> Yes <input type="checkbox"/> No	Rheumatic Fever	<input type="checkbox"/> Yes <input type="checkbox"/> No
Alcoholism	<input type="checkbox"/> Yes <input type="checkbox"/> No	Emphysema	<input type="checkbox"/> Yes <input type="checkbox"/> No	Measles	<input type="checkbox"/> Yes <input type="checkbox"/> No	Scarlet Fever	<input type="checkbox"/> Yes <input type="checkbox"/> No
Allergy Shots	<input type="checkbox"/> Yes <input type="checkbox"/> No	Epilepsy	<input type="checkbox"/> Yes <input type="checkbox"/> No	Migraine Headaches	<input type="checkbox"/> Yes <input type="checkbox"/> No	Sexually Transmitted Disease	<input type="checkbox"/> Yes <input type="checkbox"/> No
Anemia	<input type="checkbox"/> Yes <input type="checkbox"/> No	Fractures	<input type="checkbox"/> Yes <input type="checkbox"/> No	Miscarriage	<input type="checkbox"/> Yes <input type="checkbox"/> No	Stroke	<input type="checkbox"/> Yes <input type="checkbox"/> No
Anorexia	<input type="checkbox"/> Yes <input type="checkbox"/> No	Glaucoma	<input type="checkbox"/> Yes <input type="checkbox"/> No	Mononucleosis	<input type="checkbox"/> Yes <input type="checkbox"/> No	Suicide Attempt	<input type="checkbox"/> Yes <input type="checkbox"/> No
Appendicitis	<input type="checkbox"/> Yes <input type="checkbox"/> No	Goiter	<input type="checkbox"/> Yes <input type="checkbox"/> No	Multiple Sclerosis	<input type="checkbox"/> Yes <input type="checkbox"/> No	Thyroid Problems	<input type="checkbox"/> Yes <input type="checkbox"/> No
Arthritis	<input type="checkbox"/> Yes <input type="checkbox"/> No	Gonorrhea	<input type="checkbox"/> Yes <input type="checkbox"/> No	Mumps	<input type="checkbox"/> Yes <input type="checkbox"/> No	Tonsillitis	<input type="checkbox"/> Yes <input type="checkbox"/> No
Asthma	<input type="checkbox"/> Yes <input type="checkbox"/> No	Gout	<input type="checkbox"/> Yes <input type="checkbox"/> No	Osteoporosis	<input type="checkbox"/> Yes <input type="checkbox"/> No	Tuberculosis	<input type="checkbox"/> Yes <input type="checkbox"/> No
Bleeding Disorders	<input type="checkbox"/> Yes <input type="checkbox"/> No	Heart Disease	<input type="checkbox"/> Yes <input type="checkbox"/> No	Pacemaker	<input type="checkbox"/> Yes <input type="checkbox"/> No	Tumors, Growths	<input type="checkbox"/> Yes <input type="checkbox"/> No
Breast Lump	<input type="checkbox"/> Yes <input type="checkbox"/> No	Hepatitis	<input type="checkbox"/> Yes <input type="checkbox"/> No	Parkinson's Disease	<input type="checkbox"/> Yes <input type="checkbox"/> No	Typhoid Fever	<input type="checkbox"/> Yes <input type="checkbox"/> No
Bronchitis	<input type="checkbox"/> Yes <input type="checkbox"/> No	Hernia	<input type="checkbox"/> Yes <input type="checkbox"/> No	Pinched Nerve	<input type="checkbox"/> Yes <input type="checkbox"/> No	Ulcers	<input type="checkbox"/> Yes <input type="checkbox"/> No
Bulimia	<input type="checkbox"/> Yes <input type="checkbox"/> No	Herniated Disk	<input type="checkbox"/> Yes <input type="checkbox"/> No	Pneumonia	<input type="checkbox"/> Yes <input type="checkbox"/> No	Vaginal Infections	<input type="checkbox"/> Yes <input type="checkbox"/> No
Cancer	<input type="checkbox"/> Yes <input type="checkbox"/> No	Herpes	<input type="checkbox"/> Yes <input type="checkbox"/> No	Polio	<input type="checkbox"/> Yes <input type="checkbox"/> No	Whooping Cough	<input type="checkbox"/> Yes <input type="checkbox"/> No
Cataracts	<input type="checkbox"/> Yes <input type="checkbox"/> No	High Blood Pressure	<input type="checkbox"/> Yes <input type="checkbox"/> No	Prostate Problem	<input type="checkbox"/> Yes <input type="checkbox"/> No	Other _____	
Chemical Dependency	<input type="checkbox"/> Yes <input type="checkbox"/> No	High Cholesterol	<input type="checkbox"/> Yes <input type="checkbox"/> No	Prosthesis	<input type="checkbox"/> Yes <input type="checkbox"/> No		
Chicken Pox	<input type="checkbox"/> Yes <input type="checkbox"/> No	Kidney Disease	<input type="checkbox"/> Yes <input type="checkbox"/> No	Psychiatric Care	<input type="checkbox"/> Yes <input type="checkbox"/> No		
				Rheumatoid Arthritis	<input type="checkbox"/> Yes <input type="checkbox"/> No		

EXERCISE

- None
- Moderate
- Daily
- Heavy

WORK ACTIVITY

- Sitting
- Standing
- Light Labor
- Heavy Labor

HABITS

- Smoking
- Alcohol
- Coffee/Caffeine Drinks
- High Stress Level

Packs/Day _____
 Drinks/Week _____
 Cups/Day _____
 Reason _____

Are you pregnant? Yes No Due Date _____

Injuries/Surgeries you have had	Description	Date
Falls	_____	_____
Head Injuries	_____	_____
Broken Bones	_____	_____
Dislocations	_____	_____
Surgeries	_____	_____

Medications

Allergies

Vitamins/Herbs/Minerals

Pharmacy Name _____

Pharmacy Phone (____) _____

Alaska Chiropractic Care, LLC
Informed Consent

Patient Name: _____

Please read this entire document prior to signing it. It is important that you understand the information contained in this document. Please ask questions before you sign if there is anything that is unclear.

The nature of the chiropractic adjustment:

The primary treatment used by doctors of chiropractic is spinal manipulative therapy. I will use that procedure to treat you. I may use my hands or a mechanical instrument upon your body in such a way as to move your joints. That may cause an audible "pop" or "click," much as you have experienced when you "crack" your knuckles. You may feel a sense of movement.

Analysis / Examination / Treatment:

As a part of the analysis, examination, and treatment, you are consenting to the following procedures:

Patient should initial each procedure they are consenting to.

<input type="checkbox"/> Basic New Patient Exam	<input type="checkbox"/> spinal manipulative therapy	<input type="checkbox"/> ultrasound
<input type="checkbox"/> hot/cold therapy	<input type="checkbox"/> electric stimulation	<input type="checkbox"/> massage
<input type="checkbox"/> mechanical traction	<input type="checkbox"/> x-rays	<input type="checkbox"/> other (explain)

The material risks inherent in chiropractic adjustment:

As with any healthcare procedure, there are certain complications which may arise during chiropractic manipulation and therapy. These complications include but are not limited to: fractures, disc injuries, dislocations, muscle strain, cervical myelopathy, costovertebral strains and separations, and burns. Some types of manipulation of the neck have been associated with injuries to the arteries in the neck leading to or contributing to serious complications including stroke.

Some patients will feel some stiffness and soreness following the first few days of treatment. The Doctor will make every reasonable effort during the examination to screen for contraindications to care; however if you have a condition that would otherwise not come to the Doctor's attention, it is your responsibility to inform the Doctor.

The probability of those risks occurring:

Fractures are rare occurrences and generally result from some underlying weakness of the bone which we check for during the taking of your history and during examination and X-ray. Stroke has been the subject of tremendous disagreement. The incidences of stroke are exceedingly rare and are estimated to occur between one in one million and one in five million cervical adjustments. The other complications are also generally described as rare.

The availability and nature of other treatment options:

Other treatment options for your condition may include:

- Self-administered, over-the-counter analgesics and rest
- Medical care and prescription drugs such as anti-inflammatory, muscle relaxants and pain-killers
- Hospitalization
- Surgery

If you chose to use one of the above noted "other treatment" options you should be aware that there are risks and benefits of such options and you may wish to discuss these with your primary medical physician.

The risks and dangers attendant to remaining untreated:

Remaining untreated may allow the formation of adhesions and reduce mobility which may set up a pain reaction further reducing mobility.

Over time this process may complicate treatment making it more difficult and less effective the longer it is postponed.

DO NOT SIGN UNTIL YOU HAVE READ AND UNDERSTAND THE ABOVE. PLEASE CHECK THE APPROPRIATE BLOCK AND SIGN BELOW.

I have read [] or have had read to me [] the above explanation of the chiropractic adjustment and related treatment. I have discussed it with Dr. Robert Wheeler, DC and have had my questions answered to my satisfaction. By signing below I state that I have weighed the risks involved in undergoing treatment and have decided that it is in my best interest to undergo the treatment recommended. Having been informed of the risks, I hereby give my consent to that treatment.

Dated: _____

Dated: _____

Patient's Name

Doctor's Name

Signature

Signature

Signature of Parent or Guardian (if a minor)

Alaska Chiropractic Care, LLC. Clinic Policies

Insurance

We bill insurance for you as a courtesy. Co-pays and deductibles are due at the time of service. Coverage disputes are your responsibility to resolve with your insurance company. Payment of your account is strictly your responsibility. I authorize and request my insurance company to pay my insurance benefits directly to ACC for any services rendered. I understand that my insurance carrier may pay less than the actual billed services. Patients belonging to a PPO network plan (such as but not limited to) Aetna, and Blue Cross will Not be billed the difference between the insurances allowed amount and the Doctor's charges. However, I am still responsible for treatments that are not covered by my plan.

Payment Options (circle) Cash Check MasterCard Visa Care Credit Insurance

Card holder Name (exactly how it appears on card): _____

Card Number: _____ CVV2: _____ Expiration: _____

Authorization and release

I authorize Alaska Chiropractic Care LLC (hereafter referred to as ACC) to release information, including the diagnosis and records of any treatment or examination rendered to me or my child during the period of such care, to third party payers and/or other health practitioners. As it is necessary in regards to my care at ACC. Additionally, I authorize photocopies of this form to be as valid as the original. I authorize ACC to charge my pre-authorized credit card for any outstanding balance on my account. If payment for services rendered are sent to me from the insurance company, such as a check, I will endorse them to ACC as payment on my account within 5 days after receiving funds. I agree to inform ACC in writing of any change in my billing or mailing address for as long as I have an outstanding balance. I accept responsibility for all costs incurred by ACC in collecting my debt owed to them, including (but not limited to) attorney fees, skip-tracing fees, lien fees, and collection agency fees. Any balances over 60 days accrue interest at the rate of 10% APR. I am giving my permission for Chiropractic, massage, or other discussed treatments at Alaska Chiropractic Care. I have received and been given opportunity to review the Notice of Privacy Practices. My signature below is an acknowledgement that I have read the clinic policies above and agree to abide by them.

*we reserve the right to refuse care to anyone.

*If you do not show up to your appointment; or if you do not cancel within 24hrs prior to the appointment there may be a charge of \$25 (no show fee)

*Minor children should be accompanied by parent or legal guardian unless other arrangements are agreed to by both parties

*3rd Party auto accidents must provide an alternate form of payment to receive care. I understand that even if I was not at fault, I am still responsible to pay for the treatment I receive at ACC until such time that my account is paid in full by the 3rd party (at fault party) or their insurer.

*Any exceptions to these policies must be agreed upon and signed by both parties (myself and ACC President or authorized representative).

Patient or Legal Guardian Signature

Date

Ask the receptionist or the doctor about our "payment at time of service" discount

Informed Consent for Massage Therapy at Alaska Chiropractic Care LLC.

Massage therapy is generally a very safe and beneficial procedure that can relieve or reduce many bodily complaints. I understand that the massage that I receive is provided for relaxation and relief of muscular tension, scar reduction, improved circulation and other benefits. If I experience pain or discomfort during the session, I will immediately inform the practitioner so that the pressure and or strokes may be adjusted to my level of comfort. I further understand that the massage should not be construed as a substitute for medical examination, diagnosis, or treatment and that I should see a physician, or other trained medical specialist for any mental or physical ailment that I am aware of. I understand that the massage practitioners are not qualified to perform spinal manipulation or adjustments, diagnose, prescribe or treat physical or mental illness and that nothing mentioned during the course of the massage should be construed as such. In rare cases you may experience soreness, bruising, dizziness or light headedness for a short time after a massage. However, there are some medical conditions where massage therapy is absolutely contraindicated.

Temporary contraindications to massage are but are not limited to:

Chickenpox, Contact dermatitis over infected areas, Diarrhea, fever, German Measles, gout when acute, hepatitis, hives, uncontrolled high blood pressure, influenza, lice, lupus during a flare up, measles, mono, mumps, pneumonia, ringworm around the area of infection, acute injuries (until cleared by a physician) or around recent surgical sites, scabies, tonsillitis and over varicose veins.

Permanent Contraindications to massage:

You must inform the doctor and massage therapists of these conditions as failure to do so could endanger your health or even be life threatening. Blood Clots, Cirrhosis of the liver, Deep Vein Thrombosis, Embolism, Uncontrolled hypertension or high blood pressure, Intestinal obstruction, kidney failure, lymphangitis, myocarditis, pericarditis, pulmonary embolism, severe acute respiratory syndrome, syncope or fainting spells, osteoporosis and tuberculosis. Other problems including shortness of breath, vertigo, visual or other sensory abnormalities including speech, hearing, smell, sweats, vomiting, chest pain or pressure, pain into the arms or legs are potential symptoms of more serious medical conditions such as stroke or heart attack and should be seen by a physician immediately or call 911.

If you have lost muscle strength such as inability to grasp or hold objects, walk on your heels or toes, loss of bowel, bladder or sexual function you should seek a physician or emergency room immediately as these conditions may indicate pressure on your spinal cord or nerves which if not removed may cause permanent nerve damage. Out of courtesy to the therapists schedules and as they are paid by the massage we require cancellation 24 hours in advance or we may charge a \$30 no show fee.

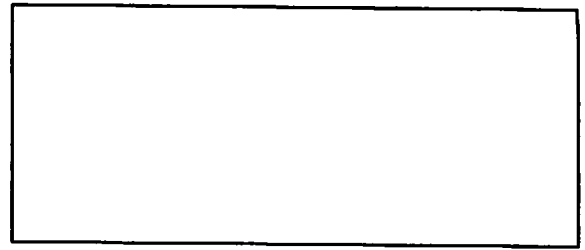
By signing below I have read the risks above and agree to receive massage therapy at Alaska Chiropractic Care LLC. I will inform the doctor/therapist if I should later develop any of the conditions mentioned above.

Patient Name Printed

Patient Signature/Date

CONSULTATION FORM

COMMONLY ASKED QUESTIONS



How should I dress for a K-Laser treatment?

Your K-Laser treatment must be delivered directly to your skin. Wear clothing that will allow access to the area. Shorts, sweat pants.

How many treatment sessions will I need?

The number of K-Laser sessions you will need depends on the nature and duration of your condition, and other factors. Some acute conditions will respond in 6 or fewer sessions, whereas chronic conditions may take more treatments.

What does it feel like to get a treatment?

Most patients describe it as a very soothing, warm sensation. Since the K-Laser is a high-powered therapy laser, your skin will get warm during the treatment. Many patients feel a significant reduction in pain on the first visit. Occasionally, patients will feel slightly more pain immediately after the treatment – and then feel much better the next day.

How will I feel after the treatment?

You may feel pain relief after just the first treatment. For other patients, it takes a while longer. Most patients report feeling very relaxed, or even tired. If you feel a lot less pain, keep in mind that pain reduction is just one goal. The K-Laser is giving your body's cells more energy so they repair and regenerate new tissues. The effect of K-Laser therapy treatments is cumulative. You will be getting more benefit with successive treatments.

Do I need to take special precautions after my K-Laser treatment?

For the most part, no. Obviously you do not want to overexert and reinjure yourself. You may need to make changes in your work station. If you are planning to work out, you may want to reduce the intensity, or change the nature of your exercise. Discuss this with your doctor.

Should I use ice or pain relief gel after my K-Laser treatment?

One effect of the K-Laser treatment is vasodilation – which means your blood and lymphatic vessels have a larger diameter. This helps with inflammation reduction, but for some people the vasodilation can also make them sore. Use ice on the area, as directed by your doctor. You could use a pain relief gel.

I feel a lot better – but I still have sessions remaining in the K-Laser treatment package I bought. What should I do?

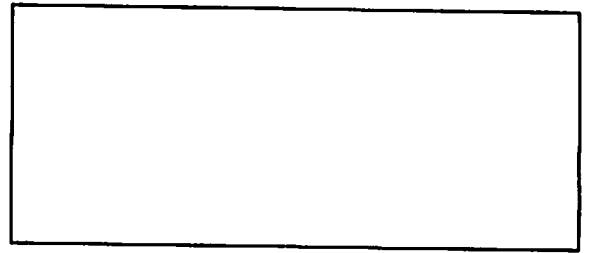
Pain relief is just one goal in your care. K-Laser treatments help your body's repair and regeneration processes. Completing your K-Laser session package will further assist the healing processes. We suggest that you use all the treatments in the package, to ensure the most effective care possible.

Why do I have to wear safety glasses during my K-Laser treatment?

The K-Laser is a high-powered therapy laser. Laser light can be focused by the lens of your eye, and potentially cause damage to your retina. The safety glasses you wear specifically block out the wavelengths of light produced by the K-Laser.

CONSULTATION FORM

INFORMED CONSENT FOR INFRARED LASER THERAPY



Laser therapy is a safe and effective therapy that is FDA cleared for the temporary relief of pain and reduction of symptoms associated with mild arthritis and muscle pain. Laser also promotes relaxation of muscle spasm and promotes vasodilation. Adverse effects from laser therapy are normally rare and temporary.

Pain relief from laser therapy may be dramatic and substantial, lasting for hours, days or weeks. However, your results may be minimal or insignificant. Adverse effects of laser therapy may occur from multiple causes including hypersensitivity, preexisting health conditions, thermal effects, excessive pressure from the probe, and laser over-stimulation. Laser light can damage the retina in your eye. Always wear the laser protective glasses provided.

The most common adverse effects are:

1. Temporary increase in pain during application of laser.
2. Temporary increase in pain the following day after laser therapy.
3. Mild bruising from vasodilation or direct pressure of laser tip.
4. Temporary dizziness.
5. Reactions when photosensitizing drugs are used with laser therapy.

I understand the risks of laser therapy and agree to the treatment program outlined by my doctor.

Patient Signature: _____ Date: _____

Please Print Name: _____

Date of Birth: _____

Employee Witness: _____ Date: _____