

Specializing in Workers' Compensation Permanent and Stationary Report Writing for California Physicians

ChiroComp

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Personal Information

Computer #: _____

Name: _____ Today's Date: _____
Last First MI

Age: _____ Birth date: ____/____/____ S.S #: _____ - _____ - _____ Driver's Lic.# _____

Sex: Male Female Status: Married Single Widowed Divorced Number of Children: _____

Home Address: _____
Street City State Zip Code

Home Phone #:() _____ Cell #:() _____ Work Phone #:() _____

Email address: _____

Employer: _____ Occupation: _____

Person Responsible for this account: _____ Health Plan _____

Where & when are the best times to reach you? _____ Whom may we "Thank" for referring you? _____

Spouse's Name: _____ Age: _____ Birth date: _____

Employer: _____ Occupation: _____

PLEASE CHECK ALL ANSWERS AND FILL IN THE BLANKS WHERE APPROPRIATE. DESCRIBE YOUR PRESENT COMPLAINT. This information is necessary to assist your health care provider understand your health condition.

Please describe your problem and how it began. Date problem Began: ____/____/____

How bad is your pain? (Circle a number.) 1 2 3 4 5 6 7 8 9 10

How often are your symptoms present? Intermittently Occasionally Frequently Constantly

Describe your current pain/symptoms:

<input type="checkbox"/> Sharp/Stabbing	<input type="checkbox"/> Throbbing	<input type="checkbox"/> Aches
<input type="checkbox"/> Dull	<input type="checkbox"/> Soreness	<input type="checkbox"/> Weakness
<input type="checkbox"/> Numbness	<input type="checkbox"/> Shooting	<input type="checkbox"/> Gripping
<input type="checkbox"/> Burning	<input type="checkbox"/> Tingling	<input type="checkbox"/> Other _____

What treatment(s) have you had for this condition in the past? (surgery, medication, injections, therapy, chiropractic)

Are you taking any of the following?

Acetaminophen	<input type="checkbox"/> Yes <input type="checkbox"/> No	Anitibiotics	<input type="checkbox"/> Yes <input type="checkbox"/> No
Antihistomines	<input type="checkbox"/> Yes <input type="checkbox"/> No	Insulin/Diabetes Drugs	<input type="checkbox"/> Yes <input type="checkbox"/> No
Asprin	<input type="checkbox"/> Yes <input type="checkbox"/> No	Nitroglycerin	<input type="checkbox"/> Yes <input type="checkbox"/> No
Blood Thinners	<input type="checkbox"/> Yes <input type="checkbox"/> No	Steroids/Cortisone	<input type="checkbox"/> Yes <input type="checkbox"/> No
Blood Pressure Medication	<input type="checkbox"/> Yes <input type="checkbox"/> No	Thyroid Medicine	<input type="checkbox"/> Yes <input type="checkbox"/> No
Cold Remedies	<input type="checkbox"/> Yes <input type="checkbox"/> No	Tranquilizers	<input type="checkbox"/> Yes <input type="checkbox"/> No

Are you taking any prescription/over the counter drugs not listed above? Yes No

If yes, please list each one: _____

Do you have or have you experienced the following?

Abnormal Bleeding	<input type="checkbox"/> Yes <input type="checkbox"/> No	High Blood Pressure	<input type="checkbox"/> Yes <input type="checkbox"/> No
Alcohol Abuse	<input type="checkbox"/> Yes <input type="checkbox"/> No	HIV/AIDS	<input type="checkbox"/> Yes <input type="checkbox"/> No
Allergies	<input type="checkbox"/> Yes <input type="checkbox"/> No	Hospitalized for any reason	<input type="checkbox"/> Yes <input type="checkbox"/> No
Anemia	<input type="checkbox"/> Yes <input type="checkbox"/> No	Kidney Problems	<input type="checkbox"/> Yes <input type="checkbox"/> No
Arthritis	<input type="checkbox"/> Yes <input type="checkbox"/> No	Leukemia	<input type="checkbox"/> Yes <input type="checkbox"/> No
Artificial Bones/Joints	<input type="checkbox"/> Yes <input type="checkbox"/> No	Liver Disease/Problems	<input type="checkbox"/> Yes <input type="checkbox"/> No
Artificial Valves	<input type="checkbox"/> Yes <input type="checkbox"/> No	Low Blood Pressure	<input type="checkbox"/> Yes <input type="checkbox"/> No
Asthma	<input type="checkbox"/> Yes <input type="checkbox"/> No	Lupus	<input type="checkbox"/> Yes <input type="checkbox"/> No
Blood Transfusion	<input type="checkbox"/> Yes <input type="checkbox"/> No	Migraine	<input type="checkbox"/> Yes <input type="checkbox"/> No
Cancer	<input type="checkbox"/> Yes <input type="checkbox"/> No	Mitral Valve Prolapse	<input type="checkbox"/> Yes <input type="checkbox"/> No
Chemotherapy	<input type="checkbox"/> Yes <input type="checkbox"/> No	Obesity	<input type="checkbox"/> Yes <input type="checkbox"/> No
Chicken Pox	<input type="checkbox"/> Yes <input type="checkbox"/> No	Pacemaker	<input type="checkbox"/> Yes <input type="checkbox"/> No
Colitis	<input type="checkbox"/> Yes <input type="checkbox"/> No	Persistent Cough	<input type="checkbox"/> Yes <input type="checkbox"/> No
Congenital Heart Defect	<input type="checkbox"/> Yes <input type="checkbox"/> No	Psychiatric Problems	<input type="checkbox"/> Yes <input type="checkbox"/> No
Depression	<input type="checkbox"/> Yes <input type="checkbox"/> No	Radiation Treatment	<input type="checkbox"/> Yes <input type="checkbox"/> No
Diabetes	<input type="checkbox"/> Yes <input type="checkbox"/> No	Rheumatism	<input type="checkbox"/> Yes <input type="checkbox"/> No
Difficulty Breathing	<input type="checkbox"/> Yes <input type="checkbox"/> No	Scarlet Fever	<input type="checkbox"/> Yes <input type="checkbox"/> No
Drug Abuse	<input type="checkbox"/> Yes <input type="checkbox"/> No	Sciatica	<input type="checkbox"/> Yes <input type="checkbox"/> No
Emphysema	<input type="checkbox"/> Yes <input type="checkbox"/> No	Scoliosis	<input type="checkbox"/> Yes <input type="checkbox"/> No
Epilepsy	<input type="checkbox"/> Yes <input type="checkbox"/> No	Seizures	<input type="checkbox"/> Yes <input type="checkbox"/> No
Fainting Spells	<input type="checkbox"/> Yes <input type="checkbox"/> No	Shingles	<input type="checkbox"/> Yes <input type="checkbox"/> No
Fatigue	<input type="checkbox"/> Yes <input type="checkbox"/> No	Sickle Cell Disease	<input type="checkbox"/> Yes <input type="checkbox"/> No
Fever Blisters	<input type="checkbox"/> Yes <input type="checkbox"/> No	Sinus Problems	<input type="checkbox"/> Yes <input type="checkbox"/> No
Glaucoma	<input type="checkbox"/> Yes <input type="checkbox"/> No	Stroke	<input type="checkbox"/> Yes <input type="checkbox"/> No
Gout	<input type="checkbox"/> Yes <input type="checkbox"/> No	Suicidal Tendencies	<input type="checkbox"/> Yes <input type="checkbox"/> No
Hay Fever	<input type="checkbox"/> Yes <input type="checkbox"/> No	Thyroid Problems	<input type="checkbox"/> Yes <input type="checkbox"/> No
Headaches	<input type="checkbox"/> Yes <input type="checkbox"/> No	Tonsillitis	<input type="checkbox"/> Yes <input type="checkbox"/> No
Heart Disease/Problems	<input type="checkbox"/> Yes <input type="checkbox"/> No	Tuberculosis	<input type="checkbox"/> Yes <input type="checkbox"/> No
Hemophila	<input type="checkbox"/> Yes <input type="checkbox"/> No	Ulcers	<input type="checkbox"/> Yes <input type="checkbox"/> No
Hepatitis	<input type="checkbox"/> Yes <input type="checkbox"/> No	Venereal Disease	<input type="checkbox"/> Yes <input type="checkbox"/> No
Herpes	<input type="checkbox"/> Yes <input type="checkbox"/> No		

Please list any serious medical condition(s) that you have experienced: _____

I affirm that the information I have given is correct to the best of my knowledge it will be held in the strictest confidence and it is my responsibility to inform this office of any changes in my medical status.

I understand and agree that health and accident insurance policies are an arrangement between an insurance carrier and myself. Furthermore, I understand that this chiropractic office will prepare necessary insurance forms to assist me in making collections from the insurance company. I clearly understand and agree that all services rendered me are charged directly to me and that I am personally responsible for payment. I also understand that if I suspend or terminate my care and treatment, any fees for professional services rendered me will be immediately due and payable.

I hereby authorize **Chirocomp** to furnish all information required by the insurance company concerning my injury or illness.

Signature

Date