Acton Family Chiropractic
789 Patton Ave. Asheville, NC 28806
Phone: 828-258-0264 Fax: 828-254-9202
www.actonfamilychiros.com

WORKER'S COMPENSATION QUESTIONAIRE

Notice: If you injured on the job, you must **REPORT THE INJURY** to your employer. Failure to do so will result in denial of any payment. In the event that your workers' compensation insurance will not cover, you are responsible for your bill.

NAME _____ DATE OF BIRTH _____

ADDRESS _____ CITY _____ STATE _____ ZIP _____

SOCIAL SECURITY # _____ HOME PH # _____ CELL PH # _____

EMPLOYER _____ ADDRESS _____

Name of person you reported the injury to: _____

Is this person your supervisor? Yes/No If no, supervisor's name _____

Who referred you to our office? _____

Date of present injury _____ Time _____ AM or PM

Please explain how the accident happened:

_____

_____

Did you feel pain immediately at the time of injury? Yes or No If yes, where?

_____

If no, please state when you began to have pain and where.

_____

Did you return to work following the injury? Yes/No

When you reported the injury to your supervisor, were you instructed to see a particular doctor? Yes or No

If yes, whom did you see? _____

How much time have you lost from work as a result of this injury? _____

Have you ever been injured before? Yes or No If yes, please indicate when, where, and how:

_____

_____

Since this injury, are your symptoms improving? _____ getting worse? _____ the same? _____

AGREEMENT TO PAY IN THE EVENT THAT COMPENSATION IS DENIED:

In the event that I fail to prosecute the claim for workers' compensation for this injury or condition, or if it is not a compensable workers' compensation claim, I hereby agree to pay this office's usual and customary fees for services rendered to me.

Signature _____ Date _____

OCCUPATIONAL EVALUATION FORM

Name _____ Date _____

To help us determine the demands of your job and how it may be affecting your progress at our office, please put a check in front of ALL that apply to your duties at work:

( ) Prolonged standing
( ) Prolonged sitting
( ) Maintaining a twisted position of the neck or back for prolonged periods (such as the side while you type)
( ) Kneeling, squatting, or crawling
( ) Repetitive or sustained stooping or bending over
( ) Reaching and lifting overhead
( ) Stair climbing
( ) Ladder climbing
( ) Working at unprotected heights
( ) Walking on slick, slippery, cluttered, or uneven surfaces
( ) Operating foot controls always with the same foot
( ) Operating awkward hand controls or keyboards that keep the wrist in an unnatural position
( ) Operating moving machinery
( ) Driving automotive equipment
( ) Exposure to dust, fumes, gases, solvents, or chemicals
( ) Lifting loads at the beginning of shift
( ) Lifting loads at the end of a shift
( ) Have you been on the job for less than 6 months?
( ) Are you shorter or thinner than your co-workers?

_____ Total number of checks = SCORE

(Developed by Greater Houston area chapter of the American Red Cross sponsored by the American Chiropractic Association)

WORKERS' COMPENSATION
CHANGE OF PHYSICIAN REQUEST
Pursuant to N.C.G.S. 97-25

EMPLOYEE:
NAME: _____

Date of Birth: _____ Social Security Number: _____

IC File #: _____ (Required: ***Patient*** may obtain from employer or the Industrial Commission Statistics Department)
(919) 807-2506

Current Physician:
Name: _____ Phone #: _____

Address: _____

Phone #: _____ Fax #: _____

Reason for Requested Change:

_____

_____

_____

Has the patient received previous chiropractic care: _____

If so, what was the outcome: _____

Date: _____ Employee Signature: _____

☐ Check this box to request a copy of the ruling to be faxed to the requested physician.

FAX THIS DOCUMENT TO: Office of the Executive Secretary
North Carolina Industrial Commission
4333 Mail Service Center
Raleigh, NC 27699-4333
Fax: (919) 715-0282

Review of Systems: Please indicate any personal history prior to your injury.

CONSTITUTIONAL SYMPTOMS

Good general health lately	Yes	No
Recent weight change	Yes	No
Fever	Yes	No
Fatigue	Yes	No
Headaches	Yes	No

EYES

Eye disease or injury	Yes	No
Wear glasses/contact lenses	Yes	No
Blurred or double vision	Yes	No

EARS/NOSE/MOUTH/THROAT

Hearing loss or ringing	Yes	No
Earaches or drainage	Yes	No
Chronic Sinus problems or rhinitis	Yes	No
Nose bleeds	Yes	No
Mouth sores	Yes	No
Bleeding gums	Yes	No
Bad breath or bad taste	Yes	No
Sore throat of voice change	Yes	No
Swollen glands in neck	Yes	No

CARDIOVASCULAR

Heart trouble	Yes	No
Chest pain or angina pectoris	Yes	No
Palpitation	Yes	No
Shortness of breath with walking or lying flat	Yes	No
Swelling of feet, ankles, or hands	Yes	No

RESPIRATORY

Chronic or frequent coughs	Yes	No
Spitting up blood	Yes	No
Shortness of breath	Yes	No
Wheezing	Yes	No

GASTROINTESTINAL

Loss of appetite	Yes	No
Change in bowel movements	Yes	No
Nausea or vomiting	Yes	No
Frequent diarrhea	Yes	No
Painful bowel movements or constipation	Yes	No
Rectal bleeding or blood in stool	Yes	No
Abdominal pain	Yes	No

GENITOURINARY

Frequent urination	Yes	No
Burning or painful urination	Yes	No
Blood in urine	Yes	No
Change in force of strain when urinating	Yes	No
Incontinence or dribbling	Yes	No
Kidney Stones	Yes	No
Sexual difficulty	Yes	No
Male-testicle pain	Yes	No
Female-pain with periods	Yes	No
Female-vaginal discharge	Yes	No
Female-# of pregnancies: _____		
Female-# miscarriages: _____		
Female-date of last pap smear: _____		

MUSCULOSKELETAL

Joint pain	Yes	No
Joint stiffness or swelling	Yes	No
Weakness of muscles or joints	Yes	No
Muscle pain or cramps	Yes	No
Back pain	Yes	No
Cold Extremities	Yes	No
Difficulty in walking	Yes	No

INTEGUMENTARY (skin, breast)

Rash or itching	Yes	No
Change in skin color	Yes	No
Change in hair or nails	Yes	No
Varicose veins	Yes	No
Breast pain	Yes	No
Breast lump	Yes	No
Breast discharge	Yes	No

NEUROLOGICAL

Frequent or recurring headaches	Yes	No
Light headed or dizzy	Yes	No
Convulsions or seizures	Yes	No
Numbness or tingling sensations	Yes	No
Tremors	Yes	No
Paralysis	Yes	No
Head injury	Yes	No

PSYCHIATRIC

Memory loss or confusion	Yes	No
Nervousness	Yes	No
Depression	Yes	No
Insomnia	Yes	No

ENDOCRINE

Glandular/hormone problem	Yes	No
Excessive thirst or urination	Yes	No
Heat or cold intolerance	Yes	No
Skin becoming dryer	Yes	No
Change in hat or glove size	Yes	No

HEMATOLOGIC/LYMPHATIC

Slow to heal after cuts	Yes	No
Bleeding or bruising tendency	Yes	No
Anemia	Yes	No
Phlebitis	Yes	No
Past transfusion	Yes	No
Enlarged glands	Yes	No

ALLERGIC/IMMUNOLOGIC

History of skin reaction or other adverse reaction to:		
Penicillin or other antibiotic	Yes	No
Morphine, Demerol, or other narcotics	Yes	No
Novocain or other anesthetics	Yes	No
Aspirin or other pain remedies	Yes	No
Tetanus antitoxin or other serums	Yes	No
Iodine, methiolate or other antiseptics	Yes	No

Other drugs/medications:

_____
_____
_____
_____
_____
_____

Known food allergies:

_____
_____
_____
_____
_____
_____

Environmental allergies:

_____
_____
_____
_____
_____
_____

AUTHORIZATION AND RELEASE

To the best of my knowledge, the questions on this form have been accurately answered. I understand that providing incorrect information can be dangerous to my health. It is my responsibility to inform the doctor's office of any changes in my medical status. I also authorize the health care staff to perform the necessary service I may need.

Patient Name: _____ **Signature of Patient:** _____ **Date:** _____

North Carolina Industrial Commission

IC File # _____

NOTICE OF ACCIDENT TO EMPLOYER AND CLAIM OF EMPLOYEE, REPRESENTATIVE, OR DEPENDENT (G.S. §§97-22 THROUGH 24)

Emp. Code # _____

Carrier Code # _____

Employer FEIN _____

The I.C. File # is the unique identifier for this injury. It will be provided by return letter and is to be referenced in all future correspondence.

The Use of This Form Is Required Under the Provisions of the Workers' Compensation Act

Employee's Name

Address

City State Zip

( ) -
Home Telephone

- - ☐ M ☐ F / /
Social Security Number Sex Date of Birth

Employer's Name ( ) -
Telephone Number

Employer's Address City State Zip

Insurance Carrier Policy Number

Carrier's Address City State Zip

( ) - ( ) -
Carrier's Telephone Number Carrier's Fax Number

EMPLOYEE – This form must be filed with the Industrial Commission within two years of the date of injury or occupational disease or your claim may be barred. Notice shall be given to the employer immediately after the accident or as soon as practicable and within 30 days. (This form should also be used for occupational disease claims; however, for asbestosis, silicosis and byssinosis, Form 18B is to be used.)

Notice is hereby given, as required by law, that the above-named employee sustained an injury or contracted an occupational disease, described as follows: _____ (Time of Injury) on ___/___/___ (Date (required)) at _____ (City and County). Describe the injury or occupational disease, including the specific body part involved (e.g., right hand, left hand) _____

Describe how the injury or occupational disease occurred: _____

Occupation when injured: _____ Nature of employer's business: _____

Number of days out of work due to injury:

Medical treatment received? ☐Yes ☐No

Weekly wage: $_____ Number of hours worked per day: _____ Days worked per week: _____

NOTE: If employee is unable to sign this form, another may sign for him. This form should be typed or printed by hand in black ink, if possible. Employee should retain one signed copy of this notice, mail one signed copy to the Industrial Commission at the address below, and provide one signed copy to employer.

_____ ( ) -
Signature of (Check One) ☐ Employee, ☐ Attorney, ☐ Representative, or ☐ Dependent — Telephone Number

Address City State Zip / /
Date Completed

EMPLOYER: This notice is being sent to you in compliance with requirements of the North Carolina Workers' Compensation Act, in order that the medical services prescribed by the Act may be obtained; and, if disability extends beyond 7 days duration, or if death ensues, compensation may be paid according to law.

FOR IC USE ONLY

RESEARCHER: _____
CC: _____
EC: _____
DATA ENTRY: _____

FORM 18

FORM 18
02/2017
PAGE 1 OF 1

ATTORNEYS: FILE WITH AN **IC FILE NUMBER** VIA **EDFP**
HTTP://WWW.IC.NC.GOV/DOCFILING.HTML OR
IF NO IC FILE NUMBER, FOLLOW EMPLOYEE FILING OPTIONS.
EMPLOYEES: E-MAIL TO: **FORMS@IC.NC.GOV**
OR MAIL TO: **NCIC - CLAIMS SECTION**
4335 MAIL SERVICE CENTER
RALEIGH, NC 27699-4335
MAIN TELEPHONE**: (919) 807-2500** HELPLINE: **(800) 688-8349**
WEBSITE: **HTTP://WWW.IC.NC.GOV/**

GENERAL INFORMATION ON THE FORM 18

1. What does a Form 18 do?

A Form 18 establishes a legal claim of injury on your behalf if filed within two years of the date of injury or occupational disease, and gives the required written notice to the employer if a copy is submitted to the employer within 30 days of the injury. The employer is required by law to file a Form 19 if the employee misses more than one day of work due to the injury or if the medical bills exceed $2,000.00. However, the employer's filing of a Form 19 does not satisfy the employee's obligation to file a claim. In order to ensure the employee's rights are protected, the employee must file a Form 18 even though the employer may be paying compensation or the Industrial Commission may have opened a file for the injury.

2. To whom should the Form 18 be sent?

The original Form 18 should be submitted to the Industrial Commission. The injured worker should keep one copy for his or her records and one copy should be submitted to the employer at the time of the injury.

3. What numbers do I write in the upper right corner?

You do not need to fill in the spaces on the upper right corner of the Form 18. If you know that your employer has already filed a report of injury, (Form 19) and you know what your I.C. (Industrial Commission), File Number is, you may write the number in the "I.C. File No." space. If you do not already have an I.C. File Number, the Industrial Commission will assign one upon receipt of the Form 18. The other three spaces, "Emp. Code No.," "Carrier Code No.," and "Employer FEIN" are for internal use only.

4. What if I do not know who my employer's insurance carrier is?

If you do not know who the employer's insurance carrier is you may either ask your employer for the information, call the Industrial Commission's Claims Administration Section at (800) 688-8349 then press "1" after the prompt, or simply leave the line blank.

5. When listing the number of days out of work, do I count partial days?

Yes, you include partial as well as whole calendar days not worked. However, the days do not need to be consecutive.

6. What happens after I file the Form 18?

The Industrial Commission will mail an acknowledgement letter to you after your Form 18 is processed. Processing time varies according to current workload. The Industrial Commission will mail a copy of the acknowledgement letter to the employer or its workers' compensation insurance carrier asking them to contact you and inform you if compensation will be paid to you voluntarily.

FOR IC USE ONLY

RESEARCHER: _____
CC: _____
EC: _____
DATA ENTRY: _____

FORM 18

ATTORNEYS: FILE WITH AN **IC FILE NUMBER** VIA **EDFP**
HTTP://WWW.IC.NC.GOV/DOCFILING.HTML OR
IF NO IC FILE NUMBER, FOLLOW EMPLOYEE FILING OPTIONS.
EMPLOYEES: E-MAIL TO: **FORMS@IC.NC.GOV**
OR MAIL TO: **NCIC - CLAIMS SECTION**
4335 MAIL SERVICE CENTER
RALEIGH, NC 27699-4335
MAIN TELEPHONE**: (919) 807-2500** HELPLINE: **(800) 688-8349**
WEBSITE: **HTTP://WWW.IC.NC.GOV/**