Last Name _____ First _____ Middle In. _____ Date _____

Address _____ City _____ State _____ Zip _____

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

E-mail _____ Referred by: _____

Occupation _____ Employer _____ Hours per week worked _____

D.O.B. ____/____/_____ Age _____ Social Security # _____ ❑ Male ❑ Female ❑ Married ❑ Single

Emergency Contact _____ Ph.# _____ Relationship: _____

Family Doctor _____ Phone #_____ Last Exam Date _____

What is your main complaint(s)? _____

Is condition: □ Job related □ Auto Accident □ Home Injury □ Fall □ Unknown □ Other _____

Circle the INTENSITY of your PAIN WHEN PRESENT (0=no pain, 10=severe pain): 0 - 1 - 2 - 3 - 4 - 5 - 6 - 7 - 8 - 9 - 10

Mark the FREQUENCY of your PAIN: □ Constant (75-100%) □ Frequent (50-75%) □ Occasional (25-50%) □ Intermittent (0-25%)

Describe the Pain (mark all that apply): □Dull, □Sharp, □Ache, □Throb, □Burning, □Numb, □Tingling, □Cramping, □Spasm, □Shooting

Other Conditions RELATED TO INJURY: □ Headaches, □ Neck Pain, □ Shoulder pain (R - L), □ Pain between shoulders, □ Low back pain, □ Buttock Pain (R - L), □ Hip Joint Pain (R - L), □ Arm/hand numb/tingle (R - L), □ Leg/foot numb/tingle (R - L)

Financial Release and Assignment:
Payment is expected on the date that services are rendered. Insurance filing is a courtesy for our patients. Balance for services is the patient responsibility. I understand any outstanding accounts beyond 90 days may result in a 25% finance charge per month. If the account is sent to collections, any fees associated with the collection of charges will also be billed to the patient (according to Collection Agency fee amounts). I authorize the release of any information necessary to process my insurance claims and request payment be sent directly to my physicians.

X-ray Consent:
The purpose of the x-ray examination to be performed is to analyze the spine for evidence of vertebral subluxation, rate and level of degeneration of the spine, and to determine the appropriateness of spinal adjustments. If the doctor discovers a non-chiropractic "unusual finding" when reviewing the x-rays, I will be informed. With the help of the doctor, I thus must determine if I should seek the services of an additional healthcare provider for advice, diagnosis, or treatment of the unusual finding. I understand that seeking advice from another healthcare provider will likely not interfere with the subluxation correction care provided by this office. I fully understand the above and consent to chiropractic spinal x-rays.

WOMEN ONLY - Pregnancy Release: This is to certify that to the best of my ability I am not pregnant and I give my permission to perform an x-ray evaluation. I understand the risks of an x-ray to an unborn child. Date of last menstrual period: _____

Consent to Receive Chiropractic Care:
I, the undersigned, give this office and its doctor(s) permission and authority to provide care in accordance with standard chiropractic tests, analysis, diagnosis, and treatment. Chiropractic care seldom causes complications, but in rare cases, due to underlying physical defects, deformities, or pathologies may render a patient susceptible to injury. The doctor(s) will not provide care, without consent of the patient, if they are aware of any contraindication that my be present. It is the responsibility of the patient to discuss with the doctor(s) any known underlying deformities or defects that may not otherwise come to the attention of the doctor. I do not expect the doctor(s) to be able to anticipate and explain all risks and complications and I wish to rely on the doctor(s) to exercise judgment during the course of the procedure which the doctor(s) feels at the time, based upon the facts then known, is in my best interests.

HIPAA Privacy Rule: This office is required by law to maintain the privacy and confidentiality of your protected health information. By signing this form, I release this office from all liability and give permission to use my first and last name for the purpose of speaking with me in the presence of others. I understand that I may request a detailed copy of the HIPAA privacy rule at any time.

I have read and fully understand the above statements and accept chiropractic care on this basis.

Patient/Parent/Advocate Signature: _____ Date: _____

Print Name:_____ **Date of Accident**_____ **Today's Date**_____

Please answer the questions below. If you do not know the answer to a question, leave that one blank.

Were you: □ Driver □ Passenger □ Front Seat □ Rear Seat □ Pedestrian □ Other _____

Were you wearing a seat belt? □ Yes □ No **Did airbag deploy?** □ Yes □ No

Was it your vehicle? □ Yes □ No **What was the make/model of the vehicle you were in?** _____

Other people in your vehicle? _____

Where was the impact to your vehicle? □ Front □ Back □ Left side □ Right side □ Other: _____

What did your vehicle strike? Another vehicle Tree Ditch Other: _____

If another vehicle was involved, what was its make/model? _____

Area of impact of other vehicle? _____

Did any of your body parts hit anything inside your vehicle? (Ex: Head hit side window/steering wheel) _____

_____

Were you completely conscious after the impact? □ Yes □ No **Explain:**

Since the accident have you had more difficulty/issues with remembering/concentration? □ Yes □ No

How fast was your vehicle travelling? _____ **mph What were the weather conditions?** _____

Did you go to the hospital? □ Yes □ No **Via:** □ Ambulance □ Other: _____

What tests were performed? □ X-rays □ MRI □ Other:_____ **Results:** _____

Did you suffer any cuts, bruises, fractures? □ Yes □ No **Body part/region:** _____

Have you missed any work due to this injury? □ Yes □ No **Dates missed:** _____

Are you working at the present time? □ Yes □ No

At work you are required to (in hours) □ Stand (____) □ Drive (____) □ Walk (____) □ Lift (____) □ Sit (____) □ Type (____)

Are you experiencing limitations in any activities due to this injury? □ Standing □ Driving □ Walking □ Lifting □ Sit □ Typing

Describe limitations: _____

Describe the accident in your own words: _____

_____

_____

_____

_____

_____

_____

Describe how you have felt since the accident in your own words: _____

_____

_____

_____

The Neck Disability Index

Please read instructions: This questionnaire has been designed to give the doctor information as to how your neck pain has affected your ability to manage everyday life.

Mark only ONE box per section that applies to how it is affected by your neck pain/condition and not by your lower back or other body region. We realize that you may consider that two of the statements in any one section relate to you, but please just mark the one box that most closely describes your problem.

SECTION 1 - PAIN INTENSITY
1. ☐ I have no pain at the moment.
2. ☐ The pain is very mild at the moment.
3. ☐ The pain is moderate at the moment.
4. ☐ The pain is fairly severe at the moment.
5. ☐ The pain is very severe at the moment.
6. ☐ The pain is the worst imaginable at the moment.

SECTION 2 - HEADACHES
1. ☐ I have no headaches at all.
2. ☐ I have slight headaches that come infrequently.
3. ☐ I have moderate headaches that come infrequently.
4. ☐ I have moderate headaches that come frequently.
5. ☐ I have severe headaches that come frequently.
6. ☐ I have headaches almost all the time.

SECTION 3 - PERSONAL CARE (Washing, Dressing, etc.)
1. ☐ I can look after myself normally, without causing extra pain.
2. ☐ I can look after myself normally, but it causes extra pain.
3. ☐ It is painful to look after myself and I am slow and careful.
4. ☐ I need some help, but manage most of my personal care.
5. ☐ I need help every day in most aspects of self care.
6. ☐ I do not get dressed; I wash with difficulty and stay in bed.

SECTION 4 - WORK
1. ☐ I can do as much work as I want to.
2. ☐ I can do my usual work, but no more.
3. ☐ I can do most of my usual work, but no more.
4. ☐ I cannot do my usual work.
5. ☐ I can hardly do any work at all.
6. ☐ I can't do any work at all.

SECTION 5 - SLEEPING
1. ☐ I have no trouble sleeping.
2. ☐ My sleep is slightly disturbed, less than 1 hr sleepless.
3. ☐ My sleep is mildly disturbed, 1-2 hrs sleepless.
4. ☐ My sleep is moderately disturbed, 2-3 hrs sleepless.
5. ☐ My sleep is greatly disturbed, 3-5 hrs sleepless.
6. ☐ My sleep is completely disturbed, 5-7 hrs sleepless.

SECTION 6 -DRIVING
1. ☐ I can drive my car without any neck pain.
2. ☐ I can drive my car as long as I want, with slight neck pain.
3. ☐ I can drive my car as long as I want, with moderate neck pain.
4. ☐ I can't drive my car as long as I want, due to moderate neck pain.
5. ☐ I can hardly drive at all, because of severe neck pain.
6. ☐ I can't drive my car at all.

SECTION 7 -LIFTING
1. ☐ I can lift heavy weights without extra pain.
2. ☐ I can lift heavy weights, but it gives extra pain.
3. ☐ Pain prevents me from lifting heavy weights off the floor, but I can manage if they are conveniently positioned, for example, on a table.
4. ☐ Pain prevents me from lifting heavy weights off the floor, but I can manage light to medium weights if they are conveniently positioned.
5. ☐ I can lift very light weights.
6. ☐ I cannot lift or carry anything at all.

SECTION 8 -CONCENTRATION
1. ☐ I can concentrate fully when I want to, with no difficulty.
2. ☐ I can concentrate fully when I want to, with slight difficulty.
3. ☐ I have a fair degree of difficulty in concentrating when I want to.
4. ☐ I have a lot of difficulty in concentrating when I want to.
5. ☐ I have a great deal of difficulty in concentrating when I want to.
6. ☐ I cannot concentrate at all.

SECTION 9 - READING
1. ☐ I can read as much as I want to, with no pain in my neck.
2. ☐ I can read as much as I want to, with slight pain in my neck.
3. ☐ I can read as much as I want to, with moderate pain in my neck.
4. ☐ I can't read as much as I want, due to moderate pain in my neck.
5. ☐ I can hardly read at all, due to severe pain in my neck.
6. ☐ I cannot read at all.

SECTION 10 -RECREATION
1. ☐ I am able to engage in recreation activities, with no neck pain.
2. ☐ I am able to engage in recreation activities, with some neck pain.
3. ☐ I am able to engage in most, but not all, of my usual recreation activities, because of neck pain.
4. ☐ I am able to engage in few recreation activities, due to neck pain.
5. ☐ I can hardly do any recreation activities, because of neck pain.
6. ☐ I can't do any recreation activities at all.

Office use only:
Score = _____. Neck disability is _____.

The Revised Oswestry Disability Index (for low back pain/dysfunction)

Please read instructions: This questionnaire has been designed to give the doctor information as to how your back pain has affected your ability to manage everyday life.

Mark only ONE box per section that applies to how it is affected by your back pain/condition and not by your neck or other body region. We realize that you may consider that two of the statements in any one section relate to you, but please just mark the one box that most closely describes your problem.

SECTION 1 - PAIN INTENSITY

1. ☐ The pain comes and goes and is very mild.
2. ☐ The pain is mild and does not vary much.
3. ☐ The pain comes and goes and is moderate.
4. ☐ The pain is moderate and does not vary much.
5. ☐ The pain comes and goes and is very severe.
6. ☐ The pain is severe and does not vary much.

SECTION 2 - PERSONAL CARE (Washing, Dressing, etc.)

1. ☐ I would not have to change my way of washing or dressing in order to avoid pain.
2. ☐ I do not normally change my way of washing or dressing even though it causes some pain.
3. ☐ Washing and dressing increases the pain, but I manage not to change my way of doing it.
4. ☐ Washing and dressing increases the pain and I find it necessary to change my way of doing it.
5. ☐ Because of the pain, I am unable to do some washing and dressing without help.
6. ☐ Because of the pain, I am unable to do any washing and dressing without help.

SECTION 3 - WALKING

1. ☐ I have no pain on walking.
2. ☐ I have some pain on walking, but it does not increase with distance.
3. ☐ I cannot walk more than one mile without increasing pain.
4. ☐ I cannot walk more than 1/2 mile without increasing pain.
5. ☐ I cannot walk more than 1/4 mile without increasing pain.
6. ☐ I cannot walk at all without increasing pain.

SECTION 4 - SITTING

1. ☐ I can sit in any chair as long as I like.
2. ☐ I can only sit in my favorite chair as long as I like.
3. ☐ Pain prevents me from sitting more than one hour.
4. ☐ Pain prevents me from sitting more than 1/2 hour.
5. ☐ Pain prevents me from sitting more 10 minutes.
6. ☐ I avoid sitting because it increases pain right away.

SECTION 5 - SLEEPING

1. ☐ I get no pain in bed.
2. ☐ I get pain in bed, but it does not prevent me from sleeping well.
3. ☐ Because of pain, my normal night's sleep is reduced by less than 1/4.
4. ☐ Because of pain, my normal night's sleep is reduced by less than 1/2.
5. ☐ Because of pain, my normal night's sleep is reduced by less than 3/4.
6. ☐ Pain prevents me from sleeping at all.

SECTION 6 - TRAVELLING

1. ☐ I get no pain while travelling.
2. ☐ I get some pain while travelling, but none of my usual forms of travel makes it any worse.
3. ☐ I get extra pain while travelling, but it does not compel me to seek alternative forms of travel.
4. ☐ I get extra pain while travelling, which compels me to seek alternative forms of travel.
5. ☐ Pain restricts all forms of travel.
6. ☐ Pain prevents all forms of travel except that done lying down.

SECTION 7 -LIFTING

1. ☐ I can lift heavy weights without extra pain.
2. ☐ I can lift heavy weights, but it causes extra pain.
3. ☐ Pain prevents me from lifting heavy weights off the floor, but I manage if they are conveniently positioned (e.g., on a table).
4. ☐ Pain prevents me from lifting heavy weights off the floor.
5. ☐ Pain prevents me from lifting heavy weights, but I can manage light to medium weights if they are conveniently positioned.
6. ☐ I can only lift very light weights at the most.

SECTION 8 -CHANGING DEGREES OF PAIN

1. ☐ My pain is rapidly getting better.
2. ☐ My pain fluctuates, but is definitively getting better.
3. ☐ My pain seems to be getting better, but improvement is slow.
4. ☐ My pain is neither getting better nor worse.
5. ☐ My pain is gradually worsening.
6. ☐ My pain is rapidly worsening.

SECTION 9 - STANDING

1. ☐ I can stand as long as I want without pain.
2. ☐ I have some pain on standing, but it does not increase with time.
3. ☐ I cannot stand for longer than one hour without increasing pain.
4. ☐ I cannot stand for longer than 1/2 hour without increasing pain.
5. ☐ I cannot stand for longer than 10 minutes without increasing pain.
6. ☐ I avoid standing because it increases the pain right away.

SECTION 10 - SOCIAL LIFE

1. ☐ My social life is normal and gives me no pain.
2. ☐ My social life is normal, but increases the degree of pain.
3. ☐ Pain has no significant effect on my social life apart from limiting my more energetic interests, e.g., dancing, etc.
4. ☐ Pain has restricted my social life and I do not go out very often.
5. ☐ Pain has restricted my social life to my home.
6. ☐ I have hardly any social life because of the pain.

Office use only:

Score = _____. Low back disability is _____.