HARBOR CHIROPRACTIC

**New Patient Intake Form – Bradenton**
**PERSONAL INJURY PROTECTION**

## CONTACT INFORMATION

Name_____ Preferred to be called _____ □ Male □ Female
Address_____ City_____ State_____ Zip_____ Date of Birth _____
Home Phone_____ Cell Phone_____ E-mail _____
SSN_____ Marital Status: S M D W Spouse's Name: _____
Primary Care Physician_____ Preferred Language _____ Race/Ethnicity: _____
Emergency Contact _____ Phone Number _____ Relationship _____

Who referred you to our office? _____
Occupation_____ Employer_____

## BILLING INFORMATION □ Self Pay

Please check any and all insurance coverage that may be applicable in this case:

□ Major Medical □ Medicare □ Auto Accident □ Medical Savings Account & Flex Plans □ Other

Insurance Company Name _____
Insured's Name _____ Insured's DOB _____
Name of Secondary Insurance Company (if any) _____

**If you are not financially responsible for your account, who is?**

Name:_____ Phone:_____

**MEDICARE**: We do accept assignment from Medicare. The check is usually sent directly to our office in payment of the services that Medicare will cover which for Chiropractors is ONLY manual manipulation of the spine. All other services we provide are NON-COVERED. These services include, but are not limited to, x-rays, examinations, therapies, supports, and/or nutritional supplements. Medicare patients are fully responsible for charges of non-covered services. Secondary insurance may or may not pay for these non-covered services. Our office completes and files the forms for Medicare at no charge.

**Authorization and Release:** I authorize RHC Health Services, LLC d/b/a Harbor Chiropractic to release any information pertinent to my case to my insurance carrier and to submit a claim for all services rendered by this office. I authorize and direct my insurance carrier or its intermediaries to issue payment checks directly to this office for services rendered. I understand I am financially responsible to this office for any balance, regardless of insurance coverage. I understand that if I suspended or terminate my care and treatment, any fees for professional services rendered will be immediately due and payable. If it is necessary for this office to employ collections counsel, I understand that I am responsible for those collection charges. A copy of this signature is as valid as the original.

**Patient Signature: _____Date: _____**
**(If patient is a minor, signature of parent/guardian)**

## NOTICE OF OUR PRIVACY PRACTICES

We want you to know how your Patient Health Information (PHI) is going to be used in this office and your rights concerning those records. Before we will begin any health care treatments we must require you to read and sign this consent form stating that you understand and agree with how your records will be used. If you would like to have a more detailed account of our policies and procedures concerning the privacy of your Patient Health Information we encourage you to read the HIPAA NOTICE that is available to you at the front desk before signing this consent.

## PLEASE REVIEW THIS NOTICE CAREFULLY

1. The patient understands and agrees to allow this chiropractic office to use their Patient Health Information (PHI) for the purpose of treatment, payment, healthcare operations, and coordination of care. As an example, the patient agrees to allow this chiropractic office to submit requested PHI to the Health Insurance Company (or companies) provided to us by the patient for the purpose of payment. Be assured that this office will limit the release of all PHI to the minimum needed for what the insurance companies require for payment.

2. The patient has the right to examine and obtain a copy of his or her own health records at any time and request corrections. The patient may request to know what disclosures have been made and submit in writing any further restrictions on the use of their PHI. Our office is not obligated to agree to those restrictions.

3. A patient's written consent need only be obtained one time for all subsequent care given the patient in this office.

4. The patient may provide a written request to revoke consent at any time during care. This would not effect the use of those records for the care given prior to the written request to revoke consent but would apply to any care given after the request has been presented.

5. For your security and right to privacy, all staff has been trained in the area of patient record privacy and a privacy official has been designated to enforce those procedures in our office. We have taken all precautions that are known by this office to assure that your records are not readily available to those who do not need them.

6. Patients have the right to file a formal complaint with our privacy official about any possible violations of these policies and procedures.

7. If the patient refuses to sign this consent for the purpose of treatment, payment and health care operations, the chiropractic physician has the right to refuse to give care. I have read and understand how my Patient Health Information will be used and I agree to these policies and procedures.

**Please list who we may speak with regarding your care and account. Please note, we cannot speak with or release any information to anyone not listed: _____**

**Patient Signature: _____Date: _____**

**(If patient is a minor, signature of parent/guardian)**

**CONSENT TO TREAT**

I hereby request and consent to the performance of chiropractic adjustments and procedures, including various modes of physio therapy (spinal-decompression, acupuncture, myofascial release, therapeutic exercises, ultrasound therapy, electrical muscle stimulation, graston/gua sha, ect.), diagnostic x-rays, and any supportive therapies (low level laser therapy) on me (or on the patient named below, for whom I am legally responsible) by the doctors of chiropractic and support staff who now or in the future treat me while employed by, working or associated with or serving as back-up for the doctor(s) of chiropractic at Harbor Chiropractic, including those working at the clinic or office listed below or any other office or clinic, whether signatories to this form or not.

I have had an opportunity to discuss with the doctor(s) of chiropractic at Harbor Chiropractic and/or with other office or clinic personnel the nature and purpose of chiropractic adjustments and procedures.

I understand and I am informed that, as is with all healthcare treatments, results are not guaranteed and there is no promise to cure. I further understand and I am informed that, as is with all healthcare treatments, in the practice of chiropractic there are some risks to treatment, including, but not limited to, muscle spasms for short periods of time, aggravating and/or temporary increase in symptoms, 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. I do not expect the doctor to be able to anticipate and explain all risks and complications, and I wish to rely on the doctor to exercise judgment during the course of the procedure which the doctor feels at the time, based upon the facts then known, is in my best interests.

I further understand that chiropractic adjustments and supportive treatment are designed to reduce and/or correct subluxations allowing the body to return to improved health. It can also alleviate certain symptoms through a conservative approach with hopes to avoid more invasive procedures. However, like all other health modalities, results are not guaranteed and there is no promise to cure. Accordingly, I understand that all payment(s) for treatment(s) are final and no refunds will be issued. However, prorated fees for unused, prepaid treatments will be refunded if I wish to cancel the treatment.

I further understand that there are treatment options available for my condition other than chiropractic procedures. These treatment options include, but not limited self-administered, over the counter analgesics and rest; medical care with prescription drugs such as anti-inflammatories, muscle relaxants and painkillers; physical therapy; steroid injections; bracing; and surgery. I understand and have been informed that I have the right to have a second opinion and secure other opinions if I have concerns as to the nature of my symptoms and treatment options.

I have read, or have had read to me, the above consent. I have also had an opportunity to ask questions about its content, and by signing below I agree to the above-named procedures. I intend this consent to cover the entire course of treatment for my present condition and for any future condition(s) for which I seek treatment.

**Patient Signature: _____Date: _____**

**(If patient is a minor, signature of parent/guardian)**

**RHC Health Services, LLC d/b/a Harbor Chiropractic**: **IRREVOCABLE ASSIGNMENT OF INSURANCE BENEFITS, RELEASE, & DEMAND**

**Insurer and Patient Please Read the Following in its Entirety Carefully**!

I, the undersigned patient/insured knowingly, voluntarily, and intentionally irrevocably assign the rights and benefits of my automobile Insurance, also known as Personal Injury Protection (hereinafter PIP), Uninsured Motorist and Medical Payments policy of insurance to the above health care provider. I understand it is the intention of the provider to accept this assignment of benefits in lieu of demanding payment at the time services are rendered. I understand this document will allow the provider to file suit against an insurer for payment of the insurance benefits or an explanation of benefits and to seek §627.428 damages from the insurer. If the provider's bills are applied to a deductible, I agree this will serve as a benefit to me. This assignment of benefits includes transportation, medications, supplies, overdue interest and any potential claim for common law or statutory bad faith/unfair claims handling. If the insurer disputes the validity of this assignment of benefits, then the insurer is instructed to notify the provider in writing within five days of receipt of this document. Failure to inform the provider shall result in a waiver by the insurer to contest the validity of this document. Failure to inform the provider shall result in a waiver by the insurer to contest the validity of this document. The undersigned directs the insurer to pay the health care provider the maximum amount directly without any reductions & without including the patient's name on the check. To the extent the PIP insurer contends there is a material misrepresentation on the application for insurance resulting in the policy of insurance is declared voided, rescinded, or canceled, I as he named insured under said policy of insurance, hereby assign the right to receive the premiums paid for my PIP insurance to this provider and to file suit for recovery of the premiums. The insurer is directed to issue such a refund check payable to this provider only. Should the medical bills not exceed the premium refunded, then the provider is directed to mail the patient/named insured a check which represents the difference between the medical bills and the premiums paid.

**Disputes:** The insurer is directed by the provider and the undersigned to not issue any checks or drafts in partial settlement of a claim that contain or are accompanied by language releasing the insurer or its insured/patient from liability unless there has been a prior written settlement agreed to by the health provider (specifically the office manager) and the insurer as to the amount payable under the insurance policy. The insured and provider hereby contests and objects to any reductions or partial payments. Any partial or reduced payment, regardless of the accompanying language, issued by the insurer and deposited by the provider shall be done so under protest, at the risk of the insurer, and the deposit shall not be deemed a waiver, accord, satisfaction, discharge, settlement or agreement by the provider to accept a reduced amount as payment in full. The insurer is hereby placed on notice that this provider reserves the right to seek the full amount of the bills submitted. If the PIP insurer states it can pay claims at 200% of the Medicare Fee Schedule or any other fee schedule contained within F.S. 627.736 then the insurer is instructed & directed to provide this provider with a copy of the policy of insurance within 10 days. Any effort by the insurer to pay a disputed debt as full satisfaction must be mailed to the address above, after speaking with the office/billing manager and mailed to the attention of the **Office/Billing Manager.** See Fla. Stat. §673.3111.

**EUOs and IMEs:** If the insurer schedules a defense examination or examination under oath (hereinafter "EUO") the insurer is hereby INSTRUCTED to send a copy of said notification to this provider. The provider or the provider's attorney is expressly authorized to appear at any EUO or IME set by the insurer. The health care provider is not the agent of the insurer or the patient for any purpose.

This assignment applies to both past and future medical expenses and is valid even if undated. A photocopy of this assignment is to be considered as valid as the original. I agree to pay any applicable deductible, co-payments, for services rendered after the policy of insurance exhausts and for any other services unrelated to the automobile accident. The health care provider is given the power of attorney to: endorse my name on any check for services rendered by the above provider; and to request and obtain a copy of any statements or examinations under oath given by patient.

**Release of information:** I hereby authorize this provider to: furnish an insurer, an insurer's intermediary, the patient's other medical providers, and the patient's attorney via mail, fax, or email, with any and all information that may be contained in the medical records; and for my insurance carrier **to send insurance coverage information (declaration sheet & policy of insurance) in writing and telephonically to the above-named provider**; request from any insurer all explanation of benefits (EOBs) for all providers and non-redacted PIP payout sheets; obtain any written and verbal statements the patient or anyone else provided to the insurer; obtain copies of the entire claim file and all medical records, including but not limited to, documents, reports, scans, notes, bills, opinions, X-rays, IMEs, and MRIs, from any other medical provider or any insurer. The provider is permitted to produce my medical records to its attorney in connection with any pending lawsuits. The insurer is directed to keep the patient's medical records from this provider private and confidential. The insurer is not authorized to provide these medical records to anyone without the patient's and the provider's prior express written permission. **PLEASE NOTE: The insurer is not authorized to release protected health information (PHI) to third party vendors that schedule independent medical examinations or independent medical examination physicians.**

**Demand:** Demand is hereby made for the insurer to pay all bills within 30 days without reductions and to mail the latest non-redacted PIP payout sheet and the insurance coverage declaration sheet, and the insurance policy to the above provider within 15 days, as well as notify the provider pursuant to F.S. 627.736(6)(f) when benefits have been exhausted. The insurer is directed to pay the bills in the order they are received. However, if a bill from this provider and a claim from anyone else is received by the insurer on the same day the insurer is directed to not apply this provider's bill to the deductible. If a bill from this provider and claim from anyone else is received by the insurer on the same day then the insurer is directed to pay this provider first before the policy is exhausted. In the event the provider's medical bills are disputed or reduced by the insurer for any reason, or amount, the insurer is to: set aside the entire amount disputed or reduced; escrow the full amount at issue; and not pay the disputed amount to anyone or any entity, including myself, until the dispute is resolved by a Court. Do not exhaust the policy. The insurer is instructed to inform, in writing, the provider of any dispute.

**Certification:** I certify that: I have read and agree to the above; I have not been solicited or promised anything in exchange for receiving health care; I have not received any promises or guarantees from anyone as to the results that may be obtained by any treatment or service; I agree the provider's prices for medical services, treatment and supplies are reasonable and customary.

**Caution: Please read before signing. If you do not completely understand this document please ask us to explain it to you. If you sign below we will assume you understand and agree to the above.**

**Patient Signature: _____Date: _____**

**(If patient is a minor, signature of parent/guardian)**

# Doctor's Lien

To: Attorney/Insurance Carrier
_____
_____
_____
_____

RHC Health Services, LLC
d/b/a Harbor Chiropractic
1813 Manatee Ave W
Bradenton, FL 34205
941-761-1100

Re: Medical Reports and Doctor's Lien

I do hereby authorize the above provider to furnish you with a report of his examination, diagnosis, treatment, prognosis, etc., of myself in regard to the accident in which I was involved.

I hereby authorize and direct you to pay directly to said doctor such sums as may be due and owing him for medical services rendered me both by reason of this accident and by reason of any other bills that are due his office and to withhold such sums from settlement, judgment, or verdict as may be necessary to adequately protect said doctor. And I hereby further give a lien on my case to said doctor against any and all proceeds of any settlement, judgment, or verdict which may be paid to you or myself as the result of the injuries for which I have been treated or injuries in connection herewith.

I fully understand that I am directly and fully responsible to said doctor for all medical bills submitted by him for service rendered to me and that this agreement is made solely for said doctor's additional protection and in consideration of his awaiting payment. And I further understand that such payment is not contingent on any settlement, judgment, or verdict by which I may eventually recover said fee.

**Patient Name : _____**
**Patient Signature: _____ Date: _____**
**(If patient is a minor, signature of parent/guardian)**

The undersigned does hereby agree to observe all the terms of the above and agrees to withhold such sums from any settlement, judgment, or verdict as may be necessary to adequately protect said doctor above named.

This lien does not constitute a request or agreement between the parties for the attorney or law firm to act as a collection agency for the above-named doctor/doctor's office.

Attorney Signature: _____ Date: _____

**Name:** _____ **Date:** _____

**CURRENT COMPLAINT(S):**

Please answer each section for each individual symptom. (i.e.: Low back pain and neck pain would be completed separately) If only one symptom, only complete region #1. If more than 2 regions of complaint, please request an additional sheet.

**#1: Location on body:** _____ **R / L Pain Intensity:** no pain 0 1 2 3 4 5 6 7 8 9 10 worst pain

**When did your symptoms begin?** _____ **How did they begin?** _____

**Are your symptoms a result of:** □ Motor Vehicle Accident □ Work Related Accident □ Other_____
**Current Open Insurance Claim:** □ Yes □ No

**How often do you experience your symptoms?**
□ Constantly: (76-100% of the day) □ Frequently (51-75% of the day) □ Intermittently (26-50% of the day) □ Occasionally (0-25% of the day)

**Is the pain:** □ Not applicable
□ Unaffected by time of day? □ Worse in the morning? □ Worse in the afternoon? □ Worse at night

**What describes the nature of your symptoms?**
□ Ache □ Burning □ Dull □ Sharp □ Stabbing □ Throbbing
□ Weakness □ Numbness/Tingling □ Stiffness □ Other _____ □ Radiates into _____

**Does anything aggravate your pain?** □ No If yes, check below
□ Activity (circle: Heavy / Light / Moderate) □ Bending □ Lifting □ Standing □ Stress
□ Temperature Changes □ Twisting □ Other _____

**Does anything improve your pain?** □ No If yes, check below
□ Cold □ Heat □ Activity □ Lying Down □ OTC Medication □ Postural Changes □ Rest
□ Prescribed Medications □ Stretching □ Support Brace □ Adjustments □ Other _____

**#2: Location on body:** _____ **R / L Pain Intensity:** no pain 0 1 2 3 4 5 6 7 8 9 10 worst pain

**When did your symptoms begin?** _____ **How did they begin?** _____

**Are your symptoms a result of:** □ Motor Vehicle Accident □ Work Related Accident □ Other_____
**Current Open Insurance Claim:** □ Yes □ No

**How often do you experience your symptoms?**
□ Constantly: (76-100% of the day) □ Frequently (51-75% of the day) □ Intermittently (26-50% of the day) □ Occasionally (0-25% of the day)

**Is the pain:** □ Not applicable
□ Unaffected by time of day? □ Worse in the morning? □ Worse in the afternoon? □ Worse at night

**What describes the nature of your symptoms?**
□ Ache □ Burning □ Dull □ Sharp □ Stabbing □ Throbbing
□ Weakness □ Numbness/Tingling □ Stiffness □ Other _____ □ Radiates into _____

**Does anything aggravate your pain?** □ No If yes, check below
□ Activity (circle: Heavy / Light / Moderate) □ Bending □ Lifting □ Standing □ Stress
□ Temperature Changes □ Twisting □ Other _____

**Does anything improve your pain?** □ No If yes, check below
□ Cold □ Heat □ Activity □ Lying Down □ OTC Medication □ Postural Changes □ Rest
□ Prescribed Medications □ Stretching □ Support Brace □ Adjustments □ Other _____

**If there are MORE regions of complaint, please request additional sheet from one of our chiropractic assistants.**

**Name:** _____ **Date:** _____

**Social History:** (Check all that apply to you)

Tobacco Use: □ Current tobacco use □ Not a current tobacco user □ Never a tobacco user
Alcohol Use: □ None □ Light/Moderate □ Heavy □ Former Alcoholic
Activity Level: □ None □ Light □ Moderate □ Vigorous

**Hospitalizations:**_____

**Surgeries:** _____

**Prior Accidents/Injuries:**_____

**Past Medical History/Current Conditions** (Check any/all that apply to you)

□ Arthritis □ Cancer □ Diabetes □ Heart Disease □ High Blood Pressure □ Stroke
□ Psychiatric Illness □ Skin Disorder □ Fibromyalgia □ Asthma □ Osteopenia/Osteoporosis
□ Other: _____

**Current Medications/Supplements: Please List:** _____

**Allergies:** _____

**Family History (If known):**

□ Arthritis □ Cancer □ Diabetes □ Heart Disease □ High Blood Pressure □ Stroke □ Other: _____

**Previous Chiropractic Care:** □ Yes □ No If yes, Doctor's Name_____

Date of last chiropractic visit_____ Reason for Care_____

Date of last chiropractic x-rays _____ How long were you under care? _____

Preferred Method of Adjusting (if applicable): □ Manual/Hands On □ Instrument

**Previous Tests:** □ MRI □ X-Rays □ CT

Region, Date, and Results: _____

**WOMEN ONLY:** Are you pregnant or possibility of being pregnant? □ Yes □ No □ Uncertain (LMP: ____)

If yes, due date: _____

**Name:** _____ **Date:** _____

**Review of Systems** (Check box if you have/have had trouble with any of the following. Leave blank if not applicable)

| **General** | **Have** | **Had** | **HEENT** | **Have** | **Had** | **Skin/Hair** | **Have** | **Had** |
|---|---|---|---|---|---|---|---|---|
| Lethargy/Weakness | | | Headaches/Migraines | | | Rashes/Skin Trouble | | |
| Recurring Fever | | | Eye/Vision Problem | | | Flushing | | |
| Weight Loss/Gain | | | Nose Bleeds | | | Excess Acne | | |
| Dizziness | | | Sore Throat | | | Eczema | | |
| Fever | | | Hoarseness | | | Psoriasis | | |
| Chills | | | Swollen glands | | | Skin Cancer | | |
| | | | Sinus Trouble | | | Skin Color Change | | |
| **Cardiovascular:** | | | Ear/Hearing Problem | | | Change in hair/nail | | |
| Chest Pain/Pressure | | | Dental Problems | | | Easy Bruising | | |
| Heart Attack | | | TMJ Problems | | | | | |
| Shortness of Breath | | | | | | **Gastrointestinal** | | |
| Palpitations | | | **Respiratory** | | | Loss of Appetite | | |
| Swelling hands/feet | | | Chronic Cough | | | Nausea/Vomiting | | |
| Hypertension (HBP) | | | Asthma/Wheezing | | | Diarrhea | | |
| High Cholesterol | | | Short of Breath | | | Constipation | | |
| Heart Murmur | | | Exercise Intolerance | | | Abdominal Pain | | |
| Blood Clots | | | Sleep Apnea | | | Ulcers | | |
| Pacemaker | | | Emphysema | | | Bloating/Cramping | | |
| Mitral Valve Prolapse | | | | | | Heartburn | | |
| | | | **Musculoskeletal** | | | Hemorrhoids | | |
| **Neurologic** | | | Arthritis | | | Hepatitis | | |
| Frequent Headache | | | Joint Pain/Swell | | | Cirrhosis | | |
| Migraines | | | Neck Pain | | | Gastric Reflux | | |
| Dizziness | | | Back Pain | | | Bowel/Bladder Issues | | |
| Fainting | | | Trauma | | | | | |
| Memory Loss | | | Osteoporosis | | | **Blood/Lymph** | | |
| Poor Balance | | | Scoliosis | | | Anemia | | |
| Numbness/tingling | | | Cramping | | | Bleeding | | |
| Pins/Needles | | | | | | Bruising | | |
| Muscle Weakness | | | **Endocrine** | | | Blood Clots | | |
| Seizures | | | Diabetes | | | Past Transfusions | | |
| Stroke | | | Thyroid Problems | | | Leukemia | | |
| Tremors | | | Sweating | | | Lymphoma | | |
| Head Injury | | | Hot/Cold Intolerance | | | HIV/AIDS | | |
| | | | Weight Loss | | | Sickle Cell | | |
| **Psychiatric** | | | Weight Gain | | | | | |
| Insomnia | | | Excess Urination | | | **Urinary** | | |
| Diff Concentrating | | | Excess thirst | | | Excess/Pain Urination | | |
| Memory Loss/Confusion | | | Appetite Change | | | Incontinence | | |
| Depression | | | | | | Urgency | | |
| Anxiety | | | **Female** | | | Kidney Stones | | |
| Agitation/Irritability | | | Menstrual Irregularity | | | | | |
| | | | Hot Flashes | | | **Male** | | |
| **Allergies** | | | Breast Pain/Lumps | | | Testicular Pain/Lumps | | |
| Seasonal | | | Menopause | | | Prostate Disease | | |
| Food | | | | | | | | |
| Medication | | | | | | | | |

**Name:** _____ **Date:** _____

Rate your current difficulties by placing the appropriate number in the box (below; a **1 / 2 / 3**). NO check marks! If an activity does not cause pain or if pain does not affect an activity, leave box **blank**.

**[1]** This activity causes some pain, but it is of minor annoyance.
**[2]** This activity causes a significant amount of pain.
**[3]** I cannot perform this activity due to pain and disability.

**Self-Care and Personal Hygiene:** ___bathing ___brushing teeth ___putting on shoes ___doing laundry ___grooming hair ___making bed ___putting on pants ___doing dishes ___washing face ___putting on shirt ___cooking ___taking out trash ___going to bathroom or sitting on toilet

**Physical Activities:** ___standing ___walking ___reaching ___bending right ___twisting right ___sitting ___squatting ___bending ___bending left ___twisting left ___reclining ___bending back ___kneeling ___looking left ___looking right

**Functional Activities:** ___carrying small objects ___lifting weight off table ___push/pull standing ___carrying large objects ___climbing stairs/incline ___exercising upper body ___exercising lower body ___carrying purse/case ___lifting objects off floor ___push/pull seated

**Social & Recreational Activities:** ___jogging ___biking ___swimming ___dancing ___golfing ___bowling ___hunting ___fishing ___gardening ___basketball ___soccer ___hockey ___competitive sports

**Difficulties with Travel:** ___driving in car ___riding as passenger ___entering and exiting vehicle ___driving for long periods of time ___riding as passenger for long period of time

**Other Activities:** ___concentrating ___studying ___listening ___reading ___writing ___using computer ___sleeping ___sexual relation

**How does your condition interfere with the things you do every day? Please think about the 4 following areas and make notes on how these daily activities have been affected since the condition began.**

**HOME:** _____

_____

**WORK:** _____

_____

**RECREATION:** _____

_____

**PERSONAL LIFE:** _____

_____

**Name:** _____ **Date:** _____

## *NECK PAIN (if applicable)*

***Neck Disability Index***

This questionnaire has been designed to give the doctor information as to how your NECK pain has affected your ability to manage in everyday life. In each section, please circle the choice which **most closely** describes your problem.

**Section 1 – Pain Intensity**

- ❑ I have no pain at the moment.
- ❑ The pain is mild at the moment.
- ❑ The pain comes and goes and is moderate.
- ❑ The pain is moderate and does not vary much.
- ❑ The pain is very severe but comes and goes.
- ❑ The pain is severe and does not vary much.

**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, 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 only 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 neck pain.
- ❑ I can read as much as I want to with slight neck pain.
- ❑ I can read as much as I want with moderate neck pain.
- ❑ I cannot read as much as I want because of moderate neck pain.
- ❑ I cannot read as much as I want because of severe neck pain.
- ❑ I cannot read at all.

**Section 5 – Headaches**

- ❑ I have no headaches at all.
- ❑ I have slight headaches that 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 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 neck pain.
- ❑ I can drive my car as long as I want with moderate pain
- ❑ 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 neck pain.
- ❑ I cannot drive my car at all.

**Section 9 – Sleeping**

- ❑ I have no trouble sleeping.
- ❑ My sleep is slightly disturbed (< 1 hour sleepless).
- ❑ My sleep is mildly disturbed (1-2 hours sleepless).
- ❑ My sleep is moderately disturbed (2-3 hours sleepless).
- ❑ My sleep is greatly disturbed (3-5 hours sleepless).
- ❑ My sleep is completely disturbed (5-7 hours 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.

**Name:** _____ **Date:** _____

## *LOWER BACK PAIN (if applicable)*

***Oswestry Disability Index***

This questionnaire has been designed to give the doctor information as to how your low back pain has affected your ability to manage in everyday life. In each section, please circle the choice 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, 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 (i.e. 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 cannot lift or carry anything.

**Section 4 – Walking**
- ❑ Pain does not prevent me walking any distance.
- ❑ Pain prevents me walking more than 1mile.
- ❑ Pain prevents me walking more than 1/2 of a mile.
- ❑ Pain prevents me walking more than 100 yards.
- ❑ I can only walk using a stick or crutches.
- ❑ I am in bed most of the time.

**Section 5 – Sitting**
- ❑ I can sit in any chair as long as I like.
- ❑ I can sit in my favorite chair as long as I like.
- ❑ Pain prevents me from sitting for more than 1 hr.
- ❑ Pain prevents me from sitting for more than 30 min.
- ❑ Pain prevents me from sitting for more than 10 min.
- ❑ Pain prevents me from sitting at all.

**Section 6 – Standing**
- ❑ I can stand as long as I want without extra pain.
- ❑ I can stand as long as I want but it gives me extra pain.
- ❑ Pain prevents me from standing more than 1 hour.
- ❑ Pain prevents me from standing for more than 30 min.
- ❑ Pain prevents me from standing for more than 10 min.
- ❑ Pain prevents me from standing at all.

**Section 7 – Sleeping**
- ❑ My sleep is never disturbed by pain.
- ❑ My sleep is occasionally disturbed by pain.
- ❑ Because of pain, I have less than 6 hours sleep.
- ❑ Because of pain, I have less than 4 hours sleep.
- ❑ Because of pain, I have less than 2 hours sleep.
- ❑ Pain prevents me from sleeping at all.

**Section 8 – Sex life (if applicable)**
- ❑ My sex life is normal and causes no extra pain.
- ❑ My sex life is normal but causes some extra pain.
- ❑ My sex life is nearly normal but is very painful.
- ❑ My sex life is severely restricted by pain.
- ❑ My sex life is nearly absent because of pain.
- ❑ Pain prevents any sex life at all.

**Section 9 – Social Life**
- ❑ My social life is normal and cause me no extra pain.
- ❑ My social life is normal but increases the degree of pain.
- ❑ Pain has no significant effect on my social life apart from limiting my more energetic interests, i.e. sport.
- ❑ Pain has restricted my social life and I do not go out as often.
- ❑ Pain has restricted social life to my home.
- ❑ I have no social life because of pain.

**Section 10 – Traveling**
- ❑ I can travel anywhere without pain.
- ❑ I can travel anywhere but it gives extra pain.
- ❑ Pain is bad but I manage journeys of over 2 hours.
- ❑ Pain restricts me to journeys of less than 1 hour.
- ❑ Pain restricts me to short necessary journeys under 30 min.
- ❑ Pain prevents me from traveling except to receive treatment.

**Name:** _____ **Date:** _____

**PIP Insurance Information**

Your Insurance Company _____
Insurance Company Address_____
Have you been contacted by an insurance adjustor regarding this claim? □Yes □No
If yes, name of adjustor: _____Phone Number: _____
Claim Number: _____
Do you have an attorney that has advised you in this case? □Yes □No
If yes: Attorney's name_____
Address_____
Phone Number: _____

**Patient Signature: _____Date: _____**
**(If patient is a minor, signature of parent/guardian)**

***MOTOR VEHICLE COLLISION / PERSONAL INJURY QUESTIONNAIRE***

Date of Accident: _____ Time of Accident: _____ Location: _____

Make and Model of the vehicle you were in: _____

Were you wearing a seat belt? □Yes □No

Did your car impact another vehicle? □Yes □No If yes, explain: _____

Make and Model of OTHER vehicle: _____

Were you**:** □Driver □Front Passenger □Rear Left Passenger □Rear Right Passenger □Pedestrian

Did any part of your body strike anything in the vehicle? □Yes □No
If yes, describe: □Head Rest □Steering Wheel □Side Window □Other _____

Was impact from: □Front □Rear □Left □Right □Other _____

Was the air bag deployed? □Yes □No

At the time of impact were you:
□Looking straight ahead □Looking right □Looking left □Looking up □Looking down

Were you: □Surprised by impact □Braced for impact

Was a traffic violation issued? □Yes □No If yes, to whom? _____

Accident Description: _____
_____
_____

**Name:** _____ **Date:** _____

Did you lose consciousness? ☐Yes ☐No Were you able to walk unaided? ☐Yes ☐No

Immediately following the accident, did you feel any of the following? ☐No
☐Dizzy ☐Weak ☐Nauseated ☐Dazed ☐Nervous ☐Disoriented

Immediately following the accident, where did you go?
☐Drove home ☐Was driven home ☐Drove to work ☐Was driven to work ☐Drove to school
☐Was driven to school ☐Drove to hospital ☐Was driven to hospital ☐Taken to hospital via EMS

If you went to the hospital, which one? _____

If you DID NOT go immediately to the hospital, when did you go? _____

Were you admitted? ☐Yes ☐No If yes, how long? _____

To the best of your knowledge what was done at the hospital? ☐Exam ☐Stitches ☐X-rays ☐CT
☐Medications prescribed, What type? _____

If you DID NOT go to the hospital, did you consult another physician before you came to this office? ☐Yes ☐No

If yes, Name of Doctor consulted: _____ Are you still under his/her care? ☐Yes ☐No

Did you see any other doctor for follow up? ☐Yes ☐No
If yes, please answer: ☐Neurologist ☐Orthopedic Surgeon ☐Family Doctor
Please provide doctor names: _____

Did you have any special tests performed? ☐Yes ☐No
☐MRI ☐CT ☐EMG ☐Bone Scan ☐Nerve Tests ☐Other: _____

Did your major complaints exist prior to the accident? ☐Yes ☐ No

Since the accident, is your pain getting worse: ☐Yes ☐ No ☐No improvement ☐Little improvement

In what areas did you IMMEDIATELY feel pain?

| | | | | | | | |
|---|---|---|---|---|---|---|---|
| ☐Head | Shoulder | ☐Left | ☐Right | Buttock | ☐Left | ☐Right |
| ☐Neck | Arm | ☐Left | ☐Right | Hip | ☐Left | ☐Right |
| ☐Upper back | Elbow | ☐Left | ☐Right | Thigh | ☐Left | ☐Right |
| ☐Mid back | Wrist | ☐Left | ☐Right | Knee | ☐Left | ☐Right |
| ☐Ribs | Hand | ☐Left | ☐Right | Calf | ☐Left | ☐Right |
| ☐Chest | Fingers | ☐Left | ☐Right | Ankle | ☐Left | ☐Right |
| ☐Abdomen | | | | Foot | ☐Left | ☐Right |
| ☐Low Back | | | | Toes | ☐Left | ☐Right |
| ☐Pelvis | | | | | | |

Did you experience lacerations (cuts)? If so, where? _____

**Name:** _____ **Date:** _____

Check symptoms you have noticed since the accident:

| | | | | |
|---|---|---|---|---|
| □Headaches | □Neck Pain | □Upper Back Pain | □Mid Back Pain | □Low Back Pain |
| □Rib Pain | □Chest Pain | □Shoulder Pain | □Depression | □Dizziness |
| □Fatigue | □Irritability | □Fever | □Nervousness | □Paralysis |
| □Tension | □Fainting | □Sciatica | □Sinus Pain | □Sore Muscles |
| □Menstrual Problems | □Pinched Nerve | □Loss of Sleep | □Loss of Balance | □Light Bothers Eyes |
| □Jaw Pain/Clicking | □Buzzing in Ears | □Arm/Leg Pain | □Numbness/Tingling | □Loss of Memory |
| □Cold Hands/Feet | □Loss of Smell | □Digestive Issues | □Stomach Upset | □Joint Pain/Stiffness |
| □Vision Problems | □Urinary Problems | □Sleeping Issues | □Pins/Needles Feeling | |
| □Difficulty Swallowing | | □Head Feels Too Heavy | □Other: _____ | |

Before injury, were you capable of working on an equal basis with others your age? □Yes □ No

Are your work activities restricted because of this accident? □Yes □ No

Have you lost time from work? □Yes □No □Haven't returned to work at this time

□Returned to work on: _____ □Dates of disability: From: _____ to _____

**Patient Signature:** _____**Date:** _____

**(If patient is a minor, signature of parent/guardian)**