Patient Intake Pt. ID:_____ Oxy %:____ Pulse:____ Ht:____ Wt:___ New Spring Chiropractic, Palm Coast, FL

Legal Name: First _____ Middle: _____ Last _____ Preferred: _____

Date of Birth ____/____/____ Gender ☐M ☐F Marital Status: ☐S ☐M ☐D ☐W SSN: ____-____-____

Home Address: _____ City: _____ State: _____ Zip Code: _____

Home Phone: _____ Cell Phone: _____ ☐ I wish to be opted-out of text reminders.

Email _____ Do you wish to receive email appointment reminders? ☐Y ☐N

Whom may we thank for referring you? _____ Employed? ☐Y ☐N Employer: _____

Have you seen a chiropractor? ☐Y ☐N *If yes, who was the last chiropractor you saw? _____

Emergency Contact Name _____ Emergency Contact Phone Number _____

Please read, sign and date:

- I understand that I am financially responsible to New Spring Chiropractic for all charges incurred and not covered by insurance.
- I understand any balances over 30 days are subject to accrued interest of 1.5 percent per month.
- I have read all information in this sheet and have completed the above answers. I certify that this information is true and correct to the best of my knowledge. I will notify you of any changes in my status of the above information.
- I agree to notify staff immediately if my contact number changes and will not hold New Spring Chiropractic responsible for text messages that are sent to the wrong number because of lack of notification.

Patient Signature _____ ☐Parent (if minor) Date: _____

I agree to pay a no-call, no-show fee of $25 on subsequent appointments if I have a scheduled appointment and don't show up. (Reschedules are always welcome.)

Patient Signature _____ ☐Parent (if minor) Date: _____

Reason For Seeking Care (please mark diagram below where pain is present)

1: _____ What event caused the problem? _____

Date problem began: ____/____/____ What makes it worse? _____

What makes it better? _____ Quality: ☐Aching ☐Stabbing ☐Burning ☐Pins and Needles

Rate severity on a scale of 0 to 10: ____ ☐Has been getting worse ☐Staying the same **Frequency:** ☐Intermittent ☐Constant

2: _____ What event caused the problem? _____

Date problem began: ____/____/____ What makes it worse? _____

What makes it better? _____ Quality: ☐Aching ☐Stabbing ☐Burning ☐Pins and Needles

Rate severity on a scale of 0 to 10: ____ ☐Has been getting worse ☐Staying the same **Frequency:** ☐Intermittent ☐Constant

3: _____ What event caused the problem? _____

Date problem began: ____/____/____ What makes it worse? _____

What makes it better? _____ Quality: ☐Aching ☐Stabbing ☐Burning ☐Pins and Needles

Rate severity on a scale of 0 to 10: ____ ☐Has been getting worse ☐Staying the same **Frequency** ☐Intermittent ☐Constant

Mark if you are experiencing: ☐Dizziness ☐Visual Disturbances

• Mark if any of the below activities are affected:

☐ Work: Severity 0-10 ____ w/ bending forward/backward/left/right

☐ Bathing: Severity 0-10 ____ w/ bending forward/backward/left/right

☐ Cooking: Severity 0-10 ____ w/ bending forward/backward/left/right

☐ Yardwork: level 0-10 ____ w/ bending forward/backward/left/right

☐ Dressing: Severity 0-10 ____ forward/backward/left/right

☐ Sleep: Severity 0-10 ____ forward/backward/left/right

☐ Cleaning: Severity 0-10 ____ forward/backward/left/right

☐ Maintenance:Severity 0-10 ____ orward/backward/left/right

Do you have any numbness or radiating pain? ☐Y ☐N

If yes, please describe: _____

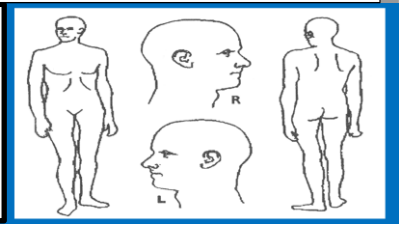
Previous treatments and outcome: _____

Primary Care Physician: _____

Are you pregnant?

☐**Y** ☐**N**

Due Date: _____



REVIEW OF SYSTEMS- Mark Any of These Problems you have NOW or in the PAST– Mark NO if none apply

Cardiovascular	Past	Present	No	**Respiratory**	Past	Present	No	**Allergic/Immunologic**	Past	Present	No
Poor Circulation	☐	☐	☐	Asthma	☐	☐	☐	Hives	☐	☐	☐
Hypertension	☐	☐	☐	Tuberculosis	☐	☐	☐	Immune Disorder	☐	☐	☐
Aortic Aneurism	☐	☐	☐	Short Breath	☐	☐	☐	HIV/AIDS	☐	☐	☐
Heart Disease	☐	☐	☐	Emphysema	☐	☐	☐	Allergy Shots	☐	☐	☐
Heart Attack	☐	☐	☐	Cold/Flu	☐	☐	☐	Cortisone Use	☐	☐	☐
Chest Pain	☐	☐	☐	Cough	☐	☐	☐				
High Cholesterol	☐	☐	☐	Wheezing	☐	☐	☐	**Ear, Nose and Throat**	Past	Present	No
Pace Maker	☐	☐	☐					Difficulty Swallowing	☐	☐	☐
Jaw Pain	☐	☐	☐	**Eyes**	Past	Present	No	Dizziness	☐	☐	☐
Irregular Heartbeat	☐	☐	☐	Glaucoma	☐	☐	☐	Hearing Loss	☐	☐	☐
Swelling of legs	☐	☐	☐	Double Vision	☐	☐	☐	Sore Throat	☐	☐	☐
Genitourinary	Past	Present	No	Blurred Vision	☐	☐	☐	Nosebleeds	☐	☐	☐
Kidney Disease	☐	☐	☐	**Psychiatric**	Past	Present	No	Bleeding Gums	☐	☐	☐
Burning Urination	☐	☐	☐	Depression	☐	☐	☐	Sinus Infections	☐	☐	☐
Frequent Urination	☐	☐	☐	Anxiety	☐	☐	☐	**Gastrointestinal**	Past	Present	No
Blood in Urine	☐	☐	☐	Stress	☐	☐	☐	Gall Bladder Problems	☐	☐	☐
Kidney Stones	☐	☐	☐					Bowel Problems	☐	☐	☐
Lower Side Pain	☐	☐	☐	**Endocrine**	Past	Present	No	Constipation	☐	☐	☐
Neurologic	Past	Present	No	Thyroid	☐	☐	☐	Liver Problems	☐	☐	☐
Stroke	☐	☐	☐	Diabetes	☐	☐	☐	Ulcers	☐	☐	☐
Seizures	☐	☐	☐	Hair Loss	☐	☐	☐	Diarrhea	☐	☐	☐
Head Injury	☐	☐	☐	Menopausal	☐	☐	☐	Nausea/Vomiting	☐	☐	☐
Brain Aneurysm	☐	☐	☐	Menstrual	☐	☐	☐	Bloody Stools	☐	☐	☐
Numbness	☐	☐	☐					Poor Appetite	☐	☐	☐
Severe Headaches	☐	☐	☐	**Hematologic**	Past	Present	No	**Musculoskeletal**	Past	Present	No
Pinched Nerves	☐	☐	☐	Hepatitis	☐	☐	☐	Gout	☐	☐	☐
Parkinson's	☐	☐	☐	Blood Clots	☐	☐	☐	Arthritis	☐	☐	☐
Carpal Tunnel	☐	☐	☐	Cancer	☐	☐	☐	Joint Stiffness	☐	☐	☐
Vertigo	☐	☐	☐	Bruising	☐	☐	☐	Muscle Weakness	☐	☐	☐
Constitutional	Past	Present	No	Bleeding	☐	☐	☐	Osteoporosis	☐	☐	☐
Weight Loss/Gain	☐	☐	☐	Fever, Chills	☐	☐	☐	Broken Bones	☐	☐	☐
Low Energy Level	☐	☐	☐	Sweating	☐	☐	☐	Joints Replaced	☐	☐	☐

GENERAL HEALTH HISTORY

Please list any surgeries and approximate date: _____

Medications: ☐ None ☐ Yes: Start Date Brand Name Dosage Condition

_____

_____

_____

FAMILY HISTORY

Mother's side: ☐ **Cancer** ☐ **Diabetes** ☐ **Heart Disease** ☐ **Mental Health** ☐ **Stroke** ☐ **Headaches** ☐ **Other:** _____

Father's side: ☐ **Cancer** ☐ **Diabetes** ☐ **Heart Disease** ☐ **Mental Health** ☐ **Stroke** ☐ **Headaches** ☐ **Other:** _____

Any other blood relatives with similar conditions? _____

SOCIAL HISTORY (check all that are true) ☐ Sexually active ☐ Currently use tobacco ☐ Formerly used tobacco

☐ Balanced diet ☐ Eat fast food ☐ Take vitamins ☐ Exercise regularly ☐ Sleep well ☐ Sleep poor ☐ Drink alcohol ☐ Use Drugs

Informed Consent for Treatment

I hereby request and consent to the performance of chiropractic adjustments and other chiropractic procedures, to include, but not limited to, various modes of physical therapy, diagnostic x-rays and spinal decompression, physical examination, or any other medical procedures on me (or on the patient named below, for whom I am legally responsible) by the doctor of chiropractic named below and/or other licensed doctors of chiropractic who now or in the future treat me while employed by, working, or associated with, or serving as back-up for the chiropractor named below, including those working at the clinic or office listed below or any other office or clinic associated with the following clinic: New Spring Chiropractic

Chiropractic care centrally involves what is known as a chiropractic adjustment. There may be additional supportive procedures or recommendations as well. When providing an adjustment, we use our hands or an instrument to reposition anatomical structures, such as vertebrae. Potential benefits of an adjustment include restoring normal joint motion, reducing swelling and inflammation in a joint, reducing pain in the joint, and improving neurological functioning and overall well-being.

I have had an opportunity to discuss with the doctor of chiropractic named below the nature and purpose of chiropractic adjustments and other procedures. I understand that results are not guaranteed.

I understand and am informed that, as in the practice of medicine, in the practice of chiropractic there are some risks to treatment including, but not limited to, fractures, disc injuries, strokes, dislocations and sprains. 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 judgement during the course of the procedure which the doctor feels at the time, based upon the facts then known, and is in my best interest. Alternative treatments may include: medication, surgery, or physical therapy procedures. As with any of these alternative procedures there are risks. If no treatment is sought, your condition could get worse, remain the same, or improve.

I have read, or have had read to me, the above consent. I appreciate that it is not possible to consider every possible complication to care. I have also had an opportunity to ask questions about its content, and by signing below, I agree with the current or future recommendation to receive chiropractic care as is deemed appropriate for my circumstance. I intend this consent to cover the entire course of care from all providers in this office for my present condition and for any future condition(s) for which I seek chiropractic care from this office.

Patient Name: _____ Signature: _____ Date: _____

Parent or Guardian: _____ Signature: _____ Date: _____

Witness Name: _____ Signature: _____ Date: _____

HIPAA Compliance Acknowledgement of Receipt

We respect our legal obligation to keep health information that identifies you private. We are obligated by law to give you notices of our privacy practice. We protect your health information and what rights you have regarding it, if we need to disclose your health information outside of our office for these reasons we will ask for your written permission. If you would like a copy of this policy please feel free to ask for one.

I acknowledge that I have reviewed this policy and that I was offered a copy of the "Notices of Privacy Practices."

Signature: _____ Date: _____

Release of Information Authorization- I hereby authorize New Spring Chiropractic to release information.

Information to Be Used or Disclosed- The information covered by this authorization includes:

☒ Healthcare and Financial Records (Healthcare records include examination findings, diagnoses, treatments, lab/imaging results)
☐ Healthcare records
☐ Financial Records

Persons to Whom Information May Be Disclosed- Information described above may be disclosed to:

☒ All of the Following:
☐ Primary Insurance Carrier
☐ Secondary Insurance Carrier
☐ Other Healthcare Provider as described above
☐ Personal Attorney
☐ Guardian/ Parent
☐ Spouse
☐ Release to: _____

Signature: _____ Date: _____

Assignment of Benefits and Direction to Pay Benefits Owed

I, the undersigned insured or beneficiary of an insurance policy, irrevocably assign to **New Spring Chiropractic, Inc.** whatever rights, interest, and benefits I have under any policy of insurance and under Florida law, including, without limitation, any and all claims for attorney's fees, injunctive, declaratory, and equitable relief, and costs, interest and/or damages, pursuant to common law, the Florida or US Constitution, and federal or Florida Statutes, including, but not limited to, § 624.155., *Fla. Stat.* This Assignment of Benefits (AOB) includes an assignment of any potential claim or cause of action for common law or statutory bad faith. If the Insurer disputes the validity of this AOB, then the insurer is instructed to notify the provider in writing within 10 days of receipt of this document. Failure to do so shall result in the provider relying on this AOB for direct payment and could constitute a waiver by the insurer to contest the validity of this document. I do hereby confirm that this AOB is irrevocable and instruct any insurance company or other collateral source for which I am entitled to benefits to pay for monies owed as a result of medical services rendered by **New Spring Chiropractic, Inc.** to promptly make payment in the name of and directly to **New Spring Chiropractic, Inc.** or its chosen billing service.

In the event that any insurance company reduces or denies benefits for services or treatment that **New Spring Chiropractic, Inc.** rendered to me, pursuant to this AOB, **New Spring Chiropractic, Inc.** is authorized to file suit in the Provider's own name or on my behalf and prosecute causes of action or claim I might have or that may exist in my favor against the insurance company and to collect any damages awarded or settlement monies for services rendered, plus interest, costs, reasonable attorney 's fees and a contingency fee multiplier. I further authorize **New Spring Chiropractic, Inc.** to compromise, settle or otherwise resolve any such claim or cause of action as it sees fit. I understand that in any such lawsuit, my name or other identifying information will need to be included in and/or portions of my medical file attached to pleadings and/or formal discovery. I waive any confidentiality of my records and/or information but only to the extent necessary to prosecute a claim for unpaid or owed medical expenses against the insurance company or any other responsible party.

I acknowledge that **New Spring Chiropractic, Inc.** objects to any reductions or partial payments by the Insurer. Any partial or reduced payment, regardless of the accompanying language, issued by the Insurer and deposited by **New Spring Chiropractic, Inc.** shall be done 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. **New Spring Chiropractic, Inc.** reserves the right to seek the full amount of the bill submitted from the insurance company(ies) or me. Accordingly, the insurer is hereby instructed to set aside (escrow) any and all reduced or denied benefit payments for medical services rendered by this provider and not pay the disputed amount to anyone until the dispute is resolved.

I further instruct my insurance company to cooperate with **New Spring Chiropractic, Inc.** in resolving all billing or other disputes. Cooperation includes, but is not limited to, providing any and all declaration pages, PIP logs, payout ledgers, explanations of benefits, copies of checks, and any and all other documents or information to **New Spring Chiropractic, Inc.** or its attorneys, employees or other representatives acting on behalf of **New Spring Chiropractic, Inc..** If the insurer schedules a defense examination, examination under oath (EUO) or Independent Medical Examination (IME) of the patient, the insurer is hereby instructed to send a copy of said notification to this provider and the provider's attorneys. The provider and/or the provider's attorneys are authorized to appear at any patient EUO or IME set by the insurer.

New Spring Chiropractic
2 Pine Lakes Pkwy N, Suite 3
Palm Coast, Florida 32137
(386) 227-7534 / info@newspringchiro.com

THIS ASSIGNMENT OF BENEFITS DOES NOT ASSIGN ANY RIGHTS OR OBLIGATIONS UNDER THE POLICY OF INSURANCE, TO SUBMIT TO AN EUO OR RECORDED STATEMENT. I further direct and authorize the insurance company to speak to an attorney, employee or any other representative of **New Spring Chiropractic, Inc.** or anyone acting on its behalf over the phone and otherwise and to provide them with any and all information the insurance company may have or documentation not previously listed above that they may request.

I, as the patient, agree to remain personally liable for the amounts billed by **New Spring Chiropractic, Inc.** regardless of the amount paid by the insurance company, unless ordered by a court of law. I fully understand that said services or treatment were provided to me in consideration for an unconditional promise to pay and for me providing these instructions to my insurance company. I, as the patient, further agree to be liable for reasonable attorney's fees and costs incurred in collecting any delinquent accounts or unpaid balances. By executing this document, I am placing my insurance company(ies) on notice that the claims for services or treatment rendered by **New Spring Chiropractic, Inc.** are related to my accident (or my covered conditions) and should be paid directly to **New Spring Chiropractic, Inc.** pursuant to this assignment of benefits and applicable law. Any delay in paying benefits owed under the insurance policy could adversely affect me.

ERISA Authorization

I hereby designate the Provider as my Authorized Representative with respect to insurance coverage for health care services, and thereby authorize, and convey to Provider to the full extent permissible under law and under any applicable insurance policy and/or employee health care benefit plan: (1) the right and ability to act on my behalf in connection with any claim, right, or cause in action that I may have under such insurance policy and/or benefit plan; and (2) the right and ability to act on my behalf to pursue such claim, right, or cause of action in connection with said insurance policy and/or benefit plan (including but not limited to, the right to act on my behalf in respect to a benefit plan governed by the provisions of ERISA as provided in 29 C.F.R. §2560.5031(b)(4)) with respect to any healthcare expense incurred as a result of the services I received from Provider and, to the extent permissible under the law, to claim on my behalf, such benefits, claims, or reimbursement, and any other applicable remedy, including fines.

BY EXECUTING THIS DOCUMENT, I AM PLACING MY INSURANCE COMPANY ON NOTICE THAT THIS IS A DIRECT ASSIGNMENT OF BENEFITS PURSUANT TO FLORIDA LAW. AS THE INSURED OR BENEFICIARY OF SAID INSURANCE POLICY, I AM IRREVOCABLY ASSIGNING WHATEVER RIGHTS, INTEREST, AND BENEFITS I HAVE UNDER MY POLICY OF INSURANCE (LESS THE DUTY TO ATTEND AN EUO) AND UNDER FLORIDA LAW TO THIS PROVIDER. **The rights of New Spring Chiropractic, Inc. under this assignment shall not be extinguished upon my death, and my estate shall be subject to the terms and conditions of this AOB and my obligations and representations hereunder. A photocopy of this Assignment/Authorization shall be as effective and valid as the original.**

Patient's Name DOB

Signature of Policy Holder / Date

Name of Policy Holder or Claimant

New Spring Chiropractic, Inc./ Date

New Spring Chiropractic
2 Pine Lakes Pkwy N, Suite 3
Palm Coast, Florida 32137
(386) 227-7534 / info@newspringchiro.com

Duties Performed Under Duress at Work and Home

Patient name _____ Date of Injury _____ Today's Date _____

☐ Initial ☐ Update

Please check all that apply to your WORK because of the accident

- ☐ I go to work but work in pain
- ☐ I limit my work activities
- ☐ Bending at work hurts
- ☐ Stooping at work hurts
- ☐ Sitting at work hurts
- ☐ Using the computer at work hurts
- ☐ Pushing at work hurts
- ☐ Kneeling at work hurts
- ☐ I have lost status in my company
- ☐ I have lost job security
- ☐ I didn't get a promotion
- ☐ I don't enjoy work as much as before
- ☐ I doze off at work
- ☐ I take unpaid time off work to go to Dr.
- ☐ I daydream at work more than before
- ☐ I feel tired at work
- ☐ _____
- ☐ _____

- ☐ I work in pain because I have bills to pay
- ☐ I can't take time off because I would lose my job
- ☐ I keep working so I don't lose status at company
- ☐ My business would fail if I took time off
- ☐ I believe in working even when I'm in pain
- ☐ I feel obligated to work even though I'm in pain
- ☐ My business would lose money if I took time off
- ☐ My work is not as good as it was before accident
- ☐ My boss reprimanded me for poor performance
- ☐ I got a different job within the same company
- ☐ I got a different job in another company
- ☐ I make less money than before the accident
- ☐ I cannot do the same work/job as before accident
- ☐ I can't concentrate as well at work
- ☐ I take paid time off to go to Dr.
- ☐ I make mistakes at work I didn't use to
- ☐ I hide my poor work performance from my boss
- ☐ _____
- ☐ _____

Please check all that apply to your HOME/DOMESTIC because of the accident

- ☐ My house is not as clean now
- ☐ My yard is not as neat now
- ☐ My garden is not as productive now
- ☐ I do yard work, but do it in pain
- ☐ I cannot do my normal yard work
- ☐ I do house work, but do it in pain
- ☐ I cannot do my normal house work
- ☐ Doing laundry hurts me
- ☐ I cannot do laundry now
- ☐ Washing dishes hurts me
- ☐ I cannot vacuum now
- ☐ Cooking hurts me
- ☐ I cannot cook now
- ☐ Washing the car hurts me
- ☐ I cannot wash my car
- ☐ _____
- ☐ _____

- ☐ I cannot take time off because I care for children
- ☐ I have _____ children ages _____
- ☐ I had to hire a paid housekeeper
- ☐ I asked someone for unpaid housekeeping help
- ☐ I had to hire a paid gardener
- ☐ I asked someone for unpaid yard work help
- ☐ Mowing the lawn hurts me
- ☐ I cannot mow the lawn
- ☐ Taking out the trash hurts me
- ☐ I cannot take out the trash
- ☐ I do not enjoy my gardening/yardwork like I used to
- ☐ I do not enjoy my housework like I used to
- ☐ Gardening hurts me
- ☐ I cannot do my gardening at all since the accident
- ☐ Others living with me do my share of the work now
- ☐ Others living with me do my share of the yard now
- ☐ Others living with me do my share of the gardening
- ☐ _____

_____ _____

Signature Date

Loss of Enjoyment of Sports, Hobbies, Travel, Daily activities, & School (1 of 2 pages)

Patient's name _____ Date of Injury _____ Today's date _____

☐ Initial ☐ Update

Please check all that apply to your EXERCISE & SPORTS Activity because of the accident

- ☐ My exercise was affected by this crash
- ☐ I go to the gym & work out in pain
- ☐ I no longer go to the gym to work out
- ☐ I run but in pain
- ☐ I no longer run
- ☐ I take walks & have pain while walking
- ☐ I no longer take walks
- ☐ I used to make income at sports
- ☐ I have lost sports income since crash
- ☐ I am an amateur athlete
- ☐ I am a professional athlete
- ☐ _____
- ☐ _____

- ☐ I have gained _____ pounds since the accident
- ☐ I had to quit my _____ team after the accident
- ☐ I had to quit my _____ team after the accident
- ☐ I had to quit my _____ team after the accident
- ☐ I had to quit my _____ team after the accident
- ☐ I don't enjoy the sport of _____ anymore
- ☐ I didn't enjoy the sport of _____ for _____ weeks
- ☐ I don't enjoy the sport of _____ anymore
- ☐ I didn't enjoy the sport of _____ for _____ weeks
- ☐ I don't enjoy the sport of _____ anymore
- ☐ I didn't enjoy the sport of _____ for _____ weeks
- ☐ I don't enjoy the sport of _____ anymore
- ☐ I didn't enjoy the sport of _____ for _____ weeks

Please check all that apply to your HOBBY Activities because of the accident

- ☐ My hobbies were affected by accident
- ☐ Hobby #1 _____
- ☐ I can't do hobby #1 anymore
- ☐ I do hobby #1 but in pain
- ☐ I have lost money from not doing #1
- ☐ I didn't do hobby #1 for _____ weeks
- ☐ Hobby #2 _____
- ☐ I can't do hobby #2 anymore
- ☐ I do hobby #2 but in pain
- ☐ I have lost money from not doing #2
- ☐ I didn't do hobby #2 for _____ weeks

- ☐ Hobby #3 _____
- ☐ I can't do hobby #3 anymore
- ☐ I do hobby #3 but in pain
- ☐ I have lost money from not doing #3
- ☐ I didn't do hobby #3 for _____ weeks
- ☐ Hobby #4 _____
- ☐ I can't do hobby #4 anymore
- ☐ I do hobby #4 but in pain
- ☐ I have lost money from not doing #4
- ☐ I didn't do hobby #4 for _____ weeks
- ☐ _____

Please check all that apply to your TRAVEL Activities because of the accident

- ☐ Business travel was affected by crash
- ☐ Pleasure travel was affected by crash
- ☐ I hurt driving in my own car
- ☐ I am in too much pain to drive
- ☐ I hurt when a passenger in a car
- ☐ I am in too much pain to sit in a car
- ☐ I have anxiety when I'm in a car
- ☐ I hurt when I'm on an airplane
- ☐ I am in too much pain too much pain to travel by plane

- ☐ Travel Plan #1
- ☐ I did not go on travel plan #1
- ☐ I went, but did not enjoy #1 as much
- ☐ I went and the accident had no effect on #1
- ☐ Travel Plan #2
- ☐ I did not go on travel plan #2
- ☐ I went, but did not enjoy #2 as much
- ☐ I went and the accident had no effect on #2
- ☐ I missed time with my family/friends b/c can't travel

Loss of Enjoyment of Sports, Hobbies, Travel, Daily activities, & School (2 of 2 pages)

Patient's name _____ Date of Injury _____ Today's date _____

☐ Initial ☐ Update

Please check all the DAILY LIVING activities that cause you pain because of the accident

- ☐ Dressing
- ☐ Putting on pants
- ☐ Putting on shoes
- ☐ Tying my shoes
- ☐ Putting on shirt
- ☐ Drying my hair
- ☐ Combing my hair
- ☐ Washing my hair
- ☐ Taking a shower
- ☐ Taking a bath
- ☐ Leaning forward
- ☐ Laying in bed
- ☐ Sitting in my favorite chair
- ☐ Sleeping
- ☐ Going out with my friends
- ☐ Sitting at a restaurant
- ☐ Shopping
- ☐ Driving to/from work
- ☐ Sitting in Church
- ☐ Playing with my children
- ☐ Caring for my children
- ☐ Bending in a movie theatre
- ☐ Sitting in a movie theatre
- ☐ Exercise
- ☐ Eating
- ☐ Stooping
- ☐ Squatting down
- ☐ Kneeling
- ☐ Brushing my teeth
- ☐ Riding in a car
- ☐ Opening a jar
- ☐ Lifting a pan when cooking
- ☐ Closing the trunk on my car
- ☐ Opening the garage door
- ☐ Using my home computer
- ☐ Climbing stairs
- ☐ Sexual activity
- ☐ Turning my head to left or right
- ☐ Holding my head up all day
- ☐ Watching TV
- ☐ I have pain sitting & doing nothing
- ☐ Talking on the phone
- ☐ Reading
- ☐ Writing
- ☐ Opening doors
- ☐ Drying with a towel after a bath or shower
- ☐ Life has become a chore just to do normal things
- ☐ It is depressing to live like this
- ☐ _____
- ☐ _____
- ☐ _____
- ☐ _____
- ☐ _____
- ☐ _____
- ☐ _____
- ☐ _____

Please check all that apply to your SCHOOL & EDUCATION Activities because of the accident

- ☐ School was affected by the accident
- ☐ I am a student at _____
- ☐ I am in the _____ year/grade
- ☐ I was ☐ full time ☐ part time
- ☐ I am now ☐ full time ☐ part time
- ☐ I had to take fewer classes b/c of crash
- ☐ I missed _____ days of school
- ☐ I had to drop out of school b/c of crash
- ☐ My grades are lower since the crash
- ☐ I have pain carrying my school books
- ☐ I hurt sitting in class more than _____ minutes
- ☐ My neck hurts when I look down to read
- ☐ I don't learn as quickly as before the crash
- ☐ I don't learn things as well as before the crash
- ☐ I have difficulty concentrating in class
- ☐ It takes much longer to study/do my homework
- ☐ _____
- ☐ _____

_____ _____

Signature of Patient Date

Patient's Name_____ Number_____ Date_____

LOW BACK DISABILITY QUESTIONNAIRE (REVISED OSWESTRY)

This questionnaire has been designed to give the doctor information as to how your back pain has affected your ability to manage in everyday life. **Please answer every section and mark in each section only ONE box** which applies to you. We realize you may consider that two of the statements in any one section relate to you, but **please just mark the box which MOST CLOSELY describes your problem.**

Section 1 - Pain Intensity

- ☐ I can tolerate the pain without having to use painkillers.
- ☐ The pain is bad but I can manage without taking painkillers.
- ☐ Painkillers give complete relief from pain.
- ☐ Painkillers give moderate relief from pain.
- ☐ Painkillers give very little relief from pain.
- ☐ Painkillers have no effect on the pain and I do not use them.

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, I 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 lift very light weights.
- ☐ I cannot lift or carry anything at all.

Section 4 – Walking

- ☐ Pain does not prevent me from walking any distance.
- ☐ Pain prevents me from walking more than one mile.
- ☐ Pain prevents me from walking more than one-half mile.
- ☐ Pain prevents me from walking more than one-quarter mile
- ☐ I can only walk using a stick or crutches.
- ☐ I am in bed most of the time and have to crawl to the toilet.

Section 5 -- Sitting

- ☐ I can sit in any chair as long as I like
- ☐ I can only sit in my favorite chair as long as I like
- ☐ Pain prevents me from sitting more than one hour.
- ☐ Pain prevents me from sitting more than 30 minutes.
- ☐ Pain prevents me from sitting more than 10 minutes.
- ☐ Pain prevents me from sitting almost all the time.

Scoring: Questions are scored on a vertical scale of 0-5. Total scores and multiply by 2. Divide by number of sections answered multiplied by 10. A score of 22% or more is considered significant activities of daily living disability.
(Score___ x 2) / (____Sections x 10) = _____ %ADL

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 extra pain.
- ☐ Pain prevents me from standing more than 1 hour.
- ☐ Pain prevents me from standing more than 30 minutes.
- ☐ Pain prevents me from standing more than 10 minutes.
- ☐ Pain prevents me from standing at all.

Section 7 -- Sleeping

- ☐ Pain does not prevent me from sleeping well.
- ☐ I can sleep well only by using tablets.
- ☐ Even when I take tablets I have less than 6 hours sleep.
- ☐ Even when I take tablets I have less than 4 hours sleep.
- ☐ Even when I take tablets I have less than 2 hours sleep.
- ☐ Pain prevents me from sleeping at all.

Section 8 – Social Life

- ☐ My social life is normal and gives 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, e.g. dancing.
- ☐ Pain has restricted my social life and I do not go out as often.
- ☐ Pain has restricted my social life to my home.
- ☐ I have no social life because of pain.

Section 9 – Traveling

- ☐ I can travel anywhere without extra pain.
- ☐ I can travel anywhere but it gives me extra pain.
- ☐ Pain is bad but I manage journeys over 2 hours.
- ☐ Pain is bad but I manage journeys less than 1 hour.
- ☐ Pain restricts me to short necessary journeys under 30 minutes.
- ☐ Pain prevents me from traveling except to the doctor or hospital.

Section 10 – Changing Degree of Pain

- ☐ My pain is rapidly getting better.
- ☐ My pain fluctuates but overall is definitely getting better.
- ☐ My pain seems to be getting better but improvement is slow at the present.
- ☐ My pain is neither getting better nor worse.
- ☐ My pain is gradually worsening.
- ☐ My pain is rapidly worsening.

Comments_____

Reference: Fairbank, Physiotherapy 1981; 66(8): 271-3, Hudson-Cook. In Roland, Jenner (eds.), Back Pain New Approaches To Rehabilitation & Education. Manchester Univ Press, Manchester 1989: 187-204

Patient's Name_____ Number_____ Date_____

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. **Please answer every section and mark in each section only ONE box** which applies to you. We realize you may consider that two of the statements in any one section relate to you, but **please just mark the box 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, I 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 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 pain in my neck.
- ☐ I can read as much as I want to with slight pain in my neck.
- ☐ I can read as much as I want with moderate pain.
- ☐ I can't read as much as I want because of moderate pain in my neck.
- ☐ I can hardly read at all because of severe pain in my neck.
- ☐ I cannot read at all.

Section 5-Headaches

- ☐ I have no headaches at all.
- ☐ I have slight headaches which come infrequently.
- ☐ I have slight headaches which come frequently.
- ☐ I have moderate headaches which come infrequently.
- ☐ I have severe headaches which come frequently.
- ☐ I have headaches almost all the time.

Scoring: Questions are scored on a vertical scale of 0-5. Total scores and multiply by 2. Divide by number of sections answered multiplied by 10. A score of 22% or more is considered a significant activities of daily living disability.
(Score___ x 2) / (____Sections x 10) = _____ %ADL_____

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 only 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 can't do any work at all.

Section 8 – Driving

- ☐ I drive my car without any neck pain.
- ☐ I can drive my car as long as I want with slight pain in my neck.
- ☐ I can drive my car as long as I want with moderate pain in my neck.
- ☐ I can't drive my car as long as I want because of moderate pain in my neck.
- ☐ I can hardly drive my car at all because of severe pain in my neck.
- ☐ I can't drive my car at all.

Section 9 – Sleeping

- ☐ I have no trouble sleeping.
- ☐ My sleep is slightly disturbed (less than 1 hr. sleepless).
- ☐ My sleep is moderately disturbed (1-2 hrs. sleepless).
- ☐ My sleep is moderately disturbed (2-3 hrs. sleepless).
- ☐ My sleep is greatly disturbed (3-4 hrs. sleepless).
- ☐ My sleep is completely disturbed (5-7 hrs. 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 can't do any recreation activities at all.

Comments_____ %ADL

Reference: Vernon, Mior. JMPT 1991; 14(7): 409-15

THE QuickDASH OUTCOME MEASURE

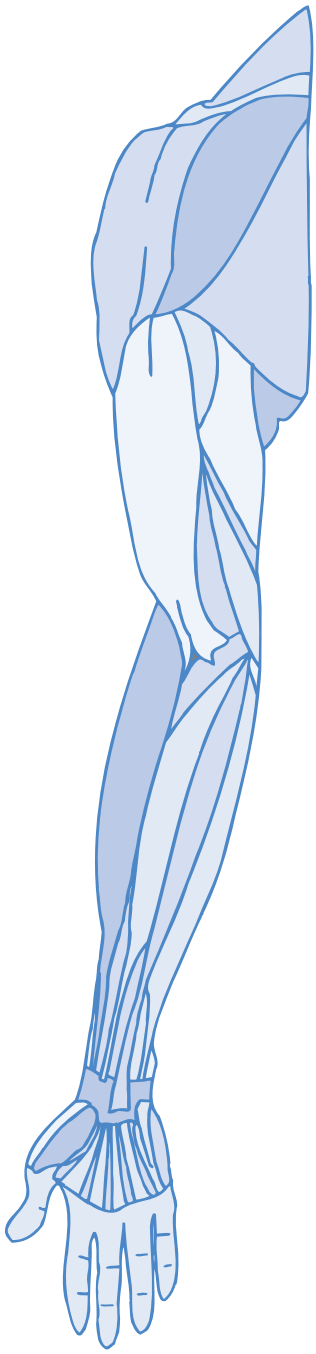
INSTRUCTIONS

This questionnaire asks about your symptoms as well as your ability to perform certain activities.

Please answer *every question*, based on your condition in the last week, by circling the appropriate number.

If you did not have the opportunity to perform an activity in the past week, please make your *best estimate* of which response would be the most accurate.

It doesn't matter which hand or arm you use to perform the activity; please answer based on your ability regardless of how you perform the task.



*Quick*DASH

Please rate your ability to do the following activities in the last week by circling the number below the appropriate response.

	NO DIFFICULTY	MILD DIFFICULTY	MODERATE DIFFICULTY	SEVERE DIFFICULTY	UNABLE
1. Open a tight or new jar.	1	2	3	4	5
2. Do heavy household chores (e.g., wash walls, floors).	1	2	3	4	5
3. Carry a shopping bag or briefcase.	1	2	3	4	5
4. Wash your back.	1	2	3	4	5
5. Use a knife to cut food.	1	2	3	4	5
6. Recreational activities in which you take some force or impact through your arm, shoulder or hand (e.g., golf, hammering, tennis, etc.).	1	2	3	4	5

	NOT AT ALL	SLIGHTLY	MODERATELY	QUITE A BIT	EXTREMELY
7. During the past week, *to what extent* has your arm, shoulder or hand problem interfered with your normal social activities with family, friends, neighbours or groups?	1	2	3	4	5

	NOT LIMITED AT ALL	SLIGHTLY LIMITED	MODERATELY LIMITED	VERY LIMITED	UNABLE
8. During the past week, were you limited in your work or other regular daily activities as a result of your arm, shoulder or hand problem?	1	2	3	4	5

Please rate the severity of the following symptoms in the last week. *(circle number)*	NONE	MILD	MODERATE	SEVERE	EXTREME
9. Arm, shoulder or hand pain.	1	2	3	4	5
10. Tingling (pins and needles) in your arm, shoulder or hand.	1	2	3	4	5

	NO DIFFICULTY	MILD DIFFICULTY	MODERATE DIFFICULTY	SEVERE DIFFICULTY	SO MUCH DIFFICULTY THAT I CAN'T SLEEP
11. During the past week, how much difficulty have you had sleeping because of the pain in your arm, shoulder or hand? *(circle number)*	1	2	3	4	5

*Quick*DASH DISABILITY/SYMPTOM SCORE = $\left(\left[\frac{\text{sum of n responses}}{n}\right] - 1\right) \times 25$, where n is equal to the number of completed responses.

A *Quick*DASH score may <u>not</u> be calculated if there is greater than 1 missing item.

WORK MODULE (OPTIONAL)

The following questions ask about the impact of your arm, shoulder or hand problem on your ability to work (including homemaking if that is your main work role).

Please indicate what your job/work is: _____

☐ I do not work. (You may skip this section.)

Please circle the number that best describes your physical ability in the past week.

Did you have any difficulty:	NO DIFFICULTY	MILD DIFFICULTY	MODERATE DIFFICULTY	SEVERE DIFFICULTY	UNABLE
1. using your usual technique for your work?	1	2	3	4	5
2. doing your usual work because of arm, shoulder or hand pain?	1	2	3	4	5
3. doing your work as well as you would like?	1	2	3	4	5
4. spending your usual amount of time doing your work?	1	2	3	4	5

SPORTS/PERFORMING ARTS MODULE (OPTIONAL)

The following questions relate to the impact of your arm, shoulder or hand problem on playing *your musical instrument or sport or both*. If you play more than one sport or instrument (or play both), please answer with respect to that activity which is most important to you.

Please indicate the sport or instrument which is most important to you: _____

☐ I do not play a sport or an instrument. (You may skip this section.)

Please circle the number that best describes your physical ability in the past week.

Did you have any difficulty:	NO DIFFICULTY	MILD DIFFICULTY	MODERATE DIFFICULTY	SEVERE DIFFICULTY	UNABLE
1. using your usual technique for playing your instrument or sport?	1	2	3	4	5
2. playing your musical instrument or sport because of arm, shoulder or hand pain?	1	2	3	4	5
3. playing your musical instrument or sport as well as you would like?	1	2	3	4	5
4. spending your usual amount of time practising or playing your instrument or sport?	1	2	3	4	5

SCORING THE OPTIONAL MODULES: Add up assigned values for each response; divide by 4 (number of items); subtract 1; multiply by 25.

An optional module score may <u>not</u> be calculated if there are any missing items.

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Automobile Crash Questionnaire

Date of your accident: Number of vehicles in collision
Number of people in your vehicle Where did the accident occur
Your Auto Insurance Company: Claim Number:
At Fault Auto Insurance Company: Claim Number:

About Your Motor Vehicle Accident

How fast were the involved vehicles traveling at the time of impact?

Your Vehicle: ☐ 0-10mph ☐ 10-25mph ☐ 25-50mph ☐ more than 50mph
Other Vehicle: ☐ 0-10mph ☐ 10-25mph ☐ 25-50mph ☐ more than 50mph

Your Vehicle: ☐ Hit another vehicle ☐ Was hit in the: ☐ Right side ☐ left side ☐ Rear ☐ Front
Who was at fault: ☐ I was at fault ☐ Other driver was at fault ☐ under investigation/unknown at this time
In your own words please describe what happened.

About Your Body at the Time of Impact

Were you the driver or a passenger?	☐ Driver	☐ Passenger
Were you wearing your seatbelt?	☐ Yes	☐ No
Were you intoxicated?	☐ Yes	☐ No
Did your vehicle's airbags deploy?	☐ Yes	☐ No
Did you lose consciousness?	☐ Yes	☐ No

At the time of the accident, what parts of your head/body hit what parts of the inside of the vehicle: _____

What symptoms (pain, stiffness, other) did you feel immediately after the accident? _____

What symptoms (pain, Stiffness, other) did you feel about 24 hours after the accident? _____

About Medical Care You Received

Did you receive medical care for your injuries? ☐ Yes ☐ No
Were X-rays taken? ☐ Yes ☐ No - If yes, explain:
What was your diagnosis?
What treatment was provided?
What effect did the treatment have?

About Your Health History

Have you been in a motor vehicle collision prior to this most recent one?	☐ Yes	☐ No
Do you have a history of headaches (more than once per month)?	☐ Yes	☐ No
Do you have a history of neck pain (more than once per month)?	☐ Yes	☐ No
Do you have a history of back pain (more than once per month)?	☐ Yes	☐ No
Have you seen a chiropractor before?	☐ Yes	☐ No

Injury Magnifiers

About Your Body at the Time of Impact

1. Did you have time to brace for impact? ☐ Yes ☐ No
2. Was your head or body turned to the right or left? ☐ Yes ☐ No
3. Was your head rest up and level with your head? ☐ Yes ☐ No
4. Was your car moving at the time of impact? ☐ Yes ☐ No
5. Were the roads wet outside? ☐ Yes ☐ No

Make model and year of **MY** vehicle:_____

Make model, and Year of **Other** vehicle:_____

For Office use only

Weight of **MY** vehicle: _____

Weight of the **OTHER** vehicle: _____

Safety rating of my vehicle: _____

Patient Signature_____ Date_____

Guardian Signature_____ Date_____

MEDICAL LIEN AGREEMENT

PATIENT NAME: _____ DATE OF INJURY/INCIDENT: _____
PROVIDER NAME: _____
ATTORNEY NAME: _____ LAW FIRM NAME: _____

Patient ("Patient") desires medical treatment by Provider, including all entities and specialists that provide services for, at or through Provider (collectively, "Provider") for injuries sustained in a personal injury incident ("Incident"). Patient has or shall retain Attorney ("Attorney") to seek compensation ("Litigation"). At Patient's request, Provider agrees to treat Patient on a "lien" basis ("Medical Lien"), establishing a debtor-creditor contractual relationship, whereby Patient remains responsible to pay Provider's bill ("Bill"), but Provider agrees to wait to be paid until the conclusion of the Litigation. However, if any provision of this Medical Lien is not strictly complied with by Patient or Attorney, Provider may declare a breach of this Medical Lien agreement, and Patient agrees to then pay the full balance owed Provider immediately; and, if Patient fails to timely pay, Provider may immediately file a lawsuit for the monies owed plus any other claims and/or entitlements based upon the number, type and extent of the breach(es) involved. The following terms and conditions apply:

1. Provider's Medical Lien is against all payments arising from the Incident, including but not limited to, settlement proceeds, "med pay", or payment of a judgment arising from the Litigation ("Proceeds").
2. Patient and Attorney acknowledge that even if Attorney drops Patient in the Lawsuit, or, the Litigation results in no recovery, Patient must still pay Provider the full Bill amount regardless of the Litigation outcome. Patient and Attorney further acknowledge there is no requirement that Provider discount the Bill.
3. Provider considers lien reduction requests on a case-by-case basis, provided Patient and Attorney are timely, fully cooperative, and provide all information requested by Provider. Any reduction on Patient's Bill must be agreed to by Provider in writing. Bill reduction requests should be made prior to any Lawsuit settlement, so that Patient knows if, and the extent, Provider is willing to reduce the Bill.
4. All Bill reductions are contingent upon Provider receiving the agreed payment within 10 calendar days of receipt by Attorney or Patient of any Proceeds, or within sixty 60 calendar days from the date of Provider's signed reduction agreement, whichever occurs first (even if no expiration period is stated in the Bill reduction letter or agreement). If payment is not timely received by Provider, the prior Bill reduction agreement is rendered null and void, and the full Bill is due and owing (and Attorney or Patient will need to make a new reduction request which Provider is not obligated to accept).
5. Any modification of this Medical Lien not initialed by Provider in writing, will result in the original non-modified Medical Lien as originally presented by Provider (prior to any attempted changes) being the binding Medical Lien, without the modifying language.
6. All "med pay" arising from the Incident is expressly and permanently assigned by Patient to Provider and will be immediately paid to Provider if received by Attorney or Patient. Med pay received will reduce the outstanding Bill by the amount of the "med pay" received by Provider.
7. Any sums owing to Provider shall accrue interest at the rate of 1 ½% per month- 18% per annum, beginning 90 days from the final date of treatment by Provider until the outstanding balance is fully paid ("the full Bill"). Provider is also entitled to any consequential damages incurred (e.g., costs of third party collection services, administrative fees/costs to address matter with Attorney and/or Patient). The prevailing party in any action to enforce this Medical Lien shall be entitled to their reasonable attorney's fees and costs. Venue for any disputes arising under this Medical Lien shall be in the county where Provider is located. If Patient is or becomes unrepresented by an attorney or brings a Small Claims action rather than a Lawsuit in Municipal or Superior Court, then Provider may declare a breach of this Medical Lien. Attorney and Patient shall keep Provider or Provider's agent updated on the Lawsuit status, communicate timely the date of filing of a Complaint, setting or moving of trial/arbitration/mediation, filing a Small Claims action, any change in Patient's representation or if co-counsel brought in to try the matter (co-counsel to be bound by this same Medical Lien). Best efforts shall be used, and time is of the essence, for all performances under this Medical Lien. This Medical Lien may be sold, transferred or assigned by Provider to a third party.

ALL THE ABOVE IS AGREED TO:

PATIENT (SIGN): _____ DATE: _____
ATTORNEY (SIGN): _____ DATE: _____
PROVIDER (SIGN): _____ DATE: _____