

MOTOR VEHICLE ACCIDENT BILLING

Advanced Health Chiropractic and Massage will bill an auto insurance company for services related to a motor vehicle accident ONLY under the following circumstances:

- 1) The auto insurance company we are billing is your own- A.K.A your Personal Injury Protection (PIP) coverage.
- 2) The auto insurance company we are billing is for the vehicle in which you were a passenger- A.K.A. **their** PIP coverage.

If PIP coverage is not available to you, Advanced Health Chiropractic and Massage DOES NOT wait for settlement to receive payment for these accident related services. Depending on your circumstances, your billing for these services will be handled as follows:

If you have health insurance:

Your health insurance policy will be billed. You are responsible for notifying your health plan that these services are related to a Motor Vehicle Accident. They will want to collect from the party at fault when your treatment is concluded. You will be responsible for payment of any copayments, deductibles, coinsurance, or any other insurance deemed patient remainders as services are rendered.

If you do not have health insurance:

In the event you are not covered by PIP coverage AND you do not have health insurance, you are solely responsible for payment for these services at the time services are rendered.

Signature _____ Date _____

For PIP coverage billing, please provide the following information:

Name of Motor Vehicle Insurance Plan:

Insurance Plan Address: _____

Street/ PO Box: _____

City: _____ State: _____ Zip Code: _____

Claim Number: _____ Date of Accident: _____

Claim Adjustor's Name: _____ Phone #: _____

Patient Information

Today's Date: _____

Name _____ Age _____ Gender: M F (Pregnant: Yes No)
 Home Address _____ Home Phone _____
 City, State, Zip _____ Cell Phone _____
 Email Address _____
 Birth date _____ Social Security Number _____ Marital Status: S M D W P
 Occupation, Employer _____ How many people in your household? _____
 Emergency Contact _____ Phone _____
 How were you referred to this office? _____
 Who is your Primary Care Doctor? _____

Is This Visit Related To A: Work Injury Car Collision Injury Home Injury Non-Injury Symptoms Gradual Onset Other

Experience with Chiropractic

DO YOU HAVE P.I.P.? Yes No Not Sure

Have you seen a Chiropractor before? Yes No Who? _____
 Reason for visit(s) with previous provider: _____
 Did your previous provider take x-rays? Yes: Year _____ No What was the diagnosis? _____
 Did they recommend a specific course of treatment? Yes No
 Did they recommend a home health care program? Yes No If yes, what? _____
 How long were you treated? _____ Last treatment date: _____
 How did you respond? _____ Have you ever had Massage Therapy Treatments? Yes No

Health & Lifestyle

Do you exercise? Yes No How often? _____ day(s) per week; Other: _____
 What are your current Hobbies? _____
 Do you smoke? Yes No How much/how often? _____
 Do you drink alcohol? Yes No How much/how often? _____
 Do you drink coffee? Yes No How much/how often? _____
 How much water do you drink daily? _____ cups (1 cup = 8oz)
 Do you take supplements? Yes No Please list: _____
 Do you sleep on your: Back Side Stomach

Health History

Have any of your family members ever been diagnosed with the following?

- | | | | | |
|---|---|--|--|--|
| <input type="checkbox"/> STROKE | <input type="checkbox"/> Varicose Veins | <input type="checkbox"/> Neurological Problems | <input type="checkbox"/> Lung Disease | <input type="checkbox"/> Lumbago |
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> Circulatory Problems | <input type="checkbox"/> Migraine Headaches | <input type="checkbox"/> Heat Murmur | <input type="checkbox"/> Eczema/Psoriasis |
| <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Heart Disease | <input type="checkbox"/> Cancer | <input type="checkbox"/> Osteoporosis | <input type="checkbox"/> Epilepsy/Seizures |
| <input type="checkbox"/> Kidney Disease | <input type="checkbox"/> Paralysis | <input type="checkbox"/> Arthritis | <input type="checkbox"/> Rheumatic Fever | <input type="checkbox"/> Small Pox |
| <input type="checkbox"/> Liver Disease | <input type="checkbox"/> Metal Implants | <input type="checkbox"/> Infectious Disease | <input type="checkbox"/> Gall Bladder | <input type="checkbox"/> Measles |
| <input type="checkbox"/> Broken Bones/Fractures | <input type="checkbox"/> Appendectomy | <input type="checkbox"/> Tonsillectomy | <input type="checkbox"/> Hernia | <input type="checkbox"/> Pleurisy |
| <input type="checkbox"/> Pneumonia/Bronchitis | <input type="checkbox"/> Polio | <input type="checkbox"/> Tuberculosis | <input type="checkbox"/> Anemia | <input type="checkbox"/> Mumps |
| <input type="checkbox"/> Whooping Cough | <input type="checkbox"/> Chicken Pox/Shingles | <input type="checkbox"/> Blood Sugar Problems | <input type="checkbox"/> Influenza | <input type="checkbox"/> Thyroid Problems |
| <input type="checkbox"/> Other: _____ | | | | |

Injury History

List ALL past **Auto Collisions**, Month/Year, type of collision (rear-end, side impact) and if care was given.
 1. _____
 2. _____
 List ALL **Worker's Compensation** claims, Injured Body Regions, Month/Year, and what type of care received.
 1. _____
 2. _____
 List ALL past **Hospitalizations and Surgeries** (including augmentation), Month/Year, and type of injury.
 1. _____
 2. _____
 3. _____
 Please list all **medications** you are currently taking: _____

Patient Name: _____
Date of Collision: _____

Today's Date: _____

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

1. Your Vehicle Type <input type="checkbox"/> Car <input type="checkbox"/> Truck <input type="checkbox"/> Van <input type="checkbox"/> Bus Year: _____ Make: _____ Model: _____	2. Your Position in the Car <input type="checkbox"/> Driver <input type="checkbox"/> Front Passenger <input type="checkbox"/> Left Rear Passenger <input type="checkbox"/> Right Rear Passenger <input type="checkbox"/> Other _____	3. What was your vehicle doing at the time of the collision? <input type="checkbox"/> Stopped @ Intersection <input type="checkbox"/> Stopped in traffic <input type="checkbox"/> Stopped at Light <input type="checkbox"/> Making a Right Turn <input type="checkbox"/> Making a Left Turn <input type="checkbox"/> Parking <input type="checkbox"/> Proceeding along <input type="checkbox"/> Slowing Down <input type="checkbox"/> Accelerating <input type="checkbox"/> Other _____
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4. Time/Speed/Damage Time of Accident: _____ Your Speed: _____ mph Their Vehicle's Speed: _____ mph Damage to your Vehicle <input type="checkbox"/> Mild <input type="checkbox"/> Moderate <input type="checkbox"/> Totalled Cost of Damage to Car? \$ _____	5. Details of Collision Visibility at time of collision <input type="checkbox"/> Poor <input type="checkbox"/> Fair <input type="checkbox"/> Good Who hit who/what? <input type="checkbox"/> You hit other vehicle <input type="checkbox"/> Other Vehicle hit you You Hit....(object) _____	6. Road Conditions Road conditions at the time of collision <input type="checkbox"/> Icy <input type="checkbox"/> Snowy <input type="checkbox"/> Sandy <input type="checkbox"/> Dark <input type="checkbox"/> Clean and Dry Weather conditions at time of collision <input type="checkbox"/> Sunny <input type="checkbox"/> Cloudy <input type="checkbox"/> Foggy <input type="checkbox"/> Rainy <input type="checkbox"/> Snowing Point of Impact <input type="checkbox"/> Head-On <input type="checkbox"/> Left Front <input type="checkbox"/> Right Front <input type="checkbox"/> Rear-End <input type="checkbox"/> Left Rear <input type="checkbox"/> Right Rear Was your vehicle moved during the impact? <input type="checkbox"/> No <input type="checkbox"/> Less than 1/2 car length <input type="checkbox"/> 1/2 car length <input type="checkbox"/> One car length <input type="checkbox"/> More than one car length
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7. Other Vehicle Type <input type="checkbox"/> Car <input type="checkbox"/> Truck <input type="checkbox"/> Van <input type="checkbox"/> Bus Year: _____ Make: _____ Model: _____	8. What was their vehicle doing at the time of the collision? <input type="checkbox"/> Stopped @ Intersection <input type="checkbox"/> Stopped in traffic <input type="checkbox"/> Stopped at Light <input type="checkbox"/> Making a Right Turn <input type="checkbox"/> Making a Left Turn <input type="checkbox"/> Parking <input type="checkbox"/> Proceeding along <input type="checkbox"/> Slowing Down <input type="checkbox"/> Accelerating <input type="checkbox"/> Other _____
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9. Body Position Did you see the collision coming? Yes <input type="checkbox"/> No <input type="checkbox"/> Were you braced for the impact? Yes <input type="checkbox"/> No <input type="checkbox"/> Did you have a seat belt on? Yes <input type="checkbox"/> No <input type="checkbox"/> Did you have a shoulder harness on? Yes <input type="checkbox"/> No <input type="checkbox"/> Do you have any bruising/tenderness in the area of the seatbelt? Yes <input type="checkbox"/> No <input type="checkbox"/>	At the time of the collision, what was the position of your hands? _____ At the time of the collision, what was the position of your legs? _____ At the time of the collision, were you wearing: <input type="checkbox"/> Eyeglasses <input type="checkbox"/> Hat <input type="checkbox"/> Other _____
--	---

Did driver side air bags deploy? Yes No Did passenger side airbags deploy? Yes No Did side airbags deploy? Yes No
If yes, did you receive any injury from the airbag? _____

Does your vehicle have headrests? Yes <input type="checkbox"/> No <input type="checkbox"/> What was the position of your headrest a the time of the impact? <input type="checkbox"/> Even with top of head <input type="checkbox"/> Even with bottom of head <input type="checkbox"/> Middle of Neck Did your head go back over the top of the headrest? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unsure Was the headrest altered or damaged in the collision? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the direction of your head at the time of the impact? <input type="checkbox"/> Facing straight forward <input type="checkbox"/> Turned to the right <input type="checkbox"/> Turned to the left <input type="checkbox"/> Forward and looking up <input type="checkbox"/> Forward and looking down	On what part of the vehicle did the following body parts hit: Head Hit: _____ Chest Hit: _____ Right/Left Shoulder: _____ Right/Left Arm: _____ Right/Left Hip: _____ Right/Left Leg: _____ Right/Left Knee: _____ Other: _____
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Which of the following car parts broke during this collision? <input type="checkbox"/> Windshield <input type="checkbox"/> Steering Wheel <input type="checkbox"/> Drivers Window <input type="checkbox"/> Front Seat Back <input type="checkbox"/> Passenger Window <input type="checkbox"/> Other _____	What bruises and cuts did you get from this collision?: _____ _____ _____
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10. Treatment History Fill in any other doctor(s) seen prior to your first visit to this office. 1. Dr. _____ First visit date: _____ Specialty: _____ XRAYs done: Yes <input type="checkbox"/> No <input type="checkbox"/> Type of treatment received? _____ How many treatments received? _____ Did treatments benefit you? Yes <input type="checkbox"/> No <input type="checkbox"/> Last Visit Date: _____
--

Patient Name: _____

Patient Signature: _____

Is This Visit Related To A: **Work Injury** **Car Collision Injury** **Home Injury** **Non-Injury Symptoms** **Gradual Onset** **Other**

Patient Name: _____

What brought you in to see us today?

How did you hurt yourself?

When did the symptoms begin?

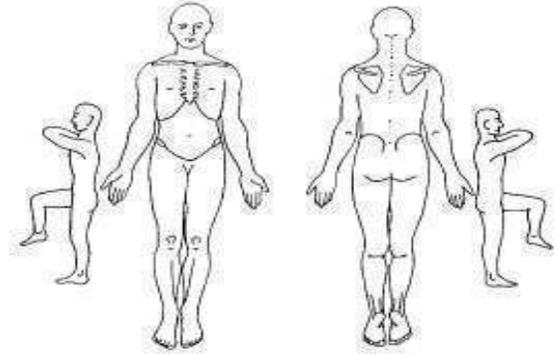
On the picture below, use the **indicated marks** to show areas where you have, at any time, experienced:

Indicator Marks:

Pain: XXXX

Numbness: ///

Tingling: ****



Please indicate your pain from 0-10; with 10 being the worst pain and 0 being no pain.

Circle all that Apply

Neck ___/10; At Worst ___/10; At Best ___/10	Mid-Back ___/10; At Worst ___/10; At Best ___/10	Low-Back ___/10; At Worst ___/10; At Best ___/10																																																
Is the pain on the: Left Right Center	Is the pain on the: Left Right Center	Is the pain on the: Left Right Center																																																
Type of Pain: Burning Numbness Stabbing Dull Sharp Throbbing Tight Aching Tingling Tender	Type of Pain: Burning Numbness Stabbing Dull Sharp Throbbing Tight Aching Tingling Tender	Type of Pain: Burning Numbness Stabbing Dull Sharp Throbbing Tight Aching Tingling Tender																																																
How Often is Pain during Waking Hours? Intermittent (0-25%) Frequent (51-75%) Occasional (26-50%) Constant (76-100%)	How Often is Pain during Waking Hours? Intermittent (0-25%) Frequent (51-75%) Occasional (26-50%) Constant (76-100%)	How Often is Pain during Waking Hours? Intermittent (0-25%) Frequent (51-75%) Occasional (26-50%) Constant (76-100%)																																																
Are you experiencing Headaches? Yes <input type="checkbox"/> <input type="checkbox"/> No If yes how often?	Do you get pain with breathing? Yes <input type="checkbox"/> <input type="checkbox"/> No If Yes, Where? _____	Do you have pain with coughing, sneezing or going to the bathroom? Yes <input type="checkbox"/> <input type="checkbox"/> No If Yes, Where? _____																																																
Are you experiencing pain down your arms? Yes <input type="checkbox"/> <input type="checkbox"/> No If yes, Left Arm or Right Arm or Both	Does your pain wrap around your ribs? Yes <input type="checkbox"/> <input type="checkbox"/> No If Yes, Where? _____	Do you have pain in butt or down the leg? Yes <input type="checkbox"/> <input type="checkbox"/> No																																																
How do the following motions affect your pain? <table style="width:100%; border:none;"> <tr> <td style="width:33%;"></td> <td style="width:33%; text-align:center;">No Change</td> <td style="width:33%; text-align:center;">Relieves</td> <td style="width:33%; text-align:center;">Increased</td> </tr> <tr> <td>Looking Up</td> <td style="text-align:center;"><input type="checkbox"/></td> <td style="text-align:center;"><input type="checkbox"/></td> <td style="text-align:center;"><input type="checkbox"/></td> </tr> <tr> <td>Looking Down</td> <td style="text-align:center;"><input type="checkbox"/></td> <td style="text-align:center;"><input type="checkbox"/></td> <td style="text-align:center;"><input type="checkbox"/></td> </tr> <tr> <td>Right Head Rotation</td> <td style="text-align:center;"><input type="checkbox"/></td> <td style="text-align:center;"><input type="checkbox"/></td> <td style="text-align:center;"><input type="checkbox"/></td> </tr> <tr> <td>Left Head Rotation</td> <td style="text-align:center;"><input type="checkbox"/></td> <td style="text-align:center;"><input type="checkbox"/></td> <td style="text-align:center;"><input type="checkbox"/></td> </tr> </table>		No Change	Relieves	Increased	Looking Up	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Looking Down	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Right Head Rotation	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Left Head Rotation	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	How many hours per day do you sit in a chair? _____ hrs How many hours per day are you at a computer? _____ hrs	How do the following motions affect your pain? <table style="width:100%; border:none;"> <tr> <td style="width:33%;"></td> <td style="width:33%; text-align:center;">No Change</td> <td style="width:33%; text-align:center;">Relieves</td> <td style="width:33%; text-align:center;">Increased</td> </tr> <tr> <td>Sitting</td> <td style="text-align:center;"><input type="checkbox"/></td> <td style="text-align:center;"><input type="checkbox"/></td> <td style="text-align:center;"><input type="checkbox"/></td> </tr> <tr> <td>Walking</td> <td style="text-align:center;"><input type="checkbox"/></td> <td style="text-align:center;"><input type="checkbox"/></td> <td style="text-align:center;"><input type="checkbox"/></td> </tr> <tr> <td>Standing</td> <td style="text-align:center;"><input type="checkbox"/></td> <td style="text-align:center;"><input type="checkbox"/></td> <td style="text-align:center;"><input type="checkbox"/></td> </tr> <tr> <td>Lying Down</td> <td style="text-align:center;"><input type="checkbox"/></td> <td style="text-align:center;"><input type="checkbox"/></td> <td style="text-align:center;"><input type="checkbox"/></td> </tr> <tr> <td>Lifting</td> <td style="text-align:center;"><input type="checkbox"/></td> <td style="text-align:center;"><input type="checkbox"/></td> <td style="text-align:center;"><input type="checkbox"/></td> </tr> <tr> <td>Bending</td> <td style="text-align:center;"><input type="checkbox"/></td> <td style="text-align:center;"><input type="checkbox"/></td> <td style="text-align:center;"><input type="checkbox"/></td> </tr> </table>		No Change	Relieves	Increased	Sitting	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Walking	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Standing	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Lying Down	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Lifting	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Bending	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
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Bending	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>																																															

Patient Initials: _____ Date: _____

List of Extremities:

Shoulder	TMJ/Jaw	Knee
Elbow	Ribs	Ankle
Wrist	Hand	Foot

Please indicate Right or Left by Circling R or L



Extremity: R L _____/10			Extremity: R L _____/10		
Type of Pain:	Burning	Numbness	Type of Pain:	Burning	Numbness
Stabbing	Dull	Sharp	Stabbing	Dull	Sharp
Throbbing	Tight	Aching	Throbbing	Tight	Aching
Tingling	Tender		Tingling	Tender	
How Often is Pain during Waking Hours?			How Often is Pain during Waking Hours?		
Intermittent (0-25%)		Frequent (51-75%)	Intermittent (0-25%)		Frequent (51-75%)
Occasional (26-50%)		Constant (76-100%)	Occasional (26-50%)		Constant (76-100%)

What have you done to try to relieve the pain?

Heat	Ice	Stretching	Nothing Helps
Rest	Medicine	Massage	Other: _____

Have you seen another professional for this condition?

Medical Doctor: _____

Chiropractor: _____

Physical Therapist: _____

Other: _____

Prior Similar Symptoms

I have NOT had prior symptoms similar to my current complaints

My current complaints DID exist before, but have not been bothering me.

My current complaints ALREADY existed and were worsened.

Has your History contributed to your current symptoms?

My history HAS contributed to my current symptoms.

My history HAS NOT contributed to my current symptoms.

I'm NOT SURE if my history has contributed.

Circle the TOP 3 activities which are most affected by your pain. Circling an activity does not necessarily mean you are unable to perform it, it simply means your pain affects the activity, even just your enjoyment.

Walking	Sitting	Showering	Jogging	Standing	Dishes
Reading	Driving	Sex	Shaving	Gym	Chores
Working	Swimming	Sleeping	Bending	Dressing	Gardening

Please mark each that apply to your Daily Activities:

- Stays at home most of the time due to the problem
- Changes position frequently to try and get comfortable
- Walks more slowly than usual because of the problem
- Does not do jobs about the house because of the problem
- Has to use handrails to get up the stairs
- Has to lie down and rest frequently due to the problem
- Has to hold onto something to sit or stand from a chair
- Has to get other people to do things for you
- Has difficulty getting dressed due to the problem
- Can only stand for short periods due to the problem
- Has difficulty bending or kneeling due to the problem
- Has difficulty turning over in bed due to the problem
- Has a loss of appetite due to the problem
- Can only walk short distances because of the problem
- Has difficulty sleeping because of the problem
- Has to get dressed with someone's help
- Has to sit most of the day because of the problem
- Has more irritable because of the problem
- Stays in bed most of the day because of the problem

How often do you have to stop activities to sit or lie down to control your pain?

- All Day
- Several times a day
- Occasionally
- Approx Once per day
- Never

Patient Initials: _____ Date: _____

Patient Name: _____

Date: _____

Did your head hit any part of the car?		
Windshield	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Dashboard	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Other Passenger	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Steering Wheel	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Side Car Window	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Mirror	<input type="checkbox"/> Yes	<input type="checkbox"/> No

What part of your head was hit?	
<input type="checkbox"/> Forehead	<input type="checkbox"/> Back of Head
<input type="checkbox"/> Left Side of Head	<input type="checkbox"/> Right Side of Head
<input type="checkbox"/> Top of Head	<input type="checkbox"/> Other

What is the very last thing you remember before the collision?

What is the very next thing you remember after the collision?

History

- Yes No Did you lose consciousness or black out for any time (seconds or minutes)?
- Yes No Did you feel an altered state of awareness, dazed or confused?
- Yes No Have you lost any memory of events prior to your head injury?
- Yes No Has your memory been different since the head injury?
- Yes No Did you have a lump or bruise on part of your head after the head injury? Where?
- Yes No Have you had any head injuries in your past?
- Yes No Have you had any x-rays taken?
- Yes No Have you had a CT or MRI scan taken of your head?

Please check the following boxes that correspond to any symptoms that you have had since your neck or head injury.

YES

- Headaches
- Loss of Coordination
- Reduced Drive/Motivation
- Poor Memory
- Difficulty Finishing Tasks
- Sleep Disorders
- Abnormal Levels of Anxiety
- Reduced Tolerance to Alcohol
- More Assertive
- Forgetful
- Anger Outbursts
- Depression
- Fatigue
- Absence of Ability to Anticipate
- Inflexibility
- Impaired Sexual Function
- Language Difficulty
- Impaired Judgement
- Need day-timer to remember home/work activities

YES

- Blurry Vision
- Loss of Balance
- Difficulty Handling Multiple Tasks
- Dizziness/Lightheadedness
- Irritability
- Personality Change
- Head Tremors
- Ringing in Ears
- Less Diplomatic than Normal
- Mood Swings
- Reduced Attention Span
- Blackouts
- Indifference to Other People
- More Shallow Relationships
- Difficulty with Problem Solving
- Less Mental Stamina
- Performance Inconsistencies
- Verbal Learning Problems
- Slower Reaction Times

NECK PAIN DISABILITY INDEX QUESTIONNAIRE

Name: _____ Date: _____

This questionnaire is designed to enable us to understand how much your neck pain has affected your ability to manage your everyday activities. Please answer each section by circling the ONE CHOICE that most applies to you. We realize that you may feel that more than one statement may apply to you, but please just circle the one choice which most clearly describes your problem right now.

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: Recreation

- 1) I am able to engage in all of my recreational activities, with no neck pain at all.
- 2) I am able to engage in all of my recreational activities, with some pain in my neck.
- 3) I am able to engage in most, but not all of my usual recreational activities because of pain in my neck.
- 4) I am able to engage in a few of my usual recreational activities.
- 5) I can hardly do any recreational activities because of pain in my neck.
- 6) I cannot do any recreational activities at all.

Section 3: 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 can manage if they are conveniently positioned, e.g. on a table
- 4) Pain prevents me from lifting heavy weights, 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 4: 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 cannot read as much as I want because of moderate pain in my neck.
- 5) I cannot read as much as I want because of severe pain in my neck.
- 6) I cannot read at all.

Section 5: Headaches

- 1) I have no headaches at all.
- 2) I have slight headaches, which come frequently.
- 3) I have moderate headaches, which come infrequently.
- 4) I have moderate headaches, which come frequently.
- 5) I have severe headaches, which come frequently.
- 6) I have headaches almost all of the time.

Section 6: 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 great deal 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 7: Work

- 1) I can do as much work as I want to.
- 2) I can do only 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 cannot do any work at all.

Section 8: Driving

- 1) I can drive my car without any neck pain.
- 2) I can drive my car as long as I want with slight pain in my neck.
- 3) I can drive my car as long as I want with moderate pain in my neck.
- 4) I cannot drive my car as long as I want because of moderate pain in my neck.
- 5) I can hardly drive at all because of severe pain in my neck.
- 6) I cannot drive my car at all.

Section 9: 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 10: Personal Care

- 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 was with difficulty and stay in bed.

Neck Bournemouth Questionnaire

Patient Name: _____ Date: _____

Instructions: The following scales have been designed to find out about your neck pain and how it is affecting you. Please answer ALL the scales, and mark the ONE number on EACH scale that best describes how you feel.

1. Over the past week, on average, how would you rate your neck pain?

No Pain											Worst Pain Possible
0	1	2	3	4	5	6	7	8	9	10	

2. Over the past week, how much has your neck pain interfered with your daily activities (housework, washing, dressing, lifting, reading, driving)?

No Interference											Unable to carry out activity
0	1	2	3	4	5	6	7	8	9	10	

3. Over the past week, how much has your neck pain interfered with your ability to take part in recreational, social, and family activities?

No Interference											Unable to carry out activity
0	1	2	3	4	5	6	7	8	9	10	

4. Over the past week, how anxious (tense, uptight, irritable, difficulty in concentrating/relaxing) have you been feeling?

Not at all anxious											Extremely anxious
0	1	2	3	4	5	6	7	8	9	10	

5. Over the past week, how depressed (down-in-the-dumps, sad, in low spirits, pessimistic, unhappy) have you been feeling?

Not at all depressed											Extremely depressed
0	1	2	3	4	5	6	7	8	9	10	

6. Over the past week, how have you felt your work (both inside and outside the home) has affected (or would affect) your neck pain?

Have made it no worse											Have made it much worse
0	1	2	3	4	5	6	7	8	9	10	

7. Over the past week, how much have you been able to control (reduce/help) your neck pain on your own?

Completely control it											No control whatsoever
0	1	2	3	4	5	6	7	8	9	10	

Other Comments: _____

REVISED OSWESTRY CHRONIC LOW BACK PAIN DISABILITY QUESTIONNAIRE

Name: _____

Date: _____

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 severe.
- 6) The pain is severe and does not vary much.

Section 2: Personal Care

- 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 or dressing without help.

Section 3: 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.
- 4) Pain prevents me from lifting heavy weights off the floor, but I can manage if they are conveniently positioned, e.g. on a table.
- 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 4: Walking

- 1) Pain does not prevent me from walking any distance.
- 2) Pain prevents me from walking more than one mile.
- 3) Pain prevents me from walking more than 1/2 mile.
- 4) Pain prevents me from walking more than 1/4 mile.
- 5) I can only walk while using a cane or on crutches.
- 6) I am in bed most of the time and have to crawl to move.

Section 5: Sitting

- 1) I can sit in any chair as long as I like without pain.
- 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 for more than 1/2 hour.
- 5) Pain prevents me from sitting more than ten minutes.
- 6) Pain prevents me from sitting at all.

Section 6: Standing

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

Section 7: Sleeping

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

Section 8: Social Life

- 1) My social life is normal; it gives me no pain.
- 2) My social life is normal, but increases the degree of my 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; 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.

Section 9: Traveling

- 1) I get no pain while traveling.
- 2) I get some pain while traveling, but none of my usual forms of travel make it any worse.
- 3) I get extra pain while traveling, but it does not compel me to seek alternate forms of travel.
- 4) I get extra pain while traveling 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 10: Changing Degree of Pain

- 1) My pain is rapidly getting better.
- 2) My pain fluctuates, but overall is definitely getting better.
- 3) My pain seems to be getting better, but improvement is slow at present.
- 4) My pain is neither getting better nor worse.
- 5) My pain is gradually worsening.
- 6) My pain is rapidly worsening.

Back Bournemouth Questionnaire

Patient Name: _____ Date: _____

Instructions: The following scales have ben designed to find out about your neck pain and how it is affecting you. Please answer ALL the scales, and mark the ONE number on EACH scale that best describes how you feel.

1. Over the past week, on average, how would you rate your back pain?

No Pain											Worst Pain Possible
0	1	2	3	4	5	6	7	8	9	10	

2. Over the past week, how much has your back pain interfered with your daily activities (housework, washing, dressing, lifting, reading, driving)?

No Interference											Unable to carry out activity
0	1	2	3	4	5	6	7	8	9	10	

3. Over the past week, how much has your back pain interfered with your ability to take part in recreational, social, and family activities?

No Interference											Unable to carry out activity
0	1	2	3	4	5	6	7	8	9	10	

4. Over the past week, how anxious (tense, uptight, irritable, difficulty in concentrating/relaxing) have you been feeling?

Not at all anxious											Extremely anxious
0	1	2	3	4	5	6	7	8	9	10	

5. Over the past week, how depressed (down-in-the-dumps, sad, in low spirits, pessimistic, unhappy) have you been feeling?

Not at all depressed											Extremely depressed
0	1	2	3	4	5	6	7	8	9	10	

6. Over the past week, how have you felt your work (both inside and outside the home) has affected (or would affect) you back pain?

Have made it no worse											Have made it much worse
0	1	2	3	4	5	6	7	8	9	10	

7. Over the past week, how much have you been able to control (reduce/help) your back pain on your own?

Completely control it											No control whatsoever
0	1	2	3	4	5	6	7	8	9	10	

Other Comments: _____

Pain Disability Questionnaire

Name: _____

Date: _____

Instructions: This survey asks for your views about how your pain affects how you function in everyday activities. This information will help you and your doctor know how you feel and how well you are able to do your daily tasks at this time.

Please answer every question by marking an "X" along the line to show how much your pain problem has affected you (from having no problems at all to having the most severe problems you can imagine).

1. Does your pain interfere with your normal work inside and outside the home?

Work Normally Unable to work at all

2. Does your pain interfere with personal care (such as washing, dressing, etc)?

Take care of myself completely Need help with all my personal care

3. Does your pain interfere with your traveling?

Travel anywhere I like Only travel to see Doctors

4. Does your pain affect your ability to sit or stand?

No problems Cannot do at all

5. Does your pain affect your ability to lift overhead, grasp objects, or reach for things?

No problems Cannot do at all

6. Does your pain affect your ability to lift objects off the floor, bend, stoop, or squat?

No problems Cannot do at all

7. Does your pain affect your ability to walk or run?

No problems Cannot do at all

Complete Other Side →

Name: _____

Date: _____

8. Has your income declined since your pain began?

No Decline

Lost all income

9. Do you have to take medication every day to control your pain?

No medication needed

On pain medication throughout the day

10. Does your pain force you to see doctors much more often than before your pain began?

Never see doctors

See doctors weekly

11. Does your pain interfere with your ability to see the people who are important to you as much as you would like?

No problem

Never see them

12. Does your pain interfere with recreational activities and hobbies that are important to you?

No interference

Total interference

13. Do you need help of your family and friends to complete everyday tasks (including both work outside the home and housework) because of your pain?

Never need help

Need help all the time

14. Do you now feel more depressed, tense, or anxious than before your pain began?

No depression/tension

Severe depression/tension

15. Are there emotional problems caused by your pain that interfere with your family, social, or work activities?

No problems

Severe Problems

Office Use Only

Functional: 1 _____ +2 _____ +3 _____ +4 _____ +5 _____ +6 _____ +7 _____ +12 _____ +13 _____ = _____

Psychosocial: 8 _____ +9 _____ +10 _____ +11 _____ +14 _____ +15 _____ = _____

Total = _____

Patient Name:

Informed Consent to Chiropractic Treatment

As with any healthcare procedure there are certain complications which may arise during chiropractic manipulation and therapy. Doctors of Chiropractic are required to advise patients that there are risks associated with such treatment. In particular you should note:

- 1.) Some patients may experience some stiffness or soreness following the first few days of treatment.
- 2.) Some types of manipulation have been associated with injuries to the arteries of the neck leading or contributing to serious complications including stroke. This occurrence is exceptionally rare and remote. However, you are being informed of the possibility regardless of the extreme remote chance.
- 3.) I will make every effort to screen for any contraindications to care; however, if you have a condition that would otherwise not come to my attention, it is your responsibility to inform me.
- 4.) Other complications may include fractures, disc injuries, dislocations, muscle strain, cervical myelopathy, costovertebral strains and separations, and burns.

The probabilities of these complications are rare and generally result from some underlying weakness of the bone or tissue which Dr. Robinson checks for during the history, examination, and x-ray (when warranted).

I acknowledge I have had the opportunity to discuss the associated risks as well as the nature and purpose of treatment with my chiropractor.

I authorize and agree to allow the doctor and his designated staff to work with my case, my spine and the spine of the charge I represent through the use of spinal adjustments and rehabilitative exercises for the sole purpose of postural and structural restoration of normal bio-mechanical and neurological function.

I intend this consent to apply to all my present and future chiropractic care.

Patient Printed Name: _____ **Date:** _____

Patient Signature: _____