Important Information About Your Injury, Treatment and Recovery

- It is EXTREMELY important that you Take Your Time to fill out the information in this packet. Please fill it out to the best of your ability. In order to get your recovered to pre-injury status, our clinic needs the most accurate information – no detail is too large or small. If you have any questions at any time, stop and contact us.
- During your care at this clinic we ask THREE items from you as the patient:
    1. Stay off all Social Media Sites – **GO DARK**. Information about you and your condition can be gathered online and may be used against you; which prevents you from obtaining the care that you need to heal from this injury.
    2. Journaling – we ask that you make a journal entry each day during your treatment at our clinic. This information helps us to see what your daily status of pain is affecting your life and to ensure that our services are aiding in your healing process.
    3. Follow Your Treatment Care Plan – it is imperative that you follow through with all recommended treatment care plans. Make your treatments a priority – by doing this you will ensure that you will heal in a timely manner and achieve recovery goals.
- Finally – if at any time you have questions about your treatment at our clinic, please ask freely of your provider or front desk staff. Your feedback and ultimately your recovery are our priorities.

MOTOR VEHICLE COLLISION BILLING

Advanced Health Chiropractic and Massage will bill an auto insurance company for services related to a motor vehicle collision 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 collision 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 Collision. They will want to collect from the party at fault when your treatment is concluded. You will be responsible for payment of any co-payments, deductibles, co-insurance, 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: _____

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; Do You Play An Instrument:_____

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

Indicate whether **F**ather, **M**other, **S**ister, **B**rother, or **S**elf has been diagnosed with the following:

___ **STROKE**	___ Diabetes	___ Neurological Problems	___ Lung Disease	___ Lumbago
___ Heart Disease	___ Circulatory Problems	___ Whooping Cough	___ Heat Murmur	___ Eczema/Psoriasis
___ Cancer	___ Broken Bones/Fractures	___ Pneumonia/Bronchitis	___ Osteoporosis	___ Varicose Veins
___ High Blood Pressure	___ Paralysis	___ Arthritis	___ Rheumatic Fever	___ Small Pox
___ Liver Disease	___ Metal Implants	___ Infectious Disease	___ Gall Bladder	___ Measles
___ Migraine Headaches	___ Appendectomy	___ Tonsillectomy	___ Hernia	___Pleurisy
___ Kidney Disease	___ Polio	___ Tuberculosis	___ Anemia	___ Mumps
___ Epilepsy/Seizures	___ Chicken Pox/Shingles	___ Blood Sugar Problems	___ Influenza	___Thyroid Problems

___ 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: _____ Today's Date: _____

Date of Collision: _____

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

1. Your Vehicle Type
□ Car □ Truck
□ Van □ Bus
Year: _____
Make: _____
Model: _____

2. Your Position in the Car
□ Driver □ Front Passenger
□ Left Rear Passenger
□ Right Rear Passenger
□ Other _____

3. What was your vehicle doing at the time of the collision?
□ Stopped @ Intersection □ Stopped in traffic □ Stopped at Light
□ Making a Right Turn □ Making a Left Turn □ Parking
□ Proceeding along □ Slowing Down □ Accelerating
□ Other _____

4. Time/Speed/Damage
Time of Accident: _____
Your Speed: _____ mph
Their Vehicle's Speed:
_____ mph
Damage to your Vehicle
□ Mild □ Moderate
□ Totalled
Cost of Damage to Car?
$_____

5. Details of Collision
Visability at time of collision
□ Poor □ Fair □ Good
Who hit who/what?
□ You hit other vehicle
□ Other Vehicle hit you
You Hit….(object)
_____

6. Road Conditions
Road conditions at the time of collision
□ Icy □ Snowy □ Sandy □ Dark □ Clean and Dry
Weather conditions at time of collision
□ Sunny □ Cloudy □ Foggy □ Rainy □ Snowing
Point of Impact
□ Head-On □ Left Front □ Right Front
□ Rear-End □ Left Rear □ Right Rear
Was your vehicle moved during the impact?
□ No □ Less than 1/2 car length □ 1/2 car length
□ One car length □ More than one car length

7. Other Vehicle Type
□ Car □ Truck
□ Van □ Bus
Year: _____
Make: _____
Model: _____

8. What was their vehicle doing at the time of the collision?
□ Stopped @ Intersection □ Stopped in traffic □ Stopped at Light
□ Making a Right Turn □ Making a Left Turn □ Parking
□ Proceeding along □ Slowing Down □ Accelerating
□ Other _____

9. Body Position
Did you see the collision coming? Yes □ □ No
Were you braced for the impact? Yes □ □ No
Did you have a seat belt on? Yes □ □ No
Did you have a shoulder harness on? Yes □ □ No
Do you have any bruising/tenderness in the area of the seatbelt? Yes □ □ No

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:
□ Eyeglasses □ Hat □ 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 □ □ No
What was the position of your headrest a the time of the impact?
□ Even with top of head □ Even with bottom of head □ Middle of Neck
Did your head go back over the top of the headrest?
□ Yes □ No □ Unsure
Was the headrest altered or damaged in the collision?
□ Yes □ No
What was the direction of your head at the time of the impact?
□ Facing straight forward □ Turned to the right □ Turned to the left
□ Forward and looking up □ 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:

Which of the following car parts broke during this collision?
□ Windshield □ Steering Wheel
□ Drivers Window □ Front Seat Back
□ Passenger Window □ Other _____

What bruises and cuts did you get from this collision?:

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 □ □ No
Type of treatment received? _____
How many treatments received? _____
Did treatments benefit you? Yes □ □ No Last Visit Date: _____

Patient Name: _____ Patient Signature: _____

11. After the accident

Did authorities show up?
□ WA State Patrol □ City Police
□ County Police □ No Investigation

When did you first notice pain or symptoms?
□ Immediately □ Within 24 Hours
□ Within 1-7 Days □ Other

Did your head hit any part of the car?
Windshield Yes □ □ No
Dashboard Yes □ □ No
Other Passenger Yes □ □ No
Steering Wheel Yes □ □ No
Side Car Window Yes □ □ No
Mirror Yes □ □ No

What part of your head was hit?
Forehead Yes □ □ No
Back of head Yes □ □ No
Left side of head Yes □ □ No
Right Side of head Yes □ □ No
Top of head Yes □ □ No
Other: _____

Did you lose consciousness? Yes □ □ No

Did you black out? Yes □ □ No

Have you lost any memories prior to your injury? Yes □ □ No

Immediately after did you feel an altered state of awareness, dazed, confused, shock, or anger? Yes □ □ No

Has your memory been different since your injury? Yes □ □ No

Did you have a lump or bruise on a part of your head? Yes □ □ No

Have you had any head injuries in your past? Yes □ □ No

Please Explain:

Where did you go after the accident?
□ Home □ Work □ ER □ Private Doctor

How did you get there?
□ Drove Self □ Police □ Ambulance □ Somebody Else

Were XRAYS taken? Yes □ □ No **Was lab work done? Yes □ □ No**

Body parts XRAYed? _____

What lab work? _____

The XRAYS revealed: _____

Did you have an MRI or CT Scan? Yes □ □ No

Treatments: □ **Cervical Collar** □ **Ice** □ **Other:** _____

Medications: _____

Follow-Up Instructions: _____

Check off your symptoms right after and a few days following:

□ Headaches
□ Neck pain
□ Neck Stiffness
□ Fainting
□ Ringing in Ears
□ Loss of Smell
□ Poor Memory
□ More Assertive
□ Forgetful
□ Anger Outbursts
□ Depression
□ Mid Back Pain
□ Low Back Pain
□ Nervousness
□ Loss of Taste
□ Toe Numbness
□ Constipation
□ Fatigue
□ Blackouts
□ Loss of Balance
□ Pain behind eyes
□ Others: _____

□ Dizziness
□ Nausea
□ Confusion
□ Fatigue
□ Tension
□ Irritability
□ Inflexibility
□ LanguageDifficulty
□ Personality Change
□ Head Tremors
□ Mood Swings
□ Cold Hands
□ Cold Feet
□ Diarrhea
□ Depression
□ Anxious
□ Chest Pain
□ Impaired Judgement
□ Blurry Vision

□ Loss of Concentration
□ Reduced Drive/Motivation
□ Reduced Tolerance to Alcohol
□ Absence of ability to Anticipate
□ Difficulty Finishing Task
□ Abnormal Levels of Anxiety
□ Impaired Sexual Function
□ Difficulty handling multiple tasks
□ Less Diplomatic than Normal
□ Reduced Attention Span
□ Indifference to other People
□ More Shallow Relationships
□ Difficulty with Problem Solving
□ Less Mental Stamina
□ Performance Inconsistencies
□ Verbal Learning Problems
□ Slower Reaction Times
□ Sleeping Problems
□ Shortness of Breath
□ Need Reminders

12. Please describe, to the best of your knowledge, exactly what happened minutes before the collision to when you arrived home. Including car positioning, surroundings, road conditions, car speed, who helped, etc.

Please draw the position of the car(s), the street(s) and any other objects.

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?

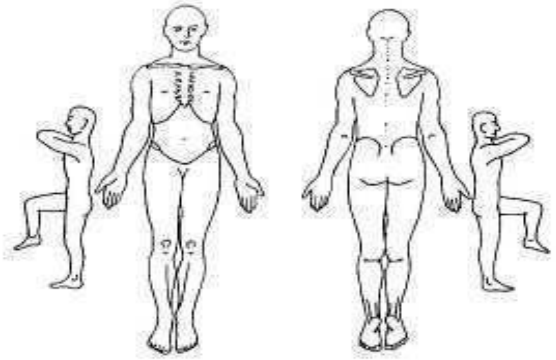
How did you hurt yourself?

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

Is the pain on the: **Left** **Right** **Center**

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%)

Are you experiencing Headaches? Yes □ □ No

If yes how often?

Are you experiencing pain down your arms? Yes □ □ No

If yes, Left Arm or Right Arm or Both

How do the following motions affect your pain?

	No Change	Relieves	Increased
Looking Up	□	□	□
Looking Down	□	□	□
Right Head Rotation	□	□	□
Left Head Rotation	□	□	□

Mid-Back ___/10; At Worst ___/10; At Best ____/10

Is the pain on the: **Left** **Right** **Center**

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%)

Do you get pain with breathing? Yes □ □ No

If Yes, Where? _____

Does your pain wrap around your ribs? Yes □ □ No

If Yes, Where? _____

How many hours per day do you sit in a chair? _____ hrs

How many hours per day are you at a computer? _____ hrs

Low-Back ___/10; At Worst __/10; At Best ___/10

Is the pain on the: **Left** **Right** **Center**

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%)

Do you have pain with coughing, sneezing or going to the bathroom? Yes □ □ No

If Yes, Where? _____

Do you have pain in butt or down the leg? Yes □ □ No

How do the following motions affect your pain?

	No Change	Relieves	Increased
Sitting	□	□	□
Walking	□	□	□
Standing	□	□	□
Lying Down	□	□	□
Lifting	□	□	□
Bending	□	□	□

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

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%)

Extremity: **R L**_____ ___/10

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%)

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 exsist 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	□ Yes	□ No
Dashboard	□ Yes	□ No
Other Passenger	□ Yes	□ No
Steering Wheel	□ Yes	□ No
Side Car Window	□ Yes	□ No
Mirror	□ Yes	□ No

What part of your head was hit?	
□ Forehead	□ Back of Head
□ Left Side of Head	□ Right Side of Head
□ Top of Head	□ 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 yo uhave had since your neck or head injury.

YES		YES	
□	Headaches	□	Blurry Vision
□	Loss of Coordination	□	Loss of Balance
□	Reduced Drive/Motivation	□	Difficulty Handling Multiple Tasks
□	Poor Memory	□	Dizziness/Lightheadedness
□	Difficulty Finishing Tasks	□	Irritablility
□	Sleep Disorders	□	Personality Change
□	Abnormal Levels of Anxiety	□	Head Tremors
□	Reduced Tolerance to Alcohol	□	Ringing in Ears
□	More Assertive	□	Less Diplomatic than Normal
□	Forgetful	□	Mood Swings
□	Anger Outbursts	□	Reduced Attention Span
□	Depression	□	Blackouts
□	Fatigue	□	Indifference to Other People
□	Absence of Ability to Anticipate	□	More Shallow Relationships
□	Inflexibility	□	Difficulty with Problem Solving
□	Impaired Sexual Function	□	Less Mental Stamina
□	Language Difficulty	□	Performance Inconsistencies
□	Impaired Judgement	□	Verbal Learning Problems
□	Need day-timer to remember home/work activities	□	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 difficutly.
2) I can concentrate fully when I want to with slight difficuly.
3) I have a fair degree of dificulty 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 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 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 convienently 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 ormal 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 and "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 Page 2 ⟶

Pain Disability Questionnaire

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 that 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:

We would like to take a moment to welcome you to our clinic and assure you that you will receive the very best of care available for your condition. The following are our clinic financial policies please familiarize yourself with our policies, please initial each section. If you have any questions, please contact the front desk. Thank You

Covered/Non-Covered Services

I understand that the services rendered and/or supplies/aides given to me may not be considered eligible for benefits (eg. Services and/or supplies/aides may be determined to be not medically necessary, non-covered or investigational) by my health insurance company. I understand that my health insurance coverage has certain restrictions and limitations, such as authorization requirements, and non-covered services and/or supplies/aides. Since I have chosen to obtain the services and/or supplies/aides, I agree to be financially responsible for any and all related charges, if they are not covered by my insurance.

Your treatment plan makes it necessary to utilize not only Chiropractic Care codes, but to also utilize what is best described as Physical Rehabilitation codes. Policy benefits for both areas of care vary greatly by insurance policy and we cannot be aware of each person's specific policy benefits. To provide our best level of care, we provide a treatment plan that is specific for you and not based on your insurance policy benefits. Your specific policy benefits will determine what your patient responsibility will be. Our clinic will not quote insurance benefits; therefore, you are encouraged to contact your health plan. **It is ultimately your responsibility to check with your insurance to understand the contract and coverage.**

If you are unsure of your insurance benefits or your deducible, a charge of $50 will be applied for each date of service until benefits can be determined by your insurance carrier. These monies will be placed on your account towards any out of pocket expenses as determined by your insurance plan.

Primary Insurance Company: _____ Secondary Insurance Company: _____

Member ID #: _____ Member ID #: _____

Group #: _____ Group #: _____

____ PLEASE INITIAL AFTER READING

Billing and Payments

You, the patient or legal guardian, are responsible for all claims made to your insurance. Billing is a courtesy service which we provide to our patients at no extra charge. This clinic will provide any necessary reports or required information to aid in insurance reimbursement of services. In the event of the insurance plan's denial of benefits or claim payments, the patient is responsible for the total balance due to the provider. If the insurance carrier requires the patient to send in more information regarding his/her claim and the patient fails to return the required information to the carrier, the patient will be billed for the entire balance on the claim, as the insurance company requires the provider to do.

All co-pays and known co-insurance amounts are due at the time of service.

In the event you do not have health insurance coverage, we do offer a Time of Service reduction of our fee schedule. This reduced fee must be paid at time of service in order to receive the reduction; if payment is not received on the same date of service, then our regular fee schedule rates will be applied to your account.

Patient statements are sent out monthly for the previous months billing and payment activities. Payments on your account are due by the last day of the month in which the statement was sent. Patients are given 90 days to make payments on account before sent to pre-collections. If at any time a payment cannot be made, please call our clinic to set up a payment plan or inform the clinic of your situation as you may qualify for deferred payments.

All accounts with patient portion balance showing no patient payment activity will be charged a $5 monthly Account Maintenance Fee, for each month no payment is made on the account.

Patient Name:

All outstanding unpaid patient account balances over $100 will result in the inability for the patient to schedule future appointments, until the patient portion of the account is paid, or payment arrangements are made.

____ PLEASE INITIAL AFTER READING

Assignment of Benefits

By signing this form you are authorizing payment of medical benefits will be made directly to this clinic. If your insurance carrier sends payment to you for services incurred in this clinic, you agree to send or bring those payments to this clinic upon receipt. However if you pay for your visits in full the assignment will not be reported by this provider and any payment will be send directly to you.

____ PLEASE INITIAL AFTER READING

Reminders/Missed Appointments

With the exception of emergencies, it is vital that you keep all your appointments. Reminder cards, emails and text messages are available to help you save the date and time of your appointments.

Our patient's, staff and doctor's time is valuable, and we wish to provide every patient with an excellent experience. Please provide us the courtesy of a **48 hour cancellation** or change notice if you are unable to keep your appointment time. A $25 missed appointment fee will be charged for a no call, no show appointment, or an appointment change without 48 hour notice.

____ PLEASE INITIAL AFTER READING

Statement of Privacy

We use and disclose the information we collect from you only as allowed by Health Insurance Portability and Accountability Act and Washington State. This includes issues relating to your treatment, payment, and care operations. Your personal health information will never be otherwise given to anyone without your written consent. You may give written authorization for us to disclose your information to anyone you choose, for any purpose. Our clinic and systems are secure from unauthorized access and our team is trained to make certain that the confidentiality of your records is always protected. Our privacy policy and practices apply to all former, current, and future patients. We will only request personal information needed to provide our standard of quality chiropractic or massage care, implement payment activates, conduct normal business operations, and comply with the law. This includes name, address, phone numbers, SSN, employment date, medical history, health records, etc. We are obligated to provide information to law enforcement and governmental officials under certain circumstances. We may use and/or disclose your information to communicate reminders about your appointments including text messaging, voicemail messages, and mailings. You have a right to request copies of your healthcare information; all requests must be in writing. We may charge for copies in the amounts allowed by law. If you believe your rights have been violated, we urge you to notify us immediately. You can also notify the US Dept of Health and Human Services. We thank you for being a patient at our clinic.

____ PLEASE INITIAL AFTER READING

Release of Information

If we bill your insurance company, and you insurance company requires medical reports or records to document your treatment or progress, your signature below authorizes this clinic to release the medical information necessary to process your claim.

If you pay at the Time of Service and insurance is not billed by our clinic, then your signature below verifies that our clinic will not bill insurance for any services rendered and in turn your health insurance company will not be able to request medical records for services rendered.

____ PLEASE INITIAL AFTER READING

Patient Name:

Terms of Acceptance

When a patient seeks chiropractic care, it is essential for both patient and clinic to be working towards the same objective. Chiropractic has only one goal. It is important that each patient understand both the objective and the method used to attain it. This will prevent any confusion or disappointment. An adjustment is the specific application of forces to facilitate the body's correction of vertebral subluxation. Vertebral Subluxation is a misalignment of one or more of the 24 vertebra in the spinal column which causes alteration of nerve transmission of mental impulses, resulting in a lessening of the body's innate ability to express its maximum health potential. We do not offer to diagnose or treat any disease or condition other than vertebral subluxation. However, if during the course of a chiropractic spinal examination, we encounter non-chiropractic or unusual findings, we will advise you. If you desire advice, diagnosis or treatment for those findings, we will recommend that you seek the service of a health care provider who specializes in that area. Regardless of what the disease is called, we do not offer to treat it. Nor do we offer advice regarding the treatment prescribed by others. OUR ONLY PRACTICE OBJECTIVE is to eliminate a major interference to the expression of the body's innate wisdom. Our only method is specific adjusting to correct vertebral subluxations. The doctor and/or his staff will not be held responsible for any health conditions or diagnoses which are pre-existing, given by another health care provider, or are not related to the spinal structural conditions diagnosed at this clinic.

____ PLEASE INITIAL AFTER READING

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 obtain your informed consent before starting 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 stroke; strokes from chiropractic adjustments are very rare. I am aware that nerve or brain damage including stroke is reported to occur once in one to ten million treatments. Once in a million is about the same chance as getting hit by lightening. Once in ten million is about the same change as a normal dose of aspirin or Tylenol causing death.

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. When osteoporosis, degenerative disc or other abnormality is detected, this clinic will proceed with extra caution.

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: _____