



## Confidential Personal Injury Questionnaire

Welcome to our clinic. This information is needed so we can better serve you. Please fill in ALL portions of the form. If you need help please don't hesitate to ask.

Printed Name: \_\_\_\_\_ Date: \_\_\_\_\_

1. Do you have health insurance? YES / NO
2. Who is the policy holder? \_\_\_\_\_
3. Have you treated anywhere else for this auto case?
  - Ambulance? YES / NO
  - Emergency room? YES / NO
  - Doctor's office? YES / NO
  - Physical therapy? YES / NO
  - MRI/CAT scan? YES / NO
  - Other? YES / NO\_\_\_\_\_
4. Do you have an attorney? YES / NO

Signature of person completing questionnaire: \_\_\_\_\_

Printed Name: \_\_\_\_\_ Date: \_\_\_\_\_

**ACCIDENT HISTORY REPORT**

Name: \_\_\_\_\_

Address: \_\_\_\_\_

Date of Accident: \_\_\_\_\_

Employer: \_\_\_\_\_ Occupation: \_\_\_\_\_

Social Security #: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

Referred by:

Person: \_\_\_\_\_

Doctor: \_\_\_\_\_

Attorney: \_\_\_\_\_

At-fault party's Insurance Carrier: \_\_\_\_\_

Claim #: \_\_\_\_\_ Name of Rep: \_\_\_\_\_

Health Insurance Carrier: \_\_\_\_\_

Member #: \_\_\_\_\_ Group #: \_\_\_\_\_

**HISTORY**

Incident occurred at work       Incident occurred in a public establishment

Other: \_\_\_\_\_

Location: \_\_\_\_\_

Street \_\_\_\_\_ City, State: \_\_\_\_\_

**DESCRIPTION OF INCIDENT**

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Select from the following list, the part or parts of the body that struck the object:

- Head     Face     Chest     Neck     Back     Shoulder(s) (Rt / Lt)
- Arms (Rt / Lt)                       Elbow(s) (Rt / Lt)                       Wrist(s) (Rt / Lt)
- Leg(s) (Rt / Lt)                       Knee(s) (Rt / Lt)                       Ankle(s) (Rt / Lt)
- Other \_\_\_\_\_

Was the patient:       Unconscious       Dazed       Cut or Bleeding       None

If applicable, indicate normal or abnormal sensations experience by the patient immediately following the accident:

- Felt no immediate pain
- Semiconscious state
- Upper extremity pain (Rt / Lt)
- Pain began shortly after the accident
- Low back pain (Rt / Lt)
- Other \_\_\_\_\_
- Head pain (headache)
- Mid back pain (Rt / Lt)
- Pain began several hours after accident
- Neck pain (Rt / Lt)
- Lower extremity pain (Rt / Lt)

Indicate the action taken by the patient immediately following the accident:

- Was taken to hospital by ambulance
- Went home and rested
- Went home and (shortly after / later that night / the following morning) began to experience (neck / mid back / low back) pain
- Went home and later (drove / was driven) to \_\_\_\_\_ Hospital
- Patient doctored him/herself thinking the pain would go away
- Went to physician: \_\_\_\_\_
- Hospitalization – name of hospital: \_\_\_\_\_
- Went onto normal business

Indicate method of delivery to hospital:

- Ambulance
- Patient drove him/herself
- Driven by spouse/relative/friend/employer
- Went home and was later taken or drove self
- Not Applicable

Was the patient seen in the emergency room?      Yes      No  
Was the patient admitted to the hospital?      Yes      No

Indicate any procedures performed at the hospital (including emergency room):

- Examination
- Stitches
- X-rays
- Physiotherapy
- Prescription
- Cervical Collar
- Injection
- Wounds dressed
- Complete bed rest
- Other \_\_\_\_\_

Follow his/her release from the hospital, the patient:

- Returned home and took it easy
- Returned home and went to bed
- Returned home and returned to the emergency room after \_\_\_\_ hours / \_\_\_\_ days
- Returned to work

Who was the first physician consulted?  Family physician    Chiropractor     Walk-in Clinic

When did the patient first contact a physician?  Within a few days    Other \_\_\_\_\_

\*If the patient contacted this office first, skip to Past History

What was done? (check all that apply)

- Examined
- X-rayed
- Prescription
- Physical Therapy
- Manipulation

Was the patient seen elsewhere for physiotherapy? Yes No  
If yes, where did the patient receive these treatments? \_\_\_\_\_

Was the patient referred to any other physician or sent for any special diagnostic tests or examinations?  Yes  No If yes, please explain: \_\_\_\_\_

MRI  CT Scan  EMG  NCS  SSEP  Thermography

How long was the patient under the care of his/her physician? \_\_\_\_\_

Is the patient still under the doctor's care? Yes No

If no, when was the patient discharged? \_\_\_\_\_

If yes, indicate the frequency of the patient's visits to the doctor: \_\_\_\_\_

Other pertinent information:

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### PAST HISTORY

Has the patient been involved in any previous accidents or injuries of any kind? Yes No

If yes, please provide dates and details:

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Has the patient been previously treated for neck or back problems? Yes No  
If yes, please provide dates and details:

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Has the patient been previously treated by a chiropractor? Yes No  
If yes, please provide dates and details:

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Past surgical history or any condition that could affect present condition:

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Do you have any significant medical problems? (Diabetes, heart, lungs, cancer, etc.)

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Did the patient enjoy good health prior to this accident? Yes No  
If no, please explain:

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**PRESENT COMPLAINTS**

What are the patient's present complaints? (begin with most severe)

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**DISABILITY**

Has the patient lost any time from work since the accident? Yes No  
If yes, number of days lost: \_\_\_\_\_

Is the patient still off from work? Yes No  
If no, indicate the date the patient returned to work: \_\_\_\_\_

Is the patient working at this time? Yes No

Is the patient working with any restriction? Yes No  
If yes, what are the restrictions?

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**ADDITIONAL COMMENTS**

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## Duties Performed Under Duress at Work and Home

Patient \_\_\_\_\_ Date \_\_\_\_\_ Date of Injury \_\_\_\_\_

- Initial  Update

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

- |   |  |
|---|--|
| <input type="checkbox"/> I go to work but work in pain              | <input type="checkbox"/> I can't take time off work b/c I would lose my job  |
| <input type="checkbox"/> I limit my work activities                 | <input type="checkbox"/> I keep working so I don't lose status at my company |
| <input type="checkbox"/> Bending at work hurts                      | <input type="checkbox"/> My business would fail if I took time off           |
| <input type="checkbox"/> Stooping at work hurts                     | <input type="checkbox"/> I believe in working even when I'm in pain          |
| <input type="checkbox"/> Sitting at work hurts                      | <input type="checkbox"/> I feel obligated to work even though I'm in pain    |
| <input type="checkbox"/> Using the Computer at work hurts           | <input type="checkbox"/> My business would lose money if I took time off     |
| <input type="checkbox"/> Pushing at work hurts                      | <input type="checkbox"/> My work is not as good as it was before accident    |
| <input type="checkbox"/> Pulling at work hurts                      | <input type="checkbox"/> My boss reprimanded me for poor performances        |
| <input type="checkbox"/> Kneeling at work hurts                     | <input type="checkbox"/> I got a different job within the same company       |
| <input type="checkbox"/> I have lost status at my company           | <input type="checkbox"/> I got a different job at another company            |
| <input type="checkbox"/> I have lost job security                   | <input type="checkbox"/> I make less money than before the accident          |
| <input type="checkbox"/> I didn't get a promotion                   | <input type="checkbox"/> I cannot do the same work/job as before accident    |
| <input type="checkbox"/> I don't enjoy work as much as before       | <input type="checkbox"/> I can't concentrate as well at work                 |
| <input type="checkbox"/> I doze off at work                         | <input type="checkbox"/> I take paid time off to go to Dr.                   |
| <input type="checkbox"/> I take unpaid time off work to go to Dr.   | <input type="checkbox"/> I make mistakes at work I didn't used to            |
| <input type="checkbox"/> I daydream at work more than before        | <input type="checkbox"/> I hide my poor performance from my boss             |
| <input type="checkbox"/> I feel tired at work                       | <input type="checkbox"/> _____   |
| <input type="checkbox"/> I work in pain because I have bills to pay | <input type="checkbox"/> _____   |

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

- |   |   |
|---|---|
| <input type="checkbox"/> My house is not as clean now                 | <input type="checkbox"/> Mowing the lawn hurts me                             |
| <input type="checkbox"/> My yard is not as neat now                   | <input type="checkbox"/> I cannot mow the lawn                                |
| <input type="checkbox"/> My garden is not as productive now           | <input type="checkbox"/> Taking out the trash hurts me                        |
| <input type="checkbox"/> I do yard work, but do it in pain            | <input type="checkbox"/> I cannot take out the trash                          |
| <input type="checkbox"/> I cannot do my normal yard work              | <input type="checkbox"/> I do not enjoy my gardening/yard work like I used to |
| <input type="checkbox"/> I do house work, but I do it in pain         | <input type="checkbox"/> I do not enjoy my housework like I used to           |
| <input type="checkbox"/> I cannot do my normal housework              | <input type="checkbox"/> Gardening hurts me                                   |
| <input type="checkbox"/> Doing laundry hurts me                       | <input type="checkbox"/> I cannot do my gardening at all since the accident   |
| <input type="checkbox"/> I cannot do laundry now                      | <input type="checkbox"/> Others living with me do my share of the work now    |
| <input type="checkbox"/> Washing dishes hurts me                      | <input type="checkbox"/> Others living with me do my share of the yard work   |
| <input type="checkbox"/> I cannot wash dishes now                     | <input type="checkbox"/> Others living with me do my share of the gardening   |
| <input type="checkbox"/> Vacuuming hurts me                           | <input type="checkbox"/> _____  |
| <input type="checkbox"/> I cannot vacuum now                          | <input type="checkbox"/> _____  |
| <input type="checkbox"/> Cooking hurts me                             |   |
| <input type="checkbox"/> I cannot cook now                            |   |
| <input type="checkbox"/> Washing the car hurts me                     |   |
| <input type="checkbox"/> I cannot wash my car                         |   |
| <input type="checkbox"/> I cannot take time off due to children       |   |
| <input type="checkbox"/> I have _____ children, ages _____            |   |
| <input type="checkbox"/> I have to hire a paid housekeeper            |   |
| <input type="checkbox"/> I asked someone for unpaid housekeeping help |   |
| <input type="checkbox"/> I had to hire a paid gardener                |   |
| <input type="checkbox"/> I asked someone for unpaid yard work help    |   |

## Loss of Enjoyment of Sports, Hobbies, Travel, Daily Activities, & School (Part 1 of 2)

Patient \_\_\_\_\_ Date \_\_\_\_\_ Date of Injury \_\_\_\_\_

- Initial  Update

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

- |   |   |
|---|---|
| <input type="checkbox"/> My exercise was affected by this crash         | <input type="checkbox"/> I had to quit my _____ team after the accident |
| <input type="checkbox"/> I got to the gym and workout in pain           | <input type="checkbox"/> I had to quit my _____ team after the accident |
| <input type="checkbox"/> I not longer go to the gym to workout          | <input type="checkbox"/> I had to quit my _____ team after the accident |
| <input type="checkbox"/> I run but in pain                              | <input type="checkbox"/> I don't enjoy the sport of _____ anymore.      |
| <input type="checkbox"/> I no longer run                                | <input type="checkbox"/> I didn't enjoy the sport _____ for ___ weeks   |
| <input type="checkbox"/> I take walks & have pain while walking         | <input type="checkbox"/> I don't enjoy the sport of _____ anymore.      |
| <input type="checkbox"/> I no longer take walks                         | <input type="checkbox"/> I didn't enjoy the sport _____ for ___ weeks   |
| <input type="checkbox"/> I use to make income at sports                 | <input type="checkbox"/> I don't enjoy the sport of _____ anymore.      |
| <input type="checkbox"/> I have lost sports income since crash          | <input type="checkbox"/> I didn't enjoy the sport _____ for ___ weeks   |
| <input type="checkbox"/> I am an amateur athlete                        | <input type="checkbox"/> I don't enjoy the sport of _____ anymore.      |
| <input type="checkbox"/> I am a professional athlete                    | <input type="checkbox"/> I didn't enjoy the sport _____ for ___ weeks   |
| <input type="checkbox"/> I have gained ___ pounds since the accident    | <input type="checkbox"/> I don't enjoy the sport of _____ anymore.      |
| <input type="checkbox"/> I had to quit my _____ team after the accident | <input type="checkbox"/> I didn't enjoy the sport _____ for ___ weeks   |
| <input type="checkbox"/> _____  |   |

### **Please check all that apply to your HOBBY Activity because of the accident**

- |   |  |
|---|--|
| <input type="checkbox"/> My hobbies were affected by accident | <input type="checkbox"/> Hobby#3 _____                       |
| <input type="checkbox"/> Hobby #1 _____                       | <input type="checkbox"/> I can't do Hobby #3 anymore         |
| <input type="checkbox"/> I can't do Hobby #1 anymore          | <input type="checkbox"/> I do Hobby #3 but in pain           |
| <input type="checkbox"/> I do Hobby #1 but in pain            | <input type="checkbox"/> I have lost money from not doing #3 |
| <input type="checkbox"/> I have lost money from not doing #1  | <input type="checkbox"/> Hobby #4 _____                      |
| <input type="checkbox"/> Hobby#2 _____                        | <input type="checkbox"/> I can't do Hobby #4 anymore         |
| <input type="checkbox"/> I can't do Hobby #2 anymore          | <input type="checkbox"/> I do Hobby #4 but in pain           |
| <input type="checkbox"/> I do Hobby #2 but in pain            | <input type="checkbox"/> I have lost money from not doing #4 |
| <input type="checkbox"/> I have lost money from not doing #2  | <input type="checkbox"/> _____                               |

### **Please check all that apply to your TRAVEL Activity because of the accident**

- |   |  |
|---|--|
| <input type="checkbox"/> Business travel was affected by crash    | <input type="checkbox"/> Travel Plan #1 _____                        |
| <input type="checkbox"/> Pleasure travel was affected by crash    | <input type="checkbox"/> I did not go on travel plan #1              |
| <input type="checkbox"/> I hurt driving my own car                | <input type="checkbox"/> I went, but did not enjoy #1 as much        |
| <input type="checkbox"/> I am in too much pain to drive           | <input type="checkbox"/> I went and the accident had no effect on #1 |
| <input type="checkbox"/> I hurt when I am passenger in a car      | <input type="checkbox"/> Travel Plan #2 _____                        |
| <input type="checkbox"/> I am in too much pain to sit in a car    | <input type="checkbox"/> I did not go on travel plan #2              |
| <input type="checkbox"/> I have anxiety when I'm in a car         | <input type="checkbox"/> I went, but did not enjoy #2 as much        |
| <input type="checkbox"/> I hurt when I'm on an airplane           | <input type="checkbox"/> I went and the accident had no effect on #2 |
| <input type="checkbox"/> I am in too much pain to travel by plane |  |

## Loss of Enjoyment of Sports, Hobbies, Travel, Daily Activities, & School (Part 2 of 2)

Patient \_\_\_\_\_ Date \_\_\_\_\_ Date of Injury \_\_\_\_\_

- Initial                       Update

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

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

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

- |   |   |
|---|---|
| <input type="checkbox"/> School was affected by this accident<br><input type="checkbox"/> I am a student at _____<br><input type="checkbox"/> I am in the _____ year/grade<br><input type="checkbox"/> I was: full time/ part time (circle one)<br><input type="checkbox"/> I had to take fewer classes b/c of crash<br><input type="checkbox"/> I missed _____ days of school<br><input type="checkbox"/> I had to drop out of school b/c of crash<br><input type="checkbox"/> My grades are lower since the crash | <input type="checkbox"/> I have pain caring my school books<br><input type="checkbox"/> I hurt sitting in class more than ___ minutes<br><input type="checkbox"/> My neck hurts when I look down to read<br><input type="checkbox"/> I don't learn as quickly as before the crash<br><input type="checkbox"/> I have difficulty concentrating in class<br><input type="checkbox"/> It takes much longer to study/do my homework<br><input type="checkbox"/> _____<br><input type="checkbox"/> _____ |
|---|---|



# The Oswestry (Low Back) Questionnaire

Name: \_\_\_\_\_

Today's Date: \_\_\_\_\_

*Please read carefully:*

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

## Section 1 – Pain Intensity

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

## Section 2 – Personal Care

- 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 can manage most of my personal care.
- I need help every day in most aspects of self care.
- I do not get dressed, wash with difficulty, and stay in bed.

## Section 3 – Lifting

- I can lift heavy weights without extra pain.
- I can lift heavy weights but it gives me extra pain.
- Pain prevents me from lifting heavy objects off the floor, but I can manage if they are conveniently positioned (e.g. on a table).
- Pain prevents me from lifting heavy weights, but I can manage light to medium weights if they are conveniently positioned.
- I can lift only very light weights.
- I cannot lift or carry anything at all.

## Section 4 – Walking

- Pain does not prevent me from walking any distance.
- Pain prevents me from walking more than 1 mile.
- Pain prevents me from walking more than ½ mile.
- Pain prevents me from walking more than ¼ 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 sitting more than 1 hour.
- Pain prevents me sitting more than ½ hour.
- Pain prevents me sitting more than 10 minutes.
- Pain prevents me from sitting at all.

## Section 6 – Standing

- I can stand as long as I want without extra pain.
- I can stand as long as I want but it gives me extra pain.
- Pain prevents me from standing for more than 1 hour.
- Pain prevents me from standing for more than ½ hour.
- Pain prevents me from standing for 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 – Sex Life

- My sex life is normal and causes no extra pain.
- My sex life is normal but causes extra pain.
- My sex life is nearly normal but is very painful.
- My sex life is severely restricted by pain.
- My sex life is nearly absent because of pain.
- Pain prevents any sex life at all.

## Section 9 – Social Life

- My social life is normal and gives me no extra pain.
- My social life is normal but increases the degree of pain.
- Pain has no significant affect on my social life apart from limiting my more energetic interests (e.g. dancing, etc.)
- 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 10 – 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 restricts me to journeys of less than 1 hour.
- Pain restricts me to short necessary journeys less than 30 minutes.
- Pain restricts me from traveling except to the doctor or hospital.

Other Comments:

Score: \_\_\_\_\_ / \_\_\_\_\_

# Neck Disability Questionnaire

Name: \_\_\_\_\_

Today's Date: \_\_\_\_\_

*Please read carefully:*

*This questionnaire has been designed to give the doctor information as to how your neck pain has affected your ability to manage everyday life. Please answer every section, and mark in each section only the ONE BOX which applies to you. We realize that you may consider that two of the statements in any one section relate to you, but please mark the one 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 can manage most of my personal care.
- I need help every day in most aspects of self care.
- I do not get dressed, wash with difficulty, and stay in bed.

## Section 3 – Lifting

- I can lift heavy weights without extra pain.
- I can lift heavy weights but it gives me extra pain.
- Pain prevents me from lifting heavy objects off the floor, but I can manage if they are conveniently positioned (e.g. on a table).
- Pain prevents me from lifting heavy weights, but I can manage light to medium weights if they are conveniently positioned.
- I can lift only very light weights.
- I cannot lift or carry anything at all.

## Section 4 – Reading

- I can read as much as I want with no pain in my neck.
- I can read as much as I want with slight pain in my neck.
- I can read as much as I want with moderate pain in my neck.
- I cannot 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 moderate headaches which come infrequently.
- I have moderate headaches which come frequently.
- I have severe headaches which come frequently.
- I have headaches almost all the time.

## Section 6 – Concentration

- I can concentrate fully when I want to with no difficulty.
- I can concentrate fully when I want to with slight difficulty.
- I have a fair degree of difficulty in concentrating when I want to.
- I have a lot of difficulty in concentrating when I want to.
- I have a great deal of difficulty in concentrating when I want to.
- I cannot concentrate at all.

## Section 7 – Work

- I can do as much work as I want to.
- I can 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 cannot do any work at all.

## Section 8 – Driving

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

## Section 9 – Sleeping

- I have no trouble sleeping.
- My sleep is slightly disturbed (less than 1 hour sleepless).
- My sleep is mildly disturbed (1-2 hours sleepless).
- My sleep is moderately disturbed (2-3 hours sleepless).
- My sleep is greatly disturbed (3-4 hours sleepless).
- My sleep is completely disturbed (4-5 hours sleepless).

## Section 10 – Recreation

- I am able to engage in all my recreation activities with no neck pain at all.
- I am able to engage in all my recreation activities with some pain in my neck.
- I am able to engage in most, but not all of my usual recreation activities because of pain in my neck.
- I am able to engage in a few of my usual recreation activities because of pain in my neck.
- I can hardly do any recreation activities because of pain in my neck.
- I cannot do any recreation activities at all.

Other Comments:

Score: \_\_\_\_\_ / \_\_\_\_\_

**Personal Injury Financial Policy**

1. If an attorney represents you:

You must provide us with their name and address prior to receiving services.

They must sign and fax a lien within 24 hours of your initial visit in this office.

You must provide us with the following three insurances:

- A. Personal Health Insurance
- B. Medical Pay Insurance (your auto insurance)
- C. Liability Auto Insurance (person who hit you)

2. In an attorney does not represent you:

You must sign a lien assigning payments for our services directly to us from your insurance carrier(s) prior to receiving services.

You must provide us with the following three insurances:

- A. Personal Health Insurance
- B. Medical Pay Insurance (your auto insurance)
- C. Liability Auto Insurance (person who hit you)

3. If you are an existing patient, any treatment plan or financial agreement will be suspended until you have reached maximum medical improvement from your personal injury claim.

**\*Regardless of whether or not you have an attorney, if you do not have insurance, you will be considered a cash patient and will be expected to pay for services at the time they are rendered.**

I have read and agree to the above terms.

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Patient Signature

Date

Health Ins

Liability Ins

Med-Pay Ins

## Informed Consent for Chiropractic Care

When a patient seeks chiropractic health care and we accept a patient for such care, it is essential for both to be working for the same objective. It is important that each patient understand both the objective and the method that will be used to attain it. This will prevent any confusion or disappointment. You have the right, as a patient, to be informed about the condition of your health and the recommended care and treatment to be provided so that you may make the decision whether or not to undergo chiropractic care after being advised of the known benefits, risks, and alternatives.

Chiropractic is a science and art which concerns itself with the relationship between structure (primarily the spine) and function (primarily the nervous system) as the relationship may affect the restoration and preservation of health. Health is a state of optimal physical, mental and social well-being, not merely the absence of disease or infirmity.

One disturbance to the nervous system is called a vertebral Subluxation. This occurs when one or more of the 24 vertebrae in the spinal column become misaligned and/or do not move properly. This causes alteration of the nerve function and interference to the nervous system. This may result in pain and dysfunction or may be entirely asymptomatic.

Subluxations are corrected and/or reduced by chiropractic adjustment. An adjustment is the specific application of forces to correct and/or reduce vertebral Subluxation. Our chiropractic method of correction is by specific adjustments of the spine. Adjustments are usually done by hand but may be performed by handheld instruments. In addition, ancillary procedures such as rehabilitative procedures may be included.

Chiropractic care, like all forms of health care, while offering considerable benefit, may also provide some level of risk. This level of risk is most often very minimal, yet in rare cases, injury has been associated with chiropractic care. The types of complications that have been reported secondary to chiropractic care include sprain/strain injuries, irritation of a disc condition, and rarely, fractures. One of the rarest complications associated with chiropractic care, occurring at a rate between one instance per one million to one per two million cervical spine (neck) adjustments may be a vertebral artery injury that could lead to stroke.

If during the course of care we encounter non-chiropractic or unusual findings, we will advise you of those findings and recommend that you seek the services of another health care professional.

All questions regarding the doctor's objective pertaining to my care in this office have been answered to my complete satisfaction. The benefits, risks and alternatives of chiropractic care have been explained to me to my satisfaction. I have read and fully understand the above statements and therefore accept chiropractic care on this basis.

\_\_\_\_\_  
Print Name

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Date

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Consent to evaluate and adjust a minor/child:

I, \_\_\_\_\_ being the parent of legal guardian of \_\_\_\_\_

Have read and fully understand the above Informed Consent and hereby grant permission for my child to receive chiropractic care.

\_\_\_\_\_  
Print Name

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Date

## **DIRECTIONS TO ATLANTA SPINE AND WELLNESS**

**\*\*\*\*PLEASE NOTE THAT GPS DEVICES RECOGNIZE 5070 PEACHTREE BLVD AS THE PARKVIEW ON PEACHTREE COMPLEX. WE ARE LOCATED INSIDE THE COMPLEX, AMONG OTHER OFFICES, IN SUITE E-170. OUR NEAREST NEIGHBOR IS SOLIS APARTMENT LEASING OFFICE. PARKING IS AVAILABLE, FOR FREE, IN THE STRUCTURE OR SURROUNDING LOTS\*\*\*\***

### **Traveling on I-285E:**

Traveling eastbound, use the right lane to take exit 30 to Chamblee-Dunwoody Rd. Travel 2 miles south, turn right onto Peachtree Blvd. Travel 0.5 miles southwest and turn right onto Clairmont Rd. Drive over small bridge into Parkview complex. Suite E-170 located just beyond Solis Leasing office on your right facing interior of complex. Enter below sign for Atlanta Spine and Wellness.

### **Traveling on I-285W:**

Traveling westbound, take exit 31A for GA-141 SOUTH Peachtree Ind Blvd toward Chamblee. Continue on Peachtree Blvd for 2 miles then turn right on Clairmont Rd. into Parkview complex. Drive over small bridge into Parkview complex. Suite E-170 located just beyond Solis Leasing office on your right facing interior of complex. Enter below sign for Atlanta Spine and Wellness

### **From Downtown (I75/85N):**

Merge onto I85N. Take exit 91 towards US-23/GA-155/Clairmont Rd/Decatur. Use the left 2 lanes to turn left onto US-23 N/Clairmont Rd, continue straight for 2.2 miles onto Clairmont Rd. Travel straight across Peachtree Blvd, over small bridge, into Parkview Complex. Suite E-170 located just beyond Solis Leasing office on your right facing interior of complex. Enter below sign for Atlanta Spine and Wellness

### **From I85S:**

Traveling southbound, cross over I-285 so you are inside the perimeter. Use the right 2 lanes to take Exit 94 for Chamblee-Tucker Rd toward Mercer Univ. Keep right at the fork and merge onto Chamblee Tucker Rd. Continue for 2 miles and merge onto Chamblee Tucker Rd. Continue for 0.2 mile and turn slightly left onto New Peachtree Rd. Continue for 0.3 mile and turn right onto Clairmont Rd. Continue north, cross over Peachtree Blvd. Drive to the left over small bridge into Parkview complex. Suite E-170 located just beyond Solis Leasing office on your right facing interior of complex. Enter below sign for Atlanta Spine and Wellness.

### **From Chamblee Marta via Chamblee Rail Trail:**

Exit Chamblee Marta station onto Chamblee Tucker Rd. Walk north on Chamblee Tucker Rd. 0.3 mile until you reach Chamblee Rail Trail entrance on your left. Enter rail trail, heading west, Wal Mart will be on your right if your on trail Cross under Clairmont Rd bridge above you. Stay on trail north. Take tunnel under Peachtree Blvd. Take staircase up to Parkview Complex. Suite E-170 located just beyond Solis Leasing office on your right facing interior of complex. Enter below sign for Atlanta Spine and Wellness.