Cancellation Policy

We do require a 24 hour cancellation notice for Chiropractic and Massage appointments. If cancelling, it must be done prior to 24 hours of your appointment to avoid being charged. Appointments that are not cancelled prior to the 24 hour period will be billed at $80.00 for Chiropractic and $120.00 for Massage.

Thank you in advance for your cooperation.

_____	_____
Patient's name (printed)	Date of birth
_____	_____
Patient Signature	Date
_____	_____
Office Staff Signature	Date

Informed Consent to Chiropractic Treatment

The Nature of Chiropractic Examination and Treatment: The doctor will perform a physical examination. The examination will consist of range of motion, orthopedic testing, palpation, and basic neurological testing. During treatment, the doctor will use his/her hands or a mechanical device in order to move your joints. This action may create an audible “pop” or “click”, much like the sound when you crack your knuckles. Along with the sound, you may also experience a sense of movement in the joint. The doctor may also recommend procedures such as hot or cold packs, electrical muscle stim, traction, or exercise to enhance your response to treatment.

Anticipated Benefits of Chiropractic Treatment: Many or most patients will feel improvements in motion, decreased muscle and joint pain and improved well-being after a series of chiropractic adjustments.

Possible Risks of Chiropractic Treatment: As with any health care procedures, there are some complications that may arise following a chiropractic manipulation and/or therapy. A small number of patients may experience stiffness, soreness, or bruising following the first few treatments. Less likely complications could include muscle strain, ligament sprain, fracture, joint dislocation, disc, nerve, or spinal cord damage. There has been much debate and research over the association of chiropractic care and occurrence of stroke and arterial dissection. The latest scientific evidence does not establish a causal relationship but rather an association. An extremely small percentage of patients presenting to either a medical or chiropractic physician with head and neck pain, may be in early stages of a stroke. Unfortunately, there is no recognized screening procedure to identify these patients.

Other Treatment Options for the Musculoskeletal conditions:

1. Over-the-counter medication. Risks of these medications could include irritation of the stomach, kidneys, and liver.

2. Medical care anti-inflammatory drugs, pain killers, muscle relaxers, and steroids. The uses of these prescription drugs include all above side effects plus the dependence of the prescription drugs.

3. Hospitalization used with medical care includes all of the above risks, but also the additional risk of medical error, infection, or other complications.

4. Surgery with medical care includes all above risks, with the added risk of adverse reaction to anesthesia.

I have read the above explanation of chiropractic treatment. I have had the opportunity to have any questions answered to my satisfaction. I have fully evaluated the risks and benefits of undergoing treatment. I have freely decided to undergo the recommended treatment, and herby give my full consent to treatment. This informed consent will remain in effect unless there are significant changes in my diagnosis. I have the right to withdraw my consent at any time, upon written notice. I have the right to refuse treatment at any time.

_____ _____/____/_____
Patient’s name (printed) Date of birth

_____ _____
Signature of patient Date

_____ _____
Signature of parent/guardian (if patient is a minor) Date

_____ _____ _____
Doctor Printed Name Doctor Signature Date

PATIENT INTRODUCTION FORM

Today's Date: _____

Last Name:	**MI:**	**First Name:**
Home Address:	City: State	Zip:
Date of Birth: Age:	Cell phone:	
Height: Weight:	Work phone:	
Social Security #:	Employer's Name:	
How did you hear about us?	Who can we thank for the referral?	
E-mail address:	Can we send you our monthly e-newsletter?	
Do you have insurance that you would like us to bill? (Please provide a copy of your card.)	☐ YES ☐NO If yes, name of company:	
Emergency Contact: Name: Address:	Relationship: Phone:	

IS THIS VISIT RELATED TO A:

- ☐ Work Related Injury
- ☐ Car Crash Injury
- ☐ Home Injury
- ☐ Sports or Recreational Injury
- ☐ Non-Injury Symptoms
- ☐ Check-up Only
- ☐ Other (Describe):

The patient understands and agrees to allow this chiropractic office to use their Patient Health Information for the purpose of treatment, payment, healthcare operations, and coordination of care. We want you to know how you would like to have a more detailed account of our policies and procedures concerning the privacy of your Patient Health Information we encourage you to read the HIPAA NOTICE that is available to you at the front desk before signing this consent. If there is anyone you do not want to receive your medical records, please inform our office.

Our office will provide insurance billing services for you if you so desire as a courtesy.

Remember that you are ultimately responsible for any charges incurred in this office. It is your responsibility to pay any deductible amount, co-insurance, and/or any other balances not paid by your insurance carrier.

Your signature on this document indicates that you:

1) *Agree to pay for any outstanding bills incurred in this office.*
2) *Authorize the release of information necessary to secure the payment of benefits.*
3) *Authorize insurance payments to be made directly to Summit Chiropractic & Massage.*
4) *Authorize the use of this signature on all insurance submissions.*

IN ORDER TO KEEP OUR OFFICE OVERHEAD DOWN AND KEEP OUR PATIENT FEES REASONABLE, WE EXPECT PAYMENT AT THE CONCLUSION OF EACH TREATMENT FOR TIME OF SERVICE PATIENTS AND THE CO-PAYMENT, DEDUCTIBLE OR CO-INSURANCE FOR REGULAR INSURANCE PATIENTS.

Signature of responsible party (Patient or Parent): _____ Date: _____

CHIROPRACTIC HISTORY

Name: _____ DOB: _____ Date: _____

MAIN COMPLAINT: _____

Do you have any prior history of problems with your neck, midback, or low back? If yes, explain: _____

_____

When it began and how: _____

Have you seen any other doctors for your complaint? _____

What makes this complaint worse? _____

What makes this complaint better? _____

Allergies: _____

Date of your last physical exam: _____

Have you experienced headaches? _____

Family Health History

Health problems of relatives: _____

Cardiovascular health history (i.e. stroke, TIA's, heart attack): _____

_____

Social & Occupational History

Job description: _____

Have you been able to work? _____

Work schedule: _____

Recreational Activities: _____

Lifestyle (hobbies, alcohol, tobacco & drug use, diet): _____

_____

Doctors Use Only

Patient Name: _____ DOB: _____ Date: _____

GENERAL HEALTH HISTORY

Check only those conditions that apply to you and indicate if you have had in the past or presently have:

YES	GENERAL QUESTIONS	PAST	PRESENT
☐	I bruise easily	☐	☐
☐	I heal slowly	☐	☐
☐	My body temperature is normally low (feel cold)*	☐	☐
☐	Smoke cigarettes or use tobacco products	☐	☐
☐	Diabetic-Hypoglycemic or need to have dialysis.	☐	☐
☐	Do you have a heart pacemaker or neck or chest shunt?	☐	☐
☐	Heart attack	☐	☐
☐	Do you have difficulties or intolerance to heat packs or ice packs on your skin?	☐	☐
☐	Dizziness, blacked out, or fainting spell history	☐	☐
☐	Epilepsy-Seizure-Convulsion history	☐	☐
☐	History of gout, lupus, psoriasis, temporary paralysis, or spinal meningitis	☐	☐
☐	Cancer history or treatment of any type	☐	☐
☐	Stroke history (Indicate any suspected strokes or transient ischemic attacks)	☐	☐
☐	Told that you have scoliosis, spondylolisthesis, disc degeneration, or herniated disc	☐	☐
☐	Told that you have spine bifida, abdominal aneurysm, or vascular conditions	☐	☐
☐	Have you ever been hospitalized? Why:	☐	☐
☐	Thyroid disorders	☐	☐
☐	Coma from head injury or other problem	☐	☐
☐	Told you have osteoporosis of your spine or osteopenia (weak bones)	☐	☐
☐	Told you have osteoarthritis or rheumatoid arthritis of your spine or joints	☐	☐
☐	**Women only: Check this box if you currently have any type of breast implants**	N/A	N/A
☐	**Women only: Check this box if there is any chance that you are currently pregnant**	N/A	N/A

PRIOR INJURY OR MUSCULOSKELETAL PAIN HISTORY

☐ **I have no history of previous painful injury or pain.**

If you have had prior injuries or pain, please check below:

☐ Work injury	☐ Fall	☐ Sports injury	☐ Lifting injury	☐ Car accident
☐ Motorcycle injury	☐ Bicycle injury	☐ Pedestrian injury	☐ Military injury	☐ Other injury
☐ Headaches/Migraines	☐ Neck pain or arm pain	☐ Middle back pain	☐ Low back/Leg pain	☐ Other pain

FRACTURES/BROKEN BONES

☐ **I have never had any broken bones.**

If you have broken any bones, indicate where and when:

Region	Year	Region	Year
☐ Spinal Vertebra		☐ Skull	
☐ Collar bone (clavicle)		☐ Rib bone	
☐ Arm or hand bone		☐ Leg or foot bone	
☐ Pelvis bone		☐ Other	

PREVIOUS SURGERIES

☐ **I have never had any surgical procedure.**

If you have had any previous surgery, indicate type and when:

Surgery	Year	Surgery	Year
☐ Spine surgery (neck or back)		☐ Appendix	
☐ Disc surgery in neck or back		☐ Gallbladder/Stomach/Kidney	
☐ Heart		☐ Cancer (any type)	
☐ Tonsillectomy		☐ Rib/Collar bone	
☐ Head/Brain		☐ Hernia	
☐ Shoulder/Arm/Leg		☐ Other	

*See common question answers.

Patient Name: _____ DOB: _____ Date: _____

GENERAL HEALTH HISTORY (Page 2)

LIST ALL SYMPTOM REGIONS AND HOW LONG YOU HAVE HAD THEM

CHECK ALL SYMPTOM AREAS	HOW LONG	CHECK ALL SYMPTOM AREAS	HOW LONG
❑ Headaches/Migraines		❑ Upper back pain, soreness, or stiffness	
❑ Neck pain, soreness, or stiffness		❑ Hip pain	
❑ Low back pain, soreness, stiffness		❑ Leg or foot pain, numbness, or tingling	
❑ Arm/hand pain, numbness, or tingling		❑ Other:	

Did your symptoms come on: ❑ Suddenly? or **❑ Gradually?**

SYMPTOM/PAIN DESCRIPTION

Please circle any word or words below that best describes how your symptoms currently feel to you.

Pain	Pinching	Spreading	Vicious	Unbearable
Ache	Pricking	Shooting	Sickening	Soreness
Cutting	Tingling	Stabbing	Miserable	Pins and needles
Tearing	Gnawing	Dull	Troublesome	Radiating
Crushing	Nagging	Bony	Pressing	Weakness
Pulling	Boring	Terrifying	Deep pain	Falls asleep
Irritating	Burning-Hot	Dreadful	Superficial pain	Suffocating
Annoying	Drill like	Fearful	Stinging	Punishing
Stiff or tight	Heavy	Unhappy	Throbbing	Crawling
Exhausting	Numbness	Torturing	Sharp	Tender

Have you ever been to a Chiropractor before for any condition? ❑ Yes ❑ No

If yes, Chiropractors name: _____ Year: _____

Problem seen for: _____

Do you have any problems laying face down on an examination table? ❑ Yes ❑ No

If yes, why: _____

ARE YOU TAKING ANY MEDICATIONS?

☐ I am not taking any medications currently.

Check any of the following that you are taking currently.

❑ Muscle relaxants	❑ Blood pressure/Stroke prevention medications	❑ Cortisone injections
❑ Pain/Anti-inflammatory meds	❑ Osteoporosis (bone strengthening) medications	❑ Other:

WHAT ACTIVITIES INCREASE YOUR PAIN LEVELS?

❑ Morning	❑ Bending your back	❑ Walking
❑ Afternoon or evening	❑ Lying down flat	❑ Standing
❑ During sleep hours	❑ Sitting	❑ Exercise/Stretching
❑ Standing up from sitting	❑ Poor posture	❑ Other:

HAS YOUR PAIN BEEN ASSOCIATED WITH:

❑ Excessive fatigue-malaise	❑ Bowel or bladder disorders	❑ Night pain or nighttime sweats
❑ Weight loss	❑ Ovarian pain	❑ Abdominal pain
❑ Low grade fever	❑ Kidney pain/painful urination	❑ Balance problems

DO YOU EXERCISE?

❑ I do no regular exercise.	❑ I exercise 1-2 times a week.	❑ I exercise 3-5 times a week.
❑ I stretch regularly.	❑ I do weight lifting at gym/home.	❑ I do cardiovascular work outs.
❑ I am willing to do exercise.	❑ I am not willing to do exercises.	❑ I do regular sports activities.

Patient Name: _____ DOB: _____ Date: _____

SYMPTOM QUESTIONNAIRE

Please fill out only the sections that apply to you. Skip sections that do not relate to your condition.

NECK REGION

YES	NO	
❑	❑	1. Does neck and head movement cause your neck pain to intensify?
❑	❑	2. Do you get dizzy when you look up or twist your head? If yes, how often:
❑	❑	3. Do you black out or lose your balance when you look up or twist your head? If yes, how often:
❑	❑	4. Do you have to support your head with your hand or grasp your mouth or hair to be able to lift your head up when you are lying down and attempting to sit up? If your difficulty/inability to lift your head without support is injury related, indicate how soon this occurred after injury? (_____min/hrs)
❑	❑	5. Do you feel your neck pain sends pain downwards between your shoulders?
❑	❑	6. Do you feel your neck pain sending pain downwards to the front of your chest?
❑	❑	7. Have you noticed your head leaning or tilting to one side recently?
❑	❑	8. Have you ever been diagnosed as having a disc bulge or herniation in your neck?

ARM, HAND, OR FINGER REGION

YES	NO	
❑	❑	1. Do you have pain, numbness, or tingling in your shoulder, upper arm, lower arm, or hand? Circle areas
❑	❑	2. Do you have pain, numbness, or tingling in your fingers? If yes, circle finger(s) that are involved: Thumb, Index finger, Middle finger, Ring finger, Little finger
❑	❑	3. Do you get increased arm numbness when lying flat on your back or sleeping on your side recently?
❑	❑	4. Does changing your sitting posture increase your arm/hand symptom intensity?
❑	❑	5. If you sit and slouch forward for several minutes, do your arm symptoms intensify?
❑	❑	6. If you have arm symptoms, do they improve when you lift your arms over your head?
❑	❑	7. If you have arm symptoms, do they worsen when you lift your arms over your head?
❑	❑	8. If you have nighttime hand or arm pain, does it help to shake and massage them?
❑	❑	9. Do your hands feel tender when you grasp objects recently?
❑	❑	10. Do you feel weakness in your grip strength recently?
❑	❑	11. Do you drop objects in your hand recently?
❑	❑	12. Do you have difficulty writing or doing small motions with your fingers recently?
❑	❑	13. Do your hand(s) or wrist get swollen recently?
❑	❑	14. Do your hands burn recently?
❑	❑	15. Are your fingers frequently cold?
❑	❑	16. Have you been diagnosed as having Raynaud's syndrome in your past?

MID BACK AND CHEST WALL REGION

YES	NO	
❑	❑	1. Do you have pain that shoots or radiates outward along your rib cage?
❑	❑	2. Does your mid back or chest wall pain intensify when you take a deep breath in or cough recently?
❑	❑	3. Does your mid back or chest wall pain intensify when you twist your torso, bend, or stoop forward?
❑	❑	4. When you bend your mid back to the left or right side, does your mid back pain or chest pain increase?
❑	❑	5. Have you been diagnosed as having angina before?
❑	❑	6. Do you have a tight band-like chest feeling recently?
❑	❑	7. Do you recently have any associated unusual indigestion, chest pressure, or pain down your left arm?
❑	❑	8. Does your mid back pain mostly bother you during sleep?
❑	❑	9. Does your upper-middle back pain radiate inwards or upwards into your neck?

Patient Name: _____ DOB: _____ Date: _____

SYMPTOM QUESTIONNAIRE

Please fill out only the sections that apply to you. Skip sections that do not relate to your condition.

LOW BACK, HIP AND LEG/FOOT REGION

Check any of the following body movements that intensify your low back pain or leg symptoms:

❑ Sitting	❑ Bending forwards	❑ Standing up	❑ Walking
❑ Standing still	❑ Bending backwards	❑ Lying on your back	❑ Putting on shoes

Check all locations of any current leg pain, numbness, or tingling:

❑ Hip	❑ Buttock	❑ Back of thigh	❑ Calf
❑ Groin area	❑ Knee	❑ Front of thigh	❑ Foot/toes

YES	NO	
❑	❑	1. When you cough, sneeze, or bear down to have a bowel movement, does your low back pain or leg pain get worse recently?
❑	❑	2. Do you have a consistent pattern of getting severe leg pain after walking for similar distances that is relieved by resting or sitting down? This pain resumes after walking for same distance again.
❑	❑	3. Do you get leg cramping while walking that is relieved by resting, leaning against an object, or sitting? This pain is worse at nighttime and is relieved by walking around for a couple of minutes.
❑	❑	4. Do you get leg pain or hip pain while walking that is consistently relieved by sitting down or lying down? This pain doesn't bother you at nighttime or while sitting.
❑	❑	5. Does your leg or foot drag on the floor recently?
❑	❑	6. Do you get a lot of leg cramps at nighttime recently?
❑	❑	7. Have you had any urinary or bowel incontinence recently or had difficulty urinating or having bowel movements during the same time as your having low back pain or leg pain?
❑	❑	8. Have you had abdominal pain, indigestion, and colicky symptoms with your low back pain?
❑	❑	9. Have you observed that any type of postural change does not relieve your low back pain?
❑	❑	10. Do your feet feel cold recently? If yes, indicate which foot or if both feet:
❑	❑	11. Have you ever been diagnosed as having a herniated or bulging disc in your low back in the past?
❑	❑	12. Have you ever had an injection of a steroid into your discs (spine) in your back or neck?
❑	❑	13. Have you recently noticed that either of your legs occasionally give out on you when you walk?
❑	❑	14. Does one or both of your legs feel weak recently?
❑	❑	15. Have you ever been diagnosed as having a spondylolisthesis in your low back region?
❑	❑	16. Have you or either of your parents ever been diagnosed as having an abdominal aneurysm?
❑	❑	17. If you have radiating leg or foot pain, did you notice low back pain or soreness before your leg symptoms?
❑	❑	18. If you have leg pain, is your leg pain primarily focused in front of your thigh(s)?
❑	❑	19. Has your anal-rectal region been completely numb recently?
❑	❑	**Men only: Do you have any recent prostate or urinary problems?**
❑	❑	**Women only: Do you have any recent ovarian, uterine, or bladder problems?**

SLEEPING PATTERNS

YES	NO	
❑	❑	Do you sleep poorly at night recently?
❑	❑	Do you sleep on your stomach?
❑	❑	Do you consistently feel extremely tired when you wake up in the morning recently? How old is your mattress? _____What make? _____ How old is your pillow? _____

PERSONAL INJURY INTRODUCTION FORM

Today's Date: _____

Last Name:	**MI:**	**First Name:**
Home Address:	City: State:	Zip:
Date of Birth: Age:	Cell phone #:	
Height: Weight:	Cell phone carrier:	
Social Security #:	Employer's Name:	
Drivers License No:	Marital Status: Single, Married, Divorced, Widowed	
Emergency Contact: Name: Address:	Relationship: Phone:	

AUTOMOBILE INSURANCE INFORMATION

Do you or someone else have insurance coverage for the vehicle you were in? ❑ I have coverage ❑ Someone else has coverage. Indicate name of policy holder:	
How is this person related to you? ❑ Self ❑ Parent ❑ Friend ❑ Other	
Name of your automobile insurance carrier:	
Address of your automobile insurance carrier:	
Claim Adjusters Name:	
Claim Adjusters Telephone Number:	
Claim Number:	
Do you have an insurance deductible?	❑ Yes, deductible is: $ ❑ No
Do you know your policy limits for medical bills?	❑ Yes, limit is: $ ❑ No
Have you reported this injury to your insurance carrier? ❑ Yes ❑ No	

Did you go the hospital? ❑ Yes ❑ No	Were you admitted to the hospital? ❑ Yes ❑ No
If you went to the hospital, when did you go? ❑ At the time of the accident ❑ Next day	
How did you get to the hospital? ❑ Ambulance ❑ Police car ❑ Private transportation	
Name of hospital:	Attending Doctor:

Our office will provide insurance billing services for you if you so desire as a courtesy. *Remember that you are ultimately responsible for any charges incurred in this office. It is your responsibility to pay any deductible amount, co-insurance, and/or any other balances not paid by your insurance carrier.* ***Your signature on this document indicates that you:*** *1) agree to pay for any outstanding bills incurred in this office, 2) authorize the release of information necessary to secure the payment of benefits, and 3) authorize the use of this signature on all insurance submissions.*

It is essential that if your insurance carrier sends you forms that need to be signed for authorization for records that you sign these documents and send the completed forms back to the carrier as soon as possible.

Do you have an attorney representing you? ❑ Yes ❑ No	
If yes, indicate name, address, and contact number:	Attorney Name: Address: Telephone number:

Signature of responsible party (Patient or Parent): _____ Date: _____

MOTOR VEHICLE CRASH FORM (PAGE 1)

Patient Name:	**DOB:**	**Date:**

Date of injury:	Time of injury:	❑ AM ❑ PM
City where crash occurred:	Was the street wet or dry?	❑ Wet ❑ Dry
Street (location) where crash occurred:		
What is the estimated damage to your vehicle? $		
Who made damage estimates on your vehicle?		
Who owns the vehicle you were involved in?		
Did the police come to the accident scene? ❑ Yes ❑ No		
Did the police make a written report? ❑ Yes ❑ No		
Were any photographs taken of your vehicle? ❑ Yes ❑ No	If yes, who took them?	

DESCRIBE HOW THE CRASH HAPPENED

COLLISION DESCRIPTION-TYPE

Check all that apply to you. Indicate which type of car crash you were involved in.

❑	Single-car crash	❑	Two-vehicle crash	❑	Three of more vehicles
❑	Rear-end crash	❑	Side crash	❑	Rollover
❑	Head-on crash	❑	Hit guard rail, tree, or object	❑	Ran off the road
❑	Other (please describe):				

INDICATE YOUR SEATING POSITION

❑	Driver	❑	Front passenger	❑	Left rear passenger	❑	Right rear passenger

DESCRIBE THE VEHICLE YOU WERE IN:

Model, make, and year:					
❑	Small-sized car	❑	Mid-sized car	❑	Large-sized car
❑	Pick-up truck	❑	Van	❑	Sport Utility Vehicle
❑	2 door vehicle	❑	4 door vehicle	❑	Large truck, bus, or semi-truck
❑	Sedan	❑	Hatchback	❑	Station wagon
❑	Other (please describe):				

DESCRIBE THE OTHER VEHICLE (if not certain, leave blank):

Model, make, and year:					❑ Unknown
❑	Small passenger	❑	Mid-sized passenger car	❑	Large-sized passenger car
❑	Van	❑	Pick-up truck/SUV	❑	Large truck, bus, or semi-truck

Patient Name: _____ DOB: _____ Date: _____

MOTOR VEHICLE CRASH FORM (PAGE 2)

AT THE TIME OF IMPACT, YOUR VEHICLE WAS:

❑	Stopped	❑	Slowing down	❑	Moving at steady speed	❑	Gaining speed

AT THE TIME OF IMPACT, THE OTHER VEHICLE WAS:

❑	Stopped	❑	Moving at steady speed	❑	Unknown speed
❑	Slowing down	❑	Gaining speed	❑	Other:

DURING AND AFTER THE CRASH, YOUR VEHICLE:

❑	Kept going straight, not hitting anything	❑	Spun around, not hitting anything
❑	Kept going straight, hitting car in front	❑	Spun around, hitting another car
❑	Was hit by another vehicle	❑	Spun around, hitting object other than car

INDICATE IF YOU BODY HIT SOMETHING OR WAS HIT BY ANY OF THE FOLLOWING:

Please draw lines from the body regions on the left side and match to the right side.

BODY REGION	OBJECT YOU HAD CONTACT WITH
Head	Windshield or side window
Face	Steering wheel
Shoulder	Side of door
Arm/hand	Dashboard
Front chest wall	Knee bolster/glove compartment
Side chest wall	Seatbelt (lap belt or shoulder harness)
Hip/abdomen	Frame of car near windows
Knee	Rood or top part of vehicle
Leg	Another occupant/animal
Foot	Other

CHECK IF ANY OF THE FOLLOWING VEHICLE PARTS BROKE, BENT, OR WERE DAMAGED IN YOUR CAR:

❑	Stopped	❑	Moving at steady speed	❑	Unknown speed
❑	Slowing down	❑	Gaining speed	❑	Other:

ALL TYPES OF COLLISIONS

Indicate those relevant to your case.

Yes	No	
❑	❑	Did any of the interior front or side structures, such as the side door, dashboard, steering wheel, or floorboard or your car dent inward during the crash?
❑	❑	Did the side door touch your body during the crash?
❑	❑	Did your body slide under the seatbelt?
❑	❑	Was the door(s) of your vehicle damaged to point where you could not open the door?
❑	❑	Did an airbag deploy in your vehicle during the crash? If yes, circle: side air bag or front air bag

Patient Name: _____ DOB: _____ Date: _____

MOTOR VEHICLE CRASH FORM (PAGE 3)

SEATBELT USAGE AND STERRING WHEEL HAND PLACEMENT

Indicate those relevant to your case

Yes	No	
❑	❑	Were you wearing a seatbelt? If yes, does your seatbelt have a: ❑ Lap and shoulder strap ❑ Lap belt only
❑	❑	Did you have any portion of your seatbelt positioned behind your chest, back, or shoulder?
❑	❑	Were you holding onto the steering wheel (driver only) at the time of impact? If yes, indicate where each had was positioned (use time clock face as your reference point) Left hand: ❑ Not on wheel ❑ Yes, hand at _____ o'clock ❑ Hand elsewhere Right hand: ❑ Not on wheel ❑ Yes, hand at _____ o'clock ❑ Hand elsewhere

REAR-END COLLISIONS ONLY

Answer this section only if you were hit from the rear.

Describe your vehicle's head restraint system:

❑ Movable/adjustable head restraint ❑ Fixed, non-moveable head restraint
❑ No headrests in my vehicle ❑ Bench seat in your vehicle without head restraint

Please indicate how your head restraint was positioned at the time of crash (if present):

❑ At the top of the back of your head ❑ Midway height of the back of your head
❑ Lower height of the back of your head ❑ Located at the level of your neck
❑ Level of your shoulder blades

BRUISING AFTER THE CRASH

Yes	No	
❑	❑	Did your body have any bruising (areas that were visibly black and blue) after the crash? If yes, indicate where:

AWARENESS AND BODY POSITION DESCRIPTIONS

Check all areas that apply to you.

❑	You were unaware of the impending collision. You did not see or hear brakes prior to the impact.
❑	You were aware of the impending crash and relaxed before the collision.
❑	You were aware of the impending crash and braced yourself.
❑	Your body, torso, and head were facing straight ahead.
❑	You had your head and/or torso turned at the time of collision: ❑ Turned to left ❑ Turned to right Describe how far you were turned/twisted and why you were turned/what were you doing?
❑	You were leaning forward at the time of impact resulting in a gap between your body and the seatback. If yes, indicate how far you were leaning and why you were leaning forward?
❑	Your torso and body was positioned normally against the seatback with no gaps due to leaning/twisting.

How soon did you first notice any pain/soreness after the crash? _____

_____

Patient Name: _____ DOB: _____ Date: _____

POST-TRAUMATIC SYMPTOM QUESTIONNAIRE

Patient instructions: It is important for this section to be filled out in detail. Look at each symptom listed in the left column and mark the appropriate columns for the specific symptom that applies to you. Be certain to indicate when you had the beginning of any of the following symptoms. Leave the row blank if the symptom listed below does not apply to you.

\+ mild ++ moderate +++ severe

SYMPTOM LIST (Check all that apply to you)	BEGAN IN LESS THAN 24 HOURS AFTER INJURY	BEGAN 1 TO 7 DAYS AFTER INJURY	SYMPTOMS YOU HAVE CURRENTLY	SIMILAR SYMPTOMS ONE YEAR BEFORE THIS INJURY
Headache/migraine				
Dizziness				
Tinnitus (ear ringing)				
Blurry vision				
Memory problems				
Poor concentration				
Irritability				
Balance problems				
Loss of coordination				
Sensitivity to sound				
Sensitivity to light				
Fatigue				
Anxiety				
Pain/difficulty swallowing				
Jaw pain/soreness				
Neck pain/soreness/aching				
Neck stiffness				
Shoulder pain/stiffness				
Arm pain/tingling/numbness				
Wrist/hand/finger pain/numbness				
Weakness in arms/legs				
Upper/middle back pain/soreness				
Rib cage pain				
Low back pain/soreness/aching				
Hip pain				
Leg pain				
Leg numbness/tingling				
Pain shoots down back of legs				
Pain primarily in front of thighs				
Knee pain				
Ankle/foot pain				
Other				

Patient Name: _____ DOB: _____ Date: _____

BEFORE AND AFTER INJURY PAIN COMPARISON FORM

For **SECTION 1**, please describe on a scale of 1-10 how intense your pain level was 2-3 months prior to this injury and indicate your current pain intensity. A ***zero (0)*** indicates that no symptoms exist. ***1-3 pain level*** is a minimum level and indicates that your pain is an annoyance only. A ***4 pain*** is a slight level or where pain while doing activity begins to cause some disability. A ***5-7 pain*** is moderate in severity and has to restrict or limit your activity ability to a significant degree. An ***8-10 pain*** level is severe and indicates that your pain intensity is to a point where you have complete inability to perform some tasks. For **SECTION 2**, please relate the percentage of time you had pain 2-3 months prior to this injury and indicate your current status in a percentage. Please fill in (circle) all shaded areas that best apply to your case.

SECTION 1. PRIOR AND CURRENT PAIN INTENSITY LEVELS

First, ***SQUARE*** **the box** following the area of pain that best indicates your overall average-usual pain severity **before** this injury. Secondly, ***CIRCLE*** **the box** that indicates your **current** usual pain intensity.

Pain Intensity	None	MINIMAL Discomfort/Ache/Stiff			SLIGHT-TO-MODERATE Hurts/Sore/Bearable Sensation				SEVERE Sharp/Intense Pain		
Headache	0	1	2	3	4	5	6	7	8	9	10
Neck pain/Soreness	0	1	2	3	4	5	6	7	8	9	10
Arm/hand symptoms	0	1	2	3	4	5	6	7	8	9	10
Mid-back pain	0	1	2	3	4	5	6	7	8	9	10
Low back pain	0	1	2	3	4	5	6	7	8	9	10
Leg/foot symptoms	0	1	2	3	4	5	6	7	8	9	10
Other	0	1	2	3	4	5	6	7	8	9	10

SECTION 2. PRIOR AND CURRENT PAIN FREQUENCY LEVELS

First, ***SQUARE*** **the box** following the area of pain that best indicates what average percentage of time you had pain **before** this injury. Secondly, ***CIRCLE*** **the box** that indicates your **current** usual pain intensity.

Pain Frequency	None	Occasional			Intermittent			Frequent		Constant	
Neck pain/Soreness	0%	10%	20%	30%	40%	50%	60%	70%	80%	90%	100%
Arm/hand symptoms	0%	10%	20%	30%	40%	50%	60%	70%	80%	90%	100%
Mid-back pain	0%	10%	20%	30%	40%	50%	60%	70%	80%	90%	100%
Low back pain	0%	10%	20%	30%	40%	50%	60%	70%	80%	90%	100%
Leg/foot symptoms	0%	10%	20%	30%	40%	50%	60%	70%	80%	90%	100%
Other	0%	10%	20%	30%	40%	50%	60%	70%	80%	90%	100%

HEADACHE AND/OR FREQUENCY & DURATION

During the past week or since the accident/injury, if applicable (if less than one week), indicate how frequently you have had headaches and/or migraines. Be sure to indicate how long each headache typically lasts.

How frequent did you have headaches 2-3 months before this injury? How frequent do you have headaches currently?	_____x week, _____x month _____x week, _____x month
How many hours or days did a typical headache last before this injury? How many hours or days do your typical headaches last currently?	_____ hours, _____ days _____ hours, _____ days
How many headache pills did you take prior to the accident typically? How many headache pills do you take currently since the accident?	_____ pills per month _____ pills per month

Patient Name: _____ DOB: _____ Date: _____

PROVIDERS SEEN SINCE INJURY OR WHEN CONDITION BEGAN

Start with the first doctor that you went to after your injury or your condition began and list all providers (all types of doctors or therapists) up to your last provider seen and check all that apply for each. Be certain to list these in sequence from first to last.

① Name of emergency room, hospital/doctor/therapist/center: _____

Address: _____ Date: _____

Indicate what was done:

- ❑ Exam-consultation
- ❑ IME exam or consult only
- ❑ X-ray of neck
- ❑ X-ray of chest/mid back
- ❑ X-ray of low back
- ❑ Other X-rays
- ❑ MRI/CT scan
- ❑ EMG/Nerve conduction study
- ❑ Other tests
- ❑ Rehabilitation
- ❑ Ultrasound
- ❑ Spinal adjustments
- ❑ Muscle massage/myotherapy
- ❑ Muscle stimulation
- ❑ Physical therapy
- ❑ Anti-inflammatory medications
- ❑ Pain medications
- ❑ Muscle relaxants
- ❑ Exercises
- ❑ Acupuncture
- ❑ Injection(s)
- ❑ Wrist brace-splint
- ❑ Neck collar (brace)
- ❑ Low back brace
- ❑ Heat packs
- ❑ Ice packs
- ❑ Other

Indicate if treatment with this provider: ❑ Helped ❑ Did not help ❑ Made condition worse

② Name of hospital/doctor/therapist/center: _____

Address: _____ Date: _____

Indicate what was done:

- ❑ Exam-consultation
- ❑ IME exam or consult only
- ❑ X-ray of neck
- ❑ X-ray of chest/mid back
- ❑ X-ray of low back
- ❑ Other X-rays
- ❑ MRI/CT scan
- ❑ EMG/Nerve conduction study
- ❑ Other tests
- ❑ Rehabilitation
- ❑ Ultrasound
- ❑ Spinal adjustments
- ❑ Muscle massage/myotherapy
- ❑ Muscle stimulation
- ❑ Physical therapy
- ❑ Anti-inflammatory medications
- ❑ Pain medications
- ❑ Muscle relaxants
- ❑ Exercises
- ❑ Acupuncture
- ❑ Injection(s)
- ❑ Wrist brace-splint
- ❑ Neck collar (brace)
- ❑ Low back brace
- ❑ Heat packs
- ❑ Ice packs
- ❑ Other

Indicate if treatment with this provider: ❑ Helped ❑ Did not help ❑ Made condition worse

③ Name of emergency room, hospital/doctor/therapist/center: _____

Address: _____ Date: _____

Indicate what was done:

- ❑ Exam-consultation
- ❑ IME exam or consult only
- ❑ X-ray of neck
- ❑ X-ray of chest/mid back
- ❑ X-ray of low back
- ❑ Other X-rays
- ❑ MRI/CT scan
- ❑ EMG/Nerve conduction study
- ❑ Other tests
- ❑ Rehabilitation
- ❑ Ultrasound
- ❑ Spinal adjustments
- ❑ Muscle massage/myotherapy
- ❑ Muscle stimulation
- ❑ Physical therapy
- ❑ Anti-inflammatory medications
- ❑ Pain medications
- ❑ Muscle relaxants
- ❑ Exercises
- ❑ Acupuncture
- ❑ Injection(s)
- ❑ Wrist brace-splint
- ❑ Neck collar (brace)
- ❑ Low back brace
- ❑ Heat packs
- ❑ Ice packs
- ❑ Other

Indicate if treatment with this provider: ❑ Helped ❑ Did not help ❑ Made condition worse

Neck Disability Index

Neck Index Score

Patient Name _____ Date _____

This questionnaire will give your provider information about how your neck condition affects your everyday life. Please answer every section by marking the one statement that applies to you. If two or more statements in one section apply, please mark the one statement that most closely describes your problem.

Pain Intensity

⓪ I have no pain at the moment.
① The pain is very mild at the moment.
② The pain comes and goes and is moderate.
③ The pain is fairly severe at the moment.
④ The pain is very severe at the moment.
⑤ The pain is the worst imaginable at the moment.

Sleeping

⓪ I have no trouble sleeping.
① My sleep is slightly disturbed (less than 1 hour sleepless).
② My sleep is mildly disturbed (1-2 hours sleepless).
③ My sleep is moderately disturbed (2-3 hours sleepless).
④ My sleep is greatly disturbed (3-5 hours sleepless).
⑤ My sleep is completely disturbed (5-7 hours sleepless).

Reading

⓪ I can read as much as I want with no neck pain.
① I can read as much as I want with slight neck pain.
② I can read as much as I want with moderate neck pain.
③ I cannot read as much as I want because of moderate neck pain.
④ I can hardly read at all because of severe neck pain
⑤ I cannot read at all because of neck pain.

Concentration

⓪ I can concentrate fully when I want with no difficulty.
① I can concentrate fully when I want with slight difficulty.
② I have a fair degree of difficulty concentrating when I want.
③ I have a lot of difficulty concentrating when I want.
④ I have a great deal of difficulty concentrating when I want.
⑤ I cannot concentrate at all.

Work

⓪ I can do as much work as I want.
① I can only do my usual work but no more.
② I can only do most of my usual work but no more.
③ I cannot do my usual work.
④ I can hardly do any work at all.
⑤ I cannot do any work at all.

Personal Care

⓪ I can look after myself normally without causing extra pain.
① I can look after myself normally but it causes extra pain.
② It is painful to look after myself and I am slow and careful.
③ I need some help but I manage most of my personal care.
④ I need help everyday in most aspects of self care.
⑤ I do not get dressed, I wash with difficulty and stay in bed.

Lifting

⓪ I can lift heavy weights without extra pain.
① I can lift heavy weights, but it causes extra pain.
② Pain prevents me from lifting heavy weights off the floor, but I can manage if they are conveniently positioned (e.g. on a table).
③ Pain prevents me from lifting heavy weights off the floor, but I can manage light to medium weights if they are conveniently positioned.
④ I can only lift very light weights.
⑤ I cannot lift or carry anything at all.

Driving

⓪ I can drive my car without any neck pain.
① I can drive my car as long as I want with slight neck pain.
② I can drive my car as long as I want with moderate neck pain.
③ I cannot drive my car as long as I want because of moderate neck pain.
④ I can hardly drive at all because of severe neck pain.
⑤ I cannot drive my car at all because of neck pain.

Recreation

⓪ I am able to engage in all my recreation activities without neck pain.
① I am able to engage in all my usual recreation activities with some neck pain.
② I am able to engage in most but not all my usual recreation activities because of neck pain.
③ I am only able to engage in a few of my usual recreation activities because of neck pain.
④ I can hardly do any recreation activities because of neck pain.
⑤ I cannot do any recreation activities at all.

Headaches

⓪ I have no headaches at all.
① I have slight headaches which come infrequently.
② I have moderate headaches which come infrequently.
③ I have moderate headaches which come frequently.
④ I have severe headaches which come frequently.
⑤ I have headaches almost all the time.

Revised Oswestry Questionnaire

Name: _____

Date: _____

INSTRUCTIONS: This questionnaire has been designed to enable us to understand how your back pain has affected your ability to manage your everyday activities. Please answer each section by marking the ONE CHOICE that most applies to you. We realize you may feel that more than one statement may relate to you, but PLEASE JUST MARK THE ONE CHOICE WHICH MOST CLOSELY DESCRIBES YOUR PROBLEM RIGHT NOW.

Pain Intensity	**Personal Care (Washing, Dressing, Etc.)**
❑ The pain comes and goes and is very mild. ❑ The pain is mild and does not vary much. ❑ The pain comes and goes and is moderate. ❑ The pain is moderate and does not vary much. ❑ The pain comes and goes and is severe. ❑ The pain is severe and does not vary much.	❑ I would not have to change my way of washing or dressing in order to avoid pain. ❑ I do not normally change my way of washing or dressing even though it causes some pain. ❑ Washing and dressing increases the pain, but I manage not to change my way of doing it. ❑ Washing and dressing increases the pain and I find it necessary to change my way of doing it. ❑ Because of the pain, I am unable to do some washing and dressing without help. ❑ Because of the pain, I am unable to do any washing or dressing without help.
Lifting	**Walking**
❑ I can lift heavy weights without extra pain. ❑ I can lift heavy weights, but it causes extra pain. ❑ Pain prevents me from lifting heavy weights off the floor. ❑ Pain prevents me from lifting heavy weights 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 only lift very light weights at the most.	❑ Pain does not prevent me from walking any distance. ❑ Pain prevents me from walking more than one mile. ❑ Pain prevents me from walking more than ½ mile. ❑ Pain prevents me from walking more than ¼ mile. ❑ I can only walk while using a cane or on crutches. ❑ I am in bed most of the time and have to crawl to the toilet.
Sitting	**Standing**
❑ I can sit in any chair as long as I like without pain. ❑ I can only sit in my favorite chair as long as I like. ❑ Pain prevents me from sitting more than one hour. ❑ Pain prevents me from sitting more than ½ hour. ❑ Pain prevents me from sitting more than ten minutes. ❑ Pain prevents me from sitting at all.	❑ I can stand as long as I want without pain. ❑ I have some pain while standing, but it does not increase with time. ❑ I cannot stand for longer than one hour without increasing pain. ❑ I cannot stand for longer than ½ hour without increasing pain. ❑ I cannot stand for longer than ten minutes without increasing pain. ❑ I avoid standing because it increases the pain straight away.

Revised Oswestry Questionnaire Patient Name: _____ DOB:_____

Sleeping	**Social Life**
❑ I get no pain in bed. ❑ I get pain in bed, but it does not prevent me from sleeping well. ❑ Because of pain, my normal night's sleep is reduced by less than one-quarter. ❑ Because of pain, my normal nights sleep is reduced by less than one-half. ❑ Because of pain, my normal night's sleep is reduced by less than three-quarters. ❑ Pain prevents me from sleeping at all.	❑ My social life is normal and gives me no pain. ❑ My social life is normal but increases the degree of my pain. ❑ Pain has no significant effect 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 very often. ❑ Pain has restricted my social life to my home. ❑ I have hardly any social life because of the pain.
Traveling	**Changing Degree of Pain**
❑ I get no pain while traveling. ❑ I get some pain while traveling, but none of my usual forms of travel make it any worse. ❑ I get extra pain while traveling, but it does not compel me to seek alternative forms of travel. ❑ I get extra pain while traveling which compels me to seek alternative forms of travel. ❑ Pain restricts all forms of travel. ❑ Pain prevents all forms of travel except that done lying down.	❑ My pain is rapidly getting better. ❑ My pain fluctuates, but overall is definitely getting better. ❑ My pain seems to be getting better, but improvement is slow at present. ❑ My pain is neither getting better nor worse. ❑ My pain is gradually worsening. ❑ My pain is rapidly worsening.

Patient Name: _____ DOB: _____ Date: _____

MULITPLE REGION FUNCTIONAL CAPACITY QUESTIONNAIRE

Patient instructions: Fill out sections 1 to 10. In each section, check one box that best applies to your current condition.

1. CURRENT PAIN INTENSITY (Check one box that best applies currently)

❑	I currently have no pain or soreness.
❑	My soreness/pain annoys me at work and/or at home. I am able to do all physical activity. This pain does not slow me down.
❑	My pain is now beginning to restrict my more strenuous physical activities, such as heavy lifting. Able to perform most activities.
❑	My pain causes some difficulty with the performance of moderate level physical activities. Unable to do more strenuous activities.
❑	My pain makes it difficult to do average physical activity. Unable to do all heavy physical activities and some average level activities.
❑	My pain causes significant difficulty in light physical activity. Unable to do average work. Have significant difficulty sleeping.

2. CURRENT WORK ABILITY FUNCTION (Check one box that best applies currently)

❑	I am currently able to work full time and function normally in all job requirements with no pain or other symptoms.
❑	I work full time and have annoying pain or other symptoms that do not slow me down or limit my ability to do all activities.
❑	I work full time. My work output quality and/or quantity have/has been reduced 10-20% due to pain. The pain or other symptoms caused by working results in my occasionally halting work or slowing down. I require assistance at work occasionally.
❑	I am able to work presently. I am not able to work at a normal pace beyond 2 hours and at a slower pace beyond 4 hours. My performance output quality and/or quantity is reduced by 30-60%.
❑	I am able to work on a limited basis. I am not able to work at a normal pace for more than 30-60 minutes at a time. I can work at a slower pace with less physical activity beyond 2 hours. My ability to perform job requirements has been recently reduced by 60-90%.
❑	I am not able to work at a normal or a slower pace. Job quality and quantity output are reduced by more than 90%. I am unable to work on a part-time status even with a flexible work schedule or job modification.

3. SPORTS, HOBBIES, AND SOCIAL ACTIVITIES (Check one box that best applies currently)

❑	I can perform normal sports, hobbies, and social activities with my friends, family, or business acquaintances at this time.
❑	I can perform normal sports, hobbies, and social activities, but my symptoms do occasionally slow me down.
❑	My symptoms limit my more energetic or competitive sports, hobbies, or social activities such as dancing or running.
❑	My symptoms limit my performance of moderate sports, hobbies, or social activities. I do not go out as often.
❑	My symptoms limit me to only minimal sports, hobbies, and social activities.
❑	I am unable to perform in any sports, hobbies, or social activities due to the pain or other symptoms.

4. HOME ACTIVITIES (Check one box that best applies currently)

❑	I can perform all normal home activities such as vacuuming, cooking, cleaning, and mowing the lawn presently.
❑	I am able to perform all normal home activities, but my symptoms occasionally slow me down.
❑	Symptoms prohibit very strenuous home activities. I am able to do light to moderately strenuous home activities.
❑	Symptoms limit moderate home activities. I am able to do light home activities. I sometimes need help doing activities.
❑	I am only able to do light home activities. I am unable to vacuum, mow lawns, sweep, mop, and do laundry.
❑	I am unable to do any home activities due to pain or other symptoms. I need help putting on my clothes.

5. SLEEPING ABILITY (Check one box that best applies currently)

❑	I have normal sleeping patterns recently.
❑	I have occasional difficulty sleeping due to pain or other symptoms. I wake up at night, resulting in less than 5 minutes of sleep disturbance.
❑	I have intermittent difficulty sleeping due to symptoms. I wake up at night, resulting in 30 minutes to one hour of sleep disturbance.
❑	I have frequent difficulty sleeping due to symptoms. I wake up at night, resulting in one to three hours of sleep disturbance. Medications help sleep.
❑	My sleeping pattern is very restless with about 50% less sleep hours. I need medications to sleep period I frequently feel fatigued.
❑	I have no normal sleeping hours. I am never able to sleep more than two to three hours without heavy medication. I never feel rested.

6. SITTING ACTIVITES PRESENTLY (Check one box that best applies currently)

❑	I can sit at my desk, terminal, chair/coach, or in my car normally with no difficulty for normal periods of time presently.
❑	Prolonged sitting (more than 4-6 hours) will cause annoying or mild discomfort or other symptoms.
❑	Prolonged sitting (2-4 hours) will cause pain to increase to levels that require me to change my position.
❑	I can sit or drive for 1-2 hours, but I need frequent breaks to change my body position. I am unable to sit constantly for over 1 hour.
❑	I cannot sit or drive for more than 30-60 minutes at a time due to pain severity.
❑	I cannot sit at my desk, or in my chair at home, or drive my car at any time for more than 5-10 minutes due to pain severity.

Patient Name: _____ DOB: _____ Date: _____

MULITPLE REGION FUNCTIONAL CAPACITY QUESTIONNAIRE

7. UPPER BODY FUNCTION (NECK, SHOULDER, ARMS, HANDS, AND UPPER BACK) (Check one box)

❑	I am able to use my neck, upper back, shoulders, arms, and hands in all activities with no pain or other symptoms recently.
❑	Use of my neck, upper back, shoulders, arms, and hands caused me annoying symptoms. Still able to do all activities.
❑	I am able to move my neck, lift with my arms, reach over my head, carry objects, and grip objects with my hands. I have some difficulty with heavier lifting, or reaching objects over the level of my head. I have occasional weakness with hands. I am unable to type or use a computer keyboard for more than 3-4 hours a day.
❑	I am able to lift my arms up to the height of my shoulder or head for short periods and carry light to moderate weight objects in hands. I am unable to type more than 1-2 hours due to pain, numbness, or tingling. I drop objects occasionally. I have to use two hands to do some tasks where I would normally use one hand. Unable to lift or carry heavy objects.
❑	I am able to carry and grip only light objects. I get severe neck, upper back, or arm pain/symptoms when lifting any object over 1 pound over the height of my shoulder. I am unable to lift arms with any objects in my hands over the height of my head. I have difficulty gripping and grasping objects. I drop objects daily unless I am very careful. I have to use two hands for most activities that I could do with one hand before. I am unable to type for more than 5-10 minutes at a time.
❑	I am able to lift my arms to the level of my shoulders. Lifting my arms over the height of my head causes severe pain. Every time I lift my arms or twist my upper back or neck I get severe pain and have to lower my arms or straighten my body.

8. LOWER BODY FUNCTION (LOW BACK, HIP, KNEE, LEGS AND FEET) (Check one box)

❑	I can sit, drive, stand, squat, stoop, walk, bend, use my feet, and lift with my low back, hip, and legs with no pain presently.
❑	I get annoying discomfort if doing prolonged (more than 6 hours) sitting, driving, walking or standing or very strenuous physical activities such as lifting, squatting, stooping, and bending.
❑	Heavy lifting (more than 60 pounds) causes severe low back or leg pain. Able to lift light to moderate weight with little pain. Sitting, driving, walking, standing, or bending for more than 2-3 hours a day causes pain levels to increase to point where I have to stop and take a break.
❑	I am unable to lift more than 50 pounds due to severe pain. I am able to lift 25-45 pounds with some moderate pain. Slight discomfort lifting less than 25 pounds. Sitting, driving, walking, standing, or bending for more than 1-2 hours a day causes pain levels to increase to point where I have to stop and take a break.
❑	I am unable to lift more than 25 pounds due to severe pain. I am able to lift 10-20 pounds with some moderate pain. Slight discomfort lifting less than 5pounds: Sitting, driving, walking, standing, or bending for more than 30 minutes a day causes pain levels to increase to point where I have to stop and take a break.
❑	I experience severe low back or leg pain when doing any lifting or by simply bending my back or hips. I am able to walk only with the use of a cane, crutches, back brace, or by supporting myself. I need to lie down frequently to relieve pain. I am unable to lift any object. I have severe difficulty using the bathroom. I am unable to stand or walk for more than 5 minutes.

9. HEADACHES AND/OR MIGRAINE HEAD PAIN RECENTLY (Check one box that best applies currently)

❑	I have no headaches or migraine pain recently or today.
❑	My headache pain annoys me. I am able to work and perform al normal work home/sport activities with the head pain.
❑	M headaches cause me to lose up to 30 minutes of productive time at work home each day recently.
❑	M headaches cause me to lose 30 minutes to 2 hours of productive time at work/home each day.
❑	My headaches cause me to lose 2-4 hours of productive time at work/home each day. Unable to do sport activities.
❑	My headache/migraine pain makes it impossible to work, go to school, do home activities, or do recreational activities

10. MENTAL ABILITY FUNCTION (Check one box that best applies currently)

❑	My memory and mental function are normal. I have no difficulty with work or home mental-intellectual demands recently.
❑	I am able to perform most mental activities and am able to function at work, at home, and in society. I have occasional slight difficulty with complex tasks, memory, remembering appointments, balancing checkbook, and doing math.
❑	I am able to function at work and home and society. I have difficulty with complex tasks, multiple tasks, and intense concentration projects. I have noticed about 10-25% memory loss and job performance decline recently.
❑	I am not able to handle complex or multiple tasks. I have notable memory loss and difficulty making decisions. My friends and family have noticed recent personality changes. It takes much longer to do work and home tasks. I can handle one task at a time. I use a day timer to help me remember things I need to do. I have about 25-50% loss of job performance recently.
❑	I am able to handle only one simple mental task at a time. I am unable to keep my job because of performance ratings. I have noticed 50-75% loss of memory skills and ability to perform mental skills.
❑	I am unable to hold any job at all. I am unable to balance a checkbook and need help. I am unable to shop at a grocery store without a shopping list. I am unable to remember instructions.

Patient Acknowledgement of Privacy Notice

The Notice of Privacy Policy of **Summit Chiropractic and Massage** of West Linn describes how health information about me may be used and disclosed. The following is a summary of our Notice of Privacy Policy:

Your Rights - As examples, you have the right to:

- Get a copy of the privacy notice.
- Request confidential communication.
- Ask us to limit the information we share.
- Get a copy of your paper or electronic medical record.
- File a complaint if you believe your privacy rights have been violated.

Your Choices - You have some choices in the way that we use and share information. With your permission, we may tell family and friends about your condition.

Our Uses and Disclosures - We may use and share your information as we:

- Treat you.
- Run our organization.
- Bill for your services.
- Help with public health and safety issues.
- Comply with the law.
- Respond to lawsuits and legal actions.

For further details, you may obtain a full copy of our Notice of Privacy Policy.

I, _____ hereby acknowledge that I have had an opportunity to review the Notice of Privacy Policy and may obtain a copy of the Notice of Privacy Policy at will from **Summit Chiropractic and Massage** of West Linn. Under federal law 104-191, also known as HIPAA, I am entitled to receive a copy of this *Notice* from my healthcare provider.

I understand that I am entitled to receive a copy of the *Notice of Privacy Practices* from my healthcare provider, whether I sign this Acknowledgement or not.

I authorize the following people access to my treatment and financial information and I authorize **Summit Chiropractic and Massage** to discuss treatment and finances with them:

Name: _____ Relationship: _____

Name: _____ Relationship: _____

I authorize Summit Chiropractic and Massage to leave detailed voice messages for me ❑

_____ ____/____/_____
Patient's name (printed) Date of birth

_____ _____
Signature of patient Date

_____ _____
Signature of parent/guardian (if patient is a minor) Date