



Personal Injury Questionnaire/Medical History

Full Name: _____ Birthdate: _____ Sex: ___ M ___ F

Address: _____

City: _____ State: _____ Zip: _____

Height: _____ Weight: _____ Social Security #: _____

Marital Status: ___ Single ___ Married ___ Divorced ___ Separated ___ Widowed

Home Phone: _____ Employer: _____

Cell Phone: _____ Occupation: _____

Work Phone: _____ Email Address: _____

Emergency Contact Name: _____ Contact Phone #: _____

Date of Accident: _____ How were you referred to this office? _____

Chief Complaints: (please circle all that you have experienced since the accident)

- Headaches Neck Pain Lower Back Pain Middle Back Pain Hip Pain: L R
Dizziness Weakness Shoulder Pain: L R Arm/Hand Pain: L R Leg/Pain: L R
Other: _____

Is the pain/discomfort constant? ___ Yes ___ No Is pain on and off (intermittent) ___ Yes ___ No

How would you describe the pain/discomfort? (please circle all that apply)

- Sharp/Stabbing Dull Achy Cramping Soreness
Other: _____

How would you rate the pain? 10 being the worst possible pain and 0 being no pain. (please circle)

0 1 2 3 4 5 6 7 8 9 10

What makes your pain/discomfort worse? (please circle all that apply)

- Sitting Standing Sneezing Coughing Moving arms or legs Lifting
Twisting Bathing Dressing Moving head Bending forward Rising from a chair
Driving Moving head Other: _____

Do you have any of the following? (please circle all that apply)

- Right arm/hand: numbness pain tingling Right leg/foot: numbness pain tingling
Left arm/hand: numbness pain tingling Left leg/foot: numbness pain tingling

What have you been doing to decrease your pain/discomfort? (please circle all that apply)

- Heating Pad Moving around Resting Sitting Ice
Standing Leaning forward Leaning to Side Laying on back Hot bath/shower
Other: _____

When did the pain/discomfort begin after the accident? (please circle)

Immediately Within 12 Hours Next Day 2 days later 3 days later Other: _____

Have you ever experienced this pain/discomfort before? ___ Yes ___ No If so, how long ago? _____

CAR ACCIDENT Details:

Where were you seated in the vehicle at the time of impact? (please circle)

Driver Front Passenger Rear Left Passenger Rear Right Passenger

Where were you looking at the time of impact? (please circle)

Straight Ahead To the Right To the Left To the Rear At Rear-View Mirror

Were both of your hands on steering wheel, dash, or front seat at time of impact? ___ Yes ___ No

If you were driving, was your foot on the brake pedal at time of impact? ___ Yes ___ No

Did you anticipate the crash or see that it was going to happen? ___ Yes ___ No

Were you wearing your seatbelt? ___ Yes ___ No Did airbags deploy? ___ Yes ___ No

Did you hit your head on anything? ___ Yes ___ No Did you lose consciousness? ___ Yes ___ No

Describe in detail how the recent accident occurred: _____

Did you receive medical treatment after the accident? ___ Yes ___ No

If yes, where did you go: _____

Were x-rays, MRI, or CT scans performed? ___ Yes ___ No

What, if any, treatment was recommended? (please circle)

Prescription Drugs Injection Advised me to see another doctor

Did you see another doctor for these conditions? ___ Yes ___ No

If yes, what was the Doctor's name? _____

What is this Doctor's specialty? (please circle)

Orthopedist Chiropractor Neurologist Family/General

Other: _____

Were further diagnostic test performed? (please circle)

MRI CT Scan Myelogram Other: _____

If so, where were they performed? _____

What type of treatment was rendered?

Prescriptions/Injections – please list _____

Chiropractic – Approximately how many treatments? _____

Physical Therapy – Approximately how many treatments? _____

Surgery (please list) _____

What percent better do you feel since beginning these treatments? (please circle)

0% 10% 20% 30% 40% 50% 60% 70% 80% 90% 100%

What medications/vitamins/supplements do you currently take? (please circle and write dosage)

Blood Pressure: _____ Cholesterol: _____ Diabetic: _____
 Multi-Vitamins: _____ Supplements: _____
 Over the counter meds: _____
 Other Medication: _____

Have you ever had a broken/fractured bone? _____ Yes _____ No

If so, please specify what was fractured and how long ago _____

Please list all past surgeries/hospitalizations and include approximate date(s):

Do you suffer from or have you been diagnosed with any of the following conditions? (please check)

- | | | | |
|--|--|---|---|
| <input type="checkbox"/> AIDS | <input type="checkbox"/> Alcoholism | <input type="checkbox"/> Anorexia | <input type="checkbox"/> Arthritis |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Bed Wetting | <input type="checkbox"/> Bladder Trouble | <input type="checkbox"/> Bleeding Disorders |
| <input type="checkbox"/> Breast Disease | <input type="checkbox"/> Cancer | <input type="checkbox"/> Cataracts | <input type="checkbox"/> Diabetes |
| <input type="checkbox"/> Discolored Urine | <input type="checkbox"/> Dizziness | <input type="checkbox"/> Emphysema | <input type="checkbox"/> Epilepsy |
| <input type="checkbox"/> Glaucoma | <input type="checkbox"/> Gout | <input type="checkbox"/> Heart Problems | <input type="checkbox"/> Hepatitis |
| <input type="checkbox"/> Herniated Disc | <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> High Cholesterol | <input type="checkbox"/> Irritability |
| <input type="checkbox"/> Kidney Problems | <input type="checkbox"/> Liver Problems | <input type="checkbox"/> Menstrual Cramping | <input type="checkbox"/> Menstrual Irregularity |
| <input type="checkbox"/> Mononucleosis | <input type="checkbox"/> Multiple Sclerosis | <input type="checkbox"/> Nervousness | <input type="checkbox"/> Pacemaker |
| <input type="checkbox"/> Prostate Problems | <input type="checkbox"/> Psychiatric Care | <input type="checkbox"/> Rheumatoid Arthritis | <input type="checkbox"/> Sexual Dysfunction |
| <input type="checkbox"/> Stroke | <input type="checkbox"/> Stress | <input type="checkbox"/> Thyroid Problems | <input type="checkbox"/> Tumors |

Other: _____

Do you exercise? _____ Yes _____ No **Approximately how much per week?** _____
 Do you smoke cigarettes/cigars? _____ Yes _____ No **Approximately how many per day?** _____
 Do you drink alcohol? _____ Yes _____ No **Approximately how many per week?** _____

FEMALES ONLY: When was your last menstrual cycle? _____ Are you pregnant? _____ Yes _____ No

Do the following relatives suffer from any of the following? (please check the condition)

	Mother	Father	Sibling 1	Sibling 2	Sibling 3	Sibling 4
Diabetes						
Heart Disease						
High Blood Press						
Stroke						
Cancer						
Living						
Deceased						

I certify that this information is true to the best of my knowledge.

 Patient/Guardian Signature

 Date

NECK DISABILITY INDEX

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

Section 1 - Pain Intensity

- I have no pain at the moment.
- The pain is very mild at the moment.
- The pain is moderate at the moment.
- The pain is fairly severe at the moment.
- The pain is very severe at the moment.
- The pain is the worst imaginable at the moment.

Section 2 -- Personal Care (Washing, Dressing, etc.)

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

Section 3 -- Lifting

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

Section 4 -- Reading

- I can read as much as I want to with no pain in my neck.
- I can read as much as I want to with slight pain in my neck.
- I can read as much as I want with moderate pain.
- I can't read as much as I want because of moderate pain in my neck.
- I can hardly read at all because of severe pain in my neck.
- I cannot read at all.

Section 5-Headaches

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

Section 6 -- Concentration

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

Section 7--Work

- I can do as much work as I want to.
- I can only do my usual work, but no more.
- I can do most of my usual work, but no more.
- I cannot do my usual work.
- I can hardly do any work at all.
- I can't do any work at all.

Section 8 -- Driving

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

Section 9 -- Sleeping

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

Section 10 -- Recreation

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

Comments _____ %ADL

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

LOW BACK DISABILITY QUESTIONNAIRE (REVISED OSWESTRY)

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

Section 1 - Pain Intensity

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

Section 2 -- Personal Care (Washing, Dressing, etc.)

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

Section 3 -- Lifting

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

Section 4 -- Walking

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

Section 5 -- Sitting

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

Section 6 -- Standing

- I can stand as long as I want without extra pain.
- I can stand as long as I want but it gives extra pain.
- Pain prevents me from standing more than 1 hour.
- Pain prevents me from standing more than 30 minutes.
- Pain prevents me from standing more than 10 minutes.
- Pain prevents me from standing at all.

Section 7 -- Sleeping

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

Section 8 -- Social Life

- My social life is normal and gives me no extra pain.
- My social life is normal but increases the degree of pain.
- Pain has no significant effect on my social life apart from limiting my more energetic interests, e.g. dancing.
- Pain has restricted my social life and I do not go out as often.
- Pain has restricted my social life to my home.
- I have no social life because of pain.

Section 9 -- Traveling

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

Section 10 -- Changing Degree of Pain

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

Comments _____

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

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

Informed Consent

Patient Name: _____ **Patient #:** _____

Every type of health care is associated with some risk of potential problem. Health care providers, including chiropractors, are required by law to tell you the nature of your condition, the general nature of the treatment, and the risk involved. In keeping with the Louisiana law of informed consent, you are being asked to sign and date this form which confirms our discussion of these matters.

We want to give each patient the best possible care with the least possible risk of complications. To accomplish this, we format treatment plans to suit the distinctive needs of each patient. The following paragraphs describe the most severe risks associated with chiropractic care which are extremely rare in occurrence.

1. **Stroke:** Stroke is the most serious problem associated with spinal manipulation. The consequences can be temporary or permanent dysfunction of the brain with a very rare complication of death (1 in 20 million). Spinal manipulations have been associated with strokes that arise from the vertebral artery, which runs on each side of your neck. This problem occurs so rarely that there is no conclusive data to quantify the probability.
2. **Disc Herniation Aggravation:** Disc herniations that create pressure on the spinal nerve and/or spinal cord are successfully treated by chiropractors on a daily basis. Chiropractic manipulation can aggravate an existing disc herniation resulting in an increase of symptoms, which may last for a few days but seldom for longer periods of time.
3. **Soft Tissue Injury:** Soft tissue primarily refers to muscles and ligaments. Muscles move bones and ligaments limit bone movement. Rarely, chiropractic manipulation can result in minor damage to a particular soft tissue. This may cause a temporary increase in pain and necessary treatments for resolution, but there are no long term effects on the patient.
4. **Rib Fractures:** The rib cage is found in the thoracic spine or middle back area. Rarely, chiropractic manipulation can cause a fracture to occur. Patients who have weakened bones (osteoporosis or osteopenia) have a higher risk of rib fractures because their bones are weaker than normal. We adjust all patients carefully, especially those who have indications of osteoporosis on their x-rays.
5. **Other Possible Complications:** There are many other side effects and/or complications that may also rarely occur due to spinal manipulations. These possible complications include, but are not limited to, the following: headaches, skin burns, dizziness, radiating pains into arms and/or legs, exacerbation of pain/problem, soreness, etc

I hereby authorize Recovery ChiroMed, together with assistance of their choice, to provide chiropractic treatment including examination/diagnostics, spinal manipulations/adjustments, and various modes of physical therapy that may be deemed necessary or reasonable. I have read and understand all information set forth in this document, including any attachments. I acknowledge that I had the opportunity to ask any questions about the contemplated procedure and that my questions have been answered to my satisfaction. This authorization for and consent to chiropractic treatment is and shall remain valid until revoked.

Patient or Responsible Party Signature

Date



Office Policies

Patient Name: _____ **Patient #:** _____

Thank you for choosing us as your health care provider. Please understand that payment of your bill is considered part of your treatment. The following statements refer to our office policies which we require that you read, accept, sign, and date before any treatment can begin.

1. Every new patient is required to fill out our forms concerning his/her history and general information prior to being examined.
2. Each insurance company or group has specific guidelines that we must follow to warrant payments for our services. As a courtesy to you, we file all claims to your insurance company or group. Please remember that YOU have the contract with the insurance company or group and YOU are ultimately responsible for payment. We cannot accept responsibility for collecting from your insurance company or group nor negotiating a settlement on a disputed claim. If you do need assistance with your insurance, please see our office manager; who will readily assist you.
3. Our practice is committed to providing the best treatment possible for our patients and we charge what is usual and customary for our area. Please understand that you are responsible for payment in full regardless of an insurance company's arbitrary determination of usual and customary rates.
4. Open accounts with no acceptable payment activity for 60 days will be considered past due. A billing charge may be assessed to the account balance along with a finance charge of 1.5% per month. You will be responsible for the original past due balance along with these additional charges. Acceptable payment activity will be determined on an individual basis. Please speak with our office manager to avoid any misunderstandings.
5. Open accounts with no acceptable payment activity for 120 days will automatically be placed with our collection agency. You will be responsible for payment of the original balance plus any billing charges, finance charges, collection fees, and attorney fees assessed to your account.
6. The adult accompanying the minor is responsible for full payment. The adult (i.e. parent, legal guardian) must be present with a minor and sign the Treatment Consent Form before any services can be administered.

Patient or Responsible Party's Signature

Date



CONSENT TO THE USE & DISCLOSURE OF HEALTH INFORMATION FOR TREATMENT, PAYMENT, OR HEALTHCARE OPERATIONS

Patient's Name: _____ Id #: _____

I understand that as part of my healthcare, this organization originates and maintains health records describing my health history, symptoms, examination and test results, diagnosis, treatment, and any plans for future care or treatment.

I understand that this information serves as:

- A basis for planning my care and treatment.
- A mean of communication among the many healthcare professionals who contribute to my care.
- A source of information for applying my diagnosis and surgical information to my bill.
- A means by which a third party payer can verify that services billed were actually provided.
- A tool for routine healthcare operations such as assessing care quality and reviewing the competence of healthcare professionals.

I understand that I have the right:

- To object to the use of my health information for directory purposes.
- To request restrictions as to how my health information may be used or disclosed to carry out treatment, payment, or healthcare operations – and that the organization is not required to agree to the restrictions requested.
- To revoke this consent in writing, except to the extent that the organization has already taken action in reliance thereon.

I request the following restrictions to the use or disclosure of any healthcare information:

Patient's Signature: _____

Date: _____ Witness Signature: _____



Pregnancy Warning and Consent to X-Ray

Patient Name: _____ **Patient #:** _____

I understand that if I am pregnant and have X-rays taken, which expose my lower torso to radiation, it is possible to injure the fetus.

I have been advised that the 10 days following onset of a menstrual period are generally considered to be safe for X-ray exams.

With those factors in mind, I am advising my doctor that:

	Yes	No	Don't Know
I am pregnant	_____	_____	_____
I could be pregnant	_____	_____	_____
I am late with my menstrual period	_____	_____	_____
I am taking oral contraceptives	_____	_____	_____
I have an IUD	_____	_____	_____
I have had a tubal ligation	_____	_____	_____
I have had a hysterectomy	_____	_____	_____
I have irregular menstrual periods	_____	_____	_____
My last menstrual period began on: _____			

With full understanding of the above, and believing that I am not currently at risk, I wish to have an X-ray examination performed now.

Signature

Date

RECOVERY

CHIROMED

Kevin M. Brien, D.C.
C. Brett Venable, D.C.

Shane Chaisson, D.C.
Jason Neatherlin, D.C.

I, _____, hereby authorize Kevin Brien, D.C., Brett Venable, D.C., Shane Chaisson, D.C., and/or Jason Neatherlin, D.C. and whomever they/he may designate as their assistant to administer chiropractic care as they deem necessary to my child.

Date: _____

Name of Minor: _____

Parent/Guardian:

(Printed Name)

(Signature)

Witness: _____