Lindenhurst Accident & Injury Center

# CONFIDENTIAL PATIENT INFORMATION

Dear Patient: Please complete this questionnaire. Your answers will help us determine if chiropractic care can help you. If we do not sincerely believe your condition will respond satisfactory, we will not accept your case. THANK YOU.

Name: _____ DOB: _____

SS # _____ Age: _____

Marital Status: M S W D Home # : _____

Work #: _____ Occupation: _____

Cell Phone # : _____ Email Address: _____

Home Address: _____

_____

Who may we thank for referring you? _____

Who is your Primary Care Physician? _____

PCP Address: _____ City: _____

State: _____ Zip Code: _____ Phone #: _____

## INSURANCE INFORMATION

Is this an injury due to:

☐ Work Injury ☐ Auto Injury ☐ Sports Injury ☐ Other

Do you have Major Medical Health Insurance? ☐ Yes ☐ No

Insurance Carrier: _____

Address: _____ City: _____ State: _____ Zip: _____

Insured's Name: _____ Relationship to you: _____

Insured's SS #: _____

Insured's Employer: _____

Insured's Work #: _____

Do you have a referral from your Primary Care Physician? ☐ Yes ☐ No

I understand and agree that health and accident insurance policies are an arrangement between an insurance carrier and myself. Furthermore, I understand that Gary Cullin, D.C. will prepare any necessary reports and forms to assist me in making collection from the insurance company and that any amount authorized to be paid directly to Gary Cullin, D.C., will be credited to my account on receipt. However, I understand and agree that all services rendered me are charged directly to me and that I am personally responsible for payment. I also understand that if I suspend or terminate my care and treatment, any fees for professional services rendered me will be immediately due and payable.

Patient's Signature: _____ Date: ___ / ___ / ___

Guardian/Spouse Signature: _____ Date: ___ / ___ / ___

Information taken by: _____ Date: ___ / ___ / ___

**LIEN ASSIGNMENT AGREEMENT**

I hereby enter into the following agreement with _____, hereinafter known as "the provider" in order to guarantee payment for services rendered by "the provider" to me. I understand that I am directly and fully responsible to "the provider" for all medical bills for services rendered to me. I understand that I am directly and fully responsible to "the provider" for any remaining balance on all medical bills for services rendered to me that were submitted on my behalf to the responsible insurance carrier as applicable. This document further serves to acknowledge my responsibility to repay all remaining balances subsequent to all applicable insurance payments. I agree to make myself available to appear or correspond with "the provider" as often as may be necessary for any collections effort that is undertaken. I have been made aware of the charges for the services rendered under this lien assignment and acknowledge my responsibility for the repayment of all outstanding balances. I further direct that my attorney shall not subsequently dispute these amounts and will contact this office to arrange for full payment at the time a settlement, trial or motion proceed becomes ready for disbursement.

To the extent applicable, I agree to comply with all Insurance Company regulations including, but not limited to examinations under oath and independent medical examinations. I understand that any failure on my part to comply with any condition precedent to insurance coverage, may, at the election of the medical provider, serve to revoke any assignment of No-Fault benefits. The patient herein further acknowledges their responsibility to file a timely notice of claim to the applicable insurance carrier and that any subsequent No Fault claim denied based on the failure to provide a timely notice, at the election of the provider may result in recovery efforts in reliance of the lien.

The Provider agrees to seek compensation from the appropriate insurance carrier prior to invoking the terms of this lien based on the accuracy of the information the patient has provided and to the extent applicable. The patient shall provide all necessary insurance information, police reports, and any additional documentation or information deemed necessary by the provider for the submission of the aforementioned Insurance claim as applicable. Failure to provide accurate insurance information leading to the viable source of coverage may serve to invalidate any executed assignment of No-Fault benefits and result in the reliance on this lien for reimbursement purposes.

I hereby give and grant this lien on my case to "the provider" against any and all proceeds of any settlement, judgement, verdict, or other disposition of any litigation filed or contemplated on my behalf hat may be paid to me or my ATTORNEY as a result of the injuries for which I have been treated. I grant "the provider" the aforesaid lien against such sums of the aforesaid settlement, judgement, verdict, or other disposition of any litigation filed or contemplated on my behalf as may be necessary to adequately reimburse "the provider" for services rendered to me and toward all outstanding balances. I hereby agree to provide accurate contact information for the attorney pursuing any litigation on my behalf.

I hereby direct and authorize direct payment to "the provider", such sums as may be due and owning for medical services rendered to me. I further direct my ATTORNEY to honor the aforesaid lien and to withhold such sums from any settlement, judgement, verdict or other disposition of any litigation filed or contemplated on my behalf as may ne necessary to adequately reimburse "the provider" for services rendered to me towards all outstanding balances.

**Patient's Initials**: _____

I understand that this document may not be rescinded and that my ATTORNEY shall not honor any such rescission. I hereby instruct that in the event another ATTORNEY is substituted in my care, I direct the substituted attorney to provide the incoming ATTORNEY with a copy of this lien and that I direct any incoming ATTORNEY to honor this lien as inherent to the settlement, judgement, verdict, or other disposition of any litigation field or contemplated on my behalf and enforceable upon the case as if it were executed by him/her. I hereby direct and authorize my attorney, on demand, to provide the status of such litigation to "the provider" or the attorney representing the provider prior to disbursement of any funds to ascertain any outstanding balances due to the provider, herein _____

Patient's Name: _____

Patient's Address: _____

_____

Dated: ___ / ___ / ___

**Patient's Signature: _____**

Patient's Attorney's Name: _____

Attorney's Address _____

_____

Attorney's Phone Number: _____

Attorney Signature: _____

Dated: ___ / ___ / ___

**NEW YORK MOTOR VEHICLE NO-FAULT INSURANCE LAW**
**ASSIGNMENT OF BENEFITS FORM**

(FOR ACCIDENTS OCCURRING ON AND AFTER 3/1/02)

**I, _____ , ("Assignor") hereby assign to _____ , ("Assignee")**
(Print patient's name) (Print hospital or health care provider name)
**all rights privileges and remedies to payment for health care services provided by assignee to which I am entitled under Article 51 (the No-Fault statute) of the Insurance Law.**

**The Assignee hereby certifies that they have not received any payment from or on behalf of the Assignor and shall not pursue payment directly from the Assignor for services provided by said Assignee for injuries sustained due to the motor vehicle accident which occurred on _____ , not withstanding any other agreement**
(Print accident date)
**to the contrary.**

**This agreement may be revoked by the assignee when benefits are not payable based upon the assignor's lack of coverage and/or violation of a policy condition due to the actions or conduct of the assignor.**

**ANY PERSON WHO KNOWINGLY AND WITH INTENT TO DEFRAUD ANY INSURANCE COMPANY OR OTHER PERSON FILES AN APPLICATION FOR COMMERCIAL INSURANCE OR A STATEMENT OF CLAIM FOR ANY COMMERCIAL OR PERSONAL INSURANCE BENEFITS CONTAINING ANY MATERIALLY FALSE INFORMATION, OR CONCEALS FOR THE PURPOSE OF MISLEADING, INFORMATION CONCERNING ANY FACT MATERIAL THERETO, AND ANY PERSON WHO, IN CONNECTION WITH SUCH APPLICATION OR CLAIM, KNOWINGLY MAKES OR KNOWINGLY ASSISTS, ABETS, SOLICITS OR CONSPIRES WITH ANOTHER TO MAKE A FALSE REPORT OF THE THEFT, DESTRUCTION, DAMAGE OR CONVERSION OF ANY MOTOR VEHICLE TO A LAW ENFORCEMENT AGENCY, THE DEPARTMENT OF MOTOR VEHICLES OR AN INSURANCE COMPANY, COMMITS A FRAUDULENT INSURANCE ACT, WHICH IS A CRIME, AND SHALL ALSO BE SUBJECT TO A CIVIL PENALTY NOT TO EXCEED FIVE THOUSAND DOLLARS AND THE VALUE OF THE SUBJECT MOTOR VEHICLE OR STATED CLAIM FOR EACH VIOLATION.**

| | |
|---|---|
| **(Print name of Patient)** | **(Signature of Patient)** |
| | (Date of signature) |
| (Address of Patient) | |
| Gary Cullin, D.C. | |
| **(Print name of Provider)** | **(Signature of Provider)** |
| 193 N. Wellwood Ave | (Date of signature) |
| Lindenhurst, N.Y. 11757 | |
| (Address of Provider) | |

NYS FORM NF-AOB (Rev 1/2004)

**NEW YORK MOTOR VEHICLE NO-FAULT INSURANCE LAW**
**ASSIGNMENT OF BENEFITS FORM**

(FOR ACCIDENTS OCCURRING ON AND AFTER 3/1/02)

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(Print patient's name) (Print hospital or health care provider name)
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| | |
|---|---|
| **(Print name of Patient)** | **(Signature of Patient)** |
| | (Date of signature) |
| (Address of Patient) | |
| Thomas Bradley, DPT | |
| **(Print name of Provider)** | **(Signature of Provider)** |
| 193 N. Wellwood Ave | (Date of signature) |
| Lindenhurst, N.Y. 11757 | |
| (Address of Provider) | |

NYS FORM NF-AOB (Rev 1/2004)

# NO FAULT INSURANCE INFORMATION

Patient Name: _____

Policyholder Name (if different): _____

Insurance Company: _____

Address: _____

_____

Claim #: _____

Policy #: _____

Date of Accident: ___ / ___ / ___

Were you in a company vehicle at the time of an accident? _____

**NEW YORK MOTOR VEHICLE NO-FAULT INSURANCE LAW**
**APPLICATION FOR MOTOR VEHICLE NO-FAULT BENEFITS**

| NAME AND ADDRESS OF INSURER * | NAME, ADDRESS, AND PHONE NUMBER OF INSURER'S CLAIMS REPRESENTATIVE* |
|---|---|
| | |

| DATE | POLICYHOLDER | POLICY NUMBER | DATE OF ACCIDENT | CLAIM NUMBER |
|---|---|---|---|---|
| | | | | |

TO ENABLE US TO DETERMINE IF YOUR ARE ENTITLED TO BENEFITS UNDER THE NEW YORK NO-FAULT LAW, PLEASE COMPLETE THIS FORM AND RETURN IT PROMPTLY.

IMPORTANT: 1. TO BE ELIGIBLE FOR BENEFITS YOU MUST COMPLETE AND SIGN THIS APPLICATION.
2. YOU MUST SIGN ANY ATTACHED AUTHORIZATION(S).
3. RETURN PROMPTLY WITH COPIES OF ANY BILLS YOU HAVE RECEIVED TO DATE.

| NAME AND ADDRESS OF APPLICANT* |
|---|
| |

| 1. YOUR NAME | 2. PHONE NOS. HOME | BUSINESS |
|---|---|---|
| | | |

| 3. YOUR ADDRESS (NO., STREET, CITY OR TOWN AND ZIP CODE) | 4. DATE OF BIRTH | 5. SOCIAL SECURITY NO. |
|---|---|---|
| | | |

| 6. DATE AND TIME OF ACCIDENT A.M. P.M. | 7. PLACE OF ACCIDENT (STREET), CITY OR TOWN AND STATE |
|---|---|
| | |

8. BRIEF DESCRIPTION OF ACCIDENT

9. DESCRIBE YOUR INJURY

10. IDENTITY OF VEHICLE YOU OCCUPIED OR OPERATED AT THE TIME OF THE ACCIDENT:

OWNER'S NAME MAKE YEAR

THIS VEHICLE WAS: ☐ A BUS OR SCHOOL BUS, ☐ A TRUCK, ☐ AN AUTOMOBILE, ☐ OR A MOTORCYCLE

| | YES | NO |
|---|---|---|
| 11. WERE YOU THE DRIVER OF THE MOTOR VEHICLE? | ☐ | ☐ |
| WERE YOU A PASSENGER IN THE MOTOR VEHICLE? | ☐ | ☐ |
| WERE YOU A PEDESTRIAN? | ☐ | ☐ |
| WERE YOU A MEMBER OF OUR POLICYHOLDER'S HOUSEHOLD? | ☐ | ☐ |
| DO YOU OR A RELATIVE WITH WHOM YOU RESIDE OWN A MOTOR VEHICLE? | ☐ | ☐ |

CONTINUATION ON NEXT PAGE

**APPLICATION FOR MOTOR VEHICLE NO-FAULT BENEFITS - - PAGE TWO**

12. WERE YOU TREATED BY A DOCTOR(S) OR OTHER PERSON(S) FURNISHING HEALTH SERVICES?

YES ☐ NO ☐

IF YES, NAME AND ADDRESS OF SUCH DOCTOR(S) OR PERSON(S):

13. IF YOUR WERE TREATED AT A HOSPITAL(S), WERE YOU AN

OUT-PATIENT? ☐ IN-PATIENT? ☐

DATE OF ADMISSION: _____

HOSPITAL'S NAME AND ADDRESS: _____

| 14. AMOUNT OF HEALTH BILLS TO DATE: | 15. WILL YOU HAVE MORE HEALTH TREATMENT(S)? | 16. AT THE TIME OF YOUR ACCIDENT WERE YOU IN THE COURSE OF YOUR EMPLOYMENT? |
|---|---|---|
| $ _____ | YES ☐ NO ☐ | YES ☐ NO ☐ |

| 17. DID YOU LOSE TIME FROM WORK? | DATE ABSENCE FROM WORK BEGAN: | HAVE YOU RETURNED TO WORK? |
|---|---|---|
| YES ☐ NO ☐ | | YES ☐ NO ☐ |

IF YES, DATE RETURNED TO WORK: _____ AMOUNT OF TIME LOST FROM WORK: _____

| 18. WHAT ARE YOUR GROSS AVERAGE WEEKLY EARNINGS? | NUMBER OF DAYS YOU WORK PER WEEK: | NUMBER OF HOURS YOU WORK PER DAY: |
|---|---|---|
| | | |

19. WERE YOU RECEIVING UNEMPLOYMENT BENEFITS AT THE TIME OF THE ACCIDENT?

YES ☐ NO ☐

20. LIST NAMES AND ADDRESS OF YOUR EMPLOYER AND OTHER EMPLOYERS FOR ONE YEAR PRIOR TO ACCIDENT DATE AND GIVE OCCUPATION AND DATES OF EMPLOYMENT:

| EMPLOYER AND ADDRESS | OCCUPATION | FROM | TO |
|---|---|---|---|
| EMPLOYER AND ADDRESS | OCCUPATION | FROM | TO |
| EMPLOYER AND ADDRESS | OCCUPATION | FROM | TO |

21. AS A RESULT OF YOUR INJURY HAVE YOU HAD ANY OTHER EXPENSES?

YES ☐ NO ☐

IF YES, ATTACH EXPLANATION AND AMOUNTS OF SUCH EXPENSES.

22. DUE TO THIS ACCIDENT HAVE YOU RECEIVED OR ARE YOU ELIGIBLE FOR PAYMENTS UNDER ANY OF THE FOLLOWING:

| | YES | NO |
|---|---|---|
| NEW YORK STATE DISABILITY? | ☐ | ☐ |
| WORKERS' COMPENSATION? | ☐ | ☐ |

CONTINUATION ON NEXT PAGE

**APPLICATION FOR MOTOR VEHICLE NO-FAULT BENEFITS - - PAGE THREE**

THE APPLICANT AUTHORIZES THE INSURER TO SUBMIT ANY AND ALL OF THESE FORMS TO ANOTHER PARTY OR INSURER IF SUCH IS NECESSARY TO PERFECT ITS RIGHTS OF RECOVERY PROVIDED FOR UNDER THE NO-FAULT LAW.

THIS FORM IS SUBSCRIBED AND AFFIRMED BY THE APPLICANT AS TRUE UNDER THE PENALTIES OF PERJURY

**ANY PERSON WHO KNOWINGLY AND WITH INTENT TO DEFRAUD ANY INSURANCE COMPANY OR OTHER PERSON FILES AN APPLICATION FOR COMMERCIAL INSURANCE OR A STATEMENT OF CLAIM FOR ANY COMMERCIAL OR PERSONAL INSURANCE BENEFITS CONTAINING ANY MATERIALLY FALSE INFORMATION, OR CONCEALS FOR THE PURPOSE OF MISLEADING, INFORMATION CONCERNING ANY FACT MATERIAL THERETO, AND ANY PERSON WHO, IN CONNECTION WITH SUCH APPLICATION OR CLAIM, KNOWINGLY MAKES OR KNOWINGLY ASSISTS, ABETS, SOLICITS OR CONSPIRES WITH ANOTHER TO MAKE A FALSE REPORT OF THE THEFT, DESTRUCTION, DAMAGE OR CONVERSION OF ANY MOTOR VEHICLE TO A LAW ENFORCEMENT AGENCY, THE DEPARTMENT OF MOTOR VEHICLES OR AN INSURANCE COMPANY, COMMITS A FRAUDULENT INSURANCE ACT, WHICH IS A CRIME, AND SHALL ALSO BE SUBJECT TO A CIVIL PENALTY NOT TO EXCEED FIVE THOUSAND DOLLARS AND THE VALUE OF THE SUBJECT MOTOR VEHICLE OR STATED CLAIM FOR EACH VIOLATION.**

SIGNATURE _____ DATE _____

DO NOT DETACH

AUTHORIZATION FOR RELEASE OF WORK AND OTHER LOSS INFORMATION

THIS AUTHORIZATION OR PHOTOCOPY THEREOF, WILL AUTHORIZE YOU TO FURNISH ALL INFORMATION YOU MAY HAVE REGARDING MY WAGES, SALARY OR OTHER LOSS WHILE EMPLOYED BY YOU. YOUR ARE AUTHORIZED TO PROVIDE THIS INFORMATION IN ACCORDANCE WITH THE NEW YORK COMPREHENSIVE MOTOR VEHICLE INSURANCE REPARATIONS ACT (NO-FAULT LAW).

NAME (PRINT OR TYPE) _____ SOCIAL SECURITY NO. _____

SIGNATURE _____ DATE _____

DO NOT DETACH

AUTHORIZATION FOR RELEASE OF HEALTH SERVICE OR TREATMENT INFORMATION

THIS AUTHORIZATION OR PHOTOCOPY THEREOF, WILL AUTHORIZE YOU TO FURNISH ALL INFORMATION YOU MAY HAVE REGARDING MY CONDITION WHILE UNDER YOUR OBSERVATION OR TREATMENT, INCLUDING THE HISTORY OBTAINED, X-RAYS AND PHYSICAL FINDINGS, DIAGNOSIS AND PROGNOSIS. YOU ARE AUTHORIZED TO PROVIDE THIS INFORMATION IN ACCORDANCE WITH THE NEW YORK COMPREHENSIVE MOTOR VEHICLE INSURANCE REPARATIONS ACT (NO-FAULT LAW).

NAME (PRINT OR TYPE) _____

SIGNATURE _____ DATE _____

(IF THE APPLICANT IS A MINOR, PARENT OR GUARDIAN SHALL SIGN AND INDICATE CAPACITY AND RELATIONSHIP).

*LANGUAGE TO BE FILLED IN BY INSURER OR SELF-INSURER.

NYS FORM NF-2 (Rev 1/2004)

Page 3 of 3

# POST INJURY MVA

Patient Name: First: _____ Last: _____
Today's Date: _____
Who is your Attorney? _____ Their phone #: _____

Date of Accident:
____/____/____

Did you lose Consciousness?
☐ Yes ☐ No

**Your initial reaction:**
☐ Shocked
☐ Panicky
☐ Nervous
☐ Dizzy
☐ Confused
☐ Frightened
☐ Shaken
☐ Dazed

**Where did the pain occur?**
☐ Head
☐ Neck
☐ Middle back
☐ Lower back
☐ L ☐ R Shoulder
☐ L ☐ R Elbow
☐ L ☐ R Wrist
☐ L ☐ R Hip
☐ L ☐ R Knee
☐ L ☐ R Ankle

Were you treated at the scene of the accident via EMS services? ☐ Yes ☐ No

Did you go to the hospital? ☐ Yes ☐ No Were you transported via ambulance? ☐ Yes ☐ No

Did you go to the Hospital on your own? ☐ Yes ☐ No

If you did go t the Hospital, which one? _____

Were X-rays taken? ☐ Yes ☐ No If yes, what areas of your body were examined? _____

_____

**DESCRIBE THE VEHICLE YOU WERE IN:**

VEHICLE TYPE _____ YEAR _____ YOUR POSITION _____

**DESCRIBE THE ACCIDENT:**

Action of the vehicle you were in: _____
Where was the vehicle hit? _____
Estimated amount of damage: _____
Describe the other vehicle: _____
Damage to other vehicle _____
Weather conditions _____
Road conditions: _____
Time of day: _____
Visibility? _____

**DESCRIBE THE MOMENT OF IMPACT:**

Your body position at impact: _____
Direction your body was thrown: _____
Head position at impact: _____
Direction your head was thrown: _____

Were you wearing a seatbelt? ☐ Yes ☐ No Did the airbags deploy? ☐ Yes ☐ No

Did you brace for the impact? ☐ Yes ☐ No What was the position of your headrest? _____



Your Signature: _____

# HEADACHE DISABILITY INDEX

Name: _____ Date: _____ Age: _____ Scores Total: _____ :E ____: F_____

(100) (52) (48)

Instructions: Please CIRCLE the correct response:

1. I have headache: [1] 1 per month [2] more than but less than 4 per month [3] more than one per week
2. My headache is: [1] mild [2] moderate [3] severe

Instructions: PLEASE READ CAREFULLY: The purpose of the scale is to identify difficulties that you may be experiencing because of your headache. Please check off "YES", "SOMETIMES", or "NO" to each item. Answer each item as it pertains to your headache only.

| | YES | SOMETIMES | NO |
|---|---|---|---|
| E1. Because of my headaches I feel handicapped | ☐ | ☐ | ☐ |
| F2. Because of my headaches I feel restricted in performing routine daily activities | ☐ | ☐ | ☐ |
| E3. No one understands the effect my headaches have on my life | ☐ | ☐ | ☐ |
| F4. I restrict recreational activities (sports, hobbies) because of headaches | ☐ | ☐ | ☐ |
| E5. My headaches make me angry | ☐ | ☐ | ☐ |
| E6. Sometimes I feel I am going to lose control because of my headaches | ☐ | ☐ | ☐ |
| F7. Because of my headaches, I am less likely to socialize | ☐ | ☐ | ☐ |
| E8. My spouse (significant other) or family and friends have no idea what I'm going through because of my headaches | ☐ | ☐ | ☐ |
| E9. My headaches are so bad that I think I am going to go insane | ☐ | ☐ | ☐ |
| E10. My outlook on the world is affected by my headaches | ☐ | ☐ | ☐ |
| E11. I am afraid to go outside when I feel that a headache is starting | ☐ | ☐ | ☐ |
| E12. I feel desperate because of my headaches | ☐ | ☐ | ☐ |
| F13. I am concerned that I am paying penalties at work or at home because of my headaches | ☐ | ☐ | ☐ |
| E14. My headaches place stress on my relationships with family or friends | ☐ | ☐ | ☐ |
| F15. I avoid being around people when I have a headache | ☐ | ☐ | ☐ |
| F16. I believe my headaches make it difficult to achieve my goals in life | ☐ | ☐ | ☐ |
| F17. I am unable to think clearly because of my headaches | ☐ | ☐ | ☐ |
| F18. I get tense (muscle tension) because of my headaches | ☐ | ☐ | ☐ |
| F19. I do not enjoy social gatherings because of my headaches | ☐ | ☐ | ☐ |
| E20. I feel irritable because of my headaches | ☐ | ☐ | ☐ |
| F21. I avoid travelling because of my headaches | ☐ | ☐ | ☐ |
| E22. My headaches make me feel confused | ☐ | ☐ | ☐ |
| E23. My headaches make me feel frustrated | ☐ | ☐ | ☐ |
| F24. I find it difficult to read because of my headaches | ☐ | ☐ | ☐ |
| F25. I find it difficult to focus my attention away from my headaches and on other things | ☐ | ☐ | ☐ |



Reference; Jacobson Gary ., Ramadan NM, et al,. The Henry Ford Hospital Headache Disability Inventory (HDI), Neurology 1994; 44:637-842

PLEASE PLACE AN X IN ONE BOX OF EACH SECTION THAT BEST DESCRIBES HOW YOUR INJURY IS AFFECTING YOUR LIFE.

# NECK DISABILITY INDEX

## SECTION 1 – PAIN INTENSITY
- ☐ A. No pain at the moment
- ☐ B. Mild pain at the moment.
- ☐ C. Moderate pain at the moment
- ☐ D. Fairly severe pain at the moment
- ☐ E. Very severe pain at the moment
- ☐ F. Worst imaginable pain at the moment

## SECTION 2 – PERSONAL CARE
- ☐ A. Personal care is normal without extra pain
- ☐ B. Personal care normal with extra pain
- ☐ C. Personal care painful/slow and careful
- ☐ D. Manage most personal care with some help.
- ☐ E. Needs help everyday in most aspects of care
- ☐ F. Difficulty dressing and washing/stays in bed

## SECTION 3 - LIFTING
- ☐ A. Lifts heavy weights with no pain.
- ☐ B. Lifts heavy weights with pain.
- ☐ C. Can lift heavy weights from a table.
- ☐ D. Can lift light weights from a table.
- ☐ E. Can lift only very light weights.
- ☐ F. Cannot lift or carry anything.

## SECTION 4 – READING
- ☐ A. No pain while reading
- ☐ B. Slight pain while reading.
- ☐ C. Moderate pain while reading.
- ☐ D. Moderate pain prevents reading.
- ☐ E. Severe pain prevents reading.
- ☐ F. Cannot read at all.

## SECTION 5 – HEADACHES
- ☐ A. No headaches.
- ☐ B. Slight infrequent headaches.
- ☐ C. Moderate infrequent headaches.
- ☐ D. Moderate frequent headaches.
- ☐ E. Severe, frequent headaches.
- ☐ F. Constant headaches.

## SECTION 6- CONCENTRATION
- ☐ A. Can concentrate without difficulty.
- ☐ B. Can concentrate with slight difficulty .
- ☐ C. Can concentrate with fair difficulty .
- ☐ D. Can concentrate with a lot of difficulty .
- ☐ E. Can concentrate with extreme difficulty .
- ☐ F. Cannot concentrate at all.

## SECTION 7 – WORK
- ☐ A. Work is unrestricted.
- ☐ B. Can do usual work, but no more.
- ☐ C. Can do most usual work, but no more.
- ☐ D. Cannot do usual work
- ☐ E. Can hardly do any work.
- ☐ F. Cannot do any work.

## SECTION 8 – DRIVING
- ☐ A. Can drive without pain.
- ☐ B. Driving causes slight neck pain.
- ☐ C. Driving causes moderate neck pain.
- ☐ D. Cannot drive long due to neck pain.
- ☐ E. Can hardly drive due to severe pain.
- ☐ F. Pain prevents driving.

## SECTION 9 – SLEEPING
- ☐ A. No difficulties sleeping.
- ☐ B. Sleep is mildly disturbed.
- ☐ C. 1-2 hours loss of sleep.
- ☐ D. 2-3 hours loss of sleep.
- ☐ E. 3-5 hours loss of sleep.
- ☐ F. 5-7 hours loss of sleep.

## SECTION 10–RECREATION
- ☐ A. Recreation is not affected at all.
- ☐ B. Some neck pain, but does not affect activity.
- ☐ C. Some activity is affected by pain.
- ☐ D. Most activity is affected by pain.
- ☐ E. Activity severely restricted by pain.
- ☐ F. Cannot do any activity.

PLEASE PLACE AN X IN ONE BOX OF EACH SECTION THAT BEST DESCRIBES HOW YOUR INJURY IS AFFECTING YOUR LIFE.

## OSWESTRY REVISED QUESTIONAIRE

### SECTION 1 – PAIN INTENSITY
- ☐ A. Pain comes and goes and is mild.
- ☐ B. Pain is mild and does not vary.
- ☐ C. Pain comes and goes and is moderate.
- ☐ D. Pain is moderate and does not vary much.
- ☐ E. Pain comes and goes and is severe.
- ☐ F. Pain is severe and does not vary much.

### SECTION 2 – PERSONAL CARE
- ☐ A. Does not change habits to avoid pain.
- ☐ B. Does not change habits/some pain.
- ☐ C. Does not change habits/Increases pain.
- ☐ D. Changes habits/Increases pain.
- ☐ E. Unable to do some personal care without help.
- ☐ F. Unable to wash or dress without help.

### SECTION 3 - LIFTING
- ☐ A. Lifts heavy weights with no pain.
- ☐ B. Lifts heavy weights with pain.
- ☐ C. Cannot lift heavy weights of the floor.
- ☐ D. Can lift heavy weights from a table.
- ☐ E. Can lift light weights from a table.
- ☐ F. Can lift only very light weights.

### SECTION 4 – WALKING
- ☐ A. Pain does not prevent walking.
- ☐ B. Cannot walk more than one mile.
- ☐ C. Cannot walk more than ½ mile.
- ☐ D. Cannot walk more than ¼ mile.
- ☐ E. Can walk only with crutches.
- ☐ F. Bedridden and must crawl to the toilet.

### SECTION 5 - SITTING
- ☐ A. Can sit in any chair as long as desired.
- ☐ B. Can sit only in favorite chair as long as desired.
- ☐ C. Can sit no more than 1 hour.
- ☐ D. Can sit no more than ½ hour.
- ☐ E. Can sit no more than 10 minutes.
- ☐ F. Cannot sit at all due to pain.

### SECTION 6- STANDING
- ☐ A. Can stand for an unlimited time without pain.
- ☐ B. Some pain standing/doesn't increase with time.
- ☐ C. Cannot stand for more than 1 hour.
- ☐ D. Cannot stand for more than ½ hour.
- ☐ E. Cannot stand more than 10 minutes.
- ☐ F. Cannot stand at all.

### SECTION 7 – SLEEPING
- ☐ A. No pain in bed.
- ☐ B. Gets pain in bed, buts sleep well.
- ☐ C. Normal sleep reduced by 1/4.
- ☐ D. Normal nights sleep reduced by 1/2
- ☐ E. Normal nights sleep reduced by 3/4
- ☐ F. Cannot sleep at all due to pain.

### SECTION 8 - TRAVELING
- ☐ A. Travel without pain.
- ☐ B. Travel causes some pain, but not made worse.
- ☐ C. Causes extra pain/no change in form.
- ☐ D. Causes pain/Uses alternate travel.
- ☐ E. Pain restricts all forms of travel.
- ☐ F. Pain restricts travel except lying down.

### SECTION 9 - SOCIAL
- ☐ A. Normal and causes no pain.
- ☐ B. Normal but causes extra pain.
- ☐ C. Limits energetic interests.
- ☐ D. Pain limits/doesn't go out as often.
- ☐ E. Pain restricts social life to home.
- ☐ F. Pain restricts all social life.

### SECTION 10–CHANGING DEGREE OF PAIN
- ☐ A. Pain is rapidly improving.
- ☐ B. Pain fluctuates but is improving.
- ☐ C. Improvement is slow.
- ☐ D. Pain level is unchanged.
- ☐ E. Pain is gradually worsening.
- ☐ F. Pain is rapidly worsening.

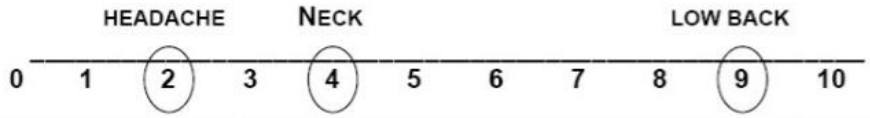
# QUADRUPLE VISUAL ANALOGUE SCALE

Patient's Name: _____ Number: _____ Date: _____

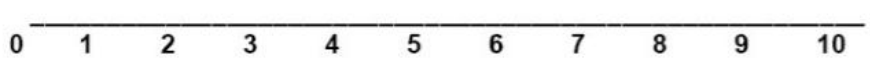
INSTRUCTIONS: Please circle the number that best describes the question being asked.

NOTE: If you have more than one complaint, please answer each question for each Individual complaint and indicate which score is for which complaint.

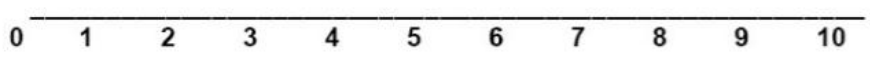
**EXAMPLE:**



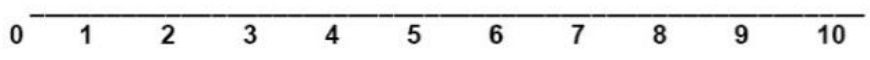

1. **What is your pain RIGHT NOW?**




2. **What is your TYPICAL or AVERAGE pain?**

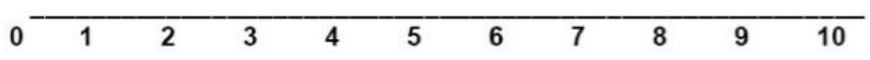



3. **What is your pain AT ITS BEST (How close to "0" does your pain get at its best)?**




**What percentage of your awake hours is your pain at its best? _____%**

4. **What is your pain AT ITS WORST (How close to "10" does your pain get at its worst)?**




**What percentage of your awake hours is your pain at its worst? _____%**

Reference: Thomeé R., Grimby G., Wright B.D., Linacre J.M. (1995) Rasch analysis of Visual Analog Scale. *Scandinavian Journal of Rehabilitation Medicine* 27, 145-151.

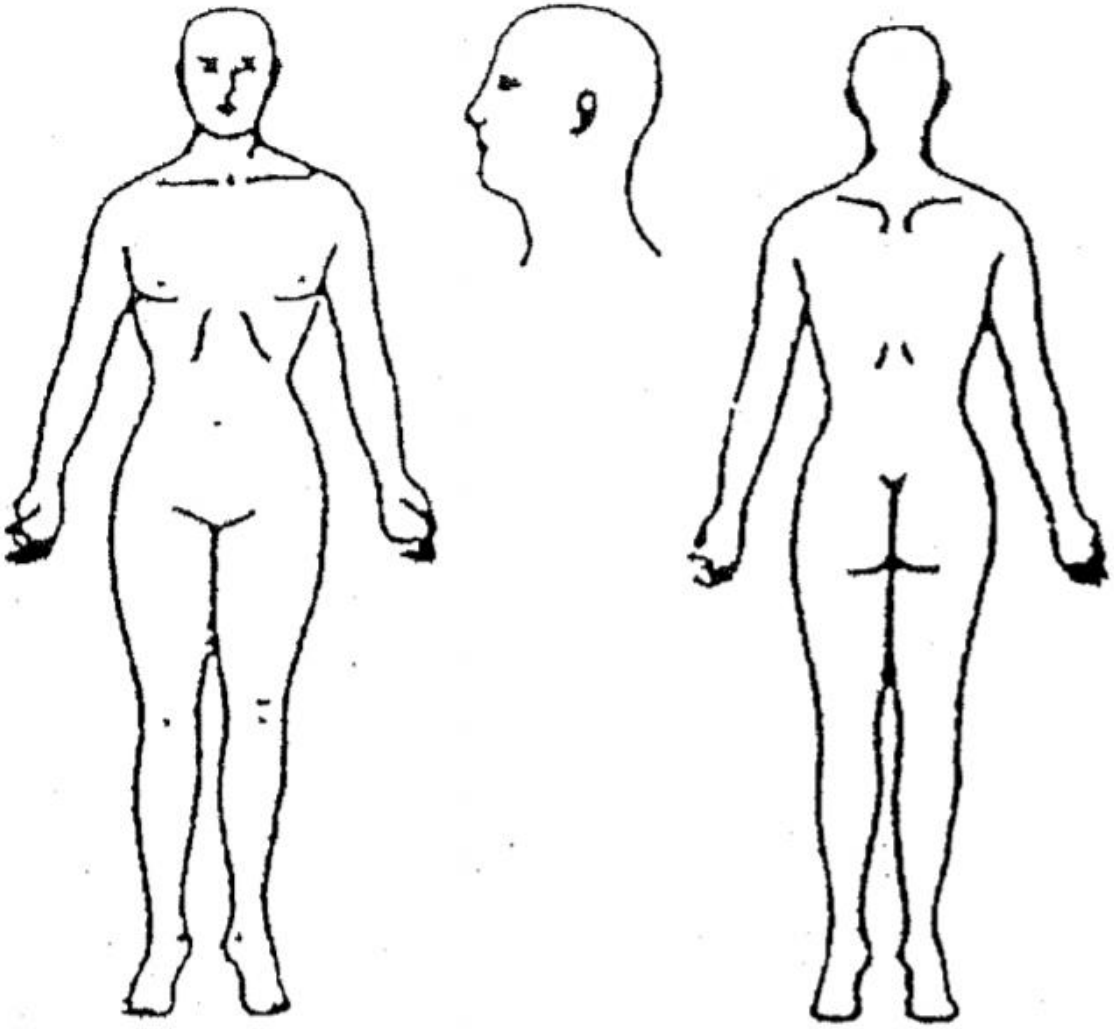
# SYMPTOM DIAGRAM

Patient's Name: _____ Number: _____ Date: _____

Please be sure to full this form out extremely accurately. Mark the area(s) on your body where you feel the described sensation(s). Use the appropriate symbol(s). Mark areas of radiating pain, and include all affected areas. You may draw on the face as well.

ACHES = ^^^^ PINS/NEEDLES = · · · · STABBING = /////

NUMBNESS = °°°° BURNING = XXXX



Please list all prescription or non-prescription medications you are currently taking:

_____

Do you smoke? _____

Right or left hand dominant? _____

Height: _____

Weight: _____

Have you ever had any prior motor vehicle collision or injury? If so, please briefly explain:

_____

_____

Are you currently working? If so, what is your job title and what types of movements are required of you?

_____

_____

Please state your current health conditions and history of health: _____

_____

_____

Have you received care from another health care provider/facility for your injury? _____

_____

_____

I hereby request and consent to the performance of chiropractic adjustments and other chiropractic procedures, including various modes of physical therapy, massage therapy, physiotherapy and diagnostic X-rays and diagnostic testing, on me (or on the patient names below, for whom I am legally responsible) by the Doctor named below and/or other licensed Doctors who now or in the future work at the clinic or office listed below or any other office or clinic.

I have had an opportunity to discuss with the Doctor named below and/or with other office or clinic personnel the nature and purpose of chiropractic adjustments and other procedures. I understand that results are not guaranteed.

I understand and am informed that, as in the practice of medicine, in the practice of chiropractic there are some risks to treatment, including but not limited to fractures, disc injuries, strokes, dislocations and sprains. I do not expect the doctor to be able to anticipate and explain all risks and complications, and I wish to rely upon the doctor to exercise judgement during the course of the procedure which the doctor feels at the time, based upon the facts then known to him or her, is in my best interest.

I have read, or have had read to me, the above consent. I have also has an opportunity to ask questions about its content, and by signing below I agree to the above-names procedures. I intend this consent form to cover the entire course of treatment for my present condition and for any future condition(s) for which I seek treatment.

Provider Signature _____ Date ____/____/____

Patient Signature _____ Date ____/____/____

Witness Signature _____ Date ____/____/____