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: ___ / ___ / ___

ASSIGNMENT, LIEN AND AUTHORIZATION

INSURANCE BENEFITS AND ATTORNEY

To Whom It May Concern:

I hereby authorize and direct you, my Insurance company, and/or my attorney, to pay directly to _____ 193 N. Wellwood Ave., Lindenhurst, NY such sums as may be due and owing his office for services rendered to me, both by reason of accident or illness, and by reason of any other bills that are due this office. And to withhold such sums form any disability benefits, medical benefits, no-fault benefits, health and accident benefits, workmen's compensation benefits, or any other insurance benefits obligated to reimburse me or from any settlement, judgement or verdict on my behalf as may be necessary to adequately protect said Office. I hereby further give a lien to said Office against any and all insurance benefits names herein, and any and all proceeds of any settlement, judgement or verdict which may be paid to me as a result of the injuries or illnesses for which I have been treated by said Office. This to act as an assignment of my rights and benefits to the extent of the Office's services provided.

In the event my insurance company obligated to make payments to me upon the charged made by this Office for their services refused to make such payments, upon demand by me or this Office, I hereby assign and transfer to this Office any and all causes of action that I might have or that might exist in my favor against such company and authorize this office to prosecute said cause of action either in my name or in the Office's name and further I authorize this Office to compromise, settle or otherwise resolve said claim or cause of action as they see fit.

I understand that I remain personally responsible for the total amounts due this Office for their services, I further understand and agree that this Assignment, Lien and authorization. I agree that the above mentioned Office be given the power of Attorney to endorse/sign my name on any and all checks for payment of my doctor bill.

Date: _____ Signed: _____

Gary Cullin, D.C.
Thomas Bradley, D.P.T.
193 N. Wellwood Avenue,
Lindenhurst, N.Y. 11757
Phone: 631-842-2424 Fax: 631-842-2082

I do hereby authorize _____ to furnish you, my attorney, with a full report of his examination, diagnosis, treatment, prognosis, and other information pertaining to my medical condition.

I hereby authorize and direct you, my attorney, to pay directly to _____ all sums as may be due and owing him for medical services rendered to me both by reason of this accident and by reason of any other bulls that are due his office, and to withhold such sums from any settlement, judgement, or verdict as may be necessary to adequately protect _____. furthermore, I hereby give a lien on my case to said doctor against any and all proceeds of my settlements, judgement or verdict which may be paid to you, my attorney, or myself as the result of the injuries for which I have been treated or the injuries in connection therewith.

I full understand that I am directly and fully responsible to said doctor for all medical bills submitted by him for services rendered me and that this agreement is made solely for the doctors additional protection and in consideration of his awaiting payment. I further understand that such payment is not contingent on any settlement, judgement or verdict by which I may eventually recover said fee.

Patient Print Name: _____

Patient Signature: _____ Date: _____

The undersigned being the attorney of record for the above named patient does hereby agree to observe all terms of the above and agrees to withhold such sums from settlement, judgement or verdict as may be necessary to adequately protect _____.

Attorney Print Name: _____

Attorney Signature: _____ Date: _____

Please note: It is the policy of his office to accept cases on a Lien, only when the patient's attorney signs in the space provided.

NEW PATIENT WORKERS' COMPENSATION QUESTIONS

DATE OF ACCIDENT: _____

TIME OF ACCIDENT: _____

PLACE OF ACCIDENT: _____

EMPLOYER NAME AND ADDRESS: _____

_____

_____

WHO WAS IT REPORTED TO AND A PHONE NUMBER: _____

_____

_____

HOW DID THE INJURY OCCUR? _____

_____

IS THE PATIENT WORKING? YES NO

WHAT DAYS DID THE PATIENT LOSE, from _____ to _____

NEW YORK STATE | Workers' Compensation Board

Employee Claim

C-3

State of New York - Workers' Compensation Board

Fill out this form to apply for workers' compensation benefits because of a work injury or work-related illness. Type or print neatly. This form may also be filled out on-line at www.wcb.ny.gov.

WCB Case Number (if you know it): _____

A. YOUR INFORMATION (Employee)

1. Name: _____ (First / MI / Last) 2. Date of Birth: ____/____/____

3. Mailing address: _____ (Number and Street/PO Box/Apartment No. / City / State / Zip Code)

4. Social Security Number: ___-___-___ 5. Phone Number: (___)_____ 6. Gender: ☐ Male ☐ Female

7. Will you need a translator if you have to attend a Board hearing? ☐ Yes ☐ No If yes, for what language? _____

B. YOUR EMPLOYER(S)

1. Employer when injured: _____ 2. Phone Number: (___)_____

3. Your work address: _____ (Number and Street / City / State / Zip Code)

4. Date you were hired: ____/____/____ 5. Your supervisor's name: _____

6. List names/addresses of any other employer(s) at the time of your injury/illness: _____

7. Did you lose time from work at the other employment(s) as a result of your injury/illness? ☐ Yes ☐ No

C. YOUR JOB on the date of the injury or illness

1. What was your job title or description? _____

2. What types of activities did you normally perform at work? _____

3. Was your job? (check one) ☐ Full Time ☐ Part Time ☐ Seasonal ☐ Volunteer ☐ Other: _____

4. What was your gross pay (before taxes) per pay period? _____ 5. How often were you paid? _____

6. Did you receive lodging or tips in addition to your pay? ☐ Yes ☐ No If yes, describe: _____

D. YOUR INJURY OR ILLNESS

1. Date of injury or date of onset of illness: ____/____/____ 2. Time of injury: _____ ☐ AM ☐ PM

3. Where did the injury/illness happen? (e.g., 1 Main Street, Pottersville, at the front door) _____

4. Was this your usual work location? ☐ Yes ☐ No If no, why were you at this location? _____

5. What were you doing when you were injured or became ill? (e.g., unloading a truck, typing a report) _____

6. How did the injury/illness happen? (e.g., I tripped over a pipe and fell on the floor) _____

7. Explain fully the nature of your injury/illness; list body parts affected (e.g., twisted left ankle and cut to forehead): _____

YOUR NAME: _____ DATE OF INJURY/ILLNESS: ____/____/____
First MI Last

D. YOUR INJURY OR ILLNESS *continued*

8. Was an object (e.g., forklift, hammer, acid) involved in the injury/illness? ☐ Yes ☐ No If yes, what? _____

9. Was the injury the result of the use or operation of a licensed motor vehicle? ☐ Yes ☐ No
   If yes, ☐ your vehicle ☐ employer's vehicle ☐ other vehicle License plate number (if known): _____
   If your vehicle was involved, give name and address of your motor vehicle insurance carrier: _____
   _____

10. Have you given your employer (or supervisor) notice of injury/illness? ☐ Yes ☐ No
    If yes, notice was given to: _____ ☐ orally ☐ in writing Date notice given: ____/____/____

11. Did anyone see your injury happen? ☐ Yes ☐ No ☐ Unknown If yes, list names: _____
    _____

E. RETURN TO WORK

1. Did you stop work because of your injury/illness? ☐ Yes, on what date? ____/____/____ ☐ No, skip to Section F.
2. Have you returned to work? ☐ Yes ☐ No If yes, on what date? ____/____/____ ☐ regular duty ☐ limited duty
3. If you have returned to work, who are you working for now? ☐ Same employer ☐ New employer ☐ Self employed
4. What is your gross pay (before taxes) per pay period? _____ How often are you paid? _____

F. MEDICAL TREATMENT FOR THIS INJURY OR ILLNESS

1. What was the date of your first treatment? ____/____/____ ☐ None received (skip to question F-5)
2. Were you treated on site? ☐ Yes ☐ No
3. Where did you receive your first off site medical treatment for your injury/illness? ☐ none received ☐ Emergency Room
   ☐ Doctor's office ☐ Clinic/Hospital/Urgent Care ☐ Hospital Stay over 24 hours
   Name and address where you were first treated: _____
   _____ Phone Number: (____)_____
4. Are you still being treated for this injury/illness? ☐ Yes ☐ No
   Give the name and address of the doctor(s) treating you for this injury/illness: _____
   _____ Phone Number: (____)_____
5. Have you had another injury to the same body part, or a similar illness? ☐ Yes ☐ No
   If yes, were you treated by a doctor? ☐ Yes ☐ No If yes, provide the names and addresses of the doctor(s) who treated you and **COMPLETE AND FILE FORM C-3.3 TOGETHER WITH THIS FORM:**
   _____
   _____
   _____
6. Was the previous injury/illness work related? ☐ Yes ☐ No
   If yes, were you working for the same employer that you work for now? ☐ Yes ☐ No

I am hereby making a claim for benefits under the Workers' Compensation Law. My signature affirms that the information I am providing is true and accurate to the best of my knowledge and belief.

Any person who knowingly and with INTENT TO DEFRAUD presents, causes to be presented, or prepares with knowledge or belief that it will be presented to, or by an insurer, or self-insurer, any information containing any FALSE MATERIAL STATEMENT or conceals any material fact, SHALL BE GUILTY OF A CRIME and subject to substantial FINES AND IMPRISONMENT.

Employee's Signature: _____ Print Name: _____ Date: ____/____/____

On behalf of Employee: _____ Print Name: _____ Date: ____/____/____

An individual may sign on behalf of the employee only if he or she is legally authorized to do so and the employee is a minor, mentally incompetent or incapacitated.

I certify to the best of my knowledge, information and belief, formed after an inquiry reasonable under the circumstances, that the allegations and other factual matters asserted above have evidentiary support, or are likely to have evidentiary support after a reasonable opportunity for further investigations or discovery.

Signature of Attorney/Representative (if any): _____ Date: ____/____/____

Print Name: _____ Title: _____

ID No., if any: R _____ If Licensed Representative, License No.: _____ Expiration Date: ____/____/____

NEW YORK STATE | Workers' Compensation Board

CLAIMANT'S AUTHORIZATION TO DISCLOSE WORKERS' COMPENSATION RECORDS

(Pursuant to Workers' Compensation Law Section 110-a)

PO Box 5205, Binghamton, NY 13902-5205 • www.wcb.ny.gov

CLAIMANTS ARE PROHIBITED FROM AUTHORIZING RELEASE OF WORKERS' COMPENSATION INFORMATION TO PROSPECTIVE EMPLOYERS OR IN CONNECTION WITH ASSESSING FITNESS OR CAPABILITY OF EMPLOYMENT.

PLEASE COMPLETE ALL ITEMS. AN INCOMPLETE FORM WILL DELAY THE PROCESSING OF YOUR REQUEST.

Claimant's Name	Claimant's Social Security or Tax Identification Number	Case Number ☐ WCB ☐ DB ☐ Discrimination ☐ PFL and/or Date of Accident

IF RELEASE IS AUTHORIZED FOR ADDITIONAL CASE FILE(S), IDENTIFY BELOW BY WCB/DB/DC/PFL CASE NUMBER AND/OR DATE OF ACCIDENT(S)

INSTRUCTIONS:

Submit original to the Workers' Compensation Board and retain a copy for your records. *Authorization for disclosure of records for certain purposes is not valid under the law. See excerpt of WCL Section 110-a on the reverse of this form.* This authorization is effective until it is revoked by the claimant. Claimant may revoke this authorization at any time upon written notice to the Workers' Compensation Board.

THIS AUTHORIZATION DOES NOT PERMIT YOU TO OPEN AN INDIVIDUAL eCASE ACCOUNT OR TO VIEW CASES VIA eCASE OUTSIDE OF A BOARD LOCATION.

Pursuant to Section 110-a of the Workers' Compensation Law, I, _____,
(CLAIMANT'S NAME)

represent that I am a person who is/was the subject of the workers' compensation cases(s) indicated above, and I authorize the Workers' Compensation Board to discuss the above-referenced Workers' Compensation Board records with and/or release a copy of the above-referenced records to _____,
(NAME OF A SPECIFIC PERSON, CORPORATION, ASSOCIATION OR PUBLIC OR PRIVATE ENTITY)

at _____.
(ADDRESS)

I understand that the requesting party may be required to pay a statutory fee prior to being provided copies of these records by the Workers' Compensation Board.

_____ _____
Claimant's Signature (ink only - use blue ink if possible) Date

Failure to provide the information requested on this form will not result in the denial of your authorization, but may delay the processing of your request. The voluntary release of your social security number enables the Board to ensure that information is associated with, and quick action is taken on, your request.

NOTICE THAT YOU MAY BE RESPONSIBLE FOR MEDICAL COSTS IN THE EVENT OF FAILURE TO PROSECUTE, OR IF COMPENSATION CLAIM IS DISALLOWED, OR IF AGREEMENT PURSUANT TO WCL §32 IS APPROVED

WCB CASE NO. (If Known)	CARRIER CASE NO. (If Known)	DATE OF INJURY	NATURE OF INJURY OR ILLNESS	INJURED PERSON'S SOC. SEC. NO.

CLAIMANT	NAME	ADDRESS	APT. NO.
EMPLOYER			
INSURANCE CARRIER			

You may become responsible for the medical costs of treatment for your illness or condition with the provider listed below if (1) you fail to prosecute the claim for workers' compensation or (2) it is determined by the Workers' Compensation Board that the illness or condition which required treatment was not a result of a compensable workplace accident or occupational disease or (3) if an agreement is executed by you and approved pursuant to Workers' Compensation Law §32 in which you waive your right to medical benefits from the workers' compensation carrier/self-insured employer for treatment/ services performed after the date the agreement is approved. If any of the above events occurs, the provider may bill you directly instead of the employer or insurance carrier, and you will be responsible for the provider's fees for services rendered.

I hereby acknowledge that I have read the above and understand the circumstances under which I may become responsible for payment.

Claimant's Signature_____ Date _____

Provider's Name and Address _____

_____

TO THE CLAIMANT

Workers' Compensation Board Regulation 325-1.23 permits your doctor or therapist to request that you sign this A-9 notice. By signing this notice, you acknowledge your obligation to pay the provider's fees for the services you receive if it turns out that such fees are not legally required to be paid by your employer or its workers' compensation insurance carrier and if such fees are not covered by other insurance. The employer or carrier may not be required to pay the doctor's fees if, for example, you fail to file a claim for workers' compensation, or fail to notify your employer of your injury or illness, or fail to attend a Board hearing if your employer challenges your right to benefits. Even if you make all required efforts to prosecute your claim, the Workers' Compensation Board may still find that you are not entitled to benefits. In such cases, this notice advises your health provider that you acknowledge your personal liability for payment of his/her bills.

Workers' Compensation Law Section 32

The A-9 notice also covers instances in which a claimant with an existing valid workers' compensation case comes to an agreement with his/her employer or its insurance carrier settling his/her case in accordance with Section 32 of the Workers' Compensation Law. A Section 32 agreement may include a provision which relieves the employer or carrier of the liability to pay future medical bills associated with the case. Your health care provider may ask you to sign this A-9 notice to insure that you acknowledge your personal liability for payment of his/her bills if you have waived your right to future medical benefits under a Section 32 agreement.

If you have any questions, contact your attorney or licensed hearing representative, if you have one. You may also contact your local district office of the Workers' Compensation Board.

TO THE HEALTH CARE PROVIDER

This notice is meant to advise the workers' compensation claimant that he/she may be responsible for payment. Failure of the claimant to sign this form does not relieve the provider of the obligation to treat the claimant, nor does it negate the claimant's responsibility for payment.

Keep the original of this form for your records and give a copy to the claimant. **Do not file with the Workers' Compensation Board.** You will receive Notices of Decisions in which the compensability of a claim, authorization of treatment, or payment of medical bills is included. You will also be notified if the claimant submits a Section 32 Agreement with the Board for approval. Do not bill the claimant unless and until you receive a Board decision finding that 1) claimant failed to prosecute the claim, or 2) the claim is denied, or 3) the treatment is not causally related to the work injury, or 4) a Section 32 agreement relieving the carrier of liability for medical treatment is approved.

ADVIERTA QUE USTED PUEDE LLEGAR A SER RESPONSABLE POR LOS COSTOS MÉDICOS EN CASO DE ABANDONO DEL PROCESO, O SI SE RECHAZA LA SOLICITUD DE INDEMNIZACIÓN, O SI SE APRUEBA UN ACUERDO EN VIRTUD DE LA LEY DE INDEMNIZACIÓN LABORAL WCL §32

Nº DE CASO WCB (si se conoce)	Nº. DE CASO DE LA ASEGURADORA (si se conoce)	FECHA DE LA LESIÓN	NATURALEZA DE LA LESIÓN O ENFERMEDAD	Nº SEG. SOC. DE PERSONAS LESIONADAS
RECLAMANTE	NOMBRE		DIRECCIÓN	APT. NO.
EMPLEADOR				
COMPAÑÍA DE SEGUROS				

Usted puede llegar a ser responsable por hacer el pago de los costos médicos del tratamiento de su enfermedad o condición al proveedor que se indica a continuación si (1) abandona el proceso de compensación laboral (2) si la institución Workers' Compensation Board (Junta de Compensación Laboral) determina que la enfermedad o condición que requería tratamiento no ocurrió por un accidente de trabajo indemnizable o enfermedad ocupacional o (3) si el acuerdo fue tramitado por usted y aprobado conforme a la Ley de Indemnización de Trabajadores WCL §32 ; en virtud de esta ley, usted renuncia a sus derechos de obtener los beneficios médicos de la compañía aseguradora de indemnizaciones laborales o del empleador auto asegurado para cubrir los tratamientos y servicios realizados después de la fecha en que se aprobó el acuerdo. Si ocurriera cualquiera de los hechos mencionados con anterioridad, el proveedor podrá cobrarle directamente el costo por los servicios recibidos en lugar de hacerlo al empleador o a la compañía aseguradora, y usted será responsable por hacer los pagos correspondientes.

Por medio de la presente reconozco que he leído el párrafo anterior y que entiendo las circunstancias bajo las cuales me hago responsable del pago.

Firma del reclamante _____ Fecha _____

Nombre y dirección del proveedor _____

AL RECLAMANTE
La Regulación 325-1.23 de la institución Workers' Compensation Board (Junta de Compensación Laboral) permite que su doctor o terapeuta le solicite que firme esta notificación A-9. Al firmar esta notificación, usted reconoce la obligación de pagar los honorarios al proveedor por los servicios que recibe en el supuesto caso que la ley no requiera que su empleador o aseguradora de indemnización laboral pague tales honorarios y si tales honorarios no están cubiertos por otro seguro. Es posible que el empleador o aseguradora no deba pagar los honorarios médicos si, por ejemplo, usted no presenta una solicitud de indemnización laboral, o si no notifica su lesión o enfermedad a su empleador, o si no asiste a la audiencia de la institución Workers' Compensation Board si su empleador desafía sus derechos a los beneficios. Aun cuando hubiese realizado todos los trámites necesarios para procesar su solicitud, la institución Workers' Compensation Board puede decidir que usted no tiene derecho a los beneficios. En tal caso, esta notificación le aconseja a su proveedor de servicios de salud que usted reconozca su responsabilidad personal por el pago de sus cuentas.

Artículo 32 de la Ley de Indemnización Laboral (WCL 32)
La notificación A-9 también cubre las instancias en las que un reclamante por un caso de compensación laboral válido existente llega a un acuerdo con su empleador/a o su compañía aseguradora tras resolver su caso según el artículo 32 de la ley WCL. Un acuerdo según el Artículo 32 puede incluir una cláusula que libere al empleador/a o aseguradora de la responsabilidad de pagar en el futuro cuentas médicas asociadas con el caso. Su proveedor de servicios médicos puede solicitar que usted firme esta notificación A-9 para garantizar que reconoce su responsabilidad personal por el pago de sus cuentas si renunció al derecho de recibir beneficios médicos futuros mediante un acuerdo conforme al artículo 32.

Si tiene alguna pregunta, comuníquese con su abogado o representante autorizado para la audiencia, de tener uno. También puede comunicarse con la institución Workers' Compensation Board (Junta de Compensación Laboral) en la oficina de su distrito.

AL PROVEEDOR DE SERVICIOS DE SALUD
Esta notificación tiene el fin de avisar al reclamante de indemnización laboral que puede ser responsable del pago. Si el reclamante no firma este formulario, no libera con este acto al proveedor de su obligación de tratar al reclamante, ni tampoco anula la responsabilidad de pago por parte del reclamante.

Mantenga el original de este formulario en sus propios registros y entregue una copia al reclamante. **No lo presente en la institución Workers Compensation Board** (Junta de Compensación Laboral). Usted recibirá notificaciones de las decisiones en las que se incluirá si la solicitud es indemnizable, la autorización del tratamiento o el pago de cuentas médicas. También se le notificará si el reclamante presenta un acuerdo conforme al Artículo 32 para que lo apruebe la institución Workers' Compensation Board. No cobre al reclamante a menos que y hasta que usted reciba una decisión de la institución Workers Compensation Board que indique: 1) que el reclamante no procesará la solicitud, o 2) que la solicitud fue rechazada, o 3) que el tratamiento no tiene relación causal con las lesiones laborales, o 4) que se aprobó un acuerdo conforme al Artículo 32 liberando a la aseguradora de la responsabilidad por el tratamiento médico.

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.

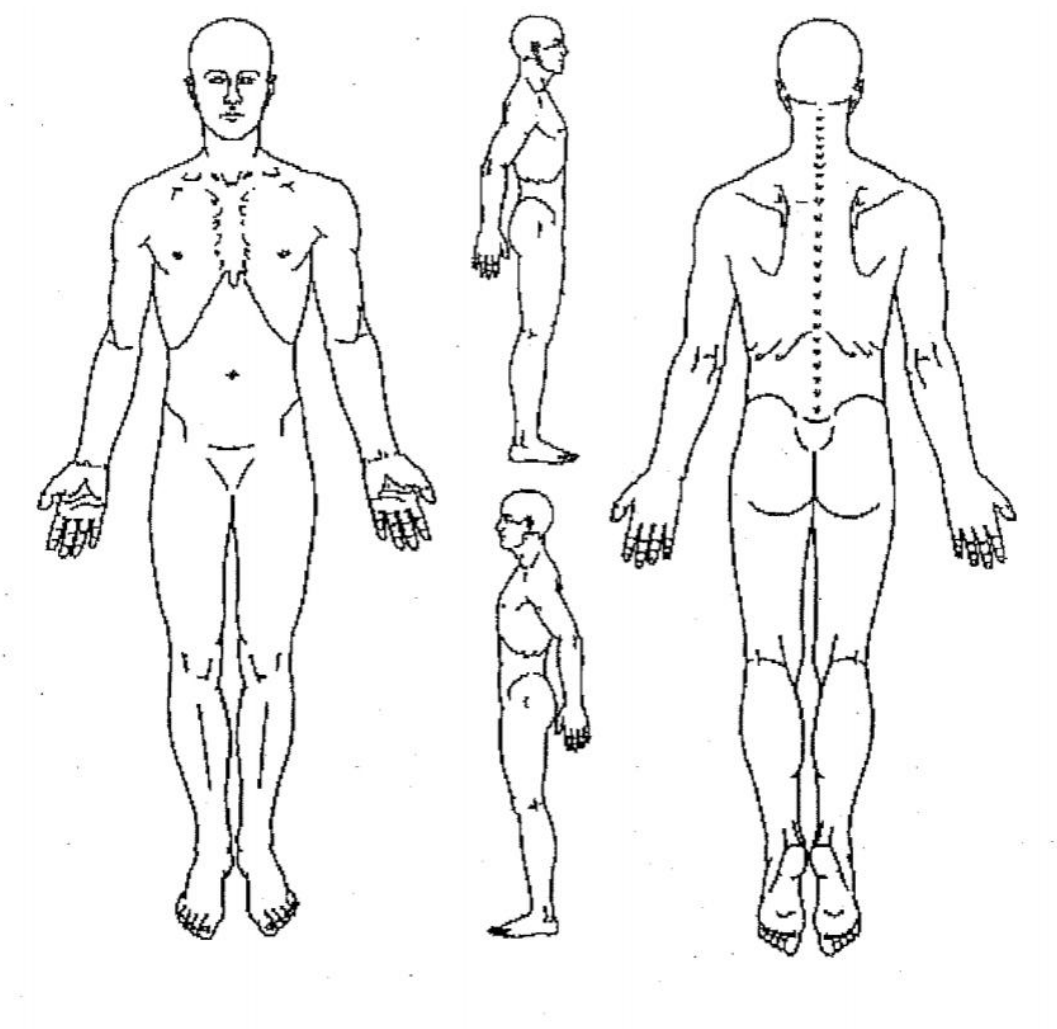
SECTION 10–CHANGING DEGREE OF PAIN
- ☐ A. Pain is rapidly improving.
- ☐ B. Pain fluctuates but is improving.
- ☐ C. Improvement is slow.
- ☐ D. Pain level is unchanged.
- ☐ E. Pain is gradually worsening.
- ☐ F. Pain is rapidly worsening.

SYMPTOM DIAGRAM

Name: _____ Date: _____

How long have you been in pain? ____ Years ____ Months ____ Weeks

On the diagram below, please indicate where you are experiencing pain or other symptoms, right now.



B = Burning S= Sharp/Shooting P = Numbness A = Dullache

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 no 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 ____/____/____

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? _____

_____

_____