Patient Basic Information

Cell Phone: _____
Cell Phone Carrier: _____
E-mail address: _____

Personal Information:

Last Name:	First Name:	M I F
Address:	City, State, Zip:	
Home Phone:	Work Phone:	Social Security No.:
Date of Birth:	Date of Injury/Onset:	
Dominant Hand: ☐ Right ☐ Left ☐ Both		
Insurance Information: Policy Holder (if different than patient):		Claim #: Policy No.:
Name of Insurance Adjuster:		
Name of Attorney:		

1. Description of Accident/Injury/Onset

Enter a full description of the accident, injury or onset in the space below.

2. Your condition during and immediately after injury/onset

Enter the details of your condition during and immediately after your injury/onset.

Patient Sign & Date:_____ **Date:**_____

State-where accident occurred _____

Automobile Accident Description

Please answer the questions below. If you do not know the answer to any of the questions, do not answer that question.

1. Your vehicle type

☐ Car ☐ Station Wagon
☐ Van ☐ Pickup Truck
☐ Large Truck ☐ Bus
Other_____

2. Your position in vehicle

☐ Driver ☐ Front Passenger
☐ Left Rear Passenger
☐ Right Rear Passenger
Other_____

3. What was your vehicle doing at the time of the accident?

☐ Stopped at intersection ☐ Stopped in traffic ☐ Stopped at light
☐ Making a right turn ☐ Making a left turn ☐ Parking
☐ Proceeding along ☐ Slowing down ☐ Accelerating
Other_____

4. Time/Speed/Damage

Time of accident_____
Your vehicle's speed: _____mph
Their vehicle's speed: _____mph
Damage to your vehicle
☐ Mild ☐ Moderate
☐ Totaled

5. Details of Accident

Visibility at time of accident
☐ Poor ☐ Fair ☐ Good

Who hit who/what?
☐ You hit other vehicle
☐ Other vehicle hit you
You hit...(object)
_____

6. Road conditions

Road conditions at time of accident
☐ Icy ☐ Wet ☐ Sandy ☐ Dark ☐ Clean and dry

Point of impact
☐ Head-On ☐ Left Front ☐ Right Front
☐ Rear-End ☐ Left Rear ☐ Right Rear

7. Body Position, etc.

Did you see the accident coming: Yes☐☐ No
Were you braced for the impact? Yes☐☐ No
Did you have a seat belt on? Yes☐☐ No
Did you have a shoulder harness on? Yes☐☐ No

Does your vehicle have headrests? Yes☐☐ No
What was the position of your headrest at the time of the impact?
☐ Even with top of head ☐ Even with bottom of head ☐ Middle of neck
What was the direction of your head at the time of the impact?
☐ Facing straight forward ☐ Turned to the right ☐ Turned to the left

Did driver side air bags deploy? Yes☐☐ No Did passenger side airbags deploy? Yes☐☐ No Did side airbags deploy? Yes☐☐ No

8. Additional accident information

In the case of a motor vehicle accident, enter any additional information here that is not covered by the above check offs.

9. During the accident:

Did your body strike the inside of your vehicle? Yes☐☐ No
If yes, describe:_____
Did you lose consciousness during the injury? Yes☐☐ No
If yes, for how long? _____
Your vehicle's estimated damage?_____
Damage to their vehicle: ☐ Mild ☐ Moderate ☐ Totaled
Did police show up at the scene? Yes☐☐ No
Was an accident report filled out? Yes☐☐ No

10. After the accident:

Check off your symptoms right after and a few days following:
☐ Headache ☐ Dizziness ☐ Mid back pain ☐ Cold hands
☐ Neck pain ☐ Nausea ☐ Low back pain ☐ Cold feet
☐ Neck stiffness ☐ Confusion ☐ Nervousness ☐ Diarrhea
☐ Fainting ☐ Fatigue ☐ Loss of taste ☐ Depression
☐ Ringing in ears ☐ Tension ☐ Toe numbness ☐ Anxious
☐ Loss of smell ☐ Irritability ☐ Constipation ☐ Chest Pain
☐ Pain behind eyes ☐ Shortness of breath ☐ Sleeping problems
Others:_____

11. Emergency Room?

Where did you go after the accident?
☐ Home ☐ Work ☐ Hospital ER ☐ Private Doctor
How did you get there?
☐ Drove self ☐ Somebody else ☐ Ambulance ☐ Police
Were X-rays done? Yes☐☐ No **Was lab work done?** Yes☐☐ No
Body parts X-rayed?_____
What lab work?_____
The X-rays revealed:_____
Treatments: ☐ Cervical Collar ☐ Ice **Other:** _____
Medications:_____
Follow-up instructions: _____
_____

12. Treatment History:

Fill in any other doctor(s) seen prior to your first visit to this office
1. Dr._____ First visit date: ___/___/___
Specialty:_____ X-rays done? Yes☐☐ No
Types of treatments received:_____
How many treatments received? ____ Currently treating? Yes☐☐ No
Did treatments benefit you? Yes☐☐ No
Last visit date: ___/___/___
2. Dr._____ First visit date: ___/___/___
Types of treatments received:_____
How many treatments received? ____ Currently treating: Yes☐☐ No
Did treatments benefit you? Yes☐☐ No
Last visit date: ___/___/___

Patient Sign & Date:_____ **Date:**_____

Description of Symptoms (Describe your symptoms in the sections below, in the order of severity, if possible.)

I. First Current Symptom: (Please check off the boxes below to describe your first symptom. Describe only ONE symptom per Section)

1. Check only one body location below

	L	R	B
☐Headaches	☐	☐	☐
☐Front of Head			
☐Top of Head			
☐Back of Head			
☐Jaw	☐	☐	☐
☐Eye	☐	☐	☐
☐Neck	☐	☐	☐
☐Upper Back	☐	☐	☐
☐Mid Back	☐	☐	☐
☐Low Back	☐	☐	☐
☐Chest	☐	☐	☐
☐Abdomen	☐	☐	☐
☐Ribs	☐	☐	☐
☐Buttocks	☐	☐	☐
☐Shoulder	☐	☐	☐
☐Upper Arm	☐	☐	☐
☐Forearm	☐	☐	☐
☐Hand	☐	☐	☐
☐Hip	☐	☐	☐
☐Leg	☐	☐	☐
☐Foot	☐	☐	☐

Other locations:_____

2. Types of pain — Other types of pain: _____

☐Dull ☐Sharp ☐Aching ☐Cutting
☐Throbbing ☐Burning ☐Numbing ☐Tingling ☐Cramping
☐Spasm ☐Stinging ☐Shooting ☐Pounding ☐Constricting

3. Pain Frequency
☐Up to 1/4 of awake time ☐1/4 to 1/2 of time
☐1/2 to 3/4 of awake time ☐Most all the time

4. Pain Intensity (How it affects your daily activites)
☐Doesn't affect ☐Somewhat affects
☐Seriously affects ☐Prevents activities

5. Does this pain radiate into other body parts?

	Left	Right	Both
☐Head	☐	☐	☐
☐Neck	☐	☐	☐
☐Shoulder	☐	☐	☐
☐Arm	☐	☐	☐
☐Hand	☐	☐	☐
☐Hip	☐	☐	☐
☐Leg	☐	☐	☐
☐Foot	☐	☐	☐

Other locations of radiation:_____

6. Actions affecting this pain

	Brings On	Aggravates	Relieves
☐In the A.M.	☐	☐	☐
☐In the P.M.	☐	☐	☐
☐Bending forward	☐	☐	☐
☐Bending back	☐	☐	☐
☐Bending left	☐	☐	☐
☐Bending right	☐	☐	☐
☐Twisting left	☐	☐	☐
☐Twisting right	☐	☐	☐
☐Coughing	☐	☐	☐
☐Sneezing	☐	☐	☐
☐Straining	☐	☐	☐
☐Standing	☐	☐	☐
☐Sitting	☐	☐	☐
☐Lifting	☐	☐	☐
Other Actions:			
_____	☐	☐	☐
_____	☐	☐	☐

II. Second Current Symptom: (Please check off the boxes below to describe your next symptom).

1. Check only one body location below

	L	R	B
☐Headaches	☐	☐	☐
☐Front of Head			
☐Top of Head			
☐Back of Head			
☐Jaw	☐	☐	☐
☐Eye	☐	☐	☐
☐Neck	☐	☐	☐
☐Upper Back	☐	☐	☐
☐Mid Back	☐	☐	☐
☐Low Back	☐	☐	☐
☐Chest	☐	☐	☐
☐Abdomen	☐	☐	☐
☐Ribs	☐	☐	☐
☐Buttocks	☐	☐	☐
☐Shoulder	☐	☐	☐
☐Upper Arm	☐	☐	☐
☐Forearm	☐	☐	☐
☐Hand	☐	☐	☐
☐Hip	☐	☐	☐
☐Leg	☐	☐	☐
☐Foot	☐	☐	☐

Other locations:_____

2. Types of pain — Other types of pain: _____

☐Dull ☐Sharp ☐Aching ☐Cutting
☐Throbbing ☐Burning ☐Numbing ☐Tingling ☐Cramping
☐Spasm ☐Stinging ☐Shooting ☐Pounding ☐Constricting

3. Pain Frequency
☐Up to 1/4 of awake time ☐1/4 to 1/2 of time
☐1/2 to 3/4 of awake time ☐Most all the time

4. Pain Intensity (How it affects your daily activites)
☐Doesn't affect ☐Somewhat affects
☐Seriously affects ☐Prevents activities

5. Does this pain radiate into other body parts?

	Left	Right	Both
☐Head	☐	☐	☐
☐Neck	☐	☐	☐
☐Shoulder	☐	☐	☐
☐Arm	☐	☐	☐
☐Hand	☐	☐	☐
☐Hip	☐	☐	☐
☐Leg	☐	☐	☐
☐Foot	☐	☐	☐

Other locations of radiation:_____

6. Actions affecting this pain

	Brings On	Aggravates	Relieves
☐In the A.M.	☐	☐	☐
☐In the P.M.	☐	☐	☐
☐Bending forward	☐	☐	☐
☐Bending back	☐	☐	☐
☐Bending left	☐	☐	☐
☐Bending right	☐	☐	☐
☐Twisting left	☐	☐	☐
☐Twisting right	☐	☐	☐
☐Coughing	☐	☐	☐
☐Sneezing	☐	☐	☐
☐Straining	☐	☐	☐
☐Standing	☐	☐	☐
☐Sitting	☐	☐	☐
☐Lifting	☐	☐	☐
Other Actions:			
_____	☐	☐	☐
_____	☐	☐	☐

III. Third Current Symptom: (Please check off the boxes below to describe your 3rd symptom).

1. Check only one body location below

	L	R	B
☐Headaches	☐	☐	☐
☐Front of Head			
☐Top of Head			
☐Back of Head			
☐Jaw	☐	☐	☐
☐Eye	☐	☐	☐
☐Neck	☐	☐	☐
☐Upper Back	☐	☐	☐
☐Mid Back	☐	☐	☐
☐Low Back	☐	☐	☐
☐Chest	☐	☐	☐
☐Abdomen	☐	☐	☐
☐Ribs	☐	☐	☐
☐Buttocks	☐	☐	☐
☐Shoulder	☐	☐	☐
☐Upper Arm	☐	☐	☐
☐Forearm	☐	☐	☐
☐Hand	☐	☐	☐
☐Hip	☐	☐	☐
☐Leg	☐	☐	☐
☐Foot	☐	☐	☐

Other locations:_____

2. Types of pain — Other types of pain: _____

☐Dull ☐Sharp ☐Aching ☐Cutting
☐Throbbing ☐Burning ☐Numbing ☐Tingling ☐Cramping
☐Spasm ☐Stinging ☐Shooting ☐Pounding ☐Constricting

3. Pain Frequency
☐Up to 1/4 of awake time ☐1/4 to 1/2 of time
☐1/2 to 3/4 of awake time ☐Most all the time

4. Pain Intensity (How it affects your daily activites)
☐Doesn't affect ☐Somewhat affects
☐Seriously affects ☐Prevents activities

5. Does this pain radiate into other body parts?

	Left	Right	Both
☐Head	☐	☐	☐
☐Neck	☐	☐	☐
☐Shoulder	☐	☐	☐
☐Arm	☐	☐	☐
☐Hand	☐	☐	☐
☐Hip	☐	☐	☐
☐Leg	☐	☐	☐
☐Foot	☐	☐	☐

Other locations of radiation:_____

6. Actions affecting this pain

	Brings On	Aggravates	Relieves
☐In the A.M.	☐	☐	☐
☐In the P.M.	☐	☐	☐
☐Bending forward	☐	☐	☐
☐Bending back	☐	☐	☐
☐Bending left	☐	☐	☐
☐Bending right	☐	☐	☐
☐Twisting left	☐	☐	☐
☐Twisting right	☐	☐	☐
☐Coughing	☐	☐	☐
☐Sneezing	☐	☐	☐
☐Straining	☐	☐	☐
☐Standing	☐	☐	☐
☐Sitting	☐	☐	☐
☐Lifting	☐	☐	☐
Other Actions:			
	☐	☐	☐
	☐	☐	☐

Patient Sign & Date:_____ **Date:**_____

Description of Symptoms (Describe your symptoms in the sections below, in the order of severity, if possible.)

IV. Fourth Symptom: (Please check off the boxes below to describe your 4th symptom. Describe only ONE symptom per Section)

1. Check only one body location below

☐Headaches L ☐ R ☐ B ☐
☐Front of Head
☐Top of Head
☐Back of Head

☐Jaw	L ☐	R ☐	B ☐
☐Eye	L ☐	R ☐	B ☐
☐Neck	L ☐	R ☐	B ☐
☐Upper Back	L ☐	R ☐	B ☐
☐Mid Back	L ☐	R ☐	B ☐
☐Low Back	L ☐	R ☐	B ☐
☐Chest	L ☐	R ☐	B ☐
☐Abdomen	L ☐	R ☐	B ☐
☐Ribs	L ☐	R ☐	B ☐
☐Buttocks	L ☐	R ☐	B ☐
☐Shoulder	L ☐	R ☐	B ☐
☐Upper Arm	L ☐	R ☐	B ☐
☐Forearm	L ☐	R ☐	B ☐
☐Hand	L ☐	R ☐	B ☐
☐Hip	L ☐	R ☐	B ☐
☐Leg	L ☐	R ☐	B ☐
☐Foot	L ☐	R ☐	B ☐

Other locations:_____

2. Types of pain Other types of pain: _____

☐Dull ☐Sharp ☐Aching ☐Cutting
☐Throbbing ☐Burning ☐Numbing ☐Tingling ☐Cramping
☐Spasm ☐Stinging ☐Shooting ☐Pounding ☐Constricting

3. Pain Frequency

☐Up to 1/4 of awake time ☐1/4 to 1/2 of time
☐1/2 to 3/4 of awake time ☐Most all the time

4. Pain Intensity (How it affects your daily activites)

☐Doesn't affect ☐Somewhat affects
☐Seriously affects ☐Prevents activities

5. Does this pain radiate into other body parts?

	Left	Right	Both
☐Head	☐	☐	☐
☐Neck	☐	☐	☐
☐Shoulder	☐	☐	☐
☐Arm	☐	☐	☐
☐Hand	☐	☐	☐
☐Hip	☐	☐	☐
☐Leg	☐	☐	☐
☐Foot	☐	☐	☐

Other locations of radiation:_____

6. Actions affecting this pain

	Brings On	Aggravates	Relieves
☐In the A.M.	☐	☐	☐
☐In the P.M.	☐	☐	☐
☐Bending forward	☐	☐	☐
☐Bending back	☐	☐	☐
☐Bending left	☐	☐	☐
☐Bending right	☐	☐	☐
☐Twisting left	☐	☐	☐
☐Twisting right	☐	☐	☐
☐Coughing	☐	☐	☐
☐Sneezing	☐	☐	☐
☐Straining	☐	☐	☐
☐Standing	☐	☐	☐
☐Sitting	☐	☐	☐
☐Lifting	☐	☐	☐
Other Actions:			
_____	☐	☐	☐
	☐	☐	☐

V. Fifth Current Symptom: (Please check off the boxes below to describe your 5th symptom).

1. Check only one body location below

☐Headaches L ☐ R ☐ B ☐
☐Front of Head
☐Top of Head
☐Back of Head

☐Jaw	L ☐	R ☐	B ☐
☐Eye	L ☐	R ☐	B ☐
☐Neck	L ☐	R ☐	B ☐
☐Upper Back	L ☐	R ☐	B ☐
☐Mid Back	L ☐	R ☐	B ☐
☐Low Back	L ☐	R ☐	B ☐
☐Chest	L ☐	R ☐	B ☐
☐Abdomen	L ☐	R ☐	B ☐
☐Ribs	L ☐	R ☐	B ☐
☐Buttocks	L ☐	R ☐	B ☐
☐Shoulder	L ☐	R ☐	B ☐
☐Upper Arm	L ☐	R ☐	B ☐
☐Forearm	L ☐	R ☐	B ☐
☐Hand	L ☐	R ☐	B ☐
☐Hip	L ☐	R ☐	B ☐
☐Leg	L ☐	R ☐	B ☐
☐Foot	L ☐	R ☐	B ☐

Other locations:_____

2. Types of pain Other types of pain: _____

☐Dull ☐Sharp ☐Aching ☐Cutting
☐Throbbing ☐Burning ☐Numbing ☐Tingling ☐Cramping
☐Spasm ☐Stinging ☐Shooting ☐Pounding ☐Constricting

3. Pain Frequency

☐Up to 1/4 of awake time ☐1/4 to 1/2 of time
☐1/2 to 3/4 of awake time ☐Most all the time

4. Pain Intensity (How it affects your daily activites)

☐Doesn't affect ☐Somewhat affects
☐Seriously affects ☐Prevents activities

5. Does this pain radiate into other body parts?

	Left	Right	Both
☐Head	☐	☐	☐
☐Neck	☐	☐	☐
☐Shoulder	☐	☐	☐
☐Arm	☐	☐	☐
☐Hand	☐	☐	☐
☐Hip	☐	☐	☐
☐Leg	☐	☐	☐
☐Foot	☐	☐	☐

Other locations of radiation:_____

6. Actions affecting this pain

	Brings On	Aggravates	Relieves
☐In the A.M.	☐	☐	☐
☐In the P.M.	☐	☐	☐
☐Bending forward	☐	☐	☐
☐Bending back	☐	☐	☐
☐Bending left	☐	☐	☐
☐Bending right	☐	☐	☐
☐Twisting left	☐	☐	☐
☐Twisting right	☐	☐	☐
☐Coughing	☐	☐	☐
☐Sneezing	☐	☐	☐
☐Straining	☐	☐	☐
☐Standing	☐	☐	☐
☐Sitting	☐	☐	☐
☐Lifting	☐	☐	☐
Other Actions:			
_____	☐	☐	☐
	☐	☐	☐

VI. Sixth Current Symptom: (Please check off the boxes below to describe your 6th symptom).

1. Check only one body location below

☐Headaches L ☐ R ☐ B ☐
☐Front of Head
☐Top of Head
☐Back of Head

☐Jaw	L ☐	R ☐	B ☐
☐Eye	L ☐	R ☐	B ☐
☐Neck	L ☐	R ☐	B ☐
☐Upper Back	L ☐	R ☐	B ☐
☐Mid Back	L ☐	R ☐	B ☐
☐Low Back	L ☐	R ☐	B ☐
☐Chest	L ☐	R ☐	B ☐
☐Abdomen	L ☐	R ☐	B ☐
☐Ribs	L ☐	R ☐	B ☐
☐Buttocks	L ☐	R ☐	B ☐
☐Shoulder	L ☐	R ☐	B ☐
☐Upper Arm	L ☐	R ☐	B ☐
☐Forearm	L ☐	R ☐	B ☐
☐Hand	L ☐	R ☐	B ☐
☐Hip	L ☐	R ☐	B ☐
☐Leg	L ☐	R ☐	B ☐
☐Foot	L ☐	R ☐	B ☐

Other locations:_____

2. Types of pain Other types of pain: _____

☐Dull ☐Sharp ☐Aching ☐Cutting
☐Throbbing ☐Burning ☐Numbing ☐Tingling ☐Cramping
☐Spasm ☐Stinging ☐Shooting ☐Pounding ☐Constricting

3. Pain Frequency

☐Up to 1/4 of awake time ☐1/4 to 1/2 of time
☐1/2 to 3/4 of awake time ☐Most all the time

4. Pain Intensity (How it affects your daily activites)

☐Doesn't affect ☐Somewhat affects
☐Seriously affects ☐Prevents activities

5. Does this pain radiate into other body parts?

	Left	Right	Both
☐Head	☐	☐	☐
☐Neck	☐	☐	☐
☐Shoulder	☐	☐	☐
☐Arm	☐	☐	☐
☐Hand	☐	☐	☐
☐Hip	☐	☐	☐
☐Leg	☐	☐	☐
☐Foot	☐	☐	☐

Other locations of radiation:_____

6. Actions affecting this pain

	Brings On	Aggravates	Relieves
☐In the A.M.	☐	☐	☐
☐In the P.M.	☐	☐	☐
☐Bending forward	☐	☐	☐
☐Bending back	☐	☐	☐
☐Bending left	☐	☐	☐
☐Bending right	☐	☐	☐
☐Twisting left	☐	☐	☐
☐Twisting right	☐	☐	☐
☐Coughing	☐	☐	☐
☐Sneezing	☐	☐	☐
☐Straining	☐	☐	☐
☐Standing	☐	☐	☐
☐Sitting	☐	☐	☐
☐Lifting	☐	☐	☐
Other Actions:			
_____	☐	☐	☐
	☐	☐	☐

Patient Sign & Date:_____ **Date:**_____

Description of Symptoms

(Describe your symptoms in the sections below, in the order of severity, if possible.)

VII. Seventh Symptom:

(Please check off the boxes below to describe your 7th symptom. Describe only ONE symptom per Section)

1. Check only one body location below

	L	R	B
☐Headaches	☐	☐	☐
☐Front of Head			
☐Top of Head			
☐Back of Head			
☐Jaw	☐	☐	☐
☐Eye	☐	☐	☐
☐Neck	☐	☐	☐
☐Upper Back	☐	☐	☐
☐Mid Back	☐	☐	☐
☐Low Back	☐	☐	☐
☐Chest	☐	☐	☐
☐Abdomen	☐	☐	☐
☐Ribs	☐	☐	☐
☐Buttocks	☐	☐	☐
☐Shoulder	☐	☐	☐
☐Upper Arm	☐	☐	☐
☐Forearm	☐	☐	☐
☐Hand	☐	☐	☐
☐Hip	☐	☐	☐
☐Leg	☐	☐	☐
☐Foot	☐	☐	☐

Other locations:_____

2. Types of pain

Other types of pain: _____

☐Dull ☐Sharp ☐Aching ☐Cutting
☐Throbbing ☐Burning ☐Numbing ☐Tingling ☐Cramping
☐Spasm ☐Stinging ☐Shooting ☐Pounding ☐Constricting

3. Pain Frequency

☐Up to 1/4 of awake time ☐1/4 to 1/2 of time
☐1/2 to 3/4 of awake time ☐Most all the time

4. Pain Intensity (How it affects your daily activites)

☐Doesn't affect ☐Somewhat affects
☐Seriously affects ☐Prevents activities

5. Does this pain radiate into other body parts?

	Left	Right	Both
☐Head	☐	☐	☐
☐Neck	☐	☐	☐
☐Shoulder	☐	☐	☐
☐Arm	☐	☐	☐
☐Hand	☐	☐	☐
☐Hip	☐	☐	☐
☐Leg	☐	☐	☐
☐Foot	☐	☐	☐

Other locations of radiation:_____

6. Actions affecting this pain

	Brings On	Aggravates	Relieves
☐In the A.M.	☐	☐	☐
☐In the P.M.	☐	☐	☐
☐Bending forward	☐	☐	☐
☐Bending back	☐	☐	☐
☐Bending left	☐	☐	☐
☐Bending right	☐	☐	☐
☐Twisting left	☐	☐	☐
☐Twisting right	☐	☐	☐
☐Coughing	☐	☐	☐
☐Sneezing	☐	☐	☐
☐Straining	☐	☐	☐
☐Standing	☐	☐	☐
☐Sitting	☐	☐	☐
☐Lifting	☐	☐	☐
Other Actions:			
_____	☐	☐	☐
	☐	☐	☐

VIII. Eighth Current Symptom:

(Please check off the boxes below to describe your 8th symptom).

1. Check only one body location below

	L	R	B
☐Headaches	☐	☐	☐
☐Front of Head			
☐Top of Head			
☐Back of Head			
☐Jaw	☐	☐	☐
☐Eye	☐	☐	☐
☐Neck	☐	☐	☐
☐Upper Back	☐	☐	☐
☐Mid Back	☐	☐	☐
☐Low Back	☐	☐	☐
☐Chest	☐	☐	☐
☐Abdomen	☐	☐	☐
☐Ribs	☐	☐	☐
☐Buttocks	☐	☐	☐
☐Shoulder	☐	☐	☐
☐Upper Arm	☐	☐	☐
☐Forearm	☐	☐	☐
☐Hand	☐	☐	☐
☐Hip	☐	☐	☐
☐Leg	☐	☐	☐
☐Foot	☐	☐	☐

Other locations:_____

2. Types of pain

Other types of pain: _____

☐Dull ☐Sharp ☐Aching ☐Cutting
☐Throbbing ☐Burning ☐Numbing ☐Tingling ☐Cramping
☐Spasm ☐Stinging ☐Shooting ☐Pounding ☐Constricting

3. Pain Frequency

☐Up to 1/4 of awake time ☐1/4 to 1/2 of time
☐1/2 to 3/4 of awake time ☐Most all the time

4. Pain Intensity (How it affects your daily activites)

☐Doesn't affect ☐Somewhat affects
☐Seriously affects ☐Prevents activities

5. Does this pain radiate into other body parts?

	Left	Right	Both
☐Head	☐	☐	☐
☐Neck	☐	☐	☐
☐Shoulder	☐	☐	☐
☐Arm	☐	☐	☐
☐Hand	☐	☐	☐
☐Hip	☐	☐	☐
☐Leg	☐	☐	☐
☐Foot	☐	☐	☐

Other locations of radiation:_____

6. Actions affecting this pain

	Brings On	Aggravates	Relieves
☐In the A.M.	☐	☐	☐
☐In the P.M.	☐	☐	☐
☐Bending forward	☐	☐	☐
☐Bending back	☐	☐	☐
☐Bending left	☐	☐	☐
☐Bending right	☐	☐	☐
☐Twisting left	☐	☐	☐
☐Twisting right	☐	☐	☐
☐Coughing	☐	☐	☐
☐Sneezing	☐	☐	☐
☐Straining	☐	☐	☐
☐Standing	☐	☐	☐
☐Sitting	☐	☐	☐
☐Lifting	☐	☐	☐
Other Actions:			
_____	☐	☐	☐
	☐	☐	☐

IX. Ninth Current Symptom:

(Please check off the boxes below to describe your 9th symptom).

1. Check only one body location below

	L	R	B
☐Headaches	☐	☐	☐
☐Front of Head			
☐Top of Head			
☐Back of Head			
☐Jaw	☐	☐	☐
☐Eye	☐	☐	☐
☐Neck	☐	☐	☐
☐Upper Back	☐	☐	☐
☐Mid Back	☐	☐	☐
☐Low Back	☐	☐	☐
☐Chest	☐	☐	☐
☐Abdomen	☐	☐	☐
☐Ribs	☐	☐	☐
☐Buttocks	☐	☐	☐
☐Shoulder	☐	☐	☐
☐Upper Arm	☐	☐	☐
☐Forearm	☐	☐	☐
☐Hand	☐	☐	☐
☐Hip	☐	☐	☐
☐Leg	☐	☐	☐
☐Foot	☐	☐	☐

Other locations:_____

2. Types of pain

Other types of pain: _____

☐Dull ☐Sharp ☐Aching ☐Cutting
☐Throbbing ☐Burning ☐Numbing ☐Tingling ☐Cramping
☐Spasm ☐Stinging ☐Shooting ☐Pounding ☐Constricting

3. Pain Frequency

☐Up to 1/4 of awake time ☐1/4 to 1/2 of time
☐1/2 to 3/4 of awake time ☐Most all the time

4. Pain Intensity (How it affects your daily activites)

☐Doesn't affect ☐Somewhat affects
☐Seriously affects ☐Prevents activities

5. Does this pain radiate into other body parts?

	Left	Right	Both
☐Head	☐	☐	☐
☐Neck	☐	☐	☐
☐Shoulder	☐	☐	☐
☐Arm	☐	☐	☐
☐Hand	☐	☐	☐
☐Hip	☐	☐	☐
☐Leg	☐	☐	☐
☐Foot	☐	☐	☐

Other locations of radiation:_____

6. Actions affecting this pain

	Brings On	Aggravates	Relieves
☐In the A.M.	☐	☐	☐
☐In the P.M.	☐	☐	☐
☐Bending forward	☐	☐	☐
☐Bending back	☐	☐	☐
☐Bending left	☐	☐	☐
☐Bending right	☐	☐	☐
☐Twisting left	☐	☐	☐
☐Twisting right	☐	☐	☐
☐Coughing	☐	☐	☐
☐Sneezing	☐	☐	☐
☐Straining	☐	☐	☐
☐Standing	☐	☐	☐
☐Sitting	☐	☐	☐
☐Lifting	☐	☐	☐
Other Actions:			
_____	☐	☐	☐
	☐	☐	☐

Patient Sign & Date:_____ **Date:**_____

Activities of Daily Living Assessment

Rate your current difficulties, resulting from your accident/illness, with regard to the various activities listed below. Use the following 1 to 5 scale and **WRITE IN THE APPROPRIATE NUMBER** that most closely describes your current degree of difficulty: **1** = "I can do it without any difficulty" **2** = "I can do it without much difficulty, despite some pain", **3** = "I manage to do it by myself, despite marked pain", **4** = "I manage to do it, despite the pain, but only if I have help", **5** = "I cannot do it at all, because of the pain". **NOTE: Only fill in areas that are affected.**

Difficulties with Self Care and Personal Hygiene Activities

Bathing ____	Drying hair ____	Brushing teeth ____	Putting on shoes ____	Preparing meals ____	Taking out trash ____
Showering ____	Combing hair ____	Making bed ____	Tying shoes ____	Eating ____	Doing laundry ____
Washing hair ____	Washing face ____	Putting on shirt ____	Putting on pants ____	Cleaning dishes ____	Going to toilet ____

Difficulties with Physical Activities

Standing ____	Walking ____	Kneeling ____	Bending back ____	Twisting left ____	Leaning back ____
Sitting ____	Stooping ____	Reaching ____	Bending left ____	Twisting right ____	Leaning left ____
Reclining ____	Squatting ____	Bending forward ____	Bending right ____	Leaning forward ____	Leaning right ____
Standing for long periods ____		Sitting for long periods ____		Walking for long periods ____	Kneeling for long periods ____

Difficulties with Functional Activities

Carrying small objects ____	Lifting weights off floor ____	Pushing things while seated ____	Exercising upper body ____
Carrying large objects ____	Lifting weights off table ____	Pushing things while standing ____	Exercising lower body ____
Carrying brief case ____	Climbing stairs ____	Pulling things while seated ____	Exercising arms ____
Carrying large purse ____	Climbing inclines ____	Pulling things while standing ____	Exercising legs ____

Difficulties with Social and Recreational Activities

Bowling ____	Jogging ____	Swimming ____	Ice Skating ____	Competitive Sports ____	Dating ____
Golfing ____	Dancing ____	Skiing ____	Roller Skating ____	Hobbies ____	Dining out ____

Difficulties with Travelling

Driving a motor vehicle ____	Riding as a passenger in a motor vehicle ____	Riding as a passenger on a train ____
Driving for long periods of time ____	Riding as a passenger on an airplane ____	Riding as a passenger for long periods ____

Use the following **1 to 5** scale to describe the difficulties below:
1 = "This area is not affected by my condition", **2** = "This area is slightly affected by my condition", **3** = "My condition moderately restricts my ability in this area", **4** = " My condition seriously limits my ability in this area", **5** = "My condition prevents me from using this ability"

Difficulties with Different Forms of Communication

Concentrating____ Hearing____ Listening____ Speaking____ Reading____ Writing____ Using a keyboard____

Difficulties with the Senses

Seeing____ Hearing____ Sense of touch____ Sense of taste____ Sense of smell____

Difficulties with Hand Functions

Grasping____ Holding____ Pinching____ Percussive movements____ Sensory discrimination____

Difficulties with Sleep and Sexual Function

Being able to have normal, restful nights sleep____ Being able to participate in desired sexual activity____

Write in below any additional information regarding your Activities of Daily Living (that wasn't covered above):

Prior Symptom History

Prior Similar Symptoms

- ☐ I have NOT had prior symptoms similar to my current complaints.
- ☐ My current complaints DID exist before, but have not been bothering me.
- ☐ My current complaints ALREADY existed and were worsened.

My most recent prior similar symptoms (if applicable) occured____ ☐ months ago / ☐ years ago Or on Date:____/____/____

Has your History Contributed to your Current Symptoms?

- ☐ My history HAS contributed to my current symptoms.
- ☐ My history HAS NOT contributed to my current symptoms.
- ☐ I 'm NOT SURE if my history has contributed to my current symptoms.

Write in below any other Prior Symptom History, not covered above:

Patient Sign & Date:_____ **Date:**_____

AUTHORIZATION & ASSIGNMENT

TO: Dr. Robert M. Monahan, D.C.

In consideration of your undertaking to treat me, I agree to the following:

RELEASE OF INFORMATION

You are authorized to release any information you deem necessary and appropriate concerning my condition, to any insurance carrier, attorney or adjuster, in order to process any claim for reimbursement of charges incurred at your facility by me.

AUTHORITY TO PAY DOCTOR

I authorize the direct payment to you, of any sum I now or hereafter may owe you, be either my carrier or my attorney, out of the proceeds of any settlement of my case, or for which my insurance carrier has been billed, or otherwise obligated to make payment either to me or to you, based in whole or in part on the charges made for your services.

IRREVOCABLE ASSIGNMENT

I authorize you to compromise, settle or otherwise resolve said claim as you see fit. I further agree that the foregoing assignment shall be binding until you are paid in full and will be irrevocable for such period. I further agree to grant you my full and complete permission to endorse any check from my carrier, payable to me, with a facsimile of my signature.

PATIENT RESPONSIBLE FOR BALANCE

I understand that I am personally liable for any amount owed after reasonable efforts have been made to collect from any carrier so obligated.

Date: _____ Signed: _____

FORT LEE HEALTH CENTER, INC.

Dr. Robert M. Monahan, D.C.

1067 Palisade Avenue, Fort Lee, NJ 07024

Patient Privacy Policy & Procedure Statement

(HIPAA)

Dear Patient:

Fort Lee Health Center, Inc. maintains compliance with the Health Insurance Portability and Accountability Act of 1996 (HIPAA) privacy regulations passed into law on December 20, 2000.

We obtain your voluntary consent, to provide treatment, release medical records to the appropriate entities and those who you designate to provide health care treatment, payment and daily operations of the facility.

Our clinical and front office staff uses patient information to ensure quality care and appropriate billing for services.

You may correct, amend, access and request a copy of your medical records and access history by signing a letter for release of your medical information. The cost for copies and of medical records is in accordance with state law.

We protect all patient information within the guidelines provided by federal, state and local government.

If you have any grievance pertaining to the privacy of medical records or wish to inquire further about how our facility manages patient information, please contact our Privacy Officer at 201-886-8184.

Fort Lee Health Center, Inc. reserves the right to amend, change and/or revise our privacy policy at any time in accordance with federal, state and local rules, regulations and guidelines.

THANK YOU FOR CHOOSING FORT LEE HEALTH CENTER, INC. FOR YOUR HEALTHCARE!!

Signature:_____ Date:_____

VERIFICATION OF INSURANCE COVERAGE

**** THIS OFFICE IS NOT RESPONSIBLE TO VERIFY BENEFITS ****

Please contact your insurance company to obtain your chiropractic benefits and coverage.

Date:_____

Name of Insured:_____

Name of Patient:_____

Insurance Company Policy #:_____Group #:_____

Insurance Company:_____

Address:_____

Insured's Employer:_____

This is to verify coverage, as stated in our telephone conversation of _____

When I spoke to _____ Coverage was stated, as follows:

Amount of deductible:_____

Individual:_____ Family:_____

Has the deductible been met?:_____

Co-insurance responsibility:_____

Co-payment responsibility:_____

Maximum number of visits allowed per year_____

Contract Year or Calendar Year?_____

Reference Number for the call:_____

Date:_____ Signature:_____

DOCTOR'S LIEN

To: Attorney/ Insurance Carrier

_____
_____
_____

Doctor

Dr. Robert M. Monahan, D.C.
Fort Lee Health Center
1067 Palisade Avenue
Fort Lee, New Jersey 07024
P 201-886-8184 / F 201-886-8483

RE: Patient records and doctor's lien

I do hereby authorize the above doctor to furnish you, my attorney/ insurance carrier, with a full report of his case history, examination, diagnosis, treatment and prognosis of myself in regard to my accident/ illness which occurred/began on _____.

I hereby give a lien to said doctor on any settlement, claim, judgment, or verdict as a result of said accident/illness, and authorize and direct you, my attorney/insurance carrier, to pay directly to said doctor such sums as may be due and owing him for service rendered to me, and to withhold such sums from such settlement, claim, judgment, or verdict as may be necessary to protect said doctor adequately.

I fully understand that I am directly and fully responsible to said doctor for all chiropractic bills submitted by him for service rendered me, and that this agreement is made solely for said doctor's additional protection and in consideration of his awaiting payment. And I further understand that such payment is not contingent on any settlement, claim, judgment, or verdict by which I may eventually recover said fee.

Dated: _____ Patient's signature _____

The undersigned, being attorney of record or authorized representative of insurance carrier for the above patient does hereby acknowledge receipt of the above lien, and does agree to honor the same to protect adequately said above named doctor.

Date: _____ Authorized signature: _____

NOTICE: Please date, sign and return one copy to doctor's office at once.
Keep one copy for your records