Personal Injury Intake

PERSONAL DATA

Today's Date:_____ Date of Accident: _____

Last Name:_____ First Name:_____ M.I.___

Cell phone:_____ Home phone: _____

Address: _____

City: _____ State:_____ Zip:_____

Birthdate:_____ Age:_____ Sex: M F Height:_____ Weight: _____

Please check one: ❑Minor ❑Single ❑Married ❑Divorced ❑Separated ❑Widowed

SSN:_____/_____/_____ Your Driver's Lic.#:_____

Are you/have you been disabled from work?_____

E-mail address: _____

BUSINESS DATA

Business phone:_____

Business/Employer:_____

Type of work:_____

Address:_____

City: _____ State:_____ Zip:_____

FAMILY DATA

Spouse's name:_____

Social Security #_____

Business phone:_____

Business/Employer:_____

Type of work:_____

CHILDRENS NAMES

Name_____ Age:_____

Name_____ Age:_____

Name_____ Age:_____

Name_____ Age:_____

EMERGENCY CONTACT

Name and address of nearest relative not living with you:

Name:_____ Relationship: _____

Phone# (Cell) _____ (Home) _____ (Work) _____

REFERRAL

Referred to this office by:_____

Informed Consent

To the Patient: Please read this entire document prior to signing it. It is important that you understand the information contained in this document. Please ask questions before you sign if there is anything that is unclear.

The nature of the chiropractic adjustment:

The primary treatment used by doctors of chiropractic is spinal manipulative therapy. I will use that procedure to treat you. I may use my hands or a mechanical instrument upon your body in such a way as to move your joints. That may cause an audible "pop" or "click," much as you have experienced when you "crack" your knuckles. You may feel a sense of movement.

Analysis / Examination / Treatment

As a part of the analysis, examination, and treatment, you are consenting to the following procedures:

__● range of motion testing __● orthopedic testing __● basic neurological testing
__● muscle strength testing __● ultrasound __● hot/cold therapy
__● posture analysis test __● EMS
__● Other: all physiotherapy in the office including but not limited to laser, PEMF, compression boots, traction, etc...

The risks inherent in chiropractic adjustment:

As with any healthcare procedure, there are certain complications which may arise during chiropractic manipulation and therapy. These complications include but are not limited to: fractures, disc injuries, dislocations, muscle strain, cervical myelopathy, costovertebral strains and separations, and burns. Some types of manipulation of the neck have been associated with injuries to the arteries in the neck leading to or contributing to serious complications including stroke. Some patients will feel some stiffness and soreness following the first few days of treatment. The Doctor will make every reasonable effort during the examination to screen for contraindications to care; however, if you have a condition that would otherwise not come to the Doctor's attention it is your responsibility to inform the Doctor.

The probability of those risks occurring:

Fractures are rare occurrences and generally result from some underlying weakness of the bone which we check for during the taking of your history and during examination and X-ray. Stroke and /or arterial dissection caused by chiropractic manipulation of the neck has been the subject of ongoing medical research and debate. The most current research on the topic is inconclusive as to a specific incident of this complication occurring. If there is a causal relationship at all it is extremely rare and remote. Unfortunately, there is no recognized screening procedure to identify patients with neck pain who are at risk of arterial stroke.

The availability and nature of other treatment options:

Other treatment options for your condition may include:

- Self-administered, over-the-counter analgesics and rest • Medical care and prescription drugs such as anti-inflammatory, muscle relaxants and pain-killers
- Hospitalization
- Surgery

If you chose to use one of the above noted "other treatment" options, you should be aware that there are risks and benefits of such options and you may wish to discuss these with your primary medical physician.

The risks and dangers attendant to remaining untreated:

Remaining untreated may allow the formation of adhesions and reduce mobility which may set up a pain reaction further reducing mobility. Over time this process may complicate treatment making it more difficult and less effective the longer it is postponed.

As of this date, I have the legal right to select and authorize health care services for the minor child named above. (If applicable) Under the terms and conditions of my divorce, separation or other legal authorization, the consent

of a spouse/former spouse or other parent is not required. If my authority to so select and authorize this care should be revoked or modified in any way, I will immediately notify this office.

DO NOT SIGN UNTIL YOU HAVE READ AND UNDERSTAND THE ABOVE. PLEASE CHECK THE APPROPRIATE BLOCK AND SIGN BELOW

[ ] I have read OR [ ] I have had read to me:

the above explanation of the chiropractic adjustment and related treatment. I have discussed it with *(the doctor and/or staff)* **and have had my questions answered to my satisfaction. By signing below, I state that I have weighed the risks involved in undergoing treatment and have decided that it is in my best interest to undergo the treatment recommended. Having been informed of the risks, I hereby give my consent to that treatment.**

Patient Name (print) _____

Patient's Signature _____ Date _____

Notice of Privacy Practices

Please review privacy practice information placard, located at the front desk.

This notice is effective as of: 1/1/2018

I have read the Privacy Notice and understand my rights contained in the notice.

By way of my signature, I provide Synergy Chiropractic Center with my authorization and consent to use and disclose my protected health care information for the purposes of treatment, payment and health care operations as described in the Privacy Notice.

Patient Name (print) _____

Patient's Signature _____ Date _____

AUTO INSURANCE INFORMATION

Who is the insured person on your policy? _____

Name of your insurance company: _____

Address: _____
(street) (city) (state) (zip)

Phone # of ins. co.: _____

Policy #: _____

Accident Claim #: _____ Who was at fault? Name: _____

(patient _____ insured _____ other _____

Have you contacted an insurance adjuster or representative regarding this claim ❒No ❒Yes

If yes Adjuster Name: _____ Adjuster Phone:_____

Is there medical payments (Med Pay) coverage: ❒No ❒Yes

What is the med-pay limit? _____

Have you filed an accident injury report? ❒No ❒Yes

OTHER PARTIES' INSURANCE COMPANY (if applicable):

Company: _____

Address: _____ Phone #: _____

Policy #: _____ Claim #: _____

MEDICAL INSURANCE INFORMATION

Name of Insured _____ Relationship to patient _____

Birth Date _____ SS# _____ Date employed _____

Address _____ City _____ State _____Zip _____

Insurance Co. _____ Phone# ( )_____-_____

Insurance Address _____ City _____ State ___ Zip _____

Group# _____ Member ID# _____

How much is your deductible? _____ How much have you met? _____

Do you have additional Insurance? NO YES

Name of Insured _____ Relationship to patient _____

Birth Date _____ SS# _____ Date employed _____

Address _____ City _____ State _____Zip _____

Insurance Co. _____ Phone# ( )_____-_____

Insurance Address _____ City _____ State ___ Zip _____

Group# _____ Employer# _____

How much is your deductible? _____ How much have you met? _____

Patient Name: _____ Signature: _____ Date: _____

VEHICLE ACCIDENT INFORMATION

ACCIDENT SITE

Road/Street Name:_____

City/State _____

Nearest intersection with road/street _____

Driving conditions ❒Dry ❒Wet ❒Icy ❒Other _____

Which direction were you headed? _____

( ) North ( ) East ( ) South ( ) West

Speed you were traveling? _____

VEHICLE

Make and model of vehicle you were in:

_____

Were you wearing a seatbelt? ❒Yes ❒No

If yes, what type? ❒Lap ❒Shoulder

Was vehicle equipped with airbags? ❒Yes ❒No

If yes, did it/they inflate properly? ❒Yes ❒No

Did your seat have a headrest? ❒Yes ❒No

If yes, what was the position of the headrest?

❒Low ❒Midposition ❒High

IMPACT

Did your car impact another vehicle? ❒Yes ❒No

Did your car impact a structure? ❒Yes ❒No

If yes, explain _____

_____

Did any part of our body strike anything in the vehicle? ❒Yes ❒No

If yes, explain _____

_____

Was impact from: ❒Front ❒Rear ❒Left ❒Right ❒Other _____

At the time of impact were you:

❒Looking straight ahead ❒Looking to the right

❒Looking to the left ❒Looking down

❒Looking up

Were both hands on the steering wheel? ❒Yes ❒No

If no, which hand was on the wheel? ❒Right ❒Left

Was your foot on the brake? ❒Yes ❒No

If yes, which foot was on the brake? ❒Right ❒Left

Were you: ❒Surprised by impact ❒Braced for impact

Were you: ( ) Driver ( ) Passenger ( ) Front Seat ( ) Back Seat

Number of people in your vehicle? _____

OTHER VEHICLE (if applicable)

Make and model of other vehicle:

_____

Which direction was other vehicle headed? _____

( ) North ( ) East ( ) South ( ) West

Speed other vehicle was traveling _____

POLICE

Did the police come to the accident site? ❒Yes ❒No

Were there any witnesses? ❒Yes ❒No

Was a police report filed? ❒Yes ❒No

Was a traffic violation issued? ❒Yes ❒No

If yes, to whom? _____

ATTORNEY

Have you engaged the services of an attorney: ❒Yes ❒No

Attorney: _____

Address: _____

City: _____ State: _____ Zip: _____ Phone: _____ Fax: _____

Patient Name: _____ Signature: _____ Date: _____

ACCIDENT INJURY

In your own words, please describe accident: _____

_____

_____

_____

_____

Were you knocked unconscious? ❒No ❒Yes If yes, for how long? _____

Did you have any physical complaints BEFORE THE ACCIDENT? ❒No ❒Yes If yes, please describe in detail: _____

_____

_____

Do you have any congenital (from birth) factors which relate to this problem? ❒No ❒Yes If yes, please describe: _____

_____

Do you have any previous illnesses that relate to this case? ❒No ❒Yes If yes, please describe: .

Have you ever been involved in an accident before? ❒No ❒Yes If yes, please describe, including date(s) and type(s) of accidents, as well as injury(ies) received: _____

_____

Please describe how you felt:

DURING the accident: _____

IMMEDIATELY AFTER the accident: _____

LATER THAT DAY: _____

THE NEXT DAY: _____

How did you feel? ❒Confused ❒Weak ❒Dazed ❒Nervous ❒Other _____

Have you missed work due to this accident/injury? ❒Missed No Work ❒Limited Work Activity

a. ❒Missed Work From ____/____/____ To: ____/____/____

b. Last Day Worked: _____

c. Type of Employment: _____

d. Present Salary: _____

e. Are you being compensated for time lost from work? ❒No ❒Yes If yes, please state type of compensation you are receiving: _____

Prior to the injury were you able to work on an equal basis with others your age? ❒No ❒Yes

❒Other _____

Patient Name: _____ Signature: _____ Date: _____

FOR THIS INJURY

TREATMENT

Did you go to the hospital? ❒Yes ❒No

When did you go? ❒Immediately after accident ❒Next Day ❒2 days or more after the accident

How did you get to the hospital? ❒Ambulance ❒Private Transportation

Name of hospital: _____ Name of Doctor: _____

Diagnosis _____

_____

Treatment received _____

_____

X-rays taken _____

Did you self-treat your symptoms? ❒Ice ❒Heat ❒Bed Rest ❒Over-the-counter medication ❒Other _____

If there were lacerations (cuts), where were they?

{Check the appropriate box(es)}

	Left/Right	Left/Right
❒Head	❒/❒Shoulders	❒/❒Buttocks
❒Neck	❒/❒Arms	❒/❒Hips
❒Upper/Mid Back	❒/❒Elbows	❒/❒Thighs
❒Lower Back	❒/❒Forearms	❒/❒Knees
❒Pelvis	❒/❒Wrists	❒/❒Legs
❒Chest/Rib Cage	❒/❒Hands	❒/❒Ankles
❒Abdomen		❒/❒Feet
❒Other _____		

If x-rays were taken, what body part(s)?

{Check the appropriate box(es)}

	Left/Right	Left/Right
❒Head	❒/❒Shoulders	❒/❒Buttocks
❒Neck	❒/❒Arms	❒/❒Hips
❒Upper/Mid Back	❒/❒Elbows	❒/❒Thighs
❒Lower Back	❒/❒Forearms	❒/❒Knees
❒Pelvis	❒/❒Wrists	❒/❒Legs
❒Chest/Rib Cage	❒/❒Hands	❒/❒Ankles
❒Abdomen		❒/❒Feet
❒Other _____		

CURRENT COMPLAINTS

TREATMENT

Since this injury occurred, are your symptoms: ( ) Improving ( ) Getting Worse ( ) Same

CHECK SYMPTOMS YOU HAVE NOTICED SINCE ACCIDENT:

❒Headache	❒Irritability	❒Numbness in Toes	❒Face Flushed	❒Feet Cold
❒Neck Pain	❒Chest Pain	❒Shortness of Breath	❒Buzzing in Ears	❒Hands Cold
❒Neck Stiff	❒Dizziness	❒Fatigue	❒Loss of Balance	❒Stomach Upset
❒Sleeping Problems	❒Head Seems Too Heavy	❒Depression	❒Fainting	❒Constipation
❒Back Pain	❒Pins & Needles in Arms	❒Lights Bother Eyes	❒Loss of Smell	❒Cold Sweats
❒Nervousness	❒Pins & Needles in Legs	❒Loss of Memory	❒Loss of Taste	❒Fever
❒Tension	❒Numbness in Fingers	❒Ears Ring	❒Diarrhea	❒Leg Pain
❒Arm/Shoulder Pain	❒Back Stiffness	❒Jaw Problems	❒Nausea	❒Blurred Vision

❒ Symptoms Other Than Above _____

Since your accident/injury have you suffered from any of the following:

❒Blurred Vision	❒Double Vision	❒Reduced Vision	❒Impaired Hearing	❒Ringing In Ears
❒Chest Pain	❒Difficulty Breathing	❒Palpitations	❒Constipation	❒Diarrhea
❒Nausea	❒Vomiting	❒Frequent Urination	❒Inability to Hold Urine	❒Painful Urination

Please complete the attached 4-page MUSCULO-SKELETAL form as thoroughly as possible, checking all appropriate boxes to document your CURRENT complaints and symptoms.

Patient Name: _____ Signature: _____ Date: _____

#1 PAIN COMPLAINT:

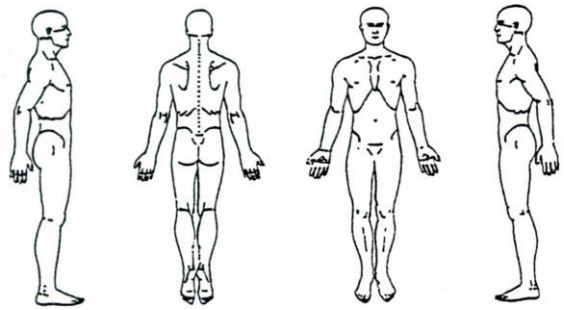
1. When did your symptoms appear?
Date of onset:_____ Was it: ❑ Sudden ❑ Gradual
2. Is this condition getting progressively worse? ❑Yes ❑No ❑Unknown
3. Describe your pain/complaint:

❑ Dull	❑ Sharp	❑ Ache	❑ Stabbing
❑ Deep	❑ Superficial	❑ Spasm/tension	❑ Numbness
❑ Tingling	❑ Burning	❑ Stiffness	❑ Pulling

4.Radiation: Does the pain go to other parts of the body?
❑ Yes ❑ No Where?_____
5. Degree: What is the degree of your pain?
❑ Mild ❑ Moderate ❑ Severe
6. Frequency: How often do you have this pain?
❑ Occasional ❑ Intermittent ❑ Frequent ❑ Constant
7. Duration: How long does the pain last? ___Min. ___ Hrs.____ Days
8. What makes the pain worse?

❑ Standing	❑ Sitting	❑ Bending	❑ Twisting
❑ Walking	❑ Lifting	❑ Sleeping	❑ Heat
❑ Cold	❑ Stooping	❑ Sex	❑ Other

9. What makes the pain better?
❑ Sitting ❑ Standing ❑ Rest ❑ Heat ❑ Cold
❑ Aspirin/medication ❑ Other_____
10. Does it interfere with your :
❑ Work ❑ Sleep ❑ Daily routine ❑ Recreation
11. What treatment have you already received for this condition?
❑ Medications ❑ Surgery ❑ Physical therapy ❑ Chiropractic services ❑ None ❑ Other_____



Draw/Shade the affected areas on the image(s) above to indicate your pain locations. Please use arrows to show the direction that the pain flows to or from these areas.

Please RATE YOUR PAIN!
Please circle the accurate pain level below (1-low; 10-high)
1 2 3 4 5 6 7 8 9 10

#2 PAIN COMPLAINT:

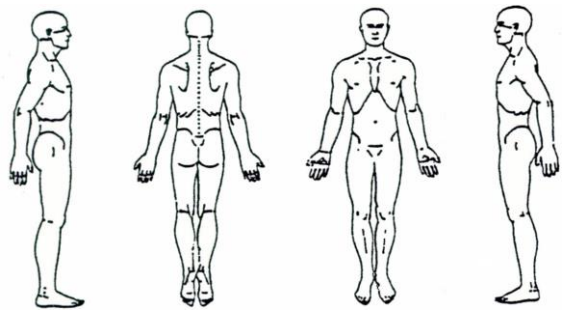
1. When did your symptoms appear?
Date of onset:_____ Was it: ❑ Sudden ❑ Gradual
2. Is this condition getting progressively worse? ❑Yes ❑No ❑Unknown
3. Describe your pain/complaint:

❑ Dull	❑ Sharp	❑ Ache	❑ Stabbing
❑ Deep	❑ Superficial	❑ Spasm/tension	❑ Numbness
❑ Tingling	❑ Burning	❑ Stiffness	❑ Pulling

4.Radiation: Does the pain go to other parts of the body?
❑ Yes ❑ No Where?_____
5. Degree: What is the degree of your pain?
❑ Mild ❑ Moderate ❑ Severe
6. Frequency: How often do you have this pain?
❑ Occasional ❑ Intermittent ❑ Frequent ❑ Constant
7. Duration: How long does the pain last? ___Min. ___ Hrs.____ Days
8. What makes the pain worse?

❑ Standing	❑ Sitting	❑ Bending	❑ Twisting
❑ Walking	❑ Lifting	❑ Sleeping	❑ Heat
❑ Cold	❑ Stooping	❑ Sex	❑ Other

9. What makes the pain better?
❑ Sitting ❑ Standing ❑ Rest ❑ Heat ❑ Cold
❑ Aspirin/medication ❑ Other_____
10. Does it interfere with your :
❑ Work ❑ Sleep ❑ Daily routine ❑ Recreation
11. What treatment have you already received for this condition?
❑ Medications ❑ Surgery ❑ Physical therapy ❑ Chiropractic services ❑ None ❑ Other_____



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Please RATE YOUR PAIN!
Please circle the accurate pain level below (1-low; 10-high)
1 2 3 4 5 6 7 8 9 10

#3 PAIN COMPLAINT:

1. When did your symptoms appear?
Date of onset:_____ Was it: ❑ Sudden ❑ Gradual

2. Is this condition getting progressively worse? ❑Yes ❑No ❑Unknown

3. Describe your pain/complaint:

❑ Dull	❑ Sharp	❑ Ache	❑ Stabbing
❑ Deep	❑ Superficial	❑ Spasm/tension	❑ Numbness
❑ Tingling	❑ Burning	❑ Stiffness	❑ Pulling

4.Radiation: Does the pain go to other parts of the body?
❑ Yes ❑ No Where?_____

5. Degree: What is the degree of your pain?
❑ Mild ❑ Moderate ❑ Severe

6. Frequency: How often do you have this pain?
❑ Occasional ❑ Intermittent ❑ Frequent ❑ Constant

7. Duration: How long does the pain last? ___Min. ___ Hrs.____ Days

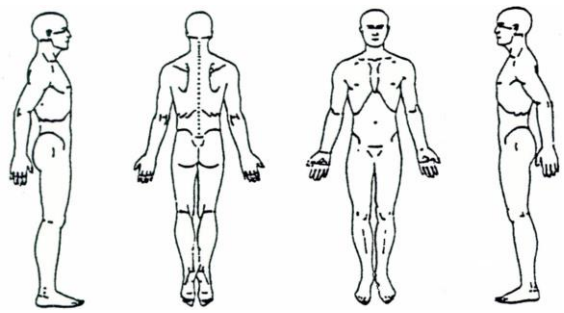
8. What makes the pain worse?

❑ Standing	❑ Sitting	❑ Bending	❑ Twisting
❑ Walking	❑ Lifting	❑ Sleeping	❑ Heat
❑ Cold	❑ Stooping	❑ Sex	❑ Other

9. What makes the pain better?
❑ Sitting ❑ Standing ❑ Rest ❑ Heat ❑ Cold
❑ Aspirin/medication ❑ Other_____

10. Does it interfere with your :
❑ Work ❑ Sleep ❑ Daily routine ❑ Recreation

11. What treatment have you already received for this condition?
❑ Medications ❑ Surgery ❑ Physical therapy ❑ Chiropractic services ❑ None ❑ Other_____



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Please RATE YOUR PAIN!
Please circle the accurate pain level below (1-low; 10-high)
1 2 3 4 5 6 7 8 9 10

#4 PAIN COMPLAINT:

1. When did your symptoms appear?
Date of onset:_____ Was it: ❑ Sudden ❑ Gradual

2. Is this condition getting progressively worse? ❑Yes ❑No ❑Unknown

3. Describe your pain/complaint:

❑ Dull	❑ Sharp	❑ Ache	❑ Stabbing
❑ Deep	❑ Superficial	❑ Spasm/tension	❑ Numbness
❑ Tingling	❑ Burning	❑ Stiffness	❑ Pulling

4.Radiation: Does the pain go to other parts of the body?
❑ Yes ❑ No Where?_____

5. Degree: What is the degree of your pain?
❑ Mild ❑ Moderate ❑ Severe

6. Frequency: How often do you have this pain?
❑ Occasional ❑ Intermittent ❑ Frequent ❑ Constant

7. Duration: How long does the pain last? ___Min. ___ Hrs.____ Days

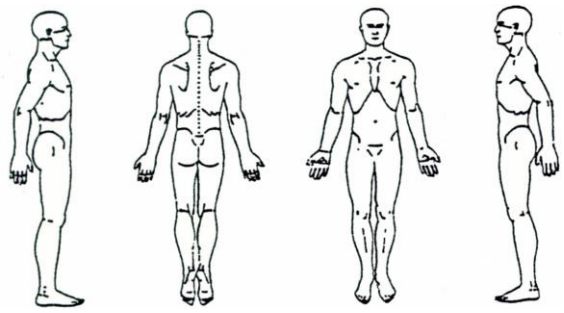
8. What makes the pain worse?

❑ Standing	❑ Sitting	❑ Bending	❑ Twisting
❑ Walking	❑ Lifting	❑ Sleeping	❑ Heat
❑ Cold	❑ Stooping	❑ Sex	❑ Other

9. What makes the pain better?
❑ Sitting ❑ Standing ❑ Rest ❑ Heat ❑ Cold
❑ Aspirin/medication ❑ Other_____

10. Does it interfere with your :
❑ Work ❑ Sleep ❑ Daily routine ❑ Recreation

11. What treatment have you already received for this condition?
❑ Medications ❑ Surgery ❑ Physical therapy ❑ Chiropractic services ❑ None ❑ Other_____



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Please RATE YOUR PAIN!
Please circle the accurate pain level below (1-low; 10-high)
1 2 3 4 5 6 7 8 9 10

#5 PAIN COMPLAINT:

1. When did your symptoms appear?
Date of onset:_____ Was it: ❑ Sudden ❑ Gradual

2. Is this condition getting progressively worse? ❑Yes ❑No ❑Unknown

3. Describe your pain/complaint:

❑ Dull	❑ Sharp	❑ Ache	❑ Stabbing
❑ Deep	❑ Superficial	❑ Spasm/tension	❑ Numbness
❑ Tingling	❑ Burning	❑ Stiffness	❑ Pulling

4.Radiation: Does the pain go to other parts of the body?
❑ Yes ❑ No Where?_____

5. Degree: What is the degree of your pain?
❑ Mild ❑ Moderate ❑ Severe

6. Frequency: How often do you have this pain?
❑ Occasional ❑ Intermittent ❑ Frequent ❑ Constant

7. Duration: How long does the pain last? ___Min. ___ Hrs.____ Days

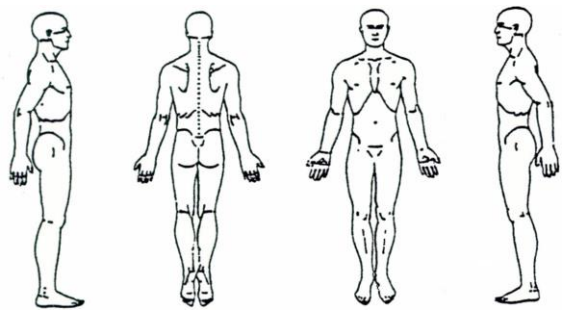
8. What makes the pain worse?

❑ Standing	❑ Sitting	❑ Bending	❑ Twisting
❑ Walking	❑ Lifting	❑ Sleeping	❑ Heat
❑ Cold	❑ Stooping	❑ Sex	❑ Other

9. What makes the pain better?
❑ Sitting ❑ Standing ❑ Rest ❑ Heat ❑ Cold
❑ Aspirin/medication ❑ Other_____

10. Does it interfere with your :
❑ Work ❑ Sleep ❑ Daily routine ❑ Recreation

11. What treatment have you already received for this condition?
❑ Medications ❑ Surgery ❑ Physical therapy ❑ Chiropractic services ❑ None ❑ Other_____



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Please RATE YOUR PAIN!
Please circle the accurate pain level below (1-low; 10-high)
1 2 3 4 5 6 7 8 9 10

#6 PAIN COMPLAINT:

1. When did your symptoms appear?
Date of onset:_____ Was it: ❑ Sudden ❑ Gradual

2. Is this condition getting progressively worse? ❑Yes ❑No ❑Unknown

3. Describe your pain/complaint:

❑ Dull	❑ Sharp	❑ Ache	❑ Stabbing
❑ Deep	❑ Superficial	❑ Spasm/tension	❑ Numbness
❑ Tingling	❑ Burning	❑ Stiffness	❑ Pulling

4.Radiation: Does the pain go to other parts of the body?
❑ Yes ❑ No Where?_____

5. Degree: What is the degree of your pain?
❑ Mild ❑ Moderate ❑ Severe

6. Frequency: How often do you have this pain?
❑ Occasional ❑ Intermittent ❑ Frequent ❑ Constant

7. Duration: How long does the pain last? ___Min. ___ Hrs.____ Days

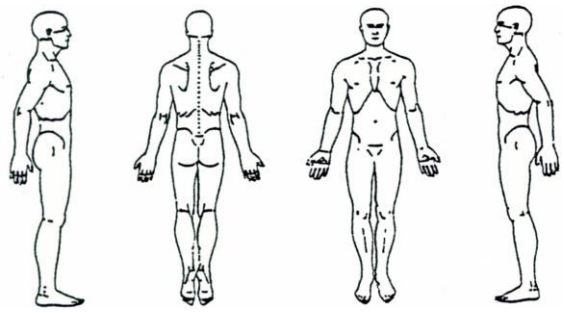
8. What makes the pain worse?

❑ Standing	❑ Sitting	❑ Bending	❑ Twisting
❑ Walking	❑ Lifting	❑ Sleeping	❑ Heat
❑ Cold	❑ Stooping	❑ Sex	❑ Other

9. What makes the pain better?
❑ Sitting ❑ Standing ❑ Rest ❑ Heat ❑ Cold
❑ Aspirin/medication ❑ Other_____

10. Does it interfere with your :
❑ Work ❑ Sleep ❑ Daily routine ❑ Recreation

11. What treatment have you already received for this condition?
❑ Medications ❑ Surgery ❑ Physical therapy ❑ Chiropractic services ❑ None ❑ Other_____



Draw/Shade the affected areas on the image(s) above to indicate your pain locations. Please use arrows to show the direction that the pain flows to or from these areas.

Please RATE YOUR PAIN!
Please circle the accurate pain level below (1-low; 10-high)
1 2 3 4 5 6 7 8 9 10

#7 PAIN COMPLAINT:

1. When did your symptoms appear?
Date of onset:_____ Was it: ❑ Sudden ❑ Gradual

2. Is this condition getting progressively worse? ❑Yes ❑No ❑Unknown

3. Describe your pain/complaint:

❑ Dull	❑ Sharp	❑ Ache	❑ Stabbing
❑ Deep	❑ Superficial	❑ Spasm/tension	❑ Numbness
❑ Tingling	❑ Burning	❑ Stiffness	❑ Pulling

4.Radiation: Does the pain go to other parts of the body?
❑ Yes ❑ No Where?_____

5. Degree: What is the degree of your pain?
❑ Mild ❑ Moderate ❑ Severe

6. Frequency: How often do you have this pain?
❑ Occasional ❑ Intermittent ❑ Frequent ❑ Constant

7. Duration: How long does the pain last? ___Min. ___ Hrs.____ Days

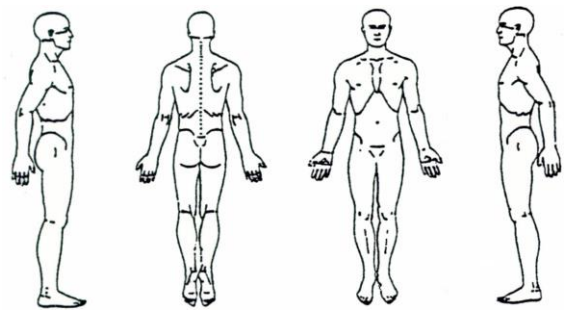
8. What makes the pain worse?

❑ Standing	❑ Sitting	❑ Bending	❑ Twisting
❑ Walking	❑ Lifting	❑ Sleeping	❑ Heat
❑ Cold	❑ Stooping	❑ Sex	❑ Other

9. What makes the pain better?
❑ Sitting ❑ Standing ❑ Rest ❑ Heat ❑ Cold
❑ Aspirin/medication ❑ Other_____

10. Does it interfere with your :
❑ Work ❑ Sleep ❑ Daily routine ❑ Recreation

11. What treatment have you already received for this condition?
❑ Medications ❑ Surgery ❑ Physical therapy ❑ Chiropractic services ❑ None ❑ Other_____



Draw/Shade the affected areas on the image(s) above to indicate your pain locations. Please use arrows to show the direction that the pain flows to or from these areas.

Please RATE YOUR PAIN!
Please circle the accurate pain level below (1-low; 10-high)
1 2 3 4 5 6 7 8 9 10

#8 PAIN COMPLAINT:

1. When did your symptoms appear?
Date of onset:_____ Was it: ❑ Sudden ❑ Gradual

2. Is this condition getting progressively worse? ❑Yes ❑No ❑Unknown

3. Describe your pain/complaint:

❑ Dull	❑ Sharp	❑ Ache	❑ Stabbing
❑ Deep	❑ Superficial	❑ Spasm/tension	❑ Numbness
❑ Tingling	❑ Burning	❑ Stiffness	❑ Pulling

4.Radiation: Does the pain go to other parts of the body?
❑ Yes ❑ No Where?_____

5. Degree: What is the degree of your pain?
❑ Mild ❑ Moderate ❑ Severe

6. Frequency: How often do you have this pain?
❑ Occasional ❑ Intermittent ❑ Frequent ❑ Constant

7. Duration: How long does the pain last? ___Min. ___ Hrs.____ Days

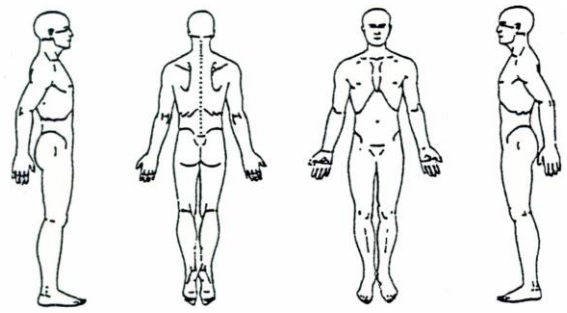
8. What makes the pain worse?

❑ Standing	❑ Sitting	❑ Bending	❑ Twisting
❑ Walking	❑ Lifting	❑ Sleeping	❑ Heat
❑ Cold	❑ Stooping	❑ Sex	❑ Other

9. What makes the pain better?
❑ Sitting ❑ Standing ❑ Rest ❑ Heat ❑ Cold
❑ Aspirin/medication ❑ Other_____

10. Does it interfere with your :
❑ Work ❑ Sleep ❑ Daily routine ❑ Recreation

11. What treatment have you already received for this condition?
❑ Medications ❑ Surgery ❑ Physical therapy ❑ Chiropractic services ❑ None ❑ Other_____



Draw/Shade the affected areas on the image(s) above to indicate your pain locations. Please use arrows to show the direction that the pain flows to or from these areas.

Please RATE YOUR PAIN!
Please circle the accurate pain level below (1-low; 10-high)
1 2 3 4 5 6 7 8 9 10

Loss of Enjoyment of Sports, Hobbies, Travel, Daily activities, & School (2 of 2 pages)

☐ Initial ☐ Update

Please check all the DAILY LIVING activities that cause you pain because of the accident

- ☐ Dressing
- ☐ Putting on pants
- ☐ Putting on shoes
- ☐ Tying my shoes
- ☐ Putting on shirt
- ☐ Drying my hair
- ☐ Combing my hair
- ☐ Washing my hair
- ☐ Taking a shower
- ☐ Taking a bath
- ☐ Leaning forward
- ☐ Laying in bed
- ☐ Sitting in my favorite chair
- ☐ Sleeping
- ☐ Going out with my friends
- ☐ Sitting at a restaurant
- ☐ Shopping
- ☐ Driving to/from work
- ☐ Sitting in Church
- ☐ Exercise
- ☐ Stooping
- ☐ Kneeling
- ☐ Riding in a car
- ☐ Opening a jar
- ☐ Lifting a pan when cooking
- ☐ Closing the trunk on my car
- ☐ Opening the garage door
- ☐ Using my home computer
- ☐ Climbing stairs
- ☐ Sexual activity
- ☐ Turning my head to left or right
- ☐ Holding my head up all day
- ☐ Watching TV
- ☐ I have pain sitting & doing nothing
- ☐ Talking on the phone
- ☐ Reading
- ☐ Writing
- ☐ Opening doors
- ☐ Drying with a towel after a bath or shower
- ☐ Life has become a chore just to do normal things
- ☐ It is depressing to live like this
- ☐ Brushing my teeth
- ☐ Eating

Please check all that apply to your SCHOOL & EDUCATION Activities because of the accident

- ☐ School was affected by the accident
- ☐ I am a student at _____
- ☐ I am in the _____ year/grade
- ☐ I was ☐ full time ☐ part time
- ☐ I am now ☐ full time ☐ part time
- ☐ I had to take fewer classes b/c of crash
- ☐ I missed _____ days of school
- ☐ I had to drop out of school b/c of crash
- ☐ My grades are lower since the crash
- ☐ I have pain carrying my school books
- ☐ I hurt sitting in class more than _____ minutes
- ☐ My neck hurts when I look down to read
- ☐ I don't learn as quickly as before the crash
- ☐ I don't learn things as well as before the crash
- ☐ I have difficulty concentrating in class
- ☐ It takes much longer to study/do my homework

_____

_____

Patient Name: _____ Signature: _____ Date: _____

Physician's Lien

Attorney: _____ Date: _____

Patient Name: _____

I do hereby authorize Eric Blum, D.C. and/or Ryan Rubin D.C. to furnish you, my attorney, with a full report of his examination, diagnosis, treatment, prognosis, etc., of myself in regard to the accident in which I was recently involved.

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

I agree never to rescind this document and that a rescission will not be honored by my attorney. I hereby instruct that in the event another is substituted in this matter, the new attorney shall honor this lien as inherent to settlement and enforceable upon the case as if it were executed by him.

I fully understand that I am directly and fully responsible to said doctor for all medical 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, judgment or verdict by which I may eventually recover said fee. I also understand my account will be charged interest at the rate of 1.5% monthly after 90 (ninety) days from my initial office consultation.

In the event any party to this lien commences legal proceedings against the other to enforce the terms hereof, or to declare rights there under as the result of any breach of any covenant or condition of this lien, the prevailing party in any such proceeding shall be entitled to recover from the losing party its cost of suit, including reasonable attorney's fees, as may be fixed by the court.

Please acknowledge this letter by signing and returning to the doctor's office. I have been advised that if my attorney does not wish to cooperate in protecting the doctor's interest, the doctor will not await payment but will require me to make payments on a current basis.

Date: _____ _____

Patient's Signature

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

Date: _____ _____

Attorney's Signature