



Personal Injury Intake

PERSONAL DATA	<p>Today's Date: _____ Date of Accident: _____</p> <p>Last Name: _____ First Name: _____ M.I. _____</p> <p>Cell phone: _____ Home phone: _____</p> <p>Address: _____</p> <p>City: _____ State: _____ Zip: _____</p> <p>Birthdate: _____ Age: _____ Sex: M F Height: _____ Weight: _____</p> <p>Please check one: <input type="checkbox"/> Minor <input type="checkbox"/> Single <input type="checkbox"/> Married <input type="checkbox"/> Divorced <input type="checkbox"/> Separated <input type="checkbox"/> Widowed</p> <p>SSN: _____ / _____ / _____ Your Driver's Lic.#: _____</p> <p>Are you/have you been disabled from work? _____</p> <p>E-mail address: _____</p>
BUSINESS DATA	<p>Business phone: _____</p> <p>Business/Employer: _____</p> <p>Type of work: _____</p> <p>Address: _____</p> <p>City: _____ State: _____ Zip: _____</p>
FAMILY DATA	<p>Spouse's name: _____</p> <p>Social Security # _____</p> <p>Business phone: _____</p> <p>Business/Employer: _____</p> <p>Type of work: _____</p> <div style="border: 1px solid black; padding: 5px; width: fit-content; margin-left: auto; margin-right: auto;"> <p style="text-align: center; margin: 0;">CHILDRENS NAMES</p> <p>Name _____ Age: _____</p> <p>Name _____ Age: _____</p> <p>Name _____ Age: _____</p> <p>Name _____ Age: _____</p> </div>
EMERGENCY CONTACT	<p>Name and address of nearest relative not living with you:</p> <p>Name: _____ Relationship: _____</p> <p>Phone# (Cell) _____ (Home) _____ (Work) _____</p>
REFERRAL	<p>Referred to this office by: _____</p>



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.



**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 _____

HIPAA Compliance

Synergy Chiropractic & Physical Therapy is required by law to maintain the HIPAA Notice of Privacy Practices. This notice explains our legal duties and privacy practices with respect to your protected health information. Signature below acknowledges that I have read this Notice of our Privacy Practices. A copy will be provided to me upon request.

Patient Signature: _____ Date: _____

Witness: _____ Date: _____

Staff Initials: _____

Consent for Treatment of a Minor

I hereby authorize all Synergy Chiropractic and Physical Therapy employees to perform diagnostic tests and render chiropractic adjustments and other treatment to my minor son/daughter _____.

Guardian Name (print): _____

Guardian 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

<p style="text-align: center;">ACCIDENT SITE</p> <p>Road/Street Name: _____</p> <p>City/State _____</p> <p>Nearest intersection with road/street _____</p> <p>Driving conditions <input type="checkbox"/>Dry <input type="checkbox"/>Wet <input type="checkbox"/>Icy <input type="checkbox"/>Other _____</p> <p>Which direction were you headed? _____</p> <p>() North () East () South () West</p> <p>Speed you were traveling? _____</p>	<p style="text-align: center;">IMPACT</p> <p>Did your car impact another vehicle? <input type="checkbox"/>Yes <input type="checkbox"/>No</p> <p>Did your car impact a structure? <input type="checkbox"/>Yes <input type="checkbox"/>No</p> <p style="padding-left: 40px;">If yes, explain _____</p> <p>_____</p> <p>Did any part of our body strike anything in the vehicle? <input type="checkbox"/>Yes <input type="checkbox"/>No</p> <p style="padding-left: 40px;">If yes, explain _____</p> <p>_____</p> <p>Was impact from: <input type="checkbox"/>Front <input type="checkbox"/>Rear <input type="checkbox"/>Left <input type="checkbox"/>Right <input type="checkbox"/>Other _____</p> <p>At the time of impact were you:</p> <p><input type="checkbox"/>Looking straight ahead <input type="checkbox"/>Looking to the right</p> <p><input type="checkbox"/>Looking to the left <input type="checkbox"/>Looking down</p> <p><input type="checkbox"/>Looking up</p> <p>Were both hands on the steering wheel? <input type="checkbox"/>Yes <input type="checkbox"/>No</p> <p style="padding-left: 40px;">If no, which hand was on the wheel? <input type="checkbox"/>Right <input type="checkbox"/>Left</p> <p>Was your foot on the brake? <input type="checkbox"/>Yes <input type="checkbox"/>No</p> <p style="padding-left: 40px;">If yes, which foot was on the brake? <input type="checkbox"/>Right <input type="checkbox"/>Left</p> <p>Were you: <input type="checkbox"/>Surprised by impact <input type="checkbox"/>Braced for impact</p> <p>Were you: () Driver () Passenger () Front Seat () Back Seat</p> <p>Number of people in your vehicle? _____</p>
<p>VEHICLE</p> <p>Make and model of vehicle you were in:</p> <p>_____</p> <p>Were you wearing a seatbelt? <input type="checkbox"/>Yes <input type="checkbox"/>No</p> <p>If yes, what type? <input type="checkbox"/>Lap <input type="checkbox"/>Shoulder</p> <p>Was vehicle equipped with airbags? <input type="checkbox"/>Yes <input type="checkbox"/>No</p> <p>If yes, did it/they inflate properly? <input type="checkbox"/>Yes <input type="checkbox"/>No</p> <p>Did your seat have a headrest? <input type="checkbox"/>Yes <input type="checkbox"/>No</p> <p>If yes, what was the position of the headrest?</p> <p style="padding-left: 40px;"><input type="checkbox"/>Low <input type="checkbox"/>Midposition <input type="checkbox"/>High</p>	<p style="text-align: center;">POLICE</p> <p>Did the police come to the accident site? <input type="checkbox"/>Yes <input type="checkbox"/>No</p> <p>Were there any witnesses? <input type="checkbox"/>Yes <input type="checkbox"/>No</p> <p>Was a police report filed? <input type="checkbox"/>Yes <input type="checkbox"/>No</p> <p>Was a traffic violation issued? <input type="checkbox"/>Yes <input type="checkbox"/>No</p> <p>If yes, to whom? _____</p>
<p style="text-align: center;">OTHER VEHICLE (if applicable)</p> <p>Make and model of other vehicle:</p> <p>_____</p> <p>Which direction was other vehicle headed? _____</p> <p>() North () East () South () West</p> <p>Speed other vehicle was traveling _____</p>	

ATTORNEY

<p>Have you engaged the services of an attorney: <input type="checkbox"/>Yes <input type="checkbox"/>No</p> <p>Attorney: _____</p> <p>Address: _____</p> <p>City: _____ State: _____ Zip: _____ Phone: _____ Fax: _____</p>

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 |
|---|------------------------------------|-----------------------------------|
| <input type="checkbox"/> Head | <input type="checkbox"/> Shoulders | <input type="checkbox"/> Buttocks |
| <input type="checkbox"/> Neck | <input type="checkbox"/> Arms | <input type="checkbox"/> Hips |
| <input type="checkbox"/> Upper/Mid Back | <input type="checkbox"/> Elbows | <input type="checkbox"/> Thighs |
| <input type="checkbox"/> Lower Back | <input type="checkbox"/> Forearms | <input type="checkbox"/> Knees |
| <input type="checkbox"/> Pelvis | <input type="checkbox"/> Wrists | <input type="checkbox"/> Legs |
| <input type="checkbox"/> Chest/Rib Cage | <input type="checkbox"/> Hands | <input type="checkbox"/> Ankles |
| <input type="checkbox"/> Abdomen | | <input type="checkbox"/> Feet |
| <input type="checkbox"/> Other _____ | | |

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

{ Check the appropriate box(es) }

- | | Left/Right | Left/Right |
|---|------------------------------------|-----------------------------------|
| <input type="checkbox"/> Head | <input type="checkbox"/> Shoulders | <input type="checkbox"/> Buttocks |
| <input type="checkbox"/> Neck | <input type="checkbox"/> Arms | <input type="checkbox"/> Hips |
| <input type="checkbox"/> Upper/Mid Back | <input type="checkbox"/> Elbows | <input type="checkbox"/> Thighs |
| <input type="checkbox"/> Lower Back | <input type="checkbox"/> Forearms | <input type="checkbox"/> Knees |
| <input type="checkbox"/> Pelvis | <input type="checkbox"/> Wrists | <input type="checkbox"/> Legs |
| <input type="checkbox"/> Chest/Rib Cage | <input type="checkbox"/> Hands | <input type="checkbox"/> Ankles |
| <input type="checkbox"/> Abdomen | | <input type="checkbox"/> Feet |
| <input type="checkbox"/> Other _____ | | |

CURRENT COMPLAINTS

TREATMENT

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

CHECK SYMPTOMS YOU HAVE NOTICED SINCE ACCIDENT:

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

Symptoms Other Than Above _____

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

- | | | | | |
|---|---|---|--|--|
| <input type="checkbox"/> Blurred Vision | <input type="checkbox"/> Double Vision | <input type="checkbox"/> Reduced Vision | <input type="checkbox"/> Impaired Hearing | <input type="checkbox"/> Ringing In Ears |
| <input type="checkbox"/> Chest Pain | <input type="checkbox"/> Difficulty Breathing | <input type="checkbox"/> Palpitations | <input type="checkbox"/> Constipation | <input type="checkbox"/> Diarrhea |
| <input type="checkbox"/> Nausea | <input type="checkbox"/> Vomiting | <input type="checkbox"/> Frequent Urination | <input type="checkbox"/> Inability to Hold Urine | <input type="checkbox"/> Painful Urination |

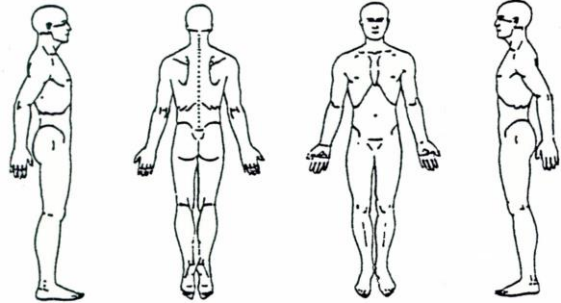
Please complete the attached 4-page MUSCULO-SKELETAL form as thoroughly as possible, checking all appropriate boxes to document your CURRENT complaints and symptoms.

Patient Name: _____ Signature: _____ Date: _____



#1 PAIN COMPLAINT:

- When did your symptoms appear?
Date of onset: _____ Was it: Sudden Gradual
- Is this condition getting progressively worse? Yes No Unknown
- Describe your pain/complaint:
 Dull Sharp Ache Stabbing
 Deep Superficial Spasm/tension Numbness
 Tingling Burning Stiffness Pulling
- Radiation: Does the pain go to other parts of the body?
 Yes No Where? _____
- Degree: What is the degree of your pain?
 Mild Moderate Severe
- Frequency: How often do you have this pain?
 Occasional Intermittent Frequent Constant
- Duration: How long does the pain last? ___Min. ___Hrs. ___Days
- What makes the pain worse?
 Standing Sitting Bending Twisting
 Walking Lifting Sleeping Heat
 Cold Stooping Sex Other
- What makes the pain better?
 Sitting Standing Rest Heat Cold
 Aspirin/medication Other _____
- Does it interfere with you :
 Work Sleep Daily routine Recreation
- What treatment have you already received for this condition?
 Medications Surgery Physical therapy Chiropractic services None Other _____



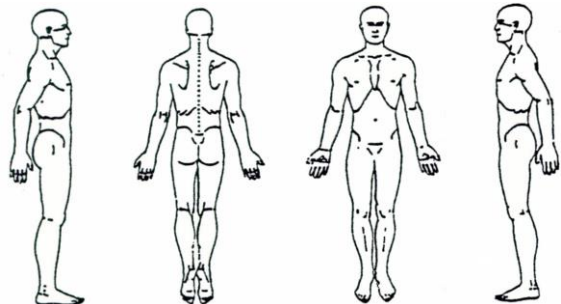
Draw/Shade the affected areas on the image(s) above to indicate your pain locations. Please use arrows to show the direction that the pain flows to or from these areas.

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:

- When did your symptoms appear?
Date of onset: _____ Was it: Sudden Gradual
- Is this condition getting progressively worse? Yes No Unknown
- Describe your pain/complaint:
 Dull Sharp Ache Stabbing
 Deep Superficial Spasm/tension Numbness
 Tingling Burning Stiffness Pulling
- Radiation: Does the pain go to other parts of the body?
 Yes No Where? _____
- Degree: What is the degree of your pain?
 Mild Moderate Severe
- Frequency: How often do you have this pain?
 Occasional Intermittent Frequent Constant
- Duration: How long does the pain last? ___Min. ___Hrs. ___Days
- What makes the pain worse?
 Standing Sitting Bending Twisting
 Walking Lifting Sleeping Heat
 Cold Stooping Sex Other
- What makes the pain better?
 Sitting Standing Rest Heat Cold
 Aspirin/medication Other _____
- Does it interfere with you :
 Work Sleep Daily routine Recreation
- 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



#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?

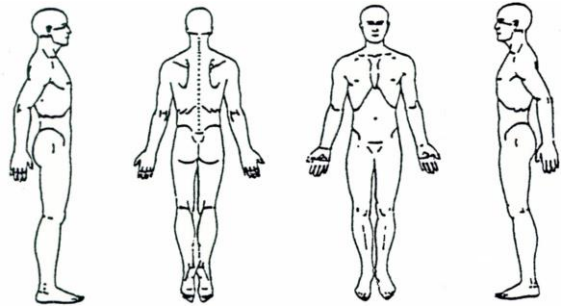
- Sitting Standing Rest Heat Cold
 Aspirin/medication Other _____

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 _____



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

#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?

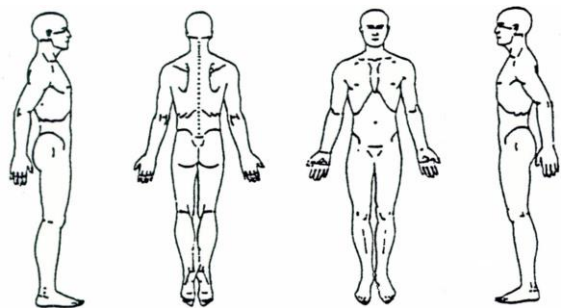
- Sitting Standing Rest Heat Cold
 Aspirin/medication Other _____

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 _____



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

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

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

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

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 herein.

Date: _____

Attorney's Signature