PERSONAL INJURY QUESTIONNAIRE

Name _____ *Date* _____

Address _____ *City* _____ *State* _____ *Zip* _____

Home Phone _____ *Work* _____ *Cell* _____

SS# _____ *Sex: M F* *Date of Birth* _____ *Age* _____

Email(personal) _____ *(business)* _____

Driver's License No. _____ *State* ___ *Married*__ *Single*__ *Divorced*__ *Widowed*__

Employer's Name _____ *Position* _____

Spouse's Name _____ *Work Phone* _____

Nearest Relative not living with you _____ *Phone #* _____

Have you obtained an attorney? Yes ( ) No ( ) Name _____ *Phone* _____

NATURE OF ACCIDENT:

Date of Accident: _____ *Time of Accident:* _____ *AM PM*

Were you on-the-job at the time of the accident? Yes ( ) No ( )

Please explain in ***detail*** *how the accident happened* _____

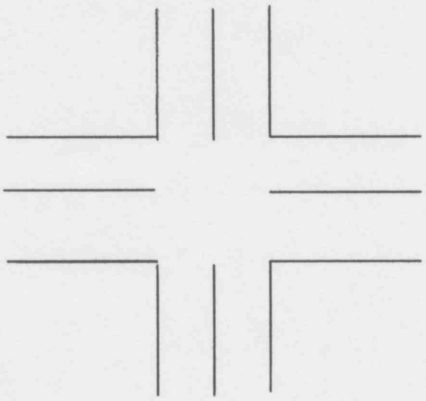
_____

_____

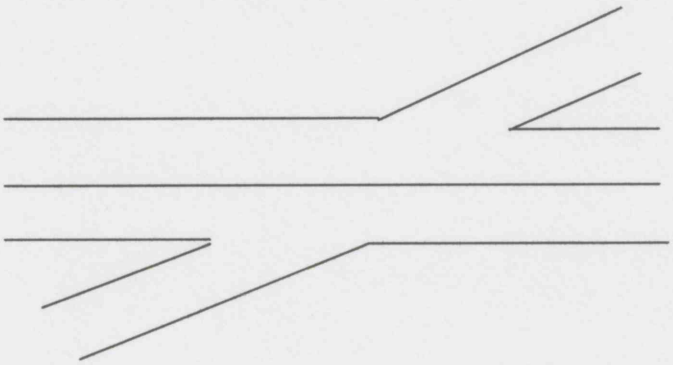
Address or intersection where accident occurred _____

Please complete the appropriate diagram of how your accident occurred. List #1 as your car and #2 as the other driver.

(Intersection diagram)



(Merge diagram)



Road conditions: Wet ( ) Dry ( ) Icy ( ) Other _____

1. *What is the year, make and model of the vehicle you were in:* _____
   Are you the registered owner of this vehicle ( ) Yes If not, who is? _____
2. *Were you: Driver ( ) Passenger ( ) Front seat ( ) Back seat ( )*
3. *Where was the damage to your vehicle? Rear ( ) Front ( ) Left side ( ) Right side ( )*
   What was the cost of damage done to the vehicle you were in? _____
4. *Did police come to the scene of the accident? Yes ( ) No ( )*
   If a ticket was issued, to whom and what for? _____
5. *Were you knocked unconscious? Yes ( ) No ( ) If yes, how long?* _____

6. *Initial symptoms immediately following the accident: ( ) None ( ) Headache ( ) Dizzy ( ) Disoriented ( ) Shock ( ) Nauseated ( ) Neck pain/stiff ( ) Mid back pain/stiff ( ) Lower back pain/stiff ( ) Numbness/tingling where _____ Other _____*

If no symptoms immediately, when did they first appear: ( )hours _____ ( )days _____ ( )weeks _____

7. *What bruises did you receive from the accident? _____*

8. *What cuts or scratches did you receive from the accident? _____*

9. *List any and all body parts that hit the interior of the vehicle during impact and what they hit.*

(Example: right knee hit dashboard, right ribcage hit armrest)_____

_____

_____

_____

_____

10. *Do your symptoms (or pain) increase when you: Cough ( ) Sneeze ( ) Walk ( ) Stand ( ) Sit ( ) Bend ( ) Lift ( ) Twist( ) At Bowel Movement ( ) ?*

11. *Where were you taken after the accident? _____*
Doctors name _____ Treatment/medication given _____
Were x-rays taken? Yes ( ) No ( ) Neck ( ) Low Back ( ) Mid Back ( ) Other_____

12. *What other doctor's have you been treated by and care rendered since the accident?_____*

_____

13. *Are you on **any** medication at this time? Yes ( ) No ( ) If yes, what for? _____*

_____

14. *Were you wearing a seat belt? Yes ( ) No ( ) Lap belt only ( ) Combination shoulder-lap belt ( )*

15. *Where did the top of the headrest or seatback reach: Neck or lower ( ) Bottom of skull ( ) Middle of skull ( ) Top of head or higher ( ) Not sure ( )*

16. *Were you aware of the approaching collision prior to impact, or did it catch you by surprise? Aware ( ) Surprise ( )*

17. *Was your vehicle stopped at the time of impact? Yes ( ) No ( )*

If yes, was the driver's foot on the brake? Yes ( ) No ( )
If no, estimate the speed of the vehicle you were in: _____m.p.h.

18. *If your vehicle was moving at the time of impact, was it: Slowing down ( ) Gaining speed ( )*

Traveling at a steady rate ( ) Other _____

19. *What direction was your head positioned at time of impact?*

Forward ( ) Right ( ) Left ( ) Back ( ) Up ( ) Down ( ) Other _____

20. *What direction was your body positioned at the time of impact?*

Forward ( ) Right ( ) Left ( ) Back ( ) Other _____

22. *Before the accident, were you capable of working on an equal basis with others your age? Yes( ) No( )*
Are your work activities restricted as a result of this accident: Yes ( ) No ( )
If yes, please explain_____
Have you lost time from work since the accident? From_____ To_____

23. Have you been involved in other accidents in the last 10 years? Yes ( ) No ( )

Accident #1 *When? _____ What happened? _____*
What injuries were you treated for? _____
When were you released from care?_____
Accident #2 *When? _____ What happened? _____*
What injuries were you treated for? _____
When were you released from care?_____

Your car insurance (or the car in which you were injured):

Name of Insured_____ Phone_____

Insurance Co. _____ Policy # _____

Agents name _____ Phone_____

Your personal health insurance carrier:

Name of Insured _____ Relationship _____

SS# of Insured(if other than self) _____ Policy # _____

Insurance Co. _____ Phone # _____

****

Other driver's information:

1. *What is the year, make and model of the other vehicle _____*

2. *Was the other vehicle moving at the time of the collision: Yes ( ) No ( )*
   Were you told how fast he/she was traveling? Yes ( ) No ( ) _____m.p.h.

3. *If the other vehicle was moving at the time of impact, do you know if it was:*
   Slowing down ( ) Gaining speed ( ) Traveling at a steady rate ( ) Not sure ( )

Driver of the other vehicle _____

Name of Insured _____

Insurance Co. _____ Policy # _____

Agent's name _____ Phone# _____

****

I understand and agree that health and accident insurance policies are an arrangement between an insurance carrier and myself. Furthermore, I understand that the Doctor's Office will prepare any necessary reports and forms to assist me in making collection from the insurance and that any amount authorized to be paid directly to the Doctor's Office will be credited to my account on receipt. However, I clearly 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 at this office, any outstanding charges for professional services rendered me will immediately due and payable. If I fail to pay such outstanding charges within 90 days from my last treatment, I understand I will be responsible for any and all fees incurred in the outside collections of this account. These, but not limited to these, include court cost, attorney fees and collection agencies.

Patient's Signature_____ Date _____

Guardian's Signature (if necessary) authorizing care and payment _____

PLEASE CHECK WHICH SYMPTOMS YOU HAVE EXPERIENCED SINCE THE TIME OF THE ACCIDENT.

MUSCULO-SKELETAL SYSTEM

_____ Low back problems
_____ Pain between shoulders
_____ Neck problems
_____ Arm problems
_____ Leg problems
_____ Swollen joints
_____ Painful joints
_____ Stiff joints
_____ Sore muscles
_____ Weak muscles
_____ Walking problems
_____ Ruptures
_____ Broken bones

GENITO-URINARY SYSTEM

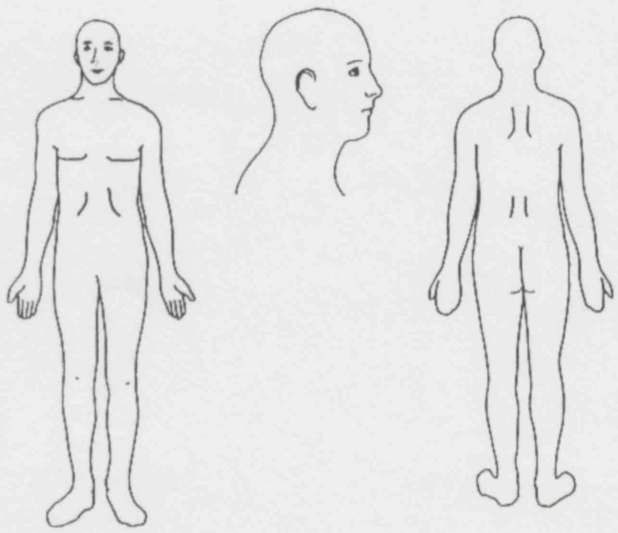
_____ Bladder trouble
_____ Excessive urination
_____ Scanty urination
_____ Painful urination
_____ Discolored urine

FEMALE

_____ Vaginal discharge
_____ Vaginal bleeding
_____ Vaginal pain
_____ Breast pain
_____ Lumps on breast

Are you pregnant?
_____ Yes _____ No

Please mark your areas of pain on the figure below.
pain scale 1-10 (10 the worst)



GASTRO-INTESTINAL SYSTEM

_____ Poor appetite
_____ Excessive hunger
_____ Difficult chewing
_____ Difficult swallowing
_____ Excessive thirst
_____ Nausea
_____ Vomiting food
_____ Vomiting blood
_____ Abdominal pain
_____ Diarrhea
_____ Constipation
_____ Black stool
_____ Bloody stool
_____ Hemorrhoids
_____ Liver trouble
_____ Gall bladder problems
_____ Weight trouble

NERVOUS SYSTEM

_____ Numbness
_____ Loss of feeling
_____ Paralysis
_____ Dizziness
_____ Fainting
_____ Headaches
_____ Muscle jerking
_____ Convulsions
_____ Forgetfulness
_____ Confusion
_____ Depression

CARDIO-VASCULAR-RESPIRATORY

_____ Chest pain
_____ Pain over heart
_____ Difficult breathing
_____ Persistent cough
_____ Coughing phlegm
_____ Coughing blood
_____ Rapid heartbeat
_____ Blood pressure problems
_____ Heart problems
_____ Lung problems
_____ Varicose Veins

EYE, EAR, NOSE, AND THROAT

_____ Eye strain
_____ Eye inflammation
_____ Vision problems
_____ Ear pain
_____ Ear noises
_____ Ear discharge
_____ Hearing loss
_____ Nose pain
_____ Nose bleeding
_____ Nose discharge
_____ Difficult breathing thru nose
_____ Sore gums
_____ Dental problems
_____ Sore mouth
_____ Sore throat
_____ Hoarseness
_____ Difficult speech

_____
Patient's Signature

DO NOT WRITE BELOW THIS LINE

Patient accepted? Yes_____ No_____ Doctor's signature_____

Name_____ **Date**_____

AUTO ACCIDENT CASE HISTORY

Please review and mark all that apply to assist us with your case.

Neck and Head Pain

- **Do you have neck pain?** ☐ YES ☐ NO If YES, is the pain: ☐ Constant ☐ Sharp ☐ Dull ☐ Ache ☐ Burning ☐ Tingling ☐ Numb
- Is the pain increased with: ☐ Head movements ☐ When first get up in the morning ☐ After work ☐ When first go to bed ☐ When relaxing
- Does the pain awaken you? ☐ YES ☐ NO
- **Do you have headaches with your neck pain?** ☐ YES ☐ NO If YES, is the pain felt in ☐ Forehead ☐ Temples ☐ Top ☐ Right side ☐ Left side ☐ Base of skull
- Are you experiencing memory loss? ☐ YES ☐ NO If YES: ☐ Short term ☐ Long term
- Are you experiencing loss of concentration? ☐ YES ☐ NO
- Do you feel that you can't think of how to do your job? ☐ YES ☐ NO
- Please explain how it has affected your home, work and/or social life

  _____

- **Do you have jaw pain?** ☐ YES ☐ NO If YES, is the pain ☐ Constant ☐ Sharp ☐ Dull ☐ Burning ☐ Tingling ☐ Numb
- Were you experiencing any of these symptoms prior to this accident? ☐ YES ☐ NO
- If YES, please explain_____

Arm Pain

- **Do you have arm pain?** ☐ YES ☐ NO If YES, is the pain: ☐ Right ☐ Left
- Is the arm pain: ☐ Constant ☐ Sharp ☐ Dull ☐ Achy ☐ Burning ☐ Tingling ☐ Numb
- Do you have arm weakness? ☐ YES ☐ NO If YES, ☐ Both arms ☐ Right only ☐ Left only ☐ Down to the elbow ☐ Down to the wrist ☐ Down to the fingers
- Do any of the following increase your arm pain? ☐ Lifting above head ☐ Head Movements ☐ Coughing ☐ Sneezing ☐ Having a bowel movement ☐ Reaching forward ☐ Reaching backwards ☐ When relaxing
- Does pain cause you difficulty using the arm? ☐ YES ☐ NO ☐ Occasionally
  If so, how?_____
- Cause you to drop things? ☐ YES ☐ NO If YES, ☐ Frequently ☐ Occasionally ☐ Almost
- Were you experiencing any of these symptoms prior to this accident? ☐ YES ☐ NO
- If YES, please explain_____

Shoulder Pain

- **Do you have shoulder pain?** ☐ YES ☐ NO If YES, where is the shoulder pain? ☐ Right ☐ Left ☐ Front ☐ Back ☐ Neck to joint ☐ Joint only
- Is shoulder pain: ☐ Constant ☐ Sharp ☐ Dull ☐ Ache ☐ Burning ☐ Tingling ☐ Numb
- Do any of the following increase your shoulder pain? ☐ Lifting above head ☐ Head Movements ☐ Reaching forward ☐ Reaching backwards ☐ When relaxing
- Were you experiencing any of these symptoms prior to the accident? ☐ YES ☐ NO
- If YES, please explain_____

Mid-Back and Chest Pain

- **Do you have mid-back pain?** ☐ YES ☐ NO If YES, does it hurt on the
  ☐ Right ☐ Left ☐ Middle ☐ Between shoulder blades
  ☐ Right shoulder blade ☐ Left shoulder blade ☐ Right ribs ☐ Left ribs
- Is the pain ☐ Constant ☐ Sharp ☐ Dull ☐ Ache ☐ Burning ☐ Tingling ☐ Numb
- **Do you have chest pain?** ☐ YES ☐ NO If YES, ☐ Right ☐ Left ☐ Middle
- Were you experiencing any of these symptoms prior to this accident? ☐ YES ☐ NO
- If YES, please explain_____

Low Back Pain

- **Do you have low-back pain?** ☐ YES ☐ NO If YES, does it hurt on the ☐ Right
  ☐ Left ☐ Middle
- Is the pain ☐ Constant ☐ Sharp ☐ Dull ☐ Ache ☐ Burning ☐ Tingling ☐ Numb
- Do any of the following increase your low back pain? ☐ Coughing ☐ Sneezing
  ☐ Having a bowel movement ☐ Bending ☐ Rising from sitting ☐ Rising from bed
  ☐ When relaxing ☐ When first go to bed ☐ Walking
- Since the accident, have you had constipation ☐ YES ☐ NO / Diarrhea ☐ YES ☐ NO
- Have you had a change in urine flow? ☐ YES ☐ NO If YES, ☐ Increase ☐ Decrease
- Were you experiencing any of these symptoms prior to this accident? ☐ YES ☐ NO
- If YES, please explain_____

Leg Pain - Hip – Ankle - Foot

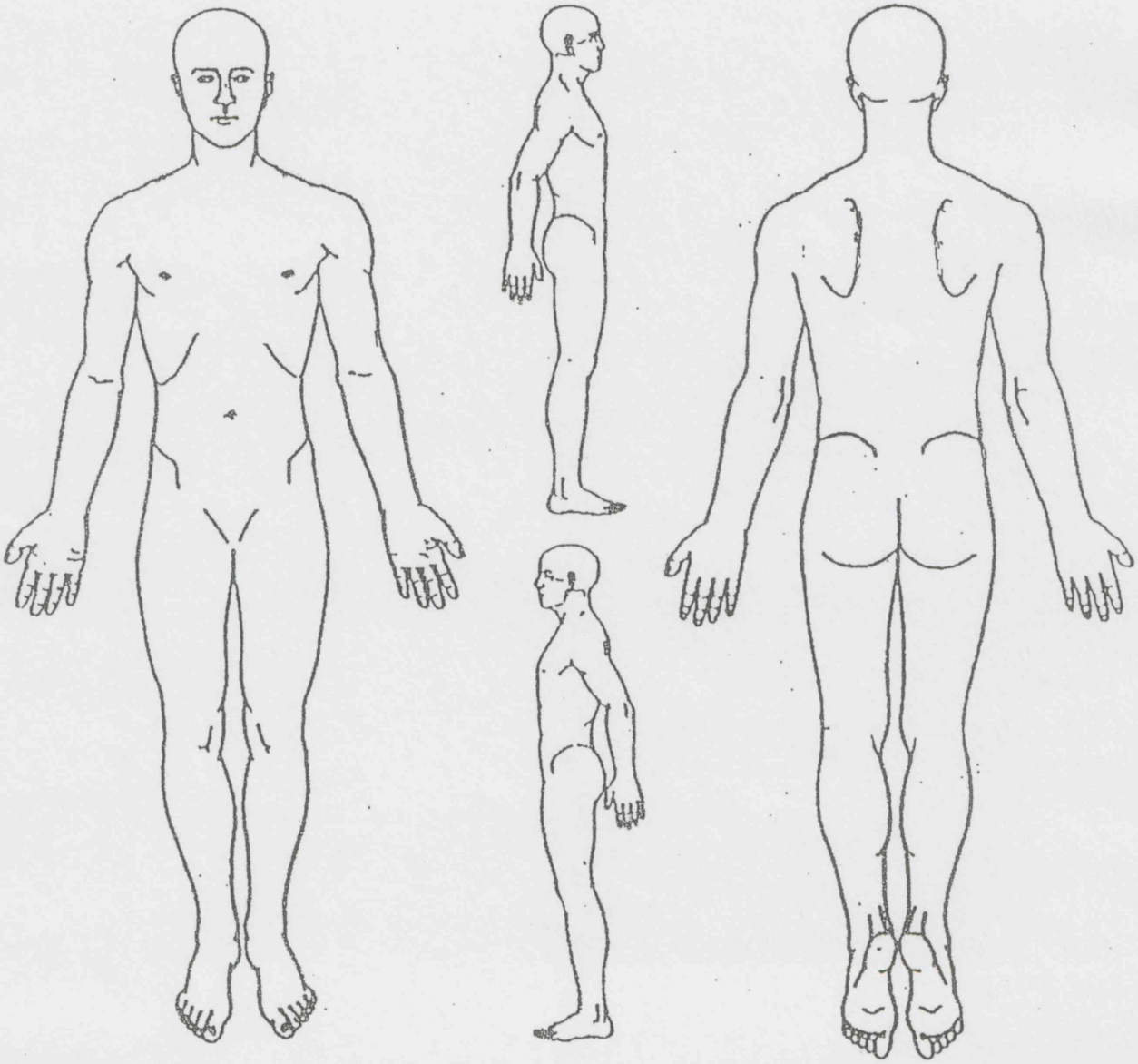
- **Do you have pain in your hip?** ☐ YES ☐ NO
  If YES, is the pain in: ☐ Right ☐ Left ☐ Front ☐ Back ☐ Hip joint ☐ Groin
- Is the pain ☐ Constant ☐ Sharp ☐ Dull ☐ Ache ☐ Burning ☐ Tingling ☐ Numb
- **Do you have leg pain?** ☐ YES ☐ NO
  If YES, is the pain in: ☐ Both legs ☐ Right only ☐ Left only ☐ Front ☐ Back
- Is the pain ☐ Constant ☐ Sharp ☐ Dull ☐ Ache ☐ Burning ☐ Tingling
  ☐ Numb ☐ Down to knee ☐ Down to ankle ☐ Down to toes
- Does the leg pain make you ☐ Limp ☐ Drag your feet ☐ Shuffle
- Do any of these increase leg pain? ☐ Walking ☐ Twisting at the waist ☐ Coughing
  ☐ Sneezing ☐ Having a bowel movement ☐ Going up steps ☐ Down steps ☐ When relaxing
- Is the pain worse ☐ Upon arising in the morning ☐ After work ☐ When lying down
- Does the leg pain awaken you? ☐ YES ☐ NO
- **Do you have ankle pain?** ☐ YES ☐ NO If YES, ☐ Right ☐ Inside ☐ Outside
  ☐ Left ☐ Inside ☐ Outside
- Is the pain ☐ Constant ☐ Sharp ☐ Dull ☐ Ache ☐ Burning ☐ Tingling ☐ Numb
- **Do you have foot pain?** ☐ YES ☐ NO If YES, ☐ Right ☐ Left ☐ Top ☐ Bottom
- Is the pain ☐ Constant ☐ Sharp ☐ Dull ☐ Ache ☐ Burning ☐ Tingling ☐ Numb
- Were you experiencing any of these symptoms prior to this accident ☐ YES ☐ NO
- If YES, please explain_____

THE REVISED OSWESTRY PAIN QUESTIONNAIRE

NAME: _____ DATE: _____

USE THE LETTERS BELOW TO INDICATE THE TYPE AND LOCATION OF YOUR SENSATIONS RIGHT NOW:

A = ACHE	B = BURNING	N = NUMBNESS
P = PINS & NEEDLES	S = STABBING	O = OTHER



LOW BACK PAIN AND DISABILITY INDEX (REVISED OSWESTRY)

Patient Name: _____ Date: _____/_____/_____

Please read instructions carefully.

This questionnaire has been designed to give the doctor information as to how your low back pain has affected your ability to manage everyday life. Please read all statements in each section and mark the box which most closely describes your problem.

SECTION 1 - PAIN INTENSITY

- ☐ The pain comes and goes and is very mild.
- ☐ The pain is mild and does not vary much.
- ☐ The pain comes and goes and is moderate.
- ☐ The pain is moderate and does not vary much.
- ☐ The pain comes and goes and is very severe.
- ☐ The pain is severe and does not vary much.

SECTION 2 - PERSONAL CARE

- ☐ I do not have to change my way of washing or dressing to avoid pain.
- ☐ I do not normally change my way of washing or dressing even though it causes some pain.
- ☐ Washing and dressing increases the pain but I manage not to change my way of doing it.
- ☐ Washing and dressing increases the pain and I find it necessary to change my way of doing it.
- ☐ Because of the pain, I am unable to do some washing and dressing without help.
- ☐ Because of the pain, I am unable to do any washing or dressing without help.

SECTION 3 - LIFTING

- ☐ I can lift heavy objects without any extra pain.
- ☐ I can lift heavy objects, but it gives extra pain.
- ☐ Pain prevents me from lifting heavy objects off the floor.
- ☐ Pain prevents me from lifting heavy objects off the floor but I can manage if they are conveniently positioned on a table.
- ☐ Pain prevents me from lifting heavy objects but I can manage light to medium objects.
- ☐ I can only lift very light objects at the most.

SECTION 4 - WALKING

- ☐ I have no pain on walking.
- ☐ I have some pain but it does not increase with distance.
- ☐ I cannot walk more than one mile without increasing pain.
- ☐ I cannot walk more than 1/2 mile without increasing pain.
- ☐ I cannot walk more than 1/4 mile without increasing pain.
- ☐ I cannot walk at all without increasing pain.

SECTION 5 - SITTING

- ☐ I can sit in any chair as long as I like.
- ☐ I can only sit in my favorite chair as long as I like.
- ☐ Pain prevents me from sitting more than one hour.
- ☐ Pain prevents me from sitting more than half an hour.
- ☐ Pain prevents me from sitting more than 10 minutes.
- ☐ I avoid sitting because it increases pain.

SECTION 6 - STANDING

- ☐ I can stand as long as I want without pain.
- ☐ I have some pain on standing but it does not increase with time.
- ☐ I cannot stand for longer than one hour without increasing pain.
- ☐ I cannot stand for longer than 1/2 hour without increasing pain.
- ☐ I cannot stand longer than 10 minutes without increasing pain.
- ☐ I avoid standing because it increases the pain.

SECTION 7 - SLEEPING

- ☐ I get no pain in bed.
- ☐ I get pain in bed but it does not prevent me from sleeping well.
- ☐ Pain reduces my normal sleep by 1/4 each night.
- ☐ Pain reduces my normal sleep by 1/2 each night.
- ☐ Pain reduces my normal sleep by 3/4 each night.
- ☐ Pain prevents me from sleeping at all.

SECTION 8 - SOCIAL LIFE

- ☐ My social life is normal and gives me no pain.
- ☐ My social life is normal but increases the degree of pain.
- ☐ My social life is unaffected by pain apart from limiting more energetic interests.
- ☐ Pain has restricted my social life and I do not go out very often.
- ☐ Pain has restricted my social life to my home.
- ☐ I have hardly any social life because of the pain.

SECTION 9 - DRIVING / RIDING IN CAR, ETC.

- ☐ I get no pain while traveling.
- ☐ I get some pain while traveling but none of my usual forms of travel make it any worse.
- ☐ I get extra pain while traveling but it does not compel me to seek alternate forms of travel.
- ☐ I get extra pain while traveling which compels me to seek alternate forms of travel.
- ☐ Pain restricts all forms of travel.
- ☐ Pain prevents all forms of travel except that done lying down.

SECTION 10 - CHANGING DEGREE OF PAIN

- ☐ My pain is rapidly getting better.
- ☐ My pain fluctuates but overall is definitely getting better.
- ☐ My pain seems to be getting better but improvement is slow at present.
- ☐ My pain is neither getting better or worse.
- ☐ My pain is gradually worsening.
- ☐ My pain is rapidly worsening.

Score:_____

Neck Disability Index

Name:_____ Date:_____

THIS QUESTIONNAIRE IS DESIGNED TO HELP US BETTER UNDERSTAND HOW YOUR NECK PAIN AFFECTS YOUR ABILITY TO MANAGE EVERYDAY -LIFE ACTIVITIES. PLEASE MARK IN EACH SECTION THE ONE BOX THAT APPLIES TO YOU.

ALTHOUGH YOU MAY CONSIDER THAT TWO OF THE STATEMENTS IN ANY ONE SECTION RELATE TO YOU, PLEASE MARK THE BOX THAT MOST CLOSELY DESCRIBES YOUR PRESENT -DAY SITUATION.

SECTION 1 - PAIN INTENSITY

- ☐ I have no neck pain at the moment.
- ☐ The pain is very mild at the moment.
- ☐ The pain is moderate at the moment.
- ☐ The pain is fairly severe at the moment.
- ☐ The pain is very severe at the moment.
- ☐ The pain is the worst imaginable at the moment.

SECTION 2 - PERSONAL CARE

- ☐ I can look after myself normally without causing extra neck pain.
- ☐ I can look after myself normally, but it causes extra neck pain.
- ☐ It is painful to look after myself, and I am slow and careful
- ☐ I need some help but manage most of my personal care.
- ☐ I need help every day in most aspects of self -care.
- ☐ I do not get dressed. I wash with difficulty and stay in bed.

SECTION 3 – LIFTING

- ☐ I can lift heavy weights without causing extra neck pain.
- ☐ I can lift heavy weights, but it gives me extra neck pain.
- ☐ Neck pain prevents me from lifting heavy weights off the floor but I can manage if items are conveniently positioned, ie. on a table.
- ☐ Neck pain prevents me from lifting heavy weights, but I can manage light weights if they are conveniently positioned
- ☐ I can lift only very light weights.
- ☐ I cannot lift or carry anything at all.

SECTION 4 – READING

- ☐ I can read as much as I want with no neck pain.
- ☐ I can read as much as I want with slight neck pain.
- ☐ I can read as much as I want with moderate neck pain.
- ☐ I can't read as much as I want because of moderate neck pain.
- ☐ I can't read as much as I want because of severe neck pain.
- ☐ I can't read at all.

SECTION 5 – HEADACHES

- ☐ I have no headaches at all.
- ☐ I have slight headaches that come infrequently.
- ☐ I have moderate headaches that come infrequently.
- ☐ I have moderate headaches that come frequently.
- ☐ I have severe headaches that come frequently.
- ☐ I have headaches almost all the time.

SECTION 6 – CONCENTRATION

- ☐ I can concentrate fully without difficulty.
- ☐ I can concentrate fully with slight difficulty.
- ☐ I have a fair degree of difficulty concentrating.
- ☐ I have a lot of difficulty concentrating.
- ☐ I have a great deal of difficulty concentrating.
- ☐ I can't concentrate at all.

SECTION 7 –WORK

- ☐ I can do as much work as I want.
- ☐ I can only do my usual work, but no more.
- ☐ I can do most of my usual work, but no more.
- ☐ I can't do my usual work.
- ☐ I can hardly do any work at all.
- ☐ I can't do any work at all.

SECTION 8 – DRIVING

- ☐ I can drive my car without neck pain.
- ☐ I can drive my car with only slight neck pain.
- ☐ I can drive as long as I want with moderate neck pain.
- ☐ I can't drive as long as I want because of moderate neck pain.
- ☐ I can hardly drive at all because of severe neck pain.
- ☐ I can't drive my car at all because of neck pain.

SECTION 9 – SLEEPING

- ☐ I have no trouble sleeping.
- ☐ My sleep is slightly disturbed for less than 1 hour.
- ☐ My sleep is mildly disturbed for up to 1-2 hours.
- ☐ My sleep is moderately disturbed for up to 2-3 hours.
- ☐ My sleep is greatly disturbed for up to 3-5 hours.
- ☐ My sleep is completely disturbed for up to 5-7 hours.

SECTION 10 – RECREATION

- ☐ I am able to engage in all my recreational activities with no neck pain at all.
- ☐ I am able to engage in all my recreational activities with some neck pain.
- ☐ I am able to engage in most, but not all of my recreational activities because of pain in my neck.
- ☐ I am able to engage in a few of my recreational activities because of neck pain.
- ☐ I can hardly do recreational activities due to neck pain.
- ☐ I can't do any recreational activities due to neck pain

Score:_____[50]

ACTIVITIES OF DAILY LIVING HISTORY

PATIENT NAME_____ **DATE**_____

PERSONAL ACTIVITIES

As a result of your injury, do you have any difficulty with the following activities?

Bathing/Showering	☐ Yes ☐ No ☐ Partial	Sitting for Long periods	☐ Yes ☐ No ☐ Partial
Wash/Dry Hair	☐ Yes ☐ No ☐ Partial	Laundry	☐ Yes ☐ No ☐ Partial
Going to the Toilet	☐ Yes ☐ No ☐ Partial	Vacuuming/Sweeping	☐ Yes ☐ No ☐ Partial
Sex	☐ Yes ☐ No ☐ Partial	Load/Unload Dishwasher	☐ Yes ☐ No ☐ Partial
Child Care	☐ Yes ☐ No ☐ Partial	Climbing Stairs	☐ Yes ☐ No ☐ Partial
Making Bed	☐ Yes ☐ No ☐ Partial	Taking out Garbage	☐ Yes ☐ No ☐ Partial
Ironing	☐ Yes ☐ No ☐ Partial	Wash/Wax Vehicle	☐ Yes ☐ No ☐ Partial
Preparing Meals	☐ Yes ☐ No ☐ Partial	Window Washing	☐ Yes ☐ No ☐ Partial
Reading	☐ Yes ☐ No ☐ Partial	Gardening	☐ Yes ☐ No ☐ Partial
Kneeling/Squatting	☐ Yes ☐ No ☐ Partial	Mowing Lawn/Yard Work	☐ Yes ☐ No ☐ Partial
Carrying Purse/Briefcase/Laptop	☐ Yes ☐ No ☐ Partial	Heavy Briefcase/Laptop	☐ Yes ☐ No ☐ Partial
Desk/Computer Work at home	☐ Yes ☐ No ☐ Partial	Other _____	☐ Yes ☐ No ☐ Partial

Explain other _____

RECREATIONAL ACTIVITIES

List the hobbies or recreational activities you enjoyed prior to your injury and designate your current level of activity as a result of your injury:

	Yes	No	Partial	If you selected partial, please explain:
1) _____	☐	☐	☐	_____
2) _____	☐	☐	☐	_____
3) _____	☐	☐	☐	_____

Do you have any other exercise program or sport in which you are currently active? ☐Yes ☐No

Please explain _____

WORK ACTIVITIES

Has your employer or other doctor put you on light or altered duty since your accident? ☐Yes ☐No

If yes, please explain _____

When at work do you: (check all that apply):

LIFT FROM:	☐ FLOOR	☐ WAIST	☐ OVERHEAD
TWIST WITH WEIGHT FROM:	☐ FLOOR	☐ WAIST	☐ OVERHEAD
TWIST WITHOUT WEIGHT FROM:	☐ FLOOR	☐ WAIST	☐ OVERHEAD
PUSH FROM:	☐ FLOOR	☐ WAIST	☐ OVERHEAD
PULL FROM:	☐ FLOOR	☐ WAIST	☐ OVERHEAD
MISC:	☐ DRIVE	☐ PHONE USE	☐ TYPE / COMPUTER WORK

OTHER _____

AT WORK I: SIT ☐ 0-2hrs ☐ 2-4hrs ☐ 4-6hrs ☐ 6-8hrs ☐ 10+hrs

STAND/WALK ☐ 0-2hrs ☐ 2-4hrs ☐ 4-6hrs ☐ 6-8hrs ☐ 10+hrs

I TAKE A _____ BREAK EVERY _____ HOUR(S) or ☐ 8 HR. SHIFT

ACTIVITIES OF DAILY LIVING

Name of Applicant: _____ Date: _____

APPLICANT HAS DIFFICULTY WITH: Place "N/A" if Not Applicable to you.						
	CATEGORY OF ACTIVITY	ACTIVITY	Without Difficulty	With Some Difficulty	With Much Difficulty	Mostly Unable to Do
1.	**Self-care, personal hygiene** (Urinating, defecating, brushing teeth, combing hair, bathing, dressing oneself, eating)	Take a shower				
		Take a bath				
		Wash & dry body				
		Wash & dry face				
		Turn on/off faucets				
		Brush teeth				
		Get on/off toilet				
		Comb/brush hair				
		Dress self				
		Put on/off shoes/socks				
		Open carton of milk				
		Open a jar				
		Lift glass/cup to mouth				
		Make a meal				
		Lift fork/spoon to mouth				
		Describe other: (bladder and bowel function difficulties: incontinence, retention, constipation?)				
2.	**Physical activity** (Standing, sitting, reclining, walking, climbing stairs)	Stand				
		Sit				
		Recline				
		Rise from a chair				
		Get in/out of bed				
		Climb flight of 10 stairs				
		Work outdoors				
		Light housework				
		Shop/do errands				
		Carry groceries				
		Lift 5 lbs.				
		Lift 10 lbs.				
		Lift 20 lbs.				
		Lift 30 lbs.				
		Walk				
		Care for children or parents				
		Engage in hobbies (music or crafts, etc.) Indicate hobby:				
		Describe other: (eating/chewing difficulty: TMJ?)				

	CATEGORY OF ACTIVITY	ACTIVITY	Without Difficulty	With Some Difficulty	With Much Difficulty	Mostly Unable to Do
3.	**Communication** (Writing, typing, seeing, hearing, speaking)	Write a note				
		Type a message on a computer/typewriter				
		See a television screen				
		Use a telephone				
		Speak clearly				
		Hear clearly				
		Describe other:				
4.	**Nonspecified hand activities** (Grasping, lifting, tactile, discrimination)	Pick up small items				
		Turn a knob on a door				
		Write with a pen/pencil				
		Steer wheel of car				
		Describe other:				
5.	**Sensory function** (Hearing, seeing, tactile feeling, tasting, smelling)	Feel what you touch				
		Taste what you eat				
		Smell what you eat				
		Describe other:				
6.	**Travel** (Riding, driving, flying)	Get in/out of a car				
		Drive a car				
		Ride in a car				
		Fly in a plane				
		Ride a bicycle				
		Describe other:				
7.	**Sleep** (Restful sleep, nocturnal sleep pattern)	Get to sleep				
		Sleep through the night				
		Have restful sleep				
		Feel refreshed after sleep				
		Describe specific difficulty: (teeth grinding at night, excessive daytime fatigue, irritability, etc.)				

(Based on Pg. 4 Guides to the Evaluation of Permanent Impairment, 5th Edition)

PERSONAL INJURY ASSIGNMENT AND LIEN

(Please let us know if you need the Spanish Translation of assignment and lien)

Provider: **Stakes Chiropractic Center** ID# **74-2274227**

Address: **7413 Old Bee Caves Rd. Austin, TX 78735-8234** Provider Type **Chiropractor**

Patient/Claimant:_____ **DOB:** _____ **DOI:** _____

Patient confirms rights to claim benefits and/or liability claims from the following Insurance Companies:

Name of Company	Policy Number	Type Ins.	Claim Number

ASSIGNMENT OF CONTRACTUAL BENEFITS : As a condition of receiving reasonable and necessary healthcare from the above named provider, I assign to the Provider all rights I may have under such policy to make claims and apply for and receive benefits under any insurance policy or benefit plan which I am qualified to receive, including: PIP, UM, UIM, Group Health, PPO, and HMO insurance benefits. This assignment includes and I give my power of attorney to the Provider to act on it's own, or in my name in collecting available benefits, signing payment checks, submitting information forms, and communicating, in any manner, with any insurance representative, including submission of records and billing statements as required under any insurance policy. I agree to cooperate with provider and providers representatives to collect any and all amounts owed.

CONTRACTUAL LIEN ON LIABILITY/UM/UIM INSURANCE SETTLEMENT FUNDS: In exchange for health care to be provided, I give provider named above a contractual lien on any and all funds paid from any policy of liability insurance or first party uninsured/underinsured motorists insurance as part of any settlement or advance payment, which shall be effective and enforceable immediately upon payment of any such funds. All parties to any settlement, who have notice, are responsible for protecting provider's right to be paid any unpaid balance on patient's account at the time of payment. Violation of provider's contractual lien rights may result in additional claims against all parties paying or receiving funds for conversion, misapplication of funds, and/or breach of fiduciary duty as the holder of funds protected by lien. Venue is agreed to be in the county of Provider's office in which health care has been rendered. All applicable statutes of limitations are extended for four years after provider receives written notice that a settlement payment has been made.

I have read and agree to the terms above:

Patient Signature_____ Date:_____

Parent/Legal Representative:_____ Relationship:_____ Date:_____

****

As authorized representative of the health provider named above, I certify a copy of this document was delivered to the following parties as follows:

Name of Party	Certified Mail Priority Mail Fax/Email	Mail Tracking Number Facsimile Number Secure email address	# Pages	Date Sent	Staff Initials

Power of Attorney to Endorse Checks

Know all men by these present: That the undersigned has made, constituted, and appointed, and by these presents does hereby make, constitute and appoint Stakes Chiropractic Center and any of its' duly authorized agents and employees as and to be the undersigned's true and lawful attorney for and in the undersigned's name, place, and stead, to endorse any and all checks, drafts, or money orders which are made payable to the undersigned alone or to the undersigned and said Stakes Chiropractic Center which checks, drafts, or money orders are to pay for services or the like which have been or are able to be performed by/at the requestor with the knowledge and approval of the undersigned and/or the maker of the check, draft, or money order.

The undersigned by these presents thus gives and grants said Stakes Chiropractic Center as attorney the full power and authority to do and perform all and every act and thing whatsoever requisite and purposes as the undersigned might or could do it personally present insofar as the endorsing and cashing of said checks are concerned.

The undersigned does hereby ratify and confirm any and all actions taken by the said attorney in accordance with this special power of attorney and which the said attorney shall do or cause to be done by the virtue of these presents.

In witness whereof the undersigned have hereto set their hands, this _____ day of _____, 20___

_____ Print name of patient

_____ Signature (Parent or Guardian if child)

_____ Printed Name

_____ Driver's License # _____ State

_____ Social Security #

HIPAA Notice of Privacy Practices

Stakes Chiropractic Center 7413 Old Bee Caves Rd. Austin, TX 78735-8234 512-892-2160

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

This Notice of Privacy Practices describes how we may use and disclose your protected health information (PHI) to carry out treatment, payment or health care operations (TPO) and for other purposes that are permitted or required by law. It also describes your rights to access and control your protected health information. "Protected health information" is information about you, including demographic information, that may identify you and that relates to your past, present or future physical or mental health or condition and related health care services.

Uses and Disclosures of Protected Health Information: Your protected health information may be used and disclosed by your physician, our office staff and others outside of our office that are involved in your care and treatment for the purpose of providing health care services to you, to pay your health care bills, to support the operation of the physician's practice, and any other use required by law. You have the right to receive an accounting of certain disclosures we have made, if any, of your protected health information. Other permitted and required uses and disclosures will be made only with your Consent, Authorization or Opportunity to Object unless required by law.

We will use and disclose your protected health information to provide, coordinate, or manage your health care and any related services, including third parties. Your protected health information will be used, as needed, to obtain payment for your health care services.

We may use or disclose, as-needed, your protected health information in order to support the business activities of your physician's practice. These activities include, but are not limited to, quality assessment activities, employee review activities, training of medical students, licensing, and conducting or arranging for other business activities.

We may use or disclose your protected health information in the following situations without your authorization. These situations include: as Required By Law, Public Health issues as required by law, Communicable Diseases: Health Oversight: Abuse or Neglect: Food and Drug Administration requirements: Legal Proceedings: Law Enforcement: Coroners, Funeral Directors, and Organ Donation: Research: Criminal Activity: Military Activity and National Security: Workers' Compensation: Inmates: Required Uses and Disclosures: Under the law, we must make disclosures to you and when required by the Secretary of the Department of Health and Human Services to investigate or determine our compliance with the requirements of Section 164.500.

You may revoke this authorization, at any time, in writing, except to the extent that your physician or the physician's practice has taken an action in reliance on the use or disclosure indicated in the authorization.

You have the right to request a restriction of your protected health information. This means you may ask us not to use or disclose any part of your protected health information for the purposes of treatment, payment or healthcare operations. You may also request that any part of your protected health information not be disclosed to family members or friends who may be involved in your care or for notification purposes as described in this Notice of Privacy Practices. Your request must state the specific restriction requested and to whom you want the restriction to apply. Your physician is not required to agree to a restriction that you may request. If the physician believes it is in your best interest to permit use and disclosure of your protected health information, your protected health information will not be restricted. You then have the right to use another Healthcare Professional.

You may complain to us or to the Secretary of Health and Human Services if you believe your privacy rights have been violated by us. You may file a complaint with us by notifying our privacy contact of your complaint. **We will not retaliate against you for filing a complaint.** We are required by law to maintain the privacy of, and provide individuals with, this notice of our legal duties and privacy practices with respect to protected health information. If you have any objections to this form, please ask to speak with our HIPAA Compliance Officer in person or by phone at our Main Phone Number.

This notice was published and becomes effective on/or before **April 14, 2003.**
You have the right to obtain a paper copy of this notice from us.

Signature below is only acknowledgement that you have received this Notice of our Privacy Practices:

Print Name:_____ Signature _____ Date_____

V: 512-892-2160 F: 512-892-7309
E: contact@stakeschiropractic.com

PATIENT AUTHORIZATION FOR RELEASE OF PHI

Patient Name _____ Date of Birth: _____

Address _____

I request and authorize _____

Address/Phone: _____

to disclose my:

- ☐ **Protected Health Information (PHI)**: PHI means information about a patient, including demographic information that may identify a patient, that relates to the patient's past, present or future physical or mental health or condition, related health care services or payment for health care services
- ☐ **Sensitive Protected Health Information (SPHI)**: SPHI means Protected Health Information that pertains to particularly sensitive information, as defined by state law, such as (i) an individual's HIV status or treatment of an individual for an HIV-related illness or AIDS, or (ii) an individual's substance abuse condition or treatment of an individual for mental illness.

I authorize disclosure of the following information from my medical record:

Note: Include a detailed description of information to be released including dates.

___ X-rays ___ MRI ___ Exams ___ Treatment records ___ Diagnostic/Lab test results
___ Other _____

Release records to:

Name: Stakes Chiropractic Center P: 512-892-2160 F: 512-892-7309
Address: 7413 Old Bee Caves Rd. Austin, TX 78735-8234
Email: contact@stakeschiropractic.com

Purpose(s) for the release:

Note: If the authorization is initiated by the individual, it is permissible to state "at the request of the individual" as the purpose.

Per patient request

I Understand that:

- Treatment will not be conditional on whether I sign this Authorization.
- This authorization will expire on ____/___/___ OR when the following event occurs:_____
- The information disclosed pursuant to this Authorization, except information protected by Federal and/or State regulations about confidentiality of drug and alcohol abuse records, HIV and Mental Health, may be subject to re-disclosure by the recipient and no longer protected by federal privacy regulations or other applicable state or federal laws.

Signature(s)

Patient signature _____ Date _____

Sign below if you are a personal representative of the patient.

Representative signature _____ Date _____

Print Name _____

Relationship to Patient _____

FOR OFFICE USE ONLY		
Verification method:	Verification By:	Date:

1500

HEALTH INSURANCE CLAIM FORM

APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE 08/05

PICA

PICA

1. MEDICARE (Medicare #)	MEDICAID (Medicaid #)	TRICARE CHAMPUS (Sponsor's SSN)	CHAMPVA (Member ID#)	GROUP HEALTH PLAN (SSN or ID)	FECA BLK LUNG (SSN)	OTHER (ID)
☐	☐	☐	☐	☐	☐	☐

1a. INSURED'S I.D. NUMBER (For Program in Item 1)

2. PATIENT'S NAME (Last Name, First Name, Middle Initial)	3. PATIENT'S BIRTH DATE MM DD YY / SEX M ☐ F ☐	4. INSURED'S NAME (Last Name, First Name, Middle Initial)
5. PATIENT'S ADDRESS (No., Street)	6. PATIENT RELATIONSHIP TO INSURED: Self ☐ Spouse ☐ Child ☐ Other ☐	7. INSURED'S ADDRESS (No., Street)
CITY / STATE	8. PATIENT STATUS: Single ☐ Married ☐ Other ☐	CITY / STATE
ZIP CODE / TELEPHONE (Include Area Code) ( )	Employed ☐ Full-Time Student ☐ Part-Time Student ☐	ZIP CODE / TELEPHONE (Include Area Code) ( )
9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)	10. IS PATIENT'S CONDITION RELATED TO:	11. INSURED'S POLICY GROUP OR FECA NUMBER
a. OTHER INSURED'S POLICY OR GROUP NUMBER	a. EMPLOYMENT? (Current or Previous) ☐ YES ☐ NO	a. INSURED'S DATE OF BIRTH MM DD YY / SEX M ☐ F ☐
b. OTHER INSURED'S DATE OF BIRTH MM DD YY / SEX M ☐ F ☐	b. AUTO ACCIDENT? ☐ YES ☐ NO PLACE (State)	b. EMPLOYER'S NAME OR SCHOOL NAME
c. EMPLOYER'S NAME OR SCHOOL NAME	c. OTHER ACCIDENT? ☐ YES ☐ NO	c. INSURANCE PLAN NAME OR PROGRAM NAME
d. INSURANCE PLAN NAME OR PROGRAM NAME	10d. RESERVED FOR LOCAL USE	d. IS THERE ANOTHER HEALTH BENEFIT PLAN? ☐ YES ☐ NO *If yes*, return to and complete item 9 a-d

READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM.

12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below.

X SIGNED _____ DATE _____

13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for services described below.

X SIGNED _____

14. DATE OF CURRENT: MM DD YY — ILLNESS (First symptom) OR INJURY (Accident) OR PREGNANCY(LMP)	15. IF PATIENT HAS HAD SAME OR SIMILAR ILLNESS. GIVE FIRST DATE MM DD YY	16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION MM DD YY FROM — TO MM DD YY
17. NAME OF REFERRING PROVIDER OR OTHER SOURCE	17a. / 17b. NPI	18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES MM DD YY FROM — TO MM DD YY
19. RESERVED FOR LOCAL USE		20. OUTSIDE LAB? ☐ YES ☐ NO $ CHARGES
21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY (Relate Items 1, 2, 3 or 4 to Item 24E by Line) 1. ____ 2. ____ 3. ____ 4. ____		22. MEDICAID RESUBMISSION CODE / ORIGINAL REF. NO.
		23. PRIOR AUTHORIZATION NUMBER

24. A. DATE(S) OF SERVICE From MM DD YY To MM DD YY	B. PLACE OF SERVICE	C. EMG	D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS / MODIFIER	E. DIAGNOSIS POINTER	F. $ CHARGES	G. DAYS OR UNITS	H. EPSDT Family Plan	I. ID. QUAL.	J. RENDERING PROVIDER ID. #
1								NPI	
2								NPI	
3								NPI	
4								NPI	
5								NPI	
6								NPI	

25. FEDERAL TAX I.D. NUMBER SSN EIN	26. PATIENT'S ACCOUNT NO.	27. ACCEPT ASSIGNMENT? (For govt. claims, see back) ☐ YES ☐ NO	28. TOTAL CHARGE $	29. AMOUNT PAID $	30. BALANCE DUE $
31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part thereof.) SIGNED DATE	32. SERVICE FACILITY LOCATION INFORMATION a. NPI b.		33. BILLING PROVIDER INFO & PH # ( ) a. NPI b.		

PATIENT AND INSURED INFORMATION

PHYSICIAN OR SUPPLIER INFORMATION

790-0129 (08-05) (OCR) 1PT.

NUCC Instruction Manual available at: www.nucc.org

APPROVED OMB-0938-0999 FORM CMS-1500 (08-05)