THOMAS CHIROPRACTIC PERSONAL INJURY QUESTIONAIRE

(PLEASE BE VERY SPECIFIC WITH YOUR ANSWERS...THANK YOU!)

Last Name_____ First Name _____ Middle _____

Home Phone_____ Work Phone _____

Street Address and Number_____

Mailing Address if Different_____

City, State, and Zip Code: _____

Age:_____ Date of Birth_____ Social Security #_____-_____-_____: E-mail:_____

Sex: **MALE FEMALE** # of Children_____ Married _____ Single_____ Widowed_____ Divorced_____

Occupation_____ Employer_____

Drivers License # _____ State _____

In Case of Emergency, Please contact: Name_____ Phone _____

Do you have an attorney representing you for your accident: **YES**_____ **NO** _____ **Who?**_____

CHIEF COMPLAINT:

Please number your symptoms (1 is the most severe) that you have developed since the accident.

___ Headaches	___ Numbness in feet **R / L Both**	___ Loss of Memory	___ Pain Behind Eyes
___ Neck Pain/Stiffness	___ Arm Weakness **R/L Both**	___ Dizziness	___ Jaw Popping
___ Leg Weakness **R/L Both**	___ Mid Back Pain	___ Sleeping Problems	___ Numbness in fingers
___ Facial Pain	___ Low Back Pain	___ Eyes Light Sensitive	___ Fainting
___ Irritability	___ Arm Pain **R / L Both**	___ Fatigue	___ Breath Shortness
___ Loss of Balance	___ Leg Pain **R / L Both**	___ Depression	___ Ringing/Buzzing
___ Cold Feet	___ Muscle Spasm/Cramping	___ Cold hands	___ Chest Pain
___ Shoulder **L or R Both**	___ Diarrhea	___ Constipation	Other_____

Which of these symptoms did you have before the Crash?#_____ **#** _____ **#**_____Are they Worse? **Yes No**

HISTORY:

1. What was the Date of the Accident? _____ Time: _____ AM/PM
2. Were you the Driver ☐ **or** Passenger ☐ **or** Pedestrian ☐
3. If you were the **passenger** where were you sitting: **FRONT, BACK DRIVER SIDE, BACK PASSENGER SIDE**
4. Cars involved in accident Year, Type, Model, and Estimated speed.
   - **Your Car** Year _____ Type _____ Model _____ Speed _____
   - **Other Car** Year _____ Type _____ Model _____ Speed _____
   - **Other Car** Year _____ Type _____ Model _____ Speed _____
6. Type of Accident: ☐ Head-on Collision ☐ Broad-side Collision ☐ Front Impact ☐ Rear-end car in front of you ☐ Rear Impact ☐ Non-collision
7. Please describe the accident in your own words! (Be very specific!!) _____

_____

_____

_____

8. Head/Body position at time of impact:
   - ☐ Head turned left ☐ Head turned right ☐ Body straight in sitting position
   - ☐ Head looking back ☐ Body rotated right ☐ Body rotated left
   - ☐ Head straight forward ☐ Other: _____
9. Were you wearing your seat belt? ☐ YES ☐ NO
10. Did you see the accident coming? ☐ YES ☐ NO
11. Did you brace yourself for impact? ☐ YES ☐ NO
12. Upon impact, do you recall striking any objects inside of the car? ☐ Yes ☐ No
    If yes, what objects did you strike? _____
13. Since the accident, are conditions becoming: ☐ BETTER ☐ WORSE ☐ SAME
14. Describe your symptoms: ☐ CONSTANT ☐ COMES & GOES
15. Please describe what symptoms you felt:
    - Immediately after the accident: _____
    - Later that day: _____
    - The next day: _____
16. Have your symptoms persisted since the point of impact ? ☐ Yes ☐ No
17. Did the EMS arrive at the scene? ☐ Yes ☐ No
    - If yes, were you treated by them? ☐ Yes ☐ No
    - Did the EMS take you to the hospital? ☐ Yes ☐ No ☐ Other: _____
    - Did you go to the hospital on your own? ☐ Yes ☐ No

18. Who was the 1st Doctor that treated you?
Name: _____
Date seen: _____
Were you examined? ☐ Yes ☐ No
Were X-rays taken? ☐ Yes ☐ No Were you: ☐ Sitting or ☐ Standing
Did you receive treatment? ☐ Yes ☐ No ☐ Medications ☐ Braces ☐ Collars
If yes, what kind of treatment did you receive? _____
What benefits did you receive from the treatment? _____
19. What relieves your symptoms? _____
20. What aggravates your symptoms? _____
21. Road conditions at time of accident: ☐ Icy ☐ Rainy ☐ Wet ☐ Clear ☐ Dark ☐ Other (describe): _____
22. Visibility at the time of the accident? ☐ Poor ☐ Fair ☐ Good ☐ Other: _____
23. Where was your car struck? _____
24. Were you wearing a hat or glasses? ☐ Yes ☐ No
If yes, where were they located after the accident? _____
25. Did you get any bleeding cuts? ☐ Yes ☐ No If yes, where? _____
26. Did you get any bruises? ☐ Yes ☐ No If yes, where? _____
27. As a result of the accident you were: ☐ Rendered unconscious ☐ In shock ☐ Dazed, circumstances vague ☐ Other: _____
28. Do you have an attorney representing you for this claim? ☐ Yes ☐ No
If yes, who? _____

PAST MEDICAL HISTORY:

29. Do you have any prior history of any of the symptoms you checked above? ☐ Yes ☐ No If yes explain: _____
_____
30. Have you ever had any prior automobile accidents or ever had any serious falls/injuries? If yes, please give dates and treatments:

_____
31. What Medications are you currently taking? _____
Taken in last 6 months? _____
32. Have you ever had any surgeries or been hospitalized overnight? If yes, please give details: _____
_____
33. Are you currently under the care of any other doctors for any Health related concerns? If yes, please describe. _____
_____
34. Have you ever seen a Chiropractor before? If yes, then who, where & what treated for? _____
_____

FAMILY HISTORY:

35. Place a (X) if any family member has suffered from:

☐ Tuberculosis	☐ Kidney Disease	☐ Spinal Disorder
☐ Mental Illness	☐ Epilepsy	☐ Diabetes
☐ Gout	☐ Allergy	☐ Arthritis
☐ High Blood Pressure	☐ Cancer	☐ Migraines
☐ Heart Attacks	☐ Other, list: _____	

36. Who is your family physician for regular check-ups? _____
Date last seen? _____ What treatment? _____

37. Are you pregnant? ☐ YES ☐ NO

SIGNATURE OF PATIENT: _____ DATE: _____

For re-ordering information, contact:
ACTIVATOR METHODS, INC., P.O. Box 80317, Phoenix, AZ 85060-0317
Phone: (602) 224-0220; Facsimile (602) 224-0230

NECK PAIN DISABILITY INDEX QUESTIONNAIRE

NAME (Please Print): _____ DATE: _____

AGE: _____ DATE OF BIRTH: _____ OCCUPATION: _____

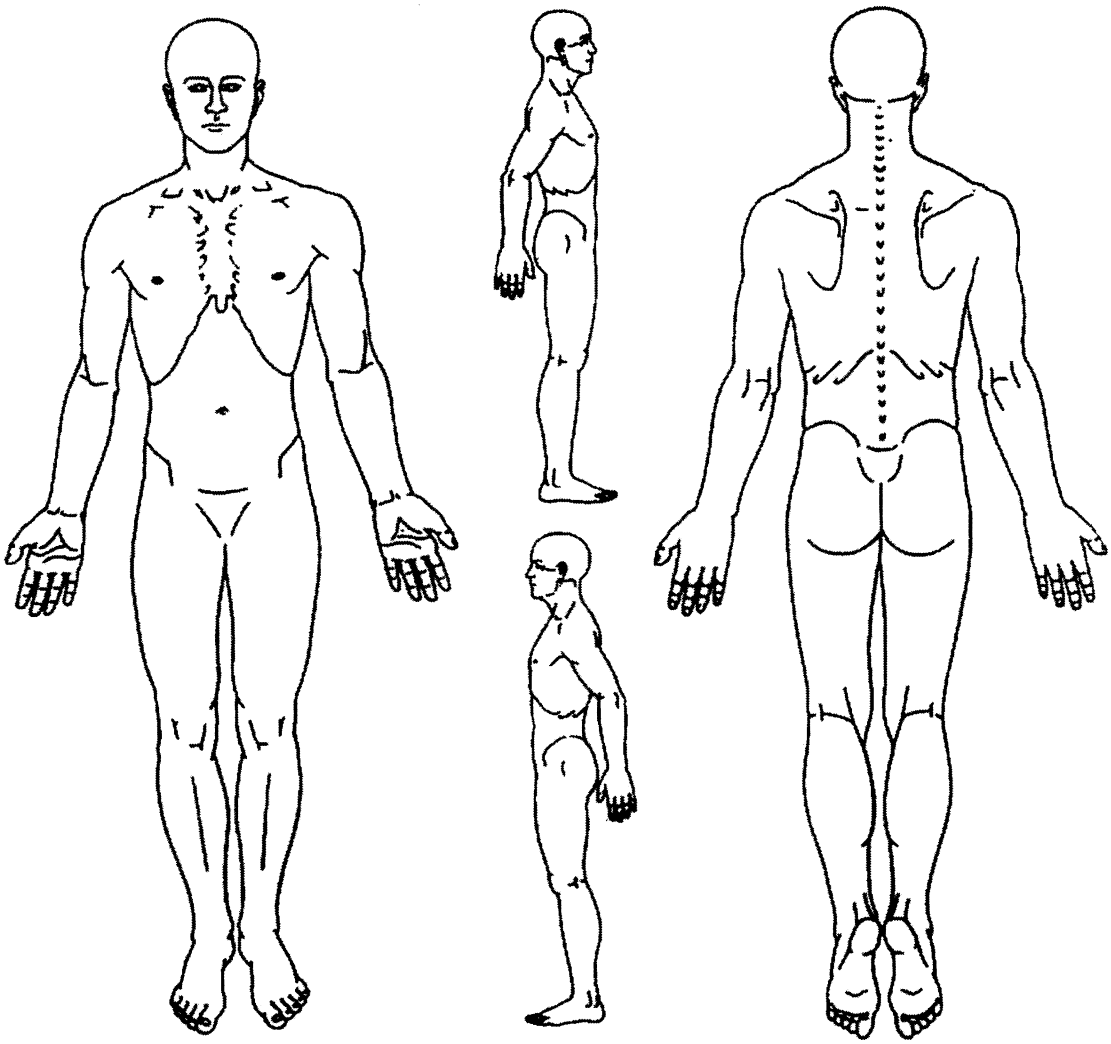
HOW LONG HAVE YOU HAD NECK PAIN? ___YEARS ___MONTHS ___WEEKS

IS THIS YOUR FIRST EPISODE OF NECK PAIN? ___YES ___NO

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

(Please remember to complete both sides of this form.)

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



OVER PLEASE

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Phone: (602) 224-0220; Facsimile (602) 224-0230

NECK PAIN DISABILITY INDEX QUESTIONNAIRE

Please Read: This questionnaire is designed to enable us to understand how much your neck pain has affected your ability to manage your everyday activities. Please answer each section by circling the **ONE CHOICE** that most applies to you. We realize that you may feel that more than one statement may relate to you, but **PLEASE, JUST CIRCLE THE ONE CHOICE WHICH MOST CLOSELY DESCRIBES YOUR PROBLEM RIGHT NOW.**

Section 1 — Pain Intensity

A I have no pain at the moment.
B The pain is very mild at the moment.
C The pain is moderate at the moment.
D The pain is fairly severe at the moment.
E The pain is very severe at the moment.
F The pain is the worst imaginable at the moment.

Section 2 — Personal Care (Washing, Dressing, etc.)

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

Section 3 — Lifting

A I can lift heavy weights, without extra pain.
B I can lift heavy weights, but it gives extra pain.
C Pain prevents me from lifting heavy weights off the floor, but I can manage if they are conveniently positioned, for example, on a table.
D Pain prevents me from lifting heavy weights, but I can manage light to medium weights if they are conveniently positioned.
E I can lift very light weights.
F I cannot lift or carry anything at all.

Section 4 — Reading

A I can read as much as I want to with no pain in my neck.
B I can read as much as I want to with slight pain in my neck.
C I can read as much as I want with moderate pain in my neck.
D I cannot read as much as I want because of moderate pain in my neck.
E I cannot read as much as I want because of severe pain in my neck.
F I cannot read at all.

Section 5 — Headaches

A I have no headaches at all.
B I have slight headaches which come infrequently.
C I have moderate headaches which come infrequently.
D I have moderate headaches which come frequently.
E I have severe headaches which come frequently.
F I have headaches almost all the time.

After Vernon & Mior, 1991
Reprinted by permission of the Journal of Manipulative and Physiological Therapeutics

Section 6 — Concentration

A I can concentrate fully when I want to with no difficulty.
B I can concentrate fully when I want to with slight difficulty.
C I have a fair degree of difficulty in concentrating when I want to.
D I have a lot of difficulty in concentrating when I want to.
E I have a great deal of difficulty in concentrating when I want to.
F I cannot concentrate at all.

Section 7 — Work

A I can do as much work as I want to.
B I can only do my usual work, but no more.
C I can do most of my usual work, but no more.
D I cannot do my usual work.
E I can hardly do any work at all.
F I cannot do any work at all.

Section 8 — Driving

A I can drive my car without any neck pain.
B I can drive my car as long as I want with slight pain in my neck.
C I can drive my car as long as I want with moderate pain in my neck.
D I cannot drive my car as long as I want because of moderate pain in my neck.
E I can hardly drive at all because of severe pain in my neck.
F I cannot drive my car at all.

Section 9 — Sleeping

A I have no trouble sleeping.
B My sleep is slightly disturbed (less than 1 hour sleepless).
C My sleep is mildly disturbed (1-2 hours sleepless).
D My sleep is moderately disturbed (2-3 hours sleepless).
E My sleep is greatly disturbed (3-5 hours sleepless).
F My sleep is completely disturbed (5-7 hours sleepless).

Section 10 — Recreation

A I am able to engage in all of my recreational activities, with no neck pain at all.
B I am able to engage in all of my recreational activities, with some pain in my neck.
C I am able to engage in most, but not all of my usual recreational activities because of pain in my neck.
D I am able to engage in a few of my usual recreational activities because of pain in my neck.
E I can hardly do any recreational activities because of pain in my neck.
F I cannot do any recreational activities at all.

REVISED January 1, 1995

Comments: _____

_____

Patient Signature: _____ Date: _____

ACTIVATOR METHODS, INC., P.O. Box 80317, Phoenix, AZ 85060-0317
(602) 224-0220 Fax: (602) 224-0230

REVISED OSWESTRY CHRONIC LOW BACK PAIN DISABILITY QUESTIONNAIRE

NAME (Please Print): _____ DATE: _____

AGE: _____ DATE OF BIRTH: _____ OCCUPATION: _____

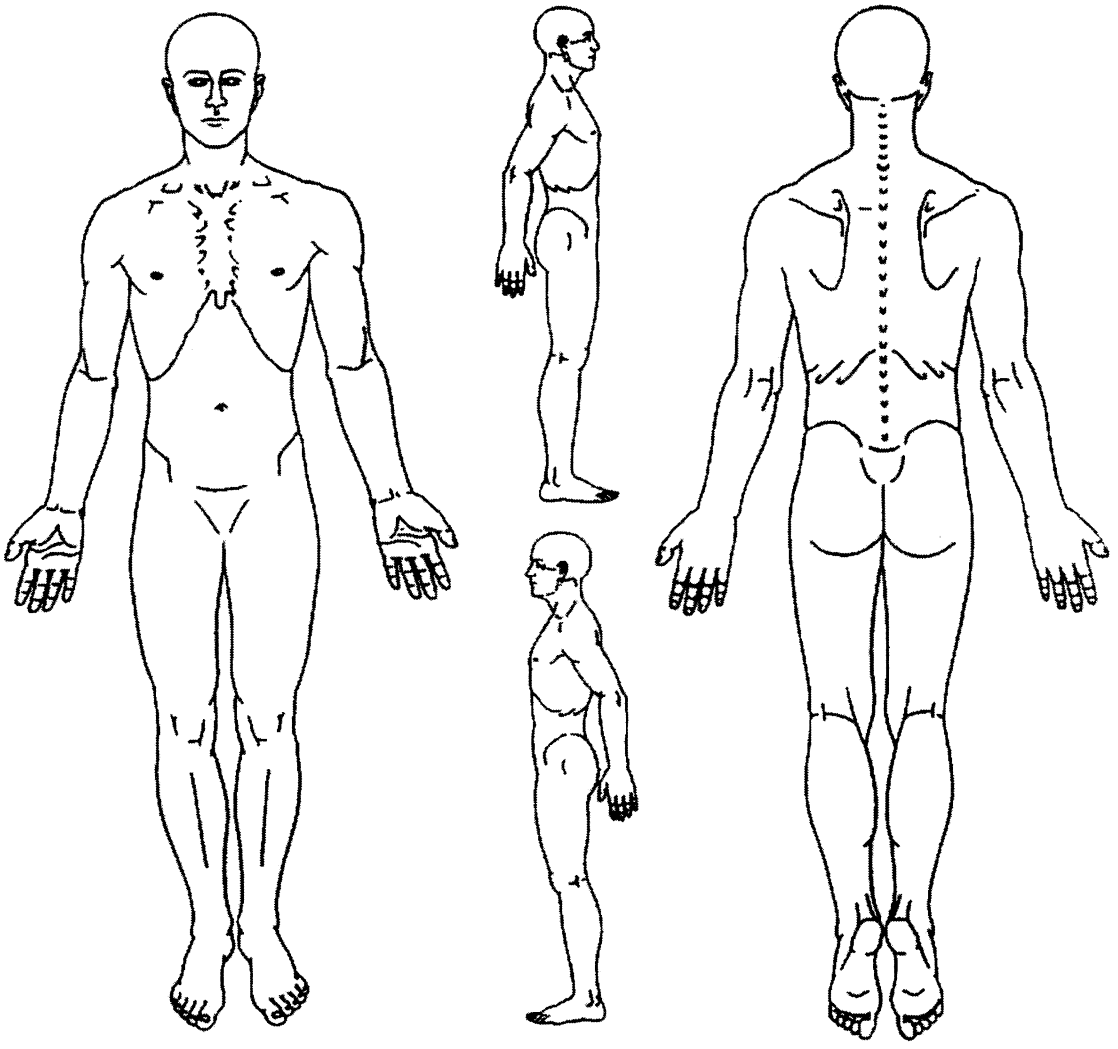
HOW LONG HAVE YOU HAD LOW BACK PAIN? ___YEARS ___MONTHS ___WEEKS

IS THIS YOUR FIRST EPISODE OF LOW BACK PAIN? ___YES ___NO

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

(Please remember to complete both sides of this form.)

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



OVER PLEASE

REVISED OSWESTRY CHRONIC LOW BACK PAIN DISABILITY QUESTIONNAIRE

Please Read: This questionnaire is designed to enable us to understand how much your low back pain has affected your ability to manage your everyday activities. Please answer each section by circling the **ONE CHOICE** that most applies to you. We realize that you may feel that more than one statement may relate to you, but **PLEASE JUST CIRCLE THE ONE CHOICE WHICH MOST CLOSELY DESCRIBES YOUR PROBLEM RIGHT NOW.**

SECTION 1 -- Pain Intensity

A The pain comes and goes and is very mild.
B The pain is mild and does not vary much.
C The pain comes and goes and is moderate.
D The pain is moderate and does not vary much.
E The pain comes and goes and is severe.
F The pain is severe and does not vary much.

SECTION 2 -- Personal Care

A I would not have to change my way of washing or dressing in order to avoid pain.
B I do not normally change my way of washing or dressing even though it causes some pain.
C Washing and dressing increases the pain, but I manage not to change my way of doing it.
D Washing and dressing increases the pain and I find it necessary to change my way of doing it.
E Because of the pain, I am unable to do some washing and dressing without help.
F Because of the pain, I am unable to do any washing or dressing without help.

SECTION 3 -- Lifting

A I can lift heavy weights without extra pain.
B I can lift heavy weights, but it causes extra pain.
C Pain prevents me from lifting heavy weights off the floor.
D Pain prevents me from lifting heavy weights off the floor, but I can manage if they are conveniently positioned, e.g., on a table.
E Pain prevents me from lifting heavy weights, but I can manage light to medium weights if they are conveniently positioned.
F I can only lift very light weights, at the most.

SECTION 4 -- Walking

A Pain does not prevent me from walking any distance.
B Pain prevents me from walking more than one mile.
C Pain prevents me from walking more than 1/2 mile.
D Pain prevents me from walking more than 1/4 mile.
E I can only walk while using a cane or on crutches.
F I am in bed most of the time and have to crawl to the toilet.

SECTION 5 -- Sitting

A I can sit in any chair as long as I like without pain.
B I can only sit in my favorite chair as long as I like.
C Pain prevents me from sitting more than one hour.
D Pain prevents me from sitting more than 1/2 hour.
E Pain prevents me from sitting more than ten minutes.
F Pain prevents me from sitting at all.

From: N. Hudson, K. Tome-Nicholson, A. Breen; 1989

REVISED 9/11/92

SECTION 6 -- Standing

A I can stand as long as I want without pain.
B I have some pain while standing, but it does not increase with time.
C I cannot stand for longer than one hour without increasing pain.
D I cannot stand for longer than 1/2 hour without increasing pain.
E I cannot stand for longer than ten minutes without increasing pain.
F I avoid standing, because it increases the pain straight away.

SECTION 7 -- Sleeping

A I get no pain in bed.
B I get pain in bed, but it does not prevent me from sleeping well.
C Because of pain, my normal night's sleep is reduced by less than one-quarter.
D Because of pain, my normal night's sleep is reduced by less than one-half.
E Because of pain, my normal night's sleep is reduced by less than three-quarters.
F Pain prevents me from sleeping at all.

SECTION 8 -- Social Life

A My social life is normal and gives me no pain.
B My social life is normal, but increases the degree of my pain.
C Pain has no significant effect on my social life apart from limiting my more energetic interests, e.g., dancing, etc.
D Pain has restricted my social life and I do not go out very often.
E Pain has restricted my social life to my home.
F I have hardly any social life because of the pain.

SECTION 9 -- Traveling

A I get no pain while traveling.
B I get some pain while traveling, but none of my usual forms of travel make it any worse.
C I get extra pain while traveling, but it does not compel me to seek alternative forms of travel.
D I get extra pain while traveling which compels me to seek alternative forms of travel.
E Pain restricts all forms of travel.
F Pain prevents all forms of travel except that done lying down.

SECTION 10 -- Changing Degree of Pain

A My pain is rapidly getting better.
B My pain fluctuates, but overall is definitely getting better.
C My pain seems to be getting better, but improvement is slow at present.
D My pain is neither getting better nor worse.
E My pain is gradually worsening.
F My pain is rapidly worsening.

Comments: _____

Patient Signature: _____ Date: _____

Patient Name _____ **Date** _____

Payment/Insurance Information:

Who is responsible for your bill? Self Health Insurance Spouse Worker's Comp
Auto Insur. Medicare Medicaid Other _____

Personal Health Insurance Carrier: _____ Insur. Card ID # _____

Policy Holder's Name: _____ Group # _____

Policy Holder's Date of Birth _____ / _____ / _____ Primary Care Physician _____

Worker's Compensation Injury / Auto / Personal Injury:

Have you filed an injury report with your employer? Yes No Date: ____/____/____ Time: _____am / pm

HIPAA Privacy Practices

I acknowledge that I have received and /or have been given the opportunity to review this Chiropractic Office's Notice of HIPAA Privacy Practices for protected health information.

Print Patient's Name _____

Patient's Signature _____
Date_____

Consent to Treat a Minor: (Minor's Printed Name) _____

Guardian / Spouse's Signature Authorizing Care _____
Date_____

SIGNATURE OF PHYSICIAN: _____**Date:** _____

OUR OFFICE POLICY'S

RE: PERSONAL INJURY

If you have been involved in an auto accident, or related injury, and have insurance that covers medical expenses at 100% or an attorney\attorneys representing you, we will gladly accept your case with the following regulations:

1. If you have an attorney, notify us as soon as possible and ask him, or her to send us a letter of representation. All bills will be sent to the attorney for you. It is our policy to have this information within 5 working days from your initial presentation to our office.
2. If you do not have an attorney you will need to ask the insurance adjuster handling your claim to contact our office and provide all information for billing the insurance company. NO BILLS, OR COPIES OF BILLS WILL BE GIVEN TO YOU OR THE INSURANCE COMPANY UNTIL YOUR ADJUSTER HAS CALLED US AND GIVEN AN INDICATION THAT THEY WILL DO EVERYTHING POSSIBLE TO PROTECT THE DOCTOR'S INTEREST.

Once your case has been settled and all Chiropractic bills have been paid, if an overpayment exists on your account (due to having more than one insurance) we will forward that overpayment to you.

By signing below I am stating that I have read the above and do understand I will not be presented with copies of bills until the proper procedures have been followed.

X_____

Patients Initials:

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

I understand and have provided with a *notice of information practices* that provides a more complete description of information uses and disclosures. I understand that I have the following and privileges:

- The right to review the notice prior to signing this consent
- The right to object to the use of my health information for directory purposes, and
- The right to request restrictions as to how my health information may be used or disclosed to carry out treatment, payment, or health care operations

X_____

Patients Initials

Appointment Reminders and Health Care Information Authorization

Your chiropractor and members of the practice staff may need to use your name, address, phone number, and your clinical records to contact you with appointment reminders, information about treatment alternatives, or other health related information that may be of interest to you. If this contract is made by phone and you are not home, a message will be left on your answering machine. By signing this form, you are giving us authorization to contact you with these reminders and information.

You may restrict the individuals or organizations to which your health care information is released or you may revoke your authorization to us at any time; however, your revocation must be in writing and mailed to us at our office address. We will not be able to honor your revocation request if we have already released your health information before we receive your request to revoke your authorization. In addition, if you were required to give your authorization as a condition of obtaining insurance, the insurance company may have a right to your health information if they decide to contest any of your claims.

Information that we use or disclose based on the authorization you are giving us may be subject to re-disclosure by anyone who has access to the reminder or other information and may no longer be protected by the federal privacy rules.

You have the right to refuse to give us this authorization. If you do not give us authorization, it will not affect the treatment we provide to you or the methods we use to obtain reimbursement for your care.

You may inspect or copy the information that we use to contact you to provide appointment reminders, information about treatment alternatives, or other health related information at any time (164.524).

This notice is effective as of April 14, 2003. This authorization will expire seven years after the date on which you have received services from us.

I authorize you to use or disclose my health information in the manner described above. I am acknowledging that I have received a copy of this authorization.

_____ _____

Patients Printed Name Date

X_____

Patient Signature

INFORMED CONSENT FORM

PATIENT NAME: _____ DATE: _____

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

The nature of the chiropractic adjustment

The primary treatment I use as a Doctor 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:

_✓_ spinal manipulative therapy	_✓_ palpation	_✓_ vital signs
_✓_ range of motion testing	_✓_ orthopedic testing	_✓_ basic neurological testing
_✓_ muscle strength testing	_✓_ postural analysis	
_✓_ ultrasound	_✓_ hot/cold therapy	_✓_ Electrical Stim
_✓_ radiographic studies	_✓_ mechanical traction	

___ Other (please explain)

_____

_____

_____

The material 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. I 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 my attention, it is your responsibility to inform me.

The probability of those risks occurring.

Fractures are rare occurrences and generally result from some underlying weakness of the bone which I check for during the taking of your history and during examination and X-ray. Stroke has been the subject of tremendous disagreement. The incidences of stroke are exceedingly rare and are estimated to occur between one in one million and one in five million cervical adjustments. The other complications are also generally described as rare.

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 have had read to me [ ] the above explanation of the chiropractic adjustment and related treatment. I have discussed it with *Dr. Richard Thomas* 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.

Dated: _____

_____

Patient's Name

_____

Signature

_____

Signature of Parent or Guardian (if a minor)

Dated: _____

_____

Doctor's Name

_____

Signature