Healing Hands Chiropractic

PERSONAL INJURY PATIENT HISTORY

Date: _____ Social Security #_____

Name: _____
Last First M.I

Address_____

E-mail (please provide for communication purposes) _____

Cell Phone:_____ Home Phone: _____

Sex: _____Male _____ Female Age:_____ Birthdate:_____

___Married ____Separated ____Widowed ____Divorced ____Single ____Partnered for ___Yrs ____Minor

Preferred method of communication: (Check one) Email___ Text___ + Carrier Name _____

Preferred Language: _____ Ethnicity (Circle): Hispanic or Latino / Not Hispanic or Latino/ Decline

Race (Circle): American Indian or Alaska Native / Asian / Black or African American / White (Caucasian) /
Native Hawaiian or Pacific Islander / Other / I Decline to Answer

Patient Employer/School _____

Address:_____

Phone: _____ Occupation:_____

Spouse's Name:_____ SS#_____ - _____ - _____ Phone:_____

Birthdate:_____ Spouse's Employer: _____

Emergency Contact:_____ Relationship:_____ Phone_____

Insurance Company:_____ **Claim Number:** _____

Adjuster's Name:_____ **Insurance Phone #:**_____

1. Date of Accident: _____ 2. Time:_____ AM/PM
2. Driver of Car: _____
3. Where were you seated? _____
4. Who owns the car? _____
5. Year & Model of your car. _____

   Year & Model of the **other car**: _____
6. What was the approximate damage done to your car? $_____
7. Visibility at time of accident: ☐ Poor ☐ Fair ☐ Good ☐ Other: _____
8. Road Conditions at time of accident: ☐ Icy ☐Rainy ☐Wet ☐Clear ☐Dark

   Other (describe): _____

9. Where was your car struck?

In your own words, please describe the accident: _____

_____

_____

10. Type of Accident: □Head-on Collision □Broad-side Collision □Front Impact
□Rear-end car in front □Rear Impact □Non- collision

11. At the time of the accident, recall what parts of your head or body hit what parts on the inside of your car: _____

12. Did you see the accident coming? □ Yes □ No

13. Did you brace for impact? □ Yes □ No

14. Were seatbelts worn? □ Yes □ No

15. Were shoulder harnesses worn? □ Yes □ No

16. Does your car have headrests? □ Yes □ No

17. If yes, what was the position of those headrests compared to your head before the accident?

□ Top of headrest even with **bottom** of head

□ Top of headrest even with **top** of head

□ Top of headrest even with **middle** of neck

18. Was your car braking? □ Yes □ No

19. Was your car moving at the time of the accident? □ Yes □ No

20. If yes, how fast would you estimate you were going? _____ mph

21. How fast would you estimate the other car was going? _____ mph

22. Head/ Body position at the time of impact:

□ Head turned left/right □ Body straight in sitting position

□ Head looking back □ Body rotated right/left

□ Head straight forward □ Other:_____

23. As a result of the accident you were: □ Rendered unconscious □ In shock

□ Dazed, circumstances vague □ Other: _____

24. How was the shoulder harness adjusted? □Loose □ Snug

Did your vehicle have airbags? □ Yes □ No Where? _____

Did your airbags deploy? □ Yes □ No

25. Were you wearing a hat or glasses? □ Yes □ No

26. Could you move all parts of your body? □ Yes □ No

27. If no, what parts couldn't you move and why?

_____

28. Were you able to get out of the car and walk unaided? □ Yes □ No

29. If no, why not? _____

30. Did you get any bleeding cuts? □ Yes □ No If yes, where? _____

31. Did you get any bruises? □ Yes □ No If yes, where? _____

32. Please describe how you felt:

Immediately after the accident: _____

Later that day: _____

The **next** day: _____

33. Check symptoms apparent since the accident:

□ Headache	□ Neck pain/ Stiffness	□ Mid back pain
□ Eyes Light Sensitive	□ Pain Behind Eyes	□ Dizziness
□ Fainting	□ Sleeping problems	□ Numbness in Fingers
□ Numbness in toes	□ Loss of smell	□ Loss of taste
□ Loss of memory	□ Fatigue	□ Breath shortness
□ Irritability	□ Depression	□Ringing/ Buzzing
□ Loss of Balance	□ Tension	□ Cold hands
□ Cold feet	□ Diarrhea	□ constipation
□ Chest pain	□ Nervousness	□ Cold Sweats
□ Anxious	□ Facial pain	□ Clicking or popping jaw
□ Low back pain	□ Other: _____	

_____

34. Occupation: _____

35. Employer: _____

36. Have you missed **any** time from work: □ Yes □ No

37. If yes, full time off work: _____ to _____

38. If yes, part time off work: _____ to _____

39. Did you seek **any** medical help immediately after the accident? □ Yes □ No

40. If yes, how did you get there? □ Ambulance □ Police

□ Someone else drove me □ Drove own car □ Other: _____

41. Doctor #1 / Hospital Name: _____

42. First Visit Date: _____

43. Were you examined? □ Yes □ No **Admitted?** □ Yes □ No

44. Were X-rays taken? □ Yes □ No **Other tests:** _____

45. Did you receive treatment? □ Yes □ No □ Medications □ Braces □ Collars

46. If yes, what kind of treatment did you receive? _____

47. What benefits did you receive from the treatment? _____

48. Date of last treatment: _____

49. Doctor #2 / Office Name: _____

50. First Visit Date: _____

51. Were you examined? □ Yes □ No

52. Were X-rays taken? □ Yes □ No

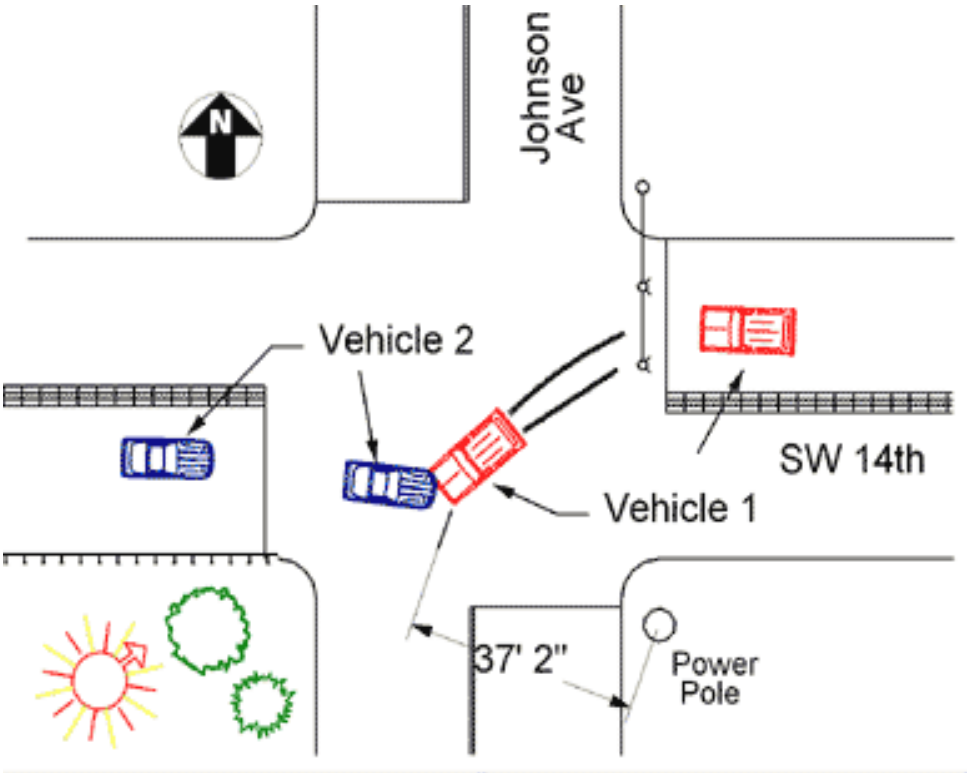
53. Did you receive treatment? □ Yes □ No

54. If yes, what kind of treatment did you receive? _____

Please diagram the accident below. **When you do please remember to draw in all streets, traffic lights and traffic signs. If you can label the names of the roads or pertinent landmarks. Please label which car is yours, and if there were other cars that had to avoid the accident or caused the accident please diagram those as well. Make sure it is easy to identify the direction your car was traveling at the time of the accident with motion arrows.**

(See an excellent and detailed diagram at the bottom of the page.)

Example:



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 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 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 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 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 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 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 to 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 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)**
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.**	***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 recreational activities because of pain in my neck.** **D I am able to engage in a few of my 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.**

COMMENTS: _____

_____

_____

_____

NAME: _____ **DATE:** _____ **SCORE:** _____

REVISED OSWESTRY LOW BACK PAIN DISABILITY QUESTIONNAIRE v.C-2

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 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 minute without increasing pain.** **F I avoid standing, because it increases the pain straight away.**
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 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 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 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, eg. 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 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, My 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 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 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 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.**	***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: _____

_____

_____

NAME: _____ **DATE:** _____ **SCORE:** _____

Fairbank J, Davies J, et al. The Oswestry Low Back Pain Disability Questionnaire. Physiother 1980; 66(18): 271-273.

PAIN LOCATION

Please mark off *ALL the current areas* of your complaint(s) on the diagrams above. Please use the following symbols on the pain diagram to accurately describe your condition.

PPP	**Where you experience Pain**
NNN	**Where you experience Numbness**
TTT	**Where you experience Tingling**
BBB	**Where you experience Burning**
CCC	**Where you experience Cramping**

Please place an "X" on the line below relating to where you condition exists today.

NO Pain/Numb/etc. Pain/Numb/Tingle
All Activities OK |----------| Activity Difficulty
Best Ever Felt **Worst Ever Felt**

Office use only: VAS=____

PATIENT SIGNITURE_____ DATE_____

The Rivermead Post-Concussion Symptoms Questionnaire*

After a head injury or accident some people experience symptoms which can cause worry or nuisance. We would like to know if you now suffer from any of the symptoms given below. As many of these symptoms occur normally, we would like you to compare yourself now with before the accident. For each one, please circle the number closest to your answer.

0 = Not experienced at all
1 = No more of a problem
2 = A mild problem
3 = A moderate problem
4 = A severe problem

Compared with before the accident, do you now (i.e., over the last 24 hours) suffer from:

Headaches.....	0	1	2	3	4	
Feelings of Dizziness	0	1	2	3	4	
Nausea and/or Vomiting	0	1	2	3	4	
Noise Sensitivity,						
easily upset by loud noise	0	1	2	3	4	
Sleep Disturbance	0	1	2	3	4	
Fatigue, tiring more easily	0	1	2	3	4	
Being Irritable, easily angered	0	1	2	3	4	
Feeling Depressed or Tearful	0	1	2	3	4	
Feeling Frustrated or Impatient		0	1	2	3	4
Forgetfulness, poor memory	0	1	2	3	4	
Poor Concentration	0	1	2	3	4	
Taking Longer to Think	0	1	2	3	4	
Blurred Vision	0	1	2	3	4	
Light Sensitivity,						
Easily upset by bright light	0	1	2	3	4	
Double Vision	0	1	2	3	4	
Restlessness	0	1	2	3	4	

Are you experiencing any other difficulties?

1. _____	0	1	2	3	4
2. _____	0	1	2	3	4
3. _____	0	1	2	3	4

*King, N., Crawford, S., Wenden, F., Moss, N., and Wade, D. (1995) J. Neurology 242: 587-592

06/23/08

INFORMED CONSENT

DOCTOR-PATIENT RELATIONSHIP IN CHIROPRACTIC

CHIROPRACTIC

It is important to acknowledge the difference between the health care specialties of chiropractic, osteopathy and medicine. Chiropractic health care seeks to restore health through natural means without the use of medicine or surgery. This gives the body maximum opportunity to utilize its inherent recuperative powers. The success of the chiropractic doctor's procedures often depends on environment, underlying causes, physical and spinal conditions. It is important to understand what to expect from chiropractic health care services.

ANALYSIS & DIAGNOSIS

A doctor of chiropractic conducts a clinical analysis to determine if you are a chiropractic candidate. If it is determined you are a chiropractic candidate, chiropractic adjustments and ancillary procedures may be given in an attempt to restore spinal integrity. It is the chiropractic premise that spinal alignment allows nerve transmission throughout the body and gives the body an opportunity to use its inherent recuperative powers. Due to the complexities of nature, no doctor can promise you specific results. This depends on the inherent recuperative powers of the body.

INFORMED CONSENT FOR CHIROPRACTIC CARE

A patient, in coming to the doctor of chiropractic, gives the doctor permission and authority to care for the patient in accordance with the chiropractic tests, diagnosis and analysis. The chiropractic adjustment or other clinical procedures are usually beneficial and seldom cause any problem, in rare cases, underlying physical defects, deformities or pathologies may render the patient susceptible to injury. The doctor, of course, will not be giving chiropractic adjustment, or health care, if he/she is aware that such care may be contraindicated. The doctor of chiropractic provides specialized, non-duplicating health service. The doctor of chiropractic is licensed in a special practice and is available to work with other types of providers in your health care regime.

RESULTS

The purpose of chiropractic services is to promote natural health through the reduction of the VSS or VSC. Since there are so many variables, it is difficult to predict the time schedule or efficacy of the chiropractic procedures. Sometimes the response is phenomenal.

In most cases there is a more gradual, but quite satisfactory response. Occasionally, the results are less than expected. Two or more similar conditions may respond differently to the same chiropractic care. Many medical failures find quick relief through chiropractic. In turn, we must admit that conditions which do not respond to chiropractic care may come under the control or be helped through medical science. The fact is that the science of chiropractic and medicine may never be so exact as to provide definite answers to all problems. Both have made great strides in alleviating pain and controlling disease.

TO THE PATIENT

Please discus any questions or problems with the doctor before signing this statement of policy.
I have read, and understand the foregoing.

_____ _____

Signature Date