# Patient Introduction Case #____________________ Date: ____/____/____

**Fees payable when services are rendered unless other arrangements are made. We are required to maintain original x-rays and records as property of this clinic. I agreed to pay interest on the amount owing until paid and collection costs including a reasonable attorney's fee.** **Signature**_______________________________________________

## Personal Information

Full Name_______________________________________________ Email______________________________

Address_______________________________________________ City______________ State__________ Zip___________

Home Phone (   )_____________ Cell Phone (   )_____________ Occupation ________________________________

Sex ☐ M ☐ F Marital Status ☐ S ☐ M ☐ D ☐ W Age_________ Birthday ___/___/___ SS#______________________

How Did You Hear About Our Clinic?______________________________________________________________

Name Of Person Responsible For Account__________________________________ Method Of Payment______________________

Emergency Contact Name_______________________________________________ Phone (     )__________________________

## Present Complaint

Briefly Describe Symptoms__________________________________________________________________

______________________________________________________________________________________

______________________________________________________________________________________

Other Doctors Seen For This Condition______________________________ Treatment Rendered______________________________

Are You Taking Any Medication? ☐ Yes ☐ No What Kind?____________________________________________

List Physicians Seen Within The Last Year | For What Condition(s)

______________________________________ | ______________________________________

______________________________________ | ______________________________________

Woman Only:

Are you Pregnant? ☐ No ☐ Yes Date of Last Menstrual Period ____/____/____

## Insurance Information

Relationship to Insured: ☐ Self ☐ Spouse ☐ Child ☐ Other

If insured is self, complete any information not listed above.

If insured is someone other than yourself, please complete all information below

| | |
|---|---|
| Insured's Full Name | Insured's Date of Birth / / |
| Address City | State Zip |
| Home Phone (     ) | SS# |
| Attorney Name | Phone (     ) |
| Insurance Company | Phone (     ) |
| Group # | Insured's ID# |
| Employed By | Phone (     ) |
| Address City | State Zip |
| Additional Insurance Company | Phone (     ) |
| Relationship to Insured ☐ Self ☐ Spouse ☐ Child ☐ Other | |
| Insured's Full Name | Insured's Date of Birth / / |
| Employed By | Phone (     ) |
| Insured's SS# | Policy # |

# Auto Accident Information

**Patient's Name____________________ Today's Date__________**
**Date of Accident:_________________ Time of Accident:____________**

**Please Describe How the Accident Happened (include just before the accident also):**

________________________________________________________________________________________
________________________________________________________________________________________
________________________________________________________________________________________

***My vehicle was:***

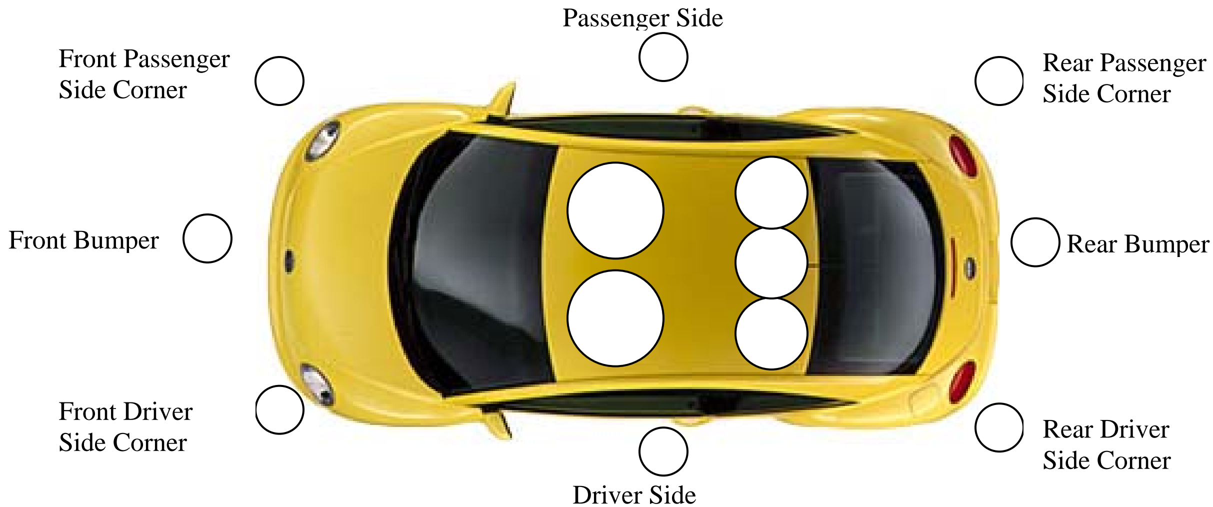
☐ **At a Traffic Light** ☐ **At a stop sign going straight** ☐ **Making a Right/Left Turn**
☐ **Entering Traffic from a side street/Driveway** ☐ **Other: (Explain)**

**I was traveling at ___ MPH** **The other vehicle was traveling at ___ MPH**

***The Other Vehicle:***

☐ **Hit me in the rear** ☐ **Ran a light** ☐ **Making a Right/Left Turn**
☐ **Entering Traffic from a side street/Driveway** ☐ **Ran across my lane** ☐ **Other: (Explain)**

**Mark with "X" where you were sitting – and then fill in the bubble where your vehicle was hit:**




**I was the Driver/Passenger involved in the accident in (City) ___________ (State)_____**
**I was sitting in the:** ☐ **Middle Front Seat** ☐ **Right Front Seat** ☐ **Left Rear Seat** ☐ **Middle Rear Seat** ☐ **Right Rear Seat**
**I was a pedestrian in an accident in (City) ______________________ (State)_________**

**I was a pedestrian:** ☐ **Standing** ☐ **Sitting** ☐ **Riding a bike** ☐ **Walking** ☐ **Other**

**Auto Accident Information**

**The vehicle I was traveling in was: Year_____ Make _________________ Model___________**

**The other vehicle in the accident was: Year_____ Make _________________ Model___________**

**Your transmission was: ☐ Manual ☐ Automatic**

**Road conditions were: ☐ Dry ☐ Damp ☐ Wet ☐ Dark ☐ Clear ☐ Raining**

**Visibility was: ☐ Poor ☐ Fair ☐ Good**

**The road was made of: ☐ Concrete ☐ Asphalt ☐ Gravel ☐ Dirt ☐ Other ___________**

**Did your car have a head rest: ☐ Yes ☐ No**

**If your car had a head rest, What position was it in: ☐ Up ☐ Middle ☐ Down**

**Were you: Wearing your seatbelt: ☐ Yes ☐ No Wearing your harness: ☐ Yes ☐ No**

**Did your airbag deploy: ☐ Yes ☐ No**

**At the time of the accident my head was looking:**

**☐ Left ☐ Right ☐ Straight ☐ Down ☐ Up ☐Other____________________**

**Were your brakes applied at the time of the impact: ☐ Yes ☐ No**

**My elbows were: ☐ Left ☐ Right ☐ On the arm rest ☐ Other___________________**

**My hands were: ☐ Left ☐ Right ☐ Both ☐ On the steering wheel ☐ Other___________________**

**Were you aware of the impending collision before it happened: ☐ Yes ☐ No**

**Did you tighten your body and brace for the collision: ☐ Yes ☐ No**

**Your hands as a result of the impact: ☐ Grabbed the steering wheel tightly**

**☐ Were forced off the steering wheel/stick shift ☐ Other__________________________________**

**As a result of the impact your body was thrown: ☐ Forward ☐ Backward ☐ Right ☐ Left**

**☐ Turned to the right (clockwise) ☐ Turned to the left (counterclockwise) ☐ Can't remember**

**As a result of the impact your head hit the:**

| | | | | |
|---|---|---|---|---|
| **☐ Front windshield** | **☐ Rearview mirror** | **☐ Steering Wheel** | **☐ Back of the seat ahead of me** | **☐ Side Driver / Passenger** |
| **☐ Inside window / Door** | **☐ Another persons body** | **☐ Back of my head hit the headrest** | **☐ Other** | **☐ Nothing** |

**As a result of the impact your shoulders were: ☐ Impacted with the inside of the door / car**

**☐ Pressed firmly against the shoulder harness ☐ Other_________________________________________**

**As a result of the collision what other parts of your body struck the inside of the vehicle:______________**

___________________________________________________________________________________

**Did another car hit you: ☐ Yes ☐ No**

**Point of impact was: ☐ Head on ☐ Rear end ☐ Left Front ☐ Left Rear ☐ Right Front ☐ Right Rear**

**Did your vehicle strike or impact with a second object after the first impact: ☐ Yes ☐ No**

**Did your vehicle strike another:** ☐ **Car** ☐ **Truck** ☐ **Road/Median** ☐ **Building** ☐ **Other**

**Were you wearing your glasses at the time of the accident:** ☐ **Yes** ☐ **No**

**If yes, were your glasses still on following the accident:** ☐ **Yes** ☐ **No**

**Did you lose consciousness as a result of the accident:** ☐ **Yes** ☐ **No**

**If yes, how long were your unconsciousness:** _____________

**Damage to my vehicle was:** ☐ **Mild** ☐ **Moderate** ☐ **Severe** **Is your vehicle drivable:** ☐ **Yes** ☐ **No**

**Damage to the other vehicle:** ☐ **Mild** ☐ **Moderate** ☐ **Severe** **Was the other car drivable:** ☐ **Yes** ☐ **No**

**Estimated cost to repair your car:** _______________________

**At the time of the accident, how many people were in the car with you:** __________

**Names of the occupants:**

| | |
|---|---|
| | |
| | |
| | |

**Were the other occupants injured:** ☐ **Yes** ☐ **No** **Were the police called:** ☐ **Yes** ☐ **No**

**Was a police report taken:** ☐ **Yes** ☐ **No** **Was a ticket given to you:** ☐ **Yes** ☐ **No**

**Was a ticket given to the other driver:** ☐ **Yes** ☐ **No**

**As a result of the accident I felt my symptoms:**

☐ **Immediately** ☐ **Within the hour** ☐ **Within 6 hours** ☐ **During the night**

☐ **Next Morning** ☐ **Next Day** ☐ **Other**_____________________________________

**As a result of the accident I felt:**

☐ **Headaches** ☐ **Upper Back Pain** ☐ **Chest Pain/Soreness** ☐ **Wrist / Elbow / Pain / Soreness**

☐ **Neck Pain** ☐ **Low Back Pain** ☐ **Stomach Pain / Soreness** ☐ **Knee/Angle Pain / Soreness**

☐ **Shoulder Pain** ☐ **Numb/Tingling/Burning Arms** ☐ **Numb/Tingling/Burning Legs** ☐ **Loss of Bowel/Bladder**

**Other areas of pain include:** __________________________________________________

**List the location of any other cuts or bruises as a result of the accident:**

__________________________________________________________________________

**Did you go to the hospital:** ☐ **Yes** ☐ **No** **If No, Where did you go:**______________________________

**If Yes, When:** ☐ **Immediately** ☐ **Next Day** ☐ **Later in same day** ☐ **Other**________________________

**How did you get to the hospital:** ☐ **Ambulance** ☐ **Private Transportation**

☐ **Drove yourself** ☐ **Someone else Drove**

**Name of the Hospital:**_________________________________ **City:** __________________

**Were you admitted:** ☐ **Yes** ☐ **No** **If Yes, How long did you stay:** ___________________

**What treatments did you receive at the hospital:** ☐ **Exam** ☐ **X-Ray** ☐ **MRI**

☐ **CT** ☐ **Lab Work**

**What follow up recommendations were made:** ☐ **See your own Dr.** ☐ **See orthopedist**

☐ **See Neurologist** ☐ **Physical Therapist** ☐ **Braces/Collars** ☐ **Released**

☐ **Prescriptions: What types:** _____________________________________________________

**List any special test taken at the hospital:** ___________________________________________

**Please list all the Doctors you have seen since the accident:**

| Doctor Name | First Visit Date | Treatment | City | Released |
|---|---|---|---|---|
| | | | | ☐ Yes ☐ No |
| | | | | ☐ Yes ☐ No |
| | | | | ☐ Yes ☐ No |

**Are you working now:** ☐ **Yes** ☐ **No**

**Were you employed at the time of the accident:** ☐ **Yes** ☐ **No**

**Type of work you do:** ______________________________________________________________

**Are you currently working with restrictions:** ☐ **Yes** ☐ **No**

**Has the doctor placed you on:** ☐ **Total Disability** ☐ **Partial Disability** ☐ **Does not apply**

**Please list work restrictions:** ______________________________________________________

_______________________________________________________________________________

**Since the accident you feel:** ☐ **Better** ☐ **Worse** ☐ **No Change** ☐ **Other** ____________________________

**% of improvement: 10% 20% 30% 40% 50% 60% 70% 80% 90% 100%**

**Pain Scale: 1=No pain 10=Worst pain ever 1 2 3 4 5 6 7 8 9 10**

**Additional Notes:**

_______________________________________________________________________________

_______________________________________________________________________________

_______________________________________________________________________________

_______________________________________________________________________________

_______________________________________________________________________________

_______________________________________________________________________________

_______________________________________________________________________________

Patient Name:____________________________________Case #__________Date:___/___/___

# Neck Pain and Disability Index (Vernon – Mior)

Please Read Instructions:
This questionnaire has been designed to give the doctor information as to how your neck pain has affected your ability to manage in everyday life. Please answer every section and mark in each section only the ONE Box which applies to you. We realize you may consider that two of the statements in any one section relate to you, but just mark the box which most closely describes your problem.

**Section 1 Pain Intensity**
☐ I have no 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 (Washing, Dressing, Ect.)**
☐ I can look after myself normally, without causing extra pain
☐ I can look after myself normally, but it causes extra pain
☐ 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 everyday 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 extra pain
☐ I can lift heavy weights but it gives extra pain
☐ pain prevents me from lifting heavy weights off the floor, but I can manage if they are conveniently positioned, for example on the table
☐ pain prevents me from lifting heavy weights, but I can manage light to medium weights if they are conveniently positioned
☐ I can lift very light weights
☐ I cannot lift or carry anything at all

**Section 4 Reading**
☐ I can read as much as I want to with no pain in my neck
☐ I can read as much as I want to with slight pain in my neck
☐ I can read as much as I want with moderate pain in my
☐ I can't read as much as I want because of moderate pain in my neck
☐ I can hardly read at all because of severe pain in my neck
☐ I cannot read at all

**Section 5 Headaches**
☐ I have no headaches at all
☐ I have slight headaches which come infrequently
☐ I have moderate headaches which come infrequently
☐ I have moderate headaches which come frequently
☐ I have severe headaches which come frequently
☐ I have headaches almost all the time

**Section 6 Concentration**
☐ I can concentrate fully when I want to, with no difficulty
☐ I can concentrate fully when they want to, with slight difficulty
☐ I have a fair degree of difficulty in concentrating when I want to
☐ I had a lot of difficulty in concentrating when I want to
☐ I have a great deal of difficulty in concentrating when I want to
☐ I cannot concentrate all

**Section 7 Work**
☐ I can do as much work as I want to
☐ I can only do my usual work, but no more
☐ I can do most of my usual work, but no more
☐ I cannot do my usual work
☐ I can hardly do any work at all
☐ I cannot do any work at all

**Section 8 Driving**
☐ I can drive my car without any neck pain
☐ I can drive my car as long as I want with slight pain in my neck
☐ I can drive my car as long as I want with moderate pain in my neck
☐ I can't drive my car as long as I want because of moderate pain in my neck
☐ I can hardly drive at all because of severe pain in my neck
☐ I can't drive my car

**Section 9 Sleeping**
☐ I have no trouble sleeping
☐ my sleep is slightly disturbed(less than 1 hour sleepless)
☐ my sleep is mildly disturbed(1 -- 2 hours sleepless)
☐ my sleep is moderately disturbed(2 -- 3 hours sleepless)
☐ my sleep is greatly disturbed(3 -- 5 hours sleepless)
☐ my sleep is completely disturbed(five -- 7 hours sleepless)

**Section 10 Recreation**
☐ I'm able to engage in all my recreation activities with no neck pain at all
☐ I am able to engage in all my recreation activities, with some pain in my neck
☐ I am able to engage in most, but not all of my usual recreation activities because of pain in my neck
☐ I'm able to engage in a few of my usual recreation activities because of pain in my neck
☐ I can hardly do any recreation activities because of pain in my neck
☐ I can't do any recreation activities at all

## Pain scale:

## Rate the severity of your pain by checking one box on the following scale:

| No pain | 0 | 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | 10 | Excruciating pain |
|---|---|---|---|---|---|---|---|---|---|---|---|---|

Patient Name:_____________________________________ Case #___________ Date___/___/___

# Low Back Pain and Disability Questionnaire

Please Read Instructions:

This questionnaire has been designed to give the doctor information as to how your low back pain has affected your ability to manage in everyday life. Please answer every section and mark in each section only the ONE Box which applies to you. We realize you may consider that two of the statements in any one section relate to you, but just mark the box which most closely describes your problem.

**Section 1 Pain Intensity**

- ☐ the pain comes in 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 (Washing, Dressing, Ect.)**

- ☐ I would not have to change my way of washing or dressing in order to avoid pain
- ☐ I do not normally change my way of washing or dressing even though it causes some pain
- ☐ washing and dressing increase the pain but I managed not to change my way of doing it
- ☐ washing and dressing increase 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 and dressing without help

**Section 3 Lifting**

- ☐ I can lift heavy weights without extra pain
- ☐ I can lift heavy weights but it causes extra pain
- ☐ pain prevents me from lifting heavy weights off the floor
- ☐ pain prevents me from lifting heavy weights off the floor, but I manage if they are conveniently positioned (e.g. on a table)
- ☐ pain prevents me from lifting heavy weights but I can manage light in weights if they are conveniently positioned
- ☐ I can only lift very light weights at the most

**Section 4 Walking**

- ☐ I have no pain on walking
- ☐ I have some pain on walking but it does not increase with distance
- ☐ I cannot walk more than 1 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 hour
- ☐ pain prevents me from sitting more than 10 minutes
- ☐ I avoid sitting because it increases pain immediately

**Section 6 Standing**

- ☐ I can stand as long as I want without pain
- ☐ I have some pain on standing but it is 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 for longer than 10 minutes without increasing pain
- ☐ I avoid standing because it increases the pain immediately

**Section 7 Sleeping**

- ☐ I get no pain in bed
- ☐ I get pain in bed but it does not prevent me from sleeping well
- ☐ because of pain my normal night's sleep is reduced by less than 1/4
- ☐ because of pain my normal night's sleep is reduced by less than 1/2
- ☐ because of pain my normal night's sleep is reduced by less than 3/4
- ☐ 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
- ☐ pain has no significant effect on my social life apart from limiting my more energetic interest, example dancing
- ☐ 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 Travelling**

- ☐ 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 alternative forms of travel
- ☐ I get extra pain while traveling which compels me to seek alternative 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 worse
- ☐ my pain seems to be getting better but improvement is slow at present
- ☐ my pain is neither getting better nor worse
- ☐ my pain is gradually worsening
- ☐ my pain is rapidly worsening

## Pain scale:

## Rate the severity of your pain by checking one box on the following scale:

| **No pain** | 0 | 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | 10 | **Excruciating pain** |
|---|---|---|---|---|---|---|---|---|---|---|---|---|

# ASSIGNMENT OF BENEFITS

Jacksonville Chiropractic
& Acupuncture

**Financial Responsibility**

I understand that insurance billing is a service provided as a courtesy and that I am at all times financially responsible to Jacksonville Chiropractic & Acupuncture and/or its affiliated entities for any charges not covered by health care benefits. It is my responsibility to notify Jacksonville Chiropractic & Acupuncture of any changes in my health care coverage. In some cases exact insurance benefits cannot be determined until the insurance company receives the claim. I am responsible for the entire bill or balance of the bill as determined by Jacksonville Chiropractic & Acupuncture and/or my health care insurer if the submitted claims or any part of them are denied for payment. I understand that by signing this form that I am accepting financial responsibility as explained above for all payment for medical services and/or supplies received.

**Assignment of Benefits**

I authorize direct remittance of payment of all insurance benefits, including Medicare, if I am a Medicare beneficiary, to Jacksonville Chiropractic & Acupuncture for all covered medical services and supplies provided to me during all courses of treatment and care provided by Jacksonville Chiropractic & Acupuncture and/or its affiliated entities or otherwise at its direction. I understand and agree this Assignment of Benefits will have continuing effect for so long as I am being treated or cared for by Jacksonville Chiropractic & Acupuncture, and will constitute a continuing authorization, maintained on file with Jacksonville Chiropractic & Acupuncture, which will authorize and allow for direct payment to Jacksonville Chiropractic & Acupuncture of all applicable and eligible insurance benefits for all subsequent and continuing treatment, services, supplies and/or care provided to me by Jacksonville Chiropractic & Acupuncture.

**Authorization to Release Information**

I authorize the release of any medical or any other information to the Health Care Financing Administration, my insurance carrier(s), or other entity necessary to determine insurance benefits or the benefits payable for related medical services and/or supplies provided to me by Jacksonville Chiropractic & Acupuncture. A copy of this authorization will be sent to the Health Care Financing Administration, my insurance carrier(s), or other medical entity, if requested. The original authorization will be kept on file by Jacksonville Chiropractic & Acupuncture.

Patient/Insured Name(print)___________________________

Date of birth_____/_____/_____

SS#______-_____-_______

Patient Signature__________________________________Date:____/____/____

Witness (Signature)________________________________Date:____/____/____

Jacksonville Chiropractic
& Acupuncture

# Informed Consent to Chiropractic Adjustments and Care

| Doctor | Patient | |
|---|---|---|
| Doctor ☐ Initials | Patient ☐ Initials | I have been informed that it is not uncommon that patients have some increased discomfort after an adjustment. If that happens I will apply ice to the area and rest it. If I am concerned about this discomfort or develop any new symptoms I can call the number listed below during office hours for emergency attention. If I am out of town or unable to contact the doctor, I can present myself to an emergency room. If any tests were performed outside of this office (laboratory or other diagnostic procedures) I understand that the doctor will notify me of the results at my next scheduled appointment. |
| Doctor ☐ Initials | Patient ☐ Initials | I hereby request and consent to the performance of chiropractic adjustments and other chiropractic procedures, including various modes of physical therapy and, if necessary, diagnostic x-ray, on me by the doctor of chiropractic names below and/or in this clinic authorized by the doctor of chiropractic listed below. I have had an opportunity to discuss with the doctor of chiropractic names below and/or with other office or clinic personnel, the nature and purpose of chiropractic adjustments and other procedures. I understand that results are not guaranteed. I further understand and am informed that, as in all health care, in the practice of chiropractic there are some very slight risks to treatment, including, but not limited to, muscle strains and sprains, disc injuries, physical therapy burns, rib injury, and strokes. Strokes are the most serious complication of chiropractic treatment. The most recent studies (Journal of the CAA, Vol. 37 No. 2, June, 1993) estimate that the incidence of this type of stroke is 1 in every 3 million upper cervical adjustments. I do not expect the doctor to be able to anticipate and explain all risks and complications and wish to rely on the doctor to exercise judgment during the course of the procedure which the doctor feels at the time, based upon the facts then known, as in my best interests. |
| Doctor ☐ Initials | Patient ☐ Initials | I have read the above consent, with the doctor, as indicated by our initials. I have also had an opportunity to ask questions about its content, and by signing below I agree to the above names procedures. I intend this consent form to cover the entire course of treatment for my present condition and for any future conditions for which I seek treatment. |

**To Be Completed By The Patient:**

Print Patient Name: ______________________ Date Signed ____/____/____

Patient Signature: ______________________

Doctors Signature: ______________________