

**Lifepus Health Center
Personal Injury Questionnaire**

Today's Date _____

Date of Accident _____

PATIENT DATA

First Name _____ Middle Initial _____ Last Name _____

Age _____ Date of Birth _____ Referred By _____

CONTACT INFORMATION

Street Address _____ City _____ State _____ Zip _____

Home # (_____) _____ Work # (_____) _____ Cell # (_____) _____

E-mail _____

THESE SECTIONS MUST BE FILLED OUT COMPLETELY IN ORDER TO PROCESS YOUR CLAIM!!

Your Auto Insurance Co.: _____ Claim #: _____

Agent's Name: _____ Agent's Phone #: _____

Have you retained an attorney? No Yes Name: _____

Attorney's Phone #: _____ (Please supply us with a business card if possible)

Were there any witnesses? No Yes Names: _____

Were the police notified? No Yes

COPY OF ACCIDENT REPORT

COPY OF PRIVATE HEALTH INSURANCE CARD REQUIRED

Your Health Insurance Company: _____

Insured's Name _____ Policy Number: _____

Health Insurance Co. Phone #: _____ Group #: _____

Name of Driver of other vehicle: _____

Auto Insurance Co.: _____ Claim #: _____

Adjuster's Name: _____ Phone #: _____

The pages to follow are very important! Please take your time in sorting out the details and answer all questions as completely as possible, thank you.

AUTO ACCIDENT INFORMATION

1. Were you the: Driver Front Passenger Rear Passenger
2. Make and model of the vehicle you were occupying: _____
3. If traffic violation was issued, to whom was it issued? _____
4. Did the police come to the accident site? Yes No
5. Was a police report filed? Yes No
6. Were there any witnesses? Yes No
7. In relation to the base of your skull, where was the headrest? Above Below At base of skull
8. What did your vehicle impact? Another vehicle Other _____
9. Did any part of your body strike anything in the vehicle? Yes No
If yes, please describe: _____

NATURE OF ACCIDENT

1. Time of Day: _____ AM PM City: _____
2. # of people in your vehicle: _____ # in other vehicle: _____
3. Road Conditions at the time of accident: Wet Dry Icy Other, explain: _____
4. Direction you were heading: North South East West Name of Street: _____
5. Other car direction: North South East West Name of Street: _____
6. Were you struck from: Behind Front Left Side Right Side
7. Were you wearing a seatbelt: Yes No If yes: Lap Shoulder belt Both
Any bruising or soreness from belt: Yes No Explain: _____
8. Airbags Activated: Yes No
9. Head position at time of impact: Facing forward Head Turned Right Head Turned Left
10. Were you knocked unconscious: Yes No If yes, for how long: _____
11. Were you aware of approaching impact: Yes No
If yes, did you brace for impact: Yes No If yes, how: _____
12. Was your car stopped at time of impact: Yes No
If yes, was driver's foot on brake pedal: Yes No
If yes, did your car move forward on impact: Yes No
If no, were you: Gaining speed Slowing down Traveling at steady speed
13. What was your approximate speed: _____ mph
14. Were there more than 2 cars involved in the accident: Yes, How many? _____
 No Another object involved _____
15. How fast was the other vehicle traveling: _____ mph
16. Was the other vehicle: Gaining speed Slowing down Traveling a steady speed
17. What type of car impacted you: _____

18. In your own words, please describe the accident. Include what you heard, saw, or felt: _____

19. Please describe how you felt. Did you feel pain:

A) DURING the accident: _____

B) IMMEDIATELY FOLLOWING the accident: _____

C) THE FOLLOWING DAY: _____

20. Estimated cost of damage to your vehicle: _____ Totaled? Yes No Photo of Damage? Yes No

21. CIRCLE which of the following car parts were damaged during the accident:

A) Windshield

D) Front of vehicle

B) Right side of vehicle

E) Rear of vehicle

C) Left side of vehicle

F) Other _____

22. Did you receive emergency care IMMEDIATELY following the accident: Yes No If yes, type of treatment, where, and name of doctor: _____

If yes, how did you get there? Ambulance Private Transportation

If yes, were x-rays taken? Yes No

Was other imaging performed (e.g. CT scan, MRI, diagnostic ultrasound)? Yes No

23. Have you been treated by another doctor since the accident: Yes No

If yes, doctor's name and treatment received: _____

Was medication prescribed? Yes No

If yes, what medications: _____

24. Since the injury occurred, are symptoms: Improving Getting Worse Same Comes and goes

25. Have you been able to work since the injury? Yes No

26. Type of work you are employed in: _____

27. Since the accident do you notice any activity restrictions in your capacity for:

Work: _____

Family: _____

Recreation: _____

Chores: _____

28. Have you ever been involved in an accident before: Yes No If yes, describe (include dates, type of accident, and injury(s) received): _____

29. Is there a possibility you may be pregnant? Yes No

Height: _____

Weight: _____

Left-Handed

Right-Handed

SYMPTOMS

CHECK THE APPROPRIATE BOX:

Symptoms	Before Accident	After Accident	Symptoms	Before Accident	After Accident
Neck Pain			Headaches		
Neck Stiffness			“Pressure in head”		
Upper Back Pain			Head seems Heavy		
Mid Back Pain			Loss of Memory		
Low Back Pain			Dizziness		
Shoulder Pain			Fainting		
Elbow Pain			Balance Problems		
Wrist Pain			Blurred Vision		
Arm Pain			Nausea or Vomiting		
Leg Pain			Ears Ringing		
Hip Pain			Sensitivity to Light		
Knee Pain			Sensitivity to Noise		
Foot Pain			Feeling Slowed Down		
Chest Pain			Feeling like “In a Fog”		
Jaw Pain			“Don’t Feel Right”		
Numb Head/Face			Difficulty Concentrating		
Tingling Head/Face			Difficulty Remembering		
Numb Arm/Hand			Fatigue or low energy		
Tingling Arm/Hand			Confusion		
Numb Leg/Foot			Drowsiness		
Tingling Leg/Foot			Sleeping Problems		
Diarrhea			More Emotional		
Constipation			Irritability		
Face Flushing			Depression/Sadness		
Fever			Nervous/Anxious		
Cold Sweats			Loss of Taste		
Feet Cold			Loss of Smell		
Hands Cold			Shortness in Breath		
Pain with Breathing					

SYMPTOMS other than above: _____

Other pertinent information: _____



INFORMED CONSENT TO CHIROPRACTIC CARE

TERMS OF ACCEPTANCE FOR CARE

When a patient seeks chiropractic health care and we accept a patient for such care, it is essential for both to be working towards the same objective. It is important that each patient understand both the objective and the method that will be used to attain it. This will prevent any confusion or disappointment. You have the right, as a patient, to be informed about the condition of your health and the recommended care and treatment to be provided so that you may make the decision whether or not to undergo chiropractic care after being advised of the known benefits, risks, and alternatives. Please be aware the clinic is under video and audio surveillance for training and security purposes.

Chiropractic is a science and art which concerns itself with the relationship between structure (primarily the spine) and function (primarily the nervous system) as that relationship may effect the restoration and preservation of health.

Health is a state of optimal physical, mental and social well-being, not merely the absence of disease or infirmity.

Vertebral subluxation is a disturbance to the nervous system that occurs when one or more of the 24 vertebrae in the spinal column becomes misaligned and/ or do not move properly. This causes alteration of nerve function and interference to the nervous system. This may result in pain and dysfunction or may be entirely asymptomatic. Subluxations are corrected and/ or reduced by an adjustment.

Adjustment is the specific application of forces to correct and/ or reduce vertebral subluxation. Our chiropractic method of correction is by specific adjustments of the spine. Adjustments are usually done by hand but may be performed by handheld instruments. In addition, ancillary procedures such as extremity adjustment, physiotherapy and/ or rehabilitative procedures may be included.

If during the course of care we encounter non-chiropractic or unusual findings, we will advise you of those findings and recommend that you seek the services of another health care provider.

All questions regarding the doctor’s objective pertaining to my care in this office have been answered to my complete satisfaction. The benefits, risks and alternatives of chiropractic care have been explained to me to my satisfaction. I have read and fully understand the above statements and therefore accept chiropractic care on this basis.

_____ **Print Name**

_____ **Signature**

CONSENT TO EVALUATE AND ADJUST A MINOR CHILD

I, _____ being the parent or legal guardian of _____ have read and fully understand the above Informed Consent and hereby grant permission for my child to receive chiropractic care.

PREGNANCY RELEASE

This is to certify that to the best of my knowledge I am not pregnant and the above doctor and his/ her associates have my permission to perform an x-ray evaluation. I have been advised that x-ray can be hazardous to an unborn child.

Date of last menstrual cycle: _____



FINANCIAL PAYMENT POLICY

INSURANCE

Insurance coverage is never guaranteed. Any benefits quoted by our staff are not a guarantee of benefits. Your signature below assigns assignment to this office for collection of benefits and also authorizes this office to use and disclose protected health information for purposes of treatment, payment, and healthcare operations. You have a right to review our posted privacy policy before you sign this consent and you may void your consent at anytime by contacting us.

FINANCIAL POLICY

The office manager may approve account balances. Active monthly payments are required. Monthly payments are due on the 10th of each month. If account becomes 60 days past due, agreement is null and void and payment must be made at the time of service. Past due accounts may be sent to a third party collection agency.

We do offer a *time of service* discount when services are paid in full at time of the visit. This discounted amount will be passed on to your insurance company contract permitting. Please feel free to ask us any financial question you may have. Our intent is to provide you with the highest level of service as well as care.

All questions regarding financial matters have been answered to my complete satisfaction. I have read and fully understand the above financial payment policy.

Signature

Date



**CONSENT to LEAVING MESSAGES
CONSENT to SHARING INFORMATION with Family/ Friends**

CONSENT to LEAVING MESSAGES

I understand that my healthcare information at Lifepus Health Centers, P.S. is protected and I have received a copy of its Notice of Privacy Practices.

I further understand that, in order for Lifepus Health Centers to leave **detailed messages containing specific medical information** on my voice mail or answering machine, I need to give permission to Lifepus Health Centers.

Consent for Leaving Messages

I consent to information regarding my or my child’s (under the age of 18) detailed appointment reminders, insurance benefit information, and/ or instructions be left on my voice mail or answering machine.

YES NO

CONSENT for SHARED INFORMATION with Family & Friends

The name(s) listed below are family members or friends to whom I grant permission for my health care providers and their representatives at Lifepus Health Centers to verbally discuss my care using their best judgment, and grant them permission to disclose health information that is relevant to my care or relevant for payment. YES NO

Under the HIPAA Privacy Law we are permitted and we may make a professional judgment that certain disclosures are in your best interests even without this signature.

I understand that information is limited to verbal discussions and that no paper copies of my protected healthcare information will be provided without my signature on a Release of information form.

NAME	RELATIONSHIP
1. _____	_____
2. _____	_____
3. _____	_____

Patient/ Parent Signature

Date

**It will be my responsibility to keep this information up to date, as I recognize that relationships and friendships may change over time.
This consent will be considered valid until such time that I revoke it. I reserve the right to revoke it at any time. I understand that to revoke this consent, I must provide written notice to my provider at Lifepus Health Centers.**

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

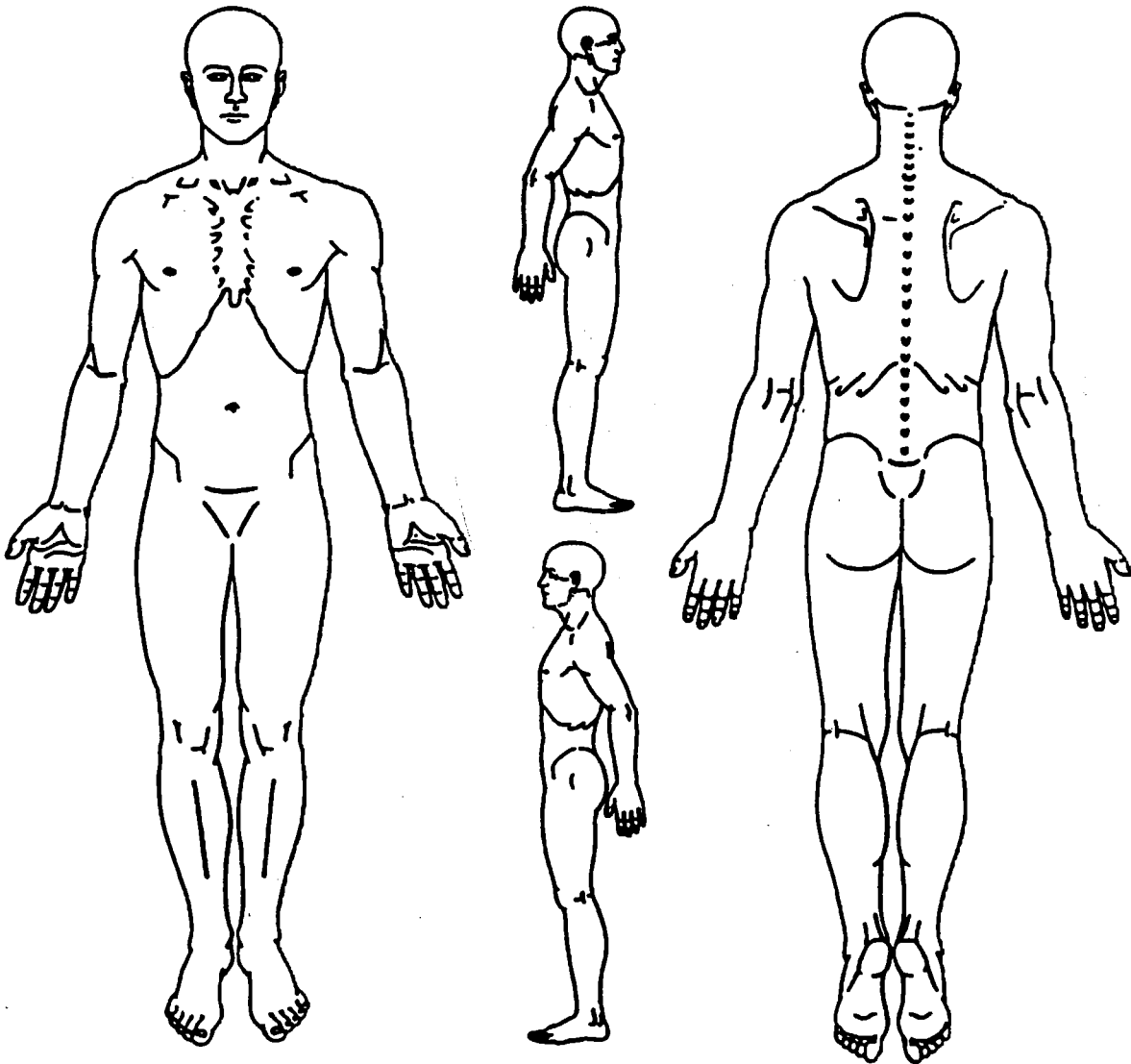
B = BURNING

N = NUMBNESS

P = PINS & NEEDLES

S = STABBING

O = OTHER



OVER PLEASE

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

- 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 causes extra pain.
- C. Pain prevents me from lifting heavy weights off the floor, but I can manage if they are conveniently positioned, e.g., 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.

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.

After Vernon & Mior, 1991

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REVISED 1/1/95

Comments: _____

Patient's Signature: _____

Date: _____

ROLAND-MORRIS ACUTE 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

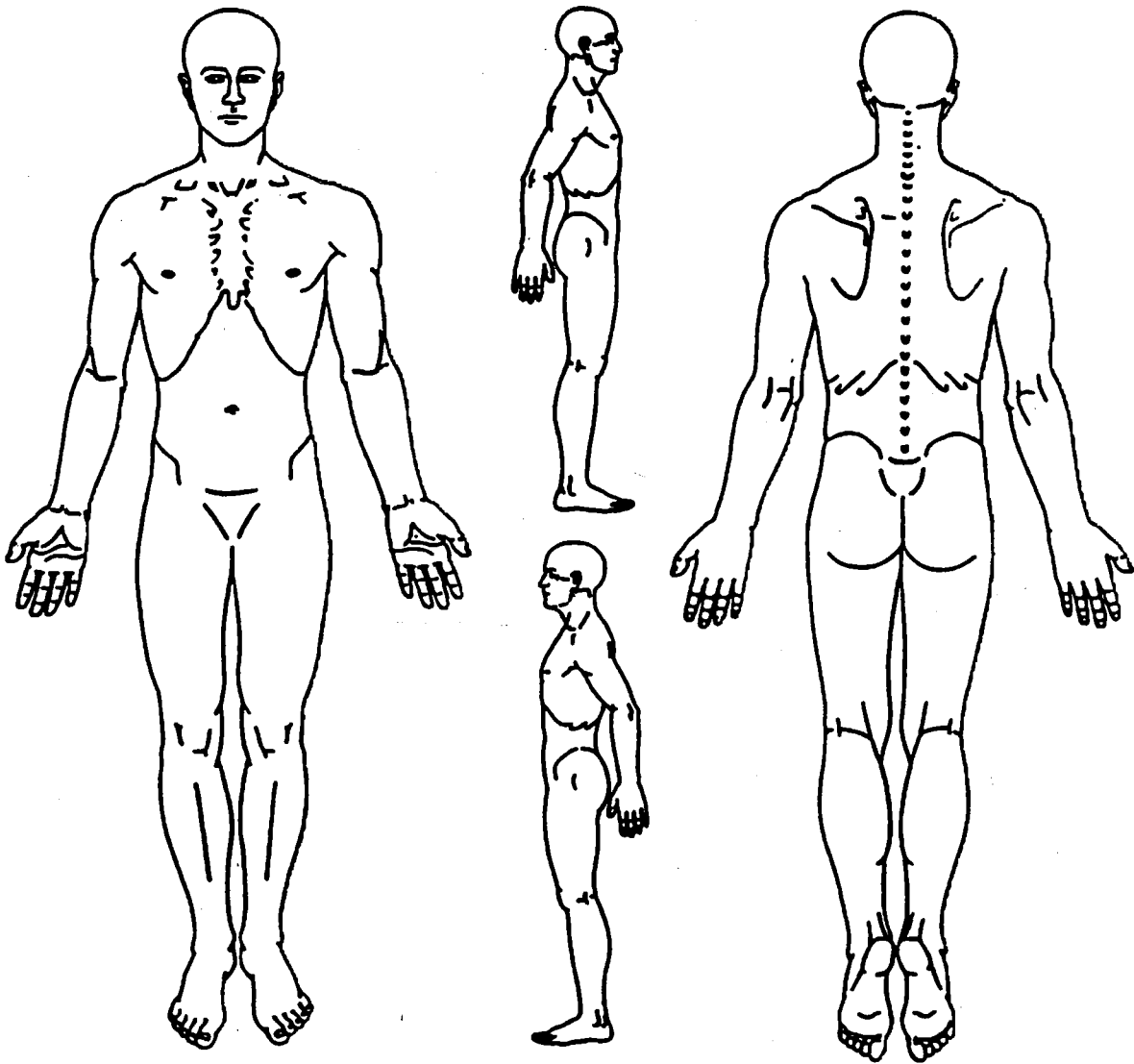
B = BURNING

N = NUMBNESS

P = PINS & NEEDLES

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O = OTHER



OVER PLEASE

ROLAND-MORRIS ACUTE LOW BACK PAIN DISABILITY QUESTIONNAIRE

When your back hurts, you may find it difficult to do some of the things you normally do.

This list contains some sentences that people have used to describe themselves when they have back pain. When you read them, you may find that some stand out because they describe you *today*. As you read the list, think of yourself *today*. Check the box next to any sentence that describes you *today*. If the sentence does not describe you, then leave the space blank and go on to the next one. Remember, only check the sentence if you are sure that it describes you *today*.

1. I stay at home most of the time because of my back.
2. I change position frequently to try and get my back comfortable.
3. I walk more slowly than usual because of my back.
4. Because of my back, I am not doing any of the jobs that I usually do around the house.
5. Because of my back, I use a handrail to get upstairs.
6. Because of my back, I lie down to rest more often.
7. Because of my back, I have to hold on to something to get out of an easy chair.
8. Because of my back, I try to get other people to do things for me.
9. I get dressed more slowly than usual because of my back.
10. I only stand up for short periods of time because of my back.
11. Because of my back, I try not to bend or kneel down.
12. I find it difficult to get out of a chair because of my back.
13. My back is painful almost all the time.
14. I find it difficult to turn over in bed because of my back.
15. My appetite is not very good because of my back pain.
16. I have trouble putting on my socks (or stockings) because of the pain in my back.
17. I only walk short distances because of my back pain.
18. I sleep less well because of my back pain.
19. Because of my back pain, I get dressed with help from someone else.
20. I sit down for most of the day because of my back.
21. I avoid heavy jobs around the house because of my back.
22. Because of my back pain, I am more irritable and bad tempered with people than usual.
23. Because of my back pain, I go upstairs more slowly than usual.
24. I stay in bed most of the time because of my back.

SIGNATURE: _____

DATE: _____

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Appendix 1: Disability Questionnaire from "A Study of the Natural History of a Reliable and Sensitive Measure of Disability in Low Back Pain." Spine 1983; 8(2): 141-4.

For re-ordering information, contact:

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