

<b>PERSONAL INJURY CONSULTATION AND INFORMATION</b>
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Welcome to Our Office! Please complete all questions.

The purpose of this office is to educate as many families as possible about the spinal condition known as *Vertebral Subluxation*. *Vertebral Subluxation* destroys an *optimal spine* and your ability to have *Optimal Health*. Your experience with this office will not only be of healing but also of learning the truth about **optimal health and healing**.

Name:		Today's Date:	
Address:			
City/State/Zip:			
Home Phone:		Work Phone:	Cell Phone:
Birthdate:	Age:	Social Security #:	
Marital Status:	M	W	D S
Your Employer:		Your E-Mail Address:	
Your Employer:		Occupation:	
Spouse's Name:		Spouse's Employer:	
Children's Names & Ages:			
Your Favorite Hobbies:			
Who may we thank for referring you?			
When did you last see a Chiropractor?		Dr.:	
Are you here because of a recent auto or work injury?		Date of Accident:	
Other Doctors you've seen recently:			
Medicines you take:			
Surgeries you've had:			
Ever diagnosed with cancer?		What kind?	
Who is financially responsible for this bill?			
Method of Payment: <input type="checkbox"/> Cash <input type="checkbox"/> Check <input type="checkbox"/> Credit Card <input type="checkbox"/> Insurance			
Emergency Contact:		Phone:	

## Nature of Injury

1. Date of Accident \_\_\_\_\_ Time of Day \_\_\_\_\_
2. Were there any witnesses ( ) Yes ( ) No Name(s) \_\_\_\_\_
3. Were you: ( ) Driver ( ) Passenger ( ) Front Seat ( ) Back Seat
4. Number of people in your vehicle? \_\_\_\_\_ Were you wearing seat belts? ( ) Yes ( ) No
5. Type of vehicle \_\_\_\_\_
6. What direction were you headed? ( ) North ( ) East ( ) South ( ) West
7. Type of other vehicle(s) \_\_\_\_\_
8. What direction was the other vehicle headed? ( ) North ( ) East ( ) South ( ) West
9. Were you struck from: ( ) Behind ( ) Front ( ) Left Side ( ) Right Side
10. Approximate speed of your car \_\_\_\_\_ mph. Other car \_\_\_\_\_ mph
11. Were you knocked unconscious? ( ) Yes ( ) No
12. Were police notified? ( ) Yes ( ) No
13. In your own words, please describe accident: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_
14. What hospital did you go to? \_\_\_\_\_
15. Were x-rays taken? \_\_\_\_\_ Previous diagnosis \_\_\_\_\_
16. Have you been treated by another doctor since the accident? ( ) Yes ( ) No  
If yes, please list doctor's name and address: \_\_\_\_\_  
\_\_\_\_\_  
What type of treatment did you receive from him/her? \_\_\_\_\_
17. Did you have any physical complaints BEFORE THE ACCIDENT? ( ) Yes ( ) No  
If yes, describe in detail: \_\_\_\_\_  
\_\_\_\_\_
18. Do you have any congenital (from birth) factors which relate to this problem? ( ) Yes ( ) No  
If yes, please describe: \_\_\_\_\_  
\_\_\_\_\_
19. Do you have any previous illnesses which relate to this case? ( ) Yes ( ) No  
If yes, please describe: \_\_\_\_\_  
\_\_\_\_\_
20. Have you ever been involved in an accident before? ( ) Yes ( ) No  
If yes, please describe, including date(s) and type(s) of accidents, as well as injury(ies) received:  
\_\_\_\_\_  
\_\_\_\_\_

21. Since the accident, are your symptoms: ( ) Improving ( ) Getting Worse ( ) Same
22. Where is the pain? \_\_\_\_\_
23. Type of pain (sharp, dull, burn, etc.) \_\_\_\_\_
24. Does it spread? \_\_\_\_\_ Where does pain spread to? \_\_\_\_\_
25. Any numbness? \_\_\_\_\_ Where? \_\_\_\_\_
26. Does pain wake you at night? \_\_\_\_\_ Type of pain at night \_\_\_\_\_
27. Does it cause pain when you cough or sneeze? \_\_\_\_\_ Type of pain \_\_\_\_\_
28. Is there pain when you go from a sit to a standing position? \_\_\_\_\_ Where, type of pain \_\_\_\_\_
29. What activities make it better (B) or worse (W)? \_\_\_\_\_  
\_\_\_\_\_
30. What gives relief? Ice, heat, medication, other \_\_\_\_\_
31. Mark if any of the below aggravate or help your condition (W) worse (B) better (N) no change.  
Working \_\_\_\_\_ Walking \_\_\_\_\_ Step climbing \_\_\_\_\_ Driving \_\_\_\_\_ Other \_\_\_\_\_  
Recreation \_\_\_\_\_ Bowel movements give pain or pressure to low back? Yes \_\_\_\_ No \_\_\_\_
32. Any joint motion limited? (EX. elbow, knee, wrist, ankle, hip, shoulder, hand) \_\_\_\_\_  
\_\_\_\_\_
33. Any difficulties with these areas since the accident and how? Digestion \_\_\_\_\_  
Sinuses \_\_\_\_\_ Vision \_\_\_\_\_ Hearing \_\_\_\_\_ Breathing \_\_\_\_\_  
Smelling \_\_\_\_\_ Sleeping \_\_\_\_\_ Menstrual (if female) \_\_\_\_\_
34. Do you have any of these headaches? (circle) Throb, Tension, Migraine, Sinus  
Worse in A.M., P.M., Afternoon
35. Have you lost time from work as a result of this accident ( ) Yes ( ) No  
If yes, when was the last day worked: \_\_\_\_\_
36. Are you being compensated for time lost from work ( ) Yes ( ) No If yes, please state type of  
compensation you are receiving: \_\_\_\_\_
37. Do you smoke? ( ) Yes ( ) No How much? \_\_\_\_\_
38. What is your daily intake of: Milk \_\_\_\_\_ Pop \_\_\_\_\_ Sugar/Sweets \_\_\_\_\_
39. Were you aware that the accident was going to occur? \_\_\_\_\_
40. Which direction were you looking upon impact? \_\_\_\_\_

CONFIDENTIAL: Please make the doctor aware if you are HIV positive, or if you have any other communicable diseases, i.e., T.B., Hepatitis, etc.

All first visit charges are payable when services are rendered.

The fee paid for treatment x-rays is for analysis only. The film itself is the property of this office. Once films are used for treatment purposes they cannot be released.

I understand and agree that health and accident insurance policies are an arrangement between an insurance carrier and myself. Furthermore, I understand North Coast Chiropractic will prepare any necessary reports and forms to assist me in making collections from the insurance company and that any amount authorized to be paid directly to North Coast Chiropractic will be credited to my account upon receipt. However, I clearly understand and agree that I am personally responsible for payment.

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Patient's Signature

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Date

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Guardian's Signature Authorizing Care For Minor

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Date

# ACTIVITIES OF DAILY LIVING IMPAIRMENT

Dear Patient/Claimant:

Please be aware that the purpose of this examination is to determine your level of impairment. Impairment is defined as the loss of, loss of use of, or derangement of any part, system or function. It is an alteration of an individuals health status that is assessed by medical means. (Functional capabilities of activities of daily living). Disability is the limiting loss or absence of the capacity of an individual to meet personal, social, or occupational demands, or to meet statutory or regulatory requirements. Disability is assessed by non-medical means (employability).

Please read the following directions and complete the impairment check list. In terms of a normal day where you are active 16 hours and sleep 8 hours "occasionally" means 33%, "frequently" means 34% to 66%, and "continuously" means 67% to 100% of the day. Please mark how the specific injury(ies) you are being examined for now impair your life in a normal day.

ACTIVITIES OF DAILY LIVING	IMPAIRED			
	Not At All	Occasionally	Frequently	Continuously
Self care and personal hygiene	( )	( )	( )	( )
Normal living postures (Sitting, lying down, etc.)	( )	( )	( )	( )
Travel	( )	( )	( )	( )
Sexual function	( )	( )	( )	( )
Social and recreational activities	( )	( )	( )	( )
Communication	( )	( )	( )	( )
Ambulation (moving around)	( )	( )	( )	( )
Nonspecialized hand activities	( )	( )	( )	( )
Sleep	( )	( )	( )	( )
Writing	( )	( )	( )	( )
Other _____	( )	( )	( )	( )
Other _____	( )	( )	( )	( )

Signature \_\_\_\_\_ Date \_\_\_\_\_

\* The following information has been taken from the AMA Guides.

# PATIENT PAIN FORM

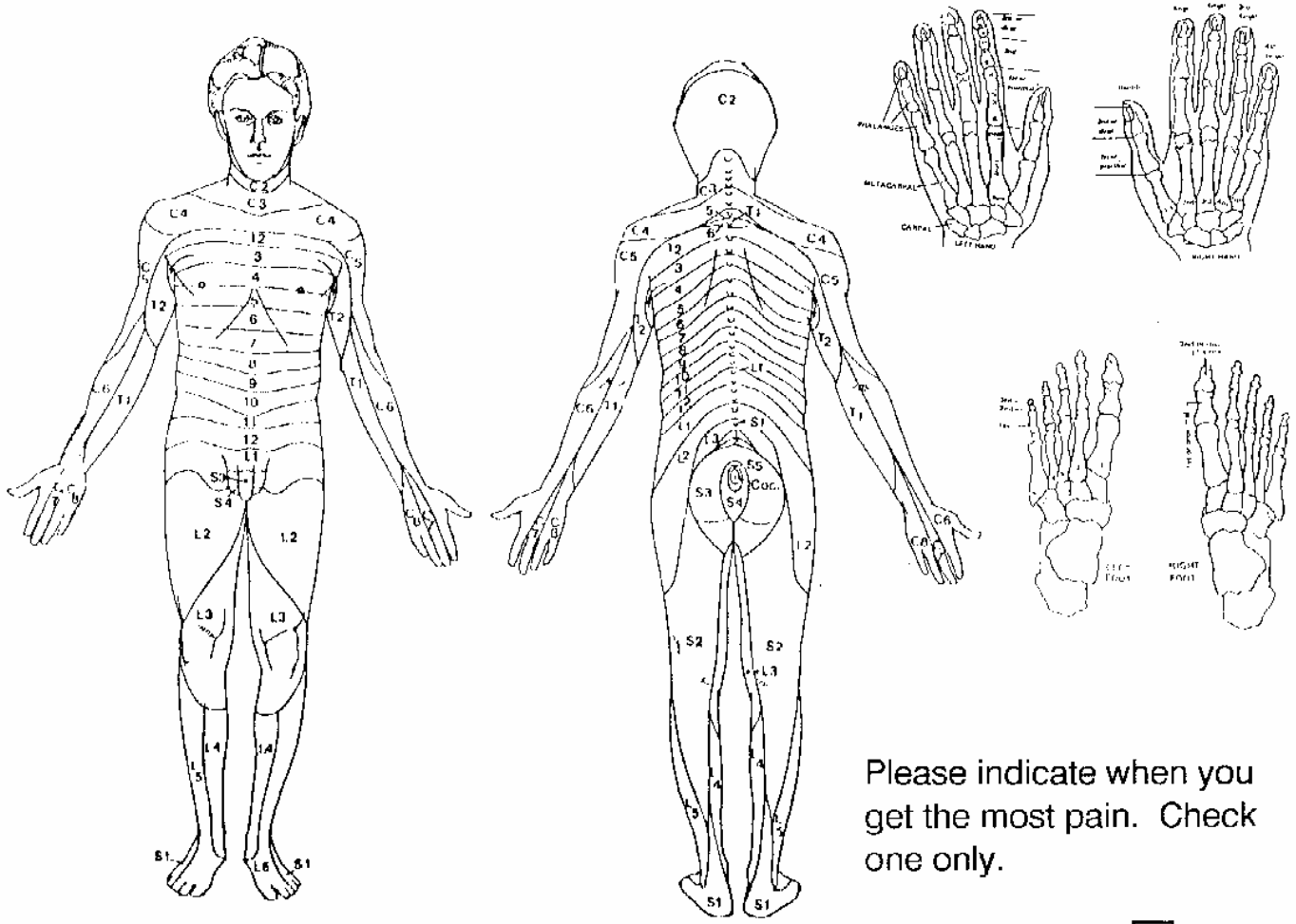
Please circle on this line the level or intensity of pain that you are presently experiencing.

Absolutely Pain Free	<div style="border-top: 2px solid black; position: relative; height: 10px;"> <span style="position: absolute; left: 0; top: -10px;">1</span> <span style="position: absolute; left: 15%; top: -10px;">2</span> <span style="position: absolute; left: 30%; top: -10px;">3</span> <span style="position: absolute; left: 45%; top: -10px;">4</span> <span style="position: absolute; left: 60%; top: -10px;">5</span> <span style="position: absolute; left: 75%; top: -10px;">6</span> <span style="position: absolute; left: 90%; top: -10px;">7</span> <span style="position: absolute; left: 105%; top: -10px;">8</span> <span style="position: absolute; left: 120%; top: -10px;">9</span> <span style="position: absolute; left: 135%; top: -10px;">10</span> </div>	Worse Pain you Could Ever Have
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Mark the areas on your body where you feel the described sensations. Use the appropriate symbol. Mark the areas of radiation. Include all affected areas.

**Numbness**    **Dull Ache**    **Hot Burning**    **Sharp Stabbing**    **Pins & Needles**  
 ===            000            XXX            ///            +++

Other discomfort \_\_\_\_\_ (Use \*\*\* to indicate area on body.)



Please indicate when you get the most pain. Check one only.

Sit	<input type="checkbox"/>
Stand	<input type="checkbox"/>
Lying Down	<input type="checkbox"/>
Other	<input type="checkbox"/>

Signed: \_\_\_\_\_

Date: \_\_\_\_\_