WELCOME TO A BETTER LIFE CHIROPRACTIC AND MEDICAL MASSAGE

9882 Colerain Avenue
Cincinnati, Ohio 45251
www.abetterlifechiro.com
(513)385-2273

PATIENT INFORMATION

(PLEASE PRINT)

Name_________________________________ SS#_____-___-______ Date: _____/_____/_____

Phone: Home__________________ Work___________________ Cell __________________

Address_________________________________ City_______________ State______ Zip________

Date of Birth:___/___/____E-Mail_____________________________ Marital Status__s__m__w__d

Employer____

Seeking help for: ______Auto Accident ______Work Injury ______Other conditions

Have you had Chiropractic Care in the last year? ______yes _______no

If the primary policy holder is someone other than you, please give the following information:

Name:______________________________ SS#____________________ DOB__________

(please give health insurance information to receptionist)

ACKNOWLEDGEMENT

I, ____,consent to exams, tests, x-rays, and treatment if **John S. Smith, D. C.** deems them medically necessary in the course of my visit today. I realize that there is no guarantee of results from the above exams, tests, x-rays, or treatment. All x-rays are the property of A Better Life Chiropractic by state law, and I understand that if I want copies I will be charged a fee for materials and labor. I certify that all the above information is true and correct. I understand that I am financially responsible for my services at A Better Life Chiropractic and that I may be billed for any deductible amounts not covered by my insurance company, whether applied to in-network or out-of-network benefits, and for any unpaid co-payment amounts from previous visits. I understand that if I am told by any personnel at A Better Life Chiropractic that I have coverage, this may indicate in-network or out-of-network coverage, and it is up to me to know my insurance plan benefits.

Patient Name_____________________________ Signature___________________________

Guardian Name____________________________ Signature___________________________

EXPERIENCE HEALTH!

We look forward to helping you!

ACCIDENT QUESTIONNAIRE

Patient's Name______________________________ Date of Injury__________ Today's Date____________

DESCRIBE YOUR VEHICLE

1. **Vehicle Type :**
   a. Sports Car
   b. Coupe
   c. Sedan
   d. Sports Utility Vehicle
   e. Station Wagon
   f. Pick-up truck
   g. Bus
   h. Other: ____________________

   Make:________________________ Year:__________

   Model:______________________ Estimated Speed:________

2. **Vehicle Size:**
   a. Compact
   b. Mid-Sized
   c. Full-Sized

DESCRIBE THE ACCIDENT

3. **Date of Accident:** ____________________

4. **Actions of patient's vehicle:**
   a. crossing an intersection
   b. stopped at an intersection
   c. stopped for a pedestrian
   d. stopped for traffic
   e. traveling at posted speed limit
   f. traveling faster than the posted speed limit
   g. turning

5. **How was the patient's vehicle hit:**
   a. hit head-on
   b. was hit on the left front
   c. was hit on the right front
   d. was hit on the left rear
   e. was hit on the right rear
   f. was rear-ended
   g. Other: ________________________

6. **Damage to patient's vehicle:**
   a. complete
   b. extensive
   c. minimal
   d. moderate

7. **Describe the second vehicle:**
   a. compact
   b. full size
   c. mid size
   d. semi trailer
   e. pick-up truck

   Make:________________________ Year:__________

   Model:______________________ Estimated Speed:________

8. **Damage to the other vehicle?**
   a. complete
   b. extensive
   c. minimal
   d. moderate

9. **Weather Conditions**
   a. Clear
   b. Cloudy
   c. Drizzling
   d. Foggy
   e. Rainy
   f. Snowy
   g. Stormy
   h. Sunny

10. **Road Conditions**
    a. Damp
    b. Dry
    c. Dry with icy patches
    d. Iced over
    e. Snowed over
    f. Wet

DESCRIBE THE MOMENT OF IMPACT

11. **Body position at time of impact:**
    a. leaning forward
    b. slouched down in seat
    c. straight
    d. turned to the left
    e. turned to the right

12. **Direction body was thrown:**
    a. backward then forward
    b. forward then backward
    c. to the left
    d. to the right
    e. about the vehicle
    f. outside the vehicle
    g. under the vehicle

13. **Head position at impact:**
    a. straight
    b. tilted forward
    c. turned to the left
    d. turned to the right

14. **Direction head was thrown:**
    a. backward then forward
    b. forward then backward
    c. side to side

15. **Type of restraint:**
    a. lap belt
    b. shoulder belt
    c. shoulder lap belt

16. **Place patient was seated in the vehicle:**
    a. Driver
    b. front passenger
    c. back passenger driver side
    d. back passenger right side
    e. back passenger middle
    f. other________________________

17. **Did Airbags deploy:**
    a. yes
    b. no

18. **Were you seen at a Medical Facility following your accident:**
    a. Yes
    b. No
    If so name and address of the facility:

    ____

    ____

Patient Signature ______________________________

PAIN DISABILITY QUESTIONNAIRE

Patient Name ______________________________ Date ________________

Instructions: These questions ask your views about how your pain now affects how you function in everyday activities. Please answer every question and mark the ONE number on EACH scale that best describes how you feel.

1. **Does your pain interfere with your normal work inside and outside the home?**
Work normally — Unable to work at all
0 ——— 1 ——— 2 ——— 3 ——— 4 ——— 5 ——— 6 ——— 7 ——— 8 ——— 9 ——— 10

2. Does your pain interfere with personal care (such as washing, dressing, etc.)?
Take care of myself completely — Need help with all my personal care
0 ——— 1 ——— 2 ——— 3 ——— 4 ——— 5 ——— 6 ——— 7 ——— 8 ——— 9 ——— 10

3. Does your pain interfere with your traveling?
Travel anywhere I like — Only travel to see doctors
0 ——— 1 ——— 2 ——— 3 ——— 4 ——— 5 ——— 6 ——— 7 ——— 8 ——— 9 ——— 10

4. Does your pain affect your ability to sit or stand?
No problems — Can not sit/stand at all
0 ——— 1 ——— 2 ——— 3 ——— 4 ——— 5 ——— 6 ——— 7 ——— 8 ——— 9 ——— 10

5. Does your pain affect your ability to lift overhead, grasp objects, or reach for things?
No problems — Can not do at all
0 ——— 1 ——— 2 ——— 3 ——— 4 ——— 5 ——— 6 ——— 7 ——— 8 ——— 9 ——— 10

6. Does your pain affect your ability to lift objects off the floor, bend, stoop, or squat?
No problems — Can not do at all
0 ——— 1 ——— 2 ——— 3 ——— 4 ——— 5 ——— 6 ——— 7 ——— 8 ——— 9 ——— 10

7. Does your pain affect your ability to walk or run?
No problems — Can not walk/run at all
0 ——— 1 ——— 2 ——— 3 ——— 4 ——— 5 ——— 6 ——— 7 ——— 8 ——— 9 ——— 10

8. Has your income declined since your pain began?
No decline — Lost all income
0 ——— 1 ——— 2 ——— 3 ——— 4 ——— 5 ——— 6 ——— 7 ——— 8 ——— 9 ——— 10

9. Do you have to take pain medication every day to control your pain?
No medication needed — On pain medication throughout the day
0 ——— 1 ——— 2 ——— 3 ——— 4 ——— 5 ——— 6 ——— 7 ——— 8 ——— 9 ——— 10

10. Does your pain force your to see doctors much more often than before your pain began?
Never see doctors — See doctors weekly
0 ——— 1 ——— 2 ——— 3 ——— 4 ——— 5 ——— 6 ——— 7 ——— 8 ——— 9 ——— 10

11. Does your pain interfere with your ability to see the people who are important to you as much as you would like?
No problem — Never see them
0 ——— 1 ——— 2 ——— 3 ——— 4 ——— 5 ——— 6 ——— 7 ——— 8 ——— 9 ——— 10

12. Does your pain interfere with recreational activities and hobbies that are important to you?
No interference — Total interference
0 ——— 1 ——— 2 ——— 3 ——— 4 ——— 5 ——— 6 ——— 7 ——— 8 ——— 9 ——— 10

13. Do you need the help of your family and friends to complete everyday tasks (including both work outside the home and housework) because of your pain?
Never need help — Need help all the time
0 ——— 1 ——— 2 ——— 3 ——— 4 ——— 5 ——— 6 ——— 7 ——— 8 ——— 9 ——— 10

14. Do you now feel more depressed, tense, or anxious than before your pain began?
No depression/tension — Severe depression/tension
0 ——— 1 ——— 2 ——— 3 ——— 4 ——— 5 ——— 6 ——— 7 ——— 8 ——— 9 ——— 10

15. Are there emotional problems caused by your pain that interfere with your family, social and or work activities?
No problems — Severe problems
0 ——— 1 ——— 2 ——— 3 ——— 4 ——— 5 ——— 6 ——— 7 ——— 8 ——— 9 ——— 10

____
Examiner

OTHER COMMENTS:

With Permission from: Anagnostis C et al: The Pain Disability Questionnaire: A New Psychometrically Sound Measure for Chronic Musculoskeletal Disorders. *Spine* 2004; 29 (20): 2290-2302.

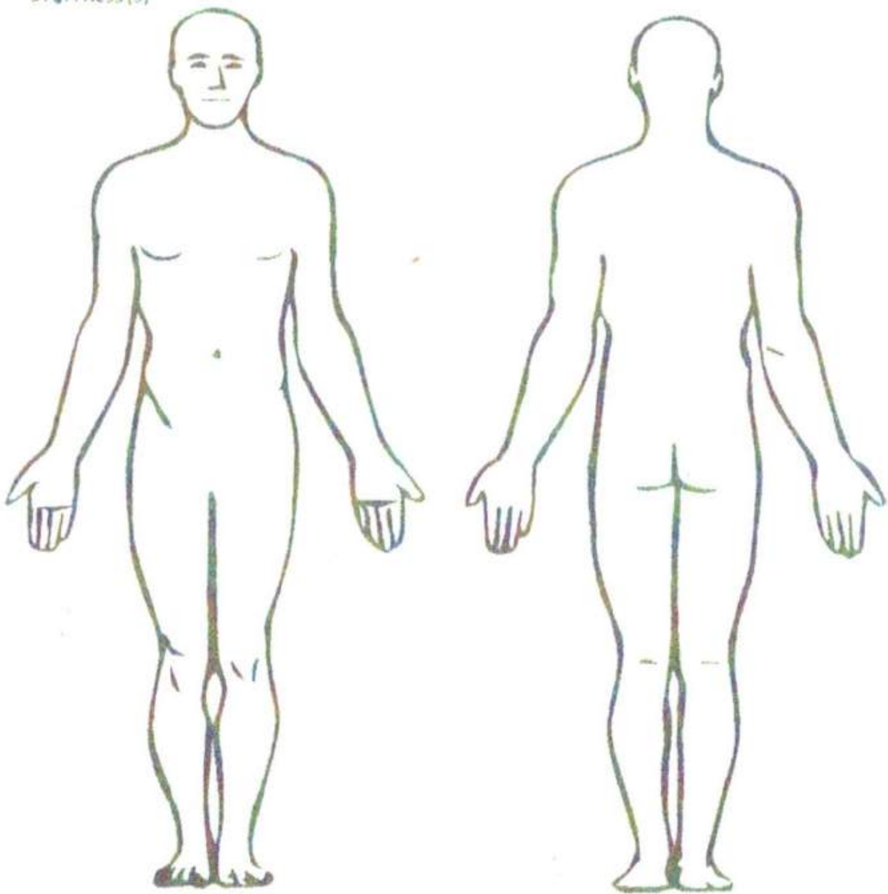
Spinal Instability Pain Correlation Form

PATIENT NAME: ______________________ TODAY'S DATE: ________

PLEASE, COMPLETE THE FOLLOWING "PAIN DIAGRAM" BY USING LETTERS AT THE LEFT TO INDICATE ON THE DIAGRAM YOUR AREAS OF PAIN

PATIENT'S SIGNATURE:

PAIN (P)
TINGLING (T)
NUMBNESS (N)
BURNING (B)
STIFFNESS (S)



Commonly Mapped Pain Patterns

AMSIIC SmartInjuryForms© 2015

A Better Life Chiropractic

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Do you have or are you experiencing ANY of the following conditions or feelings?

___Headaches How often?______
___Neck Pain How often?______
___Neck Stiffness How often?______
___Sleeping Problems How often?______
___Depression How often?______
___Anxiety How often?______
___Fainting How often?______
___Muscle Spasms How often?______
___Middle Back Pain How often?______
___Chest Pain How often?______
___Bruised Chest Which side?______
___Bruising anywhere else? Where?______
___Blurred Vision Right eye______ Left eye______ Both______
___Sensitivity to Light
___Upper Arm Pain R/L____How often?______
___Lower Arm Pain R/L____How often?______
___Lower Back Pain How often?______
___Lower Back Stiffness How often?______
___Radiating Pain Where/How often?______
___Tingling in Leg(s) One_____ Which one? R/L_____ Both______
___Tingling in Arm(s) One_____ Which one? R/L_____ Both______
___Jaw Pain How often?______
___Upper Leg Pain R/L____ How often?______
___Lower Leg Pain R/L____ How often?______
___Ringing in Ear(s) R/L____ How often?______
___Buzzing in Ear(s) R/L____ How often?______
___Dizziness How often?______
___Loss of Smell
___Loss of Taste
___Any Burns Where?______
___Any Stitches Where?______
___Any Cuts Where?______

Patient Signature______________________ Date__________

"Balance Your Body and Have A Better Life"

A Better Life Chiropractic

John S. Smith, D.C.

9882 Colerain Avenue

Cincinnati, OH 45251

Review of Systems

It is important for the doctor to know of your past history. Please check all that apply to your past medical history.

General Symptoms

___Allergy (type)__________
___Bronchitis
___Chills
___Convulsions
___Dizziness
___Fainting
___Fatigue
___Fever
___Headache
___Loss of sleep
___Loss of weight
___Nervousness
___Neuralgia
___Night Sweats
___Numbness or pain
In arms/legs/hands
___Wheezing

Respiratory

___Chest pain
___Chronic cough
___Difficulty Breathing
___Spitting blood
___Spitting phlegm

Genito-Urinary

___Bed wetting
___Blood in urine
___Frequent urination
___Inability to control urine
___Kidney infection
___Painful urination
___Prostate problems

Gastro-Intestinal

___Belching or Gas
___Colon trouble
___Constipation
___Diarrhea
___Excessive hunger
___Gall bladder trouble
___Hemorrhoids
___Jaundice
___Liver trouble
___Nausea
___Pain over stomach
___Poor appetite
___Poor digestion
___Vomiting
___Vomiting blood

Cardio-Vascular

___High blood pressure
___Low blood pressure
___Pain over heart
___Poor circulation
___Previous heart trouble
___Rapid heart
___Slow heart
___Strokes
___Swelling ankles
___Varicose veins

For Women Only

___Cramps or backaches
___Excessive flow
___Hot flashes
___Irregular cycles
___Miscarriage
___Painful periods
___Vaginal dryness
___Pregnant at this time
___Last PAP date___/___/___
By Whom______________________________

Eye/Ear/Nose/Throat

___Asthma
___Crossed eyes
___Deafness
___Ear ache
___Ear discharge
___Enlarged thyroid
___Frequent colds
___Hay fever
___Hoarseness
___Nasal obstruction
___Nose bleeds
___Eye pain
___Poor vision
___Sinusitis
___Sore throats
___Tonsillitis

Skin or Allergies

___Boils
___Bruising easily
___Dryness
___Eczema
___Hives or allergy
___Itching
___Sensitive skin
___Skin eruptions

Signature ____ Date: ___/___/___

AUTHORIZATION TO RELEASE MEDICAL INFORMATION

Name of doctor, hospital, clinic, etc ____

Phone # and/or fax # ____

Patient's name____

Date of birth_____/______/______ Social Security Number ______-_______-________

I request the following information to be released to:

A Better Life Chiropractic
John S. Smith, DC
9882 Colerain Avenue
Cincinnati, OH 45251
Phone: (513)385-2273
Fax: (513) 385-2603

X-rays___History___Records___Diagnosis____Treatment____Reports____Billings_____

Concerning my: Accident___Injury____Illness_____Other_____

DOI ____________________

Signed____Date____/____/_______

Patient____ Spouse_____Parent______Guardian______

**This authorization includes release of information concerning treatment of drug/alcohol abuse, drug related conditions, alcoholism, psychiatric/psychological conditions, AIDS/AIDS related conditions, and/or HIV testing. Review of the record is authorized.

A Better Life Chiropractic
John S. Smith, D.C.
9882 Colerain Avenue
Cincinnati, OH 45251
Phone: (513) 385-2272
Fax: (513) 385-2603

PREGNANCY RELEASE

I. This is to certify that to the best of my knowledge **I am not pregnant** and Dr. John Smith has my permission to take X-rays. I believe that I am not pregnant because **(state reason).**

____

I will assume all responsibility for any effect on a fetus that is potentially present.

____________________________________ Today's date____/____/_____
Patient's signature

II. **I am _______ months pregnant**. Please do not take any x-rays.

____________________________________ Today's date ____/____/_____
Patient's signature

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Phone (513) 385-2273   Fax (513) 385-2603

ACKNOWLEDGMENT OF FINANCIAL RESPONSIBILITY

I acknowledge that upon settlement of my claim number ________________, I am fully responsible for checking with A Better Life Chiropractic to make sure that any payments made by ________________________ Insurance Company for services received by me at A Better Life Chiropractic have been paid to A Better Life Chiropractic. I further understand that just because I receive settlement monies from ________________________ Insurance Company, this does not mean that A Better Life Chiropractic has been paid. If my balance at A Better Life Chiropractic has not been paid, I will become immediately responsible for any unpaid balance.

In the event that I obtain an attorney, I direct said attorney to pay A Better Life Chiropractic for any outstanding balance for services rendered to me as a result of said motor vehicle collision. Payment is to be made directly to A Better Life Chiropractic from any settlement proceeds I or my attorney may receive. This directive is non-revocable. It is fully my responsibility to see that my attorney is informed of this agreement and that said attorney pays A Better Life Chiropractic.

I also understand that if I withhold payments that belong to A Better Life Chiropractic, inadvertently or intentionally, I will be subject to legal fees and interest charges incurred in order to collect the appropriate amounts.

I fully understand and agree to abide by this agreement.

________________________   ________________________
Patient Signature   Name Printed

________________________   ________________________
Date   Attorney

A Better Life Chiropractic

9882 Colerain Avenue
Cincinnati, OH 45251

Telephone (513) 385-2273
fax (513) 385-2603

Authorization For Release of Information

I, the undersigned, directly

authorize ____ to release

information from my medical records, to

____.

Patient Information (Please Print)

Last Name	First	Middle	Maiden	M/F

Address	City/State	Zip

Date of Birth	Social Security #	Phone #

This shall include all billing, medical notes, x-ray and other diagnostic reports, and history/exam records.

This statement must be signed and dated, and may be reviewed at any time. I hereby consent to the disclosure of the treatment records to the purpose and extent stated above.

**Parents must sign the authorization if the request is for a minor.

Signature & Date: ____

PERSONAL INJURY
VERIFICATION OF INSURANCE

PATIENT'S CAR INSURANCE INFORMATION

Patient's name____

Name of Insured (if not patient)______________________________

Car Insurance Company____

Address to send to claims_____________________________________

Representative's name____

Insurance Company's phone number______________________________

Fax number(____)____

Claim number____

3rd PARTY'S CAR INSURANCE INFORMATION

3rd Party is the person who is at fault in the accident

3rd party (person's name)_____________________________________

Name of insured (if not 3rd party)____________________________

3rd Party Insurance company___________________________________

Address to send claims____

3rd Party insurance company phone number______________________

3rd Party Adjustor's name_____________________________________

Claim number____

Fax number(____)____

ATTORNEY INFORMATION

Attorney's name____

Attorney's phone number_______________________________________

Attorney's address____

Have you spoken with this attorney regarding this accident and is this attorney representing you in this personal injury case? Yes/No

Explain:____

____