

PERSONAL INJURY REFERENCE SHEET



DATE OF INJURY

____-____-____

TODAY'S DATE:

INSURANCE COMPANY NAME

INSURANCE COMPANY ADJUSTER

CLAIM #

IS YOUR CLAIM OPEN OR CLOSED? _____

DO YOU HAVE AN ATTORNEY (YES OR NO)? _____

ATTORNEY PHONE NUMBER:

DO YOU HAVE HEALTH INSURANCE (YES OR NO)? _____

HAVE YOU HAD IMAGING?

HAVE YOU SEEN ANY OTHER
PROVIDER FOR THIS
CONDITION YES OR NO)?

**WORKER'S
COMPENSATION
FORM**



Dr. Shilpa S. Parikh, Dr. Anthony C. Heaverlo

Patient Name _____ Phone () _____
Address _____ City _____ State _____ Zip _____
Age _____ Birthdate _____ Sex _____ SS# _____
Employer's Name _____
Employer's Address _____
Insurance Co. _____ Phone# _____
Agent _____ Claim# _____
Address _____ City _____ State _____ Zip _____

1. Type of Business _____ Your Occupation _____
2. Date Injured _____ Hour _____ AM / PM Last Date worked _____
Are you off work? () Yes () No If yes, since when? _____
3. Previous Worker's Compensation Injury? () Yes () No
4. Accident reported to employer? () Yes () No
Name of person reported accident to _____
5. Injured at _____ City _____ State _____ Zip _____
6. Length of time worked there prior to accident: _____
7. Type of work being done at the time of injury: _____

8. In your own words, please describe the accident: _____

9. Have you been treated by another doctor for this accident? () Yes () No
If yes, please list doctor's name and address: _____

What type of treatment did you receive? _____
How long were you treated by this doctor? _____
10. Are you: () Improved () Unchanged () Getting worse
11. What types of medicines are you taking? _____

12. Have you had physical therapy? () Yes () No If yes, how often?
() Daily () Every other day () Several times a week () Weekly () Every other
week () Monthly () Other _____

13. Prior to this accident, have you ever had any of the physical complaints similar to what you have now? () Yes () No () Don't Know If yes, describe: _____

Were these similar complaints the results of a previous accident (s)? () Yes () No
Please provide details of accident(s): _____

14. Have you had any other serious accidents which required medical care? () Yes () No
Describe: _____

15. Have you had any serious illnesses that required hospitalization? () Yes () No
Describe: _____

16. Have you had any surgeries? () Yes () No
If yes, list type of surgery and date: _____

17. Have you had any nervous or mental illnesses? () Yes () No
Have you had psychiatric care? () Yes () No

18. Have you received a medical discharge from the armed forces? () Yes () No

19. Have you returned to work since this accident? () Yes () No

If you have returned to work since your accident, please fill out the information below:

Date	Employer	Occupation	Light Duty Reg. Duty	Full-Time Part-Time

CURRENT MEDICAL COMPLAINTS

BACK PAIN

- Currently, I have pain in my: () Low back () mid back () upper back
- My pain began: () gradually () suddenly
- I have pain: () sometimes () all of the time
- My pain goes into my: () right leg () left leg () both
- I have tingling and/or numbness in my: () right leg () left leg () both
- My pain is worse when I:
Cough or sneeze () Yes () No
Sit () Yes () No
Bend () Yes () No
Walk () Yes () No

- | | | |
|--|---------|--------|
| Lift | () Yes | () No |
| Push | () Yes | () No |
| Pull | () Yes | () No |
| 7. My back is worse with sexual activity | () Yes | () No |
| 8. My pain wakes me up during the night | () Yes | () No |
| 9. Changes in the weather affect my pain | () Yes | () No |

NECK PAIN

- | | | |
|---|---------------|-----------------------|
| 1. My pain began: | () gradually | () suddenly |
| 2. I have pain: | () sometimes | () all of the time |
| 3. My pain goes into my: | () right arm | () left arm () both |
| 4. I have tingling and/or numbness in my: | () right arm | () left arm () both |
| 5. My pain is worse when I: | | |
| Cough or sneeze | () Yes | () No |
| Bend forward | () Yes | () No |
| Lift | () Yes | () No |
| Push | () Yes | () No |
| Pull | () Yes | () No |
| Turn my head | () Yes | () No |
| 6. My pain wakes me up during the night | () Yes | () No |
| 7. Changes in the weather affect my pain | () Yes | () No |
| 8. I have neck stiffness | () Yes | () No |
| 9. I have headaches | () Yes | () No |
| 10. If I do get headaches, they occur: | () sometimes | () all of the time |

OTHER PAIN

Please describe any current medical complaints which you are experiencing and were not previously covered on this questionnaire, or list any additional comments you wish to make regarding your condition:

JOB DESCRIPTION

(In terms of an 8-hour workday, "occasionally" means 33%, "frequently" means 34% to 66%, and "continuously" means 67% to 100% of the day)

1. In a typical 8-hour workday, I: (Circle # of hours / activity)

Sit:	1	2	3	4	5	6	7	8	hours
Stand:	1	2	3	4	5	6	7	8	hours
Walk:	1	2	3	4	5	6	7	8	hours

2. On the job, I perform the following activities:

	NOT AT ALL	OCCASIONALLY	FREQUENTLY	CONTINUOUSLY
Bend / stoop	()	()	()	()
Squat	()	()	()	()
Crawl	()	()	()	()
Climb	()	()	()	()
Reach above shoulder level	()	()	()	()
Crouch	()	()	()	()
Kneel	()	()	()	()
Balancing	()	()	()	()
Pushing / Pulling	()	()	()	()

3. On the job, I lift:
- | | NOT AT ALL | OCCASIONALLY | FREQUENTLY | CONTINUOUSLY |
|------------------|------------|--------------|------------|--------------|
| Up to 10 pounds | () | () | () | () |
| 11 to 24 pounds | () | () | () | () |
| 25 to 34 pounds | () | () | () | () |
| 35 to 50 pounds | () | () | () | () |
| 51 to 74 pounds | () | () | () | () |
| 75 to 100 pounds | () | () | () | () |

4. Do you have to bend over while doing any lifting? () Yes () No

5. Are your feet used for repetitive movements, such as in operating foot controls? () Yes () No

6. Do you use your hands for repetitive actions, such as:

	SIMPLE GRASPING	FIRM GRASPING	FINE MANIPULATING
Right Hand	() Yes () No	() Yes () No	() Yes () No
Left Hand	() Yes () No	() Yes () No	() Yes () No

7. Are you required to work on unprotected heights? () Yes () No

Describe: _____

8. Are you required to be around moving machinery? () Yes () No

Describe: _____

9. Are you exposed to marked changes in temperature and humidity? () Yes () No

Describe: _____

10. Are you required to drive automotive equipment? () Yes () No

Describe: _____

11. Are you exposed to dust, fumes, and/or gases? () Yes () No

Describe: _____

12. Please list any additional comments:-

Signature _____ Date: _____



PATIENT INTAKE FORM

Patient's Name: _____ Date of Birth: _____
(LAST, FIRST, MIDDLE INITIAL)

Patient's Guardian Name (if applicable): _____

Address: _____

Phone: _____ Email: _____ Gender: M / F

Primary Healthcare Provider and/or Clinic: _____

Please tell us who you were referred by so we may thank them:

☐ Physician: _____ ☐ Other (friend/family/patient): _____

Marital status? (Please check most current status)

- ☐ Single
☐ Married
☐ Living with Significant Other
☐ Divorced/Separated
☐ Widowed

Are you being seen for:

- ☐ Motor Vehicle Accident
☐ Workers Compensation

What is your race?

(Defined by the federal government; please check one)

- ☐ Asian or Pacific Islander
☐ Black/African American
☐ Hispanic
☐ American Indian or Alaskan Native
☐ White
☐ Other _____

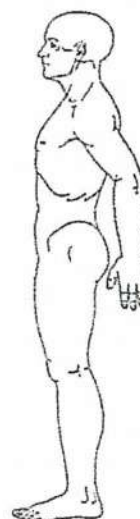
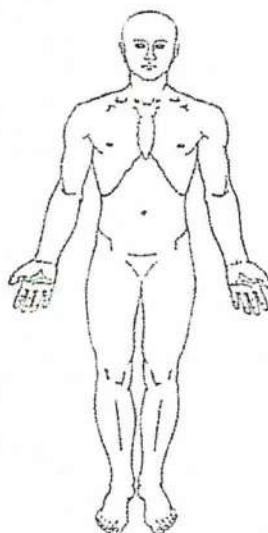
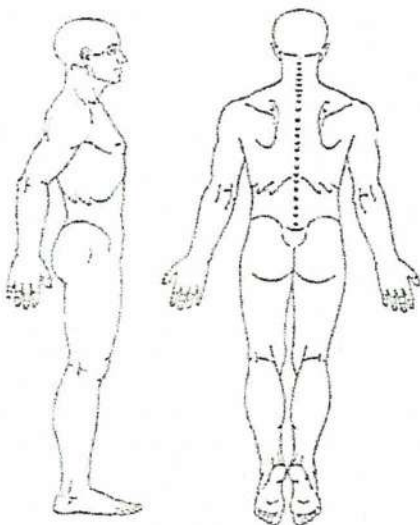
What is the reason for your visit today? _____

Was there a triggering event? _____

How long have you had the problem? _____

What do you want your treatment to accomplish? _____

Please indicate where you have pain or other symptoms below:



NUMBNESS

=====

PINS & NEEDLES

000000

BURNING

XXXXX

STABBING

//////

ACHING

+++++

Other

Please list any significant traumas or injuries you have had: _____

Patient/Guardian Signature _____ Date _____

PATIENT REVIEW OF SYSTEMS

Please check the "Current" box for all conditions that you are now experiencing and mark the "Past" box for any condition or symptom(s) experienced previously. Please do not write in the spaces marked "Clinician's Notes Only".

	Current	Past	Clinician's Notes Only Please do not write in this space.		Current	Past	Clinician's Notes Only Please do not write in this space.
GENERAL				LUNGS			
Fever				Difficulty breathing			
Sweats				Asthma			
Chills				Pneumonia			
Fatigue				Wheezing			
Weight loss/gain				Persistent cough			
Sleep disturbance				Coughing up phlegm			
Change in routine				Coughing up blood			
HEAD				Tuberculosis			
Headache				CARDIO VASCULAR			
Dizziness				Chest pain			
Head trauma				Palpitations			
Fainting				Ankle swelling			
Blacking out				Cold/hot feet or hands			
EYES				Discolored foot/hand			
Change in vision				Leg cramps/calf pain			
Glasses/Contacts				Varicose veins			
Blurry/double vision				High/low blood pressure			
Cataracts				G-I SYSTEM			
Sensitive to light				Gas			
Flashes in vision				Heartburn/Indigestion			
Spots in vision				Ulcers			
EARS				Vomiting/Nausea			
Ring in ears				Abdominal pain			
Frequent infection				Diarrhea/constipation			
Hearing loss				Blood in stool			
Drainage				Hemorrhoids			
Ear pain				Gall bladder disease			
NOSE				Liver disease			
Post nasal drip				Colonoscopy			
Nosebleeds				G-U SYSTEM			
Sinus problems				Difficulty urinating			
MOUTH				Pain urinating			
Bleeding gums				Blood in urine			
Cold sores				Incontinence			
Dentures				Foul odor of urine			
Trouble Swallowing				Increase/decreased urination			
Sore throat				Urinary infection			
Jaw pain				Genital infection			
Changes in taste				Kidney stones			
Swelling				Last prostate exam (males) _____			
Hoarseness				Last PSA (males) _____			
Last dental appt _____				Last testicular exam (males) _____			
MEDICAL				MEDICATION			
Substance abuse				Prescription medications			(please bring)
Hospitalization				OTC medication			(please bring)
Psychiatric care				Vitamins			(please bring)
Surgeries _____				Herbs			
Last chest x-ray (for those over age 55) _____				Drug allergies _____			

	Current	Past	Clinician's Notes Only Please do not write in this space.		Current	Past	Clinician's Notes Only Please do not write in this space.
PSYCHOLOGIC				NECK			
Excessive Stress				Masses			
Depression				Swelling			
Anxiety				Stiffness			
Mood swings				SOCIAL			
SKIN				Consume alcohol			
Rash				Consume caffeine			
Bruising				Tobacco use			
Hair loss				Recreational drugs			
Brittle nails				Exercise	Y	N	
Changes in moles				Safe at home	Y	N	
Itching/peeling				Guns at home	Y	N	
NEUROLOGIC				Seat belts used	Y	N	
Seizures/Epilepsy				Text while driving	Y	N	
Strokes				Hobbies _____			
Tingling/numbness				Drink _____ glasses water/day			
Weakness				Sleep _____ hours/night			
Difficulty walking				Occupation _____			
Poor coordination				OB GYN (females)			
MUSCLE/BONE				Pregnancy			
Osteoporosis				Breast cancer			
Joint pain				Lumps in breast			
Stiffness				Nipple discharge			
Muscle ache				PMS			
Arthritis				Irregular periods			
Deformity				Hot flashes			
Bone pain				Menopause			
Dislocations				Menstrual cramps			
Fractures (please list):				Age period began _____			
LABORATORY				Last breast exam _____			
Last fasting blood glucose _____ (date)				Last PAP _____			
Last cholesterol _____ (date)				Last mammogram _____			
VACCINATIONS (if age >60 y/o)				PAST MEDICAL HISTORY			
Flu				Allergies _____			
Varicella				Hypertension			
Pneumonia				Diabetes			
Tetanus				Cancer/Tumor			
FAMILY HISTORY (immediate family members)				Anemia			
Cancer				Other _____			
Alcoholism							
Depression							
Epilepsy							
Alzheimer's							
Heart Disease							
Other _____							
<p>Patient Name _____ Date _____</p> <p>Patient Signature _____</p> <p>Clinician's Name _____</p>							

The Keele STarT Back Screening Tool

Patient name: _____ Date: _____

Thinking about the **last 2 weeks** tick your response to the following questions:

	Disagree 0	Agree 1
1 My back pain has spread down my leg(s) at some time in the last 2 weeks	<input type="checkbox"/>	<input type="checkbox"/>
2 I have had pain in the shoulder or neck at some time in the last 2 weeks	<input type="checkbox"/>	<input type="checkbox"/>
3 I have only walked short distances because of my back pain	<input type="checkbox"/>	<input type="checkbox"/>
4 In the last 2 weeks, I have dressed more slowly than usual because of back pain	<input type="checkbox"/>	<input type="checkbox"/>
5 It's not really safe for a person with a condition like mine to be physically active	<input type="checkbox"/>	<input type="checkbox"/>
6 Worrying thoughts have been going through my mind a lot of the time	<input type="checkbox"/>	<input type="checkbox"/>
7 I feel that my back pain is terrible and it's never going to get any better	<input type="checkbox"/>	<input type="checkbox"/>
8 In general I have not enjoyed all the things I used to enjoy	<input type="checkbox"/>	<input type="checkbox"/>

9. Overall, how **bothersome** has your back pain been in the **last 2 weeks**?

Not at all	Slightly	Moderately	Very much	Extremely
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
0	0	0	1	1

Total score (all 9): _____ Sub Score (Q5-9): _____

List Your Pains/Complaints From Most Severe (Problem #1) To Least

Today, you have the following physical complaints:	Location Of Problem #1	Location Of Problem #2	Location Of Problem #3	Location Of Problem #4
Is this complaint: Sharp, Dull, Achy, Throbbing, Numb, Shooting, or Other (explain)?	<input type="checkbox"/> Sharp <input type="checkbox"/> Dull <input type="checkbox"/> Achy <input type="checkbox"/> Throbbing <input type="checkbox"/> Numb <input type="checkbox"/> Tingle <input type="checkbox"/> Electric/Shooting	<input type="checkbox"/> Sharp <input type="checkbox"/> Dull <input type="checkbox"/> Achy <input type="checkbox"/> Throbbing <input type="checkbox"/> Numb <input type="checkbox"/> Tingle <input type="checkbox"/> Electric/Shooting	<input type="checkbox"/> Sharp <input type="checkbox"/> Dull <input type="checkbox"/> Achy <input type="checkbox"/> Throbbing <input type="checkbox"/> Numb <input type="checkbox"/> Tingle <input type="checkbox"/> Electric/Shooting	<input type="checkbox"/> Sharp <input type="checkbox"/> Dull <input type="checkbox"/> Achy <input type="checkbox"/> Throbbing <input type="checkbox"/> Numb <input type="checkbox"/> Tingle <input type="checkbox"/> Electric/Shooting
How long have you had this?				
Since it began is it getting:	<input type="checkbox"/> Better <input type="checkbox"/> Same <input type="checkbox"/> Worse	<input type="checkbox"/> Better <input type="checkbox"/> Same <input type="checkbox"/> Worse	<input type="checkbox"/> Better <input type="checkbox"/> Same <input type="checkbox"/> Worse	<input type="checkbox"/> Better <input type="checkbox"/> Same <input type="checkbox"/> Worse
What makes it better?				
What makes it worse?				
On a scale of 0-10 rate your discomfort:	<u>0 1 2 3 4 5 6 7 8 9 10</u> 10 = Excruciating 0 = No Discomfort	<u>0 1 2 3 4 5 6 7 8 9 10</u> 10 = Excruciating 0 = No Discomfort	<u>0 1 2 3 4 5 6 7 8 9 10</u> 10 = Excruciating 0 = No Discomfort	<u>0 1 2 3 4 5 6 7 8 9 10</u> 10 = Excruciating 0 = No Discomfort
How have you taken care of this, and how has it worked?				
This issue is affecting my:	<input type="checkbox"/> Job o Childcare <input type="checkbox"/> Marriage/Sex <input type="checkbox"/> Sports/Hobbies <input type="checkbox"/> Finances <input type="checkbox"/> Bowel/Bladder <input type="checkbox"/> Digestion	<input type="checkbox"/> Job o Childcare <input type="checkbox"/> Marriage/Sex <input type="checkbox"/> Sports/Hobbies <input type="checkbox"/> Finances <input type="checkbox"/> Bowel/Bladder <input type="checkbox"/> Digestion	<input type="checkbox"/> Job o Childcare <input type="checkbox"/> Marriage/Sex <input type="checkbox"/> Sports/Hobbies <input type="checkbox"/> Finances <input type="checkbox"/> Bowel/Bladder <input type="checkbox"/> Digestion	<input type="checkbox"/> Job o Childcare <input type="checkbox"/> Marriage/Sex <input type="checkbox"/> Sports/Hobbies <input type="checkbox"/> Finances <input type="checkbox"/> Bowel/Bladder <input type="checkbox"/> Digestion
Helping this issue would increase my quality of life by:	<input type="checkbox"/> 10-30% <input type="checkbox"/> 40-75% <input type="checkbox"/> 80-100%	<input type="checkbox"/> 10-30% <input type="checkbox"/> 40-75% <input type="checkbox"/> 80-100%	<input type="checkbox"/> 10-30% <input type="checkbox"/> 40-75% <input type="checkbox"/> 80-100%	<input type="checkbox"/> 10-30% <input type="checkbox"/> 40-75% <input type="checkbox"/> 80-100%

People see us for different reasons. Some come for relief of pain, some to correct the cause, and others to prevent future ailments. Your doctor will weigh your needs and desires when recommending your health program. Please check the type of care desired so that we may be guided by your wishes.

☐ Relief
 ☐ Correction of the cause
 ☐ Prevention
 ☐ Let the doctor choose for me

Have you experienced any of the following symptoms associated with your reason for visiting us today? Check all that any/all that apply:



- ☐ Double vision
- ☐ Dizziness
- ☐ Sudden numbness/weakness of face, arms or legs
- ☐ Difficulty speaking
- ☐ Difficulty walking due to poor coordination
- ☐ Vomiting/queasiness
- ☐ Involuntary, rapid eye movements
- ☐ Loss of bowel/bladder function
- ☐ Pain that wakes you up at night
- ☐ Excessive weight loss/gain within the past 6 months
- ☐ Blood in urine or bowel
- ☐ Night sweats
- ☐ Pain that doesn't increase/decrease with changes in position
- ☐ Deep, aching pain

What type of chiropractic care are you interested in? Check all that apply:

- ☐ Structural spinal adjustments
- ☐ Neurological/instrument assisted adjustments
- ☐ Nutrition counseling
- ☐ Whole food supplementation
- ☐ Plantar Fasciitis relief
- ☐ Instrument assisted soft tissue mobilization
- ☐ Pre-pregnancy planning
- ☐ Detoxification/weight-loss
- ☐ Ayurveda
- ☐ Other: _____

What kind of chiropractic care have you received in the past?
Check all that apply:

- ☐ Structural spinal adjustments
- ☐ Neurological spinal adjustments
- ☐ Nutrition counseling
- ☐ Whole Food Supplementation
- ☐ E-stim
- ☐ Instrument Assisted Soft tissue mobilization
- ☐ Exercises/Stretching
- ☐ Muscle taping
- ☐ Therapeutic ultrasound
- ☐ Lumbar decompression therapy

How was your last chiropractic experience?

What would you change?

What would you keep the same?

Neck Pain

This form is to be completed by patients being seen for neck pain. This questionnaire is designed to enable us to understand how much your **neck pain** has affected your ability to manage 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 closely describes your problem right now.

Pain intensity

- ① I have no pain at the moment.
- ② The pain is very mild at the moment.
- ③ The pain is moderate and does not vary much.
- ④ The pain is fairly severe at the moment.
- ⑤ The pain is severe but comes and goes
- ⑥ The pain is severe and does not vary much.

Personal care (washing, dressing, etc.)

- ① I can look after myself normally without causing extra pain.
- ② I can look after myself normally but it causes extra pain.
- ③ It is painful to look after myself and I am slow and careful.
- ④ I need some help but manage most of my personal care.
- ⑤ I need help every day in most aspects of self care.
- ⑥ I do not get dressed, wash with difficulty and stay in bed.

Lifting

- ① I can lift heavy weights without extra pain.
- ② I can lift heavy weights, but it causes extra pain.
- ③ Pain prevents me from lifting heavy weights off the floor but I can manage if they are conveniently positioned, e.g. on a table.
- ④ Pain prevents me from lifting heavy weights but I can manage light to medium weights if they are conveniently positioned.
- ⑤ I can lift only very light weights.
- ⑥ I cannot lift or carry anything at all.

Reading

- ① I can read as much as I want to with no pain in my neck.
- ② I can read as much as I want with slight pain in my neck.
- ③ I can read as much as I want with moderate pain in my neck.
- ④ I cannot read as much as I want because of moderate pain in my neck.
- ⑤ I cannot read as much as I want because of severe pain in my neck.
- ⑥ I cannot read at all.

Headache

- ① I have no headaches at all.
- ② I have slight headaches which come infrequently.
- ③ I have moderate headaches which come in-frequently.
- ④ I have moderate headaches which come frequently.
- ⑤ I have severe headaches which come frequently.
- ⑥ I have headaches almost all the time.

Concentration

- ① I can concentrate fully when I want to with no difficulty.
- ② I can concentrate fully when I want to with slight difficulty.
- ③ I have a fair degree of difficulty in concentrating when I want to.
- ④ I have a lot of difficulty in concentrating when I want to.
- ⑤ I have a great deal of difficulty in concentrating when I want to.
- ⑥ I cannot concentrate at all.

Work

- ① I can do as much work as I want to.
- ② I can only do my usual work, but no more.
- ③ I can do most of my usual work, but no more.
- ④ I cannot do my usual work.
- ⑤ I can hardly do any work at all.
- ⑥ I cannot do any work at all.

Driving

- ① I can drive my car without neck pain.
- ② I can drive my car as long as I want with slight pain in my neck.
- ③ I can drive my car as long as I want with moderate pain in my neck.
- ④ I cannot drive my car as long as I want because of moderate pain in my neck.
- ⑤ I can hardly drive my car at all because of severe pain in my neck.
- ⑥ I have no social life because of pain.

Sleeping

- ① My sleep is never disturbed by pain.
- ② My sleep is occasionally disturbed by pain.
- ③ Because of pain I have less than 6 hours sleep.
- ④ Because of pain I have less than 4 hours sleep.
- ⑤ Because of pain I have less than 2 hours sleep.
- ⑥ Pain prevents me from sleeping at all.

Recreation

- ① I am able engage in all recreational activities with no pain in my neck at all.
- ② I am able engage in all recreational activities with some pain in my neck.
- ③ I am able engage in most, but not all recreational activities because of pain in my neck.
- ④ I am able engage in a few of my usual recreational activities because of pain in my neck.
- ⑤ Pain restricts me to short necessary journeys under 30 minutes.
- ⑥ I cannot do any recreational activities at all

Low Back Oswestry 2.1a

This form is to be completed for patients being seen for back pain. This questionnaire is designed to give us information as to how your back (or leg) trouble affects your ability to manage in everyday life. Please answer every section. Mark one number only in each section that most closely describes you today.

Pain intensity

- ① I have no pain at the moment.
- ② The pain is very mild at the moment.
- ③ The pain is moderate at the moment.
- ④ The pain is fairly severe at the moment.
- ⑤ The pain is very severe at the moment.
- ⑥ The pain is the worst imaginable at the moment.

Personal care (washing, dressing, etc.)

- ① I can look after myself normally without causing extra pain.
- ② I can look after myself normally but it is very painful.
- ③ It is painful to look after myself and I am slow and careful.
- ④ I need some help but manage most of my personal care.
- ⑤ I need help every day in most aspects of self care.
- ⑥ I do not get dressed, wash with difficulty and stay in bed.

Lifting

- ① I can lift heavy weights without extra pain.
- ② I can lift heavy weights but it gives extra pain.
- ③ Pain prevents me from lifting heavy weights off the floor but I can manage if they are conveniently positioned, e.g. on a table.
- ④ Pain prevents me from lifting heavy weights but I can manage light to medium weights if they are conveniently positioned.
- ⑤ I can lift only very light weights.
- ⑥ I cannot lift or carry anything at all.

Walking

- ① Pain does not prevent me walking any distance.
- ② Pain prevents me walking more than one mile.
- ③ Pain prevents me walking more than a quarter of a mile.
- ④ Pain prevents me walking more than 100 yards.
- ⑤ I can only walk using a stick or crutches.
- ⑥ I am in bed most of the time and have to crawl to the toilet.

Sitting

- ① I can sit in any chair as long as I like.
- ② I can sit in my favorite chair as long as I like.
- ③ Pain prevents me from sitting for more than 1 hour.
- ④ Pain prevents me from sitting for more than half an hour.
- ⑤ Pain prevents me from sitting for more than 10 minutes.
- ⑥ Pain prevents me from sitting at all.

Standing

- ① I can stand as long as I want without extra pain.
- ② I can stand as long as I want but it gives me extra pain.
- ③ Pain prevents me from standing for more than 1 hour.
- ④ Pain prevents me from standing for more than half an hour.
- ⑤ Pain prevents me from standing for more than 10 minutes.
- ⑥ Pain prevents me from standing at all.

Sleeping

- ① My sleep is never disturbed by pain.
- ② My sleep is occasionally disturbed by pain.
- ③ Because of pain I have less than 6 hours sleep.
- ④ Because of pain I have less than 4 hours sleep.
- ⑤ Because of pain I have less than 2 hours sleep.
- ⑥ Pain prevents me from sleeping at all.

Sex life (if applicable)

- ① My sex life is normal and causes no extra pain.
- ② My sex life is normal but causes some extra pain.
- ③ My sex life is nearly normal but is very painful.
- ④ My sex life is severely restricted by pain.
- ⑤ My sex life is nearly absent because of pain.
- ⑥ Pain prevents any sex life at all.

Social life

- ① My social life is normal and causes me no extra pain.
- ② My social life is normal but increases the degree of pain.
- ③ Pain has no significant effect on my social life apart from limiting my more energetic interests, e.g. sport, etc.
- ④ Pain has restricted my social life and I do not go out as often.
- ⑤ Pain has restricted social life to my home.
- ⑥ I have no social life because of pain.

Travelling

- ① I can travel anywhere without pain.
- ② I can travel anywhere but it gives extra pain.
- ③ Pain is bad but I manage journeys over two hours.
- ④ Pain restricts me to journeys of less than one hour.
- ⑤ Pain restricts me to short necessary journeys under 30 minutes.
- ⑥ Pain prevents me from travelling except to receive treatment.



CHIROPRACTIC INFORMED CONSENT

I hereby give my consent to the performance of diagnostic tests and procedures and chiropractic treatment or management of my condition(s).

Initials: _____ Date: _____

Chiropractic treatment or management of conditions almost always includes the chiropractic adjustment, a specific type of joint manipulation. Like most health care procedures, the chiropractic adjustment carries with it some risks. Unlike many such procedures, the serious risks associated with the chiropractic adjustment are extremely rare. **Following are the known risks:**
Temporary soreness or increased symptoms or pain It is not uncommon for patients to experience temporary soreness or increased symptoms or pain after the first few treatments.

Dizziness, nausea, flushing These symptoms are relatively rare. It is important to notify the chiropractor if you experience these symptoms during or after your care.

Fractures When patients have underlying conditions that weaken bones, like osteoporosis, they may be susceptible to fracture. It is important to notify your chiropractor if you have been diagnosed with a bone weakening disease or condition. If your chiropractor detects any such condition while you are under care, you will be informed and your treatment plan will be modified to minimize risk of fracture.

Disc herniation or prolapse Spinal disc conditions like bulges or herniations may worsen even with chiropractic care. It is important to notify your chiropractor if symptoms change or worsen.

Stroke A certain extremely rare type of stroke has been associated with chiropractic care. Although there is an association between this type of stroke and chiropractic visits, there is also an association between this type of stroke and primary care medical visits. According to the most recent research, there is no evidence of excess risk of stroke associated with chiropractic care. The increased occurrence of this type of stroke associated with both chiropractic and medical visits is likely explained by patients with neck pain and headache consulting both doctors of chiropractic and primary care medical doctors before or during their stroke.

Other risks associated with chiropractic treatment include rare burns from physiotherapy devices that produce heat.

Bruising Instrument assisted soft tissue manipulation may result in temporary soreness or bruising.

I understand that the practice of chiropractic, like the practice of all healing arts, is not an exact science, and I acknowledge that no guarantee can be given as to the results or outcome of my care.

• PATIENT PLEASE REVIEW • PRINT & SIGN NAME •

I have read or had read to me this informed consent document. I have discussed or been given the opportunity to discuss any questions or concerns with my chiropractor and have had these answered to my satisfaction prior to my signing this informed consent document. I have made my decision voluntarily and freely.

PATIENT'S NAME (Print) _____ DATE OF BIRTH _____

(PATIENT | GUARDIAN SIGNATURE) _____ (DATE) _____ (TRANSLATOR | INTERPRETER SIGNATURE) _____ (DATE) _____
(if applicable)

CLINICIAN ONLY

Based on my personal observation and the patient's history, I conclude that throughout the informed consent process the patient was:

- | | | | |
|---------------------------------------|---|--|--|
| <input type="checkbox"/> OF LEGAL AGE | <input type="checkbox"/> APPEARS UNIMPAIRED | <input type="checkbox"/> CONSENT GIVEN THROUGH GUARDIAN | <input type="checkbox"/> INTERN PRESENT - INITIALS _____ |
| <input type="checkbox"/> ORIENTED X3 | <input type="checkbox"/> FLUENT IN ENGLISH | <input type="checkbox"/> ASSISTED BY A TRANSLATOR OR INTERPRETER | <input type="checkbox"/> INTERN NOT PRESENT |

_____, D.C.
(D.C. SIGNATURE) _____ (DATE) _____



PATIENT FINANCIAL ACKNOWLEDGEMENT

Please read thoroughly. Initial your acknowledgement, then sign and print your name and date. Thank you.

ASSIGNMENT OF BENEFITS

☐

I assign all benefits payable to me for my care at Vitality Chiropractic & Wellness #833 55104. I understand that this health care facility will be paid directly by the insurance company or other payer. This assignment will remain in effect until revoked by me in writing. A photocopy of this assignment is considered as valid as the original.

GUARANTEE OF PAYMENT

☐

I guarantee payment of all charges incurred for treatment in accordance with the rates and terms of this health care facility.

CANCELLATION POLICY

☐

To maintain our excellence in customer service, we require a 24-hour cancellation notification for our acupuncture, massage, naturopath, nutrition, and Oriental medicine appointments. Please notify the clinic within 24 hours to avoid a charge for the missed appointment.

SIGNATURE (PATIENT/GUARDIAN)

PRINT NAME

DATE

Office Use Only

United Health Care	Medica	Preferred One	Landmark/CCMI (Health Partners, Cigna, Patient Choice)	Medicare	Medical Assistance	Select Care	BCBS	Other
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<input type="checkbox"/> CHIROPRACTIC	<input type="checkbox"/> ACUPUNCTURE	<input type="checkbox"/> NURSE PRACTITIONER
1. Deductible/co-insurance? _____	1. Deductible/co-insurance? _____	1. Deductible/co-insurance? _____
2. Is there a co-pay? \$ _____	2. Co-pay? \$ _____	2. Co-pay? \$ _____
3. Limit on visits or services? _____	3. Limit on visits or services? _____	
4. Authorization/Precertification needed? _____		
<input type="checkbox"/> 992XX (Examination)	<input type="checkbox"/> ACUPUNCTURE BENEFITS NOT VERIFIED	
<input type="checkbox"/> 97110 (Therapeutic exercise)		
<input type="checkbox"/> 97112 (NMS re-education)		
<input type="checkbox"/> EXTRA SPINAL MANIPULATION		
<input type="checkbox"/> LABORATORY		
<input type="checkbox"/> Orthotics _____ # per year		
<input type="checkbox"/> Orthotics NOT verified		
<input type="checkbox"/> Radiology non-spinal		
<input type="checkbox"/> Radiology-spinal		
<input type="checkbox"/> STRAPPING		
<input type="checkbox"/> 97010 (Hot/cold packs)		
<input type="checkbox"/> 97032 (EMS Attended)		
<input type="checkbox"/> 97035 (Ultrasound)		
<input type="checkbox"/> S8948 (Cold laser)		
<input type="checkbox"/> 97012 (Mechanical Traction)	<input type="checkbox"/> ACUPUNCTURE NOT A BENEFIT ON THIS PLAN	

BASED ON THE INFORMATION PROVIDED BY THE HEALTH INSURANCE PLAN, SERVICES CHECKED ABOVE ARE NOT COVERED.

PAYMENT POLICY



Thank you, for choosing our office to meet your health care needs. In choosing to use your group health insurance to meet your financial obligation with our office, you must clearly understand and agree to the guidelines listed below. If you have any questions regarding our policy, please do not hesitate to speak with our accounts receivable administrator.

1. You will be considered a cash patient until our office qualifies and accepts your insurance coverage. We will verify your chiropractic benefits within 72 working hours of your first visit. These benefits will be reviewed with you so that you have a clear understanding of what your financial obligation will be at each visit.
2. Many of our patients are covered by health insurance. Due to extreme variations in insurance policy coverage, we encourage our patients to check with their insurance company or employer to determine their specific coverage. This includes the participating provider list and out of network payment schedule.
3. **You must pay all deductibles and co-pays in full at the time of visit** unless prior authorization was given and a payment policy was agreed upon by a mutual payment plan agreement.
4. If your plan requires a referral from your primary care doctor or precertification prior to your visit and you fail to obtain, you will be responsible for full payment of that visit at time of services are rendered.
5. If we do not participate with your insurance plan, you are responsible for full payment of your visit, even if it exceeds the insurance's determination of "usual and customary allowance" for the procedure performed.
6. If your insurance policy requires a treatment plan be submitted for continued care, Vitality Chiropractic & Wellness will do this on your behalf. As a result of their review they may impose restrictions on the number of visits the time allotted for your care with our office, you will be responsible for any visits that exceed the imposed restriction. If an appeal process is appropriate we will help you with appealing the decision to the appropriate parties.
7. If you are restricted to a number of visits or maximum dollar limitation allowed per year imposed by your insurance plan, you will be responsible for payment of any visits over that allowance.
8. We can not accept responsibility for collecting an insurance claim after 60 days or negotiating a disputed claim. Insurance policies are a contract between you, your employer and the insurance carrier. You are ultimately responsible for payment on your account. If you have a dispute with how your insurance company processed a claim, you are responsible to contact them directly to resolve the dispute.
9. If your insurance is terminated or there is any change in your plan, it is your responsibility to notify us immediately.
10. Infrequently insurers or patients submit payments in excess of the required amount. When we receive mistaken payments or large over payments, we attempt to make a good faith effort to refund the reimbursement or apply the over payment to future billings. Certain credit balances will not be refunded due to administrative burden.

Credit balances equal to the value of an adjustment (\$48) will neither be automatically refunded to the patient or any third party payor if after any reasonable attempt, administrative burdens makes it difficult to continue to process the refund. Patient disclaims and right, title or interest to the knowingly and voluntarily waives and legal demand to the foregoing credit balance, which shall not constitute unclaimed or abandoned property in the possession of a holder as defined in the Unclaimed Property Act, 72 P.S. §1301.1 and §1301.10(1).

11. I hereby agree that in consideration of the services rendered I understand that any portion that is not covered by my insurance will be responsibility. This consent and agreement will remain in effect as long as the patient remains active in our practice.
12. There is a \$25 cancellation fee for any missed regular appointments with less than 24 hour notice.
13. Vitality Chiropractic & Wellness reserves the right to discontinue care if unpaid balances exceed the cost of 2 visits. Any unpaid balance may be sent to collections if left unpaid for greater than 30 days.

I have read and agree to the financial policy of Vitality Chiropractic & Wellness, Dr. Shilpa S. Parikh, DC & Dr. Anthony C. Heaverlo at 393 Dunlap Street North Suite #833 Saint Paul, Minnesota 55104.

PATIENT/ GUARANTOR SIGNATURE _____

PRINT NAME

DATE

WITNESS SIGNATURE _____

PRINT NAME

DATE