Cousineau Chiropractic Life Center, P.C.

AUTO ACCIDENT CASE FORM

PLEASE FILL OUT THE FOLLOWING IN COMPLETE DETAIL

Name_____ Age____ Sex____ Date_____

Occupation/job description_____ Phone Number_____

Date of auto accident_____

Claim No._____

PLEASE EXPLAIN IN DETAIL HOW YOUR ACCIDENT HAPPENED:_____

_____

_____

Name of health insurance_____

Name of auto insurance_____ Phone number_____

Auto insurance address_____

Adjustor's name_____

☐ I need attended care
☐ I do not need attended care?

Did you inform your auto insurance?
☐ Yes ☐ No

☐ I need household replacement services
☐ I do not need household replacement services

Did you inform your auto insurance?
☐ Yes ☐ No

Name of your attorney_____ Phone number_____

Address_____

City_____ State_____ Zip_____

Did you miss work due to the accident?_____ If yes, from_____ to_____

Are you off work at this time due to the accident?_____

Were you taken to the hospital following the accident?_____

If yes, what hospital?_____ How long?_____

Did you consult another doctor following the accident?____

If yes, what was the doctor's name?_____

How often did you see the doctor?_____ What treatment was given?_____

_____

Did you have any pre-existing problems before the auto accident?_____ If yes, please explain in detail

_____

Please list any past surgeries_____

Please list any accidents or injuries prior to this injury_____

_____

14550 KING ROAD • RIVERVIEW, MICHIGAN 48193 • TELEPHONE: (734) 479-1880 • FAX: (734) 479-4810

ASSIGNMENT OF RIGHTS

Patient Name _____ ("Assignor")

Medical Provider COUSINEAU CHIROPRACTIC LCC ("Assignee")

Assignor acknowledges that he/she has received treatment, products, services and/or accommodations (collectively the "Services") from Assignee and that Assignor has incurred charges for such Services.

For valuable consideration as set forth herein, Assignor hereby certifies that upon execution of this agreement, Assignor has incurred charges with respect to Services from Assignee on or before the date of execution for which the rights, privileges, claims and remedies for payment for each of those Services are hereby assigned to Assignee.

Assignor understands this Assignment is effective and irrevocable (subject to the termination provision below), as of today's date, and in furtherance of the Assignment, Assignor acknowledges the following:

This is an assignment of the right to enforce payment of charges incurred for Services, for which charges are payable under any policy of insurance, contract, legal claim and/or statute. Such assignment shall include, in Assignee's sole discretion, the right to appeal a payment denial under any procedure outlined in any insurance policy, contract or statute and/or the right to file suit to enforce the payment of benefits due or past due for the Services incurred and resulting charges.

For all purposes of enforcement of this Assignment, Assignee or its agent is designated as my attorney in fact with respect to any action taken in pursuit of payment for Services provided by Assignee. In the event Assignee files suit to enforce payment of benefits due or past due for the Services, Assignor consents that such suit may be pursued solely in Assignor's name or by Assignee on behalf of Assignor, as Assignee's sole discretion. Assignor further agrees to cooperate and assist Assignee to enforce the payment of benefits and authorizes Assignee to speak with Assignor's attorneys and representatives regarding any and all aspects of such legal claims.

Assignor and Assignee agree that as consideration for this assignment, Assignee assumes the burden, otherwise born by the Assignor, to pursue payment for Services rendered by the Assignee, from the insurance company or entity responsible to pay for such Services. This may include Assignee doing some or all of the following: (1) submitting its bills directly to the insurance company or entity; (2) pursuing the insurance company or entity which is responsible to pay Assignee's bills for payment of Assignee's bills; (3) incurring any expense associated with pursuing payment of Assignee's bills, (4) hiring or retaining the services of an attorney or collection agency to pursue payment of Assignee's bills.

To the extent that Assignor or his representatives receive any award by judgment, settlement, arbitration or otherwise, pertaining to or comprising any portion of the Services, Assignor consents to assign such portion of such award to Assignee until Assignee has received payment for the Services. Assignor further acknowledges and agrees that this agreement shall, for all purposes, constitute a lien on any such award in favor of Assignor and Assignee is authorized to provide notice of this assignment to any party who may receive such an award in favor of Assignor pertaining to or comprising any portion of the Services.

This assignment shall not reduce, diminish or impair Assignor's obligation to pay Assignee for the Services and Assignee acknowledges that, at any time hereto, Assignee may pursue Assignor directly for payment for the Services irrespective of this assignment.

This assignment shall be irrevocable unless terminated by mutual agreement of Assignee and Assignor in writing.

Assignor and Assignee agree that in the event any terms or provisions of this agreement are declared invalid or unenforceable by any Court or Federal or State Government Agency having jurisdiction over the subject matter of this agreement, the remaining terms and provisions that are not affected thereby shall remain in full force and effect.

Patient Signature _____ ("Assignor")

Date ____/____/____

COUSINEAU CHIROPRACTIC
14550 KING RD
RIVERVIEW, MI. 48193
734-479-1880

Headache Disability Index

Date _____

Patient Name: _____

INSTRUCTIONS: Please CIRCLE the correct response:

1. I have headache: (1) 1 per month (2) more than 1 but less than 4 per month (3) more than one per week
2. My headache is: (1) mild (2) moderate (3) severe

Please read carefully: The purpose of the scale is to identify difficulties that you may be experiencing because of your headache. Please check off "YES", "SOMETIMES", or "NO" to each item. Answer each question as it pertains to your headache only.

YES	SOMETIMES	NO	
____	____	____	Because of my headaches I feel disabled.
____	____	____	Because of my headaches I feel restricted in performing my routine daily activities.
____	____	____	No one understands the effect my headaches have on my life.
____	____	____	I restrict my recreational activities (eg, sports, hobbies) because of my headaches.
____	____	____	My headaches make me angry.
____	____	____	Sometimes I feel that I am going to lose control because of my headaches.
____	____	____	Because of my headaches I am less likely to socialize.
____	____	____	My spouse (significant other), or family and friends have no idea what I am going through because of my headaches.
____	____	____	My headaches are so bad that I feel that I am going to go insane.
____	____	____	My outlook on the world is affected by my headaches.
____	____	____	I am afraid to go outside when I feel that a headaches is starting.
____	____	____	I feel desperate because of my headaches.
____	____	____	I am concerned that I am paying penalties at work or at home because of my headaches.
____	____	____	My headaches place stress on my relationships with family or friends.
____	____	____	I avoid being around people when I have a headache.
____	____	____	I believe my headaches are making it difficult for me to achieve my goals in life.
____	____	____	I am unable to think clearly because of my headaches.
____	____	____	I get tense (eg, muscle tension) because of my headaches.
____	____	____	I do not enjoy social gatherings because of my headaches.
____	____	____	I feel irritable because of my headaches.
____	____	____	I avoid traveling because of my headaches.
____	____	____	My headaches make me feel confused.
____	____	____	My headaches make me feel frustrated.
____	____	____	I find it difficult to read because of my headaches.
____	____	____	I find it difficult to focus my attention away from my headaches and on other things.

Instructions: 1. Using this system, if "YES" is checked on any given line, that answer is given 4 points... a "SOMETIMES" answer is given 2 points and a "NO" answer is given zero. 2. Using this system, a score of 10-28% is considered to constitute mild disability; 30-48% is moderate; 50-68% is severe; 72% or more is complete.

Patient's Signature: _____ Date: _____

SPINAL HEALTH QUESTIONNAIRE
(OSWESTRY QUESTIONNAIRE)

DATE_____

COUSINEAU CHIROPRACTIC
14550 KING RD
RIVERVIEW, MI. 48193
734-479-1880

PATIENT NAME_____ PAT #_____

SECTION 1 - PAIN INTENSITY
- ☐ A. Pain comes and goes and is mild.
- ☐ B. Pain is mild and does not vary.
- ☐ C. Pain comes and goes and is moderate.
- ☐ D. Pain is moderate and does not vary much.
- ☐ E. Pain comes and goes and is severe.
- ☐ F. Pain is severe and does not vary much.

SECTION 2 - PERSONAL CARE
- ☐ A. Does not change habits to avoid pain.
- ☐ B. Does not change habits/Some Pain.
- ☐ C. Does not change habits/Increases pain.
- ☐ D. Changes habits/Increases Pain.
- ☐ E. Unable to do some personal care without help.
- ☐ F. Unable to wash or dress without help.

SECTION 3 - LIFTING
- ☐ A. Lifts heavy weights with no pain.
- ☐ B. Lifts heavy weights with pain.
- ☐ C. Cannot lift heavy weights off the floor.
- ☐ D. Can lift heavy weights from a table.
- ☐ E. Can lift light weights from a table.
- ☐ F. Can lift only very light weights.

SECTION 4 - WALKING
- ☐ A. Pain does not prevent walking.
- ☐ B. Cannot walk more than one mile.
- ☐ C. Cannot walk more than 1/2 mile.
- ☐ D. Cannot walk more than 1/4 mile.
- ☐ E. Can walk only with crutches.
- ☐ F. Bedridden and must crawl to the toilet.

SECTION 5 - SITTING
- ☐ A. Can sit in any chair as long as desired.
- ☐ B. Can sit only in the favorite chair as long as desired.
- ☐ C. Can sit no more than 1 hour.
- ☐ D. Can sit no more than 1/2 hour.
- ☐ E. Can sit no more than 10 minutes.
- ☐ F. Cannot sit at all due to pain.

SECTION 6 - STANDING
- ☐ A. Can stand for an unlimited time without pain.
- ☐ B. Some pain standing/doesn't increase with time.
- ☐ C. Cannot stand for more than 1 hour.
- ☐ D. Cannot stand for more than 1/2 hour.
- ☐ E. Cannot stand more than 10 minutes.
- ☐ F. Cannot stand at all.

SECTION 7 - SLEEPING
- ☐ A. No pain in bed.
- ☐ B. Gets pain in bed, but sleeps well.
- ☐ C. Normal sleep reduced by 1/4.
- ☐ D. Normal night's sleep reduced by 1/2.
- ☐ E. Normal night's sleep reduced by 3/4.
- ☐ F. Cannot sleep at all due to pain.

SECTION 8 - TRAVELING
- ☐ A. Travel without pain.
- ☐ B. Travel causes some pain, but not made worse.
- ☐ C. Causes extra pain/No change in form.
- ☐ D. Causes pain/Uses alternate travel.
- ☐ E. Pain restricts all form of travel.
- ☐ F. Pain restricts travel except lying down.

SECTION 9 - SOCIAL
- ☐ A. Normal and causes no pain.
- ☐ B. Normal but causes extra pain.
- ☐ C. Limits energetic interests.
- ☐ D. Pain limits/doesn't go out as often.
- ☐ E. Pain restricted social life to home.
- ☐ F. Pain restricts all social life.

SECTION 10 - CHANGING DEGREE OF PAIN
- ☐ A. Pain is rapidly improving.
- ☐ B. Pain fluctuates but is improving.
- ☐ C. Improvement is slow.
- ☐ D. Pain level is unchanged.
- ☐ E. Pain is gradually worsening.
- ☐ F. Pain is rapidly worsening.

☐ Need attended care (i.e. personal, feeding, bathing, dressing, driving, etc.)_____

☐ Need household replacement services (i.e. laundry, dishes, cooking, yardwork, etc.) _____

☐ Working ☐ Not working

FOR DOCTOR USE ONLY

A = 0 B = 2 C = 4 D = 6 E = 8 F = 10

Score _____

Percent Range Correlated With Disability_____

Additional Notes/Comments

COUSINEAU CHIROPRACTIC
14550 KING RD
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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 (Washing, Dressing, etc.)

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 gives extra pain.
C Pain prevents me from lifting heavy weights off the floor, but I can manage if they are conveniently positioned, for example, 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 to 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)

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 recreational activities because of pain in my neck.
D I am able to engage in a few of my 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.

COMMENTS: _____

_____

_____

NAME: _____ **DATE:** _____ **SCORE:** _____

Please Answer Every Question

Body Shop Questionnaire

Client:_____ Date:_____

Make/Model_____ Your estimate of Repair_____

1. Please include frame time cost and OEM parts in the estimate. You may do an alternative estimate for non OEM parts.

$_____

2. Did the rear bumper absorbers move more than one inch? If so, how many inches? This should be memorialized with a 35mm photograph, if possible.

Yes_____ How many inches?_____ No_____

3. Did rear bumper absorbers not move at all and is there rust or other buildup visible on the absorber armature? (This should be memorialized with a 35mm photograph if possible.)

Yes_____ No_____ 35mm available?_____

4. Was this a submarine style accident? In other words, was there undercarriage damage but little visible damage to the unibody of the vehicle?

Yes_____ No_____

5. Are more than two hours of frame repair time required? (If at all possible, also document this with a certified frame inspection. Often times this is overlooked when the insurance carrier completes the estimate. They are taught to write only what can be seen.)

Yes_____ No_____

6. Does the damage travel beyond the rear wheel well? (This should be documented by a 35mm photograph taken along the side of the vehicle. Often times this is overlooked when the insurance carrier completes the estimate. They are taught to write only what can be seen.)

Yes_____ No_____ 35mm available?_____

7. Is there significant prior damage to the same impact area of the vehicle?

Yes_____ No_____

8. Please note if this is not a unibody vehicle.

Yes_____ No_____

9. Please note if the vehicle had an attached item; which would eliminate the effectiveness of the unibody and/or low impact bumper. (This is often seen when the vehicle has a trailer hitch directly mounted onto the frame of the vehicle. Also, watch for items such as bicycle carriers, wheelchair lifts or other such devices, which would eliminate the functionality of the low impact bumper or unibody structure.)

Yes_____ No_____

If yes what is the item?_____

10. Were seatbelts and seatbelt locking mechanisms checked for replacement?

Yes_____ No_____

11. If so, which ones?_____

12. Were the driver or passenger seat mounts damaged? Or were any of the seats knocked off their mounts?

Yes_____ No_____

13. If so, which one?_____

14. Was the headrest for either the driver or passenger seat damaged?

Yes_____ No_____

15. If so, which one?_____

Printed Name:_____

Signature:_____

Phone #_____

MOTOR VEHICLE ACCIDENT QUESTIONAIRRE

Patient Name: _____ Date: _____ Acct. #: _____

Date of Accident: _____ Time of Accident: _____

City/County/State where accident happened: _____

Type of Vehicles involved in accident: Yours _____ Other Vehicle: _____

Your position in Vehicle: ☐ Driver ☐ Front middle ☐ Passenger ☐ Back left ☐ Back middle ☐ Back Right
☐ Pedestrian that was hit by vehicle.

DESCRIPTION OF THE ACCIDENT:

Your vehicle was:

☐ Crossing an intersection
☐ Stopped at an intersection
☐ Stopped for a crossing pedestrian
☐ Stopped in traffic
☐ Traveling at the posted speed
☐ Traveling faster than the speed limit
☐ Traveling slower than the speed limit
☐ Turning left
☐ Turning right
☐ Heading North
☐ Heading Northeast
☐ Heading Northwest
☐ Heading South
☐ Heading Southeast
☐ Heading Southwest
☐ Heading East
☐ Heading West

Your car was:

☐ Hit head on
☐ Hit on the front right
☐ Hit on the front left
☐ Hit on the rear right
☐ Hit on the rear left
☐ Rear-ended
☐ Side swiped on the left
☐ Side swiped on the right
☐ Hit the other car head on
☐ Hit the other car on the front right
☐ Hit the other car on the front left
☐ Hit the other car on the right rear
☐ Hit the other car on the left rear
☐ Rear – ended the other car
☐ Side swiped the other car on the left
☐ Side swiped the other car on the right

Amount of damage to your car:
☐ Complete ☐ Extensive ☐ Minimal ☐ Moderate

Speed of your car at time of impact: _____

Amount of damage to other car:
☐ Complete ☐ Extensive ☐ Minimal ☐ Moderate

Speed of other car at time of impact: _____

Weather condition: ☐ Clear ☐ Cloudy ☐ Drizzling ☐ Foggy ☐ Rainy ☐ Snowing ☐ Stormy ☐ Sunny

Road condition: ☐ Damp ☐ Dry ☐ Dry with icy patches ☐ Iced over ☐ Snowed over ☐ Wet

Visibility: ☐ Fair ☐ Good ☐ Poor

DESCRIBE THE MOMENT OF IMPACT

Body position at impact:

☐ Leaning forward
☐ Slouched down in the seat
☐ Sitting straight
☐ Turned to the left
☐ Turned to the right
☐ Holding on to the steering wheel.
☐ Bracing your arms against the dash
☐ Bracing your feet against the floor
☐ Not holding on the steering wheel
☐ Not bracing arms against the dash
☐ Not bracing feet against the floor

Vehicle was pushed: ☐ Forward ☐ Backward ☐ Sideways

Patient Name: _____ Date: _____ Acct. #: _____

Type of passive restraint: ☐ Lap belt ☐ Shoulder belt ☐ Lap and Shoulder belt

Direction body was thrown:

☐ Backward then forward	☐ To the right	☐ Under the vehicle
☐ Forward then backward	☐ About the vehicle	
☐ To the left	☐ Outside the vehicle	

Head position at impact: ☐ Straight ☐ Tilted forward ☐ Turned left ☐ Turned right

Direction head was thrown: ☐ Backward then forward ☐ Forward then backward ☐ Side to side

Position of headrest: ☐ High position ☐ Low position ☐ Middle position ☐ Not installed.

Did the vehicle go into a spin or roll as a result of the accident? ☐ Yes ☐ No

Were the breaks being applied? ☐ Yes ☐ No

Did the airbags deploy? ☐ Yes ☐ No

Was your ankle turned? ☐ Yes ☐ No

Did your head ride over the headrest? ☐ Yes ☐ No

Did you hit anything in the vehicle? ☐ Yes ☐ No

If yes what did you hit:

☐ Dashboard ☐ Windshield ☐ Door ☐ Seat ☐ Steering wheel ☐ Ceiling ☐ Loose objects ☐ Side window

What body part(s) hit:

☐ Head	☐ Right arm	☐ Right wrist	☐ Right knee
☐ Left shoulder	☐ Left elbow	☐ Left hip	☐ Left ankle
☐ Right shoulder	☐ Right elbow	☐ Right hip	☐ Right ankle
☐ Left arm	☐ Left wrist	☐ Left knee	

WHAT HAPPENED IMMEDIATELY FOLLOWING THE ACCIDENT?

Initial Reaction:

☐ Shaken ☐ Upset ☐ Nervous ☐ Confused ☐ Frightened ☐ Dazed ☐ Distressed ☐ Dizzy ☐ Weak

Where did you have pain?

☐ Head	☐ Left forearm	☐ Abdomen	☐ Right shin
☐ Neck	☐ Right wrist	☐ Low back	☐ Left shin
☐ Right shoulder	☐ Left wrist	☐ Pelvis	☐ Right foot
☐ Left shoulder	☐ Right hand	☐ Right buttock	☐ Left foot
☐ Right arm	☐ Left hand	☐ Left buttock	
☐ Left arm	☐ Rib cage	☐ Right leg	
☐ Right elbow	☐ Chest	☐ Left leg	
☐ Left elbow	☐ Upper back	☐ Right knee	
☐ Right forearm	☐ Mid back	☐ Left knee	

Patient Name: _____ Date: _____ Acct. #: _____

Did you receive any cuts?

- ☐ Head
- ☐ Neck
- ☐ Right shoulder
- ☐ Left shoulder
- ☐ Right arm
- ☐ Left arm
- ☐ Right elbow
- ☐ Left elbow
- ☐ Right forearm
- ☐ Left forearm
- ☐ Right wrist
- ☐ Left wrist
- ☐ Right hand
- ☐ Left hand
- ☐ Rib cage
- ☐ Chest
- ☐ Upper back
- ☐ Mid back
- ☐ Abdomen
- ☐ Low back
- ☐ Pelvis
- ☐ Right buttock
- ☐ Left buttock
- ☐ Right leg
- ☐ Left leg
- ☐ Right knee
- ☐ Left knee
- ☐ Right shin
- ☐ Left shin
- ☐ Right foot
- ☐ Left foot

What type of emergency care was provided?

☐ Bandaging ☐ Bracing ☐ CPR ☐ A neck collar ☐ Splinting

Immediate destination after accident? ☐ Work ☐ Home ☐ School ☐ Hospital ☐ Clinic ☐ Doctors office

If taken to a hospital or clinic, name: _____

If seen by a physician, name: _____

Diagnoses: _____

If admitted to hospital date admitted: _____ Date discharged: _____

Diagnostic exams performed: ☐ X-ray ☐ CAT scan ☐ MRI

Area of body diagnostic exam performed on:

- ☐ Head
- ☐ Neck
- ☐ Right shoulder
- ☐ Left shoulder
- ☐ Right arm
- ☐ Left arm
- ☐ Right elbow
- ☐ Left elbow
- ☐ Right forearm
- ☐ Left forearm
- ☐ Right wrist
- ☐ Left wrist
- ☐ Right hand
- ☐ Left hand
- ☐ Rib cage
- ☐ Chest
- ☐ Upper back
- ☐ Mid back
- ☐ Abdomen
- ☐ Low back
- ☐ Pelvis
- ☐ Right buttock
- ☐ Left buttock
- ☐ Right leg
- ☐ Left leg
- ☐ Right knee
- ☐ Left knee
- ☐ Right shin
- ☐ Left shin
- ☐ Right foot
- ☐ Left foot

Treatment administered:

- ☐ Adjustments
- ☐ Bandaging
- ☐ Bracing
- ☐ Casting
- ☐ A collar
- ☐ Hot packs
- ☐ Ice packs
- ☐ Injection
- ☐ Oral medications
- ☐ Splinting
- ☐ Supports
- ☐ Surgery
- ☐ Sutures
- ☐ Topical antiseptics

Medications prescribed:

- ☐ Antibiotics
- ☐ Anti-inflammatory
- ☐ Anxiety
- ☐ Herbal
- ☐ Muscle relaxant
- ☐ Over the counter
- ☐ Pain medication

Recommendations:

- ☐ See a chiropractor
- ☐ No further treatment
- ☐ Rest
- ☐ See a general practitioner
- ☐ See a general surgeon
- ☐ See a neurologist
- ☐ See a orthopedic surgeon
- ☐ Physical Therapy
- ☐ Ice packs
- ☐ Heat packs
- ☐ Time off work
- ☐ Use cervical collar
- ☐ Use supports