

|   |                        |                         |   |                                   |            |
|---|------------------------|-------------------------|---|-----------------------------------|------------|
| <b>PATIENT NAME</b> (FIRST, MIDDLE, LAST) |                        |                         | <b>SEX</b><br><input type="checkbox"/> M <input type="checkbox"/> F | <b>DATE OF BIRTH</b> (MM/DD/YYYY) | <b>AGE</b> |
| <b>ADDRESS</b>                            |                        | <b>CITY</b>             |   | <b>STATE</b>                      | <b>ZIP</b> |
| <b>HOME #</b><br>( ) -                    | <b>CELL #</b><br>( ) - | <b>WORK #</b><br>( ) -  | <b>EMAIL</b>  |                                   |            |
| <b>SOC. SECURITY #</b>                    | <b>EMPLOYER</b>        | <b>OCCUPATION/TITLE</b> |   |                                   |            |
| <b>EMERGENCY CONTACT/RELATIONSHIP</b>     |                        |                         |   | <b>CONTACT #</b><br>( ) -         |            |

**AUTO ACCIDENT INFORMATION**

|   |  |
|---|--|
| <b>DATE &amp; TIME OF ACCIDENT</b><br>____/____/____ at ____:____ <input type="checkbox"/> AM <input type="checkbox"/> PM | <b>CONDITIONS AT TIME OF ACCIDENT:</b><br><input type="checkbox"/> DAYLIGHT <input type="checkbox"/> NIGHT <input type="checkbox"/> DAWN <input type="checkbox"/> DUSK |
| <b>LOCATION OF ACCIDENT</b>   | <b>CONDITIONS OF ROAD AT TIME OF ACCIDENT:</b><br><input type="checkbox"/> DRY <input type="checkbox"/> WET <input type="checkbox"/> ICY                               |

|  |   |
|--|---|
| <b>WAS YOUR CAR STRUCK BY ANOTHER VEHICLE?</b><br><input type="checkbox"/> YES <input type="checkbox"/> NO | <b>DID YOUR CAR STRIKE ANOTHER VEHICLE OR OBJECT?</b><br><input type="checkbox"/> YES <input type="checkbox"/> NO |
|--|---|

|                            |              |              |
|----------------------------|--------------|--------------|
| <b>YOUR VEHICLE MODEL:</b> | <b>MAKE:</b> | <b>YEAR:</b> |
|----------------------------|--------------|--------------|

**LOCATION IN VEHICLE AT TIME OF ACCIDENT:**  
 DRIVER (IF NOT, WHO? \_\_\_\_\_)  FRONT PASSENGER  BACK PASSENGER

**WHO ELSE WAS IN THE CAR?** \_\_\_\_\_

**AREA OF VEHICLE IMPACT:**  FRONT END (  L,  MID,  R )  REAR END (  L,  MID,  R )  OTHER: \_\_\_\_\_

**HAVE YOU REPORTED THIS ACCIDENT TO YOUR AUTO INSURANCE?**  YES  NO

**DO YOU HAVE MED PAY?**  YES  NO

**YOUR VEHICLE INSURANCE INFORMATION**

|                               |                 |                |
|-------------------------------|-----------------|----------------|
| <b>AUTO INSURANCE COMPANY</b> | <b>POLICY #</b> | <b>CLAIM #</b> |
|-------------------------------|-----------------|----------------|

|                         |                                  |
|-------------------------|----------------------------------|
| <b>ADJUSTER'S NAME:</b> | <b>ADJUSTER'S PHONE #:</b> ( ) - |
|-------------------------|----------------------------------|

**OTHER VEHICLE INFORMATION (IF APPLICABLE)**

**DAMAGE TO OTHER VEHICLE:**  NONE  MINIMAL  MODERATE  MAJOR

**ACCIDENT DETAILS**

**DESCRIBE HOW THE ACCIDENT OCCURRED**

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

**WERE YOU AWARE OF IMPENDING ACCIDENT?**  YES  NO

|   |   |
|---|---|
| <b>AT THE TIME OF COLLISION, WAS YOUR VEHICLE:</b><br><input type="checkbox"/> STOPPED <input type="checkbox"/> ACCELERATING <input type="checkbox"/> SLOWING | <b>APPROXIMATE SPEED OF YOUR VEHICLE AT TIME OF COLLISION:</b><br>_____ MPH |
|---|---|

**SEATBELT:**  NOT WEARING  WEARING (  SHOULDER & LAP  LAP ONLY  SHOULDER ONLY )

|  |  |
|--|--|
| <b>DID SEATBELT ENGAGE?</b> <input type="checkbox"/> YES <input type="checkbox"/> NO | <b>DID AIRBAGS DEPLOY?</b> <input type="checkbox"/> YES <input type="checkbox"/> NO          |
|  | <b>IF YES, DID THEY STRIKE YOU?</b> <input type="checkbox"/> YES <input type="checkbox"/> NO |

|  |  |
|--|--|
| <b>HANDS: ONE ON STEERING WHEEL?</b> <input type="checkbox"/> YES <input type="checkbox"/> NO <b>BOTH ON STEERING WHEEL?</b> <input type="checkbox"/> YES <input type="checkbox"/> NO  |  |
| <b>BODY POSITION AT IMPACT:</b> <input type="checkbox"/> GOOD <input type="checkbox"/> LEANING FORWARD <input type="checkbox"/> TURNED IN SEAT ( <input type="checkbox"/> RIGHT, <input type="checkbox"/> LEFT) <input type="checkbox"/> OTHER                                       |  |
| <b>HEAD POSITION AT IMPACT:</b> <input type="checkbox"/> FORWARD <input type="checkbox"/> UP ____° <input type="checkbox"/> DOWN ____° <input type="checkbox"/> TURNED RIGHT <input type="checkbox"/> TURNED LEFT ____°  |  |
| <b>AMBULANCE ON SCENE?</b> <input type="checkbox"/> YES <input type="checkbox"/> NO  | <b>DID YOU REQUIRE POST-ACCIDENT HOSPITALIZATION?</b> <input type="checkbox"/> YES <input type="checkbox"/> NO |
| <b>DID YOU LOSE CONSCIOUSNESS?</b> <input type="checkbox"/> YES <input type="checkbox"/> NO <b>IF YES, FOR HOW LONG?</b> _____   |  |
| <b>WERE POLICE ON SCENE?</b> <input type="checkbox"/> YES <input type="checkbox"/> NO <b>REPORT FILED?</b> <input type="checkbox"/> YES <input type="checkbox"/> NO <b>IF YES, REPORT #:</b> _____   |  |
| <b>DID YOUR BODY STRIKE ANY PART OF THE VEHICLE?</b> <input type="checkbox"/> YES <input type="checkbox"/> NO <b>IF YES, WHAT/WHERE?</b> _____   |  |
| <b>WERE YOU WEARING A HAT OR GLASSES?</b> <input type="checkbox"/> YES <input type="checkbox"/> NO <b>IF YES, WERE THEY STILL ON AFTER ACCIDENT?</b> <input type="checkbox"/> YES <input type="checkbox"/> NO  |  |
| <b>WHEN DID SYMPTOMS FIRST APPEAR AFTER COLLISION?</b> <input type="checkbox"/> IMMEDIATELY <input type="checkbox"/> ____ HOURS LATER <input type="checkbox"/> ____ DAY(S) LATER   |  |
| <b>SYMPTOMS AFTER ACCIDENT:</b>  |  |
| <input type="checkbox"/> HEADACHE  | <input type="checkbox"/> CONFUSION   |
| <input type="checkbox"/> DIZZINESS   | <input type="checkbox"/> NECK PAIN   |
| <input type="checkbox"/> NAUSEA  | <input type="checkbox"/> UPPER BACK PAIN   |
| <input type="checkbox"/> LOWER BACK PAIN   | <input type="checkbox"/> LEG PAIN/NUMBNESS   |
| <input type="checkbox"/> ARM PAIN/NUMBNESS   | <input type="checkbox"/> KNEE PAIN/CONTUSION   |
| <input type="checkbox"/> WRIST PAIN/NUMBNESS   | <input type="checkbox"/> OTHER: _____  |
| <b>WHERE DID YOU GO AFTER THE ACCIDENT?</b>  |  |
| <input type="checkbox"/> ER ( <input type="checkbox"/> AMBULANCE, <input type="checkbox"/> DROVE SELF, <input type="checkbox"/> DRIVEN BY ANOTHER) <input type="checkbox"/> WORK <input type="checkbox"/> HOME <input type="checkbox"/> DOCTOR <input type="checkbox"/> OTHER: _____ |  |
| <b>XRAYS/IMAGING DONE AFTER ACCIDENT:</b> <input type="checkbox"/> XRAYS <input type="checkbox"/> MRI <input type="checkbox"/> OTHER   |  |
| <b>WHAT HOSPITAL OR MEDICAL FACILITY PERFORMED IMAGING?</b> _____  |  |
| <b>OTHER DOCTORS YOU HAVE SEEN SINCE THIS ACCIDENT:</b>  |  |
| 1. NAME _____  | SPECIALTY _____  |
| 2. NAME _____  | SPECIALTY _____  |
| <b>TREATMENT RECEIVED:</b> _____   |  |
| <b>HAVE YOU HAD SIMILAR PHYSICAL COMPLAINTS?</b> <input type="checkbox"/> YES <input type="checkbox"/> NO <b>IF YES, WHEN?</b> _____   |  |
| <b>PRIOR TREATMENT HISTORY:</b> HAVE YOU BEEN IN ANY OTHER AUTO ACCIDENTS? <input type="checkbox"/> YES <input type="checkbox"/> NO  |  |
| <b>IF YES, LIST ALL DATES, AREAS INJURED, TYPE OF TREATMENT RECEIVED AND NAME OF TREATING HEALTHCARE PROFESSIONAL:</b>   |  |
| _____  |  |
| _____  |  |

I certify that the above information is true to the best of my knowledge. I authorize the release of any information necessary to process this claim. A copy of this authorization shall be as valid as the original.

**PATIENT'S SIGNATURE:** \_\_\_\_\_ **DATE:** \_\_\_\_\_

### APPOINTMENT CANCELLATION POLICY

PLEASE CALL US AT LEAST 24 HOURS IN ADVANCE IF YOU NEED TO CANCEL OR RESCHEDULE YOUR APPOINTMENT. IF A PATIENT FAILS TO CANCEL WITHIN 24 HOURS OF SCHEDULED APPOINTMENT, THEY MAY BE CHARGED A **\$25 CANCELLATION FEE**.

I, THE PATIENT AND/OR GUARDIAN, FULLY UNDERSTAND AND ACKNOWLEDGE THE RECOMMENDED TREATMENT PLAN AND THE CANCELLATION POLICY.

\_\_\_\_\_  
PATIENT/GUARANTOR SIGNATURE

\_\_\_\_\_  
DATE

### INFORMED CONSENT FOR CHIROPRACTIC CARE

I hereby request and consent to the performance of chiropractic adjustments and other chiropractic procedure, including various modes of physical therapy and diagnostic x-rays, and any supportive therapies on me (or on the patient named below, for whom I am legally responsible) by Dr. Nelson S. Ong, D.C. and/or other licensed doctors of chiropractic and support staff who now or in the future treat me while employed by, working or associated with or serving as back-up for the doctor of chiropractic named above, including those working at the clinic or office listed above or any other office or clinic, whether signatories to this form or not.

I have had an opportunity to discuss with the doctor of chiropractic named above and/or with other office or clinic personnel, the nature and purpose of chiropractic adjustments and procedures. I understand that results are not guaranteed.

I understand and am informed that, as in the practice of medicine and like all other health modalities, results are not guaranteed, and there is no promise of cure. I further understand and am informed that, as in practice of medicine, the practice of chiropractic, which involves the use of hands in such a way to restore proper motion to the joints, there are some risks of treatment, including, but not limited to, fractures, disc injuries, strokes, dislocations and sprains. Tests are employed in the doctor's exams to identify if I am susceptible to an injury such as stroke. I do not expect the doctor to be able to anticipate and explain all risks and complications. I wish to rely on the doctor to exercise judgment during the course of the procedure which the doctor feels at the time, based upon the facts known, is in my best interests.

I further understand that there are treatment options available for my condition other than chiropractic procedure. These treatment options include, but not limited to, self-administered, over-the-counter analgesics and rest; medical care with prescription drugs such as anti-inflammatories, muscle relaxants and painkillers; physical therapy; steroid injections; bracing; and surgery. I understand and have been informed that I have the right to a second opinion and to secure other options if I have concerns as to the nature of my symptoms and treatment options.

I have read, or have had read to me, the above consent. I have also had an opportunity to ask questions about its content, and by signing below I consent the entire course of treatment for my present condition and any future care I may receive from Dr. Nelson S. Ong, DC or any other licensed doctor of chiropractic working in their stead.

\_\_\_\_\_  
PRINT PATIENT'S NAME

\_\_\_\_\_  
PRINT REPRESENTATIVE'S NAME

\_\_\_\_\_  
SIGNATURE OF PATIENT

\_\_\_\_\_  
SIGNATURE OF REPRESENTATIVE

\_\_\_\_\_  
DATE SIGNED

\_\_\_\_\_  
RELATIONSHIP OF REPRESENTATIVE

\_\_\_\_\_  
SIGNATURE OF WITNESS

\_\_\_\_\_  
DATE SIGNED

\_\_\_\_\_  
DATE SIGNED

## ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

Notice to Patient(s):

We are required to provide you with a copy of our Notice of Privacy Practices which outlines how we may use and/or disclose your health information. Please review the Notice of Privacy Practices and complete this form as an acknowledgment of receipt. If you decline to provide a signed acknowledgment, we will continue to provide treatment and will use and disclose your protected health information for treatment, payment, and health care operations consistent with federal and state law.

---

PRINT PATIENT'S NAME

---

PRINT REPRESENTATIVE'S NAME (if applicable)

---

SIGNATURE OF PATIENT

---

SIGNATURE OF REPRESENTATIVE

---

DATE SIGNED

---

RELATIONSHIP OF REPRESENTATIVE (i.e. parent)

---

DATE SIGNED

**ASSIGNMENT AND INSTRUCTION FOR DIRECT PAYMENT TO DOCTOR**

I, \_\_\_\_\_, hereby authorize and direct \_\_\_\_\_ (Insurance Company) to make payment for services rendered to me and/or my dependents payable to:

Ong Family Chiropractic and/or Dr. Nelson S. Ong, D.C.  
9303 Laguna Springs Drive, Suite 110  
Elk Grove, CA 95758

**THIS IS A DIRECT ASSIGNMENT OF MY RIGHTS AND BENEFITS UNDER THIS POLICY.** This payment will not exceed my indebtedness to the above-mentioned assignee, and I have agreed to pay in a current manner, any balance of said professional service charges over and above this insurance payment.

I understand that it is my responsibility to know my benefits and I understand that Ong Family Chiropractic "OFC" will act on my behalf to obtain payment for services rendered to me and/or my dependents.

I understand that it is my decision to receive treatment based on the recommendations of the doctor, and I understand that my insurance company may or may not approve all medically necessary treatments. I understand that I am financially responsible for all charges whether or not paid/authorized by my insurance carrier.

I understand that I am responsible for obtaining any authorizations or referrals for services provided. Failure to do so may result in my being financially responsible for services rendered.

I understand that most health insurance plans DO NOT COVER supplies, supports, massage, etc. Such items must be paid for at the time service or purchase of supplies.

I understand that I am responsible to provide OFC with any changes in my health care coverage, my current condition, or my personal information. (ex: name change, address, phone#, etc.)

I understand and agree that health and accident policies are an arrangement between the insurance carrier and myself. Furthermore, I understand that OFC will prepare any necessary reports and forms to assist me in making collection from the insurance company and that any amount authorized to be paid directly to OFC will be credited to my account upon receipt. However, I clearly understand and agree that all services rendered to me are charged directly to me and I am personally responsible for payment. I also understand that if I suspend or terminate my care that any fees for professional services rendered to me will be due and payable within 30 days.

I understand that in the event I receive any check, draft or other payment subject to this agreement, I shall act as fiduciary agent for OFC and will immediately deliver it to OFC to be applied to my debt for services rendered.

I authorize the use of my signature on all insurance submissions. A photocopy of this assignment shall be considered as effective and valid as original. I also authorize the release of any information pertinent to my case to any insurance company, adjuster, or attorney involved in this case.

Being that this lien is contractual in nature and irrevocable, it will supersede any future bankruptcy filings and proceedings and payment will still be due.

Dated at Ong Family Chiropractic in Elk Grove, CA this \_\_\_\_\_ day of \_\_\_\_\_, 20\_\_\_\_\_.

\_\_\_\_\_  
SIGNATURE OF PATIENT/POLICYHOLDER

\_\_\_\_\_  
WITNESS SIGNATURE

**HEALTH SURVEY**

**PATIENT NAME:** \_\_\_\_\_ **DATE:** \_\_\_\_\_

**PLEASE MARK ALL CONDITIONS THAT YOU CURRENTLY HAVE OR HAVE HAD IN THE PAST:**

**GENERAL**

- | PAST                     | PRESENT                  |                     |
|--------------------------|--------------------------|---------------------|
| <input type="checkbox"/> | <input type="checkbox"/> | Abnormal Weight     |
| <input type="checkbox"/> | <input type="checkbox"/> | Allergies           |
| <input type="checkbox"/> | <input type="checkbox"/> | Bruise Easily       |
| <input type="checkbox"/> | <input type="checkbox"/> | Depression          |
| <input type="checkbox"/> | <input type="checkbox"/> | Dizziness           |
| <input type="checkbox"/> | <input type="checkbox"/> | Fainting            |
| <input type="checkbox"/> | <input type="checkbox"/> | Fatigue             |
| <input type="checkbox"/> | <input type="checkbox"/> | Fevers              |
| <input type="checkbox"/> | <input type="checkbox"/> | Headaches           |
| <input type="checkbox"/> | <input type="checkbox"/> | Hernia              |
| <input type="checkbox"/> | <input type="checkbox"/> | Loss of Appetite    |
| <input type="checkbox"/> | <input type="checkbox"/> | Loss of Sleep       |
| <input type="checkbox"/> | <input type="checkbox"/> | Night Sweats        |
| <input type="checkbox"/> | <input type="checkbox"/> | Visual Disturbances |

**CARDIOVASCULAR**

- | PAST                     | PRESENT                  |                     |
|--------------------------|--------------------------|---------------------|
| <input type="checkbox"/> | <input type="checkbox"/> | Chest Pain          |
| <input type="checkbox"/> | <input type="checkbox"/> | Fast Heart Rate     |
| <input type="checkbox"/> | <input type="checkbox"/> | Heart Attack        |
| <input type="checkbox"/> | <input type="checkbox"/> | High Blood Pressure |
| <input type="checkbox"/> | <input type="checkbox"/> | Low Blood Pressure  |
| <input type="checkbox"/> | <input type="checkbox"/> | Open Heart Surgery  |
| <input type="checkbox"/> | <input type="checkbox"/> | Poor Circulation    |
| <input type="checkbox"/> | <input type="checkbox"/> | Stroke              |

**SYSTEMIC (CONT.)**

- | PAST                     | PRESENT                  |                      |
|--------------------------|--------------------------|----------------------|
| <input type="checkbox"/> | <input type="checkbox"/> | Multiple Sclerosis   |
| <input type="checkbox"/> | <input type="checkbox"/> | Mumps                |
| <input type="checkbox"/> | <input type="checkbox"/> | Pneumonia            |
| <input type="checkbox"/> | <input type="checkbox"/> | Polio                |
| <input type="checkbox"/> | <input type="checkbox"/> | Rheumatic Fever      |
| <input type="checkbox"/> | <input type="checkbox"/> | Rheumatoid Arthritis |
| <input type="checkbox"/> | <input type="checkbox"/> | Seizures             |
| <input type="checkbox"/> | <input type="checkbox"/> | Smoking/Tobacco Use  |
| <input type="checkbox"/> | <input type="checkbox"/> | Tuberculosis         |
| <input type="checkbox"/> | <input type="checkbox"/> | Ulcers               |

**GENITOURINARY**

- | PAST                     | PRESENT                  |                    |
|--------------------------|--------------------------|--------------------|
| <input type="checkbox"/> | <input type="checkbox"/> | Bladder Problems   |
| <input type="checkbox"/> | <input type="checkbox"/> | Frequent Urination |
| <input type="checkbox"/> | <input type="checkbox"/> | Painful Urination  |
| <input type="checkbox"/> | <input type="checkbox"/> | Kidney Disorders   |
| <input type="checkbox"/> | <input type="checkbox"/> | Prostate Problems  |

**FEMALES ONLY**

- Never Pregnant  
 Currently Pregnant (# of months: \_\_\_\_)  
 # of Births: \_\_\_\_\_

**MUSCLE/JOINT**

- | PAST                     | PRESENT                  |                      |
|--------------------------|--------------------------|----------------------|
| <input type="checkbox"/> | <input type="checkbox"/> | Arthritis            |
| <input type="checkbox"/> | <input type="checkbox"/> | Bursitis             |
| <input type="checkbox"/> | <input type="checkbox"/> | Swollen/Stiff Joints |
| <input type="checkbox"/> | <input type="checkbox"/> | Whiplash             |
| <input type="checkbox"/> | <input type="checkbox"/> | Neck Pain            |
| <input type="checkbox"/> | <input type="checkbox"/> | Upper Back Pain      |
| <input type="checkbox"/> | <input type="checkbox"/> | Mid Back Pain        |
| <input type="checkbox"/> | <input type="checkbox"/> | Lower Back Pain      |
| <input type="checkbox"/> | <input type="checkbox"/> | Foot/Ankle Pain      |
| <input type="checkbox"/> | <input type="checkbox"/> | Hip/Upper Leg Pain   |
| <input type="checkbox"/> | <input type="checkbox"/> | Knee/Lower Leg Pain  |
| <input type="checkbox"/> | <input type="checkbox"/> | Shoulder Pain        |
| <input type="checkbox"/> | <input type="checkbox"/> | Elbow Pain           |
| <input type="checkbox"/> | <input type="checkbox"/> | Wrist Pain           |
| <input type="checkbox"/> | <input type="checkbox"/> | Hand Pain            |
| <input type="checkbox"/> | <input type="checkbox"/> | Jaw Pain             |
| <input type="checkbox"/> | <input type="checkbox"/> | Muscular             |

**SYSTEMIC**

- | PAST                     | PRESENT                  |                         |
|--------------------------|--------------------------|-------------------------|
| <input type="checkbox"/> | <input type="checkbox"/> | Anorexia/Bulimia        |
| <input type="checkbox"/> | <input type="checkbox"/> | Asthma                  |
| <input type="checkbox"/> | <input type="checkbox"/> | Cancer                  |
| <input type="checkbox"/> | <input type="checkbox"/> | Chicken Pox             |
| <input type="checkbox"/> | <input type="checkbox"/> | Cold Sores              |
| <input type="checkbox"/> | <input type="checkbox"/> | Diabetes                |
| <input type="checkbox"/> | <input type="checkbox"/> | Drug/Alcohol Dependence |
| <input type="checkbox"/> | <input type="checkbox"/> | Eczema                  |
| <input type="checkbox"/> | <input type="checkbox"/> | Emphysema               |
| <input type="checkbox"/> | <input type="checkbox"/> | Epilepsy                |
| <input type="checkbox"/> | <input type="checkbox"/> | Gout                    |
| <input type="checkbox"/> | <input type="checkbox"/> | Hepatitis               |
| <input type="checkbox"/> | <input type="checkbox"/> | Herpes                  |
| <input type="checkbox"/> | <input type="checkbox"/> | HIV/AIDS                |
| <input type="checkbox"/> | <input type="checkbox"/> | Lupus                   |
| <input type="checkbox"/> | <input type="checkbox"/> | Measles                 |

**OTHER HEALTH PROBLEMS**

- | PAST                     | PRESENT                  |       |
|--------------------------|--------------------------|-------|
| <input type="checkbox"/> | <input type="checkbox"/> | _____ |
| <input type="checkbox"/> | <input type="checkbox"/> | _____ |
| <input type="checkbox"/> | <input type="checkbox"/> | _____ |

**SURGERIES**

- \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

**FAMILY HISTORY-** Indicate conditions present in your family and your relationship to the family member with the condition.

| <u>Condition</u>                                | <u>Relationship:</u> | <u>Condition</u>                          | <u>Relationship:</u> |
|---|----------------------|---|----------------------|
| <input type="checkbox"/> Auto Immune Disorder   | _____                | <input type="checkbox"/> Diabetes         | _____                |
| <input type="checkbox"/> Arthritis              | _____                | <input type="checkbox"/> Heart Disease    | _____                |
| <input type="checkbox"/> Back Trouble           | _____                | <input type="checkbox"/> Kidney Disease   | _____                |
| <input type="checkbox"/> Cancer (indicate type) | _____                | <input type="checkbox"/> Seizure Disorder | _____                |

**PATIENT SIGNATURE:** \_\_\_\_\_

**DATE:** \_\_\_\_\_

**VISUAL ANALOG SCALE, PAIN DRAWING & ADL**

**PATIENT NAME:** \_\_\_\_\_ **DATE:** \_\_\_\_\_

**SECTION 1- PAIN INTENSITY & FREQUENCY:**

Please circle the appropriate # that describes your present pain levels, with 0 being no pain and 10 being the worst pain you can imagine, and indicate how frequent the pain is.

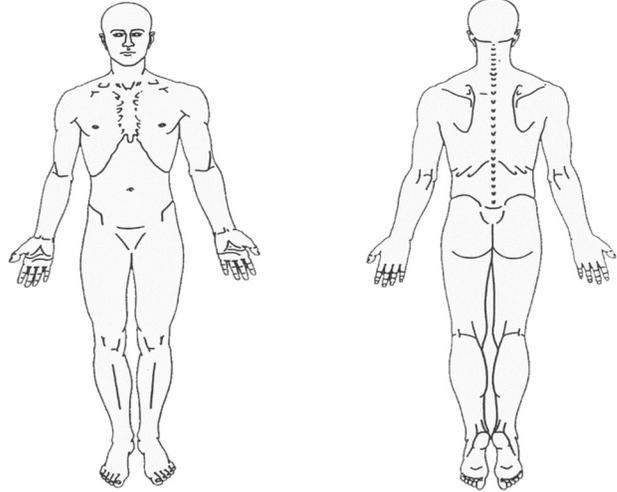
| AREA OF PAIN     | NORMAL |   | MILD |   |   | MODERATE |   |   | SEVERE |   | FREQUENCY OF PAIN |    |     |     |     |      |
|------------------|--------|---|------|---|---|----------|---|---|--------|---|-------------------|----|-----|-----|-----|------|
| NECK             | 0      | 1 | 2    | 3 | 4 | 5        | 6 | 7 | 8      | 9 | 10                | 0% | 25% | 50% | 75% | 100% |
| HEADACHES        | 0      | 1 | 2    | 3 | 4 | 5        | 6 | 7 | 8      | 9 | 10                | 0% | 25% | 50% | 75% | 100% |
| MID BACK PAIN    | 0      | 1 | 2    | 3 | 4 | 5        | 6 | 7 | 8      | 9 | 10                | 0% | 25% | 50% | 75% | 100% |
| LOW BACK PAIN    | 0      | 1 | 2    | 3 | 4 | 5        | 6 | 7 | 8      | 9 | 10                | 0% | 25% | 50% | 75% | 100% |
| HIP(S) L R       | 0      | 1 | 2    | 3 | 4 | 5        | 6 | 7 | 8      | 9 | 10                | 0% | 25% | 50% | 75% | 100% |
| SHOULDER(S) L R  | 0      | 1 | 2    | 3 | 4 | 5        | 6 | 7 | 8      | 9 | 10                | 0% | 25% | 50% | 75% | 100% |
| ARM(S) L R       | 0      | 1 | 2    | 3 | 4 | 5        | 6 | 7 | 8      | 9 | 10                | 0% | 25% | 50% | 75% | 100% |
| LEG(S) L R       | 0      | 1 | 2    | 3 | 4 | 5        | 6 | 7 | 8      | 9 | 10                | 0% | 25% | 50% | 75% | 100% |
| OTHER: _____ L R | 0      | 1 | 2    | 3 | 4 | 5        | 6 | 7 | 8      | 9 | 10                | 0% | 25% | 50% | 75% | 100% |

**SECTION 2- PAIN DRAWING:**

Please indicate the appropriate location of your pain and use the symbol that best describes the discomfort that you are feeling currently.

**LEGEND:**

- V: DULL & ACHY
- +: SHARP & STABBING
- 0: PINS & NEEDLES



**SECTION 3 – ACTIVITIES OF DAILY LIVING OR JOB DEMANDS THAT INCREASE YOUR PAIN LEVELS:**

- SITTING
- STANDING
- STOOPING
- BENDING
- CLIMBING
- REACHING
- LIFTING \_\_\_ LBS
- DRIVING
- HOUSEWORK: \_\_\_\_\_
- SPORTS/REC: \_\_\_\_\_

**SECTION 4 – MECHANISM OF INJURY:**

DESCRIBE WHAT INITIALLY CAUSED YOUR PROBLEM: \_\_\_\_\_

HOW LONG HAVE YOU HAD THIS PROBLEM? \_\_\_\_\_ IS THE PAIN GETTING:  Better  Worse  Same

PAIN AFFECTS YOUR:  WORK  SLEEP  ACTIVITIES OF DAILY LIVING

HAVE YOU LOST ANY TIME FROM WORK DUE TO YOUR INJURIES?  YES  NO IF YES, WHEN? \_\_\_\_\_

ARE YOU CURRENTLY UNDER MEDICAL CARE FOR THIS CONDITION?  YES  NO

- IF YES, WHERE & WHAT TYPE? \_\_\_\_\_

TAKING **ANY** PRESCRIPTION MEDICATIONS?  YES  NO IF YES, WHAT? \_\_\_\_\_

TAKING **ANY** NON-PRESCRIPTION MEDICATIONS?  YES  NO IF YES, WHAT? \_\_\_\_\_

HAVE YOU SEEN ANOTHER CHIROPRACTOR?  YES  NO IF YES, WHY? \_\_\_\_\_

**RE-EXAM PATIENTS ONLY:**

ANY CHANGES TO YOUR HEALTH SINCE YOUR LAST VISIT?  YES  NO

IF YES, WHAT? \_\_\_\_\_

**PATIENT NAME:** \_\_\_\_\_ **DATE:** \_\_\_\_\_

**MODIFIED ROLAND-MORRIS LOW BACK & DISABILITY (RMQ) (FOR PATIENTS with BACK INJURIES/PAIN ONLY)**

**PLEASE READ:** If treating for a back injury and/or pain, mark all boxes that apply to you TODAY.

- |  |   |
|--|---|
| <input type="checkbox"/> I stay at home most of the time because of my back.                             | <input type="checkbox"/> Because of my back, I try to get other people to do things for me.                 |
| <input type="checkbox"/> I walk more slowly than usual because of my back.                               | <input type="checkbox"/> I only stand up for short periods of time because of my back.                      |
| <input type="checkbox"/> Because of my back, I am not doing any jobs that I usually do around the house. | <input type="checkbox"/> Because of my back, I try not to bend or kneel down.                               |
| <input type="checkbox"/> I avoid heavy jobs around the house because of my back.                         | <input type="checkbox"/> My back or leg is painful almost all of the time.                                  |
| <input type="checkbox"/> Because of my back, I use a handrail to get upstairs.                           | <input type="checkbox"/> I find it difficult to turn over in bed because of my back.                        |
| <input type="checkbox"/> Because of my back, I go upstairs more slowly than usual.                       | <input type="checkbox"/> I get dressed more slowly than usual because of my back.                           |
| <input type="checkbox"/> Because of my back, I lie down to rest more often.                              | <input type="checkbox"/> I have trouble putting on my socks because of back pain.                           |
| <input type="checkbox"/> Because of my back, I must hold on to something to get out of an easy chair.    | <input type="checkbox"/> I sleep less well because of my back.  |
|  | <input type="checkbox"/> Because of back pain, I am more irritable and bad tempered with people than usual. |

**NECK DISABILITY INDEX (FOR PATIENTS with NECK INJURIES/PAIN ONLY)**

**PLEASE READ:** If treating for a neck injury and/or pain, answer each section by marking the ONE box that most applies to you in regards to your neck pain.

**Section 1: Pain Intensity**

- I have no pain at the moment.
- The pain is very mild at the moment
- The pain is moderate at the moment.
- The pain is fairly severe at the moment.
- The pain is very severe at the moment.
- The pain is the worst imaginable at the moment.

**Section 2: Personal Care (Washing, Dressing, etc.)**

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

**Section 3: Lifting**

- I can lift heavy weights without extra pain.
- I can lift heavy weights but it gives extra pain.
- Pain prevents me lifting heavy weights off the floor, but I can manage if they are conveniently placed (i.e., on a table).
- Pain prevents me from lifting heavy weights but I can manage light to medium weights if they are conveniently positioned.
- I can only lift very light weights.
- I cannot lift or carry anything.

**Section 4: Reading**

- I can read as much as I want to with no pain in my neck.
- I can read as much as I want to with slight pain in my neck.
- I can read as much as I want with moderate pain in my neck.
- I can't read as much as I want because of moderate neck pain.
- I can hardly read at all because of severe pain in my neck.
- I cannot read at all.

**Section 5: Headaches**

- I have no headaches at all.
- I have slight headaches, which come infrequently.
- I have moderate headaches, which come infrequently.
- I have moderate headaches, which come frequently.
- I have severe headaches, which come frequently.
- I have headaches almost all the time.

**Section 6: Concentration**

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

**Section 7: Work**

- I can do as much work as I want to.
- I can only do my usual work, but no more.
- I can do most of my usual work, but no more.
- I cannot do my usual work.
- I can hardly do any work at all.
- I can't do any work at all.

**Section 8: Driving**

- I can drive without any neck pain.
- I can drive as long as I want with slight pain in my neck.
- I can drive as long as I want with moderate neck pain.
- I can't drive as long as I want because of moderate neck pain.
- I can hardly drive at all because of severe neck pain.
- I can't drive my car at all.

**Section 9: Sleeping**

- I have no trouble sleeping.
- My sleep is slightly disturbed (less than 1 hr sleepless).
- My sleep is mildly disturbed (1-2 hrs sleepless).
- My sleep is moderately disturbed (2-3 hrs sleepless).
- My sleep is greatly disturbed (3-5 hrs sleepless).
- My sleep is completely disturbed (5-7 hrs sleepless).

**Section 10: Recreation**

- I can engage in all my recreation activities with no neck pain at all.
- I can engage in all my recreation activities, with some neck pain.
- I can engage in most, but not all, of my usual recreation activities due to neck pain.
- I can engage in a few of my recreation activities due to neck pain.
- I can hardly do any recreation activities because of neck pain.
- I cannot do any recreation activities at all.