INFORMATION/APPLICATION FOR CARE

The following information is needed in order to better serve you. Please complete all questions. If you need help please ask the receptionist. PLEASE PRINT

Today's Date _____

Name_____ Home Phone _____ Work Phone _____

Address _____ City _____ State _____ Zip _____

Age _____ Birthdate _____ Marital Status: S M W D No. of Children _____

Please circle one payment type: Cash Check Master Card/Visa American Express

Your Employer _____ Occupation _____ Years on Job_____

Employer Address _____ City _____ State _____ Zip _____

E-Mail _____ Your SS # _____

Do you have Medicare? Yes_____ No_____Medicaid? Yes_____No_____

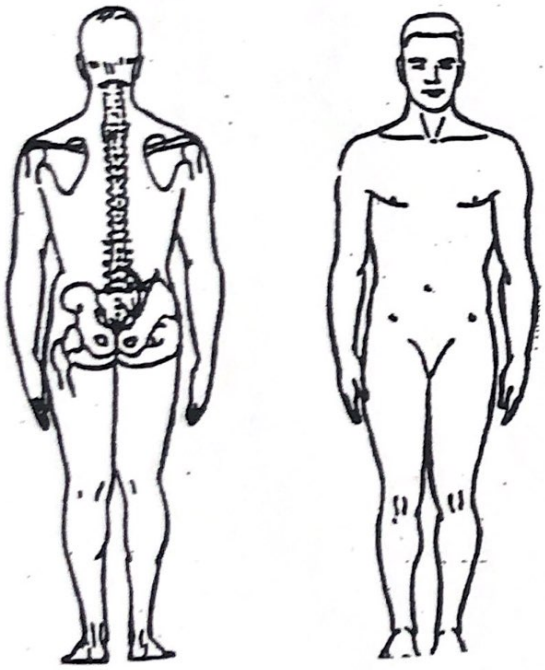
Name of Spouse or Parent _____ Birthdate _____

Spouse employed by _____ Occupation _____ Years on Job _____

Employer Address _____ City_____ State_____ Zip _____

Office phone _____ Spouse SS #_____ Driv Lic #_____

Does your spouse have health insurance at work? Yes_____ No_____



COMPLETE THESE DIAGRAMS

If you are in pain, please mark the exact location of your pain on the diagram. Also describe the type and frequency of your pain, as well as any activity which brings on or aggravates the pain. For example, dull, sharp, consistent, off & on, when standing, when sitting, etc.

MAJOR COMPLAINTS

(Please list any condition you are being treated for or experiencing.)

_____

_____

_____

_____

_____

_____

_____

Referred to our office by: _____

How Payment will be made:

_____Cash

_____Check

Type of Insurance

_____ Workmen's Comp.

_____ Credit Card

_____Health Insurance

_____Automobile Ins. Policy

Is your condition due to an accident? Yes_____ No_____ Date of Accident _____

Type of accident? Auto_____Work/On Job_____ At Home_____ Other _____

Have you ever been in an Auto Accident? Past Year _____Past 5 Years _____Over 5 Years_____Never_____

AUTOMOBILE ACCIDENT QUESTIONNAIRE

Patient's Name:_____ Today's Date:_____

Date of Accident:_____

THE FOLLOWING QUESTIONS PERTAIN TO YOU AND THE VEHICLE YOU WERE IN:

Vehicle type:

- ☐Car
- ☐Van
- ☐Station Wagon
- ☐Other_____
- ☐Pickup
- ☐Truck
- ☐Bus

Vehicle size:

- ☐Subcompact
- ☐Compact
- ☐Mid-size
- ☐Heavy
- ☐Full-size
- ☐Mini
- ☐Light
- ☐Other_____

Your position in the vehicle:

☐Driver
☐Passenger —— Location—— ☐Left ☐Middle ☐Right
☐Other _____ ☐Front Passenger ☐Rear Passenger ☐Third Seat (rear)

Speed of your vehicle:

- ☐Stopped
- ☐Parked
- ☐Slowing
- ☐Moving Slowly
- ☐Moving Moderately
- ☐Moving Fast
- ☐Moving at apprx ____MPH

Why Vehicle was slowed or stopped:

- ☐Traffic Signal
- ☐Pedestrian
- ☐Stop Sign
- ☐Parking
- ☐Traffic
- ☐Busy Intersection

Collision Type:

- ☐Driver Side Impact
- ☐Passenger Side Impact
- ☐Front Impact
- ☐Head On Collision
- ☐Rear Impact
- ☐Pedestrian Incident

THE FOLLOWING QUESTIONS CONCERN THE OTHER VEHICLE INVOLVED IN THE ACCIDENT:

Vehicle type:

- ☐Car
- ☐Van
- ☐Station Wagon
- ☐Other_____
- ☐Pickup
- ☐Truck
- ☐Bus

Vehicle size:

- ☐Subcompact
- ☐Compact
- ☐Mid-size
- ☐Heavy
- ☐Full-size
- ☐Mini
- ☐Light
- ☐Other_____

CONDITIONS AT THE TIME OF THE ACCIDENT:

Time of day:

- ☐Full daylight
- ☐Dawn
- ☐Dusk
- ☐Night

Road Conditions:

- ☐Dry
- ☐Damp
- ☐Wet
- ☐Snow covered
- ☐Ice covered
- ☐Patchy Ice/Snow

Visibility:

- ☐Excellent
- ☐Good
- ☐Fair
- ☐Poor

Visibility compromised by:

- ☐Brightness
- ☐Darkness
- ☐Rain
- ☐Snow
- ☐Fog
- ☐Traffic

THE FOLLOWING QUESTIONS CONCERN THE MOMENT OF IMPACT OF THE ACCIDENT:

Were you...

- ☐Totally unaware that the accident was impending
- ☐Aware that the accident was impending
- ☐Aware that the accident was impending and braced for it

Restraints: (check all that apply)

- ☐Seat belt
- ☐Shoulder harness
- ☐No restraints

If you were the driver of the vehicle, was your foot on the brake pedal? ☐Yes ☐No ☐Knocked off by impact

Was the air bag deployed?

- ☐Car not equipped with air bag
- ☐Air bag deployed
- ☐Air bag not deployed

What position was YOUR headrest in?

- ☐High position
- ☐Middle position
- ☐ Low position

Position of YOUR head at time of impact?
- ☐ Facing straight ahead
- ☐ Tilted forward
- ☐ Rotated to the left
- ☐ Rotated to the right

Was your head thrown...?
- ☐ Backward and then forward
- ☐ Forward then backward
- ☐ To the left ☐ To the left then the right
- ☐ To the right ☐ To the right, then the left

Position of Your body at time of impact?
- ☐ Straight
- ☐ Tilted forward
- ☐ Rotated to the left
- ☐ Rotated to the right

Was your body thrown...?
- ☐ Backward and then forward
- ☐ Forward then backward
- ☐ To the left ☐ To the left then the right
- ☐ To the right ☐ To the right, then the left
- ☐ Across the vehicle
- ☐ Outside the vehicle ☐ Under the vehicle

Damage to vehicle YOU were in:
- ☐ Incurred minimal damage
- ☐ Incurred moderate damage
- ☐ Incurred severe damage
- ☐ Was totalled
- ☐ Not known

Citations:
- ☐ None issued
- ☐ Yourself
- ☐ Driver of vehicle patient was a passenger of
- ☐ Driver of other vehicle
- ☐ Not sure

AS A RESULT OF THE FORCE OF THE COLLISION, WHICH OBJECTS IN THE VEHICLE DID YOUR BODY STRIKE?

Head
- ☐ Steering wheel
- ☐ Dashboard
- ☐ Windshield
- ☐ Armrest
- ☐ Headrest
- ☐ Rear view mirror
- ☐ Left door
- ☐ Right door
- ☐ Left window
- ☐ Right window
- ☐ Console
- ☐ Gear shift
- ☐ Front seat
- ☐ Backseat

Left Arm
- ☐ Steering wheel
- ☐ Dashboard
- ☐ Windshield
- ☐ Armrest
- ☐ Headrest
- ☐ Rear view mirror
- ☐ Left door
- ☐ Right door
- ☐ Left window
- ☐ Right window
- ☐ Console
- ☐ Gear shift
- ☐ Front seat
- ☐ Backseat

Right Arm
- ☐ Steering wheel
- ☐ Dashboard
- ☐ Windshield
- ☐ Armrest
- ☐ Headrest
- ☐ Rear view mirror
- ☐ Left door
- ☐ Right door
- ☐ Left window
- ☐ Right window
- ☐ Console
- ☐ Gear shift
- ☐ Front seat
- ☐ Backseat

Torso
- ☐ Steering wheel
- ☐ Dashboard
- ☐ Windshield
- ☐ Armrest
- ☐ Headrest
- ☐ Rear view mirror
- ☐ Left door
- ☐ Right door
- ☐ Left window
- ☐ Right window
- ☐ Console
- ☐ Gear shift
- ☐ Front seat
- ☐ Backseat

Left Leg
- ☐ Steering wheel
- ☐ Dashboard
- ☐ Windshield
- ☐ Armrest
- ☐ Headrest
- ☐ Rear view mirror
- ☐ Left door
- ☐ Right door
- ☐ Left window
- ☐ Right window
- ☐ Console
- ☐ Gear shift
- ☐ Front seat
- ☐ Backseat

Right Leg
- ☐ Steering wheel
- ☐ Dashboard
- ☐ Windshield
- ☐ Armrest
- ☐ Headrest
- ☐ Rear view mirror
- ☐ Left door
- ☐ Right door
- ☐ Left window
- ☐ Right window
- ☐ Console
- ☐ Gear shift
- ☐ Front seat
- ☐ Backseat

THE FOLLOWING QUESTIONS CONCERN THE TIME PERIOD IMMEDIATELY FOLLOWING THE ACCIDENT:

Did you lose consciousness?

☐Yes
☐No

Immediately following the accident, did you feel...?

☐Dizzy ☐Weak
☐Dazed ☐Nervous
☐Disoriented ☐Nauseated

Were you able to walk unaided?

☐Yes
☐No

Where did you go...?

☐Drove home ☐Drove to work
☐Was driven home ☐Was driven to work
☐Drove to hospital ☐Drove to school
☐Was driven to hospital ☐Was driven to school
☐Taken to hospital via ambulance

Next day discomfort...?

☐increased ☐decreased ☐same

Did your major complaints exist before the accident?

☐Yes ☐ No

In what areas did you IMMEDIATELY feel pain?

☐Head	Shoulder	☐Left☐Right	Hip	☐Left☐Right
☐Neck	Arm	☐Left☐Right	Thigh	☐Left☐Right
☐Upper back	Elbow	☐Left☐Right	Knee	☐Left☐Right
☐Mid back	Wrist	☐Left☐Right	Calf	☐Left☐Right
☐Ribs	Hand	☐Left☐Right	Ankle	☐Left☐Right
☐Chest	Fingers	☐Left☐Right	Foot	☐Left☐Right
☐Abdomen	Buttock	☐Left☐Right	Toes	☐Left☐Right
☐Low Back ☐Pelvis				

In what areas did you experience lacerations (cuts)?

☐Head	Shoulder	☐Left☐Right	Hip	☐Left☐Right
☐Neck	Arm	☐Left☐Right	Thigh	☐Left☐Right
☐Upper back	Elbow	☐Left☐Right	Knee	☐Left☐Right
☐Mid back	Wrist	☐Left☐Right	Calf	☐Left☐Right
☐Ribs	Hand	☐Left☐Right	Ankle	☐Left☐Right
☐Chest	Fingers	☐Left☐Right	Foot	☐Left☐Right
☐Abdomen	Buttock	☐Left☐Right	Toes	☐Left☐Right
☐Low Back ☐Pelvis				

At the hospital, what areas were x-rayed?

☐Head	Shoulder	☐Left☐Right	Hip	☐Left☐Right
☐Neck	Arm	☐Left☐Right	Thigh	☐Left☐Right
☐Upper back	Elbow	☐Left☐Right	Knee	☐Left☐Right
☐Mid back	Wrist	☐Left☐Right	Calf	☐Left☐Right
☐Ribs	Hand	☐Left☐Right	Ankle	☐Left☐Right
☐Chest	Fingers	☐Left☐Right	Foot	☐Left☐Right
☐Abdomen	Buttock	☐Left☐Right	Toes	☐Left☐Right
☐Low Back ☐Pelvis				

Where did you experience pain on the day FOLLOWING the accident?

☐Head	Shoulder	☐Left☐Right	Hip	☐Left☐Right
☐Neck	Arm	☐Left☐Right	Thigh	☐Left☐Right
☐Upper back	Elbow	☐Left☐Right	Knee	☐Left☐Right
☐Mid back	Wrist	☐Left☐Right	Calf	☐Left☐Right
☐Ribs	Hand	☐Left☐Right	Ankle	☐Left☐Right
☐Chest	Fingers	☐Left☐Right	Foot	☐Left☐Right
☐Abdomen	Buttock	☐Left☐Right	Toes	☐Left☐Right
☐ Low Back ☐Pelvis				

SIGNATURE: _____

The Neck Pain Disability Index

This questionnaire has been designed to give the doctor information as to how your neck pain has affected your ability to manage in everyday life. Please answer every section and mark in each section only the ONE box which applies to you. We realize you may consider that two of the statements in any one section relate to you, but just mark the **one** box that most clearly describes your problem.

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 the worst imaginable at the moment.

Section 2 – Personal Care

- ❑ 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 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 me extra pain.
- ❑ Pain prevents me from lifting heavy weights off the floor, but I can manage if they are conveniently positioned, for example on a table.
- ❑ I can lift very light weights.
- ❑ I cannot lift or carry anything at all.

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

Section 9 – Sleeping

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

Section 10 – Recreation

- ❑ I am able to engage in all my recreation activities with no neck pain at all.
- ❑ I am able to engage in all my recreation activities, with some pain in my neck.
- ❑ I am able to engage in most, but not all, of my usual recreation activities because of pain in my neck.
- ❑ I am able to engage in a few of my usual recreation activities because of pain in my neck.
- ❑ I can't do any recreation activities at all.

Low Back Pain and Disability Questionnaire (Revised Oswestry)

Patient Name: _____ **File #** _____ **Date:** _____

This questionnaire has been designed to give the doctor information as to how your back pain has affected your ability to manage everyday life. Please answer every section and mark in each section only the ONE box which applies to you. We realize you may consider that two of the statements in any one section relate to you, but please just mark the box which most closely describes your problem.

SECTION 1- PAIN INTENSITY

- ☐ The pain comes and goes and is very mild.
- ☐ The pain is mild and does not vary much.
- ☐ The pain comes and goes and is moderate.
- ☐ The pain is moderate and does not vary much.
- ☐ The pain comes and goes and is very severe.
- ☐ The pain is severe and does not vary much.

SECTION 2 - PERSONAL CARE

- ☐ I would not have to change my way of washing or dressing in order to avoid pain.
- ☐ I do not normally change my way of washing or dressing even though it causes some pain.
- ☐ Washing and dressing increase the pain but I manage not to change my way of doing it.
- ☐ Washing and dressing increase the pain and I find it necessary to change my way of doing it.
- ☐ Because of the pain I am unable to do some washing and dressing without help.
- ☐ Because of the pain I am unable to do any washing and dressing without help.

SECTION 3 - LIFTING

- ☐ I can lift heavy weights without extra pain.
- ☐ I can lift heavy weights but it causes extra pain.
- ☐ Pain prevents me from lifting heavy weights off the floor.
- ☐ Pain prevents me from lifting heavy weights off the floor, but I manage if they are conveniently positioned (e.g. 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 at the most.

SECTION 4 - WALKING

- ☐ I have no pain on walking.
- ☐ I have some pain on walking but it does not increase with distance.
- ☐ I cannot walk more than one mile without increasing pain.
- ☐ I cannot walk more than 1/2 mile without increasing pain.
- ☐ I cannot walk more than 1/4 mile without increasing pain.
- ☐ I cannot walk at all without increasing pain.

SECTION 5 - SITTING

- ☐ I can sit in any chair as long as I like.
- ☐ I can only sit in my favorite chair as long as I like.
- ☐ Pain prevents me from sitting more than one hour.
- ☐ Pain prevents me from sitting more than half hour.
- ☐ Pain prevents me from sitting more than 10 minutes.
- ☐ I avoid sitting because it increases pain straight away.

SECTION 6 - STANDING

- ☐ I can stand as long as I want without pain.
- ☐ I have some pain on standing but it does not increase with time.
- ☐ I cannot stand for longer than one hour without increasing pain.
- ☐ I cannot stand for longer than 1/2 hour without increasing pain.
- ☐ I cannot stand for longer than 10 minutes without increasing pain.
- ☐ I avoid standing because it increases the pain straight away.

SECTION 7 - SLEEPING

- ☐ I get no pain in bed.
- ☐ I get pain in bed but it does not prevent me from sleeping well.
- ☐ Because of pain my normal night's sleep is reduced by less than 1/4.
- ☐ Because of pain my normal night's sleep is reduced by less than 1/2.
- ☐ Because of pain my normal night's sleep is reduced by less than 3/4.
- ☐ Pain prevents me from sleeping at all.

SECTION 8 - SOCIAL LIFE

- ☐ My social life is normal and gives me no pain.
- ☐ My social life is normal but increases the degree of pain.
- ☐ Pain has no significant effect on my social life apart from limiting my more energetic interests, e.g. dancing, etc.
- ☐ Pain has restricted my social life and I do not go out very often.
- ☐ Pain has restricted my social life to my home.
- ☐ I have hardly any social life because of the pain.

SECTION 9 - TRAVELLING

- ☐ I get no pain whilst travelling.
- ☐ I get some pain whilst travelling but none of my usual forms of travel make it any worse.
- ☐ I get extra pain whilst travelling but it does not compel me to seek alternative forms of travel.
- ☐ I get extra pain whilst travelling which compels me to seek alternative forms of travel.
- ☐ Pain restricts all forms of travel.
- ☐ Pain prevents all forms of travel except that done lying down.

SECTION 10 - CHANGING DEGREE OF PAIN

- ☐ My pain is rapidly getting better.
- ☐ My pain fluctuates but overall is definitely getting better.
- ☐ My pain seems to be getting better but improvement is slow at present.
- ☐ My pain is neither getting better nor worse.
- ☐ My pain is gradually worsening.
- ☐ My pain is rapidly worsening.

Pain Severity Scale:

Rate the Severity of your pain by checking one box on the following scale

No pain	0	1	2	3	4	5	6	7	8	9	10	Excruciating Pain