Sheridan Chiropractic, Inc.

Shamus Sheridan, D.C. | Sean Sheridan, D.C.

Today's Date: _____ **PATIENT INFORMATION** Date of Injury (DOI): _____

PATIENT: Last Name:_____First Name: _____Mid Initial: _____

DOB (Month/Day/Year):____/____/_____Age:_____Gender: M // F SS#:_____

Address:_____City:_____Zip Code: _____

Cell #:_____Home #:_____Work #: _____

Email Address: _____

VITALS: Height:_____Weight:_____Dominant Hand: Right // Left

PRIMARY DOCTOR:_____City:_____Phone #: _____

EMPLOYER NAME:_____Occupation:_____

Address:_____City:_____Zip Code: _____

Phone #:_____Fax:_____# Hours/Week Worked: _____

EMERGENCY CONTACT:_____Relation:_____Phone #: _____

HEALTH INSURANCE INFORMATION: Policy #:_____Group #: _____

Policy Holder Name:_____Phone #: _____

ATTORNEY NAME: _____

Phone #:_____Fax #:_____Case Mgr: _____

Firm Address: _____

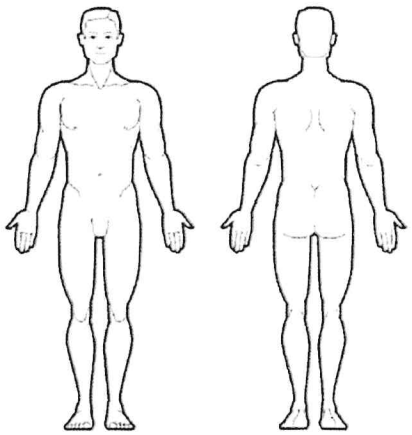
SHOW ME WHERE IT HURTS

Please mark your pain level from 0-10.

No pain Minimal Slight Moderate Severe Pain

0 1 2 3 4 5 6 7 8 9 10

Mark with an "X" on the areas of your pain.



❑ Constant
❑ Frequent
❑ Intermittent
❑ Occasional

Description of Pain: (circle all that apply.)

(DL)	Dull	(SO)	Sore
(A)	Achy	(T)	Tight
(S)	Sharp	(P)	Pins & Needles
(SB)	Stabbing	(ST)	Shooting
(AY)	Annoying	(SF)	Stiff
(B)	Burning	(TH)	Throbbing
(W)	Weak	(SP)	Superficial
(N)	Numb	(H)	Hot
(TG)	Tingling	(C)	Cold
(D)	Deep	Other: _____	

Have you treated with this office in the past? ❑ Yes ❑ No

If you answered *"yes"* when? _____

ACCIDENT HISTORY: Please explain the **details** leading up to the accident **below**. You may include diagrams.

List the types of diagnostic testing that have been performed at any other facilities you received care from FOR THIS INJURY:
❑ X-Rays ❑ Discogram ❑ CT Scan ❑ Bone Scan ❑ Myelogram ❑ EMG ❑ MRI

Where were they performed? _____

Specifics of Auto Accident:
- ❑ Driver
- ❑ Front Seat
- ❑ Braced
- ❑ Head did strike object
- ❑ Head DID NOT strike object
- ❑ Air bag(s) deployed
- ❑ Flash of Light Seen on impact
- ❑ Passenger
- ❑ Back Seat
- ❑ Not Braced
- ❑ Shock
- ❑ Car Towed
- ❑ Police Report Made

Social History:
- ❑ Single
- ❑ Married
- ❑ Divorced

Number of Children: _____

Hobbies:

- ❑ Smoker
- ❑ Non-Smoker
- ❑ Drinks Alcohol Socially
- ❑ Does not drink alcohol
- ❑ Takes Drugs
- ❑ Does not take drugs

- ❑ Motor Vehicle Collision ❑ How many cars? _____
- ❑ Work Related ❑ Non-work Related
- ❑ Sports Related Incident
- ❑ Slip & Fall
- ❑ Other: _____

Immediately following the incident:
- ❑ Ambulance / Paramedics Called
- ❑ Treated at the scene
- ❑ Transported to Hospital by Ambulance
- ❑ Went to Hospital on your own (***Date:*** _____)
- ❑ Diagnostics performed at Hospital
- ❑ Medication Prescribed
- ❑ Treatment at (***Hospital Name*** _____)
- ❑ Follow Up Recommended
- ❑ Other:

Time Loss:

❑ NO time loss from work due to injury, currently working with no limitations
❑ NO time loss from work due to injury BUT do have limitations
❑ Patient reports time loss due to injury. Indicate number of day(s) or week(s)
❑ N/A
❑ Date Last Work:_____/_____/ ____

Occupational History:
What is your current job satisfaction?

❑ Very Satisfied
❑ Satisfied
❑ Dissatisfied
❑ Very Dissatisfied
❑ N/A

❑ Any Disability Time?
❑ Limited / Light Duty
❑ Physically Demanding Work

❑ Highest Education Attained? _____

Mechanism of Injury:

Were you surprised by the impact?	❑ Yes ❑ No
In relation to the back of your head was your headrest set:	❑ Low ❑ Middle ❑ High
Where was your head facing at the time of impact?	❑ Left ❑ Forward ❑Right ❑ Unknown
Were you leaning forward at the time of impact?	❑ Yes ❑ No
Were you wearing a seat belt?	❑ Yes ❑ No
Were you rendered unconscious as a result of the incident?	❑ Yes ❑ No ***(If yes, how long?_____)***
Did you feel pain immediately after the incident?	❑ Yes ❑ No ***(If no, when?_____)***

Year and type of vehicle you were in? Year:_____Make:_____Model: _____
Size of your vehicle ❑ Small ❑ Mid ❑ Large ❑ Unknown

Year and type of other vehicle involved? Year:_____Make:_____Model:_____
Size of other vehicle ❑ Small ❑ Mid ❑ Large ❑ Unknown

What was the approximate speed of your vehicle when the incident occurred? _____MPH
What was the approximate speed of the other vehicle when the incident occurred? _____MPH
Do you have pictures of the damaged vehicles? ❑ Yes ❑ No

Medical History:

I have seen the following physician/professional for *this* condition:

Chiropractor:_____
Massage Therapist: _____
Orthopedist:_____
Physical Therapist: _____
Physician:_____
Psychiatrist/Psychologist:_____
Other: _____

List the treatments you have had for this condition:

❑ Ice
❑ Heat/Ultrasound
❑ Electrical Stimulation
❑ Exercises
❑ Traction/Decompression
❑ Bed Rest
❑ Chiropractic
❑ Osteopathy
❑ Injections
❑ Acupuncture
❑ Naturopathy
❑ Massage

Current or Past Medical History:

❑ Medication ❑ Surgery ❑ Hospitalization
❑ Previous Musculoskeletal Problems
❑ Other: _____

Mark if you have had any of the following symptoms in the past 3 years:

B4 MVC – Before Motor Vehicle Collision
MVC – Motor Vehicle Collision

B4 MVC / MVC		B4 MVC / MVC		B4 MVC / MVC		B4 MVC / MVC	
❑ / ❑	Unexplained fevers	❑ / ❑	Easy Bruising	❑ / ❑	Stomach Pain	❑ / ❑	Blood in Urine
❑ / ❑	Night Sweats	❑ / ❑	Excessive Bleeding	❑ / ❑	Changes in Bowel	❑ / ❑	Morning Stiffness
❑ / ❑	Weight Loss 10lbs+	❑ / ❑	Lump in Neck, Armpit or Groin	❑ / ❑	Persistent Diarrhea	❑ / ❑	Eye Redness
❑ / ❑	Loss of Appetite	❑ / ❑	Chest Pain or Tightness	❑ / ❑	Excessive Constipation	❑ / ❑	Muscle Tenderness
❑ / ❑	Excessive Fatigue	❑ / ❑	Persistent/Unusual Cough	❑ / ❑	Dark Black Stools	❑ / ❑	Dry Eyes or Mouth
❑ / ❑	Problems w/ Depression	❑ / ❑	Trouble Breathing w/ Exercise	❑ / ❑	Bloody Stools	❑ / ❑	Skin Rashes
❑ / ❑	Difficulty Sleeping	❑ / ❑	Trouble Breathing Lying Flat	❑ / ❑	Pain/Burning when Urinating	❑ / ❑	Joint Pain/Swelling
❑ / ❑	Unusual Stress at Home	❑ / ❑	Cough Up Blood	❑ / ❑	Difficulty Urinating	❑ / ❑	Anxiety
❑ / ❑	Unusual Stress at Work	❑ / ❑	Swollen Ankles	❑ / ❑	Need to Urinate Frequently	❑ / ❑	Irritability

HEALTH HISTORY/INJURIES/TREATMENTS:

INJURIES YOU MAY HAVE HAD IN THE PAST **DATES**

Auto Accidents: _____ _____

Work Injuries: _____ _____

Broken Bones: _____ _____

Other: _____ _____

HAVE YOU EVER BEEN DIAGNOSED AS HAVING OR SUFFERED FROM:

❒ Muscle Disorder	❒ Asthma	❒ Osteoarthritis	❒ Coughing Blood
❒ Nervous System Disorder	❒ Broken Bones	❒ Epilepsy	❒ Circulatory Problems
❒ Bone Disorder	❒ Intestinal Problems	❒ Alcoholism	❒ Kidney/Bladder Problems
❒ Rheumatoid Arthritis	❒ Seizures/Convulsions	❒ Drug Addiction	❒ Heart Disease
❒ Allergies	❒ Congenital Disease	❒ Strokes	❒ Tumors
❒ HIV	❒ Excessive Bleeding	❒ Cancer	❒ Depression
❒ Gallbladder Issues	❒ High Blood Pressure	❒ Ulcer	❒ Ear/Throat Infection
❒ Diabetes	❒ Low Blood Pressure	❒ Hernias	❒ Pacemaker

SURGERIES YOU MAY HAVE HAD FOR THIS CONDITION: **DATE(S)**

Spine Surgeries: ❒ Discectomy ❒ Laminectomy ❒ Fusion ❒ Other: _____ _____

NON-SURGICAL TREATMENTS YOU MAY HAVE RECEIVED FOR THIS CONDITION:

❒ Medication ❒ Injections ❒ Physical Therapy ❒ Massage ❒ Chiropractic ❒ Acupuncture

❒ Other: _____

❒ Medication(s) Currently Being Taken: _____

❒ Female Patients: Most recent menstrual cycle: _____

❒ Pregnant: _____ _____ (weeks)

**************FOR DOCTOR USE ONLY BELOW THIS LINE. GO TO PAGE 6. **************

HEENT

❒ The patient is normocephalic, non-traumatic

❒ Pupils are equal, round and reactive to light & accommodation

❒ TM's are clear

GASTROINTESTINAL

❒ Abdomen is soft, non-tender

❒ Bowel sounds are normoactive

❒ No history or present complaints regarding gastrointestinal system

CARDIOVASCULAR/PULMONARY

❒ No complaints or history of heart murmur, blood pressure problems or other vascular disorders

❒ Heart exam reveals a regular rate with no murmurs, gallops or rubs

❒ Lungs are clear to percussion and auscultation

Blood Pressure	**Pulse Rate**

GRIP STRENGTH:

Test 1	RIGHT _____	LEFT _____
Test 2	RIGHT _____	LEFT _____
Test 3	RIGHT _____	LEFT _____

UROGENITAL

❒ There is no complaint of frequency, urgency or difficulty w/ urination.

NEUROLOGICAL EXAMINATION

❒ Cranial nerves II-IX are grossly intact

❒ Romberg's Test

❒ Cerebellum function is grossly within normal limits

❒ Patient is alert and oriented to time, place and person

❒ Reflexes are equal and reactive bilaterally in both upper and lower extremities and are +2

DOCTOR'S INPUT: ❒ Wartenberg's pinwheel testing showed HYPERESTHESIA / HYPOESTHESIA

At dermatomal distributions _____ on the RT / LFT

❒ Sensation is intact to all primary modalities

❒ Patient can heel and toe walk without difficulty

❒ Toes are down going and pathological reflex is absent for Babinski Sign

Motor testing of the upper & lower extremity musculature revealed:

Grade: I, II, III, IV, V in the UPPER and/or LOWER extremities.

ORTHOPEDIC EXAMS

Adson's Maneuver:	❑ Left	❑ Right	❑ Bilateral	❑ N/A
Anterior Drawer:	❑ Left	❑ Right	❑ Bilateral	❑ N/A
Apley's Compression:	❑ Left	❑ Right	❑ Bilateral	❑ N/A
Apley's Distraction:	❑ Left	❑ Right	❑ Bilateral	❑ N/A
Braggard's Sign:	❑ Left	❑ Right	❑ Bilateral	❑ N/A
Cervical Distraction:	❑ Left	❑ Right	❑ Bilateral	❑ N/A
Cozen's Test:	❑ Left	❑ Right	❑ Bilateral	❑ N/A
Deep Inhalation Chest Pain:	❑ Left	❑ Right	❑ Bilateral	❑ N/A
Dugas' Test:	❑ Left	❑ Right	❑ Bilateral	❑ N/A
Ely's Heel Buttock Test:	❑ Left	❑ Right	❑ Bilateral	❑ N/A
Finklestien Test:	❑ Left	❑ Right	❑ Bilateral	❑ N/A
George's Test:	❑ Left	❑ Right	❑ Bilateral	❑ N/A
Hoover's Sign:	❑ Left	❑ Right	❑ Bilateral	❑ N/A
Kemp's Test:	❑ Left	❑ Right	❑ Bilateral	❑ N/A
Laseque's SLR Test:	❑ Left	❑ Right	❑ Bilateral	❑ N/A
Magnuson's Test:	❑ Left	❑ Right	❑ Bilateral	❑ N/A
Mankopf's Sign:	❑ Left	❑ Right	❑ Bilateral	❑ N/A
Max Cervical Comp:	❑ Left	❑ Right	❑ Bilateral	❑ N/A
McMurray's Test:	❑ Left	❑ Right	❑ Bilateral	❑ N/A
Mill's Test:	❑ Left	❑ Right	❑ Bilateral	❑ N/A
O'Donohue Test:	❑ Left	❑ Right	❑ Bilateral	❑ N/A
Patrick's Test:	❑ Left	❑ Right	❑ Bilateral	❑ N/A
Phalen's Test:	❑ Left	❑ Right	❑ Bilateral	❑ N/A
Schepelmann's Sign:	❑ Left	❑ Right	❑ Bilateral	❑ N/A
Shoulder Depression:	❑ Left	❑ Right	❑ Bilateral	❑ N/A
Straight Leg Raiser:	❑ Left	❑ Right	❑ Bilateral	❑ N/A
Supraspinatus Press:	❑ Left	❑ Right	❑ Bilateral	❑ N/A
Soto-Hall Test:	❑ Positive		❑ Negative	
Valsalva Maneuver:	❑ Left	❑ Right	❑ Bilateral	❑ N/A
Yergason's Test:	❑ Left	❑ Right	❑ Bilateral	❑ N/A

❑ The performance of the malingering exams were negative and/or were not performed due to the positive integrity of the patient and/or due to the absence of examiner perceived needed.

CERVICAL	Restrictive	Degree	Normal	Pain	Deficit
Flexion	❑		50		
Extension	❑		60		
Left Lat Flex	❑		45		
Rt Lat Flex	❑		45		
Left Rot	❑		80		
Rt Rot	❑		80		

LUMBAR	Restrictive	Degree	Normal	Pain	Deficit
Flexion	❑		50		
Extension	❑		25		
Left Lat Flex	❑		25		
Rt Lat Flex	❑		25		
Left Rot	❑		30		
Rt Rot	❑		30		

SPINAL EXAM

❑ Spinal examination consisted of static and motion palpation of the cervical, thoracic, lumbar and pelvis (all or separate)

It included:

- ❑ Intervertebral joint play analysis
- ❑ Comparative leg length analysis
- ❑ Range of Motion Evaluation

ARTICULAR DYSFUNCTION

These articular dysfunctions are associated & accompanied by:

- ❑ Joint Edema
- ❑ Joint Capsulitis
- ❑ Deep & Superficial Myospasms

❑ There is muscle splinting and tenderness upon digital palpation at the levels of articular dysfunction.

❑ There is pain on percussion of the spinous processes at these levels as well

The examination revealed dysfunctions/vertebral subluxations at the following levels:

C 1 2 3 4 5 6 7 **T** 1 2 3 4 5 6 7 8 9 10 11 12 **L** 1 2 3 4 5 **Sacrum Ilium R L**

There are myofascial trigger points located in the following musculature:

Radiology:

UPPER EXTREMITY:

LOWER EXTREMITY:

OTHER:

CAUSATION:

❑ In my opinion, the above diagnoses are a direct result of the Date of the Incident noted above.

Are your findings and diagnosis consistent with patient's account of injury or onset of illness? ❑ Yes ❑ No ❑ If "No," please explain:

Is there any other current condition that will impede or delay patient's recovery?

❑ Yes ❑ No ❑ If "Yes," please explain:

PLAN/RECOMMENDATIONS:

❑ 4 times/week ❑ Once a week
❑ 3 times/week ❑ Every 2 weeks
❑ 2 times/week ❑ Once a month

Patient will be re-evaluated in:

❑ One month ❑ 2 weeks
❑ 1 week ❑ 3 weeks

_____ Visits

❑ Chiropractic Adjustments (CMT), Activator (ACT), Neuromuscular Re-Education (NR), Joint Mobilization (JM), Myofascial Release (MR), Intersegmental Traction (IT), Electrical Stimulation (EMS), Mechanical Message (MM), Ultrasound (US), Diathermy (D), Hot/Cold Pack (HP/CP), Interferential (ITF) Transcutaneous Nerve Stimulation (TENS), Infrared (IF), Therapeutic Exercises/Outside Office (TE)/(TEO), Physician's Education Group (PEG)

❑ The patient's condition has stabilized. I have recommended periodic chiropractic check-ups in order to maintain the patient's progress.

Date: _____

The Neck Disability Index

Please rate the severity of your pain by circling a number below:

No Pain | 0 1 2 3 4 5 6 7 8 9 10 | *Unbearable Pain*

Instructions: This questionnaire has been designed to give the doctor information as to how your NECK PAIN has affected your ability to manage everyday life. Please answer every section and mark in each section only the ONE box that applies to you. We realize that you may consider that two of the statements in any one section relate to you, but please just mark the box that most closely 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 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 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 from lifting heavy weights off the floor, but I can manage if they are conveniently positioned, e.g. on a table
- ☐ Pain prevents me from lifting heavy weights off the floor, but I can manage light to medium weights when conveniently positioned.
- ☐ I can lift very light weights.
- ☐ I cannot lift or carry anything at all.

SECTION 4 – 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 5 – 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 to, 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 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 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 – HEADACHES
- ☐ I have no headaches at all.
- ☐ I have slight headaches that come infrequently.
- ☐ I have moderate headaches that come infrequently.
- ☐ I have moderate headaches that come frequently.
- ☐ I have severe headaches that come frequently.
- ☐ I have headaches almost all the time.

SECTION 8 – WORK
- ☐ I can do as much work as I want to.
- ☐ I can do 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 9 – 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.
- ☐ 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 at all.

SECTION 10 – RECREATION
- ☐ I am able to engage in all my recreation activities with no neck pain.
- ☐ I am able to engage in all my recreation activities with some neck pain.
- ☐ 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 recreation activities, because of pain in my neck.
- ☐ I can hardly do any recreation activities, because of neck pain.
- ☐ I can't do any recreational activities at all.

Patient Name: _____ Initial Appointment Date: _____

Revised 10/2020

Date: _____

Revised Oswestry Low Back Pain and Disability

Please read instructions carefully: This questionnaire has been designed to give the doctor information as to how your LOW BACK PAIN has affected your ability to manage everyday life. Please answer every section and mark in each section only the ONE box that applies to you. We realize that you may consider that two of the statements in any one section relate to you, but please just mark the box that 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 doesn't vary much.

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 extra pain.
- ☐ Pain prevents me from lifting heavy weights off the floor.
- ☐ Pain prevents me from lifting heavy weights but I can manage if they are conveniently positioned.
- ☐ Pain prevents me from lifting heavy weights but I can manage light-medium weights if they are conveniently positioned.
- ☐ I can only lift very light weights at the most.

SECTION 4 – WALKING

- ☐ I have no trouble walking.
- ☐ I cannot walk more than one mile without increasing pain.
- ☐ I cannot walk more than ½ mile without increasing pain.
- ☐ I cannot walk more than ¼ mile without increasing pain.
- ☐ I can walk with crutches.
- ☐ 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 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 ½ hour without increasing pain.
- ☐ I can't 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 doesn't prevent me from sleeping well.
- ☐ Because of pain my normal night's sleep is reduced by < ¼
- ☐ Because of pain my normal night's sleep is reduced by < ½
- ☐ Because of pain my normal night's sleep is reduced by < ¾
- ☐ Pain prevents me from sleeping at all.

SECTION 8 – TRAVELING

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

SECTION 9 – SOCIAL LIFE

- ☐ My social life is normal and gives me no pain.
- ☐ My social life is normal but increases the degree of pain.
- ☐ Pain limits 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 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.
- ☐ My pain is neither getting better nor worse.
- ☐ My pain is gradually worsening.
- ☐ My pain is rapidly worsening.

I understand that the information I have provided above is current and complete to the best of my knowledge.

Signature: _____

Revised 10/2020

Sheridan Chiropractic, Inc.

Shamus Sheridan, D.C. | Sean Sheridan, D.C.

HEAD TRAUMA EVALUATION

Patient Name: _____

Please fill in all symptoms you currently have that you did not have before the accident.

Neurological Symptoms (Please circle)

- ❒ Numb /tingling arm/hand L R
- ❒ Numb/tingling leg/foot L R
- ❒ Weakness arm/hand L R
- ❒ Weakness leg/foot L R

Symptoms Associated with Injuries

- ❒ Range of motion problems
- ❒ Headaches
- ❒ Muscle spasms
- ❒ Dizziness
- ❒ Visual disturbances
- ❒ Sleep disruption
- ❒ Radiating pain
- ❒ Anxiety
- ❒ Depression
- ❒ I am taking over-the-counter pain meds

Brain/Neuropsych/MTBI Symptoms

- ❒ Wanting to be alone
- ❒ Sleepiness
- ❒ Nausea/vomiting
- ❒ Difficulty concentrating
- ❒ Daydreaming/Mindless Staring
- ❒ Mood swings
- ❒ Difficulty learning new things
- ❒ Agitation
- ❒ Difficulty remembering things
- ❒ Re-reading things to understand
- ❒ Disoriented
- ❒ Confused
- ❒ Difficulty speaking
- ❒ Feelings of isolation from others
- ❒ Attention problems
- ❒ Appetite change
- ❒ Pupils different size
- ❒ Fatigue
- ❒ Rooms spins/woozy feeling
- ❒ Balance problems
- ❒ Difficulty walking
- ❒ Difficulty focusing/easily distracted
- ❒ Difficulty planning organizing
- ❒ Personality Change
- ❒ Can't remember numbers
- ❒ Reading problems
- ❒ Writing problems
- ❒ Difficulty with adding/subtracting
- ❒ Poor attention
- ❒ Difficulty understanding
- ❒ Sadness or tearful
- ❒ Blurry/Double vision
- ❒ Anger
- ❒ Difficulty making decisions
- ❒ Change in sensual functioning
- ❒ Reduced confidence
- ❒ Helplessness
- ❒ Apathy (Don't care)
- ❒ Irritable
- ❒ Change in the sense of taste smell
- ❒ Flashbacks to accident
- ❒ Impatience
- ❒ Frustration
- ❒ Hearing problems

Sheridan Chiropractic, Inc.
26900 Newport Rd. Ste. 110, Menifee, CA 92584 | P. (951) 672-8060 | F. (951) 672-7490
Shamus Sheridan, D.C. | Sean Sheridan, D.C.

NOTICE OF DOCTOR'S LIEN

Patient: _____ **Date of Accident:** _____

I do hereby authorize **Sheridan Chiropractic, Inc.,** to furnish you, my attorney, with a full report of their examination, diagnosis, treatment, prognosis, etc., of myself in regard to the accident in which I was recently involved.

I hereby authorize and direct to you, my attorney, to pay directly to said doctor such sums as may be due and owing him for the medical service(s) rendered me both by reason of this accident and by reason of any other bills that are due his office and to withhold such sums from any settlement, judgment or verdict as may be necessary to adequately protect and fully compensate said doctor. And I hereby further give a Lien on my case to said doctor against any and all proceeds of my settlement, judgment, or verdict which may be paid to you, my attorney, or myself, as the result of the injuries for which I have been treated or injuries in connection therewith.

I fully understand that I am directly and fully responsible to said doctor for all medical bills submitted by him for services rendered me and that this agreement is made solely for said doctor's additional protection in consideration of his awaiting payment. And I further understand that such payment is not contingent on any settlement, judgment or verdict by which I may eventually recover said fee.

I agree to promptly notify said doctor of any change or addition of attorney(s) used by me in connection with this accident, and I instruct my attorney to do the same and to promptly deliver a copy of this lien to any such substituted attorney(s).

Please acknowledge this letter by signing below and returning to the doctor's office. I have been advised that if my attorney does not wish to cooperate in protecting the doctor's interest, the doctor will not await payment and may declare the entire balance due and payable.

Dated: _____

_____
Patient Signature

_____
Printed Name

The undersigned being attorney of record for the above patient does hereby agree hereby agree to observe all of the terms above and agrees to withhold such sums from any settlement, judgment or verdict, as may be necessary to adequately protect and fully compensate said the doctor above-named. Attorney further agrees that in the event this lien is litigated, that the prevailing party will be awarded attorney fees and cost.

Dated: _____

_____
Attorney Signature

_____
Attorney Printed Name & Law Firm

erf

HOW WE PROTECT YOUR PRIVATE HEALTH INFORMATION

My "protected health information" (PHI), means personal health information, including my demographic information, collected from me and/or created or received by my physician, medical assistant or other healthcare provider. PHI may relate to my past, present or future physical or mental health or condition that identifies me, or there is a reasonable basis that the information may identify me.

I consent to the use or disclosure of my PHI by Sheridan Chiropractic, Inc. or any owner, employee, contractor or other representative thereof (collectively, "Sheridan Chiropractic"), for the purpose of diagnosing or providing treatment to me, obtaining payment for my healthcare bills or conduct healthcare operations of Sheridan Chiropractic. I understand that Sheridan Chiropractic may refuse to diagnose or treat me, if I do not consent to the use or disclosure of my PHI for the above-stated purposes. My signature on this document establishes my consent to the use or disclosure of my PHI for the above-stated purposes.

I understand I have a right to request a restriction as to how my PHI is used or disclosed to carry out treatment, payment or healthcare operations by Sheridan Chiropractic. Sheridan Chiropractic is not required to agree to the restrictions that I may request. However, if Sheridan Chiropractic agrees to a restriction that I request, the restriction is binding upon Sheridan Chiropractic.

I understand I have a right to review the office's Notice of Privacy Practices prior to signing this document. Sheridan Chiropractic's Notice of Privacy has been provided to me. Sheridan Chiropractic's Notice of Privacy Practices describes the type of uses and disclosures of my PHI that will occur in my treatment, payment of my bills or in the performance of healthcare operations by Sheridan Chiropractic's office. Notice of Privacy Practices also describe my rights and Sheridan Chiropractic's duties with respect to my PHI.

I acknowledge and understand that Sheridan Chiropractic has the right to change the privacy practices described in Sheridan Chiropractic's Notice of Privacy Practices. I may obtain a revised notice of privacy practices by contacting Sheridan Chiropractic's Privacy Officer at dd.sheridanchiro@gmail.com, to request a hard copy to be sent in the mail or by asking for one at the time of my next appointment.

I have the right to revoke this consent, in writing, except to the extent that Sheridan Chiropractic has taken action in reliance on this agreement.

I have read, or have had read to me, the above consent. I have also had an opportunity to ask questions regarding Sheridan Chiropractic's Privacy Policies, and all my questions have been answered fully and satisfactorily.

Patient's Name (PRINT): _____ Date: _____

Patient's Signature: _____

Witness Name (PRINT): _____ Date: _____

Witness Signature: _____

INFORMED CONSENT DOCUMENT

TO THE PATIENT: Please read this entire document prior to signing it. It is important that you understand the information contained. Please ask questions before you sign if there is anything that is unclear.

The nature of the chiropractic adjustment: The primary treatment used by doctors of chiropractic is spinal manipulative therapy. Sheridan Chiropractic will use that procedure to treat you. Doctors may use hands, or mechanical instrument(s) upon your body in such a way as to move your joints. That may cause an audible "pop" or "click," much as you have experienced when you "crack" your knuckles. You may feel a sense of movement.

Analysis I Examination/Treatment: As part of the analysis, exam and treatment, I consent to the following:
PLEASE INITIAL EACH PROCEDURE YOU CONSENT TO.

_____ Spinal Manipulative Therapy	_____ Palpation	_____ Vital Signs
_____ Basic Neurological Testing	_____ Muscle Strength Testing	_____ Range of Motion Testing
_____ Postural Analysis Testing	_____ EMS	_____ Orthopedic Testing

The risks inherent in chiropractic adjustment:
As with any healthcare procedure, there are certain complications which may arise during chiropractic manipulation and therapy. These complications include but are not limited to: fractures, disc injuries, disclocations, muscle strain, cervical myelopathy, costovertebral strains and separations, and burns. Some types of manipulation of the neck have been associated with injuries to the arteries in the neck leading to or contributing to serious complications including stroke. Some patients will feel some stiffness and soreness following the first few days of treatment. The Doctor will make every reasonable effort during the examination to screen for contraindications to care; however, if you have a condition that would otherwise not come to the Doctor's attention it is your responsibility to inform the Doctor.

The probability of those risks occurring: Fractures are rare occurrences and generally a result from some underlying weakness of the bone which we check for during the taking of your history and during examination and x-rays. Stroke and/or arterial dissection caused by chiropractic manipulation of the neck has been the subject of ongoing medical research and debate. The most current research on the topic is inconclusive as to a specific incident of this complication occurring. If there is a causal relationship at all it is extremely rare and remote. Unfortunately, there is no recognized screening procedure to identify patients with neck pain who are at risk of arterial stroke.

The availability and nature of other treatment options: Other treatment options for your condition may include:

- Self-administered, over-the-counter analgesics and rest
- Medical care and prescription drugs such as anti-inflammatory, muscle relaxants and painkillers
- Hospitalization
- Surgery

If you choose to use one of the above noted treatments options, you should be aware that there are risks and benefits of such options and you may wish to discuss these with your primary medical physician.

The risks and dangers attendant to remaining untreated: Remaining untreated may allow the formation of adhesions and reduce mobility which may set up a pain reaction further reducing mobility. Over time this process may complicate treatment making it more difficult and less effective the longer it is postponed.

CONSENT TO TREATMENT OF A MINOR

I hereby request and authorize Sheridan Chiropractic to perform diagnostic tests and render chiropractic adjustments and other treatment to _____. This authorization also extends to all other doctors and office staff members and is intended to include radiographic examination at the doctor's discretion.

As of this date, I have the legal right to select and authorize healthcare services for the minor named above. If applicable, under the terms and conditions of my divorce, separation or other legal authorization, the consent of a spouse/former spouse or other parent is not required. If my authority to so select and authorize this care should be revoked or modified in any way, I will immediately notify this office.

DO NOT SIGN UNTIL YOU HAVE READ AND UNDERSTAND THE ABOVE.
PLEASE SIGN AND DATE BELOW WHERE APPROPRIATE.

I have read or have had read to me the above explanation of the chiropractic adjustment and related treatment. I have discussed it with Sheridan Chiropractic and have had my questions answered to my satisfaction. By signing below I state that I have weighed the risks involved in undergoing treatment and have decided that it is in my best interest to undergo the treatment recommended. Having been informed of the risks, I hereby give my consent to any treatment rendered to me by Sheridan Chiropractic, it's doctors and staff.

PATIENT NAME (PRINTED)	SIGNATURE	DATE
PATIENT NAME (PRINTED)	SIGNATURE OF PARENT/GUARDIAN (IF MINOR)	DATE
DOCTOR NAME (PRINTED)	DOCTOR'S SIGNATURE	DATE

AUTHORIZATION TO RELEASE RECORDS

Sheridan Chiropractic, Inc.

Shamus Sheridan, D.C. | Sean Sheridan, D.C. | John Chapman, D.C.

REQUESTING FACILITY:

❒ 26900 Newport Rd. Ste. 110
Menifee, CA 92584
P. (951) 672-8060
F. (951) 672-7490

❒ 1485 Spruce St. Ste. I
Riverside, CA 92507
P. (951) 462-1285
F. (951) 462-1308

Patient: _____ P: _____

DOB: _____ / _____ / _____ DOI: _____ / _____ / _____

REQUEST SENT TO: _____

_____

_____

REQUESTED INFORMATION:

❒ X-Ray Image(s) ❒ MRI Report(s) ❒ Other: _____

_____

Patient Signature: _____ **Date:** _____ / _____ / _____

NOTE: IF PATIENT IS UNDER 18 YEARS OF AGE AND IS NOT AN EMANCIPATED MINOR THE PARENT OR GUARDIAN MUST SIGN.