

**PATIENT INFORMATION**

First Name: \_\_\_\_\_ Last Name: \_\_\_\_\_ Middle Name Initial: \_\_\_\_\_

DOB (Month/Day/Year): \_\_\_/\_\_\_/\_\_\_ Age: \_\_\_\_\_ Gender: Male / Female Social Sec. #: \_\_\_\_\_

Address: \_\_\_\_\_ City: \_\_\_\_\_ Zip Code: \_\_\_\_\_

Cell #: \_\_\_\_\_ Home #: \_\_\_\_\_ Email Address: \_\_\_\_\_

Emergency Contact & #: \_\_\_\_\_ Relationship:  Spouse  Parent  Other: \_\_\_\_\_

Social History:  Single  Married  Divorced  Widowed  Minor # of Children: \_\_\_\_\_

Primary Doctor: \_\_\_\_\_ City: \_\_\_\_\_ Phone #: \_\_\_\_\_

Health Insurance Carrier: \_\_\_\_\_ Member ID #: \_\_\_\_\_ Group #: \_\_\_\_\_

Employment Status: (Check one)

Employed  Self-Employed  PT Student  FT Student  Retired  Disability  Other: \_\_\_\_\_

Highest Education Attained: \_\_\_\_\_

Time Loss: (Check one)

- N/A
- 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); Date last worked \_\_\_\_\_

Employer Name: \_\_\_\_\_ Occupation: \_\_\_\_\_ # Hours Worked: \_\_\_\_\_

Address: \_\_\_\_\_ City: \_\_\_\_\_ Zip Code: \_\_\_\_\_

Work #: \_\_\_\_\_ Physical Stress Level at work?  Low  Medium  High

Attorney Name: \_\_\_\_\_ Case Manager: \_\_\_\_\_ Phone #: \_\_\_\_\_

**ACCIDENT HISTORY**

Date of Injury: \_\_\_/\_\_\_/\_\_\_

Motor Vehicle Collision How many cars? \_\_\_\_\_  Work Related Incident  Non-work Related

Sports Related Incident  Slip & Fall  Other: \_\_\_\_\_

Immediately following the incident: (Check one)  N/A

- Ambulance / Paramedics called
- Treated at the scene
- Transported to hospital by ambulance
- Went to hospital on own
- Diagnostics Performed
- Medication Prescribed
- Follow-up recommended
- Other: \_\_\_\_\_

Date: \_\_\_/\_\_\_/\_\_\_ Hospital name: \_\_\_\_\_ City: \_\_\_\_\_ Phone #: \_\_\_\_\_

List the types of diagnostic testing that have been performed at any other facilities you received care from for this injury:  N/A

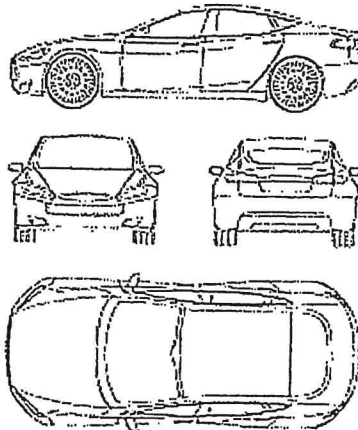
- X-rays
- MRI
- CT scan
- Bone Scan
- Myelogram
- EMG
- Discogram
- Other: \_\_\_\_\_

Where? \_\_\_\_\_ City: \_\_\_\_\_ Phone #: \_\_\_\_\_  Same as above

**Specifics of the collision:**

- Driver
- Front Seat
- Braced
- Shocked
- Head DID NOT strike object
- Head did strike object
- Airbags Deployed
- Flash of light seen on impact
- Police Report Made
- Passenger
- Back Seat
- Not Braced
- Car Towed

**Circle damage to your car:**



- Rear-end
- T-Bone/Side Impact
- Head on

**Describe your accident in 1-2 sentences:**

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

**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? \_\_\_\_\_)

**Car Specifications:**

- Year and type of vehicle you were in? Year: \_\_\_\_\_ Make: \_\_\_\_\_ Model: \_\_\_\_\_  
 Small  Mid-size  Large  Unknown
- Your approximate speed? \_\_\_\_\_ MPH
- Year and type of other vehicle? Year: \_\_\_\_\_ Make: \_\_\_\_\_ Model: \_\_\_\_\_  
 Small  Mid-size  Large  Unknown
- Approximate speed of the other vehicle? \_\_\_\_\_ MPH

**PERSONAL HEALTH HISTORY**

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

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

Injuries you may have had in the past:  N/A

- |   |                   |  |                   |
|---|-------------------|--|-------------------|
| <input type="checkbox"/> Auto Accidents | Date: ___/___/___ | <input type="checkbox"/> Fall (severe) | Date: ___/___/___ |
| <input type="checkbox"/> Work Injury    | Date: ___/___/___ | <input type="checkbox"/> Head Injury   | Date: ___/___/___ |
| <input type="checkbox"/> Broken Bones   | Date: ___/___/___ |  |                   |
| <input type="checkbox"/> Back Injury    | Date: ___/___/___ |  |                   |

Illnesses you have ever been diagnosed with as having or suffered from:  N/A

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

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

- |  |       |                                 |
|--|-------|---------------------------------|
| <input type="checkbox"/> Chiropractor        | _____ | Date of last visit: ___/___/___ |
| <input type="checkbox"/> Massage Therapist   | _____ | Date of last visit: ___/___/___ |
| <input type="checkbox"/> Orthopedist         | _____ | Date of last visit: ___/___/___ |
| <input type="checkbox"/> Physical Therapist  | _____ | Date of last visit: ___/___/___ |
| <input type="checkbox"/> Physician           | _____ | Date of last visit: ___/___/___ |
| <input type="checkbox"/> Psychiatrist/Psych. | _____ | Date of last visit: ___/___/___ |
| <input type="checkbox"/> Acupuncture         | _____ | Date of last visit: ___/___/___ |

N/A

**Please list any surgeries you have had and list dates:**

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Select all the treatments you have had for this condition:  N/A

- Ice                     Heat/Ultrasound     Electrical Stimulation  Exercises                     Bed Rest     Massage
- Chiropractic  Osteopathy             Injections                     Acupuncture                 Naturopathy
- Traction/Decompression     Other: \_\_\_\_\_

**MEDICATION CURRENTLY BEING TAKEN**

None

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Select all that apply:

- Smoker                                     Non-smoker                     Drinks Alcohol Socially             Does not drink alcohol

Female Patients:

Most recent menstrual cycle: Date: \_\_\_/\_\_\_/\_\_\_  Pregnant? \_\_\_\_\_ weeks

**FAMILY HISTORY**  N/A

- 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

**CURRENT INJURIES**

When did your symptoms appear? Date: \_\_\_/\_\_\_/\_\_\_ Is this condition getting worse?  Yes     No

Activities or movements that are difficult / painful to perform:

- Sitting             Standing             Walking             Bending             Lying Down

Circle your pain on the below scale of 0 to 10:

(At rest) ☺ No pain 0 1 2 3 4 5 6 7 8 9 10 ☹ Extreme Pain

(With Activity) ☺ No pain 0 1 2 3 4 5 6 7 8 9 10 ☹ Extreme Pain

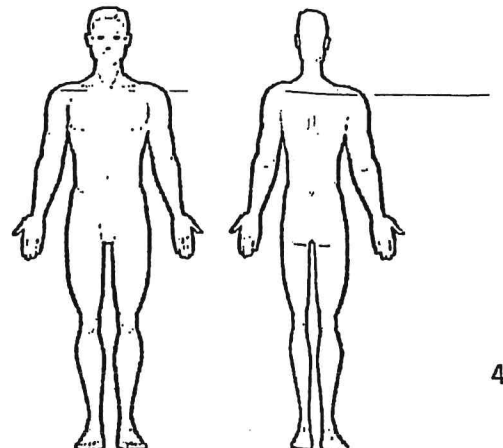
How often are you in pain?

- Constant     Intermittent
- Frequent     Occasional

Description of pain: (Circle all that apply.)

Circle on the areas of your pain:

- (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: \_\_\_\_\_



**FOR DOCTOR'S USE BELOW. SKIP TO PAGE 7.**

**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 \_\_\_\_\_  With Pain on R L
- Test 2 Right \_\_\_\_\_ Left \_\_\_\_\_  Without Pain
- Test 3 Right \_\_\_\_\_ Left \_\_\_\_\_

**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
- Wartenberg's pinwheel testing showed HYPERESTHESIA / HYPOESTHESIA at dermatomal distributions \_\_\_\_\_ on the RIGHT / LEFT
- Sensation intact to all primary modalities
- Patient can heel and toe walk without difficulty
- Toes are down going pathological reflex is absent for Babinski Sign
- Motor testing of the upper extremities normal
- Motor testing of the lower extremities normal

**UROGENITAL**

- There is no complaint of frequency, urgency, or difficulty with urination.

**ORTHOPEDIC EXAMS**

- |  |   |  |   |
|--|---|--|---|
| <input type="checkbox"/> Adson's Maneuver:           | <input type="checkbox"/> Left <input type="checkbox"/> Right <input type="checkbox"/> Bilateral <input type="checkbox"/> NA | <input type="checkbox"/> Max Cervical Comp:        | <input type="checkbox"/> Left <input type="checkbox"/> Right <input type="checkbox"/> Bilateral <input type="checkbox"/> NA |
| <input type="checkbox"/> Apley's Compression         | <input type="checkbox"/> Left <input type="checkbox"/> Right <input type="checkbox"/> Bilateral <input type="checkbox"/> NA | <input type="checkbox"/> McMurray's Test:          | <input type="checkbox"/> Left <input type="checkbox"/> Right <input type="checkbox"/> Bilateral <input type="checkbox"/> NA |
| <input type="checkbox"/> Apley's Distraction         | <input type="checkbox"/> Left <input type="checkbox"/> Right <input type="checkbox"/> Bilateral <input type="checkbox"/> NA | <input type="checkbox"/> Mill's Test:              | <input type="checkbox"/> Left <input type="checkbox"/> Right <input type="checkbox"/> Bilateral <input type="checkbox"/> NA |
| <input type="checkbox"/> Braggard's Sign:            | <input type="checkbox"/> Left <input type="checkbox"/> Right <input type="checkbox"/> Bilateral <input type="checkbox"/> NA | <input type="checkbox"/> O'Donohue Test:           | <input type="checkbox"/> Left <input type="checkbox"/> Right <input type="checkbox"/> Bilateral <input type="checkbox"/> NA |
| <input type="checkbox"/> Cervical Distraction:       | <input type="checkbox"/> Left <input type="checkbox"/> Right <input type="checkbox"/> Bilateral <input type="checkbox"/> NA | <input type="checkbox"/> Patrick's Test:           | <input type="checkbox"/> Left <input type="checkbox"/> Right <input type="checkbox"/> Bilateral <input type="checkbox"/> NA |
| <input type="checkbox"/> Cozen's Test:               | <input type="checkbox"/> Left <input type="checkbox"/> Right <input type="checkbox"/> Bilateral <input type="checkbox"/> NA | <input type="checkbox"/> Phalen's Test:            | <input type="checkbox"/> Left <input type="checkbox"/> Right <input type="checkbox"/> Bilateral <input type="checkbox"/> NA |
| <input type="checkbox"/> Deep Inhalation Chest Test: | <input type="checkbox"/> Left <input type="checkbox"/> Right <input type="checkbox"/> Bilateral <input type="checkbox"/> NA | <input type="checkbox"/> Schepelmann's Sign Test:  | <input type="checkbox"/> Left <input type="checkbox"/> Right <input type="checkbox"/> Bilateral <input type="checkbox"/> NA |
| <input type="checkbox"/> Drawer's Test:              | <input type="checkbox"/> Left <input type="checkbox"/> Right <input type="checkbox"/> Bilateral <input type="checkbox"/> NA | <input type="checkbox"/> Shoulder Depression Test: | <input type="checkbox"/> Left <input type="checkbox"/> Right <input type="checkbox"/> Bilateral <input type="checkbox"/> NA |
| <input type="checkbox"/> Dugas' Test:                | <input type="checkbox"/> Left <input type="checkbox"/> Right <input type="checkbox"/> Bilateral <input type="checkbox"/> NA | <input type="checkbox"/> Straight Leg Raiser Test: | <input type="checkbox"/> Left <input type="checkbox"/> Right <input type="checkbox"/> Bilateral <input type="checkbox"/> NA |
| <input type="checkbox"/> Ely's Heel Buttock Test:    | <input type="checkbox"/> Left <input type="checkbox"/> Right <input type="checkbox"/> Bilateral <input type="checkbox"/> NA | <input type="checkbox"/> Supraspinatus Press Test: | <input type="checkbox"/> Left <input type="checkbox"/> Right <input type="checkbox"/> Bilateral <input type="checkbox"/> NA |
| <input type="checkbox"/> Finklestein's Test:         | <input type="checkbox"/> Left <input type="checkbox"/> Right <input type="checkbox"/> Bilateral <input type="checkbox"/> NA | <input type="checkbox"/> Soto-Hall Test:           | <input type="checkbox"/> Positive <input type="checkbox"/> Negative   |
| <input type="checkbox"/> George's Test:              | <input type="checkbox"/> Left <input type="checkbox"/> Right <input type="checkbox"/> Bilateral <input type="checkbox"/> NA | <input type="checkbox"/> Tinel's Test:             | <input type="checkbox"/> Left <input type="checkbox"/> Right <input type="checkbox"/> Bilateral <input type="checkbox"/> NA |
| <input type="checkbox"/> Hoover's Sign               | <input type="checkbox"/> Left <input type="checkbox"/> Right <input type="checkbox"/> Bilateral <input type="checkbox"/> NA | <input type="checkbox"/> Thessaly's Test:          | <input type="checkbox"/> Left <input type="checkbox"/> Right <input type="checkbox"/> Bilateral <input type="checkbox"/> NA |
| <input type="checkbox"/> Kemp's Test:                | <input type="checkbox"/> Left <input type="checkbox"/> Right <input type="checkbox"/> Bilateral <input type="checkbox"/> NA | <input type="checkbox"/> Valgus Stress Test:       | <input type="checkbox"/> Left <input type="checkbox"/> Right <input type="checkbox"/> Bilateral <input type="checkbox"/> NA |
| <input type="checkbox"/> Lasegue's SLR Test:         | <input type="checkbox"/> Left <input type="checkbox"/> Right <input type="checkbox"/> Bilateral <input type="checkbox"/> NA | <input type="checkbox"/> Valsalva Maneuver:        | <input type="checkbox"/> Positive <input type="checkbox"/> Negative   |
| <input type="checkbox"/> Magnuson's Test:            | <input type="checkbox"/> Left <input type="checkbox"/> Right <input type="checkbox"/> Bilateral <input type="checkbox"/> NA | <input type="checkbox"/> Yergason's Test:          | <input type="checkbox"/> Left <input type="checkbox"/> Right <input type="checkbox"/> Bilateral <input type="checkbox"/> NA |
| <input type="checkbox"/> Mankopf's Sign:             | <input type="checkbox"/> Left <input type="checkbox"/> Right <input type="checkbox"/> Bilateral <input type="checkbox"/> NA | <input type="checkbox"/> Other: _____              | <input type="checkbox"/> Left <input type="checkbox"/> Right <input type="checkbox"/> Bilateral <input type="checkbox"/> NA |

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
Flexion	<input type="checkbox"/>		50	
Extension	<input type="checkbox"/>		60	
Left Lat Flex	<input type="checkbox"/>		45	
Rt Lat Flex	<input type="checkbox"/>		45	
Left Rot	<input type="checkbox"/>		80	
Rt Rot	<input type="checkbox"/>		80	

LUMBAR	Restrictive	Degree	Normal	Pain
Flexion	<input type="checkbox"/>		50	
Extension	<input type="checkbox"/>		25	
Left Lat Flex	<input type="checkbox"/>		25	
Rt Lat Flex	<input type="checkbox"/>		25	
Left Rot	<input type="checkbox"/>		30	
Rt Rot	<input type="checkbox"/>		30	

**SPINAL EXAMS**

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 the patient's recovery?

Yes  No If "yes," please explain:

**PLAN RECOMMENDATIONS:**

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

\_\_\_\_\_ Visits

Patient will be re-evaluated in:

- One month
- 1 week
- 2 weeks
- 3 weeks

Chiropractic adjustments (CMT), Activator (ACT), Neuromuscular Re-Education (NR), Joint Mobilization (JM), Myofascial Release (MR), Intersegmental Traction (IT), Electrical Stimulation (EMS), Mechanical Massage (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.

# 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

- |  |   |   |  |   |   |
|--|---|---|--|---|---|
| <input type="checkbox"/> Numb /tingling arm/hand | L | R | <input type="checkbox"/> Weakness arm/hand | L | R |
| <input type="checkbox"/> Numb/tingling leg/foot  | L | R | <input type="checkbox"/> Weakness leg/foot | L | R |

### Symptoms Associated with Injuries

- |   |   |
|---|---|
| <input type="checkbox"/> Range of motion problems | <input type="checkbox"/> Sleep disruption                       |
| <input type="checkbox"/> Headaches                | <input type="checkbox"/> Radiating pain                         |
| <input type="checkbox"/> Muscle spasms            | <input type="checkbox"/> Anxiety                                |
| <input type="checkbox"/> Dizziness                | <input type="checkbox"/> Depression                             |
| <input type="checkbox"/> Visual disturbances      | <input type="checkbox"/> I am taking over-the-counter pain meds |

### Brain/Neuropsych/MTBI Symptoms

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

# 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**



## 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](mailto: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

eng

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 | 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, dislocations, 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 [blank]. 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, its 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.