Welcome!

Patient Information Chart # _____

Please Complete the information below as complete as possible

First Name	MI	Last Name			Title Suffix
Street			SS# D0B		
City			Marital Status	Sex	
State	Zip	Work Phone	Home Phone	Cell Phone	Email address

Employment Information

Employer's Name	Position
What do you do there?	Spouse Name
Spouse's Employer	Time Employed?

Insurance Information

Primary Insurance Company			Insured's Name	
Address			Relationship to Insured	
City	State	Zip	SS#	DOB
Secondary Insurance Company			Insured's Name	
Address			Relationship to Insured	
City	State	Zip	SS #	D0B

Account Information

Desired Method of Payment: Circle One Cash Check Visa Mastercard Amex

Card Number	EXP, Date		Name of Person to be Billed	
Billing Address			Relationship	
City	Stale	Zip	SS#	Driver's License #
Who Referred you to our Office?				

Attorney

Have you retained an attorney? **Yes** No

Attorney's Name			
Address			Phone
City	State	Zip	Copywrite 1989

Dr Nixdorf ___ Dr. Stabile _X__ Covid-19 Patient Screening

Patient's Name_____ Date_____

Temperature _____ Washed Hands ___ Wearing Gloves ___ Wearing Mask ___

Do You have any of the following symptoms?

1. Fever and/or chills Yes ___ No ___
2. Cough (usually dry) Yes ___ No ___
3. Shortness of breath or difficulty breathing Yes ___ No ___
4. Tiredness (sometimes) Yes ___ No ___
5. Aches and pains (sometimes) Yes ___ No ___
6. Headaches (sometimes) Yes ___ No ___
7. Sore throat (sometimes) Yes ___ No ___
8. Upper respiratory symptoms, like runny nose and sinus congestion, are very uncommon in COVID-19. Yes ___ No ___
9. In the past two to three weeks have you been in contact with anyone that has tested positive for the COVID-19 Virus? Yes ___ No ___
10. Have you received the Covid Vaccine Yes___ No ___
11. If this is your follow-up visit and you have answered these questions at your last visit then have any of your answer's changed since that visit?
12. Yes ___ No ___

I have read the above and certify that it is correct to the best of my knowledge. The doctor is compliant with the necessary, accepted, and recommended precautions as they relate to the Covid 19 guidelines. I agree that if at any time on future visits any of the answers to the above questions should change I will notify the doctor immediately.

I was instructed to wash my hands prior to and after my encounter. I am socially distanced from any other patient in the office during my visit. The doctor has hand sanitizer, antiseptic spray, is wearing a N 95 Face masks and Surgical gloves. The office was sanitized prior to my entering and as I am leaving. My temperature was taken, and I was asked the above questions. I indemnify the doctor for any health problems I may have prior to and after my visit to the office.

Patient's Signature _____ Date _____

New Jersey Application for Benefits
Personal Injury Protection

Claim Number: _____

<Name>
<Address 1>
<Address 2>
<Address 3>

Important:
1. To enable us to determine if you are entitled to benefits under the Personal Injury Protection Law you must complete and sign this form.
2. You must also sign the authorizations, Affidavit and Notice attached.
3. Return promptly with any medical bills you have received to date.

Please be advised that knowingly filing a statement of claim containing any false, inaccurate or misleading information, or intentionally omitting information material to the claim will result in the denial of benefits. Any person who knowingly files a statement of claim containing any false or misleading information is subject to subject to criminal and civil penalties.

Your Name (First, Middle, Last)	Gender: Male ☐ / Female ☐		
List any aliases, maiden names or other names you use or have used in the past	Home Phone: ( ) -	Cell Phone: ( ) -	Work Phone: ( ) -
Your Address (No. & Street, City/Municipality, State, County & Zip Code	Date of Birth	Social Security No. (if none, enter "none")	
Your Previous Address (If you lived at the above address for less than 2 years from the accident date)	Email:		

Date of Accident	Time of Accident AM ☐ PM ☐	Place of Accident (Street, City/Town & State)

Brief Description of Accident

Do you own a vehicle? Yes ☐ No ☐
Name of Insurance Company _____
Does anyone living in your residence own a vehicle? Yes ☐ No ☐
Name of Insurance Company _____
Do you have health insurance? Yes ☐ No ☐
Name of Insurance Company _____

	Yes	No
Were you the driver of the vehicle?	☐	☐
Were you a passenger in the vehicle?	☐	☐
Were you a pedestrian?	☐	☐
Were you a member of vehicle owner's household?	☐	☐

As a result of this accident were you injured? Yes ☐ No ☐ If your answer is "Yes", complete the remainder of this form.
If "No", sign here and return this form to us.

Signature: _____ Date: _____

Describe your injury: _____

Were you treated by a doctor? Yes ☐ No ☐	Doctor's Name and Address
If you were treated in a hospital, were you an In-patient? ☐ Out-patient? ☐	Hospital's Name and Address

Amount of Medical Bills to Date: $_____	Will you have more medical expenses? Yes ☐ No ☐	At the time of your accident, were you in the course of your employment? Yes ☐ No ☐	Did you lose wages or salary as a result of your injury? Yes ☐ No ☐ If yes, amount loss to date: $ _____._____	What is your average weekly wage or salary? $_____

Your lost wages: Date disability from work began: Date you returned to work:

Have you received or are you eligible for benefits under:	Yes	No
(1) Any Workers' Compensation Law?	☐	☐
(2) Employees' Temporary Disability Benefit Statute?	☐	☐
(3) Medicare?	☐	☐

If yes, amount: $_____ Per week ☐ Per month ☐

If you are a Medicare beneficiary, enter your Health Insurance Claim Number (HICN) _____

List names and addresses of your employer and other employers for one year prior to accident date and give occupation and dates of employment:

Employer & Address	Occupation	Dates: From - To

As a result of your injury, have you had any other expenses? Yes ☐ No ☐ If your answer is "Yes", explain on reverse side.

Signature: _____ Date: _____

Do Not Detach - Authorization for Medical Information - Do Not Detach

This authorization or photocopy hereof, will authorize you to furnish all information you may have regarding my condition while under your observation or treatment, including the history obtained, X-ray and/or physical findings, diagnosis and prognosis related to this accident as well as any prior or subsequent treatment rendered by you or your facility. You are authorized to provide this information in accordance with the Personal Injury Protection Benefits Law.

Signature: _____ Date: _____

Do Not Detach - Authorization for Wage Information - Do Not Detach

This authorization or photocopy hereof, will authorize you to furnish all information you may have regarding my wage or salary while employed by you. You are authorized to provide this information in accordance with the Personal Injury Protection Benefits Law.

Signature: _____ Date: _____

Social Security No.: _____

Patient_____ Date_____

Automobile Accident Description

1. The accident took place on .
2. The time of the accident was o'clock.
3. The accident took place on Street Road Avenue
4. The accident happened as following;
5. The patient was driving a Car SUV Van Bus Large Truck Pickup Truck
6. The Patient was the Driver Front Passenger L. Rear Passenger R. Rear Passenger
7. The patient's vehicle was traveling mph
8. The other vehicle was traveling at mph
9. At the time of the accident the patient was stopped at an intersection stopped in traffic
   stopped at a light making a right turn making a left turn parking
   proceeding along slowing down accelerating Other
10. Visibility at the time of the accident was Good Fair Poor
11. The road condition at the time of the accident was Icy Wet Sandy Dark
    clean and Dry
12. The point of impact was head-on rear End left front right Front left rear
    right rear
13. The patient's car hit the other vehicle The other vehicle hit the patient's car

Other

14. The patient saw the accident coming did not see the accident coming.
15. The patient was was not braced for the impact.
16. The patient did did not_have a seat belt on.
17. The patient did did not have a shoulder harness on.
18. The driver's front seat air bag did did not deploy.
19. The front seat passenger air bag did did not deploy.
20. The side air bags did did not deploy.
21. The vehicle did did not have headrests.
22. Headrests were even with the top of the head Even with the bottom of the head

    Even with the middle of the neck
23. At the time of the impact the patient's head was facing straight forward

    turned to the right Turned to the left
24. The police did did not show up at the scene.
25. An accident report was was not filed out.
26. After the accident, the patient went home to work to hospital ER to private doctor
27. Immediately after the accident and within a few days following the accident the patient's symptoms were

    headaches loss of smell tension loss of taste diarrhea

    neck Pain Dizziness Irritability toe numbness depression

    heck stiffness

    nausea mid back pain constipation anxiety fainting

    confusion low back pain cold hands chest pain ringing in

the ears fatigue nervousness cold feet pain behind the eyes shortness of breath sleeping problems Other.

28.The patient did did not lose consciousness for

28. The patient’s body did did not strike the inside of the vehicle.

If yes describe

Automobile Accident Treatment, Arbitration and Litigation Statement:
You have been injured in an automobile accident and if you have retained an attorney to represent you in litigation against the party or parties that were responsible for your injuries you should consult him regarding you obligations to anyone other than your attorney's office. You are obligated to report your accident to your insurance company in a timely manner.

The Automobile Reform Act, which regulates the automobile accident injury process, allows litigation and compensation for injuries that are permanent in nature. To be considered permanent in nature the extent of the injuries has to be such that they have a permanent impact on your life and activities of daily living. You are asked to complete an Activities of Daily Living Question Sheet and a Complaint Assessment for each complaint on your initial visit to this office indicating the activities you are unable to perform as a result of your injuries. You are again asked to complete this form when you are given your Re-examinations and Final Permanency examination. It is important that you do not exaggerate or put down restrictions that are not accurate in nature. You should think about the questions carefully and only answer those questions that pertain to your activities. If you did not and do not perform certain of these activities before the accident and injury, then leave it blank. If you did not attempt to do certain of these activities after the accident and injury, then state that you did not attempt the activity by writing a * in the box and writing not attempted in the box at the bottom of the page. The answers to this questionnaire will be used along with your examination findings, subjective complaints, Pain Indexes, results of testing and other consulting physician's reports, to determine the extent of your permanency.

In order to decide Permanency, your doctor will have to sign a Permanency Statement, which is required by law. He will not exaggerate, amplify or make any statements that he feels are untrue. The extent of the permanency will be based on the actual presence of limitations that are felt to be life-long and the result of the injuries sustained in the automobile accident.

In computing permanency, the doctor must be sure that the patient has made every attempt to obtain the necessary treatment to obtain the greatest results possible. The patient must have followed the doctor's recommendations completely and reached Maximum Improvement with care. The treatment time must be enough to render the most improvement possible. The doctor will have to attests to this on the Permanency Statement. The permanency is based on the AMA Guidelines for Permanency

The AMA Guidelines for Permanency Prognosis:
The A.M.A. Guides to the Evaluation of Permanent Impairment or Maximum Improvement define impairments as conditions that interfere with an individual's Outcome Assessments and "activities of daily living", some of which are listed in the Guides' Glossary on page 315 of that book. Per the patient's own statements, daily activities must be limited to the degree listed in the "Activities of Daily Living" Section, which correlate with the Range of Motion, Orthopedic, Neurological, and the other clinical findings described in corresponding sections of the Guide.

Permanency Statement:
Based upon my professional expertise, and the findings in your narrative report, including reference to clinical objective findings and/or objective medical tests, if it is my opinion that within a reasonable degree of medical probability you have sustained a permanent injury that will have permanent residual sequelae and if it is my further opinion that within a reasonable degree of medical probability, that although further treatment in the future may alleviate some symptomatology, the permanent residuals of the injury cannot be completely resolved by way of further medical treatment or intervention and there will always be some aspect of residual permanent injury experienced for the balance of my patient's lifetime, I will certify the permanency of the patient's condition.

Since the responsibility for your Health is the Most important of the doctor's responsibilities, and the successful litigation is based on your attorney's use of the physician's Narrative Report and the doctor's interpretation of your condition's permanency, it is your responsibility to do all in your power to assist him or her in this process from the initial visit to the final examination. You must comply and follow the recommendations.

Independent Chiropractic Examination and or Paper Peer Review:
At some point in your treatment your insurance company will conclude via a Peer Paper Review and or an Independent Chiropractic Examination, that you have reached maximum improvement with treatment or they will give the opinion that you have no further need for Chiropractic Care.
If your insurance company sends you a letter to appear for an Independent Chiropractic Examination, you must appear and undergo this examination. If you receive a letter of any nature you should show it to the doctor. When you go to this examination you should not exaggerate your condition, nor should you make untrue statements. You should relate your initial condition and the current status of your condition and indicate whether you have improved and continue to improve with treatment. Exaggerating Statements that are made as well as statements that the treatment did not help you when in fact it did will not help your litigation nor will it help you to receive approval for further care. Just be truthful!

If the Independent examination report is not a fair and accurate assessment of your condition and if it contains untrue statements, which many times it does, you should continue to receive treatment until both you and your treating physician concur that you are in fact as well as you will get. You should also write a letter to your insurance carrier and

the pre-certification company, which initiated the independent examination and refute the statements you feel to be incorrect or untrue. Send a copy of the letter to your attorney and a copy to this office.

The payment of fees for treatment received after being CUT-OFF by an Independent Chiropractic Examination or a Paper/Peer Review and Non-Certification of a treatment plan, is based on an Arbitration Action, which this office will initiate on your behalf. An arbitration action is only successful if the patient has followed the doctor's advise and in fact was in need of further care.
If the arbitration is not successful the doctor will not receive payment for his services and he is not permitted to seek payment from the patient's health insurance or the patient.
He will be treating you without payment.

OFFICE POLICY REGARDING PIP ASSIGNMENT

Our office is pleased to accept your insurance assignment, as soon as the responsible party verifies your exact coverage. We will file your claim forms and assist you in any way that we can. However, it must be fully understood that the Contract is between you and your insurance company, and you are fully responsible for the amount that is not paid by your insurance company.
The privilege of Insurance assignment begins when our office receives your insurance forms and your insurance is "Qualified" for coverage. You are considered a cash patient until our office "qualifies" your coverage to determine the extent of benefits under your policy.

I have been made aware of the New Jersey No Fault Insurance Act and realize that I am responsible for payment of a deductible of $250.00 or more, whichever my policy provisions provide for and a co-payment of 20% of the approved treatment fees with a maximum per visit fee of $90.00 I am aware that this fee does not pertain to x-rays, examinations or testing, which are regulated by separate fee maximums as per the fee schedule. In consideration of the courtesy afforded to me by this office I acknowledge that if I retain an attorney the deductible and co-insurance fees as well as any fees associated with making copies of files and preparation of any Narrative reports or court testimony fees will be paid from the proceeds of any settlement obtained due to the legal action at the time funds are dispersed. In the event that there is no legal action or the legal action is not successful I hereby agree to personally make payment of all the above fees not to exceed the maximum provided for by the NJ PIP Statutes and regulations.

Lastly, it is the goal of this office to provide you with the finest quality Chiropractic care available. If you have any questions with regard to your health care, or any of our policies, please let us know. We look forward to your referrals and to a doctor-patient relationship that works for our mutual benefit.

By my signature, I agree with the above terms and conditions as outlined.

I have read the above statement, understand it and agree to co-operate with this office in every way **possible.**

_____ _____

Patient Signature **Date** **Witness**

*THIS IS A REQUIREM*ENT OF N.J.A.C. 11:16, AS OF June 1, 1986

NOTICE TO CONSUMERS

VERIFICATION REQUIRED WITH BILLS TO BE REIMBURSED

No one may ask you to pay for any materials or health services furnished in conjunction with a claim unless they give you a certification verifying that the materials or health services were necessary and were provided. The certification must be included in or attached to their bill.

CERTIFICATION:

I HAVE READ THE ATTACHED REPORT AND BILL FOR HEALTH SERVICES AND/OR MATERIALS RENDERED TO _____

I DECLARE THAT THESE TREATMENTS, SERVICES OR MATERIALS RENDERED OR PROVIDED ME WERE REASONABLE AND NECESSARY, AND WERE IN FACT, FURNISHED AND PROVIDED ON THE DATES SET FORTH.

I UNDERSTAND THAT ANY PERSON WHO KNOWINGLY FILES A STATEMENT OF CLAIM CONTAINING ANY FALSE OR MISLEADING INFORMATION IS SUBJECT TO CRIMINAL AND CIVIL PENALTIES.

I FURTHER UNDERSTAND THAT THE FURNISHING OF THIS VERIFICATION IS A CONDITION PRECEDENT TO EITHER PAYMENT BY THE INSURER OR RECOURSE AGAINST THE INSURED PERSON, WHO, OR FOR WHOM THE SERVICES, TREATMENT OR MATERIALS WERE RENDERED OR SUPPLIED.

I CERTIFY THAT THE FOREGOING STATEMENTS MADE BY ME ARE TRUE. I AM AWARE THAT IF ANY OF THE FOREGOING STATEMENTS MADE BY ME ARE WILLFULLY FALSE, I AM SUBJECT TO PUNISHMENT.

_____ _____

PRINT NAME DATE SIGNATURE

Claim # _____ Date of First Treatment _____

What is No Fault Auto Insurance?

- **No fault auto insurance/Personal Injury Protection (PIP)** in New Jersey was enacted to enable people injured in automobile accidents to have treatment for injuries related to automobile accidents without regard to who is at fault in the accident and without having to depend on their health insurance or their own funds.
- The rates you pay for Personal Injury Protection insurance do not increase due to your using the insurance to pay for treatment or accident related bills.

How it works:

There are several different situations and there are rules that differ in each as well as rules that are similar or the same.

Case Number 1:

You own the car that is in the accident, you are in the car, you are the insured and you have injuries.

- Your insurance company pays your medical bills.

Case Number 2:

You own the car and your passenger has no car and no automobile insurance and does not live in your house nor do they live in a household with anyone that owns a car or has automobile insurance.

- Your passenger completes a notarized Affidavit of No Insurance.
- Your PIP insurance pays the medical bills for this person.

Case Number 3:

You own the car and your passenger owns a car and has automobile insurance.

- The passenger's insurance company pays the medical bills for your passenger.

Case Number 4:

You own the car and your passenger lives in a household with someone that owns a car and or has automobile insurance.

- The insurance company of the member of the household that the passenger lives with pays the medical bills.

Case Number 5 Pedestrian Accidents:

1. You are a pedestrian and are struck by an automobile and you have automobile insurance and a car.
   - Your automobile insurance company pays your medical bills.
2. You are a pedestrian and you are struck by an automobile and you live in a household with someone that has a car and or automobile insurance.
   - The member of your household's insurance pays your medical bills.
3. You are a pedestrian and you are stuck by an automobile and you do not have a car or automobile insurance and no one in your household has a car or automobile insurance.
   - You complete a notarized Affidavit of No Insurance and submit the medical bills to New Jersey Property-Liability Insurance Guarantee Association (NJPLIGA). They pay these bills.

Health Insurance As Primary

You have the option of choosing your health insurance as the primary coverage for your automobile insurance PIP.

- If you choose your health insurance company to be your primary insurance for your automobile PIP portion of your automobile insurance policy you will be subjected to any deductible, co-payment or any non covered treatment.
- You are also subject to any deductible and co-payment that your automobile insurance policy may have.
- If your health insurance does not cover the treatment performed, you will have to meet the deductible and co-payments of your automobile insurance policy PIP provisions.
- The choice of health insurance as primary for PIP coverage can be very costly if you are involved in an automobile accident and receive injuries that require treatment.
- You may be responsible for as much as $5,000.00 to $6,000.00 and given the cost of hospital emergency room treatment, a trip to the ER as a result of an automobile accident can cost as much as $5,000.00 to $6,000.00.

Deductible and Co-Payments:

- No Fault Personal Injury Insurance Policies contain clauses that mandate by law the payment of **deductibles and co-payments**.
- Deductibles and Co-Payments **cannot be waived** as this would be considered insurance fraud and **punishable by a fine and or imprisonment**.

Deductible:

- The deductible is the part of the medical bill that you are responsible to pay to the provider of treatment before your automobile insurance will begin to pay for treatment bills.
- The policyholder chooses the amount of the deductibles. They can range from $250.00 to as high as $5,000.00.

Co-Payments:

- This is the difference between the approved fee schedule fee and the amount that the automobile insurance company pays.

- This fee represents 20% of the total approved fee.

Automobile Accident Injury-Fees for Treatment:

Fees for treatment of injuries incurred in an automobile accident are governed by a Fee Schedule, which is created by the New Jersey Department of Banking and Insurance.

- After the deductible has been met the insurance company will begin to pay for your treatment based on the fee schedule fee, which is approved for the service you receive.
- The payment will be 80% or the approved fee.
- At the point where your $250.00 co-payment out of pocket reaches $1,250.00 or a total of $5,000.00 of bills for treatment, the insurance company will begin to pay the fees for treatment at 100% of the fee schedule.
- If your deductible is more than $250.00 your out of pocket will be based on the deductible plus 20% of the fees to the level of $5,000.00 then 100% payment will be made.
- Deductible and co-payments can be submitted to your health insurance company along with the Explanation of Benefits from your automobile insurance company. The health insurance company will pay these based on the provisions of the health insurance policy.

Payment of Deductible and Co-payments:

We will submit your bills to your insurance company and when receive the explanation of benefits we will give you a statement reflecting the amount you owe this office.

We have a number of options available to you for payment of Deductibles and Co-Payments as follows:

- We will bill your Medical Insurance after the automobile insurance makes payments and will bill you for any balance due after they respond.
- We will give you a statement periodically so that you can remain aware of your obligation and we will send a copy to your attorney as well.

Please Initial the method you choose to satisfy your Deductible and Co-payment obligation:

- You can pay the deductible and Co-payment amounts each time we receive the Explanation Of Benefits from your automobile insurance company. _____ Initial
- You can make payments of $_____ towards the deductible and co-payments on a weekly or monthly basis. _____Initial
- You can defer the payment until your litigation is settled and the attorney can pay us from your settlement. If you choose this option we will need you to obtain a Letter of Protection from your attorney. _____Initial

IN THE EVENT THAT YOU DO NOT PREVAIL IN YOUR LITIGATION YOU MUST BE AWARE THAT YOU ARE STILL RESPONSIBLE TO PAY THIS OFFICE ANY DEDUCTIBLE AND CO-PAYMENTS THAT ARE DUE UP TO A MAXIMUM OF $1,250.00 with conventional $250.00 deductible and 20% co-payments up to $5,000.00. Other policy provisions could raise this amount depending on the deductible you have chosen and the Primary Coverage you chose.

I have read the above and fully understand the rules for automobile insurance payment of injuries sustained in an automobile accident.

_____	_____	_____	_____
Print Your Name	Signature	Date	

THE IMPORTANCE OF ATTENDING YOUR APPOINTMENTS ON A REGULAR BASIS

We have serious concerns regarding the frequency of missed appointments. The treatment plan that we recommended at your Report of Findings is a prescription for care that is no different than any other prescription from your medical doctor. If a Doctor of Medicine prescribes 3 pills per day for 12 days or a total of 36 pills, that is no different than our prescription for 3 treatments per week for 12 weeks or 36 treatments. The difference lies in the fact that you are taking the medication and in a sense self treating. The treatment we deliver can only be delivered by the doctor with you being present in our office. To have the best possible results you must follow the recommendations we made to you. If you miss a prescribed medication you slow down, stop your recovery or sometimes cause your condition to worsen. If you miss your chiropractic treatment you slow down or stop and sometimes cause your condition to worsen as well. Missing a treatment may take an additional few treatments to make up for the loss. The improper treatment or lack of treatment in the manner we recommended can often times cause the quality of your life to become compromised. This may cause difficulty performing necessary tasks which may affect your daily activities, entertainment, and work. Make your appointments for a time that you will not be having to cancel or change. We work by appointment in an effort to enable patients to spend as little time as possible receiving the necessary treatment. When you cancel or miss an appointment you not only lose out on the benefits of the treatment but affect others who could have taken that appointment time. Being late or early for an appointment without calling may cause increased waiting time for other patients who are on time for their appointments.

Missed Appointments

To enable us to efficiently attend to our patients, appointments for the following week are scheduled at the end of each week. Our Office Policy requires our patients to make appointments in advance. When an appointment time needs to be changed it is **COMMON COURTESY** that you make the change in person or by telephone prior to the scheduled appointment that is being changed. If you are running late or wish to come in earlier, we require that you call and change your scheduled appointment time. Missed appointments are required to be made up the same week or the following week. Missed appointments (i.e. "no show, no call") may result in a $50.00 charge after the first incident. Attending your appointments are to your advantage as they will enable you to heal faster and more completely preventing complications and long-lasting chronic problems.

Financial Plans:

If you have been given the Privilege of paying for your treatment with our Interest Free Financial Plan, you are being given the Privilege of receiving your necessary treatment in a manner that is to your financial advantage as noted in the Financial Agreement. You are receiving treatment that would cost you more than three to four times the fees included in your plan. We offer these Financial Plans to enable our patients to receive the necessary treatment and achieve optimal results without the burden of unknown costs. Enabling the cost of treatment to be distributed monthly over a one year time period results in reduced up-front payments.

Administering a practice is complicated and time consuming. The requirements imposed on the Doctor's Office by the Insurance Companies has become burdensome and takes time away from patient treatment. Contacting the Insurance Companies/Governmental Agencies requires that we leave a message and wait for a call back which can take days or even weeks. We must answer the call backs immediately or we lose the opportunity to receive answers to questions that affect our patient's treatment and payment. Unfortunately, many of these calls necessitate the doctor's attention and, in some instances, may require the patient to wait. Each of you may be in this situation at some time or another and we hope you can be patient and understand when this happens.

YOUR HEALTH IS OUR PRIMARY CONCERN AND IT SHOULD BE YOURS AS WELL. "WHEN YOU HAVE YOUR HEALTH, YOU HAVE EVERYTHING"! PLEASE MAKE EVERY EFFORT TO COMPLY WITH YOUR TREATMENT RECOMMENDATIONS!!!

I hereby state that I have read the above and understand its content and agree to abide by the Office Procedures and Rules.

_____	_____	_____	_____
Printed Name	Date	Signature	Witness

ASSIGNMENT OF INSURANCE BENEFITS

PATIENT'S NAME: _____

DATE OF ACCIDENT: _____

In consideration for services rendered to me or to be rendered to me in the future, I hereby authorize payment to the above-referenced provider of any and all insurance benefits to which I may otherwise be entitled for services rendered by the provider.

In the event that the provider's charges are outstanding, I hereby assign and authorize the provider to institute arbitration proceedings or other litigation for the purpose of the provider realizing payment for services rendered. It is also my intent that the provider receives payment directly from the insurance carrier, whether payment is issued prior to or as a result of arbitration proceedings or litigation.

This authorization and assignment or photocopy thereof shall authorize you to furnish all information you may have concerning my condition while under your observation or treatment, including, but not limited to the history obtained, x-ray, MRI, physical findings, diagnosis and prognosis.

SIGNATURE: _____

RELATIONSHIP TO PATIENT: _____

DATED: _____

Claim # _____

First Date of Treatment _____

DOCTORS LIEN

TO: ATTORNEY/INSURANCE CARRIER **FROM:**
_____ **Albert Stabile Jr., D.C.**
_____

REFERENCE: PATIENT RECORD'S AND DOCTOR'S LIEN

I do hereby authorize the above doctor to furnish you, my attorney/insurance carrier, with a full report of the case history, examinations, diagnosis, treatment and prognosis of myself in regard to my accident/illness which occurred or began on _____.

I hereby give a lien to said doctor on any settlement, claim, judgment, or verdict as a result of said accident/illness, and authorize and direct you, my attorney/insurance carrier, to directly pay said doctor such sums from such settlement, claim, judgment or verdict as may be necessary to protect said doctor adequately.

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

PATIENT'S SIGNATURE _____DATE _____

PATIENT'S NAME _____

WITNESS SIGNATURE _____DATE _____

WITNESS NAME _____

The undersigned, being attorney or insurance carrier's authorized representative for the above-named patient, does hereby acknowledge receipt of the above lien, and does agree to honor the same to protect adequately said above named doctor.

AUTHORIZED SIGNATURE _____ DATE _____

NOTE: PLEASE SIGN, DATE AND RETURN A COPY TO THIS OFFICE AT ONCE. KEEP ONE COPY FOR YOUR RECORDS.

Emergency Contact Information

In the rare case that an emergency involving you may occur I our office, we would like to know who to contact regarding your care; this person would be contacted immediately after we notify emergency services. For this reason, we wish to have an emergency contact on file for every patient in our office. Please provide us with the information for whom we may call in the event of an emergency.

Name of Emergency Contact: _____

Relationship: _____ Best way to contact: _____

Phone Number: _____ Extension: _____

By signing this form, you are authorizing a representative of this office to contact the above mentioned person in case we deem an there is an emergency regarding your safety, as well as to disclose any information we may have that we deem medically necessary to th situation regarding your safety to th above mentioned person and necessary medical personnel.

GENERAL RELEASE OF RECORDS AND/OR RELEASE OF X-RAYS

KNOW BY ALL MEN THAT I HAVE REQUESTED THE RELEASE OF X-RAYS AND/OR RECORDS OF _____, (Patient's Name) WHICH IS A PART OF THE RECORDS OF _____.

I hereby acknowledge the receipt of these x-rays and/or records. In consideration of the foregoing, I hereby release and forever discharge the aforesaid from any and all responsibility or liability of any kind, nature or character whatsoever arising from said treatment.

_____ _____

PATIENT OR LEGAL REPRESENTATIVE DATE

_____ _____

WITNESS DATE

INFORMED CONSENT

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

The nature of the chiropractic adjustment.

The primary treatment I use as a Doctor of Chiropractic is spinal manipulative therapy. I will use that procedure to treat you. I may use hands or a mechanical instrument 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, examination, and treatment, you are consenting to the following:

Patient should initial the procedures they are consenting to.

X Spinal Manipulation	X Palpation	X Vital Signs
X Range of Motion Testing	X Orthopedic Testing	X Basic Neurological Testing
X Muscle Strength Testing	X Postural Testing	X Ultrasound
X Hot/Cold Packs	X EMS	X Radiographic Studies

___Other (please explain) _____

The material risk 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. I will make every reasonable effort during the examination to screen for contraindications of care; however, if you have a condition that would otherwise not come to my attention, it is your responsibility to inform me.

The probability of those risks occurring.

Fractures are rare occurrences and generally result from some underlying weakness of the bone, which I check during he is taking of your history and during examination and X-ray. Stroke has been the subject of tremendous disagreement. The incidence of stroke is exceedingly rare and are estimated to occur between one in one million and one in five million in cervical adjustments. The other complications are also generally described as rare.

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 "other treatment" 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 the process may complicate treatment making it more difficult and less effective the longer it is postponed.

DO NOT SIGN UNTIL YOU HAVE READ AND UNDERSTAND THE ABOVE. PLEASE CHECK THE APPROPRIATE BLOCK AND SIGN.

I have read [X] or have had read to me [ ] the above explanation of the chiropractic adjustment and related treatment. I have discussed it with Dr. Stabile and have had my questions answered to my satisfaction. By my signature below I state that I have weighed the risks involved n 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 that treatment.

Dated	Dated
_____	_____
Patient Signature	Doctor's Signature

HIPA Notice

NOTICE OF PRIVACY PRACTICES AS REQUIRED BY THE PRIVACY REGULATIONS CREATED AS A RESULT OF THE HEALTH INSURANCE PORTABILITY AND ACCOUNTABILITY ACT OF 1996 (HlPAA)

Dr. Albert Stabile Jr. Chiropractic Physician

FFECTIVE DATE OF THIS NOTICE: THIS NOTICE DESCRIBES HOW HEALTH INFORMATION ABOUT YOU (AS A PATIENT OF THIS PRACTICE) MAYBE USED AND DISCLOSED, AND HOW YOU CAN GET ACCESS TO YOUR INDIVIDUAL IDENTIFIABLE HEALTH INFORMATION.

PLEASE REVIEW THIS NOTICE CAREFULLY.

Our practice is dedicated to maintaining the privacy of your individually identifiable health information (PHI). In conducting our business, we will create records regarding you and the treatment and services we provide to you. We are required by law to maintain the confidentiality of health information that identifies you. We also are required by law to provide you with this notice of our legal duties and the privacy practices that we maintain in our practice concerning your .PHI. By federal and state law, we must follow the terms of the notice of privacy practices that we have in effect at the time.

We realize that these laws are complicated, but we must provide you with the following important information:

- How we may use and disclose your PHI.
- Your privacy rights in your PHI.
- Our obligations concerning the use and disclosure of your PHI. .

The terms of this notice apply to all records containing your PHI that are created or retained by our practice. We reserve the right to revise or amend this Notice of Privacy Practices. Any revision or amendment to this notice will be effective for all of your records that our practice has created or maintained in. the past, and for any of your records that we may create or maintain in the future. Our practice will always post a copy of our current Notice in our offices in a visible location, and you may request a copy of our most current Notice at any time.

B. IF YOU HAVE at QUESTIONS ABOUT THIS NOTICE, PLEASE CONTACT:

Dr. Albert Stabile Jr. Chiropractic Physician

C. WE MAY USE AND DISCLOSE YOUR INDIVIDUALLY IDENTIFIABLE HEALTH INFORMATION (PHI) IN THE FOLLOWING WAYS

The following categories describe the different ways in which we may use and disclose your PHI.

1. **Treatment.** The information in your medical records will be used to determine which treatment option best addresses your health needs. The treatment selected will be documented in your medical records so that other health care professionals can make informed decisions about your care. For example, we may disclose your PHI to others who may assist in your care, such as your spouse, children or parents. Finally, we may also disclose your PHI to other, health care providers for purposes related to your treatment.

2. **Payment** Our practice may use and disclose your PHI in order to bill and collect payment for the services and items you may receive from us. For example, we may contact your health insurer to certify that you are eligible for benefits (and for what range of benefits), and we may provide your insurer with details regarding your treatment to determine if your insurer will cover, or pay for, your treatment. We also may use and disclose your PHI to obtain payment from third parties that may be responsible for such costs, such as family members. Also, we may use your PHI to bill you directly for services and items. We may disclose your PHI to other health care providers and entities to assist in their billing and collection efforts.

3. **Health Care Operations**. Our practice may use and disclose your PHI to operate our business. As examples of the ways in which we may use and disclose your information for our operations, our practice may use your PHI to evaluate the quality of care you received from us, or to conduct cost-management and business planning activities for our practice. We may disclose your PHI to other health care providers and entities to assist in their health care operations.

4. **Appointments and Reminders**. Our practice may use and disclose your PHI to contact you and remind you of an appointment or as a follow up on treatment.

5. **Non-Medical Communications**. Our practice may use your PHI to contact you for non-medical reasons. For example,', we may send you a birthday card or a holiday greeting via mail.

6. **Health-Related Benefits and Services** Our practice may use and disclose your PHI to inform you of health-related benefits or services that may be of interest to you For example, we may send you newsletters that may include information about our practice, health related issues and products and services.

8. **Release of Information to**. Family/Friends. Our practice may release your PHI to a friend or family member that is involved in your care, or who assists in taking care of you. For example, a parent or guardian may ask that a babysitter take their child to the pediatrician's office for treatment of a cold. In this example, the babysitter may have access to this child's medical information.

9. **Disclosures Required By Law**, Our practice will use and disclose your PHI when we are required to do so by federal, state or local law.

D. **USE AND DISCLOSURE OF YOUR PHI IN CERTAIN SPECIAL CIRCUMSTANCES**

The; following categories describe unique scenarios in which we may use or disclose your Identifiable health information.

1. **Public Health Risks**: Our practice may disclose your PHI to public health authorities that are authorized by law to collect information for the purpose of:

A. Maintaining vital records, such as births and deaths.
B. Reporting child abuse or neglect
C. Preventing or controlling disease, Injury or disability.
D. Notifying a person regarding potential exposure to a communicable disease.
E. Notifying a person regarding a potential risk for spreading or contracting a disease or condition.
F. Reporting reactions to drugs or problems with products or diseases
G. Notifying individuals of a product or device they may be using has been recalled.
H. Notifying appropriate government agency and authority regarding the potential abuse or neglect of an adult patient (Including domestic violence): however, we will only disclose this information if the patient agrees, or we are required or authorized by law to disclose this information; and
I**. Notifying your employer** Under limited circumstances related primarily to workplace Injury or Illness or medical surveillance.
2. **Health Oversight Activities**: Our practice may disclose your PHI to a health oversight agency for activities authorized by law. Oversight activities can include, for example, investigations, inspections, audits, surveys, licensure and disciplinary actions; civil, administrative, and criminal procedure~ or actions; or other activities necessary for the government to monitor government programs, compliance With Civil rights laws and the health care system In general.
3. **Lawsuits and Similar Proceedings** Our practice may use and disclose your PHI In response to court or administrative order, if you are involved in a lawsuit or similar proceeding. We also may disclose your PHI In response to a discovery request, subpoena, or other lawful process by another party Involved in the dispute, but only if we have made an effort to inform you of the request or to obtain an order protecting the information the party has requested.
6. **Workers' Compensation**: Our practice may release your PHI for workers' compensation and similar programs.
E. **YOUR RIGHTS REGARDING YOUR PHI**
You have the following rights regarding the PHI that we maintain about you:
1. **Confidential Communications**. You have the right to request that our practice communicate with you about your health and related issues in a particular manner or at a certain location. For instance, you may ask that we contact you at home, rather than work. In order to request a type of confidential communication, you must make a written request specifying the requested method of contact, or the location where you wish to be contacted. Our practice will accommodate reasonable requests. You do not need to give a reason for your request.
2. **Requesting Restrictions.** You have the right to request a restriction in our use or disclosure of your PHI for treatment, payment or health care operations. Additionally, you have the right to request that we restrict our disclosure of your PHI to only certain individuals involved in your care or the payment for your care, such as family members and friends. We are not required to agree to your request; however, if we do agree, we are bound by our agreement except when otherwise required by law, in emergencies, or when the information is necessary to treat you. In order to request a restriction in our use or disclosure of your PHI, you must make your request in writing your request must describe in a clear and concise fashion.
A. The information you wish restricted.
B. Whether you are requesting to limit our practice's use, disclosure or both; and
C. To whom you want the limits to apply.
3. **Inspection and Copies**. You have the right to inspect and obtain a copy of the PHI that may be used to make decisions about you, including patient medical records and billing records, but not including psychotherapy notes. You must submit your request in writing to Dr. Stabile Jr., D.C. at 179 Cedar Lane Suite B Teaneck, NJ 07666 in order to inspect and/or obtain a copy of your PHI. Our practice may charge a fee for the costs of copying, mailing, labor and supplies associated with your request. Our practice may deny your request to inspect and/or copy in certain limited circumstances; however, you may request a review of our denial. Another licensed health care professional chosen by us will conduct reviews.
4. **Amendment.** You may ask us to amend your health information if you believe it is incorrect or incomplete, and you may request an amendment for as long as the information is kept by or for our practice. To request an amendment, your request must be made in writing and submitted Dr. Stabile Jr., D.C. at 179 Cedar Lane Suite B Teaneck, NJ 07666 You must provide us with a reason that supports your request for amendment. Our practice will deny your request if you fail to submit your request (and the reason supporting your request) in writing. Also, we may deny your request if you ask us to amend information that is in our opinion: (a) accurate and complete; (b) not part of the PHI kept by or for the 'practice; (c) not part of the PHI which you would be permitted to inspect and copy; or (d) not created by our practice, unless the individual or entity that created the information is not available to amend the information.
5. **Accounting of Disclosures**. All of our patients have the right to request an "accounting of disclosures." An "accounting of disclosures" is a list of certain non-routine disclosures our practice has made of your PHI for non-treatment, non-payment or non-operations purposes. Use of your PHI as part of the routine patient care in our practice is not required to be documented. For example, the billing department using your information to file your insurance claim in order to obtain an accounting of disclosures, you must submit your request in writing to Dr. Stabile Jr., D.C. at 179 Cedar Lane Suite B Teaneck, NJ 07666
. **Right to a Paper Copy of This Notice.** You are entitled to receive a paper copy of our notice of privacy practices. You may ask us to give you a copy of this notice at any time. To obtain a paper copy of this notice, contact Dr. Stabile Jr., D.C. at 179 Cedar Lane Suite B Teaneck, NJ 07666

7. **Right to File a Complaint**. If you believe your privacy fights have been violated; you may file a complaint with our practice or with the Secretary of the Department of Health and Human Services. To file a complaint with our practice, contact Dr. Stabile Jr., D.C. at 179 Cedar Lane Suite B Teaneck, NJ 07666All complaints must be submitted in writing. You will not be penalized for filing a complaint.
8. **Right to Provide an Authorization for other Uses and Disclosures**· Our practice will maintain your Written authorization for uses and disclosures that are not Identified by this notice or permitted by applicable law Any authorization you provide to us regarding the use and disclosure of your PHI may be revoked at any time in writing after you revoke your authorization, we VviI1 no longer use or disclose your PHI for the reasons described in the authorization. **Please note, we are required to retain records of your care.**
Again. If you have any questions regarding this notice or our health information privacy policies, please contact Dr. Stabile Jr., D.C. at 179 Cedar Lane Suite B Teaneck, NJ 07666
I have read a copy of the notice of privacy practices document.

HIPPA Waiver for Modalities:

Aware of the HIPPA requirements for patient privacy, and I am consenting to waive a portion of this privacy and consent to receive my various modalities in a multi- patient area with same sex patients. Yes ____ No____

_____ _____
Patient Signature Date

_____ _____
Patient Name Printed Witness

OFFICE POLICY

PATIENT NAME: _____DATE: _____

ADDRESS: _____

SOCIAL SECURITY NUMBER: _____ DATE OF BIRTH: _____

PLEASE READ ALL TEXT, IF YOU UNDERSTAND WHAT YOU HAVE READ, PLEASE SIGN WHERE INDICATED AT THE BOTTOM OF THIS FORM.

AUTHORIZATION TO RELEASE INFORMATION ---I hereby authorize any provider insurance company, physician, employer or organization to release any information regarding history, treatment, or benefits payable and related information concerning this claim, to the plan administrator or it's authorized agent, for the purpose of validating and determining benefits in connection with this claim and to any reviewer that Albert Stabile Jr., Chiropractic Physician may deem necessary to perform a file review for the purposes of payment, rebuttal of treatment denial, retroactive review, current denial of care, payment or non payment of my claims.

PAYMENT AUTHORIZATION---I authorize payment of all benefits for services rendered from Albert Stabile Jr., Chiropractic Physician and/or the offices known as indicated on the enclosed bills.

This statement applies to insurance assignment and/or an Attorney Lien against any settlement made in conjunction with the above named for condition or injuries which I am being treated for in the offices of the above-named physicians.

OFFICE POLICY REGARDING APPOINTMENTS --- Multiple appointments may be given to you for your convenience, to minimize waiting and to facilitate incorporating these appointments into your daily schedule. Regardless of how many appointments are scheduled for you each week, please remember that it is frequency of the visits that is important, and not the days. If you are unable to keep an appointment for any reason, we require that you call immediately to reschedule your visit. IF YOU NEGLECT TO CALL TO RE-SCHEDULE AN APPOINTMENT THAT YOU CAN NOT MAKE, AND DO NOT SHOW UP FOR THAT APPOINTMENT, YOU WILL BE CHARGED. If you are late for an appointment you may have to wait for the next available opening. If you have any questions please ask the receptionist.

OFFICE POLICY REGARDING ASSIGNMENT ---Our office is pleased to accept your insurance assignment, as soon as your exact coverage is verified by the responsible party. We will file your claim forms and assist you in any way that we can. However, it must be fully understood that the Contract is between you and your insurance company, and you are fully responsible for the amount that is not paid by your insurance company.

Our Policy is as follows:

1. Since, by taking your insurance assignment, we have to wait for payment, this courtesy may be withdrawn at any time if the situation warrants it.

2. If you discontinue care without the doctor's consent, the balance of your account is due to be paid in full, even if insurance has been filed. (You will be reimbursed if your balance is zero)

3. Your insurance company should pay within 30 days. If they do not pay within 60 days, you must pay the balance due and be reimbursed by the insurance company.

4. We will bill your insurance company in 15-day cycles, for as long as you receive care.

5. All deductible payments MUST be made prior to insurance submittal. You are required to pay your co-payment as you go along.

6. You are required to sign for "Authorization to Pay the Provider" (above) and any other documents required by your insurance company, on your first visit.

7. Our office does not guarantee that your insurance company will pay. We will make every attempt to verify your coverage and collect, but all claims are your responsibility.

8. Since we do not own your policy, and occasionally, we have trouble in collecting from the carrier, we may ask for your active assistance in rectifying this situation.

9. Returned checks and balances over 30 days may be subject to additional collection fees and interest charges of 1½% per month. Charges may also be made for missed appointments and those canceled without 24 hours' notice.

10. All patients whose visitation schedule is once per month (or longer) will not be eligible for insurance assignment. Charges for services rendered will again be due as they are received.

11. This office does not promise that an insurance company will reimburse you for the usual and customary charges submitted by this office, nor will we enter into any dispute with an insurance company over the amount of reimbursement.

12. Should you discontinue care for any reason other than discharge by the doctor, any and all balances due will become immediately payable in full, regardless of any claims submitted. Any over payments will be refunded to you.

13. This office does not file for or accept co-payment for secondary Insurance coverage.

14. The privilege of Insurance assignment begins when our office receives your insurance forms, and your insurance is "Qualified" for coverage. You are considered a cash patient until our office "qualifies" your coverage to determine the extent of benefits under your policy.

15. Lastly, it is the goal of this office to provide you with the finest quality Chiropractic care available. If you have any questions with regard to your health care, or any of our policies, please let us know. We look forward to your referrals and to a doctor-patient relationship that works for our mutual benefit.

_____ _____ _____

PATIENT SIGNATURE DATE Witness

All accounts not paid within 90 days will automatically be put through your personal credit card for collection.

I_____ hereby authorize Dr. Lori Ann G. Palumbo, Chiropractic Physician and Albert Stabile Jr., Chiropractic Physician to charge my AMEX___ VISA___ MC ____Credit card account #_____ for the following services and or supplies:

_____

_____ _____ _____

Signature, Please Print Name Date

Form#201 Revised 1.2.2020

INITIAL HEALTH HISTORY

Patient Name **Date**

FAMILY HISTORY:

Do you feel that your family history has had an effect on your current condition?
Yes ☐ **No** ☐

If yes, explain why _____

Are your parents alive? **Yes** ☐ **No** ☐

If deceased at what age? Mother _____ Cause of death? _____

Father _____ Cause of death? _____

Are your parents healthy? **Yes** ☐ **No** ☐

If not what conditions do they have? Mother _____

Father _____

Do you have brothers and sisters? **Yes** ☐ **No** ☐

How many? Brothers?_____ Ages? _____ Sisters? _____ Ages? _____

Are they healthy? Brothers **Yes** ☐ **No** ☐ Sisters **Yes** ☐ **No** ☐

If not healthy what illnesses do they have? Brothers? _____

Sisters? _____

Are they alive? **Yes** ☐ **No** ☐

If not at what ages did they die and what was the cause of death?

Brothers? Ages? _____ Cause of death? _____

Sisters ? Ages? _____ Cause of death? _____

Do you have children? **Yes** ☐ **No** ☐

How Many? _____ Boys ____ Ages_____ Girls ____ Ages _____

Are they all healthy? **Yes** ☐ **No** ☐
If not healthy, what illness do they have? _____

SOCIAL HISTORY:

What is your **occupation**? _____

Do you feel that your **Social History** has had an effect on your current condition? **Yes** ☐ **No** ☐

Do you drink **alcoholic** beverages? **Yes** ☐ **No** ☐

Do you use **tobacco** products? **Yes** ☐ **No** ☐

Do you use **recreational drugs**? **Yes** ☐ **No** ☐

Do you drink beverages with **caffeine**? **Yes** ☐ **No** ☐

Do you take **vitamin** supplements? **Yes** ☐ **No** ☐

Why? _____

Do you go to a **Gym or Health Club**? **Yes** ☐ **No** ☐

Why? _____

Do you drink **Bottled water**? **Yes** ☐ **No** ☐

Why? _____

PAST MEDICAL HISTORY:

Have you been to a **Chiropractor**? **Yes** ☐ **No** ☐

How Long Ago? _____ Name of Chiropractor? _____Do Not Recall☐

What were you treated for? _____

Do you have any **drug or other allergies**? **Yes** ☐ **No** ☐

What drugs? _____

Do you have any **other allergies**? **Yes** ☐ **No** ☐

What are they? _____

Other than for your current problem, have you been **hospitalized** in the past **five years**?

Yes ☐ **No** ☐

Date / / Reason

How Long ?

Have you had any other accidents? **Yes** ☐ **No** ☐

Slip and Fall **Yes** ☐ **No** ☐

Workers Compensation? **Yes** ☐ **No** ☐

Auto? **Yes** ☐ **No** ☐

If Yes please describe:

Describe any treatment:

Have you had any significant **health problems** in the past? **Yes** ☐ **No** ☐

If you have had any of the following health problems in the past please check any of the following that may pertain to you. If not continue to the next topic.

☐ Heart Attack	☐ Heart Surgery/Pace Maker	☐ Heart Murmur
☐ Stroke	☐ Mitral Valve Prolapse	☐ Artificial Valves
☐ Congenital Heart Defect	☐ Venereal Disease	☐ Hepatitis
☐ Alcohol Abuse	☐ Shingles	☐ Cancer
☐ Drug Abuse	☐ Emphysema	☐ Anemia
☐ HIV/AIDS	☐ Glaucoma	☐ Rheumatic Heart
☐ Frequent Neck Pain	☐ Psychiatric Problems	☐ Ulcers
☐ High Blood Pressure	☐ Kidney Problems	☐ Asthma
☐ Low Blood Pressure	☐ Sinus Problems	☐ Chemotherapy
☐ Severe/Frequent Headaches	☐ Difficulty Breathing	☐ Arthritis
☐ Fainting/Seizures/Epilepsy	☐ Artificial Bones/Joints	☐ Tuberculosis
☐ Lower Back Problems	☐ Diabetes	☐ Colitis

☐ Other-Describe:_____

WOMEN ONLY

To the best of your knowledge are you pregnant? **Yes** ☐ **No** ☐

Have your past pregnancies been normal? **Yes** ☐ **No** ☐

If not, why? _____

I have never been pregnant. **Yes** ☐ **No** ☐

Do you consult an OB/GYN regularly? **Yes** ☐ **No** ☐

If Yes what is the OB/GYN's Name? _____

Date of Onset of your Current Condition? When did it start? ___ / ___ / ___

Description of Accident/Injury/Condition?
How did it happen?

_____
_____
_____

Type: ☐ **Automobile Accident** ☐ **Slip/Fall Accident**

☐ **Pedestrian Accident** ☐ **Workmen's Compensation**

☐ **Not an Accident -Explain** _____

Were you treated by any other doctors for this condition? Yes ☐ **No** ☐

Name of treating doctors and Specialists: _____

Are you currently taking any medications? Yes ☐ **No** ☐

☐ Anti-Inflammatory ☐ Tranquilizers ☐ Insulin Injection ☐ Diabetes medication Pills

☐ Muscle Relaxants ☐ Pain Medication ☐ Antibiotics ☐ Blood Thinners

☐ Thyroid Medication ☐ Birth Control Pills ☐ Blood Pressure Medications

☐ Other List: _____

Please complete the following indicating those items that pertain to your current health:

☐ Heart Attack	☐ Heart Surgery/Pace Maker	☐ Heart Murmur
☐ Stroke	☐ Mitral Valve Prolapse	☐ Artificial Valves
☐ Congenital Heart Defect	☐ Venereal Disease	☐ Hepatitis
☐ Alcohol Abuse	☐ Shingles	☐ Cancer
☐ Drug Abuse	☐ Emphysema	☐ Anemia
☐ HIV/AIDS	☐ Glaucoma	☐ Rheumatic Heart
☐ Frequent Neck Pain	☐ Psychiatric Problems	☐ Ulcers
☐ High Blood Pressure	☐ Kidney Problems	☐ Asthma
☐ Low Blood Pressure	☐ Sinus Problems	☐ Chemotherapy
☐ Severe/Frequent Headaches	☐ Difficulty Breathing	☐ Arthritis
☐ Fainting/Seizures/Epilepsy	☐ Artificial Bones/Joints	☐ Tuberculosis
☐ Lower Back Problems	☐ Diabetes	☐ Colitis

☐ Other-Describe:_____

Did you receive treatment in a hospital for your current condition? Yes ☐ No ☐

When did you go to the hospital? ☐ **Immediately** ☐ **Next day** ☐ **Days later** ☐ **Later that day**

How did you get to the hospital? ☐ **Ambulance** ☐ **Police** ☐ **Drove Self** ☐ **Someone else**

What hospital **emergency room** were you taken to?

Were you **admitted**? **Yes** ☐ **No** ☐ How many days were you hospitalized?

What treatment was given?

☐ **Oral Medication** ☐ **Injection** ☐ **Topical Antiseptics** ☐ **Bandages** ☐ **Sutures**

☐ **Ice Packs** ☐ **Hot Packs** ☐ **Splint** ☐ **Cast** ☐ **Brace**

☐ **Collar** ☐ **Surgery-explain**_____

Were x-rays taken? Yes ☐ **No** ☐ Taken by? ☐ **Doctor** ☐ **Hospital** ☐ **Radiologist**

Areas x-rayed?

☐ **Head** ☐ **Neck** ☐ **Upper/mid back** ☐ **Lower back**

☐ **Shoulder** ☐ **Elbow** ☐ **Wrist** ☐ **Hand**

☐ **Hip** ☐ **Arm** ☐ **Knee** ☐ **Ankle**

Were MRI's performed? Yes ☐ **No** ☐ Taken by? ☐ **Doctor** ☐ **Hospital** ☐ **Radiologist**

Areas?

☐ **Head** ☐ **Neck** ☐ **Upper/mid back** ☐ **Lower back**

☐ **Shoulder** ☐ **Elbow** ☐ **Wrist** ☐ **Hand**

☐ **Hip** ☐ **Arm** ☐ **Knee** ☐ **Ankle**

Were CT scans performed? Yes ☐ **No** ☐ Taken by? ☐ **Doctor** ☐ **Hospital** ☐ **Radiologist**

Areas?

☐ **Head** ☐ **Neck** ☐ **Upper/mid back** ☐ **Lower back**

☐ **Shoulder** ☐ **Elbow** ☐ **Wrist** ☐ **Hand**

☐ **Hip** ☐ **Arm** ☐ **Knee** ☐ **Ankle**

Instructions given at discharge?

☐ no further care necessary ☐ See Chiropractor ☐ See family doctor

☐ See Physical Therapist ☐ **See Neurologist** ☐ See Orthopedist

☐ Use Ice ☐ **No Work** ☐ Take Pain medication

☐ Take Anti-inflammatory ☐ Take Tranquilizers ☐ Take Antibiotics

☐ **Use** Heat ☐ **Rest** ☐ **None**

If you had these symptoms before please describe:

DIFFICULTY IN:

☐ Bending ☐ Standing ☐ Walking ☐ Lying ☐ Reaching

☐ Lifting ☐ Twisting ☐ Coughing ☐ Sitting ☐ Sneezing

☐ Rising to walk after sitting or lying down

PAIN IS RELIEVED BY:

☐ Rest ☐ Nothing ☐ Ice ☐ Heat ☐ Sitting

☐ Aspirin ☐ Advil ☐ Standing ☐ Exercise ☐ Tylenol

SYMPTOMS ARE:

☐ Improving Slowly ☐ Improving Moderately ☐ Improving Greatly

☐ Recurrent ☐ Getting Worse ☐ Not Improving

Have you missed work due to this accident/condition? ☐ Missed No Work ☐ Limited

Work Activity ☐ Missed Work From / / to / /

I ☐ **Have** ☐ **Have Not** had these symptoms before.

I ☐ **Was** ☐ **Was Not** symptomatic prior to the start of this condition or injury.

Did you self treat your symptoms? ☐ Yes ☐ No

☐ Ice ☐ Heat ☐ Bed Rest ☐ Over-The-Counter Medication

ACTIVITIES OF DAILY LIVING GENERAL PAIN DISABILITY INDEX

The rating scales are designed to measure the degree to which several aspects of the patient's life are presently disrupted by acute or chronic pain. In other words, we determine how much the pain the patient is experiencing is preventing the patient from doing what would normally be done, or-from doing it as well as the patient normally would. Each category was responded to by indicating the overall impact of pain in the patient's life, not just when the pain is at its worst.

For each of the six categories of daily living listed, the patient write the number, which best described the typical level of activities.

A score of 0 means no disruption in functioning at all, and a score of 10 signifies that all of the activities in the specific category in which the patient would normally be involved have been totally disrupted or prevented by the pain.

FAMILY/HOME RESPONSIBILITIES: This category refers to activities related to the home or family. It includes chores and duties performed around the house and errands or favors for other family members (e.g., driving the children to school, Travel, Driving, Riding as a passenger, Driving for more than 15-20 minutes, Riding as a passenger for more than 15-20 minutes, Sitting, Climbing stairs, Getting in/out of auto, Kneeling, Lifting children, Using telephone, Using computer, Yard Work, Mowing lawn, Raking leaves, Gardening, Housework, Doing Laundry, Making beds, Bending, Running, Walking, Walking for long distance, Sitting for long periods of time, Lifting more than a few pounds, Vacuuming, Washing dishes, Ironing, Carrying groceries, Caring for pets, Cooking.)

The patient indicated that Family/Home Responsibilities were affected at a level of ____.

RECREATIONAL ACTIVITIES: This category includes hobbies, Reading, Playing piano, Exercising, Swimming, sports and other similar leisure time activities.
The patient indicated that Recreation Activities were affected at a level of ____.

SOCIAL ACTIVITY: This category refers to activities, which involve participation with friends and acquaintances other than family members, it includes parties, theater, concerts, dining out, and other social functions.
The patient indicated that Social Activities were affected at a level of ____.

OCCUPATIONAL ACTIVITIES: This category refers to activities that are a part of our directly related to one's job. This includes non-paying jobs as well, such as that of a homemaker or volunteer worker.
The patient indicated that Occupational Activities were affected at a level of ____.

SELF CARE ACTIVITIES: This category includes activities which involve personal maintenance and independent daily living (e.g., taking a shower, Personal Grooming, Combing hair, Shaving, In/out bathtub, brushing teeth, Getting dressed, etc.)
The patient indicated that Social Care Activities were affected at a level of ____.

LIFE-SUPPORT ACTIVITY: This category refers to basic life-supporting behaviors such as eating, sleeping, lying in bed, Chewing, Sitting in recliner and breathing.
The patient indicated that Life-Support Activities were affected at a level of ____.

The above Activities of Daily Living Pain Indexes totaled .
By dividing the sum total of all the Activities of Daily Living Ratings by the total of possible Total Disability you arrive at a percentage of Total Activities of Daily Living Disability. The patient was given a Activities of Daily Living General Pain Disability Index Questionnaire on and had a score of ____/60 and a percentage of General Pain Disability of ___% . The percentage of disability is rated 0-20%, No Disability to Minimal disability, 21-40% Moderate disability, 41-60% Severe disability, 61-80% Crippling disability, 81-100% Bed-bound or Exaggerating.

INITIAL COMPLAINTS

PAIN SCALE - BASED ON A SCALE OF 0 TO 10, WITH 10 BEING THE MOST SEVERE and 0 being no pain. 1-2=Mild 3-4=Mild to Moderate 5-6=Moderate 7-8+ Moderate to Severe 9-10=Severe

PLEASE RATE EACH SYMPTOM ACCORDINGLY.

JAW PAIN: ☐ Right ☐ Left ☐ **Both Jaw Pops** ☐ Right ☐ Left ☐ ☐ Both

PAIN SCALE ☐ 0 ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ 7 ☐ 8 ☐ 9 ☐ 10

☐ Mild ☐ Mild to Moderate ☐ Moderate ☐ Moderate to Severe ☐ Severe

☐ Constant ☐ Frequent ☐ Occasional ☐ Intermittent

NECK PAIN: ☐ Right ☐ Left ☐ Both

PAIN SCALE ☐ 0 ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ 7 ☐ 8 ☐ 9 ☐ 10

☐ Mild ☐ Mild to Moderate ☐ Moderate ☐ Moderate to Severe ☐ Severe

PAIN INCREASED BY MOVEMENT:

ROTATION ☐ Right ☐ Left

BENDING ☐ Forward ☐ Backward ☐ Right ☐ Left

☐ Neck Stiffness ☐ Muscle Spasm ☐ Grinding and Grating Sounds

☐ Constant ☐ Frequent ☐ Occasional ☐ Intermittent

HEADACHES:

PAIN SCALE ☐ 0 ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ 7 ☐ 8 ☐ 9 ☐ 10

☐ Mild ☐ Mild to Moderate ☐ Moderate ☐ Moderate to Severe ☐ Severe

LOCATED:
☐ Front ☐ Back ☐ Temples ☐ Forehead ☐ Behind Eyes

☐ Constant ☐ Frequent ☐ Occasional ☐ Intermittent

SHOULDER PAIN: ☐ Right ☐ Left ☐ Both

PAIN SCALE ☐ 0 ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ 7 ☐ 8 ☐ 9 ☐ 10

☐ Mild ☐ Mild to Moderate ☐ Moderate ☐ Moderate to Severe ☐ Severe

☐ Constant ☐ Frequent ☐ Occasional ☐ Intermittent

SHOULDER LIMITED MOVEMENT: ☐ Right ☐ Left ☐ Both

PAIN SCALE ☐ 0 ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ 7 ☐ 8 ☐ 9 ☐ 10

☐ Mild ☐ Mild to Moderate ☐ Moderate ☐ Moderate to Severe ☐ Severe

☐ Constant ☐ Frequent ☐ Occasional ☐ Intermittent

ARM PAIN: ☐ Right ☐ Left ☐ Both ☐ Forearm ☐ Upper Arms

PAIN SCALE ☐ 0 ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ 7 ☐ 8 ☐ 9 ☐ 10

☐ Mild ☐ Mild to Moderate ☐ Moderate ☐ Moderate to Severe ☐ Severe

☐ Constant ☐ Frequent ☐ Occasional ☐ Intermittent

ARM NUMBNESS: **Hand** ☐ Right ☐ Left ☐ Both **Arm** ☐ Right ☐ Left ☐ Both

DEGREE SCALE ☐ 0 ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ 7 ☐ 8 ☐ 9 ☐ 10

☐ Mild ☐ Mild to Moderate ☐ Moderate ☐ Moderate to Severe ☐ Severe

☐ Constant ☐ Frequent ☐ Occasional ☐ Intermittent

ARM PINS/NEEDLES:

Hand ☐ Right ☐ Left ☐ Both **Arm** ☐ Right ☐ Left ☐ Both

DEGREE SCALE ☐ 0 ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ 7 ☐ 8 ☐ 9 ☐ 10

☐ Mild ☐ Mild to Moderate ☐ Moderate ☐ Moderate to Severe ☐ Severe

☐ Constant ☐ Frequent ☐ Occasional ☐ Intermittent

ARM W**EAKNESS:**

Hand ☐ Right ☐ Left ☐ Both **Arm** ☐ Right ☐ Left ☐ Both

DEGREE SCALE ☐ 0 ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ 7 ☐ 8 ☐ 9 ☐ 10

☐ Mild ☐ Mild to Moderate ☐ Moderate ☐ Moderate to Severe ☐ Severe

☐ Constant ☐ Frequent ☐ Occasional ☐ Intermittent

ELBOW ☐ Right ☐ Left ☐ Both

PAIN SCALE ☐ 0 ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ 7 ☐ 8 ☐ 9 ☐ 10

☐ Mild ☐ Mild to Moderate ☐ Moderate ☐ Moderate to Severe ☐ Severe

☐ Constant ☐ Frequent ☐ Occasional ☐ Intermittent

WRIST ☐ Right ☐ Left ☐ Both

PAIN SCALE ☐ 0 ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ 7 ☐ 8 ☐ 9 ☐ 10

☐ Mild ☐ Mild to Moderate ☐ Moderate ☐ Moderate to Severe ☐ Severe

☐ Constant ☐ Frequent ☐ Occasional ☐ Intermittent

HAND PAIN: ☐ Right ☐ Left ☐ Both

PAIN SCALE ☐ 0 ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ 7 ☐ 8 ☐ 9 ☐ 10

☐ Mild ☐ Mild to Moderate ☐ Moderate ☐ Moderate to Severe ☐ Severe

☐ Constant ☐ Frequent ☐ Occasional ☐ Intermittent

HAND PINS/NEEDLES:

Hand ☐ Right ☐ Left ☐ Both **Arm** ☐ Right ☐ Left ☐ Both

DEGREE SCALE ☐ 0 ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ 7 ☐ 8 ☐ 9 ☐ 10

☐ Mild ☐ Mild to Moderate ☐ Moderate ☐ Moderate to Severe ☐ Severe

☐ Constant ☐ Frequent ☐ Occasional ☐ Intermittent

HAND NUMBNESS:

Hand ☐ Right ☐ Left ☐ Both **Arm** ☐ Right ☐ Left ☐ Both

DEGREE SCALE ☐ 0 ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ 7 ☐ 8 ☐ 9 ☐ 10

☐ Mild ☐ Mild to Moderate ☐ Moderate ☐ Moderate to Severe ☐ Severe

☐ Constant ☐ Frequent ☐ Occasional ☐ Intermittent

HAND W**EAKNESS:**

Hand ☐ Right ☐ Left ☐ Both **Arm** ☐ Right ☐ Left ☐ Both

DEGREE SCALE ☐ 0 ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ 7 ☐ 8 ☐ 9 ☐ 10

☐ Mild ☐ Mild to Moderate ☐ Moderate ☐ Moderate to Severe ☐ Severe

☐ Constant ☐ Frequent ☐ Occasional ☐ Intermittent

UPPER BACK PAIN: ☐ Right ☐ Left ☐ Both

SPASM ☐ Right ☐ Left ☐ Both

PAIN SCALE ☐ 0 ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ 7 ☐ 8 ☐ 9 ☐ 10

☐ Mild ☐ Mild to Moderate ☐ Moderate ☐ Moderate to Severe ☐ Severe

☐ Constant ☐ Frequent ☐ Occasional ☐ Intermittent

LOWER BACK PAIN: ☐ Right ☐ Left ☐ Both

SPASM ☐ Right ☐ Left ☐ Both

PAIN SCALE ☐ 0 ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ 7 ☐ 8 ☐ 9 ☐ 10

☐ Mild ☐ Mild to Moderate ☐ Moderate ☐ Moderate to Severe ☐ Severe

☐ Constant ☐ Frequent ☐ Occasional ☐ Intermittent

SACRO-ILIAC: ☐ Right ☐ Left ☐ Both

PAIN SCALE ☐ 0 ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ 7 ☐ 8 ☐ 9 ☐ 10

☐ Mild ☐ Mild to Moderate ☐ Moderate ☐ Moderate to Severe ☐ Severe

☐ Constant ☐ Frequent ☐ Occasional ☐ Intermittent

HIP PAIN: ☐ Right ☐ Left ☐ Both

PAIN SCALE ☐ 0 ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ 7 ☐ 8 ☐ 9 ☐ 10

☐ Mild ☐ Mild to Moderate ☐ Moderate ☐ Moderate to Severe ☐ Severe

☐ Constant ☐ Frequent ☐ Occasional ☐ Intermittent

BUTTOCK PAIN ☐ Right ☐ Left ☐ Both

PAIN SCALE ☐ 0 ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ 7 ☐ 8 ☐ 9 ☐ 10

☐ Mild ☐ Mild to Moderate ☐ Moderate ☐ Moderate to Severe ☐ Severe

☐ Constant ☐ Frequent ☐ Occasional ☐ Intermittent

LEG PAIN ☐ Right ☐ Left ☐ Both

RADIATING TO THE ☐ Knee ☐ Calf ☐ Foot

DOWN THE ☐ Front ☐ Back ☐ Side

PAIN SCALE ☐ 0 ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ 7 ☐ 8 ☐ 9 ☐ 10

☐ Mild ☐ Mild to Moderate ☐ Moderate ☐ Moderate to Severe ☐ Severe

☐ Constant ☐ Frequent ☐ Occasional ☐ Intermittent

LEG NUMBNESS ☐ Right ☐ Left ☐ Both

DEGREE SCALE ☐ 0 ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ 7 ☐ 8 ☐ 9 ☐ 10

☐ Mild ☐ Mild to Moderate ☐ Moderate ☐ Moderate to Severe ☐ Severe

☐ Constant ☐ Frequent ☐ Occasional ☐ Intermittent

LEG PINS & NEEDLES ☐ Right ☐ Left ☐ Both

DEGREE SCALE ☐ 0 ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ 7 ☐ 8 ☐ 9 ☐ 10

☐ Mild ☐ Mild to Moderate ☐ Moderate ☐ Moderate to Severe ☐ Severe

☐ Constant ☐ Frequent ☐ Occasional ☐ Intermittent

LEG WEAKNESS ☐ Right ☐ Left ☐ Both **in the** ☐ Thigh ☐ Calf

DEGREE SCALE ☐ 0 ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ 7 ☐ 8 ☐ 9 ☐ 10

☐ Mild ☐ Mild to Moderate ☐ Moderate ☐ Moderate to Severe ☐ Severe

☐ Constant ☐ Frequent ☐ Occasional ☐ Intermittent

KNEE PAIN ☐ Right ☐ Left ☐ Both

PAIN SCALE ☐ 0 ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ 7 ☐ 8 ☐ 9 ☐ 10

☐ Mild ☐ Mild to Moderate ☐ Moderate ☐ Moderate to Severe ☐ Severe

☐ Constant ☐ Frequent ☐ Occasional ☐ Intermittent

ANKLE PAIN ☐ Right ☐ Left ☐ Both

PAIN SCALE ☐ 0 ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ 7 ☐ 8 ☐ 9 ☐ 10

☐ Mild ☐ Mild to Moderate ☐ Moderate ☐ Moderate to Severe ☐ Severe

☐ Constant ☐ Frequent ☐ Occasional ☐ Intermittent

FOOT PAIN ☐ Right ☐ Left ☐ Both

PAIN SCALE ☐ 0 ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ 7 ☐ 8 ☐ 9 ☐ 10

☐ Mild ☐ Mild to Moderate ☐ Moderate ☐ Moderate to Severe ☐ Severe

☐ Constant ☐ Frequent ☐ Occasional ☐ Intermittent

FOOT PINS & NEEDLES ☐ Right ☐ Left ☐ Both

DEGREE SCALE ☐ 0 ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ 7 ☐ 8 ☐ 9 ☐ 10

☐ Mild ☐ Mild to Moderate ☐ Moderate ☐ Moderate to Severe ☐ Severe

☐ Constant ☐ Frequent ☐ Occasional ☐ Intermittent

FOOT WEAKNESS ☐ Right ☐ Left ☐ Both **in the** ☐ Thigh ☐ Calf

DEGREE SCALE ☐ 0 ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ 7 ☐ 8 ☐ 9 ☐ 10

☐ Mild ☐ Mild to Moderate ☐ Moderate ☐ Moderate to Severe ☐ Severe

☐ Constant ☐ Frequent ☐ Occasional ☐ Intermittent

I understand the above information and guarantee this form was completed correctly to the best of my knowledge and understand it is my responsibility to inform this office of any changes in my medical status.

Name (Print) _____ Date / / Signature _____