

WELCOME

Red Rock Chiropractic & Wellness Center
2085 Village Center Circle #110
Las Vegas NV 89134

(702)880-5335

1 PATIENT INFORMATION

Date _____

SS/HIC/Patient ID # _____

Patient Name _____
Last Name _____
First Name _____ Middle Initial _____

Address _____

City _____

State _____ Zip _____

E-mail _____

Sex M F Age _____ Birthdate _____

Married Widowed Single Minor

Separated Divorced Partnered for _____ years

Occupation _____

Patient Employer/School _____

Employer/School Address _____

Employer/School Phone (_____) _____

Spouse's Name _____

Birthdate _____

SS# _____

Spouse's Employer _____

Whom may we thank for referring you? _____

2 INSURANCE

Who is responsible for this account? _____

Relationship to Patient _____

Insurance Co. _____

Group # _____

Is patient covered by additional insurance? Yes No

Subscriber's Name _____

Birthdate _____ SS# _____

Relationship to Patient _____

Insurance Co. _____

Group # _____

INSURANCE ASSIGNMENT AND RELEASE

I certify that I have insurance coverage with _____
Name of Insurance Company(ies) _____
and assign directly to Dr. _____
all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I authorize the use of my signature on all insurance submissions.

The above-named doctor may use my health care information and may disclose such information to the above-named insurance Company(ies) and their agents for the purpose of obtaining payment for services and determining insurance benefits or the benefits payable for related services. This consent will end when my current treatment plan is completed or one year from the date signed below.

MEDICARE/MEDIGAP AUTHORIZATION

I request that payment of authorized Medicare benefits and, if applicable, Medigap benefits, be made either to me or on my behalf to _____

Name of Doctor or Clinic _____
for any services furnished to me by that provider.

To the extent permitted by law, I authorize any holder of medical or other information about me to release to the Centers for Medicare and Medicaid Services, my Medigap insurer, and their agents any information needed to determine these benefits or benefits for related services.

Signature of Beneficiary, Guardian or Personal Representative _____

Please print name of Beneficiary, Guardian or Personal Representative _____

Date _____ Relationship to Beneficiary _____

3 PHONE NUMBERS

Home (_____) _____ Cell (_____) _____

Best time and place to reach you _____

IN CASE OF EMERGENCY, CONTACT

Name _____ Relationship _____

Home Phone (_____) _____

Work Phone (_____) _____

4 FAMILY HISTORY

Date of last physical examination _____

What is your reason for visit? _____

	FATHER	Present health or cause of death	MOTHER	Present health or cause of death	SPOUSE	Present health or cause of death
ALIVE	<input type="checkbox"/>		<input type="checkbox"/>		<input type="checkbox"/>	
DECEASED	<input type="checkbox"/>		<input type="checkbox"/>		<input type="checkbox"/>	
BROTHERS	NO. ALIVE	HEALTH		NO. DECEASED		CAUSE OF DEATH
SISTERS	NO. ALIVE	HEALTH		NO. DECEASED		CAUSE OF DEATH
CHILDREN	NO. ALIVE	AGES & HEALTH		NO. DECEASED		AGES & CAUSE OF DEATH

CHECK ILLNESSES WHICH HAVE OCCURRED Diabetes Cancer Bleeding tendency Kidney disease Tuberculosis
IN ANY OF YOUR BLOOD RELATIVES Heart disease Stroke High blood pressure Nervous illness Allergy Other _____

E MEDICAL HISTORY All information is strictly confidential

Check (✓) symptoms you currently have or have had in the past year.

<p>GENERAL</p> <input type="checkbox"/> Chills <input type="checkbox"/> Depression/Nervousness <input type="checkbox"/> Dizziness/Fainting <input type="checkbox"/> Fever <input type="checkbox"/> Forgetfulness <input type="checkbox"/> Headache <input type="checkbox"/> Loss of sleep <input type="checkbox"/> Loss of weight <input type="checkbox"/> Numbness <input type="checkbox"/> Sweats	<p>GASTROINTESTINAL</p> <input type="checkbox"/> Appetite poor <input type="checkbox"/> Bloating <input type="checkbox"/> Bowel changes <input type="checkbox"/> Constipation <input type="checkbox"/> Diarrhea <input type="checkbox"/> Excessive thirst <input type="checkbox"/> Gas <input type="checkbox"/> Hemorrhoids <input type="checkbox"/> Indigestion <input type="checkbox"/> Nausea <input type="checkbox"/> Rectal bleeding <input type="checkbox"/> Stomach pain <input type="checkbox"/> Vomiting <input type="checkbox"/> Vomiting blood	<p>EYE, EAR, NOSE, THROAT</p> <input type="checkbox"/> Bleeding gums <input type="checkbox"/> Blurred vision <input type="checkbox"/> Crossed eyes <input type="checkbox"/> Difficulty swallowing <input type="checkbox"/> Double vision <input type="checkbox"/> Earache/Ear discharge <input type="checkbox"/> Hay fever <input type="checkbox"/> Hoarseness <input type="checkbox"/> Loss of hearing <input type="checkbox"/> Nosebleeds <input type="checkbox"/> Persistent cough <input type="checkbox"/> Ringing in ears <input type="checkbox"/> Sinus problems <input type="checkbox"/> Vision - Flashes/Halos	<p>MEN only</p> <input type="checkbox"/> Erection difficulties <input type="checkbox"/> Lump in testicles <input type="checkbox"/> Penis discharge <input type="checkbox"/> Sore on penis <input type="checkbox"/> Other _____
<p>MUSCLE/JOINT/BONE Pain, weakness, numbness in:</p> <input type="checkbox"/> Arms <input type="checkbox"/> Hips <input type="checkbox"/> Back <input type="checkbox"/> Legs <input type="checkbox"/> Feet <input type="checkbox"/> Neck <input type="checkbox"/> Hands <input type="checkbox"/> Shoulders	<p>CARDIOVASCULAR</p> <input type="checkbox"/> Chest pain <input type="checkbox"/> High/Low blood pressure <input type="checkbox"/> Irregular/Rapid heart beat <input type="checkbox"/> Poor circulation <input type="checkbox"/> Swelling of ankles <input type="checkbox"/> Varicose veins	<p>SKIN</p> <input type="checkbox"/> Bruise easily <input type="checkbox"/> Hives <input type="checkbox"/> Itching/Rash <input type="checkbox"/> Change in moles <input type="checkbox"/> Scars <input type="checkbox"/> Sore that won't heal	<p>WOMEN only</p> <input type="checkbox"/> Abnormal Pap Smear <input type="checkbox"/> Bleeding between periods <input type="checkbox"/> Breast lump <input type="checkbox"/> Extreme menstrual pain <input type="checkbox"/> Hot flashes <input type="checkbox"/> Nipple discharge <input type="checkbox"/> Painful intercourse <input type="checkbox"/> Vaginal discharge <input type="checkbox"/> Other _____
<p>GENITO-URINARY</p> <input type="checkbox"/> Blood in urine <input type="checkbox"/> Frequent urination <input type="checkbox"/> Lack of bladder control <input type="checkbox"/> Painful urination			<p>Date of last menstrual period _____</p> <p>Date of last Pap Smear _____</p> <p>Have you had a mammogram? _____</p> <p>Are you pregnant? _____</p> <p>Number of children _____</p>

Check (✓) conditions you have or have had in the past.

<input type="checkbox"/> AIDS <input type="checkbox"/> Appendicitis <input type="checkbox"/> Arthritis <input type="checkbox"/> Asthma <input type="checkbox"/> Bleeding Disorders <input type="checkbox"/> Breast Lump <input type="checkbox"/> Cancer <input type="checkbox"/> Cataracts <input type="checkbox"/> Chemical Dependency	<input type="checkbox"/> Chicken Pox <input type="checkbox"/> Diabetes <input type="checkbox"/> Emphysema <input type="checkbox"/> Epilepsy <input type="checkbox"/> Glaucoma <input type="checkbox"/> Heart Disease <input type="checkbox"/> Hepatitis <input type="checkbox"/> Herpes <input type="checkbox"/> High Cholesterol	<input type="checkbox"/> HIV Positive <input type="checkbox"/> Kidney Disease <input type="checkbox"/> Liver Disease <input type="checkbox"/> Measles <input type="checkbox"/> Migraine Headaches <input type="checkbox"/> Multiple Sclerosis <input type="checkbox"/> Mumps <input type="checkbox"/> Pacemaker <input type="checkbox"/> Pneumonia	<input type="checkbox"/> Polio <input type="checkbox"/> Prostate Problem <input type="checkbox"/> Rheumatic Fever <input type="checkbox"/> Scarlet Fever <input type="checkbox"/> Stroke <input type="checkbox"/> Thyroid Problems <input type="checkbox"/> Tuberculosis <input type="checkbox"/> Ulcers <input type="checkbox"/> Venereal Disease
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Describe serious illnesses or operations _____

MEDICATIONS/ALLERGIES

List medications you are currently taking _____

Pharmacy Name _____

Phone (____) _____

List allergies to medications or substances _____

HEALTH HABITS

<p>Check (✓) which you use and how much:</p> <input type="checkbox"/> Caffeine _____ <input type="checkbox"/> Street Drugs _____ <input type="checkbox"/> Tobacco _____ <input type="checkbox"/> Other _____	<p>Check (✓) if your work exposes you to:</p> <input type="checkbox"/> Stress <input type="checkbox"/> Heavy Lifting <input type="checkbox"/> Hazardous Substances <input type="checkbox"/> Other _____
<p>Your occupation _____</p>	

F SIGNATURES

To the best of my knowledge, the above information is complete and correct. I understand that it is my responsibility to inform my doctor if I, or my minor child, ever have a change in health.

_____	_____
Signature of Patient, Parent, Guardian or Personal Representative	Date
_____	_____
Please print name of Patient, Parent, Guardian or Personal Representative	Relationship to Patient
_____	_____
Reviewed By	Date

Name _____ Age _____ Date of injury _____

What is your current weight _____ lbs., and height, _____ ft _____ in.?

Please briefly describe your condition:

Patient Signature _____ Date _____

Please mark the area(s) of injury or discomfort using the symbols below.

Numbness

Pins & Needles

OOOOO

Burning

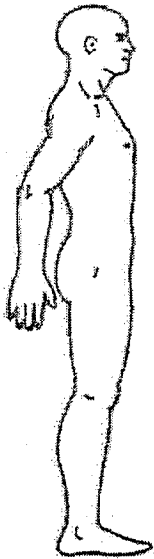
AAAAA

Aching

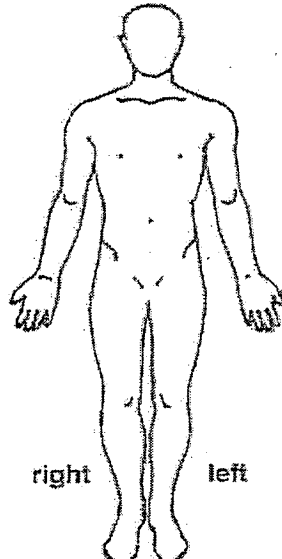
XXXXX

Stabbing

●●●●●



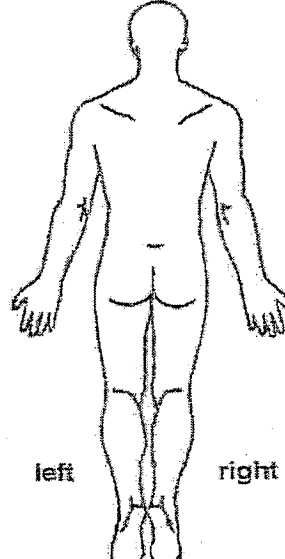
Right



right

left

Front



left

right

Back



Left

Please circle your estimated level of pain, in your opinion

0 1 2 3 4 5 6 7 8 9 10

Doctors notes: _____

Red Rock Chiropractic & Wellness Center
2085 Village Center Circle #110
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(702)880-5335

Patient Name: _____ Date of Birth: _____ Date: _____

Social Security # _____ Patient/Clinic ID# _____ Admit. Date: _____

Patient Informed Consent

Congratulations on choosing chiropractic health care. This clinic believes it is the safest, most natural health care delivery system in the world today. Chiropractic adjustments (chiropractic manipulative therapy; C.M.T.) and other care procedures are safe and cost effective.

All health care professionals (anesthesiologists, chiropractors, dentists, medical doctors, osteopaths, pharmacists, surgeons, etc.) are regulated by laws and boards. These health care professionals are required to give you, the patient, advanced notice of any care risks, because health care is not an exact science. It is not reasonable to expect any doctor to foresee all risks and/or complications. Informed consent information regarding any risks such as: paraplegia, quadriplegia, brain damage, stroke, disc injury, breaks, fractures, dislocations, drug reactions, death or loss of function of any organ or limb, or disfiguring scars associated with physical care, drugs, surgery and/or treatment is an undesirable result, but it does not necessarily indicate an error in clinical judgement. No guarantee of cure or results has been made to you, the patient in this clinic. Your care may involve the making of recommendations based upon facts known to the doctor at this time. Chiropractic care does not use drugs or surgery, and does not diagnose internal and/or medical conditions.

For your information the following is furnished to all patients who request and/or accept chiropractic care in this clinic. Again, chiropractic care does not use drugs or surgery, and does not diagnose internal and/or medical conditions. This clinic is staffed with graduate chiropractors who are licensed and recognized by government agencies regulating all the aforementioned healing arts.

Chiropractic is the science that concerns itself with the relationship between the brain, central nervous system, spine, and the function of the body. Any alteration of this relationship can cause the biomechanical and neurophysiological dynamics of the contiguous spinal and paraspinal structures to be disrupted. This can cause neuronal disturbances in the form of the vertebral subluxation complex (V.S.C.) with its physical and chemical components, which can then interrupt the body's inherent recuperative powers.

The practice of chiropractic can include exams and diagnostic testing. In some cases, this includes the utilization of specialized instrumentation, lab tests, radiological exams, nutritional and/or physical therapy, and rehabilitation procedures, etc. There is a special procedure unique to chiropractic: the chiropractic adjustment (chiropractic manipulative therapy-C.M.T.). Adjustments are made by chiropractors to correct and/or reduce and/or stabilize vertebral or extremity subluxation complexes. The goal of chiropractic health care is to reduce and/or stabilize the nerve interference caused by the VSC and its component parts. There are over 200 different adjusting techniques, some using specialized equipment. Adjustments are usually performed by hand, but may be performed by hand-guided instruments. A C.M.T. is the application of a specific force, applied to a segmental contact point, usually on a vertebra, to reduce or stabilize the V.S.C. and its component parts.

You should understand the benefits of chiropractic health care, but you also need to be aware of some of the limited inherent risks. These occur seldom enough to contraindicate care, but should be considered in your informed decision to receive chiropractic care.

All health care procedures have some risks. With C.M.T.'S these risks may include musculoskeletal sprain/strain, disc injuries, dislocations, fractures, neurological deficits, Horner's Syndrome, Vertebral Artery Syndrome (V.A.S.), stroke, etc. The chances of this occurring have been estimated by experts to be approximately only 1 per 400,000 treatments, to 1 per 1,000,000 treatments.

Appropriate tests will be performed to identify if you may be susceptible to these risks, and you will be notified, in that case. If you have any questions about these issues, please do not hesitate to speak with your doctor of chiropractic.

I have read (or have had read to me) the above information. I wish to rely on the doctors judgement during my course of care, based on the facts then known. I have also had opportunity to ask questions regarding the above information and possible consequences and risks. By signing below, I now agree to have the chiropractic care procedures recommended and performed. I have no questions, and I acknowledge no guarantee of cure has been made to me concerning results, care and treatment.

INFORMED CONSENT TO TREAT

The information I have given this office and my treating doctor is complete and true to the best of my knowledge. I understand the risks associated this form of treatment and I will take the responsibility to ask the doctor to clarify any of my considerations or areas of treatment that I do not completely understand. I authorize the doctors and staff to administer such procedures and treatment as they deem necessary. They have not stated or implied any guaranteed of cure. "24 Hour notice of cancellation is required to avoid a broken appointment charge of \$40.00. I am responsible for payment of this charge.

Patient's Signature: _____ Date: _____

Witness: _____ Date: _____

INFORMED CONSENT TO TREAT A MINOR CHILD

The information I have given this office and my treating doctor pertaining to _____ is complete and true to the best of my knowledge. I understand the risks associated with this form of treatment and will take the responsibility to ask the doctor to clarify any of my considerations or areas of treatment that I do not completely understand. I authorize the doctors and staff to administer such procedures and treatment as they deem necessary to my child/ward in my legal custody. They have not stated or implied any guaranteed of cure.

Parent/Guardian Signature: _____ Date: _____

Relationship to Minor: _____

Witness: _____ Date: _____

I CERTIFY THAT I AM THE PARENT OF THE MINOR CHILD, THE GUARDIAN, OR OTHER LEGAL REPRESENTATIVE OF THE PATIENT INVOLVED.

Parent/Guardian/Legal Representative Signature

Date

RED ROCK
CHIROPRACTIC
& WELLNESS
CENTER

Dr. Margaret R. Colucci
& Associates

Office 702 880.5335

Fax 702 880.5336

www.redrock
chiropractic.com

2085 Village Center Circle
Suite 110
Las Vegas, Nevada 89134

Consent To X-Ray

Patient Name: _____

Date: _____

FEMALES - I UNDERSTAND THAT IF I AM PREGNANT AND HAVE X-RAYS TAKEN WHICH EXPOSE MY LOWER TORSO TO RADIATION, IT IS POSSIBLE TO INJURE THE FETUS. I AHEV BEEN ADVISED THAT 10 DAYS FOLLOWING ONSET OF MENSTRUAL PERIOD ARE GENERALLY CONSIDERED TO BE SAFE FOR X-RAY EXAMS.

WITH FULL UNDERSTANDING OF THE ABOVE, I DO HEREBY STATE THAT, TO THE BEST OF MY KNOWLEDGE, I AM NOT PREGNANT, NOR IS PREGNANCY SUSPECTED OR CONFIRMED AT THIS TIME AND I WISH TO HAVE XRAYS EXAMINATION PERFORMED NOW.

MALES - I DO HERBY GIVE MY PERMISSION TO HAVE AN X-RAY EXAMINATION PERFORMED ON ME.

Patient's Signature

FINANCIAL POLICY

(702)880-5335

Thank you for choosing us as your Chiropractic provider. Our main concern is that you receive the proper chiropractic care needed to maintain optimum spinal health. If you have any questions, please do not hesitate to ask our staff and / or doctor.

Our practice firmly believes that a good doctor / patient relationship is based upon the understanding and open communication. The following is designed to provide you with detailed information about our policies to allow a better understanding of your financial liabilities for our professional services.

Please read the following carefully and initial on the line:

- _____ 1. All co-pays and deductibles are due at the time of your visit. Payments for services for cash visits are due **"In Full"** at the time of your visit. We accept cash, checks Visa and MasterCard.
- _____ 2. We will submit an insurance claim on your behalf, **as a courtesy**, if we have a provider contract with you're Insurance Company. However, it is **your** responsibility to follow-up with your insurance company in the event that your claim is unpaid. If **any** of your personal information changes, it is your responsibility to notify us and provide a copy of the new insurance card to us immediately. **(WE DO NOT BILL SECONDARY INSURANCE)**.
- _____ 3. Your insurance policy is a contract between you, your employer and your insurance company. We are **NOT** a party to that contract. Our relationship is with you and not your insurance company. You are ultimately responsible for any service provided, regardless of your insurance coverage.
- _____ 4. Your insurance company does not cover all services that are provided. It is your responsibility to know the limitations and benefits. Fees for non-covered services are due at the time they are rendered.
- _____ 5. If your insurance company requires a referral from your Primary Care Physicians (PCP), it is your responsibility to have this with you at the time of your visits or you will be responsible for payment of services.
- _____ 6. If your insurance company does not pay within 60 days from your visit, we reserve the right to begin billing you directly and that you contact your insurance carrier. Accounts will be considered delinquent after 90 days. Delinquent accounts will be placed with a private collection agency. Any and all accounts placed with a collection agency will be subject to all reasonable collection, interest and filing fees and court costs.

RED ROCK CHIROPRACTIC

Dr. Margaret R. Colucci
& Associates

Red Rock Chiropractic & Wellness Center
2085 Village Center Circle #110
Las Vegas NV 89134

(702)880-5335

- ____ 7. Should you receive payment from your insurance company or lien for services provided by **Red Rock Chiropractic**, you have **10 days** to forward the said monies to our office. Should you fail to carry out this, we will report it to the Internal Revenue Services (IRS), as an income and not a reimbursement and we will place the account with a collection agency.
- ____ 8. Returned checks are subject to a **\$25.00** returned check fee.
- ____ 9. A charge of **\$40.00** will be assessed for any **missed and cancelled appointments without 24-hour notice**. This is the **patient's personal responsibility**; we cannot bill this to the insurance company. You will be responsible to make up any missed appointments with in the week in order to not be charged the missed appointment fee.
- ____ 10. Insurance companies do not cover supplements, or supplies such as: neck and back support pillows. They are the patient's responsibility. Please consult with our front office regarding products and prices.
- ____ 11. For any unpaid past due balances over 30 days old, a late fee of 1.5% per month will be assessed. Unpaid balances over 30 days are subject to further collection action by an outside collection agency, unless payment arrangements have been made in writing.
- ____ 12. All returns on supplies and supplements are subject to a restocking fee and must be returned with in 10 days from date of purchase. All special orders are subject to a shipping fee. No cash refunds will be issued only a credit will be applied to your account. After 10 days all sales are final.
- ____ 13. All returns on Spinal Pelvic Stabilizers (Orthotics) are subject to a non refundable \$50.00 molding fee. I understand I am responsible for all shipping fees to return the product. You have 30days from the date of receipt to receive a refund. After 30 days all sales are final.
- ____ 14. I understand I am responsible to follow up with my insurance company as to when I reach my maximum benefit. (We are not always notified by all insurance carriers in a timely manner)

We do understand that temporary hardships may affect timely payment of your balance. We encourage you to communicate any such problems so that we can assist you in the management of your account.

Patient's Signature

Date

Witness

Date

AUTHORIZATION Red Rock Chiropractic & Wellness Center
FOR THE RELEASE OF PROTECTED HEALTH INFORMATION 2085 Village Center Circle #110
Las Vegas NV 89134

This Authorization authorizes the release of Protected Health Information pursuant to 45 CFR Parts 160 and 164.

1. The undersigned authorizes the above-named provider ("Provider") to release the following information:
(describe specifically)

2. The information may be disclosed by employees or business associates of (Provider).

3. The information may be disclosed to: _____ (insert name or other specific identification of the persons or entities to which the disclosure will be made)

4. The disclosure may be made for the following purpose _____ (describe specifically. If disclosure is at patient's request, "Patient request" will suffice)

5. This authorization will expire on (date) _____ (or when - describe occurrence).

6. I acknowledge: (i) that I have the right to revoke the authorization at any time, and (ii) that I understand that once the information is disclosed, it may no longer be protected by federal privacy law.

You may revoke this authorization only in a writing sent by certified mail to (the Provider) at the address above. The revocation will be effective only upon receipt, except (1) to the extent (the Provider) has acted in reliance on the authorization, or (2) the authorization was obtained as a condition of obtaining insurance coverage and the insurer wishes to use to the protected health information to lawfully contest a claim.

7. I understand that treatment by (the Provider) is not conditioned on my signing this authorization, although exceptions will be made for (a) research-related treatment, (b) for treatment the purpose of which is creating protected health information for a third party, such as pre-employment physicals, and (c) except for psychotherapy notes, for health plans who condition enrollment or on an authorization requested prior to enrollment, or where payment is conditioned on an authorization to use PHI to determine payment.

8. If this authorization is for a marketing use or disclosure of my information, (the Provider):

8.1 will be remunerated by a third party.

8.2 will not be remunerated by a third party.

Date: _____

Signed by _____

Print Patient's Name: _____

If person signing is other than patient, state authority under which signature is made:

Red Rock Chiropractic & Wellness Center
2085 Village Center Circle #110
Las Vegas, NV. 89134
Office (702) 880-5335
Fax (702) 880-5336

Authorization to Release Medical Information

Patient Name _____ Nick Name/ Maiden / Other _____

SS# _____ Date of birth ____/____/____

Home phone _____ Phone Number (Cell / Pager/ Other) _____

Work phone _____ ext. _____ Best times to call _____

Address _____

City _____ State _____ Zip _____

Please obtain information from the following:

Name of Physician _____ Facility _____

Address _____

City _____ State _____ Zip _____

Phone _____ ext. _____ Fax _____

Please send my medical information to:

Red Rock Chiropractic & Wellness Center
2085 Village Center Circle #110
Las Vegas, NV 89134
702-880-5336

All pertinent medical records : _____

Specific Information as indicated: _____

By initialing, I specifically authorize the release of the following confidential information.

- _____ HIV test, test results, and related information
- _____ Drug/Alcohol diagnosis, treatment and referral information
- _____ Mental health treatment information
- _____ Other (specify) _____

I understand that my consent may be revoked at any time. The only exception is when action has already occurred as instruction in the consent. Unless revoked earlier, this consent will expire in four months from the date of signing or shall remain in effect for the period reasonably needed to complete the request.

Signature (Patient-Parent- Guardian)

Date

For re-ordering information, contact:
ACTIVATOR METHODS, INC., P.O. Box 80317, Phoenix, AZ 85060-0317
Phone: (602) 224-0220; Facsimile (602) 224-0230

NECK PAIN DISABILITY INDEX QUESTIONNAIRE

NAME (Please Print): _____ DATE: _____

AGE: _____ DATE OF BIRTH: _____ OCCUPATION: _____

HOW LONG HAVE YOU HAD NECK PAIN? ___ YEARS ___ MONTHS ___ WEEKS

IS THIS YOUR FIRST EPISODE OF NECK PAIN? ___ YES ___ NO

USE THE LETTERS BELOW TO INDICATE THE TYPE
AND LOCATION OF YOUR SENSATIONS RIGHT NOW

(Please remember to complete both sides of this form.)

KEY:

A=ACHE

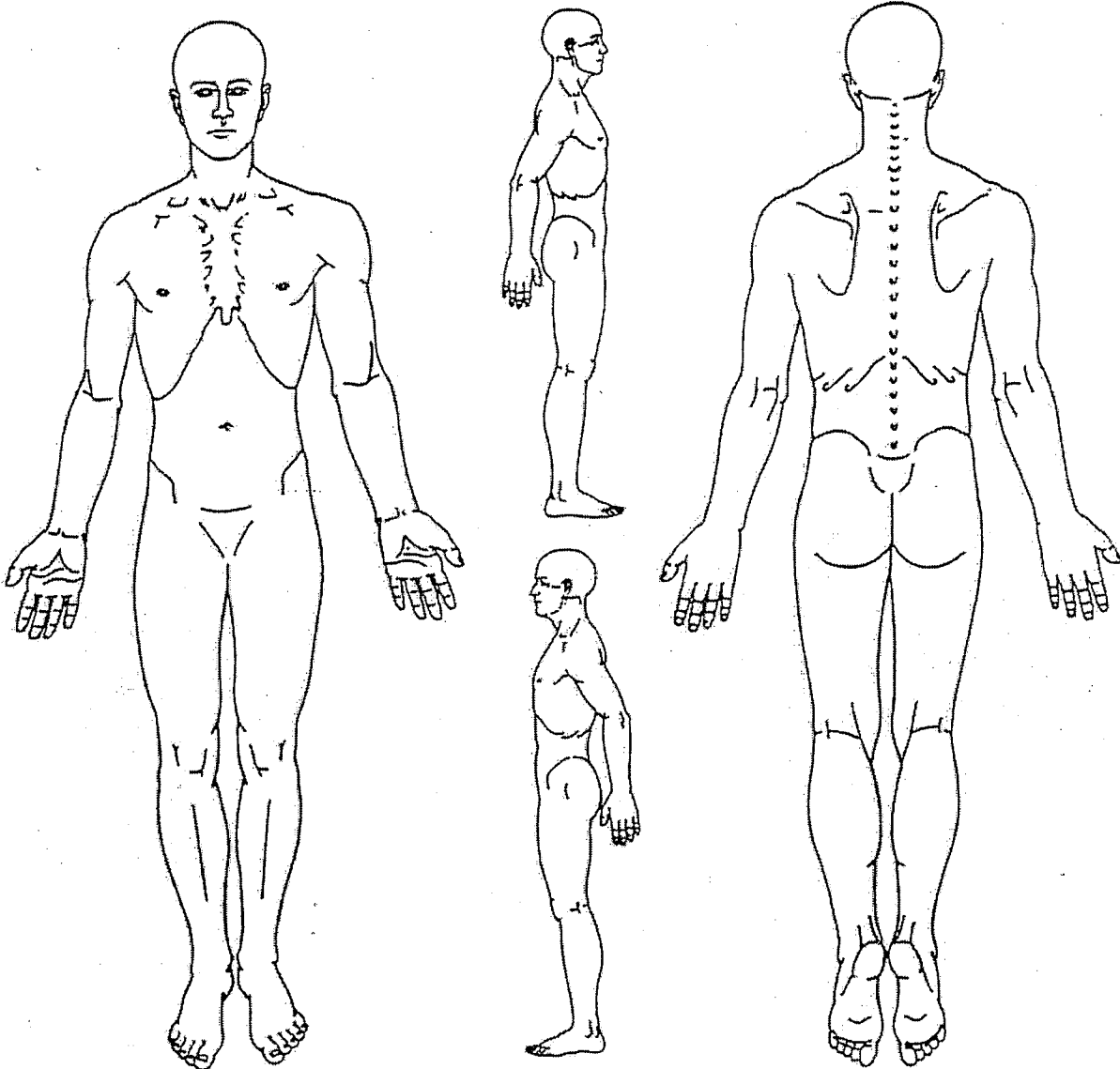
P=PINS & NEEDLES

B=BURNING

S=STABBING

N=NUMBNESS

O=OTHER



OVER PLEASE

For re-ordering information, contact:
ACTIVATOR METHODS, INC., P.O. Box 80317, Phoenix, AZ 85060-0317
 Phone: (602) 224-0220; Facsimile (602) 224-0230

NECK PAIN DISABILITY INDEX QUESTIONNAIRE

Please Read: This questionnaire is designed to enable us to understand how much your neck pain has affected your ability to manage your everyday activities. Please answer each section by circling the **ONE CHOICE** that most applies to you. We realize that you may feel that more than one statement may relate to you, but **PLEASE, JUST CIRCLE THE ONE CHOICE WHICH MOST CLOSELY DESCRIBES YOUR PROBLEM RIGHT NOW.**

Section 1 — Pain Intensity

- A I have no pain at the moment.
- B The pain is very mild at the moment.
- C The pain is moderate at the moment.
- D The pain is fairly severe at the moment.
- E The pain is very severe at the moment.
- F The pain is the worst imaginable at the moment.

Section 2 — Personal Care (Washing, Dressing, etc.)

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

Section 3 — Lifting

- A I can lift heavy weights, without extra pain.
- B I can lift heavy weights, but it gives extra pain.
- C Pain prevents me from lifting heavy weights off the floor, but I can manage if they are conveniently positioned, for example, on a table.
- D Pain prevents me from lifting heavy weights, but I can manage light to medium weights if they are conveniently positioned.
- E I can lift very light weights.
- F I cannot lift or carry anything at all.

Section 4 — Reading

- A I can read as much as I want to with no pain in my neck.
- B I can read as much as I want to with slight pain in my neck.
- C I can read as much as I want with moderate pain in my neck.
- D I cannot read as much as I want because of moderate pain in my neck.
- E I cannot read as much as I want because of severe pain in my neck.
- F I cannot read at all.

Section 5 — Headaches

- A I have no headaches at all.
- B I have slight headaches which come infrequently.
- C I have moderate headaches which come infrequently.
- D I have moderate headaches which come frequently.
- E I have severe headaches which come frequently.
- F I have headaches almost all the time.

Section 6 — Concentration

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

Section 7 — Work

- A I can do as much work as I want to.
- B I can only do my usual work, but no more.
- C I can do most of my usual work, but no more.
- D I cannot do my usual work.
- E I can hardly do any work at all.
- F I cannot do any work at all.

Section 8 — Driving

- A I can drive my car without any neck pain.
- B I can drive my car as long as I want with slight pain in my neck.
- C I can drive my car as long as I want with moderate pain in my neck.
- D I cannot drive my car as long as I want because of moderate pain in my neck.
- E I can hardly drive at all because of severe pain in my neck.
- F I cannot drive my car at all.

Section 9 — Sleeping

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

Section 10 — Recreation

- A I am able to engage in all of my recreational activities, with no neck pain at all.
- B I am able to engage in all of my recreational activities, with some pain in my neck.
- C I am able to engage in most, but not all of my usual recreational activities because of pain in my neck.
- D I am able to engage in a few of my usual recreational activities because of pain in my neck.
- E I can hardly do any recreational activities because of pain in my neck.
- F I cannot do any recreational activities at all.

After Vernon & Mior, 1991

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REVISED January 1, 1995

Comments: _____

Patient Signature: _____ Date: _____

REVISED OSWESTRY CHRONIC LOW BACK PAIN DISABILITY QUESTIONNAIRE

NAME (Please Print): _____ DATE: _____

AGE: _____ DATE OF BIRTH: _____ OCCUPATION: _____

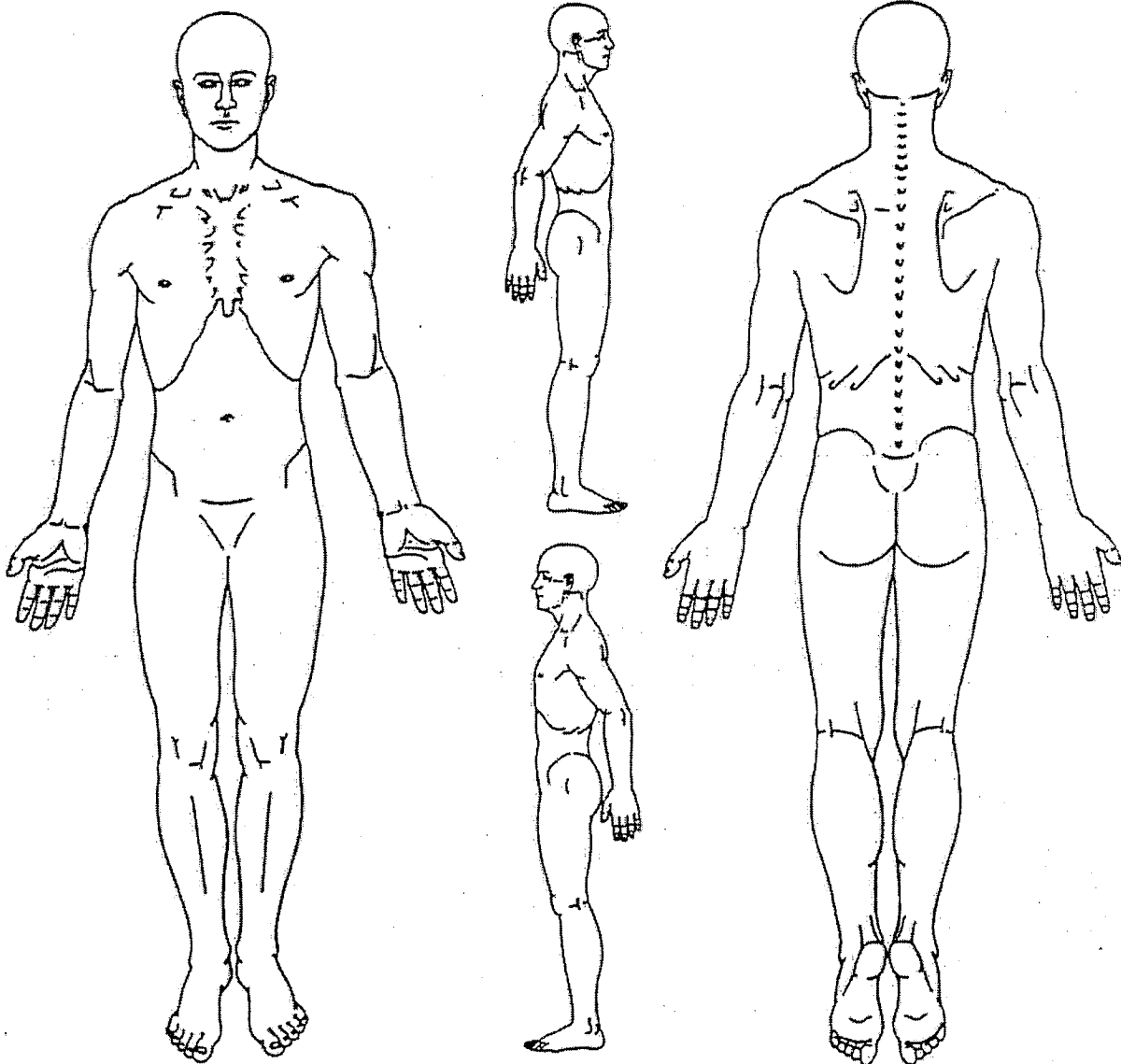
HOW LONG HAVE YOU HAD LOW BACK PAIN? _____ YEARS _____ MONTHS _____ WEEKS

IS THIS YOUR FIRST EPISODE OF LOW BACK PAIN? _____ YES _____ NO

**USE THE LETTERS BELOW TO INDICATE THE TYPE
AND LOCATION OF YOUR SENSATIONS RIGHT NOW**

(Please remember to complete both sides of this form.)

KEY: A=ACHE B=BURNING N=NUMBNESS
 P=PINS & NEEDLES S=STABBING O=OTHER



REVISED OSWESTRY CHRONIC LOW BACK PAIN DISABILITY QUESTIONNAIRE

Please Read: This questionnaire is designed to enable us to understand how much your low back pain has affected your ability to manage your everyday activities. Please answer each section by circling the **ONE CHOICE** that most applies to you. We realize that you may feel that more than one statement may relate to you, but **PLEASE JUST CIRCLE THE ONE CHOICE WHICH MOST CLOSELY DESCRIBES YOUR PROBLEM RIGHT NOW.**

SECTION 1 -- Pain Intensity

- A The pain comes and goes and is very mild.
- B The pain is mild and does not vary much.
- C The pain comes and goes and is moderate.
- D The pain is moderate and does not vary much.
- E The pain comes and goes and is severe.
- F The pain is severe and does not vary much.

SECTION 2 -- Personal Care

- A I would not have to change my way of washing or dressing in order to avoid pain.
- B I do not normally change my way of washing or dressing even though it causes some pain.
- C Washing and dressing increases the pain, but I manage not to change my way of doing it.
- D Washing and dressing increases the pain and I find it necessary to change my way of doing it.
- E Because of the pain, I am unable to do some washing and dressing without help.
- F Because of the pain, I am unable to do any washing or dressing without help.

SECTION 3 -- Lifting

- A I can lift heavy weights without extra pain.
- B I can lift heavy weights, but it causes extra pain.
- C Pain prevents me from lifting heavy weights off the floor.
- D Pain prevents me from lifting heavy weights off the floor, but I can manage if they are conveniently positioned, e.g., on a table.
- E Pain prevents me from lifting heavy weights, but I can manage light to medium weights if they are conveniently positioned.
- F I can only lift very light weights, at the most.

SECTION 4 -- Walking

- A Pain does not prevent me from walking any distance.
- B Pain prevents me from walking more than one mile.
- C Pain prevents me from walking more than 1/2 mile.
- D Pain prevents me from walking more than 1/4 mile.
- E I can only walk while using a cane or on crutches.
- F I am in bed most of the time and have to crawl to the toilet.

SECTION 5 -- Sitting

- A I can sit in any chair as long as I like without pain.
- B I can only sit in my favorite chair as long as I like.
- C Pain prevents me from sitting more than one hour.
- D Pain prevents me from sitting more than 1/2 hour.
- E Pain prevents me from sitting more than ten minutes.
- F Pain prevents me from sitting at all.

From: N. Hudson, K. Toms-Nicholson, A. Breen; 1989

SECTION 6 -- Standing

- A I can stand as long as I want without pain.
- B I have some pain while standing, but it does not increase with time.
- C I cannot stand for longer than one hour without increasing pain.
- D I cannot stand for longer than 1/2 hour without increasing pain.
- E I cannot stand for longer than ten minutes without increasing pain.
- F I avoid standing, because it increases the pain straight away.

SECTION 7 -- Sleeping

- A I get no pain in bed.
- B I get pain in bed, but it does not prevent me from sleeping well.
- C Because of pain, my normal night's sleep is reduced by less than one-quarter.
- D Because of pain, my normal night's sleep is reduced by less than one-half.
- E Because of pain, my normal night's sleep is reduced by less than three-quarters.
- F Pain prevents me from sleeping at all.

SECTION 8 -- Social Life

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

SECTION 9 -- Traveling

- A I get no pain while traveling.
- B I get some pain while traveling, but none of my usual forms of travel make it any worse.
- C I get extra pain while traveling, but it does not compel me to seek alternative forms of travel.
- D I get extra pain while traveling which compels me to seek alternative forms of travel.
- E Pain restricts all forms of travel.
- F Pain prevents all forms of travel except that done lying down.

SECTION 10 -- Changing Degree of Pain

- A My pain is rapidly getting better.
- B My pain fluctuates, but overall is definitely getting better.
- C My pain seems to be getting better, but improvement is slow at present.
- D My pain is neither getting better nor worse.
- E My pain is gradually worsening.
- F My pain is rapidly worsening.

REVISED 9/11/92

Comments: _____

Patient Signature: _____

Date: _____

ROLAND MORRIS DISABILITY INDEX

Name _____ Date ____/____/____ File# _____
(Please Print)

When your back hurts, you may find it difficult to do some of the things you normally do. Check the box before each sentence that describes you today. Leave the box blank if the sentence does not describe you.

- I stay home most of the time because of my back.
- I change positions frequently to try and get my back comfortable.
- I walk more slowly than usual because of my back.
- Because of my back , I am not doing any of the jobs that I usually do around the house.
- Because of my back, I use a handrail to get upstairs.
- Because of my back, I lie down to rest more.
- Because of my back , I have to hold on to something to get out of an easy chair.
- Because of my back, I try to get other people to do things for me.
- I get dressed more slowly because of my back.
- I only stand up for short periods of time because of my back.
- Because of my back, I try not to bend or kneel.
- I find it difficult to get out of a chair because of my back.
- My back is painful almost all of the time.
- I find it difficult to turn over in bed because of my back.
- My appetite is not very good because of my back.
- I have trouble putting on my socks (stockings) because of my back.
- I only walk short distances because of my back pain.
- I sleep less well because of my back pain.
- Because of my back pain, I get dressed with help from someone else.
- I sit down for most of the day because of my back.
- I avoid heavy jobs around the house because of my back.
- Because of my back pain, I am more irritable and bad tempered with people than usual.
- Because of my back, I go upstairs more slowly than usual.
- I stay in bed most of the time because of my back.

ACCIDENT QUESTIONNAIRE

PATIENT'S NAME _____ DATE _____

Date of Injury: ___/___/___ Attorney: _____

Date of Exam: ___/___/___

ACCIDENT HISTORY:

Type of vehicle driving: _____ (car, truck, motorcycle, other....)
Type of vehicle hit: _____ (car, truck, motorcycle, other....)
Impact collision: ___ Head on ___ Driver side ___ Passenger side
Rear-end collision _____

Did your vehicle hit other vehicles: yes ___ no ___
Were you a : driver ___ passenger: ___ front: ___ back: ___
Where there any other passengers in the vehicle? yes ___ no ___ If so, how
many? _____ Who were your passengers? _____

Was your car: stopped ___ moving ___
Estimated speed your car was traveling: _____ m.p.h.
Estimated speed of other vehicle: _____ m.p.h.
Were you braced for impact: yes ___ no ___
Were your brakes applied: yes ___ no ___
Were you wearing: lap belt ___ shoulder harness ___
Does your seat have a head restraint: yes ___ no ___
Were you looking : straight ahead ___ left ___ right ___
Were you knocked unconscious: no ___ no sure ___
If knocked unconscious: few seconds ___ few minutes ___ an hour ___
a few hours ___

List any part of your body that made contact with vehicle parts: _____

What happened at the moment of impact: tensed body ___ neck whiplash ___
thrown from side to side ___ bruised ___ cut ___
thrown over the seat ___

Immediately after the accident did you feel: stunned ___ frightened ___ dazed ___
confused ___ dizzy ___ shocked ___ shaken ___
nauseous ___

Did you receive medical aid at the accident site: yes ___ no ___

Where did you go right after the accident: hospital___ emergency treatment center___ home___ family physician___ this office___ work___

How did you get there: ambulance___ drove myself___ walked___ someone drove me___

Did your symptoms develop: immediately___ hours later___ next day___ over the next few days___ over the next few months___

Since the accident have your symptoms: gotten better___ gotten worse___ same___

Where did you have pain: neck___ shoulders___ arm___ hand___ upper back___ mid back___ low back___ leg___ knee___ foot___ headaches___ other_____

Have you seen any other Doctors for this condition: yes___ no___

If so, Name_____ D.C.____, DO.____, M.D.____ PAT.____

Test performed: Exam___ X-ray___ CT Scan___ MRI___ EGG___

Prescription received: pain killers___ muscle relaxers___ anti-inflammatory___

WORK HISTORY:

Have you missed any days from work? yes___ no___

If so how many? _____ Last day worked? _____

Have you returned to work? ___ Yes ___ NO If so, when? ___/___/___

What type of work do you do? _____

