

CONFIDENTIAL PATIENT INFORMATION
PLEASE PRINT

Date: ___ / ___ / ___

Full Name _____ Called Name _____

Address _____ City _____ State _____ Zip _____

SSN _____ - _____ - _____ Marital Status _____ Sex _____ Age _____ DOB _____

Phone _____ Work Phone _____ Cell Phone _____

Email _____ Spouse's Name _____

Occupation _____ Employer _____

Emergency Contact _____ Phone _____

How did you hear about our office? _____

What brought you into our office today (chief complaint):

Is your condition due to: An Auto Accident A Personal Injury A Work Injury Other
Type of Claim: Cash Insurance Personal Injury Worker's Comp Medicare Medicaid

HEALTH CARE AUTHORIZATIONS:

(Please Cross Out Any Permission You Would Like to Revoke)

- A. I hereby authorize release of any medical information necessary to process this claim and request payment of insurance benefits either to myself or to the party who accepts assignment.
- B. I give permission to Alliance Chiropractic Center to use my address, phone number, email and clinical records to contact me with birthday cards, holiday related cards, information about treatment alternatives, office seminar dates, patient appreciation dates or other health related information such as newsletters.
- C. I give permission to Alliance Chiropractic Center to use my name and clinical records to display my photos or x-rays and use my testimonial and experience in an effort to increase the public's awareness of chiropractic.
- D. I am aware that other persons in the office may overhear some of my protected health information during the course of care. Should I need to speak with a doctor at any time in private, the doctor will provide a room for these conversations.
- E. I understand that my travel card (Daily Visit Chart) contains protected health information and that I should keep it in my possession and upside down to prevent this information from being seen by another patient.
- F. I authorize Alliance Chiropractic Center to take any x-rays the doctor determines will be beneficial to my case during the course of my care. I also recognize that if I am a female it is my responsibility to notify the doctor if I am pregnant or it is possible that I am pregnant.
- G. I am giving Alliance Chiropractic Center permission to use and disclose my protected health information in accordance with the directives listed above.
- H. I am giving Alliance Chiropractic Center permission to contact other health care providers on my behalf to discuss treatment recommendations and co-management of my health care problems.

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES:

I understand and have been provided with a Notice of Information Practices that provides a more complete description of information uses and disclosures. I understand I have the following rights and privileges: The right to view the notice prior to signing this consent, the right to object to the use of my health information for directory purposes, and the right to request restrictions as to how my health information may be used or disclosed to carry out treatment, payment, or health care operations.

RIGHT TO REVOKE AUTHORIZATION:

You have the right to revoke this AUTHORIZATION, in writing, at any time. However, your written request to revoke this AUTHORIZATION is not effective to the extent that we have provided services or taken action in reliance on your authorization. You may revoke this AUTHORIZATION by mailing or hand delivering a written notice to Alliance Chiropractic Center. This AUTHORIZATION is requested by Alliance Chiropractic Center for its own use/disclosure of PHI.

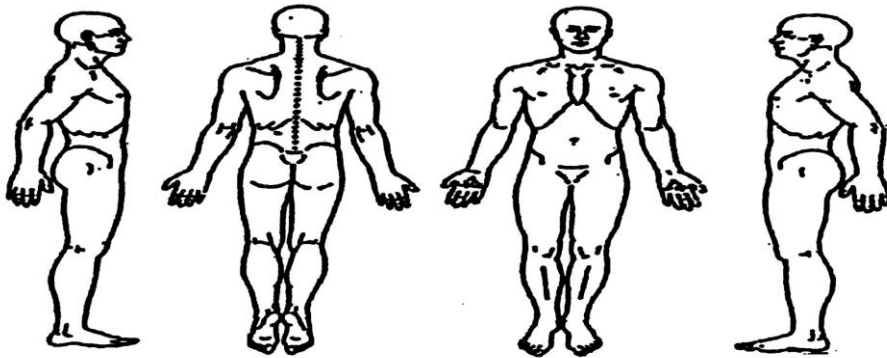
Patient Signature: _____ Date: _____

Parent or Guardian: _____ Date: _____

PATIENT INTAKE FORM

Patient Name: _____ Date: _____

Indicate on the drawings below all the areas where you have pain/symptoms:



First Complaint: _____

How often do you experience your symptoms?

- Constantly (76-100% of the time)
- Occasionally (26-50% of the time)
- Frequently (51-75% of the time)
- Intermittently (1-25% of the time)

How would you describe the type of pain?

- Sharp
- Dull
- Diffuse
- Achy
- Burning
- Shooting
- Stiff
- Numb
- Tingly
- Sharp with motion
- Shooting with motion
- Stabbing with motion
- Electric like with motion
- Other: _____

How are your symptoms changing with time? Getting Worse Staying the same Getting Better

Using a scale from 0-10 (10 being the worst), how would you rate your problem?

Indicate Pain Level (No Pain) 0 1 2 3 4 5 6 7 8 9 10 (Shoot Me Pain)

How much has the problem interfered with your work?

- Not at all
- A little bit
- Moderately
- Quite a bit
- Extremely
- N/A

How much has the problem interfered with your social activities?

- Not at all
- A little bit
- Moderately
- Quite a bit
- Extremely

Who else have you seen for your problem?

- Chiropractor
- Massage Therapist
- Primary Care Physician
- Neurologist
- Orthopedist
- ER physician
- Physical Therapist
- Other: _____

Provider Name / Date of visit: _____

How long have you had this problem? _____

How do you think your problem began?

- Cause Not Known
- Auto Accident
- Work Injury
- Slip / Fall
- Sports Injury
- Other _____

What aggravates your problem?

- Nothing
- Sneezing
- Bending
- Other – Describe: _____
- Coughing
- Lifting
- Walking
- Reaching
- Sitting
- Straining at Stool
- Standing
- Pulling
- Turning

What makes your problem better?

- Nothing
- Rest
- Sitting
- Other – Describe: _____
- Stretching
- Exercise
- Standing
- Heat
- Ice
- Medications
- Massage
- Adjustments
- Sleeping

Do you consider this problem to be severe? Yes Yes, at times No

PATIENT INTAKE FORM

Second Complaint: _____

How often do you experience your symptoms?

- Constantly (76-100% of the time)
- Occasionally (26-50% of the time)
- Frequently (51-75% of the time)
- Intermittently (1-25% of the time)

How would you describe the type of pain?

- Sharp
- Numb
- Dull
- Tingly
- Diffuse
- Sharp with motion
- Achy
- Shooting with motion
- Burning
- Stabbing with motion
- Shooting
- Electric like with motion
- Stiff
- Other: _____

How are your symptoms changing with time? Getting Worse Staying the same Getting Better

Using a scale from 0-10 (10 being the worst), how would you rate your problem?

Indicate Pain Level (No Pain) 0 1 2 3 4 5 6 7 8 9 10 (Shoot Me Pain)
--

How much has the problem interfered with your work?

- Not at all
- A little bit
- Moderately
- Quite a bit
- Extremely
- N/A

How much has the problem interfered with your social activities?

- Not at all
- A little bit
- Moderately
- Quite a bit
- Extremely

Who else have you seen for your problem?

- Chiropractor
- Massage Therapist
- Primary Care Physician
- Neurologist
- Orthopedist
- ER physician
- Physical Therapist
- Other: _____

Provider Name / Date of visit: _____

How long have you had this problem? _____

How do you think your problem began?

- Cause Not Known
- Auto Accident
- Work Injury
- Slip / Fall
- Sports Injury
- Other _____

What aggravates your problem?

- Nothing
- Stretching
- Heat
- Massage
- Rest
- Exercise
- Ice
- Adjustments
- Sitting
- Standing
- Medications
- Sleeping
- Other – Describe: _____

What makes your problem better?

- Nothing
- Rest
- Sitting
- Other – Describe: _____

Do you consider this problem to be severe? Yes Yes, at times No

What concerns you the most about your problems; what does it prevent you from doing?

What is your: Height _____ Weight _____ Date of Birth _____

Occupation _____

How would you rate your overall Health? Excellent Very Good Good Fair Poor

What type of exercise do you do? Strenuous Moderate Light None

Indicate if you have any immediate family members with any of the following:

- Rheumatoid Arthritis
- Diabetes
- Lupus
- Heart Problems
- Cancer
- ALS

For each of the conditions listed below, place a check in the "past" column if you have had the condition in the past. If you presently have a condition listed below, place a check in the "present" column.

Past	Present	Past	Present	Past	Present
<input type="checkbox"/>	<input type="checkbox"/> Headaches	<input type="checkbox"/>	<input type="checkbox"/> High Blood Pressure	<input type="checkbox"/>	<input type="checkbox"/> Diabetes
<input type="checkbox"/>	<input type="checkbox"/> Neck Pain	<input type="checkbox"/>	<input type="checkbox"/> Heart Attack	<input type="checkbox"/>	<input type="checkbox"/> Excessive Thirst
<input type="checkbox"/>	<input type="checkbox"/> Upper Back Pain	<input type="checkbox"/>	<input type="checkbox"/> Chest Pains	<input type="checkbox"/>	<input type="checkbox"/> Frequent Urination
<input type="checkbox"/>	<input type="checkbox"/> Mid Back Pain	<input type="checkbox"/>	<input type="checkbox"/> Stroke	<input type="checkbox"/>	<input type="checkbox"/> Smoking/Tobacco Use
<input type="checkbox"/>	<input type="checkbox"/> Low Back Pain	<input type="checkbox"/>	<input type="checkbox"/> Angina	<input type="checkbox"/>	<input type="checkbox"/> Drug/Alcohol Dependence
<input type="checkbox"/>	<input type="checkbox"/> Shoulder Pain	<input type="checkbox"/>	<input type="checkbox"/> Kidney Stones	<input type="checkbox"/>	<input type="checkbox"/> Allergies
<input type="checkbox"/>	<input type="checkbox"/> Elbow/Upper Arm Pain	<input type="checkbox"/>	<input type="checkbox"/> Kidney Disorders	<input type="checkbox"/>	<input type="checkbox"/> Depression
<input type="checkbox"/>	<input type="checkbox"/> Wrist Pain	<input type="checkbox"/>	<input type="checkbox"/> Bladder Infection	<input type="checkbox"/>	<input type="checkbox"/> Systemic Lupus
<input type="checkbox"/>	<input type="checkbox"/> Hand Pain	<input type="checkbox"/>	<input type="checkbox"/> Painful Urination	<input type="checkbox"/>	<input type="checkbox"/> Epilepsy
<input type="checkbox"/>	<input type="checkbox"/> Hip Pain	<input type="checkbox"/>	<input type="checkbox"/> Loss of Bladder Control	<input type="checkbox"/>	<input type="checkbox"/> Dermatitis/Eczema/Rash
<input type="checkbox"/>	<input type="checkbox"/> Upper Leg Pain	<input type="checkbox"/>	<input type="checkbox"/> Prostate Problems	<input type="checkbox"/>	<input type="checkbox"/> HIV/AIDS
<input type="checkbox"/>	<input type="checkbox"/> Knee Pain	<input type="checkbox"/>	<input type="checkbox"/> Abnormal Weight Gain/Loss	<u>For Females Only</u>	
<input type="checkbox"/>	<input type="checkbox"/> Ankle/Foot Pain	<input type="checkbox"/>	<input type="checkbox"/> Loss of Appetite	<input type="checkbox"/>	<input type="checkbox"/> Birth Control Pills
<input type="checkbox"/>	<input type="checkbox"/> Jaw Pain	<input type="checkbox"/>	<input type="checkbox"/> Abdominal Pain	<input type="checkbox"/>	<input type="checkbox"/> Hormonal Replacement
<input type="checkbox"/>	<input type="checkbox"/> Joint Pain/Stiffness	<input type="checkbox"/>	<input type="checkbox"/> Ulcer	<input type="checkbox"/>	<input type="checkbox"/> Pregnancy
<input type="checkbox"/>	<input type="checkbox"/> Arthritis	<input type="checkbox"/>	<input type="checkbox"/> Hepatitis		
<input type="checkbox"/>	<input type="checkbox"/> Rheumatoid Arthritis	<input type="checkbox"/>	<input type="checkbox"/> Liver/Gall Bladder Disorder		
<input type="checkbox"/>	<input type="checkbox"/> Cancer	<input type="checkbox"/>	<input type="checkbox"/> General Fatigue		
<input type="checkbox"/>	<input type="checkbox"/> Tumor	<input type="checkbox"/>	<input type="checkbox"/> Muscular Incoordination		
<input type="checkbox"/>	<input type="checkbox"/> Asthma	<input type="checkbox"/>	<input type="checkbox"/> Visual Disturbances		
<input type="checkbox"/>	<input type="checkbox"/> Chronic Sinusitis	<input type="checkbox"/>	<input type="checkbox"/> Dizziness		
<input type="checkbox"/>	<input type="checkbox"/> Other: _____				

List all prescription medications you are currently taking: (feel free to include separate list if needed)

List all of the supplements you are currently taking:

List all surgical procedures you have had:

What activities do you do at work? Do Not Work / Retired

<input type="checkbox"/> Sit:	<input type="checkbox"/> Most of the day	<input type="checkbox"/> Half the day	<input type="checkbox"/> A little of the day
<input type="checkbox"/> Stand:	<input type="checkbox"/> Most of the day	<input type="checkbox"/> Half the day	<input type="checkbox"/> A little of the day
<input type="checkbox"/> Computer work:	<input type="checkbox"/> Most of the day	<input type="checkbox"/> Half the day	<input type="checkbox"/> A little of the day
<input type="checkbox"/> On the phone:	<input type="checkbox"/> Most of the day	<input type="checkbox"/> Half of the day	<input type="checkbox"/> A little of the day

What activities do you do outside of work?

Have you ever been hospitalized? No Yes

if yes, when and why _____

Have you had significant past trauma? No Yes If yes, please list all previous traumas

Anything else pertinent to your visit today? _____

Patient Signature _____ Date: _____

Accident Questionnaire

1. What was the date of the accident? _____
2. What time did the accident occur? _____
3. How many vehicles were involved in the accident? _____
4. What was the estimated damage to the vehicle you were in? _____
5. What state did the accident occur in? _____
6. What city did the accident occur in? _____
7. What street or intersection were you on when the accident occurred? _____
8. What direction were you traveling in? _____
9. What type of impact was the auto accident? _____
10. Did your vehicle hit anything after the accident? if yes, please describe _____
11. Where were you sitting in the vehicle during the accident? _____
12. Did you know the accident was coming? _____
13. What type of vehicle were you in? _____
14. What type of vehicle impacted yours? _____
15. At the time of the impact, how fast was your vehicle moving? _____
16. At the time of impact, how fast was the other vehicle moving? _____
17. During and after the crash what happened to your vehicle? (circle all that apply)
 - kept going straight
 - kept going straight hitting a car in front
 - was hit by another vehicle
 - spun around
 - spun around and hit a stationary object
 - hit a stationary object
18. Did you lose consciousness during the accident? -yes - no
19. How was your head positioned during the accident? _____
20. How was your torso positioned during the accident? _____
21. How were your hands positioned during the accident? _____
22. Did your head hit anything during the accident? -no - yes, please describe _____
23. Did your face hit anything during the accident? -no - yes, please describe _____
24. Did your shoulders hit anything during the accident? -no - yes, please describe _____
25. Did your neck hit anything during the accident? -no - yes, please describe _____
26. Did your chest hit anything during the accident? -no - yes, please describe _____
27. Did your hips hit anything during the accident? -no - yes, please describe _____
28. Did your knees hit anything during the accident? -no - yes, please describe _____

29. Did your feet hit anything during the accident? -no - yes, please describe _____

30. What kind of headrest was in your vehicle?

- movable fixed headrest
- nonmovable fixed headrest
- no headrest

31. Where was the headrest positioned on your head? _____

32. Did you have your seatbelt on during the accident? - yes -no

33. Did you slide out of your seatbelt during the accident? _____

34. What was damaged in your vehicle? (Circle all that apply)

- windshield
- steering wheel
- dashboard
- seat frame
- side window
- rear window
- rear bumper
- front bumper
- trunk
- front left door
- front right door
- back left door
- mirror
- knee bolster
- back right door
- completely totalled

35. Choose the items that dented inward

- floorboards
- side door
- dashboard

36. Choose the doors that would not open as a result of the accident

- front left
- front right
- rear left
- rear right

37. Did you go to the hospital? If no, why and do not answer 38-43 _____

38. How did get to the hospital? _____

39. What was the name of the hospital? _____

40. Were you hospitalized over night? _____

41. Circle what you were prescribed at the hospital

- pain medication
- muscle relaxors
- neck brace

42. Did you recieve any stitches for any cuts at the hospital? _____

43. Were x rays taken at the hosiptal? If yes, which area was taken?

To any insurance company with coverage applicable to my claim(s) and to any attorney representing me:

ASSIGNMENT OF BENEFITS

IN CONSIDERATION of the willingness of (*Alliance Chiropractic Center*) to treat me on credit without demand for payment at the time services are rendered, I hereby agree and stipulate as follows:

I irrevocably assign to (*Alliance Chiropractic Center*) any proceeds or compensation that I am or may become entitled to receive as a result of injuries that occurred on _____ to the extent of the chiropractic services rendered. I make this agreement without prejudice to any rights I may have to prosecute legal claims against any party who may be liable for my injuries, but I hereby authorize and instruct you to pay directly to (*Alliance Chiropractic Center*), from any disability benefits, medical payments benefits, liability benefits, health and accident benefits, workers' compensation benefits, judgments, settlements, or proceeds of any kind that would otherwise be payable to me, such sums as are due or may become due to (*Alliance Chiropractic Center*) for its services rendered.

I appoint (*Alliance Chiropractic Center*) as my attorney in fact to affix my name as an endorsement upon the reverse of any check or draft upon which I am a named payee and to deposit said check or draft and apply the proceeds to any unpaid balance I may have with (*Alliance Chiropractic Center*).

I authorize (*Alliance Chiropractic Center*) to release to any insurer with applicable coverage or to my attorney or successor attorney any information regarding my injuries, prior medical history, or treatment as may be necessary to facilitate collection of proceeds under this assignment.

I acknowledge that I remain personally liable for the total amount due to (*Alliance Chiropractic Center*) for services rendered, including any balance remaining after the application of insurance payments and settlement or judgment proceeds. If (*Alliance Chiropractic Center*) is required to take legal action against me to recover any unpaid balance on my account, I agree to reimburse (*Alliance Chiropractic Center*) for its costs of recovery, including reasonable attorney's fees.

Patient

Date

Witness

NOTICE OF LIEN

Pursuant to N.C.G.S. 44-49 and 44-50, (*Alliance Chiropractic Center*) hereby asserts and gives notice of a lien upon any sums recovered in damages for personal injury in any civil action and also upon all funds paid to the above-named patient in compensation for or settlement of injuries sustained, whether in litigation or otherwise.

(*Alliance Chiropractic Center*) hereby requests that if its claim is not paid in full from the foregoing proceeds, a full disclosure and accounting of proceeds be provided in conformity with N.C.G.S 44-50.1. (*Alliance Chiropractic Center*) agrees to be bound by any confidentiality agreements regarding the contents of the accounting.

Alliance Chiropractic Center

By: _____

Office policies for Personal Injury patients

This office will accept you as a new patient based on our clinical examination and belief that chiropractic care will be effective for the treatment of your injuries. Your responsibility to this office will be to follow the doctor's recommendations and to provide the appropriate financial information so that payment for services can be received.

Patients need to bring the following:

- 1- Copy of police report and/or a copy of the exchange slip.
- 2- Copy of personal automobile policy
This is to verify Medical Payments covered by your Automobile insurance.
- 3- Name of individual and insurance company of party that's liable. Please include policy number.
- 4- Name and telephone number of attorney if an attorney has been retained.

You are asked to give 24 hour notice if you need to reschedule an appointment. All appointments that have been missed without notice may be billed to your account.

Following the completion of your treatment in this office, your bill will be forwarded to the responsible party. Please note that this account is still your responsibility & will be subject to monthly interest charges of 1.5% effective 30 days following your initial visit.

Signature_____date_____

Name: _____ Date: _____ File #: _____

Revised Lower Back Oswestery Index

This questionnaire helps us to understand how much your low back has affected your ability to perform everyday activities. Please check the one box in each section that most clearly describes your problem now.

SECTION 1 – Pain Intensity

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

SECTION 2 – Personal Care (Washing, Dressing, etc.)

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

SECTION 3 – Lifting

- I can lift heavy weights without extra pain.
- I can lift heavy weights but it gives extra pain.
- Pain prevents me from lifting heavy weights off the floor.
- Pain prevents me from lifting heavy weights off the floor, but I can manage if they are conveniently positioned (e.g. on a table).
- Pain prevents me from lifting heavy weights, but I can manage light to medium weights if they are conveniently positioned.
- I can only lift very light weights at the most.

SECTION 4 – Walking

- I have no pain on walking.
- I have some pain on walking but it does not increase with distance.
- I cannot walk more than one mile without increasing pain.
- I cannot walk more than ½ mile without increasing pain.
- I cannot walk more than ¼ mile without increasing pain.
- I cannot walk at all without increasing pain.

SECTION 5 – Sitting

- I can sit in any chair as long as I like without pain.
- I can sit only in my favorite chair as long as I like.
- Pain prevents me from sitting more than 1 hour.
- Pain prevents me from sitting more than ½ hour.
- Pain prevents me from sitting more than 10 minutes.
- I avoid sitting because it increases pain immediately.

SECTION 6 – Standing

- I can stand as long as I want without pain.
- I have some pain standing, but it does not increase with time.
- I cannot stand for longer than 1 hour without increasing pain.
- I cannot stand for longer than ½ hour without increasing
- I cannot stand for longer than 10 minutes without increasing pain.
- I avoid standing because it increases the pain immediately.

SECTION 7 – Sleeping

- I get no pain in bed.
- I get pain in bed but it does not prevent me from sleeping well.
- Because of pain, my normal night's sleep is reduced by less than ¼.
- Because of pain, my normal night's sleep is reduced by less than ½.
- Because of pain, my normal night's sleep is reduced by less than ¾.
- Pain prevents me from sleeping at all.

SECTION 8 – Social Life

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

SECTION 9 – Traveling

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

SECTION 10 – Changing Degrees of Pain

- My pain is rapidly getting better.
- My pain fluctuates, but overall is definitely getting better.
- My pain seems to be getting better, but slowly improves.
- My pain is neither getting better nor worse.
- My pain is gradually worsening.
- My pain is rapidly worsening.

From Vernon H, Minor S. JMPT 1991; 14(7):409-415

NECK DISABILITY INDEX

Name: _____ Date: _____ File #: _____

This questionnaire helps us to understand how much your neck pain has affected your ability to perform everyday activities. Please check the one box in each section that most clearly describes your problem right now.

SECTION 1 – Pain Intensity

- I have no pain at the moment.
- The pain is very mild at the moment.
- The pain is moderate at the moment.
- The pain is fairly severe at the moment.
- The pain is very severe at the moment.
- The pain is the worst imaginable at the moment.

SECTION 2 – Personal Care (Washing, Dressing, etc.)

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

SECTION 3 – Lifting

- I can lift heavy weights without extra pain.
- I can lift heavy weights but it gives extra pain.
- Pain prevents me from lifting heavy weights off the floor, but I can manage if they are conveniently positioned.
- Pain prevents me from lifting heavy weights, but I can manage light to medium weights if they are conveniently positioned
- I can lift very light weights.
- I cannot lift or carry anything at all.

SECTION 4 – Reading

- I can read as much as I want with no pain in my neck.
- I can read as much as I want with slight pain in my neck.
- I can read as much as I want with moderate pain in my neck.
- I can't read as much as I want because of moderate pain in my neck.
- I can hardly read at all because of severe pain in my neck.
- I cannot read at all due to pain.

SECTION 5 – Headaches

- I have no headaches at all.
- I have slight headaches that come infrequently.
- I have moderate headaches that come infrequently.
- I have moderate headaches that come frequently.
- I have severe headaches that come frequently.
- I have headaches almost all the time.

SECTION 6 – Concentration

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

SECTION 7 – Work

- I can do as much work as I want to.
- I can only do my usual work, but no more.
- I can do most of my usual work, but no more.
- I cannot do my usual work.
- I can hardly do any work at all.
- I can not do any work at all.

SECTION 8 – Driving

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

- I can't drive my car at all.

SECTION 9 – Sleeping

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

SECTION 10 – Recreation

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

From Vernon H, Minor S. JMPT 1991; 14(7):409-415

Informed Consent to Treatment

The nature of chiropractic treatment: The doctor may use his/her hands or a mechanical device in order to move your joints. You may feel a "click" or "pop", such as the noise when a knuckle is "cracked", and you may feel movement of the joint. Various ancillary procedures, such as hot or cold packs, electric muscle stimulation, therapeutic laser, acupuncture or mechanical traction may also be used.

Possible Risks: As with any health care procedure, complications are possible following a chiropractic manipulation. Complications could include fractures of bone, muscular strain, ligamentous sprain, dislocations of joints, or injury to intervertebral discs, nerves or spinal cord. Cerebrovascular injury or stroke could occur upon severe injury to arteries of the neck. A minority of patients may notice stiffness or soreness after the first few days of treatment. The ancillary procedures could produce skin irritation, burns or minor complications.

Probability of risks occurring: The risks of complications due to chiropractic treatment have been described as "rare", about as often as complications are seen from the taking of a single aspirin tablet. The risk of cerebrovascular injury or stroke, has been estimated at one in one million to one in twenty million, and can be even further reduced by screening procedures. The probability of adverse reaction due to ancillary procedures is also considered "rare".

Other treatment options which could be considered may include the following:

- *Over-the-counter analgesics.* The risks of these medications include irritation to stomach, liver and kidneys, and other side effects in a significant number of cases.
- *Medical care,* typically anti-inflammatory drugs, tranquilizers, and analgesics. Risks of these drugs include a multitude of undesirable side effects and patient dependence in a significant number of cases.
- *Hospitalization* in conjunction with medical care adds risk of exposure to virulent communicable disease in a significant number of cases.
- *Surgery* in conjunction with medical care adds the risks of adverse reaction to anesthesia, as well as an extended convalescent period in a significant number of cases.

Risks of remaining untreated: Delay of treatment allows formation of adhesions, scar tissue and other degenerative changes. These changes can further reduce skeletal mobility, and induce chronic pain cycles. It is quite probable that delay of treatment will complicate the condition and make future rehabilitation more difficult.

I have read the explanation above of chiropractic treatment. I have had the opportunity to have any questions answered to my satisfaction. I have fully evaluated the risks and benefits of undergoing treatment. I have freely decided to undergo the recommended treatment, and hereby give my full consent to treatment. I am here solely for the purpose of my health, and I represent no other agency, group, organization other than myself.

Patient Printed Name

Patient Signature

Date

Witness Printed Name

Witness Signature

Date