CHIROPRACTIC REGISTRATION AND HISTORY

1 PATIENT INFORMATION

Date _____

SS/HIC/Patient ID # _____

Patient Name _____
Last Name

_____
First Name Middle Initial

Address _____

E-mail _____

City _____

State _____ Zip _____

Sex ☐ M ☐ F Age _____

Birthdate _____

☐ Married ☐ Widowed ☐ Single ☐ Minor

☐ Separated ☐ Divorced ☐ Partnered for _____ years

Patient Employer/School _____

Occupation _____

Employer/School Address _____

_____

Employer/School Phone (_____) _____

Spouse's Name _____

Birthdate _____

SS# _____

Spouse's Employer _____

Whom may we thank for referring you? _____

2 INSURANCE INFORMATION

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 # _____

ASSIGNMENT AND RELEASE

I certify that I, and/or my dependent(s), have insurance coverage with

_____ and assign directly to
Name of Insurance Company(ies)

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.

_____
Signature of Patient, Parent, Guardian or Personal Representative

_____
Please print name of Patient, Parent, Guardian or Personal Representative

_____ _____
Date Relationship to Patient

3 PHONE NUMBERS

Cell Phone (_____) _____ Home Phone (_____) _____

Best time and place to reach you _____

IN CASE OF EMERGENCY, CONTACT

Name _____ Relationship _____

Home Phone (_____) _____ Work Phone (_____) _____

4 ACCIDENT INFORMATION

Is condition due to an accident? ☐ Yes ☐ No Date _____

Type of accident ☐ Auto ☐ Work ☐ Home ☐ Other

To whom have you made a report of your accident?
☐ Auto Insurance ☐ Employer ☐ Worker Comp. ☐ Other

Attorney Name (if applicable) _____

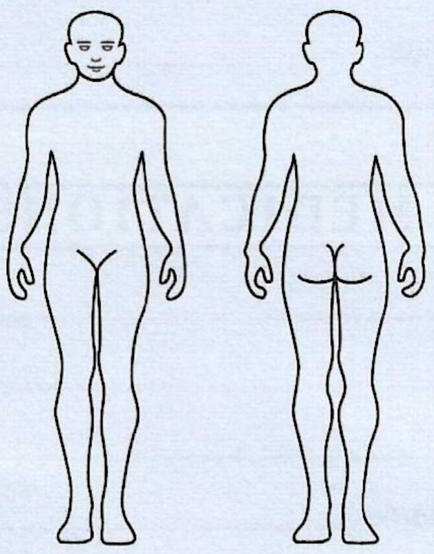
5 PATIENT CONDITION

Reason for Visit _____

When did your symptoms appear? _____

Is this condition getting progressively worse? ☐ Yes ☐ No ☐ Unknown

Mark an X on the picture where you continue to have pain, numbness, or tingling.



Rate the severity of your pain on a scale from 1 (least pain) to 10 (severe pain) _____

Type of pain: ☐ Sharp ☐ Dull ☐ Throbbing ☐ Numbness ☐ Aching ☐ Shooting
☐ Burning ☐ Tingling ☐ Cramps ☐ Stiffness ☐ Swelling ☐ Other

How often do you have this pain? _____

Is it constant or does it come and go? _____

Does it interfere with your ☐ Work ☐ Sleep ☐ Daily Routine ☐ Recreation

Activities or movements that are painful to perform ☐ Sitting ☐ Standing ☐ Walking ☐ Bending ☐ Lying Down

6 HEALTH HISTORY

What treatment have you already received for your condition? ☐ Medications ☐ Surgery ☐ Physical Therapy

☐ Chiropractic Services ☐ None ☐ Other _____

Name and address of other doctor(s) who have treated you for your condition _____

Date of Last: Physical Exam _____ Spinal X-Ray _____ Blood Test _____

Spinal Exam _____ Chest X-Ray _____ Urine Test _____

Dental X-Ray _____ MRI, CT-Scan, Bone Scan _____

Place a mark on "Yes" or "No" to indicate if you have had any of the following:

AIDS/HIV	☐ Yes	☐ No	Diabetes	☐ Yes	☐ No	Liver Disease	☐ Yes	☐ No	Rheumatic Fever	☐ Yes	☐ No
Alcoholism	☐ Yes	☐ No	Emphysema	☐ Yes	☐ No	Measles	☐ Yes	☐ No	Scarlet Fever	☐ Yes	☐ No
Allergy Shots	☐ Yes	☐ No	Epilepsy	☐ Yes	☐ No	Migraine Headaches	☐ Yes	☐ No	Sexually Transmitted Disease	☐ Yes	☐ No
Anemia	☐ Yes	☐ No	Fractures	☐ Yes	☐ No	Miscarriage	☐ Yes	☐ No			
Anorexia	☐ Yes	☐ No	Glaucoma	☐ Yes	☐ No	Mononucleosis	☐ Yes	☐ No	Stroke	☐ Yes	☐ No
Appendicitis	☐ Yes	☐ No	Goiter	☐ Yes	☐ No	Multiple Sclerosis	☐ Yes	☐ No	Suicide Attempt	☐ Yes	☐ No
Arthritis	☐ Yes	☐ No	Gonorrhea	☐ Yes	☐ No	Mumps	☐ Yes	☐ No	Thyroid Problems	☐ Yes	☐ No
Asthma	☐ Yes	☐ No	Gout	☐ Yes	☐ No	Osteoporosis	☐ Yes	☐ No	Tonsillitis	☐ Yes	☐ No
Bleeding Disorders	☐ Yes	☐ No	Heart Disease	☐ Yes	☐ No	Pacemaker	☐ Yes	☐ No	Tuberculosis	☐ Yes	☐ No
Breast Lump	☐ Yes	☐ No	Hepatitis	☐ Yes	☐ No	Parkinson's Disease	☐ Yes	☐ No	Tumors, Growths	☐ Yes	☐ No
Bronchitis	☐ Yes	☐ No	Hernia	☐ Yes	☐ No	Pinched Nerve	☐ Yes	☐ No	Typhoid Fever	☐ Yes	☐ No
Bulimia	☐ Yes	☐ No	Herniated Disk	☐ Yes	☐ No	Pneumonia	☐ Yes	☐ No	Ulcers	☐ Yes	☐ No
Cancer	☐ Yes	☐ No	Herpes	☐ Yes	☐ No	Polio	☐ Yes	☐ No	Vaginal Infections	☐ Yes	☐ No
Cataracts	☐ Yes	☐ No	High Blood Pressure	☐ Yes	☐ No	Prostate Problem	☐ Yes	☐ No	Whooping Cough	☐ Yes	☐ No
Chemical Dependency	☐ Yes	☐ No	High Cholesterol	☐ Yes	☐ No	Prosthesis	☐ Yes	☐ No	Other _____		
Chicken Pox	☐ Yes	☐ No	Kidney Disease	☐ Yes	☐ No	Psychiatric Care	☐ Yes	☐ No			
						Rheumatoid Arthritis	☐ Yes	☐ No			

EXERCISE

☐ None
☐ Moderate
☐ Daily
☐ Heavy

WORK ACTIVITY

☐ Sitting
☐ Standing
☐ Light Labor
☐ Heavy Labor

HABITS

☐ Smoking — Packs/Day _____
☐ Alcohol — Drinks/Week _____
☐ Coffee/Caffeine Drinks — Cups/Day _____
☐ High Stress Level — Reason _____

Are you pregnant? ☐ Yes ☐ No Due Date _____

Injuries/Surgeries you have had	Description	Date
Falls		
Head Injuries		
Broken Bones		
Dislocations		
Surgeries		

7

MEDICATIONS	ALLERGIES	VITAMINS/HERBS/MINERALS
_____	_____	_____
_____	_____	_____
_____	_____	_____
Pharmacy Name _____	_____	_____
Pharmacy Phone (_____) _____	_____	_____

Informed Consent to Care

You are the decision maker for your health care. Part of our role is to provide you with information to assist you in making informed choices. This process is often referred to as "informed consent" and involves your understanding and agreement regarding the care we recommend, the benefits and risks associated with the care, alternatives, and the potential effect on your health if you choose not to receive the care.

We may conduct some diagnostic or examination procedures if indicated. Any examinations or tests conducted will be carefully performed but may be uncomfortable.

Chiropractic care centrally involves what is known as a chiropractic adjustment. There may be additional supportive procedures or recommendations as well. When providing an adjustment, we use our hands or an instrument to reposition anatomical structures, such as vertebrae. Potential benefits of an adjustment include restoring normal joint motion, reducing swelling and inflammation in a joint, reducing pain in the joint, and improving neurological functioning and overall well-being.

It is important that you understand, as with all health care approaches, results are not guaranteed, and there is no promise to cure. As with all types of health care interventions, there are some risks to care, including, but not limited to: muscle spasms, aggravating and/or temporary increase in symptoms, lack of improvement of symptoms, burns and/or scarring from electrical stimulation and from hot or cold therapies, including but not limited to hot packs and ice, fractures (broken bones), disc injuries, dislocations, strains, and sprains. In addition, the literature recognizes an association between strokes and chiropractic manipulation of the cervical spine. With respect to strokes, there is a rare but serious condition known as an "arterial dissection" that typically is caused by a tear in the inner layer of the artery that may cause the development of a thrombus (clot) with the potential to lead to a stroke. The best available scientific evidence supports the understanding that chiropractic adjustment does not cause a dissection in a normal, healthy artery. Disease processes, genetic disorders, medications, and vessel abnormalities may cause an artery to be more susceptible to dissection. Strokes caused by arterial dissections have been associated with over 72 everyday activities such as sneezing, driving, and playing tennis.

Carotid and vertebral artery dissections are rare, with an annual incidence of 2.5 – 4 of every 100,000 people whether they are receiving health care or not. Patients who experience this condition often, but not always, present to their medical doctor or chiropractor with neck pain and headache. Unfortunately, a percentage of these patients will experience a stroke.

The reported association between visits to a chiropractor or a primary care physician and stroke is exceedingly rare and is estimated to be related in one in one million to one in two million visits.

It is also important that you understand there are treatment options available for your condition other than chiropractic procedures. Likely, you have tried many of these approaches already. These options may include, but are not limited to: self-administered care, over-the-counter pain relievers, physical measures and rest, medical care with prescription drugs, physical therapy, bracing, injections, and surgery. Lastly, you have the right to a second opinion and to secure other opinions about your circumstances and health care as you see fit.

I have read, or have had read to me, the above consent. I appreciate that it is not possible to consider every possible complication to care. I have also had an opportunity to ask questions about its content, and by signing below, I agree with the current or future recommendation to receive chiropractic care as is deemed appropriate for my circumstance. I intend this consent to cover the entire course of care from all providers in this office for my present condition and for any future condition(s) for which I seek chiropractic care from this office.

Patient Name: _____ Signature: _____ Date:

Parent or Guardian: _____ Signature: _____ Date:

Witness Name: _____ Signature: _____ Date:

Rumley Family Chiropractic P.A.
2221 Lee Road, Suite 20
Winter Park, FL 32789
Phone: (407) 277-0046
Fax: (407) 951-5732

Rumley Family Chiropractic P.A.
Tax ID: 46-532-2968

Assignment of Benefits and Direction to Pay Benefits Owed Rumley Family Chiropractic P.A. 2221 Lee Rd. Suite 20 Winter Park FL, 32789.
I, the undersigned insured or beneficiary of an insurance policy, irrevocably assign to Rumley Family Chiropractic P.A. on file sign the Div. of Corporations, hereafter ("Provider") whatever rights I have under any policy of insurance and under Florida law, including, without limitation, any and all claims for attorney's fees, costs, interest and/or damages pursuant to Florida Status 624.155. This Assignment of Benefits (AOB) includes an assignment of any potential claim for common law or statutory bad faith. If the Insurer disputes the validity of this AOB, then the insurer is instructed to notify the provider in writing within 10 days of receipt of this document. Failure to do so shall result in the provider relying on this AOB for direct payment and could constitute a waiver by the insurer to contest the validity of this document. I do hereby confirm that this AOB irrevocable and instruct any insurance company or other collateral source for which I am entitled to benefits to pay for monies owed as a result of medical services rendered by (Provider) to promptly make payment in the name of directly to (Provider) or its chosen billing services.

Pursuant to this AOB, (Provider) is authorized to file suit on my behalf against any insurance company that reduces of denies benefits for medical services rendered to me and to collect any damages awarded or settlement monies for services rendered, plus interest, costs, reasonable attorney's fees and a contingency fee multiplier. I understand that in any such lawsuit, my name or other identifying information will need to be included in and/or portion of my medical file attached to pleadings and/or formal discovery. I waive any confidentiality of my records and/or information but only to the extent necessary to prosecute a claim for unpaid or owed medical expenses against the insurance company or any other responsible party.

I acknowledge the (provider) objects to any reductions or partial payments by the Insurer. Any partial or reduced payment, regardless of the accompanying language, issued the Insurer and deposited by (provider) shall be done under protest, at the right of the insurer, and the deposit shall not be deemed a waiver, accord, satisfaction, discharge, settlement or agreement by the provider to accept a reduced amount as payment in full. (Provider) reserves the right to see the full amount of the bill submitted from the insurance company (ies) or me. Accordingly the insurer is hereby instructed to set aside (escrow) any all reduced or denied benefit payments for medical rendered by this provider and not pay the disputed amount to anyone until the dispute is resolved.

I further instruct my insurance company to cooperate with the above-captioned (Provider) in resolving all medical billing disputed. Cooperation includes, but is not limited to, providing any and all declaration pages, PIP logs, payout ledgers, explanations of benefits, copies of checks, and any and all other documents or information to (Provider) or its attorneys, employees, or other representatives acting on behalf of (Provider). If the insurer schedules a defense examination, examination under oath (EUO) or Independent Medical Examination (IME) of the patient, the insurer is hereby instructed to send a copy of said notification to this provider and the provider's attorneys. The provider and/or the provider's attorneys are authorized to appear at any patient EUO or IME set by the insurer. THIS ASSIGNMENT OF BENEFITS DOES NOT ASSIGN ANY RIGHTS OR OBLIGATIONS UNDER THE POLICY OF INSURANCE TO SUBMIT TO A EUO OR RECORDED STATEMENT. I further direct and authorize you to speak to an attorney, employee or any other representative of (Provider) or anyone acting on behalf over the phone and provide them with any and all information you may have or documentation not previously listed above that they may request.

I, as the patient, agree to remain personally liable for the amounts billed by (Provider) regardless of the amount paid by the insurance company, unless ordered by court of law. I fully understand that said health care services were provided to me in consideration for an unconditional promise to pay and for me providing this instruction to my insurance company. I, as a patient, further agree to be liable for reasonable attorney's fees and costs insured in collecting any delinquent accounts or unpaid balances. By executing this document, I am placing my insurance company (ies) on notice that the claims for medical treatment rendered by (Provider) are related to my accident (or covered conditions) and should be paid directly to (Provider) pursuant to this assignment of benefits and Florida law. Any delay in paying benefits owed under the insurance policy could adversely affect me.
BY EXECUTING THIS DOCUMENT, I AM PLACING MY INSURANCE COMPANY ON NOTICE THAT THIS IS A DIRECT ASSIGNMENT OF BENEFITS PURSUANT TO FLORIDA LAW, AS THE INSURED OR BENEFICIARY OR SAID INSURANCE POLICY, I AM IRREVOCABLY ASSIGNING WHATEVER RIGHTS I HAVE UNDER MY POLICY OR INSURANCE (LESS THE DUTY TO ATTEND ANY EUO) AND UNDER FLORIDA LAW TO THIS HEALTH CARE PROVIDER. A photocopy of this assignment shall be considered as affective and valid as the original.

Print Name	Date of Birth	Patient/Guarantor Sgnature

Date

OFFICE OF INSURANCE REGULATION
Bureau of Property & Casualty Forms and Rates

Standard Disclosure and Acknowledgement Form
Personal Injury Protection - Initial Treatment or Service Provided

The undersigned insured person (or guardian of such person) affirms:

1. The services or treatment set forth below were **actually rendered.** This means that those services have **already been provided.**

History, Exam, Physical Therapy, Cold Pack, EMS, Ultrasound, Hydrotherapy ,Massage therapy, Myofascial release, Chiropractic manipulation, Supplies

2. I have the right and the **duty to confirm** that the services have already been provided.

3. I was **not solicited** by any person to seek any services from the medical provider of the services described above.

4. The medical provider has **explained** the services to me for which payment is being claimed.

5. If I notify the insurer in writing of a billing error, I may be entitled to a portion of any reduction in the amounts paid by my motor vehicle insurer. If entitled, my share would be at least 20% of the amount of the reduction, up to $500.

Insured Person (patient receiving treatment or services) or Guardian of Insured Person:

Name *(PRINT or TYPE)*	Signature	Date

The undersigned licensed medical professional or medical director, if applicable, affirms the statement numbered 1 above and also:

A. I have **not solicited** or caused the insured person, who was involved in a motor vehicle accident, to be solicited to make a claim for Personal Injury Protection benefits.

B. The treatment or services rendered were explained to the insured person, or his or her guardian, **sufficiently** for that person to sign this form with informed consent.

C. The accompanying statement or bill is **properly completed** in all material provisions and all relevant information has been provided therein. This means that each request for information has been responded to **truthfully, accurately**, and in a **substantially complete** manner.

D. The coding of procedures on the accompanying statement or bill is proper. This means that **no service has been upcoded, unbundled**, or constitutes an invalid **or not medically necessary diagnostic test** as defined by Section 627.732(14) and (15), Florida Statutes or Section 627.736(5)(b)6, Florida Statutes.

Licensed Medical Professional Rendering Treatment/Services or Medical Director, if applicable *(Signature by his/ her own hand)*:

Name *(PRINT or TYPE)*	Signature	Date

Any person who knowingly and with intent to injure, defraud, or deceive any insurer files a statement of Claim or an application containing any false, incomplete, or misleading information is guilty of a felony of the third degree per Section 817.234(1)(b), Florida Statutes.

Note: The **original** of this form must be furnished to the insurer pursuant to Section 627.736(4)(b), Florida Statutes and may **not** be electronically furnished. Failure to furnish this form may result in non-payment of the claim.

OIR-B1-1571
Pub. 1/2004

Rumley Family Chiropractic P.A.
2221 Lee Rd. Suite 20
Winter Park, FL 32789
Phone: (407)277-0046
Fax: (47)951-5732

AUTHORIZATION TO RECEIVE MEDICAL RECORD INFORMATION

Rumley Family Chiropractic P.A. is hereby authorized to request the release of any medical records, laboratory test results, and radiographic or diagnostic imaging results pertinent to the health care of the above named patient from, but not inclusive of, any insurance carrier, adjustor, attorney, or other health care provider.

AUTHORIZATION TO RELEASE MEDICAL RECORD INFORMATION

Rumley Family Chiropractic P.A. is also authorized to release any medical records pertinent to the health care of the above-named patient to, but not inclusive of, any insurance carrier, adjustor, attorney, health care provider or immediate family member upon receipt of the signature of the above-named patient or the signature of the patient's legal guardian. This authorization is given with full knowledge that such disclosure may contain information of a confidential nature and may result in a denial of insurance coverage (in the event that claims are submitted to an insurance company on your behalf) for services rendered by said Rumley Family Chiropractic P.A.

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

Signature of Patient or parent/legal guardian: _____

Rumley Family Chiropractic P.A.
2221 Lee road suite 20
Orlando FL 32789

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

I acknowledge that I was provided a copy of the Notice of Privacy Practices and that I have read them or declined the opportunity to read them and understand the Notice of Privacy Practices. I understand that this form will be placed in my patient chart and maintained for six years.

By checking the lines below, I authorize being contacted for practice reminder by:

Email ____: at email address: _____:

By text message _____: Cell phone provider _____;

By checking the line below, I authorize the doctor to personally discuss with me products that may benefit my health or condition. ____

By checking the line below, I authorize the release of my medical records to my personal email, should I request a copy of them following my treatment. ____

THIS FORM WILL BE PLACED IN THE PATIENT'S CHART AND MAINTAINED FOR SIX YEARS.

List below the names and relationships of people to whom you authorize the Practice to release PHI.

_____ _____

_____ _____

_____ _____

_____ _____

Patient/Guardian Name (Please Print) **Date**

_____

Signature of Patient/Guardian/Legal Representative

COVID-19 INFORMED CONSENT TO TREAT

1. COMPLETE TESTING, HEALTH and VACCINATION INFORMATION

- Patient Name: _____
- Have you ever tested positive for COVID-19? ☐ Yes ☐ No *If Yes*: Date diagnosed: _____ Hospitalized? ☐ Yes ☐ No
- Are you experiencing any of the following potential symptoms of COVID-19: 1) Fever, 2) Dry Cough, 3) Shortness of Breath, 4) Runny Nose, 5) Sore Throat, 6) Loss of Taste or Smell? ☐ Yes ☐ No
- Have you received a COVID-19 Vaccination: ☐ Yes ☐ No
  If Yes, which Vaccine: _____ Date(s): 1st Dose: _____ 2nd Dose(if applicable): _____

2. REVIEW, CONFIRM UNDERSTANDING, CONSENT TO CARE - Initial in 4 places, Sign and Date

I understand that the novel Coronavirus (COVID-19) has been declared a global pandemic by the World Health Organization. I further understand that COVID-19 is extremely contagious and may be contracted from various sources. I understand COVID-19 has a long incubation period during which carriers of the virus may not show symptoms and still be contagious.

I understand that I am the decision maker for my healthcare. Part of this office's role is to provide me with information to assist me in making informed choices. This process is often referred to as "informed consent" and involves my understanding and agreement regarding recommended care, and the benefits and risks associated with the provision of healthcare during a pandemic. Given the current limitations of COVID-19 virus testing, I understand determining who is infected with COVID-19 is exceptionally difficult.

	Initial Below
◦ I understand that I am opting for an elective treatment that may not be urgent or medically necessary. I understand there are alternatives to receiving this care, which could include receiving care from another type of provider, or postponing care altogether at this time. However, while I understand the potential risks associated with receiving treatment during the COVID-19 pandemic, I agree to proceed with my desired treatment at this time.	_____
◦ I understand my treatment may create circumstances, such as the discharge of respiratory droplets or person-to-person contact, in which COVID-19 can be transmitted.	_____
◦ I am informed that you and your staff have implemented preventative measures intended to reduce the spread of COVID-19. However, given the nature of the virus, I understand there may be an inherent risk of becoming infected with COVID-19 by proceeding with this treatment. For example, I understand that given the nature of care, simply being in a healthcare office, where frequent patient appointments occur, may elevate the risk of contracting COVID-19. I hereby acknowledge and assume the risk of becoming infected with COVID-19 through this elective treatment and give my express permission to you and the staff at your offices to proceed with providing care.	_____
◦ I have been offered a copy of this consent form.	_____

I knowingly and willingly consent to the treatment with the full understanding and disclosure of the risks associated with receiving care during the COVID-19 pandemic. I confirm all of my questions were answered to my satisfaction.

I have read, or have had read to me, the above COVID-19 risk informed consent to treat. I appreciate that it is not possible to consider every possible complication to care. I have also had an opportunity to ask questions about its content, and by signing below, I agree with the current or future recommendation to receive care as is deemed appropriate for my circumstance. I intend this consent to cover the entire course of care from all providers in this office for my present condition and for any future condition(s) for which I seek care from this office.

Both parties agree that this agreement may be electronically signed, and that the electronic signatures appearing on this agreement are the same as handwritten signatures for the purposes of validity, enforceability, and admissibility.

Patient Signature: _____
[Parent or Guardian Signature if applicable]

Name: _____

Date: _____

Witness Signature: _____
Witness

Name: _____

Date: _____

AUTOMOBILE ACCIDENT QUESTIONNAIRE

Patient's Name:_____ Today's Date:_____

Date of Accident:_____

THE FOLLOWING QUESTIONS PERTAIN TO YOU AND THE VEHICLE YOU WERE IN:

Vehicle type:

❑Car ❑Pickup
❑Van ❑Truck
❑Station Wagon ❑Bus
❑Other_____

Vehicle size:

❑Subcompact ❑Full-size
❑Compact ❑Mini
❑Mid-size ❑Light
❑Heavy ❑Other_____

Your position in the vehicle:

❑Driver
❑Passenger ------- Location------- ❑Left ❑Middle ❑Right
❑Other _____ ❑Front Passenger ❑Rear Passenger ❑Third Seat (rear)

Speed of your vehicle:

❑Stopped ❑Moving Moderately
❑Parked ❑Moving Fast
❑Slowing ❑Moving at apprx ____MPH
❑Moving Slowly

Why Vehicle was slowed or stopped:

❑Traffic Signal ❑Parking
❑Pedestrian ❑Traffic
❑Stop Sign ❑Busy Intersection

Collision Type:

❑Driver Side Impact ❑Head On Collision
❑Passenger Side Impact ❑Rear Impact
❑Front Impact ❑Pedestrian Incident

THE FOLLOWING QUESTIONS CONCERN THE OTHER VEHICLE INVOLVED IN THE ACCIDENT:

Vehicle type:

❑Car ❑Pickup
❑Van ❑Truck
❑Station Wagon ❑Bus
❑Other_____

Vehicle size:

❑Subcompact ❑Full-size
❑Compact ❑Mini
❑Mid-size ❑Light
❑Heavy ❑Other_____

CONDITIONS AT THE TIME OF THE ACCIDENT:

Time of day:

❑Full daylight
❑Dusk
❑Night

Road Conditions:

❑Dry
❑Damp
❑Wet
❑Snow covered
❑Ice covered
❑Patchy Ice/Snow

Visibility:

❑Excellent
❑Good
❑Fair
❑Poor

Visibility compromised by:

❑Brightness
❑Darkness
❑Rain
❑Snow
❑Fog
❑Traffic

THE FOLLOWING QUESTIONS CONCERN THE MOMENT OF IMPACT OF THE ACCIDENT:

Were you...

❑Totally unaware that the accident was impending
❑Aware that the accident was impending
❑Aware that the accident was impending and braced for it

Restraints: (check all that apply)

❑Seat belt
❑Shoulder harness
❑No restraints

If you were the driver of the vehicle, was your foot on the brake pedal? ❑Yes ❑No ❑Knocked off by impact

Was the air bag deployed?

❑Car not equipped with air bag
❑Air bag deployed
❑Air bag not deployed

What position was YOUR headrest in?

❑High position
❑Middle position
❑ Low position

Position of YOUR head at time of impact?
- ❑Facing straight ahead
- ❑Tilted forward
- ❑Rotated to the left
- ❑Rotated to the right

Was your head thrown...?
- ❑Backward and then forward
- ❑Forward then backward
- ❑To the left ❑To the left then the right
- ❑To the right ❑To the right, then the left

Position of Your body at time of impact?
- ❑Straight
- ❑Tilted forward
- ❑Rotated to the left
- ❑Rotated to the right

Was your body thrown...?
- ❑Backward and then forward
- ❑Forward then backward
- ❑To the left ❑To the left then the right
- ❑To the right ❑To the right, then the left
- ❑Across the vehicle
- ❑Outside the vehicle ❑Under the vehicle

Damage to vehicle YOU were in:
- ❑Incurred minimal damage
- ❑Incurred moderate damage
- ❑Incurred severe damage
- ❑Was totaled
- ❑Not known

Citations:
- ❑None issued
- ❑Yourself
- ❑Driver of vehicle patient was a passenger of
- ❑Driver of other vehicle
- ❑Not sure

AS A RESULT OF THE FORCE OF THE COLLISION, WHICH OBJECTS IN THE VEHICLE DID YOUR BODY STRIKE?

Head
- ❑Steering wheel
- ❑Dashboard
- ❑Windshield
- ❑Armrest
- ❑Headrest
- ❑Rear view mirror
- ❑Left door
- ❑Right door
- ❑Left window
- ❑Right window
- ❑Console
- ❑Gear shift
- ❑Front seat
- ❑Backseat

Left Arm
- ❑Steering wheel
- ❑Dashboard
- ❑Windshield
- ❑Armrest
- ❑Headrest
- ❑Rear view mirror
- ❑Left door
- ❑Right door
- ❑Left window
- ❑Right window
- ❑Console
- ❑Gear shift
- ❑Front seat
- ❑Backseat

Right Arm
- ❑Steering wheel
- ❑Dashboard
- ❑Windshield
- ❑Armrest
- ❑Headrest
- ❑Rear view mirror
- ❑Left door
- ❑Right door
- ❑Left window
- ❑Right window
- ❑Console
- ❑Gear shift
- ❑Front seat
- ❑Backseat

Torso
- ❑Steering wheel
- ❑Dashboard
- ❑Windshield
- ❑Armrest
- ❑Headrest
- ❑Rear view mirror
- ❑Left door
- ❑Right door
- ❑Left window
- ❑Right window
- ❑Console
- ❑Gear shift
- ❑Front seat
- ❑Backseat

Left Leg
- ❑Steering wheel
- ❑Dashboard
- ❑Windshield
- ❑Armrest
- ❑Headrest
- ❑Rear view mirror
- ❑Left door
- ❑Right door
- ❑Left window
- ❑Right window
- ❑Console
- ❑Gear shift
- ❑Front seat
- ❑Backseat

Right Leg
- ❑Steering wheel
- ❑Dashboard
- ❑Windshield
- ❑Armrest
- ❑Headrest
- ❑Rear view mirror
- ❑Left door
- ❑Right door
- ❑Left window
- ❑Right window
- ❑Console
- ❑Gear shift
- ❑Front seat
- ❑Backseat

THE FOLLOWING QUESTIONS CONCERN THE TIME PERIOD IMMEDIATELY FOLLOWING THE ACCIDENT:

Did you lose consciousness?
- ❑Yes
- ❑No

Immediately following the accident, did you feel...?
- ❑Dizzy ❑Weak
- ❑Dazed ❑Nervous
- ❑Disoriented ❑Nauseated

Were you able to walk unaided?

❑Yes
❑No

Where did you go...?

❑Drove home
❑Was driven home
❑Drove to hospital
❑Was driven to hospital
❑Taken to hospital via ambulance
❑Drove to work
❑Was driven to work
❑Drove to school
❑Was driven to school

Next day discomfort...?

❑increased ❑decreased ❑same

Did your major complaints exist before the accident?

❑Yes ❑ No

In what areas did you IMMEDIATELY feel pain?

❑Head	Shoulder	❑Left	❑Right	Hip	❑Left	❑Right
❑Neck	Arm	❑Left	❑Right	Thigh	❑Left	❑Right
❑Upper back	Elbow	❑Left	❑Right	Knee	❑Left	❑Right
❑Mid back	Wrist	❑Left	❑Right	Calf	❑Left	❑Right
❑Ribs	Hand	❑Left	❑Right	Ankle	❑Left	❑Right
❑Chest	Fingers	❑Left	❑Right	Foot	❑Left	❑Right
❑Abdomen	Buttock	❑Left	❑Right	Toes	❑Left	❑Right
❑Low Back						
❑Pelvis						

In what areas did you experience lacerations (cuts)?

❑Head	Shoulder	❑Left	❑Right	Hip	❑Left	❑Right
❑Neck	Arm	❑Left	❑Right	Thigh	❑Left	❑Right
❑Upper back	Elbow	❑Left	❑Right	Knee	❑Left	❑Right
❑Mid back	Wrist	❑Left	❑Right	Calf	❑Left	❑Right
❑Ribs	Hand	❑Left	❑Right	Ankle	❑Left	❑Right
❑Chest	Fingers	❑Left	❑Right	Foot	❑Left	❑Right
❑Abdomen	Buttock	❑Left	❑Right	Toes	❑Left	❑Right
❑Low Back						
❑Pelvis						

At the hospital, what areas were x-rayed?

❑Head	Shoulder	❑Left	❑Right	Hip	❑Left	❑Right
❑Neck	Arm	❑Left	❑Right	Thigh	❑Left	❑Right
❑Upper back	Elbow	❑Left	❑Right	Knee	❑Left	❑Right
❑Mid back	Wrist	❑Left	❑Right	Calf	❑Left	❑Right
❑Ribs	Hand	❑Left	❑Right	Ankle	❑Left	❑Right
❑Chest	Fingers	❑Left	❑Right	Foot	❑Left	❑Right
❑Abdomen	Buttock	❑Left	❑Right	Toes	❑Left	❑Right
❑Low Back						
❑Pelvis						

Where did you experience pain on the day FOLLOWING the accident?

❑Head	Shoulder	❑Left	❑Right	Hip	❑Left	❑Right
❑Neck	Arm	❑Left	❑Right	Thigh	❑Left	❑Right
❑Upper back	Elbow	❑Left	❑Right	Knee	❑Left	❑Right
❑Mid back	Wrist	❑Left	❑Right	Calf	❑Left	❑Right
❑Ribs	Hand	❑Left	❑Right	Ankle	❑Left	❑Right
❑Chest	Fingers	❑Left	❑Right	Foot	❑Left	❑Right
❑Abdomen	Buttock	❑Left	❑Right	Toes	❑Left	❑Right
❑ Low Back						
❑Pelvis						

Modified Oswestry Low Back Pain Questionnaire

Name_____ Date_____

This questionnaire is designed to enable us to understand how much you low back pain has affected your ability to manage your everyday activities. Please answer each section by marking in each section one circle that most applies to you. We realize that you may feel that more than one statement may relate to you, but **please just mark the circle that most closely describes your problem.**

Section 1 - Pain Intensity

O The pain comes and goes and is very mild.
O The pain is mild and does not change much.
O The pain comes and goes and is moderate.
O The pain is moderate and does not change much.
O The pain comes and goes and is severe.
O The pain is severe and does not change much.

Section 2 - Personal Care

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

Section 3 - Lifting (skip if you have not attempted lifting since the onset of your low back pain)

O I can lift heavy weights without extra low back pain.
O I can lift heavy weights but it causes extra pain.
O Pain prevents me lifting heavy weights off the floor.
O Pain prevents me lifting heavy weights off the floor, but I can manage if they are conveniently positioned, e.g. on a table.
O Pain prevents me lifting heavy weights but I can manage light to medium weights if they are conveniently positioned.
O I can only lift light weights at the most.

Section 4 - Walking

O I have no pain walking.
O I have some pain on walking, but I can still walk my required to normal distances.
O Pain prevents me from walking long distances.
O Pain prevents me from walking intermediate distances.
O Pain prevents me from walking even short distances.
O Pain prevents me from walking at all.

Section 5 - Sitting

O Sitting does not cause me any pain.
O I can sit as long as I need provided I have my choice of sitting surfaces.
O Pain prevents me from sitting more than 1 hour.
O Pain prevents me from sitting more than 1/2 hour.
O Pain prevents me from sitting more than 10 minutes.
O Pain prevents me from sitting at all.

Modified Oswestry Low Back Pain Questionnaire

Section 6 - Standing

O I can stand as long as I want without pain.
O I have some pain while standing, but it does not increase with time.
O I cannot stand for longer than 1 hour without increasing pain.
O I cannot stand for longer than 1/2 hour without increasing pain.
O I cannot stand for longer than 10 minutes without increasing pain.
O I avoid standing because it increases the pain immediately.

Section 7 - Sleeping

O I have no pain while in bed.
O I have pain in bed, but it does not prevent me from sleeping well.
O Because of pain I sleep only 3/4 of normal time.
O Because of pain I sleep only 1/2 of normal time.
O Because of pain I sleep only 1/4 of normal time.
O Pain prevents me from sleeping at all.

Section 8 - Social Life

O My social life is normal and gives me no pain.
O My social life in normal, but increases the degree of pain.
O Pain prevents me from participating in more energetic activities e.g. sports, dancing.
O Pain prevents me from going out very often.
O Pain has restricted my social life to my home.
O I hardly have any social life because of pain.

Section 9 - Traveling

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

Section 10 - Employment/Homemaking

O My normal job/homemaking duties do not cause pain.
O My normal job/homemaking duties cause me extra pain, but I can still perform all that is required of me.
O I can perform most of my job/homemaking duties, but pain prevents me from performing more physically stressful activities e.g. lifting, vacuuming, etc.
O Pain prevents me from doing anything but light duties.
O Pain prevents me from doing even light duties.
O Pain prevents me from performing any job or homemaking chore.

SCORE_____

NAME:_____ DATE: _____

PDR Oswestry Neck Pain Questionnaire

This questionnaire is designed to enable us to understand how much your neck pain has affected your ability to manage 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 circle the one choice which closely describes your problem *right now*.**

Section 1 – Pain Intensity

A. I have no pain at the moment.
B. The pain is mild at the moment.
C. The pain comes and goes and is moderate
D. The pain moderate and does not vary much.
E. The pain is severe, but comes and goes.
F. The pain is severe and does not vary much.

Section 2 – Personal Care

A. I can look after myself 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 undressed, 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 causes extra pain.
C. Pain prevents me from lifting heavy weights off the floor, But I can manage if they are conveniently positioned (e.g 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 only 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 to with moderate pain in my neck.
D. I cannot read as much as I want to because of moderate pain in my neck.
E. I cannot read as much as I want to because of severe pain in my neck
F. I cannot read at all.

Section 5 – Headache

A. I have no headaches at all.
B. I have slight headaches that come infrequently.
C. I have moderate headaches that come infrequently.
D. I have moderate headaches that come frequently.
E. I have severe headaches that 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 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 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 only 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.

Section 11 – Numeric Rating Scale (NRS)

Try and assign a number from 0 to 10 to your current pain level. If you have no pain, use a 0. As the numbers get higher, they stand for pain that is getting worse. A 10 means the pain is as bad as it can be.

0 1 2 3 4 5 6 7 8 9 10
No pain Mild Moderate Severe Worst Possible Pain

OSW-SCORE:_____%

P-SCORE:_____

LOSS OF ENJOYMENT

Patient Name: _____ Date: _____

Are the areas of your life which you normally would be enjoying, but are currently not enjoying, as a result of the motor vehicle collision?

Include all areas which you have had to reduce the time you are capable of experiencing them. Include all instances where you have received lifting, stretching, bending, sitting, standing, walking or other restrictions which affect your participation in any of the following areas.

Work
(Performance while experiencing any symptoms would be an acceptable reason)

Reason for the difficulty: _____

Duration: _____

Studies/School
(Performance while experiencing any symptom would be an acceptable reason)

Reason for the difficulty: _____

Duration: _____

Hobbies
Of any kind (Example: card playing, jogging, kitting, dancing, socializing, entertainment, vacations, etc. DO NOT INCLUDE SPORTS

Reason for the difficulty: _____

Duration: _____