PATIENT INFORMATION (Personal Injury) **DATE:** _____

Patient Name: _____

Last Name First Name Middle Initial

Date of Birth: _____ SS#/Patient ID# _____

Address: _____

City: _____ State _____ Zip Code _____

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

Email address: _____

Sex: Male Female

Patient Employer/School _____

Occupation _____

Employer/School Address _____

Employer/School Phone (____) _____

Spouse's Name _____ Spouse's Date of birth _____

Emergency Contact:

Name: _____

Home Phone (____) _____ Cell Phone (___) _____

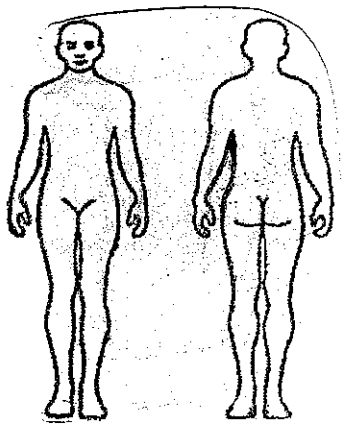
Patient Condition

Complaint area(s) _____

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) _____

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

Type of Pain (circle): Sharp Dull Throbbing Numbness Aching Shooting

Burning Tingling Cramps Stiffness Swelling Other

Insurance Information:

I certify that I, and/or my dependent(s) have insurance coverage with _____ And assign directly to Keystone Healthcare and Wellness all insurance benefits, if an, 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. Keystone Healthcare and Wellness may use my health care information and may disclose such information to the above named insurance company (ies) and their agents for the sole purpose of obtaining payment for services and determining insurance benefits or the benefits payable for related services.

_____

Signature of Patient, Parent, Guardian, or Personal Representative Relationship Date

IF YOUR INJURY IS ACCIDENT RELATED, PLEASE COMPLETE THE FOLLOWING QUESTIONS.

Date of accident: _____ Hour:_____(AM) (PM)

Location: _____

How did the accident occur? (i.e. auto collison, etc.)

_____

If an auto collison, please describe.

_____

_____

If NOT an auto collison, please describe the circumstances.

_____

_____

If an auto collision, were you: DRIVER PASSENGER PEDESTRIAN

Were there any other persons in the car with you? If so, who?

_____

Did you have your seat belt on? YES NO
Did an ambulance come to the scene of the accident? YES NO
Did you go to the emergency room? YES NO
If yes, where? _____
Have you seen any other doctor for this condition? YES NO
If yes, who? _____
Was your vehicle moving at the time of the impact? YES NO
If yes, approximately how fast? _____
If auto collision, were you struck from
BEHIND RIGHT SIDE LEFT SIDE FRONT VEHICLE WAS PARKED
Did your car strike the other (s) involved? YES NO
Did the other car strike you? YES NO
Have you lost any days of work? YES NO
If yes, what dates? _____

Patient signature: _____
Date: _____

HEALTH INFORMATION

GENERAL INFORMATION:

Patient Height: _____

_____ **Patient Weight** _____

First Middle Initial Last **Patient Blood Pressure** _____

Race: (circle ONLY 1)

American Indian Alaska Native

Asian White

Black or African American Other Pacific Islander

Native Hawaiian Declined to state

Ethnicity (circle ONLY 1)

Declined to state Hispanic or Latino Not Hispanic or Latino

Preferred Language: _____ **Email Address:** _____

Smoking Status (circle ONLY 1)

Current every day Smoker Smoking start date: _____ End date: _____

Current some day smoker Former Smoker I have never smoked

In an effort to stop smoking, I am currently taking: _____

Do you have any allergies to medication? YES NO

If yes, please indicate the following (if you need additional space, please use the other side of this sheet):

Allergy: _____ Reaction: _____

Start date: _____ End Date: _____

Are you currently taking any medications? YES NO

If yes, please indicate the following (if you need additional space, please use other side of this sheet):

Medication: _____ Frequency: _____

Route: Oral Intravenous

Other: _____

Date you started use: _____ Date you discontinued use: _____

Family Medical History (Please list any known medical conditions patient's family has had and their relationship to you):

Condition: _____ Relationship to patient: _____

Condition: _____ Relationship to patient: _____

Condition: _____ Relationship to patient: _____

HEALTH HISTORY

What treatment have you already received for your condition? __Medication __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 _____

Please circle to indicate if you have had any of the following:

AIDS/HIV	Diabetes	Measles	Rheumatic Fever
Alcoholism	Emphysema	Migraine Headaches	Scarlet Fever
Allergy Shots	Epilepsy	Miscarriage	Stroke
Anemia	Fractures	Mononucleosis	Suicide Attempt
Anorexia	Glaucoma	Multiple Sclerosis	Thyroid Problems
Appendicitis	Goiter	Mumps	Tonsillitis
Arthritis	Gonorrhea	Osteoporosis	Tuberculosis
Asthma	Gout	Pacemaker	Tumors, Growths
Bleeding disorder	Heart Disease	Parkinson's disease	Typhoid Fever
Breast Lump	Hepatitis	Pinched Nerve	Ulcers
Bronchitis	Hernia	Pneumonia	Vaginal Infections
Bulimia	Herniated Disk	Polio	Venereal Disease
Cancer	Herpes	Prostate Problem	Whooping Cough
Cataracts	High Cholesterol	Prosthesis	Other, please explain
Chemical Dependency	Kidney Disease	Psychiatric Care	_____
Chicken Pox	Liver Disease	Rheumatoid Arthritis	_____

Are you currently being treated or have you ever been treated for blood clots (i.e. PE, DVT) _____YES ____NO

EXERCISE	**WORK ACTIVITY**	**HABITS**	
___None	___Sitting	___Smoking	Packs/day_____
___Moderate	___Standing	___Alcohol	Drinks/week_____
___Daily	___Light Labor	___Coffee/Caffeine Drinks	Cups/Day_____
___Heavy	___Heavy Labor	____High Stress Level	Reason _____

Are you pregnant? ___YES ___NO If yes, what is your due date? _____

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

Medications Allergies Vitamins/Herbs\Minerals

(Please use other side if additional space is needed)

Pharmacy Name: _____ Phone: ( ) _____

Patient signature: _____ Date: _____

Neck Pain Disability Index 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.**

PAIN INTENSITY

1. I have no pain at the moment.
2. The pain is very mild at the moment.
3. The pain is moderate at the moment.
4. The pain is fairly severe at the moment.
5. The pain is very severe at the moment.
6. The pain is the worst imaginable at the moment.

PERSONAL CARE

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

LIFTING

1. I can lift heavy weights without extra pain.
2. I can lift heavy weights, but it gives me extra pain.
3. Pain prevents me from lifting heavy weights off the floor, but I can if they are conveniently positioned, e.g., on a table.
4. Pain prevents me from lifting heavy weights, but I can manage light to medium weights if they are conveniently positioned.
5. I can lift very light weights.
6. I cannot lift or carry anything at all.

READING

1. I can read as much as I want to with no pain in my neck.
2. I can read as much as I want to with slight pain in my neck.
3. I can read as much as I want with moderate pain in my neck.
4. I cannot read as much as I want because of moderate pain in my neck.
5. I cannot read as much as I want because of severe pain in my neck.
6. I cannot read at all.

HEADACHES

1. I have no headaches at all.
2. I have slight headaches which come infrequently.
3. I have moderate headaches which come infrequently.
4. I have moderate headaches which come frequently.
5. I have severe headaches which come frequently.
6. I have headaches almost all the time.

Patients signature _____

Date: _____

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

WORK

I can do as much 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 cannot do any work at all.

DRIVING

I can drive my car without any neck pain
I can drive my care 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 cannot 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 cannot drive my car at all.

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 (6-7 Hrs sleepless)

RECREATION

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

When your back hurts, you may find it difficult to do some of the things you normally do.

This list contains some sentences that people have used to describe themselves when they have back pain. When you read them, you may find that some stand out because they describe you today. As you read this list, think of yourself today. Check the box next to any sentence that describes you today. If the sentence does not describe you, then leave the space blank and go on to the next one. ***Remember, only check the sentence if you are sure that it describes you TODAY.***

o	1.	I stay at home most of the time because of my back.
o	2.	I change position frequently to try and get my back comfortable.
o	3.	I walk more slowly than usual because of my back.
o	4.	Because of my back I am not doing any of the jobs I usually do around the house.
o	5.	Because of my back, I use a handrail to get upstairs.
o	6.	Because of my back, I lie down to rest more often.
o	7.	Because of my back, I have to hold on to something to get out of an easy chair.
o	8.	Because of my back, I try to get other people to do things for me.
o	9.	I get dressed more slowly than usual because of my back.
o	10.	I only stand up for short periods of time because of my back.
o	11.	Because of my back, I try not to bend or kneel down.
o	12.	I find it difficult to get out of a chair because of my back.
o	13.	My back is painful almost all of the time.
o	14.	I find it difficult to turn over in bed because of my back.
o	15.	My appetite is not very good because of my back.
o	16.	I have trouble putting on my socks (or stockings) because of the pain in my back.
o	17.	I only walk short distances because of my back pain.
o	18.	I sleep less well because of my back.
o	19.	Because of my back pain, I get dressed with the help of someone else.
o	20.	I sit down for most of the day because of my back.
o	21.	I avoid heavy jobs around the house because of my back.
o	22.	Because of my back pain, I am more irritable and bad tempered with people than usual.
o	23.	Because of my back, I go upstairs more slowly than usual.
o	24.	I stay in bed most of the time because of my back.

On the scale below, please place one "X" that indicates how you are feeling today.

No Symptoms At all — Unbearable pain

Patient Signature: _____ DATE: _____

QUANTITATIVE HEADACHE INDEX

This questionnaire has been designed to give the doctor information as to how headaches have affected your ability to manage everyday life. Please answer every section and mark in each section only the **ONE** box which applies to you. We realize you may consider that two of the statements in any one section relates to you, but please mark the box which most describes your problem.

(1.) Current difficulties

( ) I have no headache problems at this moment.
( ) I have mild headache problems at this moment.
( ) I have moderate headache problems at this moment.
( ) My headache problems are fairly severe at this moment.
( ) My headache problems are severe at this moment.
( ) My headache problems are very severe at this moment.

2.) How many times have you ever been hospitalized for headaches? (Include emergency room visits.)

( ) Never
( ) One time
( ) Two times
( ) Three times
( ) Four times
( ) Five or more times

3.) When was the last time you had a severe flare-up or needed urgent medical treatment for your headache?

( ) Never
( ) More than twelve months ago
( ) Within the last twelve months
( ) Within the last six months
( ) Within the last month
( ) Within the last week

4.) How often do headaches awaken you at night?

( ) Never
( ) Less than once a week
( ) Once or twice a week
( ) Three of four times a week
( ) Five of six times a week
( ) Every night

5.) My headache lasts

( ) Less than one hour
( ) Less than six hours
( ) One day
( ) One day and one night
( ) Multiple days

6.) I currently have headaches

( ) Never
( ) Occasional (once a month)
( ) Sometimes (one a week)
( ) Frequently (one a day)
( ) Always (all day)
( ) Multiple days at a time

(7) Work

( ) My headaches never interfere with work activity
( ) My headaches rarely interfere with work activity
( ) My headaches interfere moderately with work activities
( ) My headaches interfere very much with work activities
( ) My headaches prevent me from doing most jobs
( ) My headaches prevent me from doing any work

(8) How much do your headaches interfere with your social activities (family, friends, neighbors, groups)?

( ) Never
( ) Rarely
( ) Slightly
( ) Moderately
( ) Frequently
( ) Extremely

(9) In the past four weeks, how much time have you Missed from work, school, or usual activities because of headaches?

( ) None
( ) One to three days
( ) Four days to one week
( ) One to two weeks
( ) Two to three weeks
( ) Three to four weeks

(10) Medication

( ) I never take medication
( ) I very rarely take medication
( ) I sometimes take medication
( ) I frequently take medication
( ) I use medication most days

ASSIGNMENT OF PROCEEDS, CONTRACTUAL LIEN, AND AUTHORIZATION ("Agreement")

I, the undersigned, hereby authorize and direct any and all insurance carriers, attorneys, agencies, governmental departments, companies, individuals, and/or other legal entities ("payees"), which may elect or be obligated to pay benefits to me for any medical conditions, accidents, injuries, or illnesses, past, present, or future ("condition") to pay directly to and exclusively in the name of Keystone Healthcare and Wellness ("office") such sums as may be owing to Keystone Healthcare and Wellness for charges incurred by me, including but not limited to, charges for treatment, narrative reports, depositions, testimony, and any other charges incurred by me at the Office ("charges"). I further grant a contractual lien to Keystone Healthcare and Wellness with respect to my charges, applicable to all payers, however, I understand that nothing in this Agreement shall be construed as an election by Keystone Healthcare and Wellness to claim protection under any statutory lien law. For the purposes of this Agreement, "benefits" shall include, but not be limited to, proceeds from any settlement, judgment, or verdict, as well as any proceeds relating to commercial health or group insurance, lost wage benefits, lost services benefit, attorney retainer agreements, medical payments benefits, personal injury protection, no-fault coverage, uninsured and underinsured motorist coverage, third-party liability distributions, disability benefits, worker's compensation benefits, malpractice proceeds, and any other benefits or proceeds payable to me for the purpose stated herein, regardless of whether such proceeds are related to my charges or not.

I further agree that, in the event a payer refuses to pay Keystone Healthcare and Wellness, I hereby assign, insofar as permitted by law, all of my rights, remedies, and benefits to Keystone Healthcare and Wellness to extent of my charges, as well as any and all causes of action that I might have against such payer, to prosecute such causes of action either in my name or in the Office's name and to settle or otherwise resolve such causes of action as the Office sees fit.

In the event that I retain one or more attorneys to represent me in this matter, I will direct each attorney to issue a letter of protection to this office regarding my charges. Upon issuance, I hereby agree that such letter(s) of protection cannot be revoked or modified without the expressed written consent of this office. I further direct each attorney to provide immediate notice of to the Office regarding any funds received by the attorney relating to my accident, to promptly pay such Office, and to provide full accounting of such funds to the Office upon its request.

I hereby direct all payers to release to Keystone Healthcare and Wellness any information regarding any coverage or benefits which I may have including, but not limited to, the amount of coverage, the amount paid thus far, and the amount of any outstanding claims.

I authorize this Office to release any information regarding my treatment or pertinent to my case(s) to all payers as defined above to facilitate collection under this Agreement. I hereby direct this Office to file a copy of this agreement, together with any applicable charges, with any or all payers, regardless of whether a claim has been established with said payers. I hereby authorize Keystone Healthcare and Wellness to endorse/sign my name on any and all checks listing me as a payee which are presented to this Office for payment of an account relating to me, my spouse, or any of my dependents. I further authorize Keystone Healthcare and Wellness to apply any credit balances on charges incurred by me to any other outstanding charges still owed by me, my spouse, or my dependents, regardless of whether these other charges are related to my condition.

I understand that I remain personally responsible for the total amounts due Keystone Healthcare and Wellness for their services. This Assignment and Lien does not constitute any consideration for this Office to await payments and it may demand payments from me immediately upon rendering services at its option. If this Office must take any action to collect an outstanding balance on my account, I will be responsible for payment and will reimburse Keystone Healthcare and Wellness for all costs of such collection efforts, including, but not limited to, all court costs and all attorney fees.

This Assignment and Lien shall not be modified or revoked without the mutual written consent of Keystone Healthcare and Wellness and myself. I hereby revoke any previously signed authorizations, whether executed at this office or any other office to the extent that the terms of those authorizations conflict with the terms of this Assignment and Lien.

I agree that each and every provision of this Agreement is reasonable necessary for the protection of the rights and interest of Keystone Healthcare and Wellness and myself. However, should any provision of this Agreement be found to be invalid, illegal, or unenforceable or for any reason cease to be binding on any party hereto, all other portions and provisions of this Agreement shall nevertheless, remain in full force and effect.

Patient Name (Please print): _____

Patient Signature: _____ DATE: _____

Name of Custodial Parent or Legal Guardian (Please Print): _____

Parent/Guardian Signature: _____ DATE: _____

Witness: _____ DATE: _____

Authorization for Use and Disclosure of Health Information

While the law requires us to give you this disclosure, please understand that we respect the privacy of your health information. However, there are some circumstances in which we may disclose your health information.

- We may disclose your health information to another health care provider or a hospital if it is necessary to refer you for diagnosis, assessment, or treatment.
- We may disclose your health information and billing records to another party if they are potentially responsible for the payment of your services.
- We may use your health information within our practice for quality control or other operational purposes.

We have a more complete notice that provides a detailed description of how your health information may be used or disclosed, which you have the right to review before signing this form (164.520). We reserve the right to change our privacy policy, but will notify you in writing of any changes either through the mail or when you come in for treatment. You may request a copy of our privacy policy at any time.

Your chiropractor and members of the practice staff may use your name, address, phone number, and clinical records to contact you with appointment reminders, information about treatment or other health related information. If contact is made by phone, a message may be left on your voicemail or answering device. By signing this form, you are giving us authorization to contact you in this manner.

Information that we disclose based on this authorization may be subject to re-disclosure by anyone who has access to the communication and may no longer be protected by the federal privacy rules.

You have the opportunity to designate a family member or other individual as a person with whom we may discuss your condition and treatment plan.

DO YOU WANT TO DESIGNATE A FAMILY MEMBER OR OTHER INDIVIDUAL WITH WHOM THE PROVIDER MAY DISCUSS YOUR MEDICAL CONDITION? IF YES, WHOM:

Answer:_____

You may **restrict** the individuals or organizations to which your health care information may be released by notifying us in writing. We are not required to agree to your restrictions; however, if we do agree, the restriction is binding on us. You may **revoke** your authorization to us at any time, but your revocation must be in writing. We will not be able to honor your revocation request if we have already released your health information before we receive your request. In addition, if you were required to give your authorization as a condition of obtaining insurance, the insurance company may have a right to your health information if they decide to contest any of your claims.

You have the right to refuse to give us this authorization. This decision will not affect the treatment we provide to you or the methods we use to obtain reimbursement for your care.

I acknowledge that I have read and received a copy of this policy and authorization request and I hereby agree to the terms and authorize you to disclose my health information in the manner described above. This authorization is effective as of the date printed below and will expire seven years after the date on which you last received services from us.

_____
Patient **PRINTED** name

_____
Authorized Provider Representative

_____
Patient **SIGNATURE**

_____
Date