



Patient Introduction Case # _____ Date: ____/____/____

Fees payable when services are rendered unless other arrangements are made. We are required to maintain original x-rays and records as property of this clinic. I agreed to pay interest on the amount owing until paid and collection costs including a reasonable attorney's fee. Signature _____

Personal Information

Full Name _____ Email _____
Address _____ City _____ State _____ Zip _____
Home Phone () _____ Cell Phone () _____ Occupation _____
Sex M F Marital Status S M D W Age _____ Birthday ____/____/____ SS# _____
How Did You Hear About Our Clinic? _____
Name Of Person Responsible For Account _____ Method Of Payment _____
Emergency Contact Name _____ Phone () _____

Present Complaint

Briefly Describe Symptoms _____

Other Doctors Seen For This Condition _____ Treatment Rendered _____

Are You Taking Any Medication? Yes No What Kind? _____

List Physicians Seen Within The Last Year _____ For What Condition(s) _____

Woman Only:

Are you Pregnant? No Yes Date of Last Menstrual Period ____/____/____



Insurance Information

Relationship to Insured: Self Spouse Child Other

If insured is self, complete any information not listed above.

If insured is someone other than yourself, please complete all information below

Insured's Full Name	Insured's Date of Birth / /
Address City	State Zip
Home Phone ()	SS#
Attorney Name	Phone ()
Insurance Company	Phone ()
Group #	Insured's ID#
Employed By	Phone ()
Address City	State Zip
Additional Insurance Company	Phone ()
Relationship to Insured <input type="checkbox"/> Self <input type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Other	
Insured's Full Name	Insured's Date of Birth / /
Employed By	Phone ()
Insured's SS#	Policy #

Auto Accident Information



Patient's Name _____ Today's Date _____
Date of Accident: _____ Time of Accident: _____

Please Describe How the Accident Happened (include just before the accident also):

My vehicle was:

- At a Traffic Light
- At a stop sign going straight
- Making a Right/Left Turn
- Entering Traffic from a side street/Driveway
- Other: (Explain)

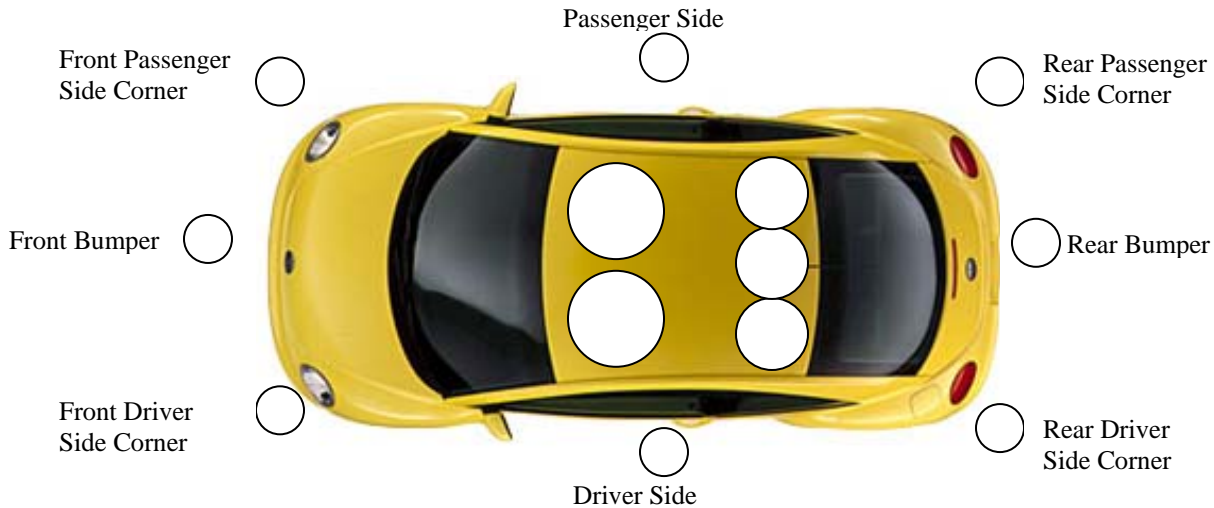
I was traveling at ___ MPH

The other vehicle was traveling at ___ MPH

The Other Vehicle:

- Hit me in the rear
- Ran a light
- Making a Right/Left Turn
- Entering Traffic from a side street/Driveway
- Ran across my lane
- Other: (Explain)

Mark with "X" where you were sitting – and then fill in the bubble where your vehicle was hit:



I was the Driver/Passenger involved in the accident in (City) _____ (State) _____

I was sitting in the: Middle Front Seat Right Front Seat Left Rear Seat
 Middle Rear Seat Right Rear Seat

I was a pedestrian in an accident in (City) _____ (State) _____

I was a pedestrian: Standing Sitting Riding a bike Walking Other

Auto Accident Information

The vehicle I was traveling in was: Year _____ Make _____ Model _____

The other vehicle in the accident was: Year _____ Make _____ Model _____

Your transmission was: Manual Automatic

Road conditions were: Dry Damp Wet Dark Clear Raining

Visibility was: Poor Fair Good

The road was made of: Concrete Asphalt Gravel Dirt Other _____

Did your car have a head rest: Yes No

If your car had a head rest, What position was it in: Up Middle Down

Were you: Wearing your seatbelt: Yes No Wearing your harness: Yes No

Did your airbag deploy: Yes No

At the time of the accident my head was looking:

Left Right Straight Down Up Other _____

Were your brakes applied at the time of the impact: Yes No

My elbows were: Left Right On the arm rest Other _____

My hands were: Left Right Both On the steering wheel Other _____

Were you aware of the impending collision before it happened: Yes No

Did you tighten your body and brace for the collision: Yes No

Your hands as a result of the impact: Grabbed the steering wheel tightly

Were forced off the steering wheel/stick shift Other _____

As a result of the impact your body was thrown: Forward Backward Right Left

Turned to the right (clockwise) Turned to the left (counterclockwise) Can't remember

As a result of the impact your head hit the:

<input type="checkbox"/> Front windshield	<input type="checkbox"/> Rearview mirror	<input type="checkbox"/> Steering Wheel	<input type="checkbox"/> Back of the seat	<input type="checkbox"/> Side Driver /
			ahead of me	Passenger
<input type="checkbox"/> Inside window /	<input type="checkbox"/> Another persons	<input type="checkbox"/> Back of my head	<input type="checkbox"/> Other	<input type="checkbox"/> Nothing
Door	body	hit the headrest		

As a result of the impact your shoulders were: Impacted with the inside of the door / car

Pressed firmly against the shoulder harness Other _____

As a result of the collision what other parts of your body struck the inside of the vehicle: _____

Did another car hit you: Yes No

Point of impact was: Head on Rear end Left Front Left Rear Right Front Right Rear

Did your vehicle strike or impact with a second object after the first impact: Yes No



Did your vehicle strike another: Car Truck Road/Median Building Other

Were you wearing your glasses at the time of the accident: Yes No

If yes, were your glasses still on following the accident: Yes No

Did you lose consciousness as a result of the accident: Yes No

If yes, how long were your unconsciousness: _____

Damage to my vehicle was: Mild Moderate Severe Is your vehicle drivable: Yes No

Damage to the other vehicle: Mild Moderate Severe Was the other car drivable: Yes No

Estimated cost to repair your car: _____

At the time of the accident, how many people were in the car with you: _____

Names of the occupants:

Were the other occupants injured: Yes No

Were the police called: Yes No

Was a police report taken: Yes No

Was a ticket given to you: Yes No

Was a ticket given to the other driver: Yes No

As a result of the accident I felt my symptoms:

- Immediately Within the hour Within 6 hours During the night
- Next Morning Next Day Other _____

As a result of the accident I felt:

- Headaches Upper Back Pain Chest Pain/Soreness Wrist / Elbow / Pain / Soreness
- Neck Pain Low Back Pain Stomach Pain / Soreness Knee/Angle Pain / Soreness
- Shoulder Pain Numb/Tingling/Burning Arms Numb/Tingling/Burning Legs Loss of Bowel/Bladder

Other areas of pain include: _____

List the location of any other cuts or bruises as a result of the accident:

Did you go to the hospital: Yes No If No, Where did you go: _____

If Yes, When: Immediately Next Day Later in same day Other _____

How did you get to the hospital: Ambulance Private Transportation
 Drove yourself Someone else Drove

Name of the Hospital: _____ City: _____



Were you admitted: Yes No If Yes, How long did you stay: _____

What treatments did you receive at the hospital: Exam X-Ray MRI
 CT Lab Work

What follow up recommendations were made: See your own Dr. See orthopedist
 See Neurologist Physical Therapist Braces/Collars Released
 Prescriptions: What types: _____

List any special test taken at the hospital: _____

Please list all the Doctors you have seen since the accident:

Doctor Name	First Visit Date	Treatment	City	Released
				<input type="checkbox"/> Yes <input type="checkbox"/> No
				<input type="checkbox"/> Yes <input type="checkbox"/> No
				<input type="checkbox"/> Yes <input type="checkbox"/> No

Are you working now: Yes No

Were you employed at the time of the accident: Yes No

Type of work you do: _____

Are you currently working with restrictions: Yes No

Has the doctor placed you on: Total Disability Partial Disability Does not apply

Please list work restrictions: _____

Since the accident you feel: Better Worse No Change Other _____

% of improvement: 10% 20% 30% 40% 50% 60% 70% 80% 90% 100%

Pain Scale: 1=No pain 10=Worst pain ever 1 2 3 4 5 6 7 8 9 10

Additional Notes:



Patient Name: _____ Case # _____ Date: ___/___/___

Neck Pain and Disability Index (Vernon – Mior)

Please Read Instructions:

This questionnaire has been designed to give the doctor information as to how your neck pain has affected your ability to manage in 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 relate to you, but just mark the box which most closely describes your problem.

<p>Section 1 Pain Intensity</p> <p><input type="checkbox"/> I have no pain at the moment</p> <p><input type="checkbox"/> the pain is very mild at the moment</p> <p><input type="checkbox"/> the pain is moderate at the moment</p> <p><input type="checkbox"/> the pain is fairly severe at the moment</p> <p><input type="checkbox"/> the pain is very severe at the moment</p> <p><input type="checkbox"/> the pain is the worst imaginable at the moment</p> <p>Section 2 Personal Care (Washing, Dressing, Ect.)</p> <p><input type="checkbox"/> I can look after myself normally, without causing extra pain</p> <p><input type="checkbox"/> I can look after myself normally, but it causes extra pain</p> <p><input type="checkbox"/> is painful to look after myself and I am slow and careful</p> <p><input type="checkbox"/> I need some help, but manage most of my personal care</p> <p><input type="checkbox"/> I need help everyday in most aspects of self-care</p> <p><input type="checkbox"/> I do not get dressed; I wash with difficulty and stay in bed</p> <p>Section 3 Lifting</p> <p><input type="checkbox"/> I can lift heavy weights without extra pain</p> <p><input type="checkbox"/> I can lift heavy weights but it gives extra pain</p> <p><input type="checkbox"/> pain prevents me from lifting heavy weights off the floor, but I can manage if they are conveniently positioned, for example on the table</p> <p><input type="checkbox"/> pain prevents me from lifting heavy weights, but I can manage light to medium weights if they are conveniently positioned</p> <p><input type="checkbox"/> I can lift very light weights</p> <p><input type="checkbox"/> I cannot lift or carry anything at all</p> <p>Section 4 Reading</p> <p><input type="checkbox"/> I can read as much as I want to with no pain in my neck</p> <p><input type="checkbox"/> I can read as much as I want to with slight pain in my neck</p> <p><input type="checkbox"/> I can read as much as I want with moderate pain in my neck</p> <p><input type="checkbox"/> I can't read as much as I want because of moderate pain in my neck</p> <p><input type="checkbox"/> I can hardly read at all because of severe pain in my neck</p> <p><input type="checkbox"/> I cannot read at all</p> <p>Section 5 Headaches</p> <p><input type="checkbox"/> I have no headaches at all</p> <p><input type="checkbox"/> I have slight headaches which come infrequently</p> <p><input type="checkbox"/> I have moderate headaches which come infrequently</p> <p><input type="checkbox"/> I have moderate headaches which come frequently</p> <p><input type="checkbox"/> I have severe headaches which come frequently</p> <p><input type="checkbox"/> I have headaches almost all the time</p>	<p>Section 6 Concentration</p> <p><input type="checkbox"/> I can concentrate fully when I want to, with no difficulty</p> <p><input type="checkbox"/> I can concentrate fully when they want to, with slight difficulty</p> <p><input type="checkbox"/> I have a fair degree of difficulty in concentrating when I want to</p> <p><input type="checkbox"/> I had a lot of difficulty in concentrating when I want to</p> <p><input type="checkbox"/> I have a great deal of difficulty in concentrating when I want to</p> <p><input type="checkbox"/> I cannot concentrate at all</p> <p>Section 7 Work</p> <p><input type="checkbox"/> I can do as much work as I want to</p> <p><input type="checkbox"/> I can only do my usual work, but no more</p> <p><input type="checkbox"/> I can do most of my usual work, but no more</p> <p><input type="checkbox"/> I cannot do my usual work</p> <p><input type="checkbox"/> I can hardly do any work at all</p> <p><input type="checkbox"/> I cannot do any work at all</p> <p>Section 8 Driving</p> <p><input type="checkbox"/> I can drive my car without any neck pain</p> <p><input type="checkbox"/> I can drive my car as long as I want with slight pain in my neck</p> <p><input type="checkbox"/> I can drive my car as long as I want with moderate pain in my neck</p> <p><input type="checkbox"/> I can't drive my car as long as I want because of moderate pain in my neck</p> <p><input type="checkbox"/> I can hardly drive at all because of severe pain in my neck</p> <p><input type="checkbox"/> I can't drive my car</p> <p>Section 9 Sleeping</p> <p><input type="checkbox"/> I have no trouble sleeping</p> <p><input type="checkbox"/> my sleep is slightly disturbed(less than 1 hour sleepless)</p> <p><input type="checkbox"/> my sleep is mildly disturbed(1 -- 2 hours sleepless)</p> <p><input type="checkbox"/> my sleep is moderately disturbed(2 -- 3 hours sleepless)</p> <p><input type="checkbox"/> my sleep is greatly disturbed(3 -- 5 hours sleepless)</p> <p><input type="checkbox"/> my sleep is completely disturbed(five -- 7 hours sleepless)</p> <p>Section 10 Recreation</p> <p><input type="checkbox"/> I'm able to engage in all my recreation activities with no neck pain at all</p> <p><input type="checkbox"/> I am able to engage in all my recreation activities, with some pain in my neck</p> <p><input type="checkbox"/> I am able to engage in most, but not all of my usual recreation activities because of pain in my neck</p> <p><input type="checkbox"/> I'm able to engage in a few of my usual recreation activities because of pain in my neck</p> <p><input type="checkbox"/> I can hardly do any recreation activities because of pain in my neck</p> <p><input type="checkbox"/> I can't do any recreation activities at all</p>
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Pain scale:

Rate the severity of your pain by checking one box on the following scale:

No pain	0	1	2	3	4	5	6	7	8	9	10	Excruciating pain
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Patient Name: _____ Case # _____ Date ____/____/____

Low Back Pain and Disability Questionnaire

Please Read Instructions:

This questionnaire has been designed to give the doctor information as to how your low back pain has affected your ability to manage in 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 relate to you, but just mark the box which most closely describes your problem.

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 moderate
- the pain is moderate and does not vary much
- the pain comes and goes and is very severe
- the pain is severe and does not vary much



Section 2 Personal Care (Washing, Dressing, Ect.)

- 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 managed 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 causes extra pain
- pain prevents me from lifting heavy weights off the floor
- pain prevents me from lifting heavy weights off the floor, but I manage if they are conveniently positioned (e.g. on a table)
- pain prevents me from lifting heavy weights but I can manage light in 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 1 mile without increasing pain
- I cannot walk more than 1/2 mile without increasing pain
- I cannot walk more than 1/4 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
- I can only sit in my favorite chair as long as I like
- pain prevents me from sitting more than one hour
- pain prevents me from sitting more than half 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 on standing but it does not increase with time
- I cannot stand for longer than one hour without increasing pain
- I cannot stand for longer than 1/2 hour without increasing pain
- 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 1/4
- because of pain my normal night's sleep is reduced by less than 1/2
- because of pain my normal night's sleep is reduced by less than 3/4
- 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 interest, example dancing
- pain has restricted my social life and I do not go out very often
- pain has restricted my social life to my home
- I have hardly any social life because of the pain

Section 9 Travelling

- I get no pain while traveling
- I get some pain while traveling, but none of my usual forms of travel make it any 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 restricts all forms of travel
- pain prevents all forms of travel except that done lying down

Section 10 Changing Degree of Pain

- my pain is rapidly getting better
- my pain fluctuates but overall is definitely getting worse
- my pain seems to be getting better but improvement is slow at present
- my pain is neither getting better nor worse
- my pain is gradually worsening
- my pain is rapidly worsening

Pain scale:

Rate the severity of your pain by checking one box on the following scale:

No pain	0	1	2	3	4	5	6	7	8	9	10	Excruciating pain
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ASSIGNMENT OF BENEFITS



Jacksonville Chiropractic
& Acupuncture

Financial Responsibility

I understand that insurance billing is a service provided as a courtesy and that I am at all times financially responsible to Jacksonville Chiropractic & Acupuncture and/or its affiliated entities for any charges not covered by health care benefits. It is my responsibility to notify Jacksonville Chiropractic & Acupuncture of any changes in my health care coverage. In some cases exact insurance benefits cannot be determined until the insurance company receives the claim. I am responsible for the entire bill or balance of the bill as determined by Jacksonville Chiropractic & Acupuncture and/or my health care insurer if the submitted claims or any part of them are denied for payment. I understand that by signing this form that I am accepting financial responsibility as explained above for all payment for medical services and/or supplies received.

Assignment of Benefits

I authorize direct remittance of payment of all insurance benefits, including Medicare, if I am a Medicare beneficiary, to Jacksonville Chiropractic & Acupuncture for all covered medical services and supplies provided to me during all courses of treatment and care provided by Jacksonville Chiropractic & Acupuncture and/or its affiliated entities or otherwise at its direction. I understand and agree this Assignment of Benefits will have continuing effect for so long as I am being treated or cared for by Jacksonville Chiropractic & Acupuncture, and will constitute a continuing authorization, maintained on file with Jacksonville Chiropractic & Acupuncture, which will authorize and allow for direct payment to Jacksonville Chiropractic & Acupuncture of all applicable and eligible insurance benefits for all subsequent and continuing treatment, services, supplies and/or care provided to me by Jacksonville Chiropractic & Acupuncture.

Authorization to Release Information

I authorize the release of any medical or any other information to the Health Care Financing Administration, my insurance carrier(s), or other entity necessary to determine insurance benefits or the benefits payable for related medical services and/or supplies provided to me by Jacksonville Chiropractic & Acupuncture. A copy of this authorization will be sent to the Health Care Financing Administration, my insurance carrier(s), or other medical entity, if requested. The original authorization will be kept on file by Jacksonville Chiropractic & Acupuncture.

Patient/Insured Name(print)_____

Date of birth____/____/____

SS#____-____-____

Patient Signature_____Date:____/____/____

Witness (Signature)_____Date:____/____/____



Jacksonville Chiropractic
& Acupuncture



**Jacksonville Chiropractic
& Acupuncture**

Informed Consent to Chiropractic Adjustments and Care

Doctor <input type="checkbox"/> Initials	Patient <input type="checkbox"/> Initials	<p>I have been informed that it is not uncommon that patients have some increased discomfort after an adjustment. If that happens I will apply ice to the area and rest it. If I am concerned about this discomfort or develop any new symptoms I can call the number listed below during office hours for emergency attention. If I am out of town or unable to contact the doctor, I can present myself to an emergency room. If any tests were performed outside of this office (laboratory or other diagnostic procedures) I understand that the doctor will notify me of the results at my next scheduled appointment.</p>
Doctor <input type="checkbox"/> Initials	Patient <input type="checkbox"/> Initials	<p>I hereby request and consent to the performance of chiropractic adjustments and other chiropractic procedures, including various modes of physical therapy and, if necessary, diagnostic x-ray, on me by the doctor of chiropractic names below and/or in this clinic authorized by the doctor of chiropractic listed below. I have had an opportunity to discuss with the doctor of chiropractic names below and/or with other office or clinic personnel, the nature and purpose of chiropractic adjustments and other procedures. I understand that results are not guaranteed. I further understand and am informed that, as in all health care, in the practice of chiropractic there are some very slight risks to treatment, including, but not limited to, muscle strains and sprains, disc injuries, physical therapy burns, rib injury, and strokes. Strokes are the most serious complication of chiropractic treatment. The most recent studies (Journal of the CAA, Vol. 37 No. 2, June, 1993) estimate that the incidence of this type of stroke is 1 in every 3 million upper cervical adjustments. I do not expect the doctor to be able to anticipate and explain all risks and complications and wish to rely on the doctor to exercise judgment during the course of the procedure which the doctor feels at the time, based upon the facts then known, as in my best interests.</p>
Doctor <input type="checkbox"/> Initials	Patient <input type="checkbox"/> Initials	<p>I have read the above consent, with the doctor, as indicated by our initials. I have also had an opportunity to ask questions about its content, and by signing below I agree to the above names procedures. I intend this consent form to cover the entire course of treatment for my present condition and for any future conditions for which I seek treatment.</p>

To Be Completed By The Patient:

Print Patient
Name:

Date Signed

____/____/____

Patient Signature:

Doctors
Signature: