COVID 19 INFORMATION &LIABILITY WAIVER

Client Name: _____ Date: _____

COVID –19 Information

1. Have you had a fever in the last 24 hours of 100° F or above? Yes ☐ No☐

2. Do you now, or have you recently had, any respiratory or flu symptoms, sore throat, or shortness of breath? Yes☐ No☐

3. Have you been in contact with anyone in the last 14 days who has been diagnosed with COVID-19 or has Coronavirus-type symptoms? Yes ☐ No☐

Consent for Treatment

I understand that, because Chiropractic Treatment involves maintained touch and close physical proximity over an extended period of time, there may be an elevated risk of disease transmission, including COVID-19. By signing this form, I acknowledge that I am aware of the risks involved from receiving treatment at this time, I voluntary agree to assume those risks, and I release and hold harmless the practitioner/business from any claims related thereto. I give my consent to receive treatment from this practitioner.

Client Signature: _____ Date: _____

Parent or Guardian signature (in case of minor): _____ Date: _____

Advance Beneficiary Notice (ABN) • Medicare Waiver of Liability

Signature Sheet

HIPAA
Protected Health Information
Authorized Access Only

CONFIDENTIAL

Patient Name _____
Address _____
_____
Social Security # _____
Date of Birth _____
Phone _____
X-ray Date _____
ICD Diagnosis _____
_____
_____
_____

Dr. Name _____
Address _____
_____
Social Security # _____
Federal ID # _____
Phone _____
E Mail _____
Modifiers _____

-GA - **ABN signed** by patient but service determined by Medicare to be **not reasonable and/or necessary.**

-GY - Item/Service is **statutorily non-covered** by Medicare.

-GZ - Item/Service expected to be **not reasonable and necessary** and **ABN not signed** by patient.

CPT:	98940	98941	98942	98943 - Extremities
	1 - 2 Regions	3 - 4 Regions	5 Regions	Non-Covered

VSC Levels: Occ C1 2 3 4 5 6 7 (8) / T1 2 3 4 5 6 7 8 9 10 11 12 (13) / L1 2 3 4 5 (6)
SAC / Coccyx / Hips RI LI

Patient Signature	Staff Initials	Patient Signature	Staff Initials	Patient Signature	Staff Initials

ADVANCE BENEFICIARY NOTICE (ABN)
MEDICARE WAIVER OF LIABILITY ~ SIGNATURE SHEET

127

EXPLANATION OF CHIROPRACTIC MEDICARE BENEFITS AND MEDICARE WAIVER OF LIABILITY FORM

Medicare will only pay for services that it determines to be "reasonable and necessary" under section 1862 (a)(1) of the Medicare law. If Medicare determines that a particular service, although it would otherwise be covered, is not "reasonable and necessary" under Medicare program standards, Medicare will deny payment for that service. I believe that, in your case, Medicare is likely to deny payment for x-rays, physical therapy, supports and braces, and nutritional supplements.

DEDUCTIBLE/CO-PAY:

Each year Medicare requires you to pay a yearly mandatory deductible of **$203.00.** This expense is not covered by your Medicare or any secondary insurance; the yearly deductible is an out of pocket expense for the patient. In addition you will be responsible for a **$8.69 co-pay per chiropractic visit** unless your copayment is covered by a secondary insurance.

PHYSICAL THERAPY, SUPPLEMENTS AND SUPPORTS:

During the course of your treatment in this office, the doctor may determine that certain physical therapy, and/or orthopedic supports are necessary to assist in the treatment of your condition. Medicare **DOES NOT COVER** these services and you will be personally responsible for payment.

Beneficiary's Acknowledgement & Agreement to Pay:

I have been notified by my Chiropractor that he/she believes that in my case Medicare is likely to deny payment for the services identified above. If Medicare denies the payment, I agree to be fully and personally responsible for payment.

Patient Signature **Date**

MEDICARE ASSIGNMENT AND RECORDS RELEASE

AUTHORIZATION AND ASSIGNMENT

I, _____ agree to the following:
(Patient's Name)

1. I hereby authorize you to release any information you deem appropriate concerning my physical condition to any insurance company, attorney or adjuster in order to process any claim for reimbursement of charges incurred.
2. I authorize the direct payment to you of any sum I now or hereafter owe you by my attorney, out of the proceeds of any settlement of my case, and by any insurance company obligated to make payment to me or you based in whole, or in part, upon the charges made for your services.
3. In the event any insurance company obligated by contractual agreement to make payment to me, or to you, for the charges made for your services refuses to make such payment upon demand by you, I hereby assign and transfer to you the cause of action that exists in my favor against any such company and authorize you to prosecute said action either in my name as you see fit and further authorize you to compromise, settle or otherwise resolve said claim as you see fit. It is understood, however, that until all reasonable efforts have been made to collect the sums due from the insurance company or companies contractually obligated, you will refrain from attempts and efforts to collect the amounts owed directly from me.

_____ _____
(Patient's Signature) (Date)

RECORDS RELEASE

I hereby authorize you to release any information including the diagnosis and records of any examination or treatment rendered to me to the following person(s):

_____

Effective dates for this authorization:___/____/_____ through____/_____/_____
This authorization will expire at the end of the above period.

I understand I have the right to:

1. Revoke this authorization by sending written notice to this office and that revocation will not affect this office's previous reliance on the uses or disclosure pursuant to this authorization.
2. Inspect a copy of Patient Health Information being used or disclosed under federal law.
3. Refuse to sign this authorization.
4. Receive a copy of this authorization.
5. Restrict what is disclosed with this authorization.

_____ _____
Signature of Patient or Patient's Authorized Representative Date

Denise Soliz _____ _____
Authorized Facility Representative Date

INFORMED CONSENT FOR CHIROPRACTIC TREATMENTS AND CARE

I hereby request and consent to the performance of chiropractic adjustments and other chiropractic procedures, including various modes of physical therapy and diagnostic x-rays, on me (or on the patient named below, for whom I am legally responsible) by the doctor or chiropractic named below and/or other licensed doctors of chiropractic who now or in the future treat me while employed by, working or associated with or serving as back-up for the doctor or chiropractic named below, including those working at the clinic or office listed below or any other office clinic.

I understand and am informed that, as in the practice of medicine, in the practice of chiropractic there are some risks to treatment including, but not limited to, fractures, disc injuries, strokes, dislocations and sprains. I do not expect the doctor to be able to anticipate and explain all risks and complications, and I wish to rely on the doctor to exercise his judgment during the course of the procedure which the doctor feels at time, based upon the facts then known, is in my best interests.

I have read or have had read to me, the above consent. I have also had the opportunity to ask questions about its content, and by signing below I agree to the above-named procedures. I intend this consent form to cover the entire course of treatment for my present condition and for any further condition (s) for which I seek treatment.

TO BE COMPLETED BY PATIENT

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

Signature of Patient: _____ **Date Signed:** _____

TO BE COMPLETED BY DOCTOR OR STAFF

Name of Clinic or Office:

Delta Chiropractic Clinic
7103 Broadway, Lemon Grove, CA 91945
Dr. Greg Ninberg, D.C.

Doctor or Staff Signature:_____

Date:_____

HEALTH QUESTIONNAIRE

Dear Patient: Please complete this questionnaire. Your answers will help us determine if we can help you. If we do not sincerely believe your condition will respond satisfactorily, we will not accept your case. THANK YOU.

Please use a **No. 2 pencil** to fill in your answers. When filling in an **Other** bubble please explain in the space allowed. Fill in bubbles **completely** as indicated here: ⬭. **Erase** changes cleanly. Do **not fold** this form.

Patient Name:

MO	DAY	YEAR
1 7	1	0
2 8	2 10	1
3 9	3 20	2
4 10	4 30	3
5 11	5 40	4
6 12	6 50	5
	10 7 60	6
	20 8 70	7
	30 9 80	8
		90 9

DR# PATIENT NUMBER

NO MARKS HERE

A. PATIENT INFORMATION

Patient's Home Address

Phone FAX

Employer Business Address

Phone

Occupation

Social Security #

Referred By

Date Of Birth Age

Sex: ⬭ Male ⬭ Female

Marital Status:
⬭ Single
⬭ Married
⬭ Widowed
⬭ Divorced
⬭ Other

Patient Resides With:
⬭ Lives Alone ⬭ Spouse ⬭ Parents
⬭ Children ⬭ Other

Children:
⬭ Yes ⬭ No How Many? 1 2 3 4 5+

Spouse

Name

Social Security #

NO MARKS HERE

B. COMPLAINTS

1. What Are Your Primary Complaints? ⬭ *None*

	LEFT SIDE								RIGHT SIDE							
	Pain	Numbness	Tingling	Stiffness	Soreness	Weakness	Swelling		Pain	Numbness	Tingling	Stiffness	Soreness	Weakness	Swelling	
LEFT	P	N	T	S	S	W	S	Head	P	N	T	S	S	W	S	RIGHT
LEFT	P	N	T	S	S	W	S	Neck	P	N	T	S	S	W	S	RIGHT
LEFT	P	N	T	S	S	W	S	Upper Back	P	N	T	S	S	W	S	RIGHT
LEFT	P	N	T	S	S	W	S	Mid Back	P	N	T	S	S	W	S	RIGHT
LEFT	P	N	T	S	S	W	S	Lower Back	P	N	T	S	S	W	S	RIGHT
LEFT	P	N	T	S	S	W	S	Shoulder	P	N	T	S	S	W	S	RIGHT
LEFT	P	N	T	S	S	W	S	Arm	P	N	T	S	S	W	S	RIGHT
LEFT	P	N	T	S	S	W	S	Forearm	P	N	T	S	S	W	S	RIGHT
LEFT	P	N	T	S	S	W	S	Wrist	P	N	T	S	S	W	S	RIGHT
LEFT	P	N	T	S	S	W	S	Hand	P	N	T	S	S	W	S	RIGHT
LEFT	P	N	T	S	S	W	S	Ribs	P	N	T	S	S	W	S	RIGHT
LEFT	P	N	T	S	S	W	S	Buttock	P	N	T	S	S	W	S	RIGHT
LEFT	P	N	T	S	S	W	S	Hip	P	N	T	S	S	W	S	RIGHT
LEFT	P	N	T	S	S	W	S	Thigh	P	N	T	S	S	W	S	RIGHT
LEFT	P	N	T	S	S	W	S	Leg	P	N	T	S	S	W	S	RIGHT
LEFT	P	N	T	S	S	W	S	Knee	P	N	T	S	S	W	S	RIGHT
LEFT	P	N	T	S	S	W	S	Ankle	P	N	T	S	S	W	S	RIGHT
LEFT	P	N	T	S	S	W	S	Foot	P	N	T	S	S	W	S	RIGHT

2. What Are Your Secondary Complaints? ⬭ *None*

	LEFT SIDE								RIGHT SIDE							
	Pain	Numbness	Tingling	Stiffness	Soreness	Weakness	Swelling		Pain	Numbness	Tingling	Stiffness	Soreness	Weakness	Swelling	
LEFT	P	N	T	S	S	W	S	Head	P	N	T	S	S	W	S	RIGHT
LEFT	P	N	T	S	S	W	S	Neck	P	N	T	S	S	W	S	RIGHT
LEFT	P	N	T	S	S	W	S	Upper Back	P	N	T	S	S	W	S	RIGHT
LEFT	P	N	T	S	S	W	S	Mid Back	P	N	T	S	S	W	S	RIGHT
LEFT	P	N	T	S	S	W	S	Lower Back	P	N	T	S	S	W	S	RIGHT
LEFT	P	N	T	S	S	W	S	Shoulder	P	N	T	S	S	W	S	RIGHT
LEFT	P	N	T	S	S	W	S	Arm	P	N	T	S	S	W	S	RIGHT
LEFT	P	N	T	S	S	W	S	Forearm	P	N	T	S	S	W	S	RIGHT
LEFT	P	N	T	S	S	W	S	Wrist	P	N	T	S	S	W	S	RIGHT
LEFT	P	N	T	S	S	W	S	Hand	P	N	T	S	S	W	S	RIGHT
LEFT	P	N	T	S	S	W	S	Ribs	P	N	T	S	S	W	S	RIGHT
LEFT	P	N	T	S	S	W	S	Buttock	P	N	T	S	S	W	S	RIGHT
LEFT	P	N	T	S	S	W	S	Hip	P	N	T	S	S	W	S	RIGHT
LEFT	P	N	T	S	S	W	S	Thigh	P	N	T	S	S	W	S	RIGHT
LEFT	P	N	T	S	S	W	S	Leg	P	N	T	S	S	W	S	RIGHT
LEFT	P	N	T	S	S	W	S	Knee	P	N	T	S	S	W	S	RIGHT
LEFT	P	N	T	S	S	W	S	Ankle	P	N	T	S	S	W	S	RIGHT
LEFT	P	N	T	S	S	W	S	Foot	P	N	T	S	S	W	S	RIGHT

NO MARKS HERE

3. Additional Complaints? ⬭ Yes ⬭ No Please List:

4. When Did Your Symptoms Begin?

⬭ Date

5. How Often Do Your Symptoms Occur?

⬭ Occasional ⬭ Intermittent ⬭ Frequent
⬭ Constant ⬭ Other

6. How Would You Rate Your Pain Today With 0 Being No Pain and 10 Being The Worst Pain?

0 1 2 3 4 5 6 7 8 9 10

No Pain — Worst Pain Possible

SCANTRON EW-270770-1:65

1198598

PLEASE MAKE NO MARKS IN THIS AREA

B. COMPLAINTS (CONTINUED)

7. **Are You Getting?** ○ Better ○ Worse ○ Same

8. **If Your Complaints Include Pain, Is It Aggravated By?**
○ Coughing ○ Reaching ○ Standing
○ Sneezing ○ Lifting ○ Walking
○ Straining At Stool ○ Bending ○ Other
○ Neck Movement ○ Sitting

9. **If Your Complaints Include Pain, Is It Relieved By?**
○ Nothing ○ Heat ○ Sitting
○ Rest ○ Stretching ○ Standing
○ Ice ○ Exercise ○ Other

10. **Have You Had Recent Treatment For This Condition?**
○ Yes ○ No If Yes, List Dates, Treatments, And Doctors:

11. **Has This Condition Existed In The Past?** ○ Yes ○ No

12. **Since Your Symptoms Began, Have You Noticed A Change In? If Yes, Indicate**

	Onset Date	Duration
○ Bowel Function		
○ Bladder Function		
○ Sexual Function		

NOTE MARKS HERE

C. REVIEW OF SYSTEMS

1. **Are You Currently Suffering From Any Of The Symptoms Listed Below?**

a. General
○ Normal
○ Fatigue ○ Chills
○ Weakness ○ Weight Change
○ Fever ○ Night Sweats
○ Loss Of Sleep ○ Other

b. Skin
○ Normal ○ Eczema
○ Rash ○ Hair Changes
○ Redness ○ Nail Changes
○ Itching ○ Bruise Easily
○ Dryness ○ Other

c. Neurologic
○ Normal ○ Convulsions
○ Headache ○ Nervousness
○ Dizziness ○ Other
○ Fainting

d. Eyes

○ Normal	Right	Left
Vision Trouble	○	○
Pain	○	○
Discharge	○	○
Other	○	○

Right
Left

e. Ears

○ Normal	Right	Left
Hearing Trouble	○	○
Ringing	○	○
Pain	○	○
Discharge	○	○
Other	○	○

Right
Left

f. Nose
○ Normal ○ Infections
○ Pain ○ Absence Of Smell
○ Bleeding ○ Other
○ Sinus Problems

g. Mouth/Throat
○ Normal ○ Absence Of Taste
○ Sores ○ Abnormal Taste
○ Bleeding ○ Tonsilitis
○ Enlarged Glands ○ Other

h. Cardio-Vascular-Pulmonary (Heart/Lungs)
○ Normal ○ Varicosities
○ Cough ○ Murmur
○ Wheezing ○ Chest Pain
○ Difficulty Breathing ○ Palpitations
○ Swollen Extremities ○ Other
○ Blue Extremities

i. Breasts
○ Normal ○ Dimpling
○ Lumps In Breast(s) ○ Discharge
○ Redness/Itching ○ Other
○ Pain

j. Gastrointestinal (Stomach/Digestion)
○ Normal ○ Excess Gas
○ Decreased Appetite ○ Vomiting
○ Increased Appetite ○ Diarrhea
○ Abdominal Pain ○ Constipation
○ Hemorrhoids ○ Other

k. Genitourinary
○ Normal ○ Painful Menstruation
○ Inability To Hold Urine ○ Abnormal Vaginal Bleeding
○ Painful Urination ○ Impotence
○ Frequent Urination ○ Sterility
○ Bedwetting ○ Prostate Problems
○ Irregular Menstruation ○ Other

l. Endocrine (Metabolism)
○ Normal ○ Goiter
○ Heat/Cold Intolerance ○ Tremor
○ Sugar In Urine ○ Other

m Psychologic
○ Normal ○ Phobias
○ Anxiety ○ Mood Swings
○ Depression ○ Other
○ Memory Loss Or Impairment

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C. REVIEW OF SYSTEMS (CONTINUED)

2. What Hobbies Do You Participate In?

List Hobbies:	Occasionally	Frequently	Constantly
1.	○	○	○
2.	○	○	○
3.	○	○	○

NO MARKS HERE

3. What Are Your Habits?

Smoking	Never	<1 Packs/Day	1-2	2-3	3-4	5+
Alcohol	Never	<1 Drinks/Day	1-2	2-3	3-4	5+
Caffeinated Drinks	Never	<1 Cups-Glasses/Day	1-2	2-3	3-4	5+
Exercise	Never	<1 Days/Week	1-2	3-4	5-6	7

Drug/Substance Abuse — Never ○ Yes ○ If Yes, Discuss With Doctor

D. MEDICAL HISTORY

1. Health Care

a. **Have You Been To A Chiropractor** . . . . . Yes ○ No ○

b. **Do You Have A Family Physician** . . . . . Yes ○ No ○

Date Of Last Physical Exam _____

Physician's Name & Address _____

NO MARKS HERE

c. **Have You Been Hospitalized In The Past Five Years** . . . . . Yes ○ No ○

Date & Reason For Hospitalization _____

d. **Have You Had Surgery In The Past Five Years** . . . . . Yes ○ No ○

Date & Reason For Surgery _____

NO MARKS HERE

e. **Have You Had A Serious Accident In The Past Five Years** . . . . . Yes ○ No ○

○ Auto ○ Work ○ Home ○ Other _____

List Date & Describe Injury _____

f. **Do You Have Any Drug Allergies** . . . . . Yes ○ No ○

List Drugs _____

NO MARKS HERE

g. **Are You Currently Taking Any Medication** . Yes ○ No ○

○ Anti-inflammatory (Aspirin, Motrin, etc.)
○ Muscle Relaxants ○ Pain Medication/Analgesic
○ Tranquilizers ○ Antibiotics
○ Blood Pressure Pills ○ Other
○ Birth Control Pills

For What Condition/s Are You Taking Medication? _____

h. **WOMEN ONLY:**

To Your Knowledge Are You Pregnant . . . . Yes ○ No ○

Have Your Past Pregnancies Been Normal . Yes ○ No ○

Are You Seeing An OB-GYN Regularly . . . . Yes ○ No ○

Date Of Last Exam _____

Physician's Name & Address _____

2. If you now have or you have had one of the following illnesses, please fill in EITHER bubble NH or bubble HH.

○ ***No Previous Conditions/Illnesses***

Now Have	Have Had		Now Have	Have Had	
NH	HH	Arthritis	NH	HH	Sexually Transmitted Disease
NH	HH	Asthma	NH	HH	Ulcer
NH	HH	Sinus Trouble	NH	HH	Cancer
NH	HH	Hay Fever	NH	HH	Polio
NH	HH	Allergies	NH	HH	Rheumatic Fever
NH	HH	Tuberculosis	NH	HH	Serious Injury
NH	HH	Diabetes	NH	HH	Bone Fracture
NH	HH	Epilepsy	NH	HH	Dislocated Joints
NH	HH	Thyroid Trouble	NH	HH	Spinal Disc Disease
NH	HH	High Blood Pressure	NH	HH	Multiple Sclerosis
NH	HH	Low Blood Pressure	NH	HH	Scoliosis
NH	HH	Heart Trouble	NH	HH	Mental/Emotional Difficulty
NH	HH	Pacemaker	NH	HH	Prostate Trouble
NH	HH	HIV/ARC	NH	HH	Kidney Trouble
NH	HH	AIDS	NH	HH	Other _____
				HH	Other _____

3. Family History

	Cancer	Diabetes	Heart Trouble	High Blood Pres	Stroke	Multiple Sclerosis	Headaches	Neck Problems	Back Problems	Disc Problems	Joint Problems	Arthritis	Pinched Nerve	Osteoporosis	Scoliosis	Bad Posture	Present Age or Age at Death	Deceased
Father	C	D	H	H	S	M	H	N	B	D	J	A	P	O	S	B		D
Mother	C	D	H	H	S	M	H	N	B	D	J	A	P	O	S	B		D
Bro 1	C	D	H	H	S	M	H	N	B	D	J	A	P	O	S	B		D
Bro 2	C	D	H	H	S	M	H	N	B	D	J	A	P	O	S	B		D
Bro 3	C	D	H	H	S	M	H	N	B	D	J	A	P	O	S	B		D
Sis 1	C	D	H	H	S	M	H	N	B	D	J	A	P	O	S	B		D
Sis 2	C	D	H	H	S	M	H	N	B	D	J	A	P	O	S	B		D
Sis 3	C	D	H	H	S	M	H	N	B	D	J	A	P	O	S	B		D
Child 1	C	D	H	H	S	M	H	N	B	D	J	A	P	O	S	B		D
Child 2	C	D	H	H	S	M	H	N	B	D	J	A	P	O	S	B		D
Child 3	C	D	H	H	S	M	H	N	B	D	J	A	P	O	S	B		D

E. OCCUPATIONAL INFORMATION - ACTIVITIES OF DAILY LIVING

1. Job Type

○ Full Time ○ Temporary
○ Part Time ○ Other _____

2. Work Week

Hours Per Day: 1 2 3 4 5 6 7 8 9 10 11 12

Days Per Week: 1 2 3 4 5 6 7

○ Other _____

3. Do Your Present Complaints Affect The Number Of Hours You Work Per Day ○ Yes ○ No

4. Length Of Time At Present Occupation

Years: 10 20 30 40 50 1 2 3 4 5 6 7 8 9

Months: 1 2 3 4 5 6 7 8 9 10 11

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E. OCCUPATIONAL INFORMATION - ACTIVITIES OF DAILY LIVING (CONTINUED)

5. Job Involves
   a. Lifting ..... ○10 ○20 ○30 ○40 ○50 ○60 ○70 ○80 ○90 ○100+ Pounds
      ○ Never ○ Frequently
      ○ Occasionally ○ Constantly

   b. Additional Job Requirements
      ○ Bending ○ Twisting ○ Carrying
      ○ Stooping ○ Turning ○ Walking
      ○ Other

6. What Is Your Primary Work Position \ Location?
   a. Position:
      ○ Seated
      ○ Standing
      ○ Other
   b. Location:
      ○ Desk ○ Counter
      ○ Workbench
      ○ Other

   c. If Seated, What Type Of Chair Do You Use?
      ○ Executive ○ Steno ○ Bench
      ○ Stool ○ Other

7. Do You Wear Shoes Or Boots With High Heels?
   ○ Never ○ Seldom ○ Occasionally ○ Frequently

8. Are You Right Or Left Handed?
   ○ Right ○ Left

9. Do Work Activities Aggravate Your Present Complaints?
   ○ Yes ○ No

10. Which Of The Following Best Describes Your Stress Level?
    ○ None ○ Minimal ○ Moderate ○ Great

11. How Do You Rate Your Physical Activity At Work?
    ○ Seated more than 50% of workday
    ○ Light Manual Labor
    ○ Moderate Manual Labor
    ○ Heavy Manual Labor

F. INSURANCE INFORMATION

1. Is Your Condition Due To:

	Yes	No
An Automobile Accident	○	○
A Personal Injury	○	○
A Job Injury	○	○

2. Do You Have Health Insurance ..... Yes ○ No ○
   Company
   Policy #

3. Is Your Spouse Employed ..... Yes ○ No ○
   Business
   Address

4. Is Your Spouse The Primary Insured ..... Yes ○ No ○
   Company
   Policy #

5. HMO, PPO Plan Coverage ..... Yes ○ No ○
   Company
   Policy #

6. Are You Covered By Medicare ..... Yes ○ No ○
   Medicare #

7. Authorization To Release Records To Patient's Insurance Carrier
   Patient or Guardian's Signature

G. PAYMENT

IF YOU HAVE MADE PRIOR FINANCIAL ARRANGEMENTS WITH OUR OFFICE THE FOLLOWING PARAGRAPH WILL NOT APPLY TO YOU.

I understand and agree that health and accident policies are an arrangement between an insurance carrier and myself. Furthermore, I understand that this Office will prepare any necessary reports and forms to assist me in making collection from the insurance company and that any amount authorized to be paid directly to this Office will be credited to my account upon receipt. However, I clearly understand and agree that all services rendered to me are charged directly to me and that I am personally responsible for payment. I also understand that if I suspend or terminate my care and treatment, any fees for professional services rendered me will be immediately due and payable.

I WILL BE PAYING TODAY BY: (If paying by credit card please confirm which cards are accepted by our office.)
○ Cash ○ Check ○ Visa
○ MasterCard ○ DiscoverCard ○ American Express
○ Other

Account #
Expiration Date

Patient's Signature Date

Guardian or Spouse's Signature Date

Doctor's Signature Date

Is There Anything Else You Would Like Us To Know?
○ Yes ○ No

NO MARKS HERE

1198599
PLEASE MAKE NO MARKS IN THIS AREA

NECK PAIN DISABILITY INDEX QUESTIONNAIRE

Patient Name:

MO	DAY	YEAR	DR#	PATIENT NUMBER

Please Read: This questionnaire is designed to enable us to understand how much your neck pain has affected your ability to manage your everyday activities.

Please answer **each section** by darkening the **one bubble** that most applies to you. We realize that you may feel that more than one statement may relate to you, but **please, just pencil in the one choice which closely describes your problem now.**

Please use a **No. 2 pencil** to fill in your answer.
Fill in bubbles **completely** as indicated here: ⬭
Erase changes cleanly. Do **not fold** this form.

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.

2. PERSONAL CARE

- 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.

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 if they are conveniently positioned, for example, 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 lift very light weights.
- I cannot lift or carry anything at all.

4. READING

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

5. HEADACHES

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

After Vernon & Mior, 1991
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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.

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 cannot do any work at all.

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 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.

9. SLEEPING

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

10. 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.

SIGNATURE: _____ DATE: _____

REVISED OSWESTRY LOW BACK PAIN DISABILITY QUESTIONNAIRE

Patient Name: _____

MO	DAY	YEAR	DR#	PATIENT NUMBER
1 7	1	0	0 0 0	0 0 0 0 0 0 0 0 0 0 0 0
2 8	2	10 1	1 1 1	1 1 1 1 1 1 1 1 1 1 1 1
3 9	3	20 2	2 2 2	2 2 2 2 2 2 2 2 2 2 2 2
4 10	4	30 3	3 3 3	3 3 3 3 3 3 3 3 3 3 3 3
5 11	5	40 4	4 4 4	4 4 4 4 4 4 4 4 4 4 4 4
6 12	6	50 5	5 5 5	5 5 5 5 5 5 5 5 5 5 5 5
	10 7	60 6	6 6 6	6 6 6 6 6 6 6 6 6 6 6 6
	20 8	70 7	7 7 7	7 7 7 7 7 7 7 7 7 7 7 7
	30 9	80 8	8 8 8	8 8 8 8 8 8 8 8 8 8 8 8
		90 9	9 9 9	9 9 9 9 9 9 9 9 9 9 9 9

From: N.Hudson, K. Tome-Nicholson, A Breen; 1989
Revised 09/11/92

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 darkening the **one bubble** that most applies to you. We realize that you may feel that more than one statement may relate to you, but **please, just pencil in the one choice which most closely describes your problem right now.**

Please use a **No. 2 pencil** to fill in your answers.
Fill in bubbles **completely** as indicated here: ⬭
Erase changes cleanly. Do **not fold** this form.

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 severe.
- Ⓕ The pain is severe and does not vary much.

2. PERSONAL CARE

- Ⓐ 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 increases the pain, but I manage not to change my way of doing it.
- Ⓓ Washing and dressing increases 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 or dressing without help.

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 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.

4. WALKING

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

5. SITTING

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

6. STANDING

- Ⓐ I can stand as long as I want without pain.
- Ⓑ I have some pain while 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 ten minutes without increasing pain.
- Ⓕ I avoid standing, because it increases the pain straight away.

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 one-quarter.
- Ⓓ Because of pain, my normal night's sleep is reduced by less than one-half.
- Ⓔ Because of pain, my normal night's sleep is reduced by less than three-quarters.
- Ⓕ Pain prevents me from sleeping at all.

8. SOCIAL LIFE

- Ⓐ My social life is normal and gives me no pain.
- Ⓑ My social life is normal, but increases the degree of my pain.
- Ⓒ Pain has no significant effect on my social life apart from limiting my more energetic interests, e.g., dancing, etc.
- Ⓓ 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.

9. TRAVELING

- Ⓐ 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.

10. CHANGING DEGREE 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 improvement is slow at present.
- Ⓓ My pain is neither getting better nor worse.
- Ⓔ My pain is gradually worsening.
- Ⓕ My pain is rapidly worsening.

SIGNATURE: _____ DATE: _____