



4711 Scenic Highway Pensacola, FL 32504 | 850.438.5900 | www.scenichealth.com
Charles P. McGrath, D.C., Clinic Director, Jason E. Stern, D.C., Stephne D. West, D.C., Bernard J. Keenum, D.C.

New Patient Information

Welcome to Scenic Health Alliance! We appreciate the opportunity to serve you with regard to your healthcare needs. We want to make your first visit with us a pleasant one and apologize in advance for the long paperwork required for thorough documentation of your patient file. At anytime during this process, please do not hesitate to ask the doctor or any member of our staff should you have any questions.

Name: _____
First "Preferred Nickname" Middle Last

Street Address _____

City: _____ State: _____ Zip: _____ Social Security #: _____

Home Phone: _____ Cell Phone: _____ Work Phone: _____
Please check which number is the best way to contact you

Emergency Contact Name: _____ Cell Phone: _____

E-mail Address: _____

Date of Birth: _____ Age: _____ Height: _____ *ft* _____ *in.* Weight: _____ Sex: Male Female

General Physician/Family Doctor: _____ Phone Number: _____

Occupation: _____ Employer: _____

Spouse's Name: _____

How did you hear about our clinic? _____

Insurance Company: _____

Named of Insured: _____ Relation: _____

Insured's Date of Birth: _____ Insured's Social Security Number: _____

I authorize **Scenic Health Alliance**, its physicians and agents, together with any other company designated by Scenic Health Alliance to perform a physical examination, adjustments and/or other treatment deemed necessary by the treating physician, including but not limited to any required examination, x-rays, physical therapy and other diagnostic/laboratory testing. I further authorize Scenic Health Alliance to disclose the above named insurer and its designated representatives, test results and findings made during the course of this examination and/or treatment, including but not limited to, medical history, treatment information, laboratory / diagnostic tests results and physical examination findings. I hereby direct the insurer to pay, without equivocation, directly to Scenic Health Alliance, any and all benefits due as a result of this claim. I am also aware that I am responsible for charges and/or balance not covered by my insurance.

By signing this authorization, I acknowledge that I have read, or had this form read and explained to me, that I fully understand its contents, and that I have been given ample opportunity to ask questions, and that my questions have been answered satisfactory.

Patient's Signature

Date

_____ *SHA Staff Member Initials*



4711 Scenic Highway Pensacola, FL 32504 | 850.438.5900 | www.scenichealth.com
Charles P. McGrath, D.C., Clinic Director, Jason E. Stern, D.C., Stephne D. West, D.C., Bernard J. Keenum, D.C.

Health Information

PATIENT NAME: _____ DATE: _____

Have you had chiropractic care previously? Yes No

What is your primary complaint? _____

Do you have any secondary complaints? _____

How long have you had this condition? _____

Have you had this or a similar condition in the past? Yes No If yes, how long ago? _____

Which activities aggravate your condition? _____

Is this condition getting progressively worse? Yes No Constantly Occasionally

Is this condition interfering with any of the following? Work Sleep Daily Routine

Other: _____

How long has it been since you really "felt good"? _____

Have any other doctors treated you for this condition? Yes No

If yes, whom have you seen? _____

Please list any operations and when: _____

Are you pregnant or believe that you may be pregnant? Yes No

Do you take any of the following medication? Muscle Relaxants Tranquilizers Insulin

Birth Control Diet or "Pep" Pills Pain Medications Over the counter medications

Other _____

What is the age of your mattress? _____ Is it comfortable? Yes No

Are you wearing any of the following?

Heel Lifts Sole Lifts Inner Soles Arch Supports Prescribed Orthotics

Do you wear a **PACEMAKER**? Yes No

What was the date of your last examination? _____

Have you been in an automobile accident? Yes No

If yes, when and please briefly describe the accident: _____

Have you been involved in any other type of accident or personal injury claim? Yes No

If yes, when and please briefly describe the accident: _____

Do you suffer from or been previously diagnosed with any of the following? (*please check all that apply*)

Sinusitis Dizziness/Vertigo Backaches Neck Pain Digestive Disorders

Heart Disease History of Stroke Diabetes Arthritis/Gout Vascular Disease

Headaches Chronic Migraines Asthma Neuritis Nervousness/Anxiety

PAIN CHART

Please mark the area(s) of injury or discomfort using the following symbols:

Numbness

Pins & Needles
00000

Burning Pain
^^^^^

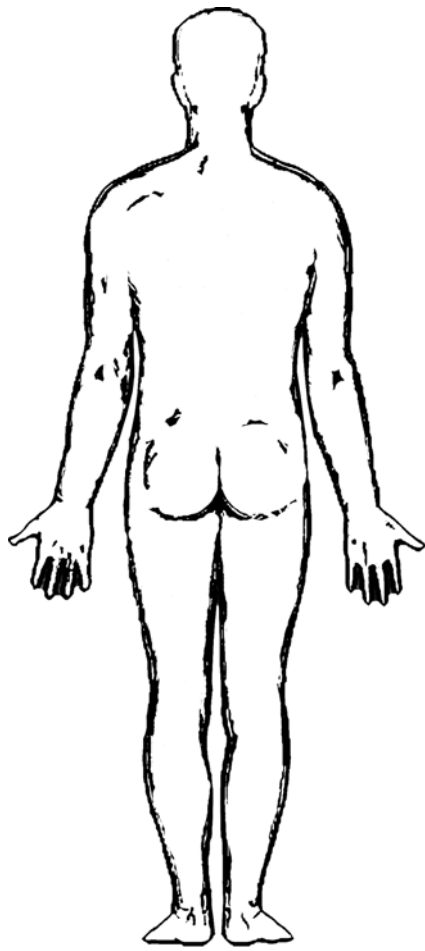
Aching Pain
xxxxx

Stabbing Pain
>>>>>



Right

Left



Left

Right



4711 Scenic Highway Pensacola, FL 32504 | 850.438.5900 | www.scenichealth.com
Charles P. McGrath, D.C., Clinic Director, Jason E. Stern, D.C., Stephne D. West, D.C., Bernard J. Keenum, D.C.

ASSIGNMENT OF BENEFITS

The undersigned patient does hereby assign to Scenic Health Alliance, Inc. and Its Providers ("Provider") the right, title, and interest in receiving personal injury protection benefits from my automobile insurance policy in payment for medical treatment rendered to me as a result of my accident on ____ / ____ / _____. Provider has my permission and consent to bill my insurance company directly for all such services and to receive payment directly from my insurance company.

I understand that I remain fully responsible for payment to Provider for all expenses incurred for medical and diagnostic treatment, regardless of payment, partial payment or denial of payment by my insurance company. Should my insurance company deny payment, I agree to make such payment arrangements as the Provider and I may agree upon.

Patient Signature

Date



4711 Scenic Highway Pensacola, FL 32504 | 850.438.5900 | www.scenichealth.com
Charles P. McGrath, D.C., Clinic Director, Jason E. Stern, D.C., Stephne D. West, D.C., Bernard J. Keenum, D.C.

FINANCIAL POLICY

Thank you for choosing Scenic Health Alliance as one of your health care providers. We are committed to the goal that your treatment with us will be both successful and as pleasant as possible. The following is a statement of our financial policy, which we request that you read thoroughly and sign prior to your treatment. Please ask to speak to our Insurance Claims Department at 850-472-0360, should you have any questions. **Payment of your co-payer time of service fee is due at the time of service. Payment of co-insurance and co-pays are required by most insurance companies, at the time of service. We accept Cash, Personal Check, Visa/MasterCard, American Express, Discover and most Debit Cards.**

VERIFICATION OF YOUR IHEALTH INSURANCE BENEFITS

Scenic Health Alliance staff will ask for your insurance information or a copy of your member identification card. We will make every effort to verify your benefits prior to your treatment in our office. While this verification does not guarantee your coverage, it does provide us with an idea of what to expect from your insurance company. We will review this information with you in detail, should you so request. We will also conference call your insurance company when possible, so that you may personally hear your benefits and directly ask questions of their claims personnel.

THIRD PARTY HEALTH INSURANCE

Scenic Health Alliance does accept third party payer health insurance; however we do require a minimum payment or co-pay at the time of service. That co-pay is usually detailed on the back of your insurance card. Your health insurance contract is between you and your insurer, and while we are not a party to the contract, Scenic Health Alliance will electronically file your claim for you directly to your insurance company. The unpaid account balance is your responsibility should your insurance company refuse to pay their agreed portion. Please be aware that some and perhaps all of the services provided may not be covered by your policy.

INSURANCE - WHEN WE ARE A PARTICIPATING PROVIDER (PPO OR HMO)

All co-pays and deductibles are due upon treatment. The co-pay is usually detailed on the back of your insurance card. In the event that your insurance coverage changes to a plan where we are not listed as a Preferred Provider, please notify our staff immediately and we will attempt to verify benefits and coverage as an "out-of-network" provider.

USUAL & CUSTOMARY RATES

Scenic Health Alliance is committed to providing the highest quality of care to our patients. Our charges are usual and customary for health care providers of our specialty within our geographical area. Most of our fees are set by the insurance plans that we participate with as a PPO provider, of which, we are contractually obligated to collect co-pays and write-off or write down certain charges.

ADULT PATIENTS AND MINORS & CHILDREN

Adult patients are responsible for payment at the time of service. The adult (parent or guardian) accompanying a minor child is responsible for full payment. For unaccompanied minors, payment is due at the time of service, unless arrangements have been made in advance.

MISSED APPOINTMENTS

We are sure that you understand that there are limited hours and appointments in a day. In an effort to assure that all patients are accommodated, please notify our office 24 hours in advance of a cancellation. Habitually failing to keep your appointments may result in your insurance company's denial of your claims as not medically necessary. By signing below, you are acknowledging that you have taken the time to read our financial policy statement, have had your questions answered by staff members, and that you understand and agree to its provisions.

Patient's Signature

Date



4711 Scenic Highway Pensacola, FL 32504 | 850.438.5900 | www.scenichealth.com
Charles P. McGrath, D.C., Clinic Director, Jason E. Stern, D.C., Stephne D. West, D.C., Bernard J. Keenum, D.C.

MEDICAL REPORTS AND HEALTH CARE LIEN

I hereby authorize Scenic Health Alliance, Inc., Dr. Charles P. McGrath, Clinic Director, and all providers affiliated with Scenic Health Alliance to furnish my attorney with a full report of the examination, diagnosis, prognosis, et cetera, of myself in regard to the accident in which I was involved and which occurred on _____.

I hereby authorize and direct my attorney to pay to Scenic Health Alliance all such sums as may be due and owing for medical services rendered to me as a result of this accident and by reason of any other bills as may be due this office, and to withhold such sums from my settlement, judgment, or arbitrated agreement as may be necessary to adequately protect and remunerate Scenic Health Alliance and affiliated providers. I hereby further grant a lien in favor of Scenic Health Alliance, Inc. upon any monetary compensation, settlement or award of damages arising from my injury or compensation claim as may be held by me, or held in trust for me by my attorney or court-appointed custodian acting on behalf of myself or my estate, and that this lien supersede and take priority over any and all subsequent or competing liens or claims upon the monies in question.

I hereby authorize and direct my attorney to ascertain the full amount of all medical costs and expenses incurred by Scenic Health Alliance, and any affiliated providers, for services rendered me and to pay all of said costs and expenses as soon as practicable from whatever settlement, judgment or award proceeds as my attorney may be holding in trust on behalf of myself or my estate and prior to any other disbursement of said proceeds.

I understand that I am directly and fully responsible to Scenic Health Alliance for all medical costs and expenses incurred for services rendered me and that this agreement is made solely for the protection of Scenic Health Alliance and as consideration for this provider's deferring demand for payment of said costs and expenses until such time as my claim is settled, litigated or otherwise resolved. I further understand that such payment is not contingent upon any settlement, judgment, arbitrated agreement or award of compensation I may eventually recover, and that I shall remain responsible for all medical costs and expenses as well as any finance charges, fees and costs incurred by Scenic Health Alliance in the collection of this account.

I hereby authorize and direct Scenic Health Alliance to serve by certified mail this **Medical Reports and Health Care Lien** signed by me, or a photo static copy of same, upon _____ as my attorney of record.

Patient's Signature

Date

Scenic Health Alliance Fee Schedule Revised 7-1-2006

| | | | | |
|-------|----------|-----------|---|-------------|
| 99203 | \$165.00 | | New Patient Office visit | |
| 99204 | \$400.00 | | New Patient Office visit | minimal |
| 99211 | \$35.00 | | Established Patient Office visit | limited |
| 99212 | \$50.00 | | Established Patient Office visit | expanded |
| 99213 | \$85.00 | | Established Patient Office visit | 1-2 regions |
| 99214 | \$325.0 | | Established Patient Office visit | 3-4 regions |
| 98940 | \$45.00 | | Chiropractic manipulation, spinal | 5 regions |
| 98941 | \$55.00 | | Chiropractic manipulation, spinal | |
| 98942 | \$65.00 | | Chiropractic manipulation, spinal | |
| 98943 | \$40.00 | | Chiropractic manipulation, extra spinal | |
| 97810 | \$125.00 | | Acupuncture - initial 15 (No E-stim.) | |
| 97811 | \$75.00 | | Acupuncture add.15 min. (No E-stim.) | |
| 97813 | \$150.00 | | Acupuncture initial 15 (With E-stim.) | |
| 97814 | \$100.00 | | Acupuncture add. 15 (With E-stim.) | |
| 72010 | \$300.00 | | x-ray, entire spine | |
| 72020 | \$50.00 | | x-ray, cervical 1 view | |
| 72040 | \$140.00 | | x-ray, cervical 2 or 3 views | |
| 72050 | \$175.00 | | x-ray, cervical 4 or more views | |
| 72052 | \$250.00 | | x-ray, cervical complete | |
| 72069 | \$50.00 | | x-ray, thoracolumbar 1 view | |
| 72070 | \$150.00 | | x-ray, thoracic, 2 views | |
| 72072 | \$175.00 | | x-ray, thoracic, 3 views | |
| 72074 | \$200.00 | | x-ray, thoracic, 4 or more views | |
| 72100 | \$175.00 | | x-ray, lumbosacral 2 or 3 views | |
| 72110 | \$200.00 | | x-ray, lumbosacral 4 or more views | |
| 97001 | \$105.00 | | Physical therapy, initial evaluation | |
| 97002 | \$75.00 | | Physical therapy, re-evaluation | |
| 95831 | \$150.00 | ea 15 min | manual muscle testing | |
| 97110 | \$50.00 | ea 15 min | therapeutic exercises | |
| 97112 | \$50.00 | ea 15 min | neuromuscular reeducation | |
| 97140 | \$50.00 | ea 15 min | manual therapy-MFR | |
| 97530 | \$50.00 | ea 15 min | therapeutic activities PROM | |
| 97116 | \$45.00 | ea 15 min | gait training | |
| 97535 | \$45.00 | ea 15 min | patient education ADL | |
| 97124 | \$45.00 | ea 15 min | massage | |
| 97010 | \$45.00 | ea 15 min | hot/cold pack | |
| 97014 | \$45.00 | ea 15 min | e-stim | |
| 97035 | \$45.00 | ea 15 min | ultrasound | |
| 97012 | \$75.00 | | Axial Decompression Therapy | |
| 97032 | \$45.00 | | microcurrent | |
| 97026 | \$55.00 | | Cold Laser/Infrared Therapy | |

Patient Signature

Date



OFFICE OF INSURANCE REGULATION
Bureau of Property & Casualty Form 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.

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.

ADDITIONAL AUTHORIZATIONS AND DIRECTIONS TO INSURER

AUTHORIZATION FOR DISCLOSURE OF INSURANCE DECLARATIONS PAGE: I, the patient and insured, further authorize and direct any insurance company that may be obligated to pay any insurance benefits to me, or on my behalf, to provide to PROVIDER NAME a copy of any declarations page of any insurance policy that may provide any insurance benefits to me for the aforesaid accident.

AUTHORIZATION FOR DISCLOSURE OF INSURANCE PAYMENT RECORD: I further authorize and direct any insurance company that may be obligated to pay any insurance benefits to me, or on my behalf, to provide to PROVIDER NAME a copy of any ledger or payment record of payments made under any insurance coverage available to me, without redacting the names of any other medical provider or entity to whom insurance benefits have been paid and without redacting the amount of any insurance benefits that have been paid.

DIRECTION NOT TO EXHAUST BENEFITS BY PAYMENT OF OTHER CLAIMS: I further authorize and direct any insurance company that may be obligated to pay any insurance benefits to me, or on my behalf, to not exhaust insurance benefits or coverage until all claims submitted by Scenic Health Alliance have been paid in full, or at 80% if the insurance policy is limited to pay 80% coverage of medical claims. If any insurance company obligated to pay any insurance benefits to me, or on my behalf, has denied payment of a claim submitted by Scenic Health Alliance, or made payment to Scenic Health Alliance at an amount lesser than the amount billed, or lesser than 80% of the amount billed if my coverage is limited to 80% for medical claims, I direct the aforesaid insurance company to hold in escrow the amount in dispute, and if other claims would exhaust benefits I direct the aforesaid insurance company to hold in escrow the disputed amount and to not exhaust benefits or coverage by payment of the amount I have hereby requested be held in escrow. I further authorize and direct the aforesaid insurance company to notify Scenic Health Alliance that benefits have been exhausted except for the amount held in escrow, to enable Scenic Health Alliance to attempt to resolve the disputed claim in a manner acceptable to Scenic Health Alliance.

DIRECTION TO INSURER TO MAINTAIN CONFIDENTIALITY: I further direct any insurance company that may be obligated to pay any insurance benefits to me, or on my behalf, to maintain the privacy and confidentiality of my medical records. I do not authorize any insurer to provide my medical records to anyone without first obtaining a written authorization from me to provide the medical records to any other entity.

AUTHORIZATION FOR RELEASE OF RECORDS TO PROVIDER: I hereby authorize any insurance company that may be obligated to pay any insurance benefits to me, or on my behalf, to release a copy of my complete medical records in possession of such insurer to PROVIDER NAME upon the request of PROVIDER NAME. This authorization includes the authorization to release to PROVIDER NAME a copy of any medical examination or evaluation of me requested by any insurance company.

DIRECTION TO INSURER TO PROVIDE TO PROVIDER ADVANCE NOTICE OF IME OR EUO: I further authorize and direct any insurance company that may be obligated to pay any insurance benefits to me, or on my behalf, to provide at least 15 days advance notice to PROVIDER NAME of any physical examination or examination under oath of myself that any insurance company may schedule.

Please read this document completely before signing . .If you do not completely understand this document or have any questions about this document, please ask us to explain it to you . .If there is any portion of this document that you do not wish to authorize, we will remove that portion from this document. Your signature below is your agreement you fully understand this document and you fully agree to the terms of this document.

Patient's signature (or guardian's signature)

Date

Witness to patient or guardian's signature

Date



4711 Scenic Highway Pensacola, FL 32504 | 850.438.5900 | www.scenichealth.com
Charles P. McGrath, D.C., Clinic Director, Jason E. Stern, D.C., Stephne D. West, D.C., Bernard J. Keenum, D.C.

ACKNOWLEDGMENT 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.

Patient's Name (please print)

Signature

Date

Parent, Guardian or Patient's legal representative (please print)

Signature

Date

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

Automobile Accident Description

If you do not know the answer to any of the following questions, please leave the question(s) blank.

| |
|---|
| 1. Your Vehicle Type <input type="radio"/> Car <input type="radio"/> Station Wagon <input type="radio"/> Van <input type="radio"/> Pickup Truck <input type="radio"/> Bus <input type="radio"/> Large Truck <input type="radio"/> Other _____ |
| 2. Your Position in Vehicle <input type="radio"/> Driver <input type="radio"/> Front Passenger <input type="radio"/> Left Rear Passenger <input type="radio"/> Right Rear Passenger <input type="radio"/> Other _____ |
| 3. What was your vehicle doing at the time of the accident? <input type="radio"/> Stopped at Intersection <input type="radio"/> Stopped in Traffic <input type="radio"/> Stopped at light <input type="radio"/> Making a Right Turning <input type="radio"/> Making a Left Turn <input type="radio"/> Parking <input type="radio"/> Proceeding Along <input type="radio"/> Slowing Down <input type="radio"/> Accelerating <input type="radio"/> Other _____ |
| 4. Time/Speed/Damage Time of Accident _____ Your Vehicle's Speed _____ mph Their Vehicle's Speed _____ mph Damage to your vehicle: <input type="radio"/> Mild <input type="radio"/> Moderate <input type="radio"/> Totaled |
| 5. Details of Accident Visibility at time of accident: <input type="radio"/> Poor <input type="radio"/> Fair <input type="radio"/> Good Who hit who/what? <input type="radio"/> You hit other vehicle <input type="radio"/> Other vehicle hit you <input type="radio"/> You hit object _____ Point of Impact: <input type="radio"/> Head on <input type="radio"/> Left-Front <input type="radio"/> Right-Front <input type="radio"/> Rear-End <input type="radio"/> Left-Rear <input type="radio"/> Right Rear |
| 6. Road Conditions at Time of Accident <input type="radio"/> Icy <input type="radio"/> Wet <input type="radio"/> Sandy <input type="radio"/> Dark <input type="radio"/> Clean and Dry |
| 7. Body Position, etc. Did you see the accident coming? <input type="radio"/> Yes <input type="radio"/> No Did you have a seat belt on? <input type="radio"/> Yes <input type="radio"/> No Were you braced for the impact? <input type="radio"/> Yes <input type="radio"/> No Did you have a shoulder harness on? <input type="radio"/> Yes <input type="radio"/> No Does your vehicle have headrests? <input type="radio"/> Yes <input type="radio"/> No What was the position of your headrest at the time of the impact? <input type="radio"/> Even with top of head <input type="radio"/> Even with bottom of head <input type="radio"/> Middle of neck What was the direction of your head at the time of the impact? <input type="radio"/> Facing Straight Forward <input type="radio"/> Turned to the right <input type="radio"/> Turned to the left |
| 8. Additional Accident Information |
| 9. During the Accident: Did your body strike the inside of your vehicle? <input type="radio"/> Yes <input type="radio"/> No If yes, describe _____ Did you lose consciousness during the injury? <input type="radio"/> Yes <input type="radio"/> No If yes, how long _____ Your vehicle's estimated damage? _____ Damage to their vehicle: <input type="radio"/> Mild <input type="radio"/> Moderate <input type="radio"/> Totaled Did police show up at the scene? <input type="radio"/> Yes <input type="radio"/> No Was an accident report filled out? <input type="radio"/> Yes <input type="radio"/> No |
| 10. After the Accident Check off your symptoms right after and a few days following: <input type="checkbox"/> Headache <input type="checkbox"/> Dizziness <input type="checkbox"/> Mid Back Pain <input type="checkbox"/> Cold Hands <input type="checkbox"/> Neck Pain <input type="checkbox"/> Low Back Pain <input type="checkbox"/> Cold Feet <input type="checkbox"/> Confusion <input type="checkbox"/> Nausea <input type="checkbox"/> Nervousness <input type="checkbox"/> Diarrhea <input type="checkbox"/> Tension <input type="checkbox"/> Neck Stiffness <input type="checkbox"/> Toe Numbness <input type="checkbox"/> Depression <input type="checkbox"/> Fainting <input type="checkbox"/> Irritability <input type="checkbox"/> Loss of Taste <input type="checkbox"/> Anxious <input type="checkbox"/> Loss of Smell <input type="checkbox"/> Ringing in Ears <input type="checkbox"/> Chest Pain <input type="checkbox"/> Fatigue <input type="checkbox"/> Constipation <input type="checkbox"/> Pain Behind Eyes <input type="checkbox"/> Shortness of Breath <input type="checkbox"/> Sleeping problems Others _____ |
| 11. Emergency Room? Where did you go after the accident? <input type="radio"/> Home <input type="radio"/> Work <input type="radio"/> Hospital ER <input type="radio"/> Private Doctor How did you get there? <input type="radio"/> Drove self <input type="radio"/> Ambulance <input type="radio"/> Police <input type="radio"/> Someone else Were X-rays done? <input type="radio"/> Yes <input type="radio"/> No Body parts X-rayed _____ Was lab work done? <input type="radio"/> Yes <input type="radio"/> No Kind of lab work? _____ X-rays revealed _____ Treatments: <input type="radio"/> Cervical Collar <input type="radio"/> Ice Other _____ Medications _____ Follow-up Instructions _____ |
| 12. Treatment History Doctors seen prior to your first visit at this office 1. Dr. _____ First visit date ____/____/____ Specialty _____ X-rays? <input type="radio"/> Yes <input type="radio"/> No Types of treatments _____ Number of Treatments _____ Currently Treating? <input type="radio"/> Yes <input type="radio"/> No Did treatments benefit you? <input type="radio"/> Yes <input type="radio"/> No Last visit date ____/____/____ 2. Dr. _____ First visit date ____/____/____ Specialty _____ X-rays? <input type="radio"/> Yes <input type="radio"/> No Types of treatments _____ Number of Treatments _____ Currently Treating? <input type="radio"/> Yes <input type="radio"/> No Did treatments benefit you? <input type="radio"/> Yes <input type="radio"/> No Last visit date ____/____/____ |

Description of Symptoms (3pgs)

(Describe your symptoms in the sections below in the order of severity if possible.)

I. FIRST CURRENT SYMPTOM - Please check off the circles below to describe your **FIRST** symptom.

Describe **ONE** symptom per section/page.

1. Check only one body location of **FIRST** symptom:

- | | |
|---|--|
| <input type="radio"/> Headaches (<input type="radio"/> Left <input type="radio"/> Right <input type="radio"/> Back <input type="radio"/> Front <input type="radio"/> Top) | <input type="radio"/> Upper Arm (<input type="radio"/> Top <input type="radio"/> Bottom) |
| <input type="radio"/> Jaw (<input type="radio"/> Left <input type="radio"/> Right <input type="radio"/> Back <input type="radio"/> Front) | <input type="radio"/> Forearm (<input type="radio"/> Top <input type="radio"/> Bottom) |
| <input type="radio"/> Eye (<input type="radio"/> Left <input type="radio"/> Right <input type="radio"/> Back <input type="radio"/> Front) | <input type="radio"/> Hand (<input type="radio"/> Top <input type="radio"/> Bottom) |
| <input type="radio"/> Neck (<input type="radio"/> Left <input type="radio"/> Right <input type="radio"/> Back <input type="radio"/> Front) | <input type="radio"/> Ankle (<input type="radio"/> Top <input type="radio"/> Bottom) |
| <input type="radio"/> Upper Back (<input type="radio"/> Left <input type="radio"/> Right <input type="radio"/> Center) | <input type="radio"/> Leg (<input type="radio"/> Top <input type="radio"/> Bottom) |
| <input type="radio"/> Mid Back (<input type="radio"/> Left <input type="radio"/> Right <input type="radio"/> Center) | <input type="radio"/> Foot (<input type="radio"/> Top <input type="radio"/> Bottom) |
| <input type="radio"/> Low Back (<input type="radio"/> Left <input type="radio"/> Right <input type="radio"/> Center) | <input type="radio"/> Hip (<input type="radio"/> Left <input type="radio"/> Right) |
| <input type="radio"/> Chest (<input type="radio"/> Left <input type="radio"/> Right <input type="radio"/> Center) | <input type="radio"/> Buttocks (<input type="radio"/> Left <input type="radio"/> Right) |
| <input type="radio"/> Abdomen (<input type="radio"/> Left <input type="radio"/> Right <input type="radio"/> Center) | <input type="radio"/> Shoulder (<input type="radio"/> Left <input type="radio"/> Right) |
| <input type="radio"/> Ribs (<input type="radio"/> Left <input type="radio"/> Right <input type="radio"/> Center) | Other _____ |

2. Types of Pain of **FIRST** Symptom:

- Dull Sharp Throbbing Burning Numbing Tingling Cramping Spasm
 Pounding Pounding
 Aching Cutting Constricting Stinging Shooting Other _____

3. Pain Frequency of **FIRST** Symptom

- Up to ¼ of awake time ¼ to ½ of awake time ½ to ¾ of awake time ¾ to 1 of awake time
 Most all the time

4. Pain Intensity of **FIRST** Symptom. (How it affects your daily activities.)

- Doesn't affect Somewhat affects Seriously affects Seriously affects Prevents activities

5. Does the pain of the **FIRST** Symptom radiate into other body parts?

- | | |
|---|--|
| <input type="radio"/> Headaches (<input type="radio"/> Left <input type="radio"/> Right <input type="radio"/> Back <input type="radio"/> Front <input type="radio"/> Top) | <input type="radio"/> Upper Arm (<input type="radio"/> Top <input type="radio"/> Bottom) |
| <input type="radio"/> Jaw (<input type="radio"/> Left <input type="radio"/> Right <input type="radio"/> Back <input type="radio"/> Front) | <input type="radio"/> Forearm (<input type="radio"/> Top <input type="radio"/> Bottom) |
| <input type="radio"/> Eye (<input type="radio"/> Left <input type="radio"/> Right <input type="radio"/> Back <input type="radio"/> Front) | <input type="radio"/> Hand (<input type="radio"/> Top <input type="radio"/> Bottom) |
| <input type="radio"/> Neck (<input type="radio"/> Left <input type="radio"/> Right <input type="radio"/> Center) | <input type="radio"/> Ankle (<input type="radio"/> Top <input type="radio"/> Bottom) |
| <input type="radio"/> Upper Back (<input type="radio"/> Left <input type="radio"/> Right <input type="radio"/> Center) | <input type="radio"/> Leg (<input type="radio"/> Top <input type="radio"/> Bottom) |
| <input type="radio"/> Mid Back (<input type="radio"/> Left <input type="radio"/> Right <input type="radio"/> Center) | <input type="radio"/> Foot (<input type="radio"/> Top <input type="radio"/> Bottom) |
| <input type="radio"/> Low Back (<input type="radio"/> Left <input type="radio"/> Right <input type="radio"/> Center) | <input type="radio"/> Hip (<input type="radio"/> Left <input type="radio"/> Right) |
| <input type="radio"/> Chest (<input type="radio"/> Left <input type="radio"/> Right <input type="radio"/> Center) | <input type="radio"/> Buttocks (<input type="radio"/> Left <input type="radio"/> Right) |
| <input type="radio"/> Abdomen (<input type="radio"/> Left <input type="radio"/> Right <input type="radio"/> Center) | <input type="radio"/> Shoulder (<input type="radio"/> Left <input type="radio"/> Right) |
| <input type="radio"/> Ribs (<input type="radio"/> Left <input type="radio"/> Right <input type="radio"/> Center) | Other _____ |

6. Does the pain of the **FIRST** Symptom radiate into other body parts?

- | | |
|---|--|
| <input type="radio"/> In the AM (<input type="radio"/> Begins <input type="radio"/> Aggravates <input type="radio"/> Relieves) | <input type="radio"/> Bending Backward (<input type="radio"/> Begins <input type="radio"/> Aggravates <input type="radio"/> Relieves) |
| <input type="radio"/> In the PM (<input type="radio"/> Begins <input type="radio"/> Aggravates <input type="radio"/> Relieves) | <input type="radio"/> Bending Forward (<input type="radio"/> Begins <input type="radio"/> Aggravates <input type="radio"/> Relieves) |
| <input type="radio"/> Sitting (<input type="radio"/> Begins <input type="radio"/> Aggravates <input type="radio"/> Relieves) | <input type="radio"/> Bending Left (<input type="radio"/> Begins <input type="radio"/> Aggravates <input type="radio"/> Relieves) |
| <input type="radio"/> Standing (<input type="radio"/> Begins <input type="radio"/> Aggravates <input type="radio"/> Relieves) | <input type="radio"/> Bending Right (<input type="radio"/> Begins <input type="radio"/> Aggravates <input type="radio"/> Relieves) |
| <input type="radio"/> Lifting (<input type="radio"/> Begins <input type="radio"/> Aggravates <input type="radio"/> Relieves) | <input type="radio"/> Twisting Left (<input type="radio"/> Begins <input type="radio"/> Aggravates <input type="radio"/> Relieves) |
| <input type="radio"/> Straining (<input type="radio"/> Begins <input type="radio"/> Aggravates <input type="radio"/> Relieves) | <input type="radio"/> Twisting Right (<input type="radio"/> Begins <input type="radio"/> Aggravates <input type="radio"/> Relieves) |
| <input type="radio"/> Sneezing (<input type="radio"/> Begins <input type="radio"/> Aggravates <input type="radio"/> Relieves) | <input type="radio"/> Other _____ |
| <input type="radio"/> Coughing (<input type="radio"/> Begins <input type="radio"/> Aggravates <input type="radio"/> Relieves) | <input type="radio"/> Other _____ |
| <input type="radio"/> Bending Forward (<input type="radio"/> Begins <input type="radio"/> Aggravates <input type="radio"/> Relieves) | <input type="radio"/> Other _____ |

II. SECOND CURRENT SYMPTOM - Please check off the circles below to describe your SECOND symptom.

Describe **ONE** symptom per section/page.

1. Check only one body location of SECOND symptom:

- | | |
|---|--|
| <input type="radio"/> Headaches (<input type="radio"/> Left <input type="radio"/> Right <input type="radio"/> Back <input type="radio"/> Front <input type="radio"/> Top) | <input type="radio"/> Upper Arm (<input type="radio"/> Top <input type="radio"/> Bottom) |
| <input type="radio"/> Jaw (<input type="radio"/> Left <input type="radio"/> Right <input type="radio"/> Back <input type="radio"/> Front) | <input type="radio"/> Forearm (<input type="radio"/> Top <input type="radio"/> Bottom) |
| <input type="radio"/> Eye (<input type="radio"/> Left <input type="radio"/> Right <input type="radio"/> Back <input type="radio"/> Front) | <input type="radio"/> Hand (<input type="radio"/> Top <input type="radio"/> Bottom) |
| <input type="radio"/> Neck (<input type="radio"/> Left <input type="radio"/> Right <input type="radio"/> Back <input type="radio"/> Front) | <input type="radio"/> Ankle (<input type="radio"/> Top <input type="radio"/> Bottom) |
| <input type="radio"/> Upper Back (<input type="radio"/> Left <input type="radio"/> Right <input type="radio"/> Center) | <input type="radio"/> Leg (<input type="radio"/> Top <input type="radio"/> Bottom) |
| <input type="radio"/> Mid Back (<input type="radio"/> Left <input type="radio"/> Right <input type="radio"/> Center) | <input type="radio"/> Foot (<input type="radio"/> Top <input type="radio"/> Bottom) |
| <input type="radio"/> Low Back (<input type="radio"/> Left <input type="radio"/> Right <input type="radio"/> Center) | <input type="radio"/> Hip (<input type="radio"/> Left <input type="radio"/> Right) |
| <input type="radio"/> Chest (<input type="radio"/> Left <input type="radio"/> Right <input type="radio"/> Center) | <input type="radio"/> Buttocks (<input type="radio"/> Left <input type="radio"/> Right) |
| <input type="radio"/> Abdomen (<input type="radio"/> Left <input type="radio"/> Right <input type="radio"/> Center) | <input type="radio"/> Shoulder (<input type="radio"/> Left <input type="radio"/> Right) |
| <input type="radio"/> Ribs (<input type="radio"/> Left <input type="radio"/> Right <input type="radio"/> Center) | Other _____ |

2. Types of Pain of SECOND Symptom:

- Dull Sharp Throbbing Burning Numbing Tingling Cramping Spasm
 Pounding Pounding
 Aching Cutting Constricting Stinging Shooting Other _____

3. Pain Frequency of SECOND Symptom

- Up to ¼ of awake time ¼ to ½ of awake time ½ to ¾ of awake time ¾ to 1 of awake time
 Most all the time

4. Pain Intensity of SECOND Symptom. (How it affects your daily activities.)

- Doesn't affect Somewhat affects Seriously affects Seriously affects Prevents activities

5. Does the pain of the SECOND Symptom radiate into other body parts?

- | | |
|---|--|
| <input type="radio"/> Headaches (<input type="radio"/> Left <input type="radio"/> Right <input type="radio"/> Back <input type="radio"/> Front <input type="radio"/> Top) | <input type="radio"/> Upper Arm (<input type="radio"/> Top <input type="radio"/> Bottom) |
| <input type="radio"/> Jaw (<input type="radio"/> Left <input type="radio"/> Right <input type="radio"/> Back <input type="radio"/> Front) | <input type="radio"/> Forearm (<input type="radio"/> Top <input type="radio"/> Bottom) |
| <input type="radio"/> Eye (<input type="radio"/> Left <input type="radio"/> Right <input type="radio"/> Back <input type="radio"/> Front) | <input type="radio"/> Hand (<input type="radio"/> Top <input type="radio"/> Bottom) |
| <input type="radio"/> Neck (<input type="radio"/> Left <input type="radio"/> Right <input type="radio"/> Center) | <input type="radio"/> Ankle (<input type="radio"/> Top <input type="radio"/> Bottom) |
| <input type="radio"/> Upper Back (<input type="radio"/> Left <input type="radio"/> Right <input type="radio"/> Center) | <input type="radio"/> Leg (<input type="radio"/> Top <input type="radio"/> Bottom) |
| <input type="radio"/> Mid Back (<input type="radio"/> Left <input type="radio"/> Right <input type="radio"/> Center) | <input type="radio"/> Foot (<input type="radio"/> Top <input type="radio"/> Bottom) |
| <input type="radio"/> Low Back (<input type="radio"/> Left <input type="radio"/> Right <input type="radio"/> Center) | <input type="radio"/> Hip (<input type="radio"/> Left <input type="radio"/> Right) |
| <input type="radio"/> Chest (<input type="radio"/> Left <input type="radio"/> Right <input type="radio"/> Center) | <input type="radio"/> Buttocks (<input type="radio"/> Left <input type="radio"/> Right) |
| <input type="radio"/> Abdomen (<input type="radio"/> Left <input type="radio"/> Right <input type="radio"/> Center) | <input type="radio"/> Shoulder (<input type="radio"/> Left <input type="radio"/> Right) |
| <input type="radio"/> Ribs (<input type="radio"/> Left <input type="radio"/> Right <input type="radio"/> Center) | Other _____ |

6. Does the pain of the SECOND Symptom radiate into other body parts?

- | | |
|---|--|
| <input type="radio"/> In the AM (<input type="radio"/> Begins <input type="radio"/> Aggravates <input type="radio"/> Relieves) | <input type="radio"/> Bending Backward (<input type="radio"/> Begins <input type="radio"/> Aggravates <input type="radio"/> Relieves) |
| <input type="radio"/> In the PM (<input type="radio"/> Begins <input type="radio"/> Aggravates <input type="radio"/> Relieves) | <input type="radio"/> Bending Forward (<input type="radio"/> Begins <input type="radio"/> Aggravates <input type="radio"/> Relieves) |
| <input type="radio"/> Sitting (<input type="radio"/> Begins <input type="radio"/> Aggravates <input type="radio"/> Relieves) | <input type="radio"/> Bending Left (<input type="radio"/> Begins <input type="radio"/> Aggravates <input type="radio"/> Relieves) |
| <input type="radio"/> Standing (<input type="radio"/> Begins <input type="radio"/> Aggravates <input type="radio"/> Relieves) | <input type="radio"/> Bending Right (<input type="radio"/> Begins <input type="radio"/> Aggravates <input type="radio"/> Relieves) |
| <input type="radio"/> Lifting (<input type="radio"/> Begins <input type="radio"/> Aggravates <input type="radio"/> Relieves) | <input type="radio"/> Twisting Left (<input type="radio"/> Begins <input type="radio"/> Aggravates <input type="radio"/> Relieves) |
| <input type="radio"/> Straining (<input type="radio"/> Begins <input type="radio"/> Aggravates <input type="radio"/> Relieves) | <input type="radio"/> Twisting Right (<input type="radio"/> Begins <input type="radio"/> Aggravates <input type="radio"/> Relieves) |
| <input type="radio"/> Sneezing (<input type="radio"/> Begins <input type="radio"/> Aggravates <input type="radio"/> Relieves) | <input type="radio"/> Other _____ |
| <input type="radio"/> Coughing (<input type="radio"/> Begins <input type="radio"/> Aggravates <input type="radio"/> Relieves) | <input type="radio"/> Other _____ |
| <input type="radio"/> Bending Forward (<input type="radio"/> Begins <input type="radio"/> Aggravates <input type="radio"/> Relieves) | <input type="radio"/> Other _____ |

II. THIRD CURRENT SYMPTOM - Please check off the circles below to describe your **THIRD** symptom.

Describe **ONE** symptom per section/page.

1. Check only one body location of **THIRD** symptom:

- | | |
|---|---|
| <input type="checkbox"/> Headaches (<input type="checkbox"/> Left <input type="checkbox"/> Right <input type="checkbox"/> Back <input type="checkbox"/> Front <input type="checkbox"/> Top) | <input type="checkbox"/> Upper Arm (<input type="checkbox"/> Top <input type="checkbox"/> Bottom) |
| <input type="checkbox"/> Jaw (<input type="checkbox"/> Left <input type="checkbox"/> Right <input type="checkbox"/> Back <input type="checkbox"/> Front) | <input type="checkbox"/> Forearm (<input type="checkbox"/> Top <input type="checkbox"/> Bottom) |
| <input type="checkbox"/> Eye (<input type="checkbox"/> Left <input type="checkbox"/> Right <input type="checkbox"/> Back <input type="checkbox"/> Front) | <input type="checkbox"/> Hand (<input type="checkbox"/> Top <input type="checkbox"/> Bottom) |
| <input type="checkbox"/> Neck (<input type="checkbox"/> Left <input type="checkbox"/> Right <input type="checkbox"/> Back <input type="checkbox"/> Front) | <input type="checkbox"/> Ankle (<input type="checkbox"/> Top <input type="checkbox"/> Bottom) |
| <input type="checkbox"/> Upper Back (<input type="checkbox"/> Left <input type="checkbox"/> Right <input type="checkbox"/> Center) | <input type="checkbox"/> Leg (<input type="checkbox"/> Top <input type="checkbox"/> Bottom) |
| <input type="checkbox"/> Mid Back (<input type="checkbox"/> Left <input type="checkbox"/> Right <input type="checkbox"/> Center) | <input type="checkbox"/> Foot (<input type="checkbox"/> Top <input type="checkbox"/> Bottom) |
| <input type="checkbox"/> Low Back (<input type="checkbox"/> Left <input type="checkbox"/> Right <input type="checkbox"/> Center) | <input type="checkbox"/> Hip (<input type="checkbox"/> Left <input type="checkbox"/> Right) |
| <input type="checkbox"/> Chest (<input type="checkbox"/> Left <input type="checkbox"/> Right <input type="checkbox"/> Center) | <input type="checkbox"/> Buttocks (<input type="checkbox"/> Left <input type="checkbox"/> Right) |
| <input type="checkbox"/> Abdomen (<input type="checkbox"/> Left <input type="checkbox"/> Right <input type="checkbox"/> Center) | <input type="checkbox"/> Shoulder (<input type="checkbox"/> Left <input type="checkbox"/> Right) |
| <input type="checkbox"/> Ribs (<input type="checkbox"/> Left <input type="checkbox"/> Right <input type="checkbox"/> Center) | Other _____ |

2. Types of Pain of **THIRD** Symptom:

- Dull Sharp Throbbing Burning Numbing Tingling Cramping Spasm
 Pounding Pounding
 Aching Cutting Constricting Stinging Shooting Other _____

3. Pain Frequency of **THIRD** Symptom

- Up to ¼ of awake time ¼ to ½ of awake time ½ to ¾ of awake time ½ to ¾ of awake time
 Most all the time

4. Pain Intensity of **THIRD** Symptom. (How it affects your daily activities.)

- Doesn't affect Somewhat affects Seriously affects Seriously affects Prevents activities

5. Does the pain of the **THIRD** Symptom radiate into other body parts?

- | | |
|---|---|
| <input type="checkbox"/> Headaches (<input type="checkbox"/> Left <input type="checkbox"/> Right <input type="checkbox"/> Back <input type="checkbox"/> Front <input type="checkbox"/> Top) | <input type="checkbox"/> Upper Arm (<input type="checkbox"/> Top <input type="checkbox"/> Bottom) |
| <input type="checkbox"/> Jaw (<input type="checkbox"/> Left <input type="checkbox"/> Right <input type="checkbox"/> Back <input type="checkbox"/> Front) | <input type="checkbox"/> Forearm (<input type="checkbox"/> Top <input type="checkbox"/> Bottom) |
| <input type="checkbox"/> Eye (<input type="checkbox"/> Left <input type="checkbox"/> Right <input type="checkbox"/> Back <input type="checkbox"/> Front) | <input type="checkbox"/> Hand (<input type="checkbox"/> Top <input type="checkbox"/> Bottom) |
| <input type="checkbox"/> Neck (<input type="checkbox"/> Left <input type="checkbox"/> Right <input type="checkbox"/> Center) | <input type="checkbox"/> Ankle (<input type="checkbox"/> Top <input type="checkbox"/> Bottom) |
| <input type="checkbox"/> Upper Back (<input type="checkbox"/> Left <input type="checkbox"/> Right <input type="checkbox"/> Center) | <input type="checkbox"/> Leg (<input type="checkbox"/> Top <input type="checkbox"/> Bottom) |
| <input type="checkbox"/> Mid Back (<input type="checkbox"/> Left <input type="checkbox"/> Right <input type="checkbox"/> Center) | <input type="checkbox"/> Foot (<input type="checkbox"/> Top <input type="checkbox"/> Bottom) |
| <input type="checkbox"/> Low Back (<input type="checkbox"/> Left <input type="checkbox"/> Right <input type="checkbox"/> Center) | <input type="checkbox"/> Hip (<input type="checkbox"/> Left <input type="checkbox"/> Right) |
| <input type="checkbox"/> Chest (<input type="checkbox"/> Left <input type="checkbox"/> Right <input type="checkbox"/> Center) | <input type="checkbox"/> Buttocks (<input type="checkbox"/> Left <input type="checkbox"/> Right) |
| <input type="checkbox"/> Abdomen (<input type="checkbox"/> Left <input type="checkbox"/> Right <input type="checkbox"/> Center) | <input type="checkbox"/> Shoulder (<input type="checkbox"/> Left <input type="checkbox"/> Right) |
| <input type="checkbox"/> Ribs (<input type="checkbox"/> Left <input type="checkbox"/> Right <input type="checkbox"/> Center) | Other _____ |

6. Does the pain of the **THIRD** Symptom radiate into other body parts?

- | | |
|--|--|
| <input type="checkbox"/> In the AM | <input type="checkbox"/> Bending Backward |
| (<input type="checkbox"/> Begins <input type="checkbox"/> Aggravates <input type="checkbox"/> Relieves) | (<input type="checkbox"/> Begins <input type="checkbox"/> Aggravates <input type="checkbox"/> Relieves) |
| <input type="checkbox"/> In the PM | <input type="checkbox"/> Bending Forward |
| (<input type="checkbox"/> Begins <input type="checkbox"/> Aggravates <input type="checkbox"/> Relieves) | (<input type="checkbox"/> Begins <input type="checkbox"/> Aggravates <input type="checkbox"/> Relieves) |
| <input type="checkbox"/> Sitting | <input type="checkbox"/> Bending Left |
| (<input type="checkbox"/> Begins <input type="checkbox"/> Aggravates <input type="checkbox"/> Relieves) | (<input type="checkbox"/> Begins <input type="checkbox"/> Aggravates <input type="checkbox"/> Relieves) |
| <input type="checkbox"/> Standing | <input type="checkbox"/> Bending Right |
| (<input type="checkbox"/> Begins <input type="checkbox"/> Aggravates <input type="checkbox"/> Relieves) | (<input type="checkbox"/> Begins <input type="checkbox"/> Aggravates <input type="checkbox"/> Relieves) |
| <input type="checkbox"/> Lifting | <input type="checkbox"/> Twisting Left |
| (<input type="checkbox"/> Begins <input type="checkbox"/> Aggravates <input type="checkbox"/> Relieves) | (<input type="checkbox"/> Begins <input type="checkbox"/> Aggravates <input type="checkbox"/> Relieves) |
| <input type="checkbox"/> Straining | <input type="checkbox"/> Twisting Right |
| (<input type="checkbox"/> Begins <input type="checkbox"/> Aggravates <input type="checkbox"/> Relieves) | (<input type="checkbox"/> Begins <input type="checkbox"/> Aggravates <input type="checkbox"/> Relieves) |
| <input type="checkbox"/> Sneezing | <input type="checkbox"/> Other _____ |
| (<input type="checkbox"/> Begins <input type="checkbox"/> Aggravates <input type="checkbox"/> Relieves) | (<input type="checkbox"/> Begins <input type="checkbox"/> Aggravates <input type="checkbox"/> Relieves) |
| <input type="checkbox"/> Coughing | <input type="checkbox"/> Other _____ |
| (<input type="checkbox"/> Begins <input type="checkbox"/> Aggravates <input type="checkbox"/> Relieves) | (<input type="checkbox"/> Begins <input type="checkbox"/> Aggravates <input type="checkbox"/> Relieves) |
| <input type="checkbox"/> Bending Forward | <input type="checkbox"/> Other _____ |
| (<input type="checkbox"/> Begins <input type="checkbox"/> Aggravates <input type="checkbox"/> Relieves) | (<input type="checkbox"/> Begins <input type="checkbox"/> Aggravates <input type="checkbox"/> Relieves) |

Activities of Daily Living Assessment

Rate your current difficulties resulting from your accident/injury. Use the following \ scale and **WRITE IN THE APROPRIATE NUMBER** that most closely describes your current degree of difficulty.

- | | |
|--|---|
| 1= Can do it without difficulty. | 2= Can do it without much difficulty, despite some pain. |
| 3= Manage to do it by myself despite pain. | 4= Manage to do it despite the pain, but only if I have help. |
| 5= Cannot do it at all, because of the pain. | |

Mark areas pertaining to your activities.

Difficulties with Self Care and Personal Hygiene Activities

| | | | |
|-----------------------------|------------------------------|------------------------------|------------------------------|
| Bathing --1 2 3 4 5 | Drying Hair --1 2 3 4 5 | Brushing Teeth --1 2 3 4 5 | Putting on Shoes --1 2 3 4 5 |
| Showering --1 2 3 4 5 | Combing Hair --1 2 3 4 5 | Preparing Meals --1 2 3 4 5 | Taking out trash --1 2 3 4 5 |
| Chewing --1 2 3 4 5 | Swallowing --1 2 3 4 5 | Tying Shoes --1 2 3 4 5 | Doing Laundry --1 2 3 4 5 |
| Washing Face --1 2 3 4 5 | Making Bed --1 2 3 4 5 | Washing Hair --1 2 3 4 5 | Drying Hair --1 2 3 4 5 |
| Cleaning Dishes --1 2 3 4 5 | Putting on shirt --1 2 3 4 5 | Putting on Pants --1 2 3 4 5 | Going to Toilet --1 2 3 4 5 |

Difficulties with Physical Activities

| | | | |
|---------------------------------------|--------------------------------------|---------------------------------------|--------------------------------------|
| Sitting --1 2 3 4 5 | Walking --1 2 3 4 5 | Squatting --1 2 3 4 5 | Running--1 2 3 4 5 |
| Bending Left --1 2 3 4 5 | Bending Right --1 2 3 4 5 | Bending Forward --1 2 3 4 5 | Bending Back --1 2 3 4 5 |
| Stooping --1 2 3 4 5 | Reaching --1 2 3 4 5 | Twisting Right --1 2 3 4 5 | Twisting Left --1 2 3 4 5 |
| Leaning Right --1 2 3 4 5 | Leaning Left --1 2 3 4 5 | Leaning Back --1 2 3 4 5 | Leaning Forward --1 2 3 4 5 |
| Standing --1 2 3 4 5 | Reclining --1 2 3 4 5 | Kneeling --1 2 3 4 5 | Sitting for Long Periods --1 2 3 4 5 |
| Standing for Long Periods --1 2 3 4 5 | Walking for Long Periods --1 2 3 4 5 | Kneeling for Long Periods --1 2 3 4 5 | |

Difficulties with Functional Activities

| | | |
|------------------------------------|--|---|
| Carrying small objects --1 2 3 4 5 | Lifting weights off of table --1 2 3 4 5 | Pushing things while seated --1 2 3 4 5 |
| Carrying large objects --1 2 3 4 5 | Lifting weights off of floor --1 2 3 4 5 | Pushing things while standing --1 2 3 4 5 |
| Exercising upper body --1 2 3 4 5 | Climbing stairs --1 2 3 4 5 | Pulling things while seated --1 2 3 4 5 |
| Exercising lower body --1 2 3 4 5 | Climbing Inclines --1 2 3 4 5 | Pulling things while standing --1 2 3 4 5 |

Difficulties with Social and Recreational Activities

| | | | |
|----------------------------|------------------------|----------------------|-------------------------------|
| Bowling --1 2 3 4 5 | Jogging --1 2 3 4 5 | Swimming --1 2 3 4 5 | Competitive Sports--1 2 3 4 5 |
| Golfing --1 2 3 4 5 | Ice Skating--1 2 3 4 5 | Dancing --1 2 3 4 5 | Skiing --1 2 3 4 5 |
| Roller skating --1 2 3 4 5 | Reaching --1 2 3 4 5 | Dating --1 2 3 4 5 | Dining out --1 2 3 4 5 |

Difficulties with Traveling

| | | |
|---|-------------------------------------|---|
| Driving a motor vehicle --1 2 3 4 5 | Riding in motor vehicle --1 2 3 4 5 | Riding on train --1 2 3 4 5 |
| Driving for long periods of time--1 2 3 4 5 | Riding airplane --1 2 3 4 5 | Riding for long periods of time --1 2 3 4 5 |

Use the following scale to describe the difficulties below:

- | | |
|--|--|
| 1= This area is not affected by my condition. | 2= This are is slightly affected by my condition. |
| 3= This area is moderately restricted by my condition. | 4= This area is seriously limited by my condition. |
| 5= This area is completely restricted by my condition. | ONLY MARK AFFECTED AREAS. |

Difficulties with Communication

| | | | | |
|----------------------------------|-------------------------------------|--------------------------------|----------------------|--------------------|
| Concentrating --1 2 3 4 5 | Hearing --1 2 3 4 5 | Listening --1 2 3 4 5 | Speaking --1 2 3 4 5 | Typing --1 2 3 4 5 |
| Reading printed type --1 2 3 4 5 | Reading computer screen --1 2 3 4 5 | Reading Road Signs --1 2 3 4 5 | | |

Difficulties with Senses

| | | | | |
|--------------------|---------------------|----------------------|----------------------|---------------------|
| Seeing --1 2 3 4 5 | Hearing --1 2 3 4 5 | Touching --1 2 3 4 5 | Smelling --1 2 3 4 5 | Tasting --1 2 3 4 5 |
|--------------------|---------------------|----------------------|----------------------|---------------------|

Difficulties with Hand Functions

| | | | |
|---------------------|----------------------|----------------------------------|------------------------------------|
| Holding --1 2 3 4 5 | Pinching --1 2 3 4 5 | Percussive Movements --1 2 3 4 5 | Sensory discrimination --1 2 3 4 5 |
|---------------------|----------------------|----------------------------------|------------------------------------|

Difficulties with Sleep and Sexual Function

| | |
|--|---|
| Ability to have normal, restful nights sleep --1 2 3 4 5 | Ability to participate in desired sexual activity --1 2 3 4 5 |
|--|---|

Additional Activity Dysfunction:

Prior Symptom History

| | |
|---|---|
| <ul style="list-style-type: none"> <input type="radio"/> I have NOT had prior symptoms similar to my current complaints. <input type="radio"/> My current complaints already existed and WERE worsened. <input type="radio"/> My current complaints already existed and were NOT worsened. <input type="radio"/> My history HAS contributed to my current symptoms. | <ul style="list-style-type: none"> <input type="radio"/> My history HAS NOT contributed to my current symptoms. <input type="radio"/> I'm not sure if my history has contributed to my current symptoms. |
|---|---|

My most recent prior similar symptoms (if applicable) occurred: ____ months ago ____ years ago Or on ____ / ____ / ____

Additional Symptom History: