PERSONAL INJURY VERIFICATION

Name_____ Email _____
Home Phone _____ Cell Phone _____
Address _____ City_____ Zip Code _____
Birth Date _____ Age _____ Marital Status _____
Employer _____ Occupation _____
Name of Spouse _____
In case of emergency, please notify _____ Phone _____

MED-PAY

Policy Holder _____
Insurance _____
City _____ State _____ Zip _____
Policy Number _____ Claim Number _____
$ Amount of coverage available _____ Adjuster _____
Phone Number _____ Fax Number_____

LIABILITY (3RD PARTY)

Policy Holder _____
Insurance _____
City _____ State _____ Zip _____
Policy Number _____ Claim Number _____
$ Amount of coverage available _____ Adjuster _____
Phone Number _____ Fax Number_____

ATTORNEY

Name _____
Address _____ City _____ State _____
Zip _____ Phone _____ Fax _____
Paralegal/Contact _____

AUTO ACCIDENT PATIENT HISTORY

Name _____ Date _____

History of the Occurrence

Date of Accident _____ Were you the DRIVER or PASSENGER

What type of vehicle were you in? CAR TRUCK VAN OTHER _____
Was it YOUR or SOMEONE ELSE's vehicle Were you wearing a seatbelt? YES or NO

Your vehicle: HIT ANOTHER VEHICLE or WAS HIT
In the: RIGHT LEFT REAR FRONT SIDE

Type of Accident: HEAD-ON COLLISION REAR-END COLLISION
BROADSIDE COLLISION FRONT IMPACT(rear-end car in front)
NON-COLLISION _____

Symptoms From The Accident

Did you get bleeding cuts or bruises? YES or NO

If Yes, what bleeding cuts did you get from this accident? _____
If Yes, what bruises did you get from this accident?_____

Please describe how you felt. Please be specific.

Immediately after the accident _____
Later that day/night _____
The next day _____

List of Medications

Medication	Purpose of Taking Medication	Any Side Effects

Work Status History

Occupation or Job Title _____
Have you missed time from work? YES or NO
If Yes, full time off work _____ to _____
Returned to Modified work _____ to _____
( ) Been unable to work since the accident

Arizona Chiropractic Neurology Center

Informed Consent Document

To the patient: Please read this entire document prior to signing it. It is important that you understand the information contained in this document. Please ask questions before you sign if there is anything that is unclear.

The nature of the chiropractic adjustment

The primary treatment we use as a Doctor of Chiropractic is spinal manipulative therapy (SMT, CMT). We will use this procedure to treat you. We may use our hands or a mechanical instrument upon your body in such a way as you move your joints. That may cause an audible "pop" or "click", much as you have experienced when you "crack" your knuckles. You may feel a sense of movement.

Analysis/Examination/Treatment

As part of the analysis, examination, and treatment, you are consenting to the following procedures:

--Spinal manipulative therapy --Palpation --Vital Signs
--Range of motion testing --Orthopedic testing --Neurological testing
--Postural analysis --EMS/TENS/Galvanic --Imaging and Lab studies as indicated
--hot/cold therapy --Stretching --massage therapy --exercise rehabilitation
--Microcurrent --low level laser therapy --SSEP --Functional medicine/supplements --Other_____

The material risks inherent in chiropractic care

As with any healthcare procedure, there are certain complications which may arise during chiropractic manipulation and physiotherapy. These complications include but are not limited to: fractures, disc injuries, dislocations, muscle strains, ligament sprains, cervical myelopathy, and burns. Some types of manipulation of the neck have been associated with injuries to the arteries in the neck leading to or contributing to complications including stroke (CVA). Some patients will feel some stiffness and soreness following the first few days of treatment. I will make every reasonable effort during the examination to screen for contraindications to care; however, if you have a condition that would otherwise not come to my attention, it is your responsibility to inform me. Cauda Equina Syndrome has been reported in rare cases which requires immediate medical care.

The probability of those risks occurring

Statistically, Chiropractic Care has been demonstrated to be one of the safest of all healthcare practices. Fractures are rare occurrences and generally result from some underlying weakness of the bone which I check for during the raking of your history and examination. CVA has been the subject of tremendous disagreement. The incidences of stroke are exceedingly rare and are estimated to occur one in five million cervical adjustments. Two major studies (2008, 2015) showed there was not causation between CMT and CVA but rather the patient was already presenting with arterial dissection. The other complications are also generally described as rare.

The availability and nature of other treatment options

Other treatment options for your condition may include:

-Self-administered, over-the-counter (OTC) analgesics, ice, head or rest.
-Medical care and prescription drugs such as anti-inflammatories, muscle relaxants and pain killers.
-Hospitalization/Surgery

If you choose to use on of the above noted "other treatment" options, you should be aware that there are severe risks associated with these treatments. Many patients taking OTC NSAID's such as Ibuprofen and Acetaminophen are not aware that every year there are thousands of deaths associated with their use. No medicine should ever be taken without discussing their side effects and inherent statistical danger with their primary care physician or pharmacist. The PDR is also a good reference regarding pharmaceutical use.

The risks and dangers attendant to remaining untreated

Remaining untreated may create adhesions or scar tissue that can weaken the area and reduce mobility. Further joint degeneration may occur as well as the development of chronic pain syndromes. Over time this process may complicate treatment making it more difficult and less effective the longer it is postponed.

DO NOT SIGN UNTIL YOU HAVE READ AND UNDERSTAND THE ABOVE.

I have read or have had read to me the above explanation of the chiropractic adjustment and related treatment. By signing below I state that I have weighed the risks involved in undergoing treatment and have decided that it is in my best interest to undergo the treatment recommended. Having been informed of the risks, I hereby give my consent to that treatment.

DATED:_____PATIENTS NAME:_____SIGNATURE_____

SIGNATURE OF PARENT OR GUARDIAN (if minor)_____

DATED:_____DOCTOR'S NAME:_____SIGNATURE_____

ASSINGMENT AND INSTRUCTION
FOR DIRECT PAYMENT TO DOCTOR
PRIVATE AND GROUP ACCIDENT AND HEALTH INSURANCE

Patient: _____

Employer: _____

Claim #: _____

I hereby instruct and direct that _____ Insurance Company to pay by check made out and mailed to:

Arizona Chiropractic Neurology
3800 W. Ray Road Suite 12
Chandler, AZ 85226

The professional or medical expense benefits allowable and otherwise payable to me under my current insurance policy as payment toward the total charges for the professional services rendered. THIS IS A DIRECT ASSIGNMENT OF MY RIGHTS AND BENEFITS UNDER THIS POLICY. This payment will not exceed my indebtedness to the above mentioned assignee, and I have agreed to pay any balance of said professional service charges over and above this insurance payment.

A photocopy of this Assignment shall be considered as effective and valid as the original.

I authorize the release of any information pertinent to my case to any Insurance Company, Adjuster, or Attorney, or for the purpose of filing a Health Care Lien.

For all Personal Injury cases, a medical lien/release of lien will be filed and copies will be sent to you.

I also authorize Doctor to complain to Insurance Commissioner on my behalf for any reason.

POLICY: Arizona Chiropractic Neurology will only file to Major Medical Carriers during Personal Injury Care if

a) He is not credentialed with that company and/or
b) If there are no other means for Settlement Re-Imbursement, ie: 3rd Party Liability, Med Pay, etc.

Dated at _____ this ____ day of _____ 20_____

_____ _____

Signature of Policy Holder/Claimant Witness

COMPLAINTS

Print Name _____ Date _____

Please answer all of the below by putting a checkmark in the appropriate box.

NECK OR CERVICAL SPINE	NONE	MILD	MODERATE	SEVERE
Neck Pain and Soreness				
Loss of Pain with Movement				
Shoulder Pain				
Pain/Numbness/Tingling in Arm or Hand				
Weakness in Arm or Hand				

MID-BACK OR THORACIC SPINE	NONE	MILD	MODERATE	SEVERE
Mid-back Pain				
Rib or Chest Pain				

LOWER BACK OR LUMBAR SPINE	NONE	MILD	MODERATE	SEVERE
Lower Back Pain and Soreness				
Loss or Pain with Movement				
Pain into Hips or Buttocks				
Pain into Legs, Knees, or Feet				
Numbness/Burning in Legs or Feet				

OTHER COMPLAINTS	NONE	MILD	MODERATE	SEVERE
Headaches				
Visual Disturbances/Blurry Vision				
Ringing or Buzzing in Ears				
Nausea or Vomiting				
Difficulty Breathing				
Dizziness				
Recent Weight Loss				
Bowel or Bladder Dysfunction				

OTHER INJURY AREAS	NONE	MILD	MODERATE	SEVERE

AGGRAVATED BY	NONE	MILD	MODERATE	SEVERE
Coughing				
Sneezing				
Prolonged Sitting				
Prolonged Standing				
Prolonged Riding in a Car				
Lying on Stomach				

Patient Signature _____ Doctor Signature _____

Neck Disability Index

Patient Name:_____ Date:_____

Please Read: This questionnaire is designed to enable us to understand how much your neck pain has affected your ability to manage every day activities. Please answer each section by circling the **ONE CHOICE** that most applies to you. We realize that you may feel that more than one statement may relate to you, but please **just circle the one choice which closely describes your problem *right now*.**

	SECTION 1 – Pain Intensity
A	I have no pain at the moment.
B	The pain is mild at the moment.
C	The pain comes and goes and is moderate.
D	The pain is moderate and does not vary much.
E	The pain is severe and comes and goes.
F	The pain is severe and does not vary much.

	SECTION 2 – Personal Care (Washing, Dressing etc.)
A	I can look after myself without causing extra pain.
B	I can look after myself normally but it causes pain.
C	It is painful to look after myself and I am slow and careful.
D	I need some help, but manage most of my personal care.
E	I need help every day in most aspects of self-care.
F	I do not get dressed, I wash with difficulty and stay in bed.

	SECTION 3 - Lifting
A	I can lift heavy weights without extra pain.
B	I can lift heavy weights, but it causes extra pain.
C	Pain prevents me from lifting heavy weights off the floor but I can if they are conveniently positioned, for example on a table.
D	Pain prevents me from lifting heavy weights, but I can manage light to medium weights if they are conveniently positioned.
E	I can lift very light weights.
F	I cannot lift or carry anything at all.

	SECTION 4 - Reading
A	I can read as much as I want to with no pain in my neck.
B	I can read as much as I want to with only slight pain in my neck.
C	I can read as much as I want with moderate pain in my neck.
D	I cannot read as much as I want because of moderate pain in my neck.
E	I cannot read as much as I want because of severe pain in my neck.
F	I cannot read at all.

	SECTION 5 – Headache
A	I have no headaches at all.
B	I have slight headaches which come infrequently.
C	I have moderate headaches which come infrequently.
D	I have moderate headaches which come frequently.
E	I have severe headaches which come frequently.
F	I have headaches almost all the time.

	SECTION 6 – Concentration
A	I can concentrate fully when I want to with no difficulty.
B	I can concentrate fully when I want to with slight difficulty.
C	I have a fair degree of difficulty concentrating when I want to.
D	I have a lot of difficulty in concentrating when I want to.
E	I have a great deal of difficulty concentrating when I want to.
F	I cannot concentrate at all.

	SECTION 7 – Work
A	I can do as much work as I want to.
B	I can only do my usual work, but no more.
C	I can do most of my usual work, but no more.
D	I cannot do my usual work.
E	I can hardly do any work at all.
F	I cannot do any work at all.

	SECTION 8 – Driving
A	I can drive my car without neck pain.
B	I can drive my car as long as I want with slight pain in my neck.
C	I can drive my car as long as I want with moderate pain in my neck.
D	I cannot drive my car as long as I want because of moderate pain in my neck.
E	I can hardly drive my car at all because of severe pain in my neck.
F	I cannot drive my car at all.

	SECTION 9 – Sleeping
A	I have no trouble sleeping.
B	My sleep is slightly disturbed (less than 1 hour sleepless).
C	My sleep is mildly disturbed (1-2 hours sleepless).
D	My sleep is moderately disturbed (2-3 hours sleepless).
E	My sleep is greatly disturbed (3-5 hours sleepless).
F	My sleep is completely disturbed (5-7 hours sleepless).

	SECTION 10 – Recreation
A	I am able to engage in all recreational activities with no pain my neck at all.
B	I am able to engage in all recreational activities with some pain my neck.
C	I am able to engage in most, but not all recreational activities because of pain in my neck.
D	I am able to engage in a few of my usual recreational activities because of pain in my neck.
E	I can hardly do any recreational activities because of pain in my neck.
F	I cannot do any recreational activities at all.

Comments:

Revised Oswestry
Low Back Pain Questionnaire

Patient Name:_____ Date:_____

Please Read: This questionnaire is designed to enable us to understand how much your back pain has affected your ability to manage every day life. Please answer each section by circling the **ONE CHOICE** that most applies to you. We realize that you may feel that more than one statement may relate to you, but please **just circle the one choice which closely describes your problem *right now*.**

	SECTION 1 – Pain Intensity
A	The pain comes and goes and is very mild.
B	The pain is mild and does not vary much.
C	The pain comes and goes and is moderate.
D	The pain is moderate and does not vary much.
E	The pain comes and goes and is severe.
F	The pain is severe and does not vary much.

	SECTION 2 – Personal Care (Washing, Dressing etc.)
A	I would not have to change my way of washing or dressing in order to avoid pain.
B	I do not normally change my way of washing or dressing even though it causes some pain.
C	Washing and dressing increases the pain, but I manage not to change my way of doing it.
D	Washing and dressing increases pain and I find it necessary to change my way of doing it.
E	Because of the pain, I am unable to do some washing and dressing without help.
F	Because of the pain, I am unable to do any washing or dressing without help.

	SECTION 3 - Lifting
A	I can lift heavy weights without extra pain.
B	I can lift heavy weights but it gives me extra pain.
C	Pain prevents me from lifting heavy weights off the floor.
D	Pain prevents me from lifting heavy weights off the floor, but I can manage if they are conveniently positioned-eg., on a table.
E	Pain prevents me from lifting heavy weights, but I can manage light to medium weights if they are conveniently positioned.
F	I can only lift very light weights, at the most.

	SECTION 4 - Walking
A	Pain does not prevent me from walking any distance.
B	Pain prevents me from walking more than 1 mile.
C	Pain prevents me from walking more than ½ mile.
D	Pain prevents me from walking more than ¼ mile.
E	I can only walk using a stick and crutches.
F	I am in bed most of the time and have to crawl to the toilet.

	SECTION 5 – Sitting
A	I can sit in any chair as long as I like without pain.
B	I can only sit in my favorite chair as long as I like.
C	Pain prevents me from sitting more than 1 hour.
D	Pain prevents me from sitting more than ½ hour.
E	Pain prevents me from sitting more than 10 minutes.
F	Pain prevents me from sitting at all.

	SECTION 6 – Standing
A	I can stand as long as I want without pain.
B	I have some pain while standing, but it does not increase with time.
C	I cannot stand for longer than 1 hour without increasing pain.
D	I cannot stand for longer than ½ hour without increasing pain.
E	I cannot stand for longer than 10 minutes without increasing pain.
F	Pain prevents me from standing at all.

	SECTION 7 – Sleeping
A	I get no pain in bed.
B	I get pain in bed, but it does not prevent me from sleeping well.
C	Because of pain, my normal night's sleep is reduced by less than one-quarter.
D	Because of pain, my normal night's sleep is reduced by less than one-half.
E	Because of pain, my normal night's sleep is reduced by less than three-quarters.
F	Pain prevents me from sleeping at all.

	SECTION 8 – Traveling
A	I get no pain while traveling.
B	I get some pain while traveling but none of my usual forms of travel make it any worse.
C	I get extra pain while I'm traveling but it does not compel me to seek alternative forms of travel.
D	I get extra pain while traveling which compels me to seek alternative forms of travel.
E	Pain restricts all forms of travel.
F	Pain prevents all forms of travel except that done lying down.

	SECTION 9 – Social Life
A	My social life is normal and gives me no pain.
B	My social life is normal, but increases the degree of my pain.
C	Pain has no significant effect on my social life apart from limiting my more energetic interests eg. dancing etc.
D	Pain has restricted my social life and I do not go out very often.
E	Pain has restricted my social life to my home.
F	I have hardly any social life because of the pain.

	SECTION 10 – Changing Degree of Pain
A	My pain is rapidly getting better.
B	My pain fluctuates, but overall is definitely getting better.
C	My pain seems to be getting better, but improvement is slow at present.
D	My pain is neither getting better nor worse.
E	My pain is gradually worsening.
F	My pain is rapidly worsening.

HEADACHE DISABILITY INDEX

Patient Name _____ Date _____

INSTRUCTIONS: Please CIRCLE the correct response:

1. I have headache: (1) 1 per month (2) more than 1 but less than 4 per month (3) more than one per week
2. My headache is: (1) mild (2) moderate (3) severe

Please read carefully: The purpose of the scale is to identify difficulties that you may be experiencing because of your headache. Please check off "YES", "SOMETIMES", or "NO" to each item. Answer each question as it pertains to your headache only.

YES	SOMETIMES	NO		
_____	_____	_____	E1.	Because of my headaches I feel handicapped.
_____	_____	_____	F2.	Because of my headaches I feel restricted in performing my routine daily activities.
_____	_____	_____	E3.	No one understands the effect my headaches have on my life.
_____	_____	_____	F4.	I restrict my recreational activities (eg, sports, hobbies) because of my headaches.
_____	_____	_____	E5.	My headaches make me angry.
_____	_____	_____	E6.	Sometimes I feel that I am going to lose control because of my headaches.
_____	_____	_____	F7.	Because of my headaches I am less likely to socialize.
_____	_____	_____	E8.	My spouse (significant other), or family and friends have no idea what I am going through because of my headaches.
_____	_____	_____	E9.	My headaches are so bad that I feel that I am going to go insane.
_____	_____	_____	E10.	My outlook on the world is affected by my headaches.
_____	_____	_____	E11.	I am afraid to go outside when I feel that a headaches is starting.
_____	_____	_____	E12.	I feel desperate because of my headaches.
_____	_____	_____	F13.	I am concerned that I am paying penalties at work or at home because of my headaches.
_____	_____	_____	E14.	My headaches place stress on my relationships with family or friends.
_____	_____	_____	F15.	I avoid being around people when I have a headache.
_____	_____	_____	F16.	I believe my headaches are making it difficult for me to achieve my goals in life.
_____	_____	_____	F17.	I am unable to think clearly because of my headaches.
_____	_____	_____	F18.	I get tense (eg, muscle tension) because of my headaches.
_____	_____	_____	F19.	I do not enjoy social gatherings because of my headaches.
_____	_____	_____	E20.	I feel irritable because of my headaches.
_____	_____	_____	F21.	I avoid traveling because of my headaches.
_____	_____	_____	E22.	My headaches make me feel confused.
_____	_____	_____	E23.	My headaches make me feel frustrated.
_____	_____	_____	F24.	I find it difficult to read because of my headaches.
_____	_____	_____	F25.	I find it difficult to focus my attention away from my headaches and on other things.

OTHER COMMENTS:_____

_____
Examiner

With permission from: Jacobson GP, Ramadan NM, et al. *The Henry Ford Hospital headache disability inventory (HDI)*. Neurology 1994;44:837-842.

ACNC Concussion Symptom Score Sheet

If you are unsure of a question or do not feel well enough to complete this form you may leave it blank and ask for assistance from one of our staff members. Thank you

Name: _____ DOB: _____ Date of Injury: _____ Today's Date: _____

(0=No Symptoms) (1-2=Very Mild) (3-4=Mild) (5-6=Moderate) (7-8=Severe) (9-10=Worst Ever)

Please circle the number that best matches the way you feel right now.

Headache:	0	1	2	3	4	5	6	7	8	9	10
Nausea:	0	1	2	3	4	5	6	7	8	9	10
Vomitting:	0	1	2	3	4	5	6	7	8	9	10
Balance Problems:	0	1	2	3	4	5	6	7	8	9	10
Dizziness:	0	1	2	3	4	5	6	7	8	9	10
Fatigue/Drowsiness:	0	1	2	3	4	5	6	7	8	9	10
Trouble Falling Asleep:	0	1	2	3	4	5	6	7	8	9	10
Needing More Sleep:	0	1	2	3	4	5	6	7	8	9	10
Sensitivity to Light:	0	1	2	3	4	5	6	7	8	9	10
Sensitivity to Noise:	0	1	2	3	4	5	6	7	8	9	10
Irritability:	0	1	2	3	4	5	6	7	8	9	10
Sadness:	0	1	2	3	4	5	6	7	8	9	10
Nervousness:	0	1	2	3	4	5	6	7	8	9	10
Feeling Emotional:	0	1	2	3	4	5	6	7	8	9	10
Numbness or Tingling:	0	1	2	3	4	5	6	7	8	9	10
Feeling Slowed Down:	0	1	2	3	4	5	6	7	8	9	10
Feeling Mentally Foggy:	0	1	2	3	4	5	6	7	8	9	10
Trouble Concentrating:	0	1	2	3	4	5	6	7	8	9	10
Memory Issues:	0	1	2	3	4	5	6	7	8	9	10
Visual Problems:	0	1	2	3	4	5	6	7	8	9	10

Name_____

Date_____ Date of Injury _____

Concussion Questionnaire

Please answer the following questions in good detail:

Have you ever had from MONO, STREP, MOLD EXPOSURE, LYME, AUTOIMMUNITY? *(Circle all that apply)*

Specifically, what symptoms or stressful situations were going on BEFORE, DURING, and IMMEDIATELY FOLLOWING your concussion?

(examples- I was going through a divorce, then I got a 24 hour gut bug, I was under immense amounts of stress at work/school, I was dealing with IBS, constipation/diarrhea, anxiety/depression, and autoimmune condition, diabetes, type A personality, I was on day 20 of my menstrual cycle)

BEFORE

DURING

IMMEDIATELY FOLLOWING