Medical & Chiropractic Clinic 4602 N. Nebraska Ave. Tampa FL 33603 (813)-237-3791

Patient Introduction Case #_____Date: ____/____/____

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

Personal Information

Full Name_____Nickname_____

Address_____ City_____ State_____ Zip_____

Home Phone ( )_____ Work Phone ( )_____ Occupation _____

Sex ☐ M ☐ F Marital Status ☐ S ☐ M ☐ D ☐ W Age_____ Birthday ___/___/___ SS#_____

How Did You Hear About Our Clinic?_____

Name Of Person Responsible For Account_____Method Of Payment_____

Emergency Contact Name_____ Phone ( )_____

Present Complaint

Briefly Describe Symptoms_____

_____

_____

Other Doctors Seen For This Condition_____ Treatment Rendered_____

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

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

Woman Only:

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

Insurance Information

Relationship to Insured: ☐ Self ☐ Spouse ☐ Child ☐ Other

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

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

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

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Auto Accident Information

Patient's Name_____ Date of Birth_____ Today's Date_____
Address:_____Date of Accident:_____
City:_____ State:_____ Zip:_____ Time of Accident:_____
Home#:_____ Work#:_____

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

_____
_____
_____

My vehicle was:

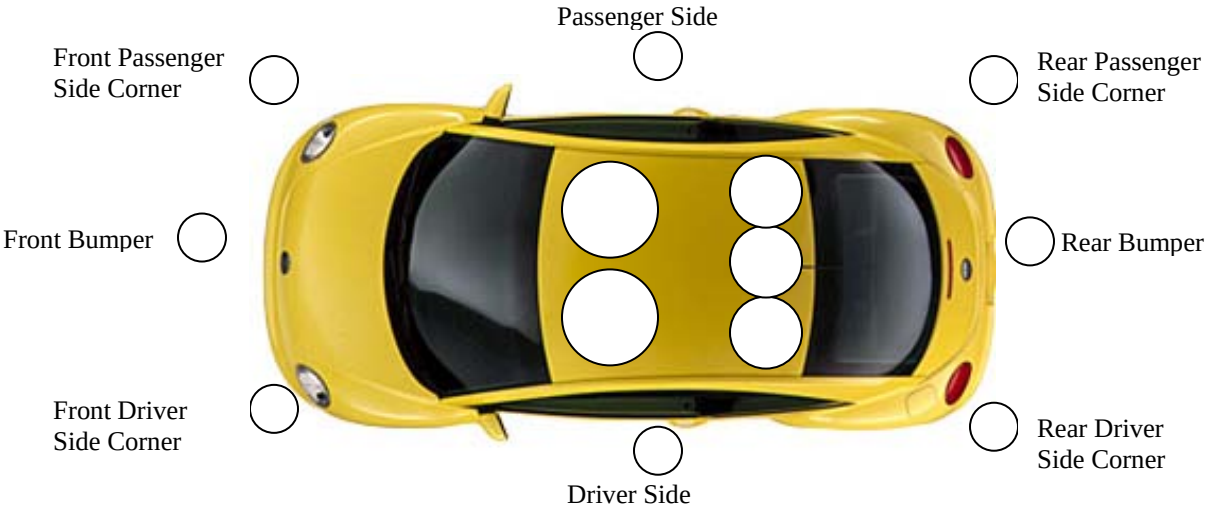
☐ **At a Traffic Light**	☐ **At a stop sign going straight**	☐ **Making a Right/Left Turn**
☐ **Entering Traffic from a side street/Driveway**	☐ **Other: (Explain)**	

I was traveling at ___ MPH **The other vehicle was traveling at ___ MPH**

The Other Vehicle:

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

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



I was the Driver/Passenger involved in the accident in (City) _____ (State)_____
I was sitting in the: ☐ Middle Front Seat ☐ Right Front Seat ☐ Left Rear Seat
☐ Middle Rear Seat ☐ Right Rear Seat
I was a pedestrian in an accident in (City) _____ (State)_____

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

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Auto Accident Information

The vehicle I was traveling in was: Year_____ Make _____ Model_____

The other vehicle in the accident was: Year_____ Make _____ Model_____

Your transmission was: ☐ Manual ☐ Automatic

Road conditions were: ☐ Dry ☐ Damp ☐ Wet ☐ Dark ☐ Clear ☐ Raining

Visibility was: ☐ Poor ☐ Fair ☐ Good

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

Did your car have a head rest: ☐ Yes ☐ No

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

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

Did your airbag deploy: ☐ Yes ☐ No

At the time of the accident my head was looking:

☐ Left ☐ Right ☐ Straight ☐ Other_____

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

My elbows were: ☐ Left ☐ Right ☐ On the arm rest ☐ Other_____

My hands were: ☐ Left ☐ Right ☐ Both ☐ On the steering wheel

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

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

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

☐ Were forced off the steering wheel/stick shift ☐ Other_____

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

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

As a result of the impact your head hit the:

☐ Front windshield	☐ Rearview mirror	☐ Steering Wheel	☐ Back of the seat ahead of me	☐ Side Driver / Passenger
☐ Inside window / Door	☐ Another persons body	☐ Back of my head hit the headrest	☐ Other	☐ Nothing

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

☐ Pressed firmly against the shoulder harness ☐ Other_____

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

_____

Did another car hit you: ☐ Yes ☐ No

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

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

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

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

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

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

If yes, how long were your unconsciousness: _____

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

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

Estimated cost to repair your car: _____

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

Names of the occupants:

Were the other occupants injured: ☐ **Yes** ☐ **No** **Were the police called:** ☐ **Yes** ☐ **No**

Was a police report taken: ☐ **Yes** ☐ **No** **Was a ticket given to you:** ☐ **Yes** ☐ **No**

Was a ticket given to the other driver: ☐ **Yes** ☐ **No**

As a result of the accident I felt my symptoms:

☐ **Immediately** ☐ **Within the hour** ☐ **Within 6 hours** ☐ **During the night**

☐ **Next Morning** ☐ **Next Day** ☐ **Other**_____

As a result of the accident I felt:

☐ **Headaches** ☐ **Upper Back Pain** ☐ **Chest Pain/Soreness** ☐ **Wrist / Elbow / Pain / Soreness**

☐ **Neck Pain** ☐ **Low Back Pain** ☐ **Stomach Pain / Soreness** ☐ **Knee/Angle Pain / Soreness**

☐ **Shoulder Pain** ☐**Numb/Tingling/Burning Arms** ☐ **Numb/Tingling/Burning Legs** ☐ **Loss of Bowel/Bladder**

Other areas of pain include: _____

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

_____

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

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

How did you get to the hospital: ☐ **Ambulance** ☐ **Private Transportation**

☐ **Drove yourself** ☐ **Someone else Drove**

Name of the Hospital:_____ **City: _____**

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

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

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

☐ **Prescriptions: What types:** _____

List any special test taken at the hospital:_____

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

Doctor Name	First Visit Date	Treatment	City	Released
				☐ Yes ☐ No
				☐ Yes ☐ No
				☐ Yes ☐ No

Are you working now: ☐ **Yes** ☐ **No**

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

Type of work you do: _____

Are you currently working with restrictions: ☐ **Yes** ☐ **No**

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

Please list work restrictions: _____

_____

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

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

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

Additional Notes:

_____

_____

_____

_____

_____

_____

_____

_____

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Patient Name:_____Case #_____Date:___/___/___

Neck Pain and Disability Index (Vernon – Mior)

Please Read Instructions:
This questionnaire has been designed to give the doctor information as to how your neck pain has affected your ability to everyday life. Please answer every section and mark in each section only the ONE Box which applies to you. We realize you may consider that two of the statements in any one section relate to you, but just mark the box which most closely describes your problem.

Section 1 Pain Intensity
☐ 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

Section 2 Personal Care (Washing, Dressing, Ect.)
☐ I can look at myself normally without causing extra pain
☐ I can look at myself normally that causes extra pain
☐ is painful to look at myself and I am slow and careful
☐ I need some help manage most of my personal care
☐ I need help everyday in most aspects of self-care
☐ I do not get dressed, I wash with difficulty and stay in bed

Section 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 manage if they are conveniently positioned, for example on the 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

Section 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
☐ I can't read as much as I want because of moderate pain in my neck
☐ I can hardly read at all because of severe pain in my neck
☐ I cannot read at all

Section 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

Section 6 Concentration
☐ I can concentrate fully when I want to with no difficulty
☐ I can concentrate fully when they want to with slight difficulty
☐ I have a fair degree of difficulty in concentrating what I want
☐ I had 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 all

Section 7 Work
☐ I can do as much work as I wanted
☐ 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

Section 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 can 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 can drive my car

Section 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(five -- 7 hours sleepless)

Section 10 Recreation
☐ I'm able to engage in all my recreation activities with no neck pain at all
☐ I am able to engage in all my recreation activities, with some pain in my neck
☐ I am able to engage in most, but not all of my usual recreation activities because of pain in my neck
☐ I'm able to engage in a few of my usual recreation activities because of pain in my neck
☐ I can hardly do any recreation activities because of pain in my neck
☐ I can't do any recreation activities at all

Pain scale:

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

No pain	0	1	2	3	4	5	6	7	8	9	10	**Excruciating pain**

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

Low Back Pain and Disability Questionnaire

Please Read Instructions:

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

Section 1 Pain Intensity

☐ the pain comes in goes and is very mild
☐ the pain is mild and is not vary much
☐ the pain comes and goes and is moderate
☐ the pain is moderate and is not vary much
☐ the pain comes and goes and is very severe
☐ the pain is severe and does not vary much

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

☐ I would not have to change my way of washing or dressing in order to avoid pain
☐ I do not normally change my way of washing or dressing even though it causes some pain
☐ washing and dressing increase the pain but I managed not to change my way of doing it
☐ washing and dressing increase the pain and I find it necessary to change my way of doing it
☐ because of the pain I am unable to do some washing and dressing without help
☐ because of the pain I am unable to do any washing and dressing without help

Section 3 Lifting

☐ I can lift heavy weights without extra pain
☐ I can lift heavy weights but it causes extra pain
☐ pain prevents me from lifting heavy weights off the floor
☐ pain prevents me from lifting heavy weights off the floor, but I manage if they are conveniently positioned (e.g. on a table)
☐ pain prevents me from lifting heavy weights but I can manage light in weights if they are conveniently positioned
☐ I can only live very light weights at the most

Section 4 Walking

☐ I have no pain on walking
☐ I have some pain on walking but it does not increase with distance
☐ I cannot walk more than 1 mile without increasing pain
☐ I cannot walk more than 1/2 mile without increasing pain
☐ I cannot walk more than 1/4 mile without increasing pain
☐ I cannot walk at all without increasing pain

Section 5 Sitting

☐ I can sit in any chair as long as I like
☐ I can only sit in my favorite chair as long as I like
☐ pain prevents me from sitting more than one hour
☐ pain prevents me from sitting more than half hour
☐ pain prevents me from sitting more than 10 minutes
☐ I avoid sitting because it increases pain straight away

Section 6 Standing

☐ I can stand as long as I want without pain
☐ I have some pain on standing but it is not increase with time
☐ I cannot stand for longer than one hour without increasing pain
☐ I cannot stand for longer than 1/2 hour without increasing pain
☐ I cannot stand for longer than 10 minutes without increasing pain
☐ I avoid standing because it increases the pain straight away

Section 7 Sleeping

☐ I get no pain in the
☐ I get pain in bed but it does not prevent me from sleeping well
☐ because of pain my normal night's sleep is reduced by less than 1/4
☐ because of pain my normal night's sleep is reduced by less than 1/2
☐ because of pain my normal night's sleep is reduced in less than 3/4
☐ pain prevents me from sleeping at all

Section 8 Social Life

☐ my social life is normal and gives me no pain
☐ my social life is normal but increases the degree of pain
☐ pain has no significant effect on my social life apart from limiting my more energetic interest, example dancing
☐ pain has restricted my social life and I do not go out very often
☐ pain has restricted my social life to my home
☐ I have hardly any social life because of the pain

Section 9 Travelling

☐ I get no pain while traveling
☐ I get some pain while traveling that none of my usual forms of travel make it any worse
☐ I get extra pain while traveling but it does not compel me to seek alternative forms of travel
☐ I get extra pain while traveling which compels me to seek alternative forms of travel
☐ pain restricts all forms of travel
☐ pain prevents all forms of travel except that done lying down

Section 10 Changing Degree of Pain

☐ my pain is rapidly getting better
☐ my pain fluctuates but overall is definitely getting 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

Pain scale:

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

No pain	0	1	2	3	4	5	6	7	8	9	10	**Excruciating pain**