PERSONAL INJURY QUESTIONNAIRE

Fill out the following information in its entirety. Do not leave anything blank and give as much information as possible. If the information does not apply to you, please write N/A.

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

INSURANCE INFORMATION:

Name of Policy Holder: _____ Insurance Company: _____

Insurance Policy #: _____ Insurance Claim #: _____

Name of Insurance Adjustor: _____ Phone Number: _____

Do you have Personal Injury Protection (PIP) on your auto policy? _____ If so, how much? $2,500 $5,000 $10,000 Other: _____

Have you retained an attorney? _____ If so, please provide the name and number: _____

ACCIDENT DETAILS:

Date of Accident: _____ Time of Day: _____ Were you... ( ) Driver ( ) Passenger ( ) Front Seat ( ) Back Seat

What city and state did the accident take place in? _____ Number of people in your vehicle? _____

Were you wearing seatbelts? _____ Were you struck from... ( ) Behind ( ) Front ( ) Left side ( ) Right side

Approximate speed of your vehicle? _____ mph Other vehicle? _____ mph Did the airbags deploy? _____

What direction were you headed? ( ) North ( ) South ( ) East ( ) West Other vehicle? ( ) North ( ) South ( ) East ( ) West

Which way were you looking during impact? (BE SPECIFIC) _____

Were the police notified? _____ Were you knocked unconscious? _____ Did either car have a Dash Cam? _____

Year, make, and model of *your* vehicle: _____ Number of cars involved in the accident? _____

Year, make, and model of *other* vehicle: _____ Did the vehicle that hit you have insurance? YES / NO

Amount of damage to your car? _____ Est. Cost? _____

In your own words, please describe the accident: _____

_____

_____

_____

How did you feel immediately after the accident?: _____

Check symptoms you have noticed **since the accident**:

___ Headache	___ Dizziness	___ Pins and Needles in Arm	___ Fatigue
___ Neck Pain	___ Sleeping Problems	___ Pins and Needles in Legs	___ Memory Loss
___ Neck Stiffness	___ Loss of Balance	___ Numbness in Fingers	___ Constipation
___ Back Pain	___ Shortness of Breath	___ Numbness in Toes	___ Chest Pain
___ Tension	___ Buzzing/Ringing in Ears	___ Sensitivity to Light	___ Fainting
___ Head Seems Heavy	___ Loss of Smell or Taste	___ Sensitivity to Sound	___ Irritability

Symptoms other than above: _____

Which of the complaints (as noted above) have you had before? _____

Were you taken to the hospital? _____ By ambulance? _____ Were you admitted? _____ If so, for how long? _____

Did you see a MD, go to ER or Urgent Care? _____ If so, when? _____ Did you lose any time from work? _____

Did the accident force you to take any medications? _____ If so, what? _____

Patient Signature: _____ Date: _____

QUADRUPLE VISUAL ANALOGUE SCALE

Patient Name _____ Date _____

Please read carefully:

Instructions: Please circle the number that best describes the question being asked.

Note: If you have more than one complaint, please answer each question for each individual complaint and indicate the score for each complaint. Please indicate your pain level right now, average pain, and pain at its best and worst.

Example:

Headache Neck Low Back

No pain _____ **worst possible pain**

0 1 (2) 3 4 (5) 6 7 (8) 9 10

---

1 – What is your pain RIGHT NOW?

No pain _____ **worst possible pain**

0 1 2 3 4 5 6 7 8 9 10

2 – What is your TYPICAL or AVERAGE pain?

No pain _____ **worst possible pain**

0 1 2 3 4 5 6 7 8 9 10

3 – What is your pain level AT ITS BEST (How close to "0" does your pain get at its best)?

No pain _____ **worst possible pain**

0 1 2 3 4 5 6 7 8 9 10

4 – What is your pain level AT ITS WORST (How close to "10" does your pain get at its worst)?

No pain _____ **worst possible pain**

0 1 2 3 4 5 6 7 8 9 10

OTHER COMMENTS:

_____

_____

_____

Examiner

Reprinted from *Spine*, 18, Von Korff M, Deyo RA, Cherkin D, Barlow SF, Back pain in primary care: Outcomes at 1 year, 855-862, 1993, with permission from Elsevier Science.

NECK Pain and Disability Questionnaire

Rate the severity of your pain by circling one number: (No Pain) 0...1...2...3...4...5...6...7...8...9...10 (Excruciating Pain)

This questionnaire has been designed to give the doctor information as to how your neck pain has affected your ability to manage everyday life. Read through each section and check only ONE line that applies to you. You may find that two of the statements in a section relate to you, but please **just check ONE line** that best describes your current predicament.

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, etc.)
___ I can look after myself normally without causing extra pain.
___ I can look after myself normally but it causes extra pain.
___ I am slow and careful because it is painful for me to look after myself.
___ I need some help but manage most of my personal care.
___ I need help every day in most aspects of care.
___ I do not get dressed, I wash with difficulty and stay in bed.

Section 3– Lifting
___ I can lift heavy weight without extra pain.
___ I can lift heavy weight but it causes extra pain.
___ I cannot lift heavy weight off the floor, but I can manage if they are conveniently positioned like on a table.
___ I cannot lift heavy weight, but I can manage light to medium weights if they are conveniently positioned.
___ I cannot lift any weight due to neck pain.

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 neck pain.
___ I can read as much as I want to with moderate neck pain.
___ I cannot read as much as I want to due to moderate neck pain.
___ I can hardly read at all because of severe neck pain.

Section 5– Headaches
___ I have no headaches at all.
___ I have slight headaches that occur infrequently.
___ I have moderate headaches that occur infrequently.
___ I have frequent moderate headaches.
___ I have frequent severe headaches.
___ I have severe headaches all the time.

Section 6- Concentration
___ I can concentrate fully when I want to with no difficulty.
___ I can concentrate fully when I want to with slight difficulty.
___ I have a fair degree of difficulty in concentrating when I want to.
___ I have a great deal of difficulty in concentrating when I want to.
___ I cannot concentrate at all.

Section 7- Work
___ I can do as much work as I want to.
___ I can only do my usual work, but no more.
___ I can do most of my usual work, but no more.
___ I cannot do my usual work.
___ I can barely 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 neck pain.
___ I can drive my car as long as I want with moderate neck pain.
___ I cannot drive my car as long as I want.
___ I can hardly drive at all because of severe neck pain.
___ I cannot drive my car at all.

Section 9- Sleeping
___ I have no trouble sleeping.
___ My sleep is slightly disturbed (less than 1 hour sleepless)
___ My sleep is mildly disturbed (1 hour sleepless)
___ My sleep is moderately disturbed (2 to 3 hours sleepless)
___ My sleep is greatly disturbed (4 to 5 hours sleepless)
___ My sleep is completely disturbed (6 to 7 hours sleepless)

Section 10- Recreation
___ I am able to engage in all my recreation activities with no neck pain.
___ I am able to engage in all my recreation activities with some neck pain.
___ I am able to engage in most, but not all of my usual recreation activities.
___ I am able to engage in a few of my usual recreation activities.
___ I can hardly do any recreation activities.
___ I cannot do any recreation activities due to neck pain.

Patient Name (Print) _____ Patient Signature _____ Date _____

FOR OFFICE USE ONLY:

_____ x 2 = _____

Total Points Disability Percentage Rating Scale

OSWESTRY LOW BACK DISABILITY QUESTIONNAIRE

Instructions: this questionnaire has been designed to give us information as to how your back pain has affected your ability to manage everyday life. Please answer every section and mark in each section only the ONE box which applies to you at this time. We realize you may consider 2 of the statements in any section may relate to you, but please mark the box which most closely describes your current condition.

1. PAIN INTENSITY
- ☐ I can tolerate the pain I have without having to use pain killers
- ☐ The pain is bad but I manage without taking pain killers
- ☐ Pain killers give complete relief from pain
- ☐ Pain killers give moderate relief from pain
- ☐ Pain killers give very little relief from pain
- ☐ Pain killers have no effect on the pain and I do not use them

2. PERSONAL CARE (e.g. Washing, Dressing)
- ☐ I can look after myself normally without causing extra pain
- ☐ I can look after myself normally but it causes extra pain
- ☐ It is painful to look after myself and I am slow and careful
- ☐ I need some help but manage most of my personal care
- ☐ I need help every day in most aspects of self care
- ☐ I don't get dressed, I was with difficulty and stay in bed

3. LIFTING
- ☐ I can lift heavy weights without extra pain
- ☐ I can lift heavy weights but it gives extra pain
- ☐ Pain prevents me from lifting heavy weights off the floor, but I can manage if they are conveniently positioned, i.e. on a table
- ☐ Pain prevents me from lifting heavy weights, but I can manage light to medium weights if they are conveniently positioned
- ☐ I can lift very light weights
- ☐ I cannot lift or carry anything at all

4. WALKING
- ☐ Pain does not prevent me walking any distance
- ☐ Pain prevents me walking more than one mile
- ☐ Pain prevents me walking more than ½ mile
- ☐ Pain prevents me walking more than ¼ mile
- ☐ I can only walk using a stick or crutches
- ☐ I am in bed most of the time and have to crawl to the toilet

5. SITTING
- ☐ I can sit in any chair as long as I like
- ☐ 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 ½ hour
- ☐ Pain prevents me from sitting more than 10 minutes
- ☐ Pain prevents me from sitting at all

6. STANDING
- ☐ I can stand as long as I want without extra pain
- ☐ I can stand as long as I want but it gives me extra pain
- ☐ Pain prevents me from standing for more than one hour
- ☐ Pain prevents me from standing for more than 30 minutes
- ☐ Pain prevents me from standing for more than 10 minutes
- ☐ Pain prevents me from standing at all

7. SLEEPING
- ☐ Pain does not prevent me from sleeping well
- ☐ I can sleep well only by using medication
- ☐ Even when I take medication, I have less than 6 hrs sleep
- ☐ Even when I take medication, I have less than 4 hrs sleep
- ☐ Even when I take medication, I have less than 2 hrs sleep
- ☐ Pain prevents me from sleeping at all

8. SOCIAL LIFE
- ☐ My social life is normal and gives me no extra 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 interests, i.e. dancing, etc.
- ☐ Pain has restricted my social life and I do not go out as often
- ☐ Pain has restricted my social life to my home
- ☐ I have no social life because of pain

9. TRAVELLING
- ☐ I can travel anywhere without extra pain
- ☐ I can travel anywhere but it gives me extra pain
- ☐ Pain is bad, but I manage journeys over 2 hours
- ☐ Pain restricts me to journeys of less than 1 hour
- ☐ Pain restricts me to short necessary journeys under 30 minutes
- ☐ Pain prevents me from traveling except to the doctor or hospital

10. EMPLOYMENT/ HOMEMAKING
- ☐ My normal homemaking/ job activities do not cause pain.
- ☐ My normal homemaking/ job activities increase my pain, but I can still perform all that is required of me.
- ☐ I can perform most of my homemaking/ job duties, but pain prevents me from performing more physically stressful activities (e.g. lifting, vacuuming)
- ☐ Pain prevents me from doing anything but light duties.
- ☐ Pain prevents me from doing even light duties.
- ☐ Pain prevents me from performing any job or homemaking chores.

PERSONAL INJURY LIEN

Patient Name: _____

Date of Accident: _____

I hereby authorize and direct:

Name of Attorney: _____

Attorney's Address: _____

Attorney's Phone: _____

Attorney's Signature: _____

and/or

Insurance Company: _____

to pay directly to Restoration Family Chiropractic, such sums that may be due and owing this office for services rendered to me, both by reason of this accident and by reason of any other bills that are due this office, and to withhold such sums from any disability benefits, medical payment benefits, liability benefits, health and accident benefits, workmen's compensation benefits, or any other insurance benefits, or from any settlement, judgment or verdict on my behalf as may be necessary to adequately protect said office.

I hereby further give a lien to said office against any and all insurance named herein, and any and all proceeds of any settlement, judgment, or verdict that may be paid to me as a result of the injuries for which I have been treated by said office. This is to act as an assignment of my rights and benefits to the extent of the office's services provided.

I understand that I remain personally responsible for the total amounts due the office for their services. I further understand and agree that this assignment, lien and authorization does not contribute any consideration for the office to await payments and they may demand payment from me upon rendering services at their option. I authorize this office to release any information pertinent to my case to any insurance company or attorney to facilitate collection under this assignment, lien, and authorization.

I further understand and agree that if this office must take any action to collect an outstanding balance on my account, I will be responsible for payment of and reimburse this office for all costs of such collection efforts including but not limited to all court costs and attorney fees.

I have been advised that if my attorney does not wish to cooperate in protecting the doctor's interest, the doctor will not await payment, but will require me to make payments on my current balance.

Patient's Signature Date

_____ _____

Countersigned/Witnessed by Staff Date

_____ _____

ASSIGNMENT OF BENEFITS, ASSIGNMENT OF RIGHTS TO PURSUE PERSONAL INJURY, WORK COMP, ERISA, AND OTHER LEGAL AND ADMINISTRATIVE CLAIMS ASSOCIATED WITH MY HEALTH INSURANCE AND /OR HEALTH BENEFIT PLAN (INCLUDING BREACH OF FIDUCIARY DUTY) AND DESIGNATION OF AUTHORIZED REPRESENTATIVE

Provider Name: Dr. Adam Smith
Clinic: Restoration Family Chiropractic
Address: 1080 W. Patrick St. Suite 15 Frederick, MD 21703

I hereby assign and convey directly to the above-named health care provider, as my designated authorized representative, any and all medical benefits and/or any insurance reimbursement, if any, otherwise payable to me for services, treatments, therapies, and/or medications rendered or provided by the above-named health care provider, regardless of its managed care network participation status. I understand that I am financially responsible for all charges regardless of any applicable insurance or benefit payments. I hereby authorize the above-named health care provider to release all medical information necessary to process my claims. Further, I hereby authorize my plan administrator fiduciary, insurer, and/or attorney to release to the above-named health care provider any and all Plan documents, summary benefit description, insurance policy, and/or settlement information upon written request from the above-named health care provider or its attorneys in order to claim such medical benefits.

In addition to the assignment of all medical benefits and/or insurance reimbursement above, I also assign and/or convey to the above named health care provider any legal or administrative claim or chose an action arising under any group health plan, employee benefits plan, health insurance or tort feasor insurance concerning medical expenses incurred as a result of the medical services, treatments, therapies, and/or medications I receive from the above-named health care provider (including any right to pursue those legal or administrative claims or chose an action). This constitutes an express and knowing assignment of ERISA breach or fiduciary duty claims and other legal and/or administrative claims.

I intend by this assignment and designation of authorized representative to convey to the above-named provider all of my rights to claim (or place a lien on) the medical benefits related to the services, treatments, therapies, and/or mediations provided by the above-named health care provider, including rights to any settlement, insurance or applicable legal or administrative remedies (including damages arising from ERISA breach of fiduciary duty claims). The assignee and/or designated representative (above-named provider) is given the right by me to (1) obtain information regarding the claim to the same extent as me; (2) submit evidence; (3) make statements about facts or law; (4) make any request including providing or receiving notice of appeal proceedings; (5) participate in any administrative and judicial actions and pursue claims or chose in action or right against any liable party, insurance company, employee benefit plan, health care benefit plan, or plan administrator. The above-named provider as my assignee and my designated authorized representative may bring suit against any such health care benefit plan, employee benefit plan, plan administrator or insurance company in my name with derivative standing at provider's expense.

Unless revoked, this assignment is valid for all administrative and judicial reviews under PPACA (health care reform legislation), ERISA, Medicare and applicable federal and state laws. A photocopy of this assignment is to be considered valid, the same as if it was the original.

I HAVE READ AND FULLY UNDERSTAND THIS AGREEMENT.

_____

Patient Signature

_____

Date