TAYLOR CHIROPRACTIC

HEALTH | WELLNESS | PERFORMANCE

Patient Information Sheet

General information

Date: _____

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

Patient Sex: M F **Age:** _____ **Email** _____

Patient Address: _____

City: _____ **State:** _____ **Zip:** _____

Home #: _____ **Work #:** _____ **Cell #:** _____

Patient Employer: _____ **Patient Occupation:** _____

***How did you hear about us?** _____

Complaint history

Describe your current complaint and how the problem began:

_____

How long have you had this condition? _____ **Date of onset:** _____

How would you describe the pain? (Cirle all that apply)

Sharp	Soreness	Throbbing	Tingling	Dull	Stiffness
Spasm	Burning	Ache	Weakness	Numbness	Shooting

How would you rate the intensity of your pain? (Circle the appropriate number)

0 1 2 3 4 5 6 7 8 9 10

(no pain) (moderate pain) (terrible/unbearable pain)

How often is the pain present?

Constant (81-100%) Frequent (51-80%) Occasional (25-50%) Intermittent (25% or less)

Since the problem began is the pain:

Getting worse Getting Better Staying the same

What makes your pain better?

Nothing Walking Sitting/Standing Exercise Lying down Computer use

What makes your pain worse?

Nothing Walking Sitting/Standing Exercise Lying down Computer use

Personal Injury Intake Form

About Your Accident:

Date & Time of Accident:___/___/___, _____ **am / pm**

Where were you seated? (Please circle) **Driver / Front Passenger / Rear Passenger**

Were you looking straight ahead, to the left or right?_____

Did the police come to the accident site? **Yes / No** Was a police report filed? **Yes / No**

Was a ticket issued? **Yes / No** If yes, to whom was it issued to?_____

Your seatbelt was: **On / Off** Did the airbags deploy? **Yes / No** Number of people in your vehicle: _____

The headrest was: (Please circle) **Above / Below / At the base of your head**

Did any part of your body strike anything in the car? **Yes / No**

If yes, please explain: _____

_____

Did your vehicle impact another vehicle or structure? **Yes / No**

Please briefly describe your accident: _____

_____

What is the make and model of the vehicle you were driving?_____

What was your approximate speed?_____

What is the make and model of the other vehicle? _____

Name of the street/intersection the other vehicle was traveling on? _____

What was their speed? _____

What direction did the impact to your vehicle come from? (Please circle)

Front / Rear / Right / Left / Other

After Your Accident:

Did you lose consciousness during the accident? **Yes / No** If yes, for how long?_____

Please describe how you immediately felt after the accident? _____

_____

Have you gone to a hospital or seen any other doctors? **Yes / No** If so, who? _____

When did you go?(Please Circle) **Just after the accident / next day / 2 or more days later**

How did you get there? (Please Circle) **Ambulance / Private Transportation**

What kind of treatment did you receive? _____

Were there X-Rays, MRI, CT Scans, etc. taken? **Yes / No**

Was medication prescribed? **Yes / No**

Damage to Vehicle:

Did your vehicle hit anything after the accident? **Yes / No** If yes, please describe:

_____

_____

What was the estimated damage to the vehicle you were in? _____

Who is your auto insurance company? _____

Do you have Medical Payments (MEDPAY)? **Yes / No** If yes, how much? _____

If known, what is your claim number and name of your adjuster? _____

Are you currently represented by an attorney? **Yes / No** If yes, who? _____

If not, would you like us to refer you to one of our expert attorneys? _____

Past or present symptoms, conditions or habits - continued

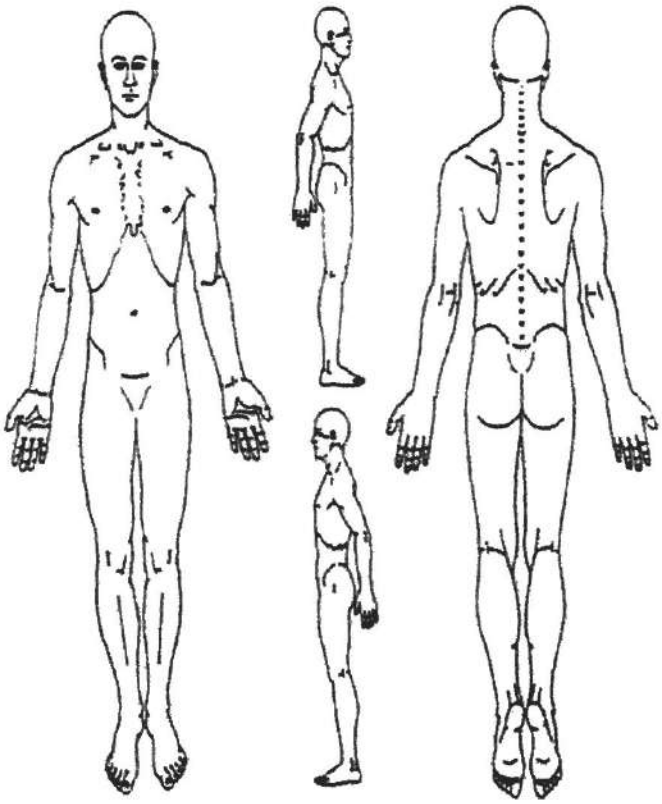
Tobacco Use:	Past	Present	Occasional	Moderate	Heavy
Alcohol Use:	Past	Present	Occasional	Moderate	Heavy
Caffeine Use:	Past	Present	Occasional	Moderate	Heavy
Pregnancy:	Past	Present			
Surgical Procedure:	Past	Present			

Please list : _____

Allergies: _____

Emergency Contact: _____ **Phone #** _____

Please mark your areas of pain with "X's"



Back Index

Form BI100

rev 3/27/2003

Patient Name _____ **Date** _____

This questionnaire will give your provider information about how your back condition affects your everyday life. Please answer every section by marking the one statement that applies to you. If two or more statements in one section apply, please mark the one statement that most closely describes your problem.

Pain Intensity

⓪ The pain comes and goes and is very mild.
① The pain is mild and does not vary much.
② The pain comes and goes and is moderate.
③ The pain is moderate and does not vary much.
④ The pain comes and goes and is very severe.
⑤ The pain is very severe and does not vary much.

Sleeping

⓪ I get no pain in bed.
① I get pain in bed but it does not prevent me from sleeping well.
② Because of pain my normal sleep is reduced by less than 25%.
③ Because of pain my normal sleep is reduced by less than 50%.
④ Because of pain my normal sleep is reduced by less than 75%.
⑤ Pain prevents me from sleeping at all.

Sitting

⓪ I can sit in any chair as long as I like.
① I can only sit in my favorite chair as long as I like.
② Pain prevents me from sitting more than 1 hour.
③ Pain prevents me from sitting more than 1/2 hour.
④ Pain prevents me from sitting more than 10 minutes.
⑤ I avoid sitting because it increases pain immediately.

Standing

⓪ I can stand as long as I want without pain.
① I have some pain while standing but it does not increase with time.
② I cannot stand for longer than 1 hour without increasing pain.
③ I cannot stand for longer than 1/2 hour without increasing pain.
④ I cannot stand for longer than 10 minutes without increasing pain.
⑤ I avoid standing because it increases pain immediately.

Walking

⓪ I have no pain while walking.
① I have some pain while walking but it doesn't increase with distance.
② I cannot walk more than 1 mile without increasing pain.
③ I cannot walk more than 1/2 mile without increasing pain.
④ I cannot walk more than 1/4 mile without increasing pain.
⑤ I cannot walk at all without increasing pain.

Personal Care

⓪ I do not have to change my way of washing or dressing in order to avoid pain.
① I do not normally change my way of washing or dressing even though it causes some pain.
② Washing and dressing increases the pain but I manage not to change my way of doing it.
③ Washing and dressing increases the pain and I find it necessary to change my way of doing it.
④ Because of the pain I am unable to do some washing and dressing without help.
⑤ Because of the pain I am unable to do any washing and dressing without help.

Lifting

⓪ I can lift heavy weights without extra pain.
① I can lift heavy weights but it causes extra pain.
② Pain prevents me from lifting heavy weights off the floor.
③ Pain prevents me from lifting heavy weights off the floor, but I can manage if they are conveniently positioned (e.g., on a table).
④ Pain prevents me from lifting heavy weights off the floor, but I can manage light to medium weights if they are conveniently positioned.
⑤ I can only lift very light weights.

Traveling

⓪ I get no pain while traveling.
① I get some pain while traveling but none of my usual forms of travel make it worse.
② I get extra pain while traveling but it does not cause me to seek alternate forms of travel.
③ I get extra pain while traveling which causes me to seek alternate forms of travel.
④ Pain restricts all forms of travel except that done while lying down.
⑤ Pain restricts all forms of travel.

Social Life

⓪ My social life is normal and gives me no extra pain.
① My social life is normal but increases the degree of pain.
② Pain has no significant affect on my social life apart from limiting my more energetic interests (e.g., dancing, etc).
③ Pain has restricted my social life and I do not go out very often.
④ Pain has restricted my social life to my home.
⑤ I have hardly any social life because of the pain.

Changing degree of pain

⓪ My pain is rapidly getting better.
① My pain fluctuates but overall is definitely getting better.
② My pain seems to be getting better but improvement is slow.
③ My pain is neither getting better or worse.
④ My pain is gradually worsening.
⑤ My pain is rapidly worsening.

Index Score = [Sum of all statements selected / (# of sections with a statement selected x 5)] x 100

Back Index Score _____

Neck Index

Form N1-100

rev 3/27/2003

Patient Name _____ **Date** _____

This questionnaire will give your provider information about how your neck condition affects your everyday life. Please answer every section by marking the one statement that applies to you. If two or more statements in one section apply, please mark the one statement that most closely describes your problem.

Pain Intensity

⓪ I have no pain at the moment.
① The pain is very mild at the moment.
② The pain comes and goes and is moderate.
③ The pain is fairly severe at the moment.
④ The pain is very severe at the moment.
⑤ The pain is the worst imaginable at the moment.

Sleeping

⓪ I have no trouble sleeping.
① My sleep is slightly disturbed (less than 1 hour sleepless).
② My sleep is mildly disturbed (1-2 hours sleepless).
③ My sleep is moderately disturbed (2-3 hours sleepless).
④ My sleep is greatly disturbed (3-5 hours sleepless).
⑤ My sleep is completely disturbed (5-7 hours sleepless).

Reading

⓪ I can read as much as I want with no neck pain.
① I can read as much as I want with slight neck pain.
② I can read as much as I want with moderate neck pain.
③ I cannot read as much as I want because of moderate neck pain.
④ I can hardly read at all because of severe neck pain.
⑤ I cannot read at all because of neck pain.

Concentration

⓪ I can concentrate fully when I want with no difficulty.
① I can concentrate fully when I want with slight difficulty.
② I have a fair degree of difficulty concentrating when I want.
③ I have a lot of difficulty concentrating when I want.
④ I have a great deal of difficulty concentrating when I want.
⑤ I cannot concentrate at all.

Work

⓪ I can do as much work as I want.
① I can only do my usual work but no more.
② I can only do most of my usual work but no more.
③ I cannot do my usual work.
④ I can hardly do any work at all.
⑤ I cannot do any work at all.

Personal Care

⓪ I can look after myself normally without causing extra pain.
① I can look after myself normally but it causes extra pain.
② It is painful to look after myself and I am slow and careful.
③ I need some help but I manage most of my personal care.
④ I need help every day in most aspects of self care.
⑤ I do not get dressed, I wash with difficulty and stay in bed.

Lifting

⓪ I can lift heavy weights without extra pain.
① I can lift heavy weights but it causes extra pain.
② Pain prevents me from lifting heavy weights off the floor, but I can manage if they are conveniently positioned (e.g., on a table).
③ Pain prevents me from lifting heavy weights off the floor, but I can manage light to medium weights if they are conveniently positioned.
④ I can only lift very light weights.
⑤ I cannot lift or carry anything at all.

Driving

⓪ I can drive my car without any neck pain.
① I can drive my car as long as I want with slight neck pain.
② I can drive my car as long as I want with moderate neck pain.
③ I cannot drive my car as long as I want because of moderate neck pain.
④ I can hardly drive at all because of severe neck pain.
⑤ I cannot drive my car at all because of neck pain.

Recreation

⓪ I am able to engage in all my recreation activities without neck pain.
① I am able to engage in all my usual recreation activities with some neck pain.
② I am able to engage in most but not all my usual recreation activities because of neck pain.
③ I am only able to engage in a few of my usual recreation activities because of neck pain.
④ I can hardly do any recreation activities because of neck pain.
⑤ I cannot do any recreation activities at all.

Headaches

⓪ I have no headaches at all.
① I have slight headaches which come infrequently.
② I have moderate headaches which come infrequently.
③ I have moderate headaches which come frequently.
④ I have severe headaches which come frequently.
⑤ I have headaches almost all the time.

~~Index Score = [Sum of all statements selected / (# of sections with a statement selected x 5)] x 100~~

Neck Index Score

Taylor Chiropractic & Wellness, LLC.

(Tuxedo Atrium)
3833 Roswell Road, Suite 105
Atlanta, GA 30342
Phone: (770) -239- 6464 Fax: (404) -264- 6327

LETTER OF PROTECTION

Patient Name: _____ Accident Date: ___/___/___

Attorney Name:_____

Doctor Name: _____

We, the undersigned patient and attorney, will protect the interests of Taylor Chiropractic & Wellness, LLC. ("practice") out of the proceeds from any settlement, judgment or verdict, relating to the accident listed above.

By "interests," we mean any outstanding balance owed to the practice for treatment rendered to me, the patient, for injuries sustained on the above date.

This letter of protection shall not be modified or revoked without the written consent of Taylor Chiropractic & Wellness, LLC.

_____ _____

Patient's Signature
Date: ___/___/___

Attorney's Signature
Date: ___/___/___

_____

Doctor's Signature
Date: ___/___/___

Authorization and Releases

Name _____

Consent for Treatment

I, the undersigned, hereby authorize the doctor(s) and whomever they may designate as their assistant to perform diagnostic tests, and to administer treatment as is necessary.
I, also, certify that no guarantee or assurance has been made to the results that may be obtained.

I understand and agree that health and accident insurance policies are an arrangement between an insurance carrier and myself. Furthermore, I understand that this office will prepare any necessary reports and forms to assist me in making collection from the insurance company and that my amount authorized to be paid directly to this office will be credited to my account upon receipt. I permit this office to endorse remittances for the conveyance of credit to my account.

HOWEVER, I CLEARLY UNDERSTAND AND AGREE THAT ALL SERVICES RENDERED TO ME ARE CHARGED DIRECTLY TO ME AND THAT I AM PERSONALLY RESPONSIBLE FOR PAYMENT.

_____

Patient Signature Date

Authorization to Release Medical Information

I authorize the doctors(s) to release any medical information pertinent to my treatment plan to my insurance company or an authorized representative for review. This authorization for release of information shall remain valid for the term of my coverage under my current policy. I certify that all insurance information given to this clinic, Taylor Chiropractic & Wellness is correct and complete. I also know that I am entitled to receive a copy of this authorization form.

_____

Patient Signature Date

Consent for Treatment of Minor (if applicable)

I hereby authorize the doctor(s) and whomever they may designate as their assistant(s) to perform diagnostic tests, and to administer treatment as they deem necessary for my _____ (indicate relationship to child. ie: daughter, son, etc.). (child's name) _____.

_____

Parent/Guardian Signature Date