

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 <input type="checkbox"/> Self <input type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> 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:

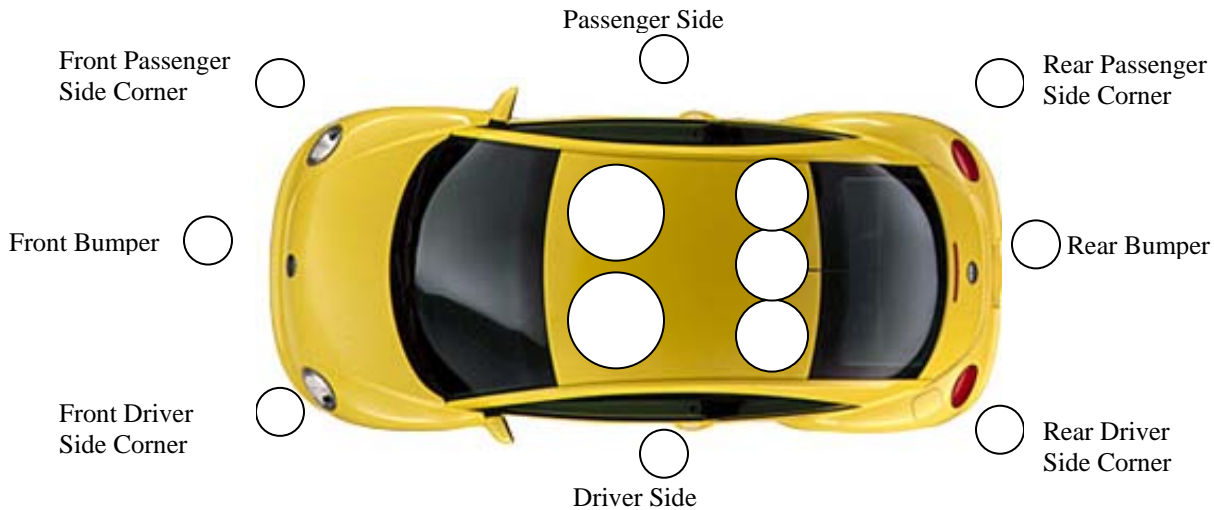
<input type="checkbox"/> At a Traffic Light	<input type="checkbox"/> At a stop sign going straight	<input type="checkbox"/> Making a Right/Left Turn
<input type="checkbox"/> Entering Traffic from a side street/Driveway	<input type="checkbox"/> Other: (Explain)	

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

The Other Vehicle:

<input type="checkbox"/> Hit me in the rear	<input type="checkbox"/> Ran a light	<input type="checkbox"/> Making a Right/Left Turn
<input type="checkbox"/> Entering Traffic from a side street/Driveway	<input type="checkbox"/> Ran across my lane	<input type="checkbox"/> 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:

<input type="checkbox"/> Front windshield	<input type="checkbox"/> Rearview mirror	<input type="checkbox"/> Steering Wheel	<input type="checkbox"/> Back of the seat	<input type="checkbox"/> Side Driver /
			ahead of me	Passenger
<input type="checkbox"/> Inside window /	<input type="checkbox"/> Another persons	<input type="checkbox"/> Back of my head	<input type="checkbox"/> Other	<input type="checkbox"/> Nothing
Door	body	hit the headrest		

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
				<input type="checkbox"/> Yes <input type="checkbox"/> No
				<input type="checkbox"/> Yes <input type="checkbox"/> No
				<input type="checkbox"/> Yes <input type="checkbox"/> 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:

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.

<p>Section 1 Pain Intensity</p> <p><input type="checkbox"/> I have no pain at the moment</p> <p><input type="checkbox"/> the pain is very mild at the moment</p> <p><input type="checkbox"/> the pain is moderate at the moment</p> <p><input type="checkbox"/> the pain is fairly severe at the moment</p> <p><input type="checkbox"/> the pain is very severe at the moment</p> <p><input type="checkbox"/> the pain is the worst imaginable at the moment</p> <p>Section 2 Personal Care (Washing, Dressing, Ect.)</p> <p><input type="checkbox"/> I can look at myself normally without causing extra pain</p> <p><input type="checkbox"/> I can look at myself normally that causes extra pain</p> <p><input type="checkbox"/> is painful to look at myself and I am slow and careful</p> <p><input type="checkbox"/> I need some help manage most of my personal care</p> <p><input type="checkbox"/> I need help everyday in most aspects of self-care</p> <p><input type="checkbox"/> I do not get dressed, I wash with difficulty and stay in bed</p> <p>Section 3 Lifting</p> <p><input type="checkbox"/> I can lift heavy weights without extra pain</p> <p><input type="checkbox"/> I can lift heavy weights but it gives extra pain</p> <p><input type="checkbox"/> pain prevents me from lifting heavy weights off the floor, but I can manage if they are conveniently positioned, for example on the table</p> <p><input type="checkbox"/> pain prevents me from lifting heavy weights, but I can manage light to medium weights if they are conveniently positioned</p> <p><input type="checkbox"/> I can lift very light weights</p> <p><input type="checkbox"/> I cannot lift or carry anything at all</p> <p>Section 4 Reading</p> <p><input type="checkbox"/> I can read as much as I want to with no pain in my neck</p> <p><input type="checkbox"/> I can read as much as I want to with slight pain in my neck</p> <p><input type="checkbox"/> I can read as much as I want with moderate pain in my neck</p> <p><input type="checkbox"/> I can't read as much as I want because of moderate pain in my neck</p> <p><input type="checkbox"/> I can hardly read at all because of severe pain in my neck</p> <p><input type="checkbox"/> I cannot read at all</p> <p>Section 5 Headaches</p> <p><input type="checkbox"/> I have no headaches at all</p> <p><input type="checkbox"/> I have slight headaches which come infrequently</p> <p><input type="checkbox"/> I have moderate headaches which come infrequently</p> <p><input type="checkbox"/> I have moderate headaches which come frequently</p> <p><input type="checkbox"/> I have severe headaches which come frequently</p> <p><input type="checkbox"/> I have headaches almost all the time</p>	<p>Section 6 Concentration</p> <p><input type="checkbox"/> I can concentrate fully when I want to with no difficulty</p> <p><input type="checkbox"/> I can concentrate fully when they want to with slight difficulty</p> <p><input type="checkbox"/> I have a fair degree of difficulty in concentrating what I want</p> <p><input type="checkbox"/> I had a lot of difficulty in concentrating when I want to</p> <p><input type="checkbox"/> I have a great deal of difficulty in concentrating when I want to</p> <p><input type="checkbox"/> I cannot concentrate at all</p> <p>Section 7 Work</p> <p><input type="checkbox"/> I can do as much work as I wanted</p> <p><input type="checkbox"/> I can only do my usual work, but no more</p> <p><input type="checkbox"/> I can do most of my usual work, but no more</p> <p><input type="checkbox"/> I cannot do my usual work</p> <p><input type="checkbox"/> I can hardly do any work at all</p> <p><input type="checkbox"/> I cannot do any work at all</p> <p>Section 8 Driving</p> <p><input type="checkbox"/> I can drive my car without any neck pain</p> <p><input type="checkbox"/> I can drive my car as long as I want with slight pain in my neck</p> <p><input type="checkbox"/> I can drive my car as long as I want with moderate pain in my neck</p> <p><input type="checkbox"/> I can drive my car as long as I want because of moderate pain in my neck</p> <p><input type="checkbox"/> I can hardly drive at all because of severe pain in my neck</p> <p><input type="checkbox"/> I can drive my car</p> <p>Section 9 Sleeping</p> <p><input type="checkbox"/> I have no trouble sleeping</p> <p><input type="checkbox"/> my sleep is slightly disturbed(less than 1 hour sleepless)</p> <p><input type="checkbox"/> my sleep is mildly disturbed(1 -- 2 hours sleepless)</p> <p><input type="checkbox"/> my sleep is moderately disturbed(2 -- 3 hours sleepless)</p> <p><input type="checkbox"/> my sleep is greatly disturbed(3 -- 5 hours sleepless)</p> <p><input type="checkbox"/> my sleep is completely disturbed(five -- 7 hours sleepless)</p> <p>Section 10 Recreation</p> <p><input type="checkbox"/> I'm able to engage in all my recreation activities with no neck pain at all</p> <p><input type="checkbox"/> I am able to engage in all my recreation activities, with some pain in my neck</p> <p><input type="checkbox"/> I am able to engage in most, but not all of my usual recreation activities because of pain in my neck</p> <p><input type="checkbox"/> I'm able to engage in a few of my usual recreation activities because of pain in my neck</p> <p><input type="checkbox"/> I can hardly do any recreation activities because of pain in my neck</p> <p><input type="checkbox"/> I can't do any recreation activities at all</p>
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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 and 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
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