

NECK PAIN AND DISABILITY INDEX

Patient Name: _____

Date: ____/____/____

Please read instructions carefully.

This questionnaire has been designed to give the doctor information as to how your neck pain has affected your ability to manage everyday life. Please read all statements in each section and then mark the box that 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 worse than 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.
- 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 do not get dressed. I wash with difficulty and stay in bed.

SECTION 3 - LIFTING

- I can lift heavy objects without any extra pain.
- I can lift heavy objects, but it gives extra pain.
- Pain prevents me from lifting heavy objects off the floor but I can manage if they are conveniently positioned on a table.
- Pain prevents me from lifting heavy objects but I can manage light to medium objects.
- I can lift very light objects.
- 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 light pain in my neck.
- I can read as much as I want to with moderate pain in my neck.
- I can't read as much as I want to 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 headache 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 I want to with slight difficulty.
- I have a fair degree of difficulty in concentrating when I want to.
- I have 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 at all.

SECTION 7 - WORK

- I can do as much work as I want.
- I can do only 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 work at all.
- I can't do any work at all.

SECTION 8 - DRIVING

- I can drive without any neck pain.
- I can drive as long as I want with slight neck pain.
- I can drive as long as I want with moderate neck pain.
- I can hardly drive at all because of severe neck pain.
- I can't drive at all.

SECTION 9 - SLEEPING

- I have no trouble sleeping.
- My sleep is slightly disturbed (less than 1 hr. sleepless).
- My sleep is mildly disturbed (1-2 hrs. sleepless).
- My sleep is moderately disturbed (3-5 hrs. sleepless).
- My sleep is completely disturbed (5-7 hrs. sleepless).

SECTION 10 - RECREATION

- I am able to engage in all my recreational activities with no neck pain.
- I am able to engage in all my recreational activities with some neck pain.
- I am able to engage in most, but not all of my usual recreational activities because of neck pain.
- I am able to engage in a few of my usual recreational activities because of neck pain.
- I can hardly do any recreational activities because of neck pain.
- I can't do any recreational activities at all.

NECK PAIN SCALE

Rate the severity of your **Neck Pain** by indicating on the following scale.

Absence I-----I **Extreme**

Score: / x 100 = % Scoring: For each section the total possible score is 5: if the first statement is marked the section score = 0, if the last statement is marked it = 5. If all ten sections are completed the score is calculated as follows: Example: 16 (total scored) / 50 (total possible score) x 100 = 32%. If one section is missed or not applicable the score is calculated: 16 (total scored) / 45 (total possible score) x 100 = 35.5%. Minimum Detectable Change (90% confidence): 10% points (Change of less than this may be attributable to error in measurement.)

LOW BACK PAIN AND DISABILITY INDEX (REVISED OSWESTRY)

Patient Name: _____

Date: ____/____/____

Please read instructions carefully.

This questionnaire has been designed to give the doctor information as to how your low back pain has affected your ability to manage everyday life. Please read all statements in each section and 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 does not vary much.
- The pain comes and goes and is moderate.
- The pain is moderate and does 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

- I do not have to change my way of washing or dressing to avoid pain.
- I do not normally change my way of washing or dressing even though it causes some pain.
- Washing and dressing increases the pain but I manage not to change my way of doing it.
- Washing and dressing increases 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 or dressing without help.

SECTION 3 - LIFTING

- I can lift heavy objects without any extra pain.
- I can lift heavy objects, but it gives extra pain.
- Pain prevents me from lifting heavy objects off the floor.
- Pain prevents me from lifting heavy objects off the floor but I can manage if they are conveniently positioned on a table.
- Pain prevents me from lifting heavy objects but I can manage light to medium objects.
- I can only lift very light objects at the most.

SECTION 4 - WALKING

- I have no pain on walking.
- I have some pain but it does not increase with distance.
- I cannot walk more than one 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 an hour.
- Pain prevents me from sitting more than 10 minutes.
- I avoid sitting because it increases pain.

SECTION 6 - STANDING

- I can stand as long as I want without pain.
- I have some pain on standing but it does 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 longer than 10 minutes without increasing pain.
- I avoid standing because it increases the pain.

SECTION 7 - SLEEPING

- I get no pain in bed.
- I get pain in bed but it does not prevent me from sleeping well.
- Pain reduces my normal sleep by 1/4 each night.
- Pain reduces my normal sleep by 1/2 each night.
- Pain reduces my normal sleep by 3/4 each night.
- 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.
- My social life is unaffected by pain apart from limiting more energetic interests.
- 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 - DRIVING / RIDING IN CAR, ETC.

- I get no pain while traveling.
- I get some pain while traveling but 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 alternate forms of travel.
- I get extra pain while traveling which compels me to seek alternate 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 or worse.
- My pain is gradually worsening.
- My pain is rapidly worsening.

LOW BACK PAIN SCALE

Rate the severity of your **Low Back Pain** by indicating on the following scale.

Absence I-----I **Extreme**

Score: / x 100 = % Scoring: For each section the total possible score is 5: if the first statement is marked the section score = 0, if the last statement is marked it = 5. If all ten sections are completed the score is calculated as follows: Example: 16 (total scored) / 50 (total possible score) x 100 = 32%. If one section is missed or not applicable the score is calculated: 16 (total scored) / 45 (total possible score) x 100 = 35.5%. Minimum Detectable Change (90% confidence): 10% points (Change of less than this may be attributable to error in measurement.)



Injury Questionnaire

Name: _____ Age _____ Home Phone #: _____ Work Phone #: _____

Address: _____ City: _____ State _____ Zip: _____

Occupation: _____ # Hours/Week Currently Working: _____

E-mail Address: _____ Cell Phone #: _____

ACCIDENT INFORMATION: Date of Accident: _____ Where (Street/Intersection): _____

Were any tickets issued and to whom? _____

Were you the: Driver Front Seat Passenger (Right) Back Seat LEFT Passenger Back Seat RIGHT Passenger

Did the impact to your vehicle come from the: Front Rear Left Side Right Side

Did the air bag deploy? Yes No Did you hit anything inside the vehicle? Yes No If yes, describe: _____

Did you experience immediate pain? Yes No Did the ambulance/paramedics arrive at the scene? Yes No

Were you taken to the hospital? Yes No Did you drive to the hospital? Yes No Which hospital? _____

Were xrays taken? Yes No MRI? Yes No CT? Yes No Did they prescribe medication? Yes No

Are you currently taking medication? Yes No If yes, please name all: _____

Please describe the accident in your own words: _____

FIRST (MAJOR) COMPLAINT: _____

Date when symptoms first appeared: _____ Have you had this condition before? _____

Did it begin Gradual? Yes No Sudden? Yes No How long has it been going on? _____

What makes symptoms increase? _____ What relieves symptoms? _____

Type of pain: Sharp Dull Aching Burning Throbbing How much of your day is pain? 10% 25% 50% 100%

Pain Intensity (circle): NONE 0 1 2 3 4 5 6 7 8 9 10 SEVERE

Does pain radiate into your (circle): L R Shoulder/Arm/Hand L R Buttox/Leg/Foot Does not radiate

SYMPTOMS: Please check if you have experienced any of the following since this accident.

- | | | |
|---|--|--|
| <input type="checkbox"/> Low Back Pain | <input type="checkbox"/> Tension Across Top of Shoulders | <input type="checkbox"/> Tired/Fatigued |
| <input type="checkbox"/> Pain between Shoulder Blades | <input type="checkbox"/> Numbness/Tingling in Arms/Hands | <input type="checkbox"/> Difficulty Sleeping |
| <input type="checkbox"/> Neck Pain | <input type="checkbox"/> Numbness/Tingling in Legs/Feet | <input type="checkbox"/> Ringing in Ears |
| <input type="checkbox"/> Difficulty talking | <input type="checkbox"/> Dizziness | <input type="checkbox"/> Brain Fog |
| <input type="checkbox"/> Tension/Headaches | <input type="checkbox"/> Pain in the legs/feet/buttox | <input type="checkbox"/> Nausea |
| <input type="checkbox"/> Changes in Vision | <input type="checkbox"/> Pain in the hand/arm/shoulders | <input type="checkbox"/> Vomiting |

Difficulty swallowing

Difficulty with balance

Other: _____

PREVIOUS ACCIDENT HISTORY:

Have you ever been involved in another motor vehicle accident? Yes No

If yes, please describe and give dates: _____

PATIENT HEALTH HISTORY

PATIENT INFORMATION

First Name: _____ M.I.: _____ Last Name: _____ Date: _____

Address: _____ City: _____ St: _____ Zip _____

SS#: _____ - _____ - _____ Age: _____ DOB: ____/____/____ Male / Female

Email Address: _____ Phone H: _____ C: _____

Primary Care Physician: _____

Do we have permission to contact your doctor regarding your care in our office? ___ Yes ___ No

Occupation: _____ Employer: _____

Type of Tasks Performed/Common Movements: _____

Marital Status: Single Married Divorced Widowed Separated Minor

Spouse's Name: _____ # of Children? _____ Children's Ages: _____

Emergency Contact Name: _____ Relation: _____ Phone #: _____

ACCIDENTS

Have you had an auto accident? (X if applies): 0-6mo 6 mo-1 yr 1-3yrs 3+yrs Never

Had a recent fall/other accident? (X if applies): 0-6mo 6 mo-1 yr 1-3yrs 3+yrs Never

Have You Ever Received Chiropractic Care? Yes No Last Visit? _____

Have You Ever Received Physical Therapy? Yes No Last Visit? _____

REFERRALS

How Did You Hear About This Office?

Walk-In/Drive-By

Shapes

LifeStyles

Massage-A-Teacher: _____

Insurance Company: _____

Existing Patient: _____

Radio: _____

Internet: _____

Ad: _____

Community Event: _____

Other: _____

INSURANCE

Do you have health insurance? Yes No Name of Carrier: _____

Do you have secondary insurance? Yes No Name of Carrier: _____

PLEASE PROVIDE THIS OFFICE WITH A COPY OF YOUR INSURANCE CARD(S)

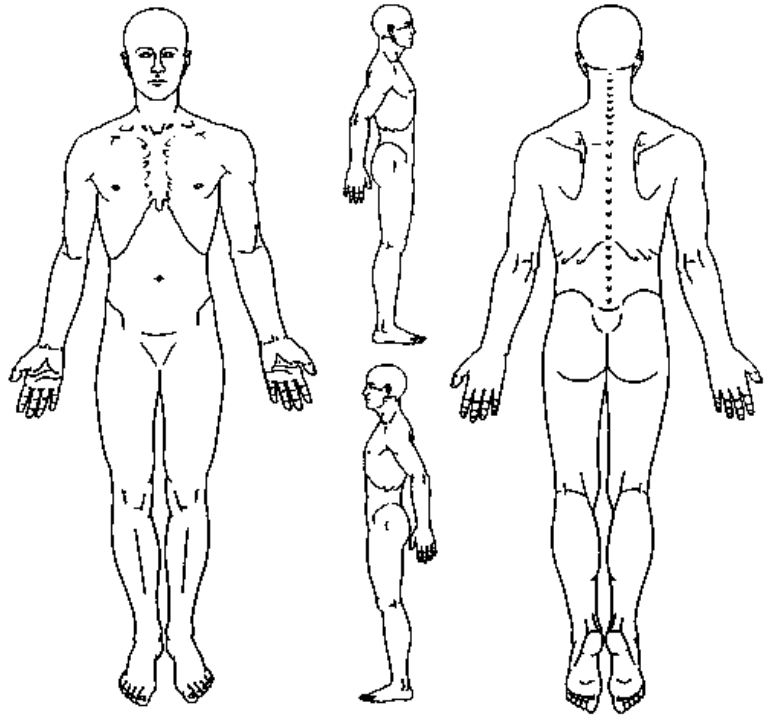
Assignment and Release (insured patients)

I certify that I (or my dependent) have insurance coverage with _____ and I AUTHORIZE, REQUEST AND ASSIGN MY INSURANCE COMPANY TO PAY DIRECTLY TO THE PHYSICIAN PRACTICE, Atlantic Coast Physical Medicine, LLC, INSURANCE BENEFITS OTHERWISE PAYABLE TO ME. I understand that I am financially responsible for all charges whether or not paid by insurance. I hereby authorize the doctor to release all information necessary, including the diagnosis and the records of any exam or treatment rendered to me, in order to secure the payment of benefits. I authorize the use of this signature on all insurance claims, including electronic submissions.

SIGNATURE (X) _____ **DATE** _____

Please check to indicate if you are currently experiencing any of the following conditions and then circle problematic areas on body to right:

- | | |
|--|--|
| <input type="checkbox"/> Neck Pain/Stiffness | <input type="checkbox"/> Pins/Needles in Arms |
| <input type="checkbox"/> Back Pain/Stiffness | <input type="checkbox"/> Pins/Needles in Legs |
| <input type="checkbox"/> Arm/Hand Pain | <input type="checkbox"/> Light Bothers Eyes |
| <input type="checkbox"/> Leg/Knee Pain | <input type="checkbox"/> Recent Weigh Change |
| <input type="checkbox"/> Headaches | <input type="checkbox"/> Loss of Memory |
| <input type="checkbox"/> Night Pain | <input type="checkbox"/> Nausea |
| <input type="checkbox"/> Depression | <input type="checkbox"/> Loss of Taste |
| <input type="checkbox"/> Cold Extremeties | <input type="checkbox"/> Fatigue |
| <input type="checkbox"/> Nervousness | <input type="checkbox"/> Chest Pain |
| <input type="checkbox"/> Sleeping Difficulties | <input type="checkbox"/> Tension |
| <input type="checkbox"/> Jaw Problems | <input type="checkbox"/> Fever |
| <input type="checkbox"/> Loss of Smell | <input type="checkbox"/> Cold Sweats |
| <input type="checkbox"/> Fainting | <input type="checkbox"/> Constipation/Diarrhea |
| <input type="checkbox"/> Dizziness | <input type="checkbox"/> Allergies |
| <input type="checkbox"/> Stomach Problems | <input type="checkbox"/> Shortness of Breath |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Blurred/Double Vision |
| <input type="checkbox"/> Swollen Joints | <input type="checkbox"/> Bowel/Bladder Changes |
| <input type="checkbox"/> Mood Changes | <input type="checkbox"/> Trouble Concentrating |
| <input type="checkbox"/> Foot Trouble | <input type="checkbox"/> Loss of Balance |



Please check if you have ever had any of the following:

- | | | | | |
|---|--|---|---|---|
| <input type="checkbox"/> ADD/ADHD | <input type="checkbox"/> Cancer | <input type="checkbox"/> Heart Attack | <input type="checkbox"/> Mouth Sores or Bleeding Gums | <input type="checkbox"/> Sexual Difficulty |
| <input type="checkbox"/> Aids/HIV | <input type="checkbox"/> Cataracts | <input type="checkbox"/> Heart Problems | <input type="checkbox"/> Multiple Sclerosis | <input type="checkbox"/> Stroke |
| <input type="checkbox"/> Alcoholism | <input type="checkbox"/> Chemical Dependency | <input type="checkbox"/> Hemorrhoids | <input type="checkbox"/> Mumps | <input type="checkbox"/> Suicide Attempt |
| <input type="checkbox"/> Allergy Shots | <input type="checkbox"/> Chicken Pox | <input type="checkbox"/> Hepatitis | <input type="checkbox"/> Nosebleeds | <input type="checkbox"/> Thyroid Problems |
| <input type="checkbox"/> Anemia | <input type="checkbox"/> Colon Trouble | <input type="checkbox"/> Hernia | <input type="checkbox"/> Osteoporosis | <input type="checkbox"/> TMJ Pain |
| <input type="checkbox"/> Anorexia | <input type="checkbox"/> Contacts/Glasses | <input type="checkbox"/> Herniated Disc | <input type="checkbox"/> Pacemaker | <input type="checkbox"/> Tonsillitis |
| <input type="checkbox"/> Appendicitis | <input type="checkbox"/> Diabetes | <input type="checkbox"/> Herpes | <input type="checkbox"/> Parkinson's Disease | <input type="checkbox"/> Tremors |
| <input type="checkbox"/> Arthritis | <input type="checkbox"/> Dry Skin | <input type="checkbox"/> High Cholesterol | <input type="checkbox"/> Pinched Nerve | <input type="checkbox"/> Tuberculosis |
| <input type="checkbox"/> Asthma/Wheezing | <input type="checkbox"/> Ear Infections | <input type="checkbox"/> Hormone/Gland Problems | <input type="checkbox"/> Pneumonia | <input type="checkbox"/> Tumors/Growths |
| <input type="checkbox"/> Bad Breath/Bad Taste | <input type="checkbox"/> Epilepsy | <input type="checkbox"/> Insomnia | <input type="checkbox"/> Polio | <input type="checkbox"/> Typhoid Fever |
| <input type="checkbox"/> Bleeding Disorders | <input type="checkbox"/> Fractures | <input type="checkbox"/> Kidney Problems | <input type="checkbox"/> Prostate Problems | <input type="checkbox"/> Ulcers |
| <input type="checkbox"/> Blood Pressure: High or Low (circle) | <input type="checkbox"/> Gall Bladder | <input type="checkbox"/> Liver Disease | <input type="checkbox"/> Prosthesis | <input type="checkbox"/> Vaginal Infections |
| <input type="checkbox"/> Breast Lump | <input type="checkbox"/> Glaucoma | <input type="checkbox"/> Measles | <input type="checkbox"/> Psychiatric Care | <input type="checkbox"/> Venereal Disease |
| <input type="checkbox"/> Broken Bones | <input type="checkbox"/> Goiter | <input type="checkbox"/> Menopausal Prob. | <input type="checkbox"/> Rheumatoid Arthritis | <input type="checkbox"/> Whooping Cough |
| <input type="checkbox"/> Bronchitis | <input type="checkbox"/> Gonorrhea | <input type="checkbox"/> Migraines | <input type="checkbox"/> Rheumatic Fever | <input type="checkbox"/> Other: _____ |
| <input type="checkbox"/> Bulimia | <input type="checkbox"/> Gout | <input type="checkbox"/> Miscarriage | <input type="checkbox"/> Scarlet Fever | _____ |
| | <input type="checkbox"/> Heartburn | <input type="checkbox"/> Mononucleosis | | _____ |

Are you currently under drug and/or medical care? Yes No If yes, explain _____

Please list any and all medications you are currently taking: _____

Please list any surgeries and/or hospitalizations you have had (type & date): _____

ALLERGIES: (Please place a check mark next to any known allergy that you have.)

Milk Eggs Peanuts Almonds Cashews Walnuts Fish Shellfish Soy Wheat
 Gluten Penicillin Sulfa Drugs Tetracycline Codeine NSAIDS Phenytoin Carbamazepine
 Mildew Mold Dust Fungus Mites Tree Pollen Grass Pollen Weed Pollen Insects
 Dog Dander Cat Dander Latex Other Animal Dander OTHER: _____ (please fill in)

Please list any supplements you are currently taking (vitamins/herbs/minerals): _____

Is there a family history of any of the following conditions? (indicate family member including parents, grandparents & siblings)

Heart Disease _____ Diabetes _____
 Cancer _____ Arthritis _____ Other _____

Do you exercise: Frequently Moderately Occasionally None

Do your work activities mostly involve: Sitting Standing Light Labor Heavy Labor

Do you sleep on your: Back Side Stomach Do you use a cervical pillow? Yes No

What is your daily/weekly intake of the following:

Caffeine _____ cups/day Alcohol _____ drinks/week Cigarettes _____ packs/day

- **I certify that the above questions were answered accurately. I understand that providing incorrect information can be dangerous to my health. will give complete and accurate information during my exam.**

SIGNATURE (X) _____ **DATE** _____

X-ray Questionnaire: For women only

Our consultation and examination may indicate that x-rays are necessary to accurately diagnose and analyze your condition. Should x-rays be necessary we would like to confirm that you are not pregnant at this time.

Name: _____

There is a possibility that I a may be pregnant at this time.

Yes, I am definitely pregnant

No, I am definitely not pregnant at this time

I request that x-ray films not be taken because: _____

Date of last menstrual period: _____

Patient's Signature

Date

Pain Disability Index

Name: _____ Date: _____

Pain disability index: The rating scales below are designed to measure the degree to which aspects of your life are disrupted by chronic pain. In other words, we would like to know how much your pain is preventing you from doing what you would normally do or from doing it as well as you normally would. Respond to each category by indicating the overall impact of pain in your life, not just when the pain is at its worst.

For each of the 7 categories of life activity listed, please circle the number on the scale that describes the level of disability you typically experience. A score of 0 means no disability at all, and a score of 10 signifies that all of the activities in which you would normally be involved have been totally disrupted or prevented by your pain.

Family/Home responsibilities: This category refers to activities of the home or family. It includes chores/duties performed around the house (eg, yard work) and errands or favors for other family member (eg, driving the children to school).

No disability 0 1 2 3 4 5 6 7 8 9 10 Worst disability

Recreation: This category includes hobbies, sports, and other similar leisure time activities.

No disability 0 1 2 3 4 5 6 7 8 9 10 Worst disability

Social activity: This category refers to activities that involve participation with friends and acquaintances other than family members. It includes parties, theatre, concerts, dining out, and other social functions.

No disability 0 1 2 3 4 5 6 7 8 9 10 Worst disability

Occupation: This category refers to activities that are a part of or directly related to one's job. This includes nonpaying jobs as well, such as that of a housewife or volunteer worker.

No disability 0 1 2 3 4 5 6 7 8 9 10 Worst disability

Sexual behavior: This category refers to the frequency and quality of one's sex life.

No disability 0 1 2 3 4 5 6 7 8 9 10 Worst disability

Self Care: This category includes activities, which involve personal maintenance and independent daily living (eg, taking a shower, driving, getting dressed, etc.)

No disability 0 1 2 3 4 5 6 7 8 9 10 Worst disability

Life-support activity: This category refers to basic life-supporting behaviors such as eating, sleeping, and breathing.

No disability 0 1 2 3 4 5 6 7 8 9 10 Worst disability

TERMS OF ACCEPTANCE AND CONSENT FOR CARE

We will attempt to identify and diagnose any ailments you may have that may be corrected through physical medicine, massage therapy, chiropractic care, and/or active/passive rehabilitation. If any condition or disease appears to be present out of our scope of practice, we will refer you to an appropriate physician to diagnose and/or treat that condition.

The primary focus of chiropractic care is the detection and correction of vertebral subluxation. This is the misalignment of one or multiple spinal bones with interference to the nervous system. Any interference to the nervous system may or may not cause various different symptoms.

Through specific chiropractic adjustments, we reduce and/or correct these subluxations. It may be necessary to examine an individual each time a new injury occurs and often x-rays are necessary to maintain the utmost safety when dealing with your body. The risks of physical medicine, chiropractic care or massage therapy are minimal when dealing with a licensed professional; however, if you have concerns about these risks, please discuss them with the doctor prior to the examination.

I also understand that the fee paid for treatment x-rays is for analysis only. The film itself is the property of this office. Once films are taken, they cannot be released, but may be copied. There is a fee for copying of the xrays.

Also, for your protection, portions of our office where patients do not disrobe are under video surveillance, specifically, but not limited to, the front desk check-out stations.

I have read and I accept the terms above and understand them fully. I hereby give consent to the ATLANTIC COAST PHYSICAL MEDICINE, to evaluate me to determine my condition and treat me for such conditions. I also understand that I may at any time discontinue with the exam and/or x-rays or any treatment if I so choose.

I also understand that if I suspend or terminate my care at this office, any outstanding charges for professional services rendered to me will be immediately due and payable. I agree that I will be responsible for all attorney and legal fees if legal action becomes necessary to collect this amount.

I, _____ have read and fully understand the above statements.
(PRINT NAME)

(SIGNATURE)

(DATE)

FOR MINORS:

I, _____ being the parent or legal guardian of _____,
(Print Guardian Name) (Print Minor's Name)

have read and fully understand the above terms of acceptance and hereby grant permission for my child to receive treatment.

(SIGNATURE)

(DATE)

NEUROLOGICAL AND VASCULAR PATIENT QUESTIONNAIRE

NAME: _____ DATE: _____

For any YES answer, please notify the Doctor.

1. Do you suffer from neck pain with pain in your shoulder, arms or hands? NO YES
Comment: _____
2. Do you have weakness, numbness or burning in your shoulder, arms or hands? NO YES
Comment: _____
3. Do your hands or arms fall asleep regularly? NO YES
Comment: _____
4. Do you have reduced feeling (sensation) or swelling in your hands or arms? NO YES
Comment: _____
5. Do you suffer from a loss of handgrip strength? NO YES
Comment: _____
6. Do you suffer from back pain with pain in your buttocks, legs or feet? NO YES
Comment: _____
7. Do you have weakness, numbness or burning in your buttocks, legs or feet? NO YES
Comment: _____
8. Do your legs or feet fall asleep regularly? NO YES
Comment: _____
9. Do you have reduced feeling (sensation) or swellings in your legs, feet? NO YES
Comment: _____
10. Do you suffer from cold hands or feet? NO YES
Comment: _____
11. Do you suffer from headaches, dizziness or memory loss? NO YES
Comment: _____
12. Do you have difficulty maintaining your balance? NO YES
Comment: _____
13. Do you suffer from vertigo or blurred vision? NO YES
Comment: _____
14. Do you suffer from a reduced hearing capacity? NO YES
Comment: _____
15. Do you suffer from ringing in your ears? NO YES
Comment: _____
16. Do you have bladder or bowel control problems on a regular basis? NO YES
Comment: _____

Privacy Notice

THIS NOTICE DESCRIBES HOW CHIROPRACTIC AND MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

In the course of your care as a patient at Atlantic Coast Physical Medicine, we may use or disclose personal and health related information about you in the following ways:

- Your personal health information, including your clinical records, may be disclosed to another healthcare provider or hospital if it is necessary to refer you for further diagnosis, assessment or treatment.
- Your healthcare records as well as your billing records may be disclosed to another party, such as an insurance carrier, an HMO, a PPO, or your employer, if they are or may be responsible for the payment of your services.
- Your name, address, phone number, and healthcare records may be used to contact you regarding appointment reminders, information about alternative to your present care, or other health related information that may be of interest to you.

If you are not at home to receive an appointment reminder, a message may be left on your answering machine. Furthermore, you have the right to inspect or obtain a copy of the information we will use for these purposes. You also have the right to refuse to provide authorization for this office to contact you regarding these matters. If you do not provide us with this authorization it will not affect the care provided to you or the reimbursement avenues associated with your care.

Under federal law, we are also permitted or required to use or disclose your health information without your consent or authorization in the following circumstances:

- If we are providing healthcare to you based on the orders of another healthcare provider.
- If we provide healthcare services to you in an emergency.
- If we are required by law to provide care to you and we are unable to obtain our consent after attempting to do so.
- If there are substantial barriers to communicating with you, but in our professional judgment we believe that you intend for us to provide care.
- If we are ordered by the courts or another appropriate agency.

Any use or disclosure of your protected health information, other than as outlined above, will only be made upon your written authorization.

We normally provide information about your health to you in person at the time you receive chiropractic care from us. We may also mail information to you regarding your healthcare or about the status of your account. If you would like to receive this information at an address other than your home or if you would like the information in a different form, please advise us in writing as to your preferences.

You have the right to inspect and/or copy your health information for seven years from the date that the record was created or as long as the information remains in our files. In addition you have the right to request an amendment to your health information. Requests to inspect, copy or amend our health related information should be provided to us in writing.

We are required by state and federal law to maintain the privacy of your patient file and the protected health information therein. We are also required to provide you with this notice of our privacy practices with respect to your health information.

We are further required by law to abide by the terms of this notice while it is in effect. We reserve the right to alter or amend the terms of this privacy notice. If changes are made to our privacy notice we will notify you in writing as soon as possible following the changes. Any change in our privacy notice will apply to all of your information in our files.

Information that we use or disclose based on this privacy notice may be subject to re-disclosure by the person to whom we provide the information and may no longer be protected by the federal privacy rules.

If you have a complaint regarding our privacy notice, our privacy practices or any aspect of our privacy activities you should direct your complaint to: Dr. Heather Lambert. If you would like further information about our privacy policies and practices please contact: Dr. Heather Lambert.

This notice is effective as of June 15, 2013. This notice, and any alterations or amendments made hereto will expire seven (7) years after the date upon which the record was created. My signature acknowledges that I have received a copy of this notice.

Name (Print)

Signature

Date