Freeport Family Chiropractic Clinic, LLC

40 Washington Street Freeport, FL 32439

Phone (850)835-9867 Fax (850)880-6089

REGISTRATION FORM

Please give the front desk your photo ID & any insurance cards

(auto & major medical if a PIP patient)

1)PATIENT INFORMATION:

Date _____ ☐ M ☐ F

Last Name _____ First Name _____ Middle _____

Mailing Address _____

_____
CITY STATE ZIP

Physical Address _____

_____
CITY STATE ZIP

SS# _____ Date of birth ___/___/___ AGE _____

E-Mail Address _____

1.) Phone #:_____ Home/Cell/Work 2.) Phone #:_____ Home/Cell/Work

Cell Phone carrier: Nextel/Sprint/AT&T/Verizon/Cingular/T-Mobile/Boost Mobile/Alltel Other: _____

Is it ok to text your cell phone regarding your appointment times? _____

☐ Married ☐ Widowed ☐ Single ☐ Minor ☐ Separated ☐ Divorced ☐ Partnered for _____ years

Race: ☐ Asian ☐ Black ☐ Hispanic ☐ Indian ☐ White ☐ Unknown ☐ Other: _____

Employers Name _____ Occupation _____

Referred by _____

2) EMERGENCY CONTACT:

Last Name _____ First Name _____ Middle _____

Phone # _____ Relationship to patient _____

3) MRI/X-RAYS/CAT SCANS:

If you have had any MRI/X-RAYS/or CAT Scans done; when and where did you get them?

_____

4) ACCIDENT INFORMATION:

Is condition due to an accident? ☐ Yes ☐ No

Type of accident Auto Work Home Other

To whom have you made a report of your accident? Auto Insurance Employer Worker Comp. Other

Attorney Name (if applicable) _____

5) INSURANCE INFORMATION: We need a copy of your card(s) for our records.

Primary Insurance: _____ Insured Name: _____

Secondary Insurance: _____ Insured Name: _____

I am authorizing that all information provided on this form is true and correct. I give Freeport Family Chiropractic Clinic authorization to bill all insurance company (ies) provided on this form. It is my responsibility to update Freeport Family Chiropractic Clinic of any changes to my personal information or insurance information.

_____ _____

SIGNATURE OF PATIENT, PARENT, GUARDIAN OR PERSONAL REPRESENTATIVE DATE

_____ _____

PLEASE PRINT NAME OF PATIENT, PARENT, GUARDIAN OR PERSONAL REPRESENTATIVE RELATIONSHIP TO PATIENT

Freeport Family Chiropractic Clinic, LLC

40 Washington Street Freeport, FL 32439
Phone (850) 835-9867 Fax (850) 880-6089

AUTHORIZATION FOR RELEASE/REQUEST OF MEDICAL INFORMATION

To Whom It May Concern:

I hereby authorize the office of Jennifer L. Laird, D.C./ Freeport Family Chiropractic Clinic to request any medical records, x-rays, MRI reports, CT scans, emergency room reports, physician's reports, police reports, and/or other pertinent information pertaining to my case as necessary. I also hereby authorize the office of Jennifer L. Laird, D.C./ Freeport Family Chiropractic Clinic to release or furnish to any requesting hospital, physician, medical attendant, insurance company, or attorney, any and all medical information, including x-rays, pertaining to my case. **This form does not expire unless the patient gives written notice to the practice.**

_____ _____

Date of Birth Social Security Number

INFORMED CONSENT FOR CHIROPRACTIC TREATMENT

I hereby request and consent to the performance of chiropractic treatments and other chiropractic/medical procedures, including various forms of physical therapy and diagnostic x-rays by Jennifer L. Laird, D.C./Freeport Family Chiropractic Clinic. This consent is extended to other licensed chiropractic physicians, chiropractic assistants or licensed massage therapists, who now or in the future, are employed by, working with or associated with this office.

While Dr. Jennifer L. Laird believes this recommended therapy to be reasonable and medically necessary and the anticipated benefits far outweigh the risks, some patients wonder what complications might occur. Thus, Dr. Jennifer L. Laird believes you should be made aware of these risks before treatment.

For the vast majority of patients, there are few, if any risks; and most of the risks are minimal, such as soreness.

As with any health care procedures, there are certain complications, which may arise during chiropractic treatments. Those complications include but are not limited to: fractures, disc injuries, dislocations, muscle strain, cervical myelopathy and costovertebral strains and separations. Some types of manipulation of the neck have been associated with injuries to the arteries in the neck leading to or contributing to complications including stroke.

I do not expect the doctor to be able to anticipate all risks and complications, and I wish to rely upon the doctor to exercise judgment during the course of the procedure(s) which the doctor feels at the time, based upon the facts then known, that are in my best interest. While none of these complications has ever occurred in our office, should they occur in your case, for your protection, you would be referred immediately to another physician for treatment or the closest ER.

I have the right to discuss the nature, purpose and risks of chiropractic treatments and other recommended procedures. I also understand that specific results are not guaranteed. This consent is designed to inform rather than frighten you. Thus, if you have any questions Dr. Jennifer L. Laird will be glad to discuss them with you before beginning treatment.

I have read (or have had read to me) the above explanation of the chiropractic treatments. I state that I have been informed and weighed the risks involved in chiropractic treatment at this health care office. I have decided that it is in my best interest to receive chiropractic treatment. I hereby give my consent to this treatment. I intend for this consent to cover the entire course of my treatment for my present condition(s) and for any future condition(s) for which I seek treatment.

SIGN ONLY AFTER YOU UNDERSTAND AND AGREE TO ALL OF THE ABOVE

Printed name of Patient _____

Signature of Patient _____ Date _____

Signature of Representative (if minor or handicapped) _____

Chart #_____ **4L** **Date:**_____

Freeport Family Chiropractic Clinic, LLC

40 Washington Street Freeport, FL 32439
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POLICY ON INSURANCE ASSIGNMENT

We are pleased to accept insurance assignment subject to verification of your coverage. We will file your claims as a courtesy to you in every way we can. However, it must be fully understood that the contract is between you and your insurance company and you are fully responsible for any amount not paid by your insurance.

1. I authorize payment of medical benefits directly to Freeport Family Chiropractic Clinic.
2. I authorize the release of any medical information necessary in the processing of my insurance claims.
3. I agree that I will pay the percentage of charges not covered by my insurance company at the time of service. (example: If my insurance pays 80% of my charges, then I pay 20% at the time of charge.)
4. I agree that I will pay in full for charges for items or services, which Freeport Family Chiropractic Clinic believes, will not be covered by my insurance company at the time they are incurred.
5. I agree that I am totally responsible for any charges in this office and, if for some reason my insurance company does not cover charges within sixty (60) days or a claim is denied, I will pay those charges immediately.
6. I agree that if my insurance company refused to accept assignment of benefits or for some reason sends the payments to me, I will bring or send those payments to Freeport Family Chiropractic Clinic immediately.
7. I understand and agree that Freeport Family Chiropractic Clinic will not enter into any dispute with my insurance company regarding a claim and that this is my responsibility and obligation.
8. I agree that a copy of this document can be considered that same as an original when used for insurance billing purposes.
9. Freeport Family Chiropractic has the right to charge 33% to my balance if it goes to collections. Plus any other fees charged by the collection agency.

PLEASE SELECT ONE OF THE FOLLOWING: **Please initial beside which one applies**

_____ **NON-INSURANCE PATIENTS:** You will be required to pay in full for all services rendered upon each visit. As long as you pay in full upon each visit and keep your balance at zero, we will discount our prices for spinal manipulation and physical therapy modalities by 20% (point of service discount). Itemized statements will be furnished to you upon request. We do not bill your insurance company for cash accounts.

_____**INSURANCE PATIENTS:** If you want us to bill your insurance for you, we will bill your insurance as long as your insurance company accepts assignment and will make payment directly to Freeport Family Chiropractic Clinic. You will be required to pay in full for services rendered while meeting your deductible (discounts may not apply). After your deductible has been met, you will be responsible for paying non-covered items at the time they are purchased and for the percentage not covered by your insurance. Verification of your insurance benefits does not guarantee payment. We will bill your insurance company as a courtesy to you and will estimate your patient portion (the percentage not covered by your insurance) as closely as possible based upon the benefits as explained to us by your insurance company.

MY SIGNATURE BELOW VERIFIES THAT I HAVE READ, FULLY UNDERSTAND AND AGREE TO THE ABOVE OFFICE POLICIES AND WILL ALLOW FREEPORT FAMILY CHIROPRACTIC CLINIC TO ACCEPT MY INSURANCE ASSIGNMENT.

_____ _____

Print Patient Name Date

_____

Signature of Patient

Chart #_____ **5L** **Date:**_____

FREEPORT FAMILY CHIROPRACTIC

40 Washington Street Freeport, FL 32439

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HIPPA RELEASE OF INFORMATION

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 Freeport Family Chiropractic Clinic 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 health care provider or hospital if it is necessary to refer you for further diagnosis, assessment or treatment.

*Your health care 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 your health care records may be used to contact you regarding appointment reminders, information about alternatives 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. Further, 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 these following circumstances:

*If we are providing health care services to you based on the orders of another health care provider.

*If we provide health care services to you in an emergency.

*If we are required by law to provide care to you and we are unable to obtain your consent after attempting to do so.

*If there are substantial barriers to communicating with you, but in our professional judgement 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 health care or about the status of your account. If you would like to receive this information at an address other that your home or, if you would like 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. After seven years the file will be destroyed. In addition you have the right to request an amendment to your health information. My practice has the right to accept or deny your request. Requests to inspect, copy or amend your health related information should be provided to us in writing. There may be a reasonable cost based fee for photocopying, postage and preparation.

We are required by state and federal law to maintain the privacy of your patient file and the health 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 to our privacy notice will apply for all of your health information in our files. Information that we use or disclose based on this privacy notice may be subject to re-disclosure by the person. 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 Janie Matthews. If you would like further information about our privacy policies and practices please contact our front office.

Please Sign back side of this sheet

Chart #_____ 6L Date_____

Please check box 1 or 2 of the following:

☐ I do not want my medical information discussed with anyone other than myself. (Place a star on patients chart)

You may discuss my medical information with the following people.

(Not including doctors or Insurance Companies or individuals stated in the above notice.)

1) _____ Relationship: _____
2) _____ Relationship: _____
3) _____ Relationship: _____

_____ _____

SIGNATURE OF PATIENT, PARENT, GUARDIAN OR PERSONAL REPRESENTATIVE **DATE**

_____ _____

PRINT NAME OF PATIENT, PARENT, GUARDIAN OR PERSONAL REPRESENTATIVE **RELATIONSHIP TO PATIENT**

Notarization:

On this _____ day of _____, _____, _____
DATE MONTH YEAR NAME OF PATIENT
personally appeared before me in _____ County (in the state of _____)
and, in my presence, signed this hippa release of information form.

Name of Notary Official: _____
Signature: _____
Commission Expires: _____

ACKNOWLEDGMENT OF RECEIPT
OF
NOTICE OF PRIVACY PRACTICES

I acknowledge that I was provided a copy of the Notice of Privacy Practices and that I have read them or declined the opportunity to read them and understand the Notice of Privacy Practices. I understand that this form will be placed in my patient chart and maintained for six years.

_____ _____
Patient Name (please print) Parent, Guardian or Patient's legal representative

_____ _____
Signature Date

THIS FORM WILL BE PLACED IN THE PATIENT'S CHART AND MAINTAINED FOR SIX YEARS.

ATTENTION ALL MASSAGE PATIENTS

DUE TO THE HIGH NUMBER OF NO SHOWS AND CANCELLATIONS THERE WILL BE A $25.00 CHARGE TO YOUR ACCOUNT FOR EACH MASSAGE THAT IS NOT CANCELLED WITHIN 24 HOURS OF YOUR APPOINTMENT. IF YOU NEED TO CANCEL YOUR APPOINTMENT AND WE ARE NOT IN THE OFFICE PLEASE LEAVE A MESSAGE ON THE MACHINE TO BE ANSWERED THE FOLLOWING BUSINESS DAY. ALL CHARGES WILL GO ON A CASH ACCOUNT AND WILL NOT BE CHARGED TO YOUR INSURANCE COMPANY. EACH PATIENT IS ENTITLED TO ONE CANCELATION. ALL MASSAGE PATIENTS WILL BE ASKED TO SIGN THAT YOU UNDERSTAND AND AGREE WITH THE TERMS OF THIS LETTER. THE FEE WILL NEED TO BE PAID BEFORE NEXT VISIT.

_____ _____

PRINT NAME DATE

_____

SIGNATURE OF PATIENT OR GUARDIAN

Chart #_____ 8L Date_____

FREEPORT FAMILY CHIROPRACTIC CLINIC

PATIENT MEDICAL HISTORY

Name: _____

Medical Information

For the following conditions please place an "x" in the box if applicable:

Health	Never Had	Had Previously	Having Now	Mother	Father	Sibling	Doctors use only
GENERAL:							
1. Chicken Pox/Measles/Mumps/Polio (Circle Which One)							
2. Rheumatic/Scarlet/Typhoid Fever (Circle Which One)							
3. Fatigue							
4. Alcoholism							
5. Smoking (1/2/3 packs a day)(Circle One)							
6. Trouble sleeping due to pain							
WOMEN ONLY (MEN LEAVE BLANK):							
7. Breast Cancer							
8. Ovarian/ Uterine Cancer							
9. Hysterectomy							
10. Pregnant							
11. Date of last period: _____							
INTEGUMENTARY (SKIN):							
12. Bruise Easily/ Slow healing (Circle Which One)							
13. Skin Cancer							
14. Tumors, Growths							
ENDOCRINE:							
15. Diabetes type I (Insulin)							
16. Diabetes type II (Medication)							
17. Recent weight loss/gain (Circle Which One)							
18. Hair loss/ Hoarseness (Circle Which One)							
19. Goiter							
20. Hyperthyroidism (High)							
21. Hypothyroidism (Low)							
RESPIRATORY:							
22. Asthma (On Medication)(Yes or No)							
23. Chest pain							
24. Coughing up blood							
25. Difficulty Breathing/Shortness of breath (Circle Which One)							
26. Emphysema							
27. Lung Cancer							
28. Tuberculosis (TB)							

CARDIOVASCULAR:							
29. Heart attack/Heart disease (Circle Which One)							
30. High blood pressure/ Low blood pressure (Circle Which One)							
31. High cholesterol levels/ High triglycerides							
32. Irregular heart beat							
33. Pacemaker							
34. Pain down left arm							
35. Pain over the heart (pressure)							
36. Perfuse sweating/ swelling in ankles (Circle Which One)(Both)							
GASTROINTESTINAL:							
37. Appendix removed							
38. Blood in stool							
39. Colitis							
40. Colon Cancer							
41. Constipation/ Diarrhea (Circle Which One)(Both)							
42. Gallbladder removed							
43. Frequent heartburn							
44. Hepatitis (A/B/C) (Circle Which One)							
45. Hiatal hernia							
46. Liver trouble							
47. Pancreatitis							
GENITOURINARY:							
48. Blood in urine							
49. Incontinence (inability to control bladder)							
50. Painful/frequent urination							
51. Kidney disease							
52. Frequent kidney stones							
53. Loss of libido							
54. Prostate Cancer (Men only)							
HEMATOLOGIC BLOOD:							
55. Anemia/ Blood disorders							
56. Blood clots/ On blood thinners (Yes or No)							
57. Lymphoma							
58. Sickle cell anemia							
MUSCULOSKELETAL:							
59. Neck/Back injury (Circle Which One)							
60. Osteoarthritis							
61. Rheumatoid arthritis (RA)							
62. Fracture/broken bones including compression fractures							
63. Lupus							
64. Bone spurs							
65. Gout							
66. Spinal bifida							

67. Muscular dystrophy							
68. Spondylolisthesis							
69. Scheurman's disease							
70. Scoliosis							
71. Osteoporosis/Osteopenia (Circle Which One)							
72. Diagnosised herniated disc							
73. Joint Pain/ Muscle Pain (Circle Which One)(Both)							
74. Leg cramps/ Restless leg syndrome (Circle Which One)(Both)							
75. Pinched nerve							
ALLERGIC/IMMUNOLOGIC:							
76. HIV/AIDS							
77. HERPES							
78. Allergies (seasonal/food/chemical)							
79. Catch colds easily							
80. Frequent sinus trouble							
PSYCHIATRIC:							
81. Anorexia/Bulimia							
82. Anxiety							
83. Bipolar							
84. Depression							
85. Previous psychiatric care							
NEUROLOGICAL:							
86. Alzheimer's/Dementia							
87. Aneurysm							
88. Difficulty speaking							
89. Difficulty walking							
90. Disorientation							
91. Epilepsy/seizures (Circle Which One)(Both)							
92. Migraines/headaches							
93. Light headed/dizzy/fainting (Circle Which One)							
94. Loss of coordination/ Memory Loss (Circle Which One)(Both)							
95. Multiple sclerosis (MS)							
96. Numbness/Tingling							
97. Parkinson's disease							
98. Stroke							
99. Tremors							
100. Weakness in extremities (upper/Lower)							
101. Blurred vision/double vision/wear glasses/contacts (circle all that apply)							
102. Ringing in ears/ Hearing loss							
103. Sore throats/ Nosebleeds (Circle Which One)(Both)							

During the past year

☐ I have not had a medical examination

☐ I have had a medical examination. By _____

List, date, and by whom (1) surgeries, (2) car accident (even minor) with injuries that occurred, (3) recent hospitalizations.

1)_____

2)_____

3)_____

Please list the name of current medications and what they are for: _____

_____

Please answer questions about your job and activities there:

Occupation/Job Title: _____

Description of work activities: _____

Lifting frequency: constant (67-100% a day)/ frequent (33-66% a day)/ Occasional (0-32% a day)

Work activity postures: bending/ climbing/ kneeling/ pulling/ reaching/ sitting/ standing/ twisting/ walking

Repetitive activities: assembly/ computer use/ phone use/ grasping/ machinery controls

Conditions effect on job performance: No effect/ mild/ moderate/ severe (can't do Job)

X-RAY CONSENT FORM

During your examination, the doctor may feel that x-rays will be needed in order to provide your treatment. In order to perform x-rays on any patient our office requires that patients consent for such tests to be performed.

Please choose one of the following:

____ I understand that the doctor may need x-rays in order to administer my treatment and I give my permission to perform such tests.

____ I understand that it may be necessary for the doctor to take x-rays to administer my care. I choose not to have any x-rays at this time and release the doctor of all liabilities. I also understand that the doctor has the right to refuse treatment to me if I choose this option.

Consent To X-Ray A Minor:

I am the parent or legal guardian of _____, who is a minor, ____years of age. I hereby authorize the performance of diagnostic x-rays of the minor named above. Freeport Family Chiropractic has requested the x-rays for further diagnostic purposes. At this time I know of no other condition which the taking of x-rays would further complicate.

Females: Regarding Possibility of Pregnancy

This is to certify that, to the best of my knowledge, I am **NOT** pregnant. The doctor and certified staff of Freeport Family Chiropractic have permission to perform diagnostic x-rays. I am aware that taking x-rays, particularly those involving the pelvis, can be hazardous to an unborn child.

	YES	NO	DON'T KNOW
I am pregnant			
I could be pregnant			
My menstrual period is late			
I have an IUD			
I have had a tubal ligation			
I have had a hysterectomy			
I have irregular menstrual periods			

I certify that the information provided is true, correct and complete to the best of my knowledge, information and belief.

_____ _____

PATIENT SIGNATURE Date patient signed

_____ _____

DOCTOR SIGNATURE AFTER REVIEWING Date doctor signed

Chart # _____ 9R Date: _____

Freeport Family Chiropractic Clinic

Oswestry Low Back Pain Disability Questionnaire

Patient Name_____

This questionnaire is designed to provide information regarding your back and/or leg pain affecting your ability to manage everyday life. Please answer by circling ONE statement, in each section, for the option which best applies to you. You may find that two or more statements in a section apply, please choose the statement that BEST describes your complaint.

Pain Intensity		**Personal Care (Washing, dressing, etc.)**	
0	I have no pain at the moment.	0	I can look after myself normally without causing extra pain.
1	The pain is very mild at the moment.	1	I can look after myself normally but it causes extra pain.
2	The pain is moderate at the moment.	2	It is painful to look after myself and I am slow and careful
3	The pain is fairly severe at the moment.	3	I need some help but manage most of my personal care.
4	The pain is very severe at the moment.	4	I need help every day in most aspects of self-care
5	The pain is the worst imaginable at the moment.	5	I do not get dressed, I wash with difficulty and stay in bed.
Sleeping		**Lifting**	
0	My sleep is never disturbed by pain	0	I can lift heavy weights without extra pain
1	My sleep is occasionally disturbed by pain	1	I can lift heavy weights but it gives extra pain
2	Because of pain I have less than 6 hours sleep	2	Pain prevents me from lifting heavy weights off the floor, but I can manage if they are conveniently placed eg. on the table
3	Because of pain I have less than 4 hours sleep	3	Pain prevents me from lifting heavy weights, but I can manage light to medium weights if they are conveniently positioned
4	Because of pain I have less than 2 hours sleep	4	I can lift very light weights
5	Pain prevents me from sleeping at all	5	I cannot lift or carry anything at all
Sitting		**Traveling**	
0	I can sit in any chair as long as I like	0	I can travel anywhere without pain
1	I can only sit in my favorite chair as long as I like	1	I can travel anywhere but it gives me extra pain.
2	Pain prevents me from sitting more than one hour	2	Pain is bad but I manage journeys of less than two hours
3	Pain prevents me from sitting more than 30 minutes	3	Pain restricts me to journeys of less than one hour
4	Pain prevent me from sitting more than 10 minutes	4	Pain restricts me to short necessary journeys under 30 minutes
5	Pain prevents me from sitting at all	5	Pain prevents me from traveling except to receive treatment.
Standing		**Social Life**	
0	I can stand as long as I want without extra pain	0	My social life is normal and gives me no extra pain
1	I can stand as long as I want but it gives me extra pain	1	My social life is normal but increases the degree of pain.
2	Pain prevents me from standing for more than 1 hour	2	Pain has no significant effect on my social life apart from limiting my more energetic interests. (Ex. Sports/ Recreation)
3	Pain prevents me from standing for more than 30 minutes	3	Pain has restricted my social life and I do not go out as often
4	Pain prevents me from standing for more than 10 minutes	4	Pain has restricted my social life to my home
5	Pain prevents me from stand at all	5	I have no social life because of pain.
Walking		**Sex Life (if applicable)**	
0	Pain does not prevent me walking any distance	0	My sex life is normal and causes no extra pain
1	Pain prevents me from walking more than 1 mile	1	My sex life is normal but causes some extra pain.
2	Pain prevents me from walking more than ½ mile.	2	My sex life is nearly normal but is very painful.
3	Pain prevent me from walking more than 100 yards	3	My sex life is severely restricted by pain
4	I can only walk using a stick or crutches	4	My sex life is nearly absent because of pain.
5	I am in bed most of the time.	5	Pain prevents any sex life at all.
Index Score = [Sum of all statements selected / (# of sections with a statement selected x 5)] x 100 _____			

Chart_____ 5R Date:_____

Freeport Family Chiropractic Clinic

40 Washington Street
Freeport, FL 32439
(850) 835-9867 Fax (850) 880-6089

Oswestry Neck Disability Questionnaire

Patient Name_____

This questionnaire is designed to provide information regarding your neck pain that is affecting your ability to manage everyday life. Please answer by circling ONE statement, in each section, for the option that best applies to you. You may find that two or more statements in a section apply, please choose the statement that BEST describes your complaint.

Pain Intensity		**Personal Care (Washing, dressing, etc.)**	
0	I have no pain at the moment.	0	I can look after myself normally without causing extra pain.
1	The pain is very mild at the moment.	1	I can look after myself normally but it causes extra pain.
2	The pain is moderate at the moment.	2	It is painful to look after myself and I am slow and careful
3	The pain is fairly severe at the moment.	3	I need some help but manage most of my personal care.
4	The pain is very severe at the moment.	4	I need help every day in most aspects of self-care
5	The pain is the worst imaginable at the moment.	5	I do not get dressed, I wash with difficulty and stay in bed.
Sleeping		**Lifting**	
0	I have no trouble sleeping	0	I can lift heavy weights without extra pain
1	My sleep is slightly disturbed (less than 1 hour sleepless)	1	I can lift heavy weights but it gives extra pain
2	My sleep is mildly disturbed (1-2 hours sleepless)	2	Pain prevents me from lifting heavy weights off the floor, but I can manage if they are conveniently placed. (ex. on the table)
3	My sleep is moderately disturbed (2-3 hours sleepless)	3	Pain prevents me from lifting heavy weights, but I can manage light to medium weights if they are conveniently positioned
4	My sleep is greatly disturbed (3-5 hours sleepless)	4	I can only lift very light weights
5	My sleep is completely disturbed (5-7 hours sleepless)	5	I cannot lift or carry anything at all
Reading		**Concentration**	
0	I can read as much as I want to with no pain in my neck.	0	I can concentrate fully when I want to with no difficulty
1	I can read as much as I want to with slight pain in my neck	1	I can concentrate fully when I want to with slight difficulty
2	I can read as much as I want with moderate pain in my neck	2	I have a fair degree of difficulty in concentrating when I want to
3	I can't read as much as I want because of moderate pain in my neck	3	I have a lot of difficulty in concentrating when I want to
4	I can hardly read at all because of severe pain in my neck	4	I have a great deal of difficulty in concentrating when I want to
5	I cannot read at all	5	I cannot concentrate at all
Headaches		**Work**	
0	I have no headaches at all	0	I can do as much work as I want to.
1	I have slight headaches, which come frequently	1	I can only do my usual work, but no more.
2	I have moderate headaches, which come infrequently.	2	I can do most of my usual work, but no more.
3	I have moderate headaches, which come frequently	3	I cannot hardly do any work at all.
4	I have severe headaches, which come frequently	4	I can hardly do any work at all.
5	I have headaches almost all the time.	5	I can't do any work at all.
Driving		**Recreation**	
0	I can drive my car without any neck pain	0	I am able to engage in all my recreation activities with no neck pain at all
1	I can drive my car as long as I want with slight pain in my neck	1	I am able to engage in all my recreation activities, with some pain in my neck
2	I can drive my car as long as I as want with moderate pain in my neck	2	I am able to engage in most, but not all of my usual recreation activities because of pain in my neck
3	I can't drive my car as long as I want because of moderate pain in my neck.	3	I am able to engage in a few of my usual recreation activities because of pain in my neck.
4	I can hardly drive at all because of severe pain in my neck	4	I can hardly do any recreation activities because of pain in my neck
5	I can't drive my car at all	5	I can't do any recreation activities
Index Score = [Sum of all statements selected / (# of sections with a statement selected x 5)] x 100 _____			

Chart #_____ **4R** **Date:**_____

PERSONAL INJURY PATIENT HISTORY

Name_____ File #_____ Date _____

Age_____ Race_____ Sex_____ Height_____ Weight_____ Handed_____

HISTORY OF OCCURRENCE:

Date of accident_____ Time_____ ☐ AM ☐ PM Where was accident_____

Yr & Model of car_____ Driver of car_____ Owner of car_____

Type of accident ☐ Head-on collision ☐ Broad side-collision
☐ Rear-end collision ☐ Front impact, rear-ended car in front
☐ Non-collision: explain:_____

Your car: ☐ Hit another car or ☐ Was hit:: in the ☐ Right ☐ Left ☐ Rear ☐ Front ☐ Side.

Where were you seated_____

What was the approximate damage done to the car you were in? $_____

Visibility at time of accident: ☐ Poor ☐ Fair ☐ Good:::Road conditions at time of accident: ☐ Icy ☐ Rainy & ☐ Wet ☐ Clear ☐ Dark

As a result of the accident were traffic citations issued to you ☐ Yes ☐ No; To the driver of the other car ☐ Yes ☐ No

IMPACT/SEAT BELT/HEADREST/SPEED

Describe in your own words what happened to you upon impact: _____

_____

_____

Were you wearing your seat belt? ☐ Yes ☐ No ::: Were you wearing your shoulder harness ☐ Yes ☐ No

Did the car have headrest? ☐ Yes ☐ No

If yes, what was the position of those headrest compared to your head before the accident?
☐ Top of headrest even with bottom of head ☐ Top of headrest even with top of head ☐ Top of headrest even with middle of neck

Did the car have airbag(s) ☐ Yes ☐ No ::: Driver & passenger ☐ Yes ☐ No ::: Did it activate ☐ Yes ☐ No

Did you see the accident coming? ☐ Yes ☐ No ::: Were you prewarned that the accident was about to happen? ☐ Yes ☐ No

Did you brace for the impact? ☐ Yes ☐ No ::: Were both hands on the steering wheel? ☐ Yes ☐ No

Was your car moving at the time of accident? ☐ Yes ☐ No ::: If yes how fast _____ MPH (estimate)

Was your car braking? ☐ Yes ☐ No ::: Was your foot on the brake? ☐ Yes ☐ No

How fast was the other car traveling? _____ MPH (estimate) Were there skid marks ☐ Yes ☐ No

HEAD/BODY POSITION/ABLE TO MOVE BODY

Head/Body position at time of impact: ☐ Head turned: ☐ Right ☐ Left ☐ Head looking back ☐ Head straight forward
☐ Body straight in sitting position ☐ Body rotated: ☐ Right ☐ Left

At the time of accident, recall what parts of the head or body hit what parts on the inside of your car: _____

_____

As a result of the accident you were: ☐ Rendered unconscious ☐ Dazed, circumstances vague ☐ Shaken up but could function

Could you move all parts of your body? ☐ Yes ☐ No If no, explain: _____

_____

Were you able to get out of the car and walk unaided? ☐ Yes ☐ No If no, explain: _____

_____

SYMPTOMS FROM ACCIDENT

Did you get bleeding cuts? ☐ Yes ☐ No If yes, explain: _____

_____

Did you get bruises? ☐ Yes ☐ No If yes, explain: _____

_____

Please describe how you felt. PLEASE BE SPECIFIC.

Immediately after the accident: _____

Later that ☐ Day ☐ Night: _____

The next day(s): _____

Have you missed any work? _____ If yes, what dates: _____

Rate symptoms apparent since the accident: 1 min through 10 severe L: Left R: Right B: Both I: Intermittent N: Numbness T: Tingling ML: Midline

_____ Base of skull	_____ Neck	_____ Shoulders
_____ Trapezius	_____ Arms	_____ Upper Back
_____ Between Scapulas	_____ Under Scapulas	_____ Lower Back
_____ Hips	_____ Legs	_____ TMJ
_____ Headache	_____ Dizziness	_____ Loss of Memory
_____ Fainting	_____ Fatigue	_____ Chest pain
_____ Nervousness	_____ Ringing/buzzing ears	_____ Tension
_____ Cold Sweats	_____ Eyes sensitive to light	_____ Loss of Balance
_____ Shortness of breath	_____ Cold Hands	_____ Pain behind eyes
_____ Loss of smell	_____ Irritability	_____ Cold feet
_____ Excessive perspiration	_____ Anxiety	_____ Double vision
_____ Digestive disorders	_____ Restriction of neck motion	_____ Eyestrain
_____ Equilibrium problems	_____ mental dullness	_____ Insomnia
_____ Nausea/vomiting	_____ Face Flushes	_____ Head seems too heavy
_____ Palpitation	_____ Tremors	_____ Change in bowel habits

_____ Pain radiating into:

_____ Left arm	_____ Right arm
_____ Neck	_____ Base of skull
_____ Shoulder	_____ Hips

Do you feel better☐ moving around or☐ resting?

Do you have difficulty:☐ walking;☐ bending;☐ sleeping; ☐ sitting;☐ standing;☐ getting up from lying position ☐ getting up from sitting position; lying down:☐ on back ☐ Lt. side☐ Rt. Side ☐ on stomach; ☐ coughing;☐ sneezing ☐ have a bowel movement; ☐ urinating; ☐ twisting;☐ lifting

Is it worse:☐ AM☐ Midday ☐ PM☐ No change

Alleviations (What makes it better): _____

_____

Home care: _____

_____

ANSWER THE FOLLOWING ONLY IF YOU HAVE HEADACHES:

I have:☐ only one type of headache ☐ 2 types of headaches☐ 3 types of headaches

The main (or worse) headache is:☐ intermittent☐ continuous (daily):::It may last:☐ hours ☐ days☐ weeks ☐ months

It is located primarily:
☐All over;☐ right side; ☐ left side;☐ both side;☐ back of head; ☐ back of neck; ☐ top;☐ front (forehead); ☐ jaw or face

The pain is mainly: ☐ variable;☐ sharp;☐ jabbing;☐ stabbing;☐ pulsating;☐ burning; ☐ throbbing;☐ pressure;☐ dull & steady ☐ aching;☐ tightness; ☐ other: _____

Factors that make my headache worse: ☐ heat;☐ light;☐ noise; ☐ cold;☐ food (type) _____; ☐ alcohol; ☐ weather change; ☐ stress;☐ lack of sleep;☐ chewing;☐ physical activity; ☐ other:_____

Factors that help my headache include: ☐ rest; ☐ sleep; ☐ cold or ice packs; ☐ heat;☐ quiet, dark room ☐ medication (type) _____; ☐ other:_____

Describe any other type headache you have: _____

_____

FIRST DOCTOR/HOSPITAL/CLINIC SEEN

Did you go to seek medical help immediately/soon after the accident? ☐ Yes ☐ No If yes when: _____

_____

If yes, how did you get there? ☐ Someone else drove me ☐ Drove own car ☐ Ambulance ☐ Police

Doctor 1/hospital/clinic seen: _____ Date of first visit _____

Were you examined? ☐ Yes ☐ No:::Were x-rays taken? ☐ Yes ☐ No:::If yes, what body part(s)? _____

Were you kept overnight? ☐ Yes ☐ No::: ☐ MRI::CT ☐ ::Other: _____

Were you given treatment? ☐ Yes ☐ No If yes, explain: _____

What benefits did you receive from treatment? _____

What recommendations were made? _____

Date of last treatment: _____

SECOND DOCTOR/CLINIC SEEN

Doctor 2/hospital/clinic seen: _____ Date of first visit _____

Were you examined? ☐ Yes ☐ No:::Were x-rays taken? ☐ Yes ☐ No:::If yes, what body part(s)? _____

Were you kept overnight? ☐ Yes ☐ No::: ☐ MRI::CT ☐ ::Other: _____

Were you given treatment? ☐ Yes ☐ No If yes, explain: _____

What benefits did you receive from treatment? _____

What recommendations were made? _____

Date of last treatment: _____

THIRD DOCTOR/CLINIC SEEN

Doctor 3/hospital/clinic seen: _____ Date of first visit _____

Were you examined? ☐ Yes ☐ No:::Were x-rays taken? ☐ Yes ☐ No:::If yes, what body part(s)? _____

Were you kept overnight? ☐ Yes ☐ No::: ☐ MRI::CT ☐ ::Other: _____

Were you given treatment? ☐ Yes ☐ No If yes, explain: _____

What benefits did you receive from treatment? _____

What recommendations were made? _____

Date of last treatment: _____

Physical Therapy: _____

PRIOR HISTORY

Did you have physical complaints before this accident? ☐ Yes ☐ No; If yes, describe: _____

_____

_____

Have you ever had same or similar symptoms? ☐ Yes ☐ No; If yes, describe: _____

_____

_____

Any prior injuries, accidents, diseases, or treatment to the area of your body now affected? ☐ Yes ☐ No; If yes please describe (be specific): _____

_____

Have you been treated for any health conditions on the last year? ☐ Yes ☐ No; If yes, explain: _____

_____

What operations have you had? _____

_____

Any fractured or broken bones? ☐ Yes ☐ No

Any serious illnesses? ☐ Yes ☐ No; If yes, explain: _____

Are you currently taking any medication? ☐ Yes ☐ No; If yes, what: _____

_____

Please draw a diagram of how the accident occurred below:

FREEPORT FAMILY CHIROPRACTIC CLINIC

DR. JENNIFER L. LAIRD

40 WASHINGTON STREET

FREEPORT, FL 32439

850-835-9867

LIEN

I, _____, agree to pay directly to Dr. Jennifer Laird,
(Patient's Name)

Hereafter referred to as DOCTOR, of Freeport Family Chiropractic Clinic at 40 Washington Street, Freeport, Florida, 32439, such sums that may be owing them for medical services rendered me by reason of my accident of _____.
(Date)

I hereby authorize and direct you, my attorney to pay directly to said DOCTOR, any sums that may be remaining on my account with them at the time of settlement of my accident case and to withhold such sums from any settlement, judgement or verdict as may be necessary to adequately protect the DOCTOR.

I fully understand that I am directly and fully responsible to the DOCTOR for all medical bills submitted by them for services rendered me and that this agreement is made solely for their protection and in consideration of their awaiting payment. I further understand that such payment is NOT contingent on any settlement, judgment or verdict by which I may eventually recover said fee.

_____ _____
(Date) Patient's Name

The undersigned, being attorney of record for the above patient does hereby agree to accept the terms of the above and agrees to withhold such sums from any settlement, judgment or verdict as may be necessary to adequately protect said provider, Dr. Jennifer Laird, above names for her services rendered to my client.

_____ _____
(Date) (Attorney's Signature)

NOTE TO ATTORNEY: (1) Please date sign and return one copy to Dr. Laird's office at the above address
(2) Please keep one for your records

Chart #_____ 10L Date:_____

OFFICE OF INSURANCE REGULATION
Bureau of Property & Casualty Forms and Rates

Standard Disclosure and Acknowledgement Form
Personal Injury Protection - Initial Treatment or Service Provided

The undersigned insured person (or guardian of such person) affirms:

1. The services or treatment set forth below were **actually rendered.** This means that those services have **already been provided.**

Chiropractic evaluation/diagnostic testing, manipulative therapy, physical therapy modalities

2. I have the right and the **duty to confirm** that the services have already been provided.

3. I was **not solicited** by any person to seek any services from the medical provider of the services described above.

4. The medical provider has **explained** the services to me for which payment is being claimed.

5. If I notify the insurer in writing of a billing error, I may be entitled to a portion of any reduction in the amounts paid by my motor vehicle insurer. If entitled, my share would be at least 20% of the amount of the reduction, up to $500.

Insured Person (patient receiving treatment or services) or Guardian of Insured Person:

Name *(PRINT or TYPE)*	Signature	Date

The undersigned licensed medical professional or medical director, if applicable, affirms the statement numbered 1 above and also:

A. I have **not solicited** or caused the insured person, who was involved in a motor vehicle accident, to be solicited to make a claim for Personal Injury Protection benefits.

B. The treatment or services rendered were explained to the insured person, or his or her guardian, **sufficiently** for that person to sign this form with informed consent.

C. The accompanying statement or bill is **properly completed** in all material provisions and all relevant information has been provided therein. This means that each request for information has been responded to **truthfully, accurately**, and in a **substantially complete** manner.

D. The coding of procedures on the accompanying statement or bill is proper. This means that **no service has been upcoded, unbundled**, or constitutes an invalid **or not medically necessary diagnostic test** as defined by Section 627.732(14) and (15), Florida Statutes or Section 627.736(5)(b)6, Florida Statutes.

Licensed Medical Professional Rendering Treatment/Services or Medical Director, if applicable *(Signature by his/ her **own hand**):*

Jennifer Laird, DC		
Name *(PRINT or TYPE)*	Signature	Date

Any person who knowingly and with intent to injure, defraud, or deceive any insurer files a statement of Claim or an application containing any false, incomplete, or misleading information is guilty of a felony of the third degree per Section 817.234(1)(b), Florida Statutes.

Note: The **original** of this form must be furnished to the insurer pursuant to Section 627.736(4)(b), Florida Statutes and may **not** be electronically furnished. Failure to furnish this form may result in non-payment of the claim.