NEW PATIENT INTAKE

Richard T. Schones, D.C.

Name: _____

Today's Date: _____

Address: _____ City: _____ Zip: _____

Home Phone: _____ Cell Phone: _____

Work Phone: _____ Would you prefer Text OR Email Reminders?

Cell Provider: _____

Email Address: _____ Male: __ Female: __ SSN: _____

Birth Date: ___ / ___ / _____ Age: ____ Occupation: _____

Employer Name & Address : _____

Marital Status : _____ Spouse's Name (if applicable) : _____

Have you been treated by a chiropractor before? (Please Circle) YES NO

If yes, where? _____

Who may we thank for referring you to our office? _____

This office conforms to the current HIPAA guidelines. You may request a copy of our HIPAA policy at the front desk. Please initial to indicate you have been made aware of its availability: _____

These statements made on this form are accurate to the best of my recollection and I consent for this office to examine me for further evaluation.

- I authorize payment of medical benefits to this office. Fees may be applied to balances over 90 days.
- I will allow this office to treat me, with other health care providers present, and to record my medical information, including consultation and examination for documentation purposes, if necessary.
- I allow this office to contact me via email, text message, or phone for scheduling and clinical need.
- I authorize Savannah Hills Family Chiropractic to securely store my credit card information and to process payments on that stored card.
- This office occasionally sends email newsletters and updates to keep patients informed. I understand that I may opt-out through the email itself.
- I give this office the right to use my name for any office promotions or publications (within HIPAA guidelines).
- I understand that this authorization may be denied or retracted by notifying the office manager in writing.
- By way of my signature, I provide Savannah Hills Family Chiropractic with my authorization and consent to use and disclose my protected health care information for the purpose of treatment, payment and health care operations as described in the Privacy Notice.

Patient Signature: _____ Date: _____

Guardian Signature: _____ Date:_____

Savannah Hills Family Chiropractic

200 Creekstone Ridge, Woodstock, GA 30188
Phone: 770-592-1909 Fax: 770-592-7303
Richard T. Schones, D.C.

For our office to properly assist you in billing insurance, we must have this page completed prior to starting care.

PARTY RESPONSIBLE:
If you were involved in an auto accident in your own vehicle, we will bill the Medical Payments (Med Pay) portion or Personal Injury Protection (PIP) portion of your insurance policy to cover the treatment charges incurred in our office. It is our policy to pursue Med pay benefits first, if available, and then 3rd party via a signed lien with an attorney.

MEDPAY: If you were a driver or passenger in your own or another vehicle, the insurance company which insures the automobile may be billed for your medical services incurred.
PIP: If you were a passenger in another vehicle, and you own a car which has PIP coverage, the insurance company which carries your policy will be responsible to pay your medical bills.
THIRD PARTY: If another vehicle has caused the accident, we will first bill your automobile MedPay or PIP policy for coverage PRIOR to submitting a claim to the insurance carrier of the party at fault.

***IF YOU DO NOT HAVE MEDPAY OR PIP COVERAGE, WE REQUIRE LOW MONTHLY PAYMENTS TO MINIMIZE YOUR OUT OF POCKET EXPENSE WHEN YOUR CASE HAS SETTLED. Payment amount will be determined after careful review of the patient's care plan by Dr. Richard T. Schones, D.C.

ATTORNEY LIENS:
If you hire an attorney to represent you in a lawsuit, it is our policy to have your attorney sign a Doctor's Lien. This will guarantee direct payment to our office for any outstanding balance upon the settlement of your law suit. We retain the right to first submit all charges to your attorney and/or auto insurance policy for payment. Further, this office does not discount or reduce the amount of your balance based upon the outcome of your settlement.

RESPONSIBILITY FOR PAYMENT:
As a courtesy to you, we will gladly submit your charges to your auto insurance company and/or your attorney; however all services rendered by this office are charged directly to you, and ultimately, you are personally responsible for payment of these charges, regardless of any insurance reimbursement or settlement you may or may not receive.

Once again, we welcome you to our office. We hope that this has answered any questions that you might have about our financial policy. If, at any time, you have further questions about your care, please, don't hesitate to ask.

I have read and agree to the above terms

_____ _____

Patient's Signature ***Date***

Savannah Hills Chiropractic

200 Creekstone Ridge, Woodstock, GA 30188
Phone: 770-592-1909 Fax: 770-592-7303
Richard T. Schones, D.C.

For our office to properly assist you in billing insurance, we must have this page completed prior to starting care.

Your car insurance company will only release this information to you, the policy holder. Please call your car insurance provider to obtain this information. Circle the information told to you.

1. Do you have medical pay? Yes No
2. If so, how much? $1,000 $2000 $5000 $10,000 $25,000 Other $_____
3. Is your medical pay primary or secondary?
4. Do you have uninsured (underinsured) motorists policy on your insurance? Yes No
5. If YES, what is the uninsured (underinsured) motorist limit? $_____
6. Patient Name: _____
7. Name of YOUR auto insurance company? _____
8. Your claim number? _____
9. Name of person handling your claim? _____
10. His/her phone number? _____
11. Date of your accident? _____

Please be prepared to have us make a copy of your:

Auto Insurance Declaration page

Drivers License

Health insurance

We also ask that you furnish our office with a copy of your incidents Police report.

Savannah Hills Family Chiropractic

200 Creekstone Ridge, Woodstock, GA 30188 770-592-1909

Richard Schones, D.C.

Informed Consent to Care

You are the decision maker for your health care. Part of our role is to provide you with information to assist you in making informed choices. This process is often referred to as “informed consent” and involves your understanding and agreement regarding the care we recommend, the benefits and risks associated with the care, alternatives, and the potential effect on your health if you choose not to receive the care.

We may conduct some diagnostic or examination procedures if indicated. Any examinations or tests conducted will be carefully performed but may be uncomfortable.

Chiropractic care centrally involves what is known as a chiropractic adjustment. There may be additional supportive procedures or recommendations as well. When providing an adjustment, we use our hands or an instrument to reposition anatomical structures, such as vertebrae. Potential benefits of an adjustment include restoring normal joint motion, reducing swelling and inflammation in a joint, reducing pain in the joint, and improving neurological functioning and overall well-being.

It is important that you understand, as with all health care approaches, results are not guaranteed, and there is no promise to cure. As with all types of health care interventions, there are some risks to care, including, but not limited to: muscle spasms, aggravating and/or temporary increase in symptoms, lack of improvement of symptoms, burns and/or scarring from electrical stimulation and from hot or cold therapies, including but not limited to hot packs and ice, fractures (broken bones), disc injuries, strokes, dislocations, strains, and sprains. With respect to strokes, there is a rare but serious condition known as an “arterial dissection” that typically is caused by a tear in the inner layer of the artery that may cause the development of a thrombus (clot) with the potential to lead to a stroke. The best available scientific evidence supports the understanding that chiropractic adjustment does not cause a dissection in a normal, healthy artery. Disease processes, genetic disorders, medications, and vessel abnormalities may cause an artery to be more susceptible to dissection. Strokes caused by arterial dissections have been associated with over 72 everyday activities such as sneezing, driving, and playing tennis.

Arterial dissections occur in 3-4 of every 100,000 people whether they are receiving health care or not. Patients who experience this condition often, but not always, present to their medical doctor or chiropractor with neck pain and headache. Unfortunately, a percentage of these patients will experience a stroke.

The reported association between chiropractic visits and stroke is exceedingly rare and is estimated to be related in one in one million to one in two million cervical adjustments. For comparison, the incidence of hospital admission attributed to aspirin use from major GI events of the entire (upper and lower) GI tract was 1219 events/ per one million persons/year and risk of death has been estimated as 104 per one million users.

It is also important that you understand there are treatment options available for your condition other than chiropractic procedures. Likely, you have tried many of these approaches already. These options may include, but are not limited to: self-administered care, over-the-counter pain relievers, physical measures and rest, medical care with prescription drugs, physical therapy, bracing, injections, and surgery. Lastly, you have the right to a second opinion and to secure other opinions about your circumstances and health care as you see fit.

I have read, or have had read to me, the above consent. I appreciate that it is not possible to consider every possible complication to care. I have also had an opportunity to ask questions about its content, and by signing below, I agree with the current or future recommendation to receive chiropractic care as is deemed appropriate for my circumstance. I intend this consent to cover the entire course of care from all providers in this office for my present condition and for any future condition(s) for which I seek chiropractic care from this office.

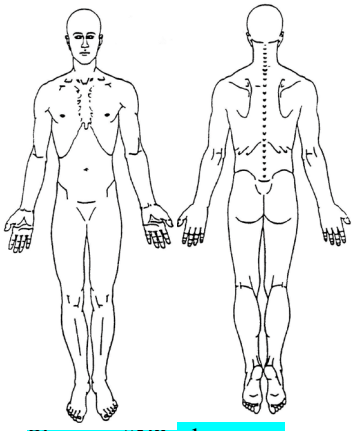
Patient Name: _____ Signature: _____ Date:

Parent or Guardian: _____ Signature: _____ Date:

Witness Name: _____ Signature: _____ Date:

Pain Location

Patient Name: _____ Date:_____/_____/_____



Place an "**X**" where you hurt for this complaint.

Complaint 1: _____

Circle all that apply when describing this complaint:

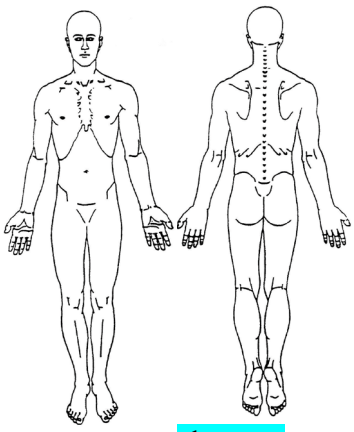
What does the pain feel like? ●Aching ●Burning ●Cramping ●Decreased range of motion ●Deep ●Dizziness ●Discomfort ●Dull ●Nausea ●Numb ●Numbness ●Radiating ●Sharp ●Shooting ●Spasm ●Stabbing ●Stiff ●Stiffness ●Throbbing ●Tingling ●Tightness ●Other:

_____

How often do you feel this pain? ●Occasionally (0-25% of the time) ●Intermittently (26-50% of the time) ●Frequently (51-75% of the time) ●Constantly (76-100% of the time) ●More in the morning ●More in the evening ●From the afternoon on ●Wakes you up

On a scale of 1-10, with 10 being the worst, when this pain is at its **worst** what is the number? _____

Have you had this exact pain prior to the accident? Yes No



Place an "**X**" where you hurt for this complaint.

Complaint 2: _____

Circle all that apply when describing this complaint:

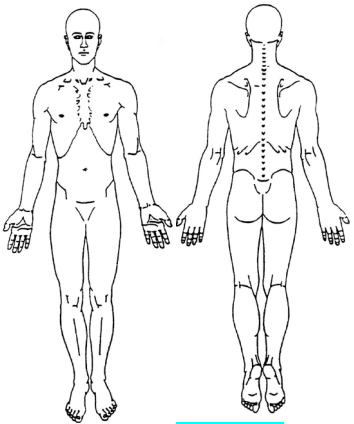
What does the pain feel like? ●Aching ●Burning ●Cramping ●Decreased range of motion ●Deep ●Dizziness ●Discomfort ●Dull ●Nausea ●Numb ●Numbness ●Radiating ●Sharp ●Shooting ●Spasm ●Stabbing ●Stiff ●Stiffness ●Throbbing ●Tingling ●Tightness ●Other:

_____

How often do you feel this pain? ●Occasionally (0-25% of the time) ●Intermittently (26-50% of the time) ●Frequently (51-75% of the time) ●Constantly (76-100% of the time) ●More in the morning ●More in the evening ●From the afternoon on ●Wakes you up

On a scale of 1-10, with 10 being the worst, when this pain is at its **worst** what is the number? _____

Have you had this exact pain prior to the accident? Yes No



Place an "**X**" where you hurt for this complaint.

Complaint 3: _____

Circle all that apply when describing this complaint:

What does the pain feel like? ●Aching ●Burning ●Cramping ●Decreased range of motion ●Deep ●Dizziness ●Discomfort ●Dull ●Nausea ●Numb ●Numbness ●Radiating ●Sharp ●Shooting ●Spasm ●Stabbing ●Stiff ●Stiffness ●Throbbing ●Tingling ●Tightness ●Other:

_____

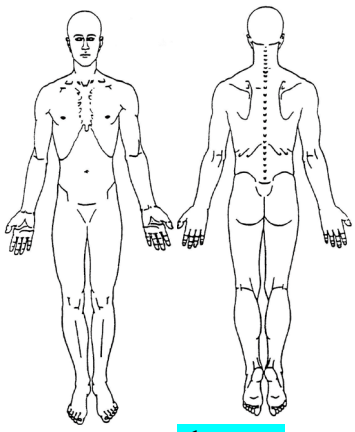
How often do you feel this pain? ●Occasionally (0-25% of the time) ●Intermittently (26-50% of the time) ●Frequently (51-75% of the time) ●Constantly (76-100% of the time) ●More in the morning ●More in the evening ●From the afternoon on ●Wakes you up

On a scale of 1-10, with 10 being the worst, when this pain is at its **worst** what is the number? _____

Have you had this exact pain prior to the accident? Yes No

Pain Location

Patient Name: _____ Date: ____/____/____



Place an "**X**" where you hurt for this complaint.

Complaint 4: _____

Circle all that apply when describing this complaint:

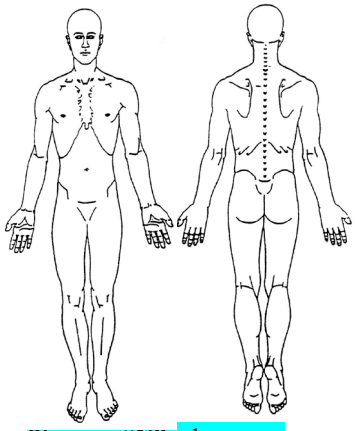
What does the pain feel like? ●Aching ●Burning ●Cramping ●Decreased range of motion ●Deep ●Dizziness ●Discomfort ●Dull ●Nausea ●Numb ●Numbness ●Radiating ●Sharp ●Shooting ●Spasm ●Stabbing ●Stiff ●Stiffness ●Throbbing ●Tingling ●Tightness ●Other:

_____

How often do you feel this pain? ●Occasionally (0-25% of the time) ●Intermittently (26-50% of the time) ●Frequently (51-75% of the time) ●Constantly (76-100% of the time) ●More in the morning ●More in the evening ●From the afternoon on ●Wakes you up

On a scale of 1-10, with 10 being the worst, when this pain is at its **worst** what is the number? _____

Have you had this exact pain prior to the accident? Yes No



Place an "**X**" where you hurt for this complaint.

Complaint 5: _____

Circle all that apply when describing this complaint:

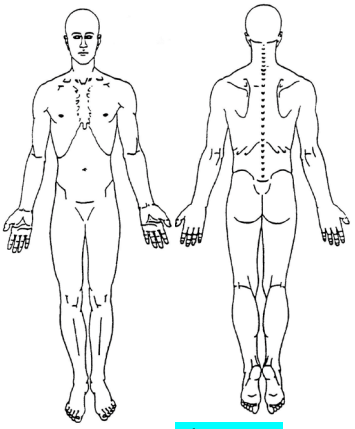
What does the pain feel like? ●Aching ●Burning ●Cramping ●Decreased range of motion ●Deep ●Dizziness ●Discomfort ●Dull ●Nausea ●Numb ●Numbness ●Radiating ●Sharp ●Shooting ●Spasm ●Stabbing ●Stiff ●Stiffness ●Throbbing ●Tingling ●Tightness ●Other:

_____

How often do you feel this pain? ●Occasionally (0-25% of the time) ●Intermittently (26-50% of the time) ●Frequently (51-75% of the time) ●Constantly (76-100% of the time) ●More in the morning ●More in the evening ●From the afternoon on ●Wakes you up

On a scale of 1-10, with 10 being the worst, when this pain is at its **worst** what is the number? _____

Have you had this exact pain prior to the accident? Yes No



Place an "**X**" where you hurt for this complaint.

Complaint 6: _____

Circle all that apply when describing this complaint:

What does the pain feel like? ●Aching ●Burning ●Cramping ●Decreased range of motion ●Deep ●Dizziness ●Discomfort ●Dull ●Nausea ●Numb ●Numbness ●Radiating ●Sharp ●Shooting ●Spasm ●Stabbing ●Stiff ●Stiffness ●Throbbing ●Tingling ●Tightness ●Other:

_____

How often do you feel this pain? ●Occasionally (0-25% of the time) ●Intermittently (26-50% of the time) ●Frequently (51-75% of the time) ●Constantly (76-100% of the time) ●More in the morning ●More in the evening ●From the afternoon on ●Wakes you up

On a scale of 1-10, with 10 being the worst, when this pain is at its **worst** what is the number? _____

Have you had this exact pain prior to the accident? Yes No

ACCIDENT QUESTIONNAIRE

Patient's Name_____

Date of incident _____Today's Date_____

DESCRIBE YOUR VEHICLE

1. **Place patient was seated in the vehicle:**
   a. driver
   b. front passenger
   c. back passenger driver side
   d. back passenger right side
   e. back passenger middle
   f. other_____

2. **Vehicle Size:**
   b. Compact
   c. Mid-Sized
   d. Full-Sized
   e. SUV

2. **Vehicle Type** :
   a. Sports Car
   b. Coupe
   c. Sedan
   d. Sports Utility Vehicle
   e. Station Wagon
   f. Pick-up truck
   g. Bus
   h. Other: _____

Year: _____

Make: _____

Model: _____

Who else was in your vehicle?

_____

_____

DESCRIBE THE ACCIDENT – mark all that apply

4. **Day and Date of Accident: _____**

5. **Time of Accident: _____**

6. **Was your vehicle hit? Or did your vehicle hit another vehicle?**
   a. Patient was hit
   b. Patient hit another vehicle

7. **Actions of patient's vehicle:**
   a. crossing an intersection
   b. stopped at an intersection
   c. stopped for a pedestrian
   d. stopped for traffic
   e. traveling at posted speed limit
   f. traveling faster than the posted speed limit
   g. turning (direction) _____
   h. stop and go
   i. Your approximate speed at impact? _____mph

8. **How was the patient's vehicle hit:**
   a. hit head-on
   b. was hit on the left front
   c. was hit on the right front
   d. was hit on the left rear
   e. was hit on the right rear
   f. was rear-ended
   g. T-Boned on drivers side or passenger side
   h. Other: _____

9. **Damage to patient's vehicle:**
   a. complete
   b. extensive
   c. minimal
   d. moderate
   e. amount: $_____

10. **Was your car towed?**
    a. Yes
    b. No
    c. Unknown

11. **DESCRIBE THE OTHER VEHICLE:**
    a. Sports Car
    b. Coupe
    c. Sedan
    d. Sports Utility Vehicle
    e. Station Wagon
    f. Pick-up truck
    g. Bus
    h. Other: _____

    Year: _____

    Make: _____

    Model: _____

12. **How was the <u>other</u> vehicle hit:**
    i. hit head-on
    j. was hit on the left front
    k. was hit on the right front
    l. was hit on the left rear
    m. was hit on the right rear
    n. was rear-ended
    o. T-Boned on drivers side or passenger side
    p. Other: _____

13. **Other vehicles approximate speed? _____ mph**

14. **Damage to the other vehicle?**
    a. complete
    b. extensive
    c. minimal
    d. moderate

15. **How many vehicles were involved in the accident?**
    _____

16. **Was the other vehicle towed?**
    a. Yes
    b. No
    c. Unknown

17. **Weather Conditions**
    a. Clear
    b. Cloudy
    c. Drizzling
    d. Foggy
    e. Rainy
    f. Snowy
    g. Stormy
    h. Sunny
    i. Night

18. **Road Conditions**
    a. Damp
    b. Dry
    c. Dry with icy patches
    d. Iced over
    e. Snowed over
    f. Wet

DESCRIBE THE MOMENT OF IMPACT– mark all that apply

19. **Type of seat belt:**
    a. lap belt
    b. shoulder belt (automatic)
    c. shoulder lap belt

20. **Were you aware of the impending impact?**
    a. Yes
    b. No
    c. Surprised

21. **Did you brace for impending impact?**
    a. Yes
    b. No

22. **Did You lose consciousness?**
    a. Yes
    b. No
    If so, how long _____

23. **Did Airbags deploy:**
    a. yes
    b. no
    If so, which
    one(s)_____

24. **Did the airbags injure you?**
    a. yes
    b. no
    if so, where
    _____

    Do you have pictures of injured areas? Yes No

25. **Did the <u>other vehicles</u> Airbags deploy?:**
    a. yes
    b. no
    If so, which
    one(s)_____

26. **Body position at time of impact:**
    a. leaning forward
    b. slouched down in seat
    c. straight
    d. turned to the left
    e. turned to the right

27. **Direction your body was thrown:**
    a. backward then forward
    b. forward then backward
    c. to the left
    d. to the right
    e. about the vehicle
    f. outside the vehicle
    g. under the vehicle

28. **Head position at impact:**
    a. straight
    b. tilted forward
    c. turned to the left
    d. turned to the right
    e. looking in left rear view mirror
    f. looking in right rear view mirror
    g. looking in rear view mirror
    h. looking at cell phone
    i. looking at the stereo

29. **Direction head was thrown:**
    a. backward then forward
    b. forward then backward
    c. side to side

30. **In relation to the base of your skull, where was the top of the headrest?**
    a. Below base of skull
    b. At the top of your head
    c. No Headrest
    d. Headrest deployed

31. **Foot positioning?**
    a. Right foot gas pedal
    b. Right foot break pedal
    c. Left foot break pedal
    d. Left foot clutch

32. **Hand positioning?**
    Left hand: _____

    Right hand:_____

Describe what happened AFTER the accident – mark all that apply:

33. How did you feel immediately after the accident?

a. pain	b. angry	c. confused
b. disoriented	e. dizzy	f. frightened
g. in shock	h. lost consciousness	i. nervous
j. shaken	k. scared	l. shocked

m. other:_____

34. If you felt immediate pain, where did you feel the pain

a. head	b. face	c. neck
d. shoulders	e. upper back	f. mid back
g. lower mid back	h. low back	i. arm R/L
j. elbow R/L	k. wrist R/L	l. hand R/L
m. fingers R/L	n. hip R/L	o. leg R/L
p. knee R/L	q. ankle R/L	r. foot R/L
s. toes R/L	t. stomach	
u. chest (seatbelt)		

35. Were you treated at the scene of the accident:

a. Yes
b. No

36. Were you advised to go to the emergency room:

a. Yes
b. No

37. If you went to the emergency room, how did you get there?

a. Ambulance
b. Self/own car
c. Family member
d. Friend

38. If you went to the ER, when did you go to the emergency?

a. Immediately after via ambulance
b. _____ Hours after
c. _____ Days after

39. Were you seen at a Medical Facility or Urgent Care following your accident (other than an ER):

a. Yes If so, date _____/_____/_____
b. No

If so name and address of the facility:

_____

_____

40. Procedures performed at the ER or other Medical Facility?

a. Exam
b. X-rays
c. MRI
d. CT Scan
e. Prescription medication prescribed
f. Hospitalized, if so, how long _____

Medications prescribed:

_____

_____

41. Did you go to your PCP or other medical professional after the accident?

a. Yes
b. No

If so name and address of the facility:

Date _____/_____/_____

_____

_____

Recommendations:

_____

_____

Describe what you have done since the accident – mark all that apply:

42. Have you had an estimate on your vehicle?

a. Yes

b. No

estimated damage $_____

43. Have you missed days from work or school because of the accident?

a. Yes if so, how many days?_____

b. No

44. Are your work or school activities restricted because of injury from this accident?

a. Yes

b. No

45. Since the accident, is your condition getting worse?

a. Yes
b. No

46. Indicate the symptoms that are a result of the accident?

a. dizziness	b. difficulty sleeping
c. jaw problems	d. nausea
e. memory loss	f. irritability
g. stomach upset	h. fatigue
i. constipation	j. chest pain
l. blurred vision	m. anger
n. short tempered	o. shortness of breath
p. diarrhea	q. buzzing in ear
r. ear ringing	s. loss of memory
t. forgetful	u. loss of appetite
v. easily provoked	w. light irritates
x. depression	y. over sleeping

z. fear of another accident while driving or passenger

Please tell us about you – mark or circle all that apply:

46. **Age: _____**
47. **Date of Birth _____/_____/_____**
48. **Employed FT PT Unemployed Student**

    where? _____

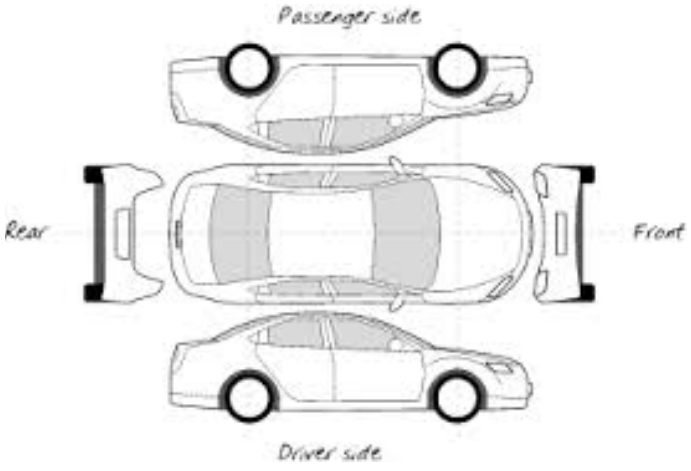
    Position? _____
49. **Height _____ft _____in**
50. **Weight _____ lbs**
51. **Right or Left handed?**
52. **Married/Single/Divorced/Widow Kids:_____**
53. **Smoker? Yes No How many cigarettes per day? ___**
54. **How would you rate your diet?**
    a. Excellent
    b. Very good
    c. Good
    d. Fair
    e. Poor
55. **In general, would you say your overall health right now is…**
    a. Excellent
    b. Very good
    c. Good
    d. Fair
    e. Poor
56. **Prior to the accident, on average, how many hours would you sleep per night? _____**
57. **Prior to the accident, how would you rate your sleep?**
    a. Restful – fall asleep easily, wake up on schedule
    b. Very good
    c. Good
    d. Fair
    e. Poor – wake up multiple times
58. **Since the accident, on average, how many hours would you sleep per night? _____**
59. **Since the accident, how would you rate your sleep?**
    a. Restful – fall asleep easily, wake up on schedule
    b. Very good
    c. Good
    d. Fair
    e. Poor – wake up multiple times
    f. Painful
60. **In general, since the accident, sleeping has been…**
    a. Better
    b. Worse
    c. Same
61. **Prior to the accident, did you exercise regularly?**
    a. Yes Hrs. per week? _____
    b. No
62. **Since the accident, have you been able to exercise as regular?**
    a. Yes
    b. No

Patient Signature

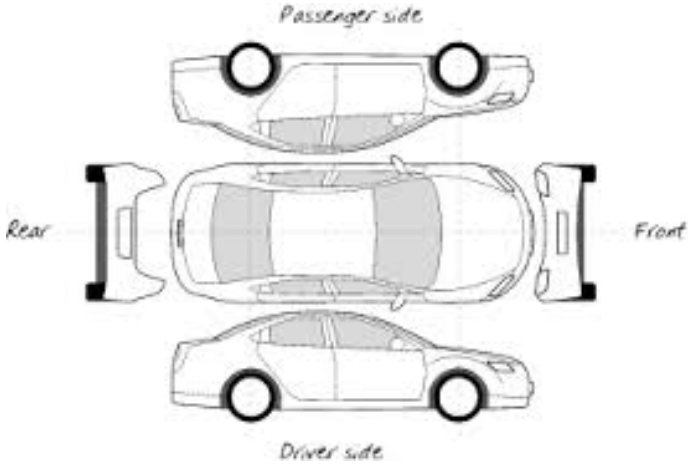
_____

Date_____/_____/_____

Place an "X" where YOUR vehicle was impacted.



Place an "X" where THE OTHER vehicle was impacted.

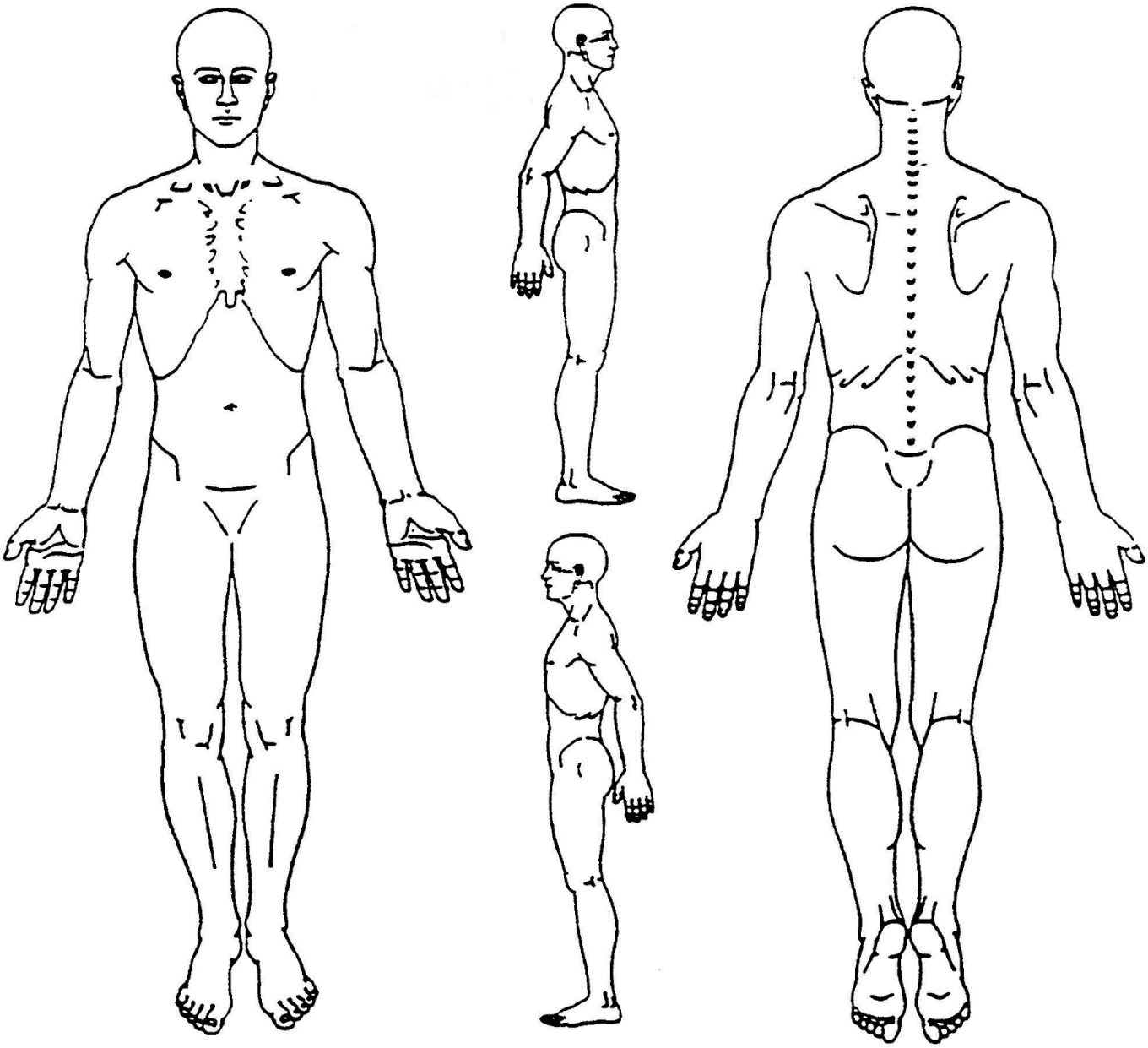


Savannah Hills Family Chiropractic

BODY PARTS STRUCK

Patient Name:_____ Date:_____/_____/_____

Instructions: **Put an "X" in the location where your body struck the inside of the vehicle**. Please write next to the "X" on the body part and describe where in the vehicle that body part struck.
Please include if you have a cut or bruise. If you have pictures of lacerations or bruises, please print them out and return with this information.



In general, since the accident, please circle the action or behavior that makes the injuries feel

(**B**) better or (**W**) worse			(**B**) better or (**W**) worse		
B	**W**	Advil	**B**	**W**	Medical Consultation
B	**W**	Aleve	**B**	**W**	Most movements
B	**W**	Arising from a chair or bed	**B**	**W**	Motrin
B	**W**	Aspirin	**B**	**W**	Nothing
B	**W**	Bathing	**B**	**W**	Physical Therapy
B	**W**	Bending	**B**	**W**	Pilates
B	**W**	Bending head to the left	**B**	**W**	Playing baseball
B	**W**	Bending head to the right	**B**	**W**	Playing football
B	**W**	Bending over	**B**	**W**	Playing racket ball
B	**W**	Bending to the left	**B**	**W**	Playing soccer
B	**W**	Bending to the right	**B**	**W**	Playing tennis
B	**W**	Boating	**B**	**W**	Pulling
B	**W**	Bright light	**B**	**W**	Reaching
B	**W**	Caring for children	**B**	**W**	Reaching above head
B	**W**	Carrying	**B**	**W**	Reading
B	**W**	Changing positions	**B**	**W**	Resting
B	**W**	Chiropractic care	**B**	**W**	Running
B	**W**	Cleaning	**B**	**W**	Prescription anti-inflammatories
B	**W**	Climbing	**B**	**W**	Prescription muscle relaxers
B	**W**	Concentrating	**B**	**W**	Prescription pain killers
B	**W**	Cooking	**B**	**W**	Shaving
B	**W**	Coughing	**B**	**W**	Sitting
B	**W**	Doing dishes	**B**	**W**	Skiing
B	**W**	Doing laundry	**B**	**W**	Sleeping
B	**W**	Dressing	**B**	**W**	Sliding
B	**W**	Driving	**B**	**W**	Sneezing
B	**W**	Eating	**B**	**W**	Squatting
B	**W**	Exercising	**B**	**W**	Standing
B	**W**	Gardening	**B**	**W**	Stooping
B	**W**	Getting in/out of the car	**B**	**W**	Straining
B	**W**	Going to the bathroom	**B**	**W**	Stress
B	**W**	Golfing	**B**	**W**	Stretching
B	**W**	Having sex	**B**	**W**	Surgery
B	**W**	Heat	**B**	**W**	Turning
B	**W**	Ibuprofen	**B**	**W**	Turning head to the left
B	**W**	Ice	**B**	**W**	Turning head to the right
B	**W**	Jumping	**B**	**W**	Twisting
B	**W**	Kneeling	**B**	**W**	Tylenol
B	**W**	Lifting	**B**	**W**	Typing
B	**W**	Looking down	**B**	**W**	Voiding bladder
B	**W**	Looking Up	**B**	**W**	Voiding bowel
B	**W**	Loud noises	**B**	**W**	Walking
B	**W**	Lying down	**B**	**W**	Working
B	**W**	Massage	**B**	**W**	Yoga

NECK DISABILITY INDEX QUESTIONNAIRE

NAME_____ **AGE**_____ **DATE**_____ **SCORE**_____

PLEASE READ*:** This questionnaire is designed to enable us to understand how much your neck pain has affected your ability to manage your everyday activities. Please answer each section by circling the ONE CHOICE that most applies to you. We realize that you may feel that more than one statement may relate to you, but ***PLEASE JUST CIRCLE THE ONE CHOICE THAT MOST CLOSELY DESCRIBES YOUR PROBLEM RIGHT NOW.

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

COMMENTS: _____

_____

_____

Vernon H, Mior S. The Neck Disability Index: A study of reliability and validity. J Manipulative Physiol Ther 1991;14:409-415.

Low Back

OSWESTRY DISABILITY INDEX 2.0

NAME_____ **DATE**_____ **SCORE**_____

PLEASE READ: Could you please complete this questionnaire. It is designed to give us information as to how your back (or leg) trouble has affected your ability to manage in everyday life.

Please answer ***every section***. Mark ***one box only*** in each section that most closely describes you ***today***.

SECTION 1 - Pain Intensity
- A ☐ I have no pain at the moment.
- B ☐ The pain is very mild at the moment.
- C ☐ The pain is moderate at the moment.
- D ☐ The pain is fairly severe at the moment.
- E ☐ The pain is very severe at the moment.
- F ☐ The pain is the worst imaginable at the moment.

SECTION 2 - Personal Care (washing, dressing, etc.)
- A ☐ I can look after myself normally without causing extra pain.
- B ☐ I can look after myself normally but it is very painful.
- C ☐ It is painful to look after myself and I am slow and careful.
- D ☐ I need some help but manage most of my personal care.
- E ☐ I need help every day in most aspects of self care.
- F ☐ I do not get dressed, wash with difficulty☐ and stay in bed.

SECTION 3 - Lifting
- A ☐ I can lift heavy weights without extra pain.
- B ☐ I can lift heavy weights, but it causes extra pain.
- C ☐ Pain prevents me from lifting heavy weights off the floor, but I can manage if they are conveniently positioned, e.g. on a table.
- D ☐ Pain prevents me from lifting heavy weights, but I can manage light to medium weights if they are conveniently positioned.
- E ☐ I can only lift very light weights, at the most.
- F ☐ I cannot lift or carry anything at all.

SECTION 4 - Walking
- A ☐ Pain does not prevent me from walking any distance.
- B ☐ Pain prevents me from walking more than one mile.
- C ☐ Pain prevents me from walking more than 1/4 mile.
- D ☐ Pain prevents me from walking more than 100 yards.
- E ☐ I can only walk while using a stick or crutches.
- F ☐ I am in bed most of the time and have to crawl to the toilet.

SECTION 5 - Sitting
- A ☐ I can sit in any chair as long as I like.
- B ☐ I can only sit in my favorite chair as long as I like.
- C ☐ Pain prevents me from sitting more than 1 hour.
- D ☐ Pain prevents me from sitting more than 1/2 hour.
- E ☐ Pain prevents me from sitting more than ten minutes.
- F ☐ Pain prevents me from sitting at all.

SECTION 6 - Standing
- A ☐ I can stand as long as I want without extra pain.
- B ☐ I can stand as long as I want but it gives me extra pain.
- C ☐ Pain prevents me from standing for more than 1 hour.
- D ☐ Pain prevents me from standing for more than 1/2 hour.
- E ☐ Pain prevents me from standing for more than 10 minutes.
- F ☐ Pain prevents me from standing at all.

SECTION 7 - Sleeping
- A ☐ My sleep is never disturbed by pain.
- B ☐ My sleep is occasionally disturbed by pain.
- C ☐ Because of pain I have less than 6 hours' sleep.
- D ☐ Because of pain I have less than 4 hours' sleep.
- E ☐ Because of pain I have less than 2 hours' sleep.
- F ☐ Pain prevents me from sleeping at all.

SECTION 8 - Sex Life (if applicable)
- A ☐ My sex life is normal and causes me no extra pain.
- B ☐ My sex life is normal, but causes some extra pain.
- C ☐ My sex life is nearly normal but is very painful.
- D ☐ My sex life is severely restricted by pain.
- E ☐ My sex life is nearly absent because of pain.
- F ☐ Pain prevents any sex life at all.

SECTION 9 - Social Life
- A ☐ My social life is normal and causes me no extra pain.
- B ☐ My social life is normal, but increases the degree of pain.
- C ☐ Pain has no significant effect on my social life apart from limiting my more energetic interests, e.g., sport, etc.
- D ☐ Pain has restricted my social life and I do not go out as often.
- E ☐ Pain has restricted my social life to my home.
- F ☐ I have no social life because of the pain.

SECTION 10 - Traveling
- A ☐ I can travel anywhere without pain.
- B ☐ I can travel anywhere but I gives extra pain.
- C ☐ Pain is bad but I manage journeys over 2 hours.
- D ☐ Pain restricts me to journeys of less than 1 hour.
- E ☐ Pain restricts me to short necessary journeys under 30 minutes.
- F ☐ Pain prevents me from traveling except to receive treatment.

COMMENTS: _____

_____

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_____

Roland, M. and J. Fairbank (2000). "The Roland-Morris Disability Questionnaire and the Oswestry Disability Questionnaire." Spine 25(24): 3115-24.

LOW BACK PAIN AND DISABILITY QUESTIONNAIRE

(Roland-Morris)

NAME_____ **DATE**_____

AGE_____ **SCORE**_____

When your back hurts, you may find if difficult to do some of the things you normally do.
Mark only the sentences that describe you today.

1. ☐ I stay at home most of the time because of my back.
2. ☐ I walk more slowly than usual because of my back.
3. ☐ Because of my back, I am not doing any jobs that I usually do around the house.
4. ☐ Because of my back, I use a handrail to get upstairs.
5. ☐ Because of my back, I lie down to rest more often.
6. ☐ Because of my back, I have to hold onto something to get out of an easy chair.
7. ☐ Because of my back, I try to get other people to do things for me.
8. ☐ I get dressed more slowly than usual because of my back.
9. ☐ I stand up only for short periods of time because of my back.
10. ☐ Because of my back, I try not to bend or kneel down.
11. ☐ I find it difficult to get out of a chair because of my back.
12. ☐ My back or leg is painful almost all of the time.
13. ☐ I find it difficult to turn over in bed because of my back.
14. ☐ I have trouble putting on my socks (or stockings) because of pain in my back.
15. ☐ I sleep less well because of my back.
16. ☐ I avoid heavy jobs around the house because of my back.
17. ☐ Because of back pain, I am more irritable and bad tempered with people than usual.
18. ☐ Because of my back, I go upstairs more slowly than usual.

*Roland Morris Citation info - Roland, M. and J. Fairbank (2000). "The Roland-Morris Disability Questionnaire and the Oswestry Disability Questionnaire." Spine **25**(24): 3115-24.*

Savannah Hills Chiropractic

200 Creekstone Ridge, Woodstock, GA 30188
Phone: 770-592-1909 Fax: 770-592-7303
Richard T. Schones, D.C.

Patient Name: _____ Date: _____

The Rivermead Post-Concussion Symptoms Questionnaire*

After a head injury or accident some people experience symptoms which can cause worry or nuisance. We would like to know if you now suffer from any of the symptoms given below. As many of these symptoms occur normally, we would like you to compare yourself now with before the accident. For each one, please circle the number closest to your answer.

0 = Not experienced at all
1 = No more of a problem
2 = A mild problem
3 = A moderate problem
4 = A severe problem

Compared with before the accident, do you now (i.e., over the last 24 hours) suffer from:

Headaches	0	1	2	3	4
Feelings of Dizziness	0	1	2	3	4
Nausea and/or Vomiting	0	1	2	3	4
Noise Sensitivity, easily upset by loud noise	0	1	2	3	4
Sleep Disturbance	0	1	2	3	4
Fatigue, tiring more easily	0	1	2	3	4
Being Irritable, easily angered	0	1	2	3	4
Feeling Depressed or Tearful	0	1	2	3	4
Feeling Frustrated or Impatient	0	1	2	3	4
Forgetfulness, poor memory	0	1	2	3	4
Poor Concentration	0	1	2	3	4
Taking Longer to Think	0	1	2	3	4
Blurred Vision	0	1	2	3	4
Light Sensitivity, Easily upset by bright light	0	1	2	3	4
Double Vision	0	1	2	3	4
Restlessness	0	1	2	3	4

Are you experiencing any other difficulties?

1. _____	0	1	2	3	4
2. _____	0	1	2	3	4

*King, N., Crawford, S., Wenden, F., Moss, N., and Wade, D. (1995) J. Neurology 242: 587-592

Duties Performed Under Duress at Work and Home

Patient name_____ Date of Injury _____ Today's Date_____

☐ Initial ☐ Update

Please check all that apply to your WORK because of the accident

- ☐ I go to work but work in pain
- ☐ I limit my work activities
- ☐ Bending at work hurts
- ☐ Stooping at work hurts
- ☐ Sitting at work hurts
- ☐ Using the computer at work hurts
- ☐ Pushing at work hurts
- ☐ Kneeling at work hurts
- ☐ I have lost status in my company
- ☐ I have lost job security
- ☐ I didn't get a promotion
- ☐ I don't enjoy work as much as before
- ☐ I doze off at work
- ☐ I take unpaid time off work to go to Dr.
- ☐ I daydream at work more than before
- ☐ I feel tired at work
- ☐ _____
- ☐ _____
- ☐ I work in pain because I have bills to pay
- ☐ I can't take time off because I would lose my job
- ☐ I keep working so I don't lose status at company
- ☐ My business would fail if I took time off
- ☐ I believe in working even when I'm in pain
- ☐ I feel obligated to work even though I'm in pain
- ☐ My business would lose money if I took time off
- ☐ My work is not as good as it was before accident
- ☐ My boss reprimanded me for poor performance
- ☐ I got a different job within the same company
- ☐ I got a different job in another company
- ☐ I make less money than before the accident
- ☐ I cannot do the same work/job as before accident
- ☐ I can't concentrate as well at work
- ☐ I take paid time off to go to Dr.
- ☐ I make mistakes at work I didn't use to
- ☐ I hide my poor work performance from my boss
- ☐ _____
- ☐ _____

Please check all that apply to your HOME/DOMESTIC because of the accident

- ☐ My house is not as clean now
- ☐ My yard is not as neat now
- ☐ My garden is not as productive now
- ☐ I do yard work, but do it in pain
- ☐ I cannot do my normal yard work
- ☐ I do house work, but do it in pain
- ☐ I cannot do my normal house work
- ☐ Doing laundry hurts me
- ☐ I cannot do laundry now
- ☐ Washing dishes hurts me
- ☐ I cannot vacuum now
- ☐ Cooking hurts me
- ☐ I cannot cook now
- ☐ Washing the car hurts me
- ☐ I cannot wash my car
- ☐ _____
- ☐ _____
- ☐ I cannot take time off because I care for children
- ☐ I have _____children ages_____
- ☐ I had to hire a paid housekeeper
- ☐ I asked someone for unpaid housekeeping help
- ☐ I had to hire a paid gardener
- ☐ I asked someone for unpaid yard work help
- ☐ Mowing the lawn hurts me
- ☐ I cannot mow the lawn
- ☐ Taking out the trash hurts me
- ☐ I cannot take out the trash
- ☐ I do not enjoy my gardening/yardwork like I used to
- ☐ I do not enjoy my housework like I used to
- ☐ Gardening hurts me
- ☐ I cannot do my gardening at all since the accident
- ☐ Others living with me do my share of the work now
- ☐ Others living with me do my share of the yard now
- ☐ Others living with me do my share of the gardening
- ☐ _____

_____ _____

Signature Date

Loss of Enjoyment of Sports, Hobbies, Travel, Daily activities, & School

Patient's name_____ Date of Injury_____ Today's date_____

☐ Initial ☐ Update

Please check all that apply to your EXERCISE & SPORTS Activity because of the accident

☐ My exercise was affected by this crash	☐ I have gained_____ pounds since the accident
☐ I go to the gym & work out in pain	☐ I had to quit my _____ team after the accident
☐ I no longer go to the gym to work out	☐ I had to quit my _____team after the accident
☐ I run but in pain	☐ I had to quit my _____team after the accident
☐ I no longer run	☐ I had to quit my _____team after the accident
☐ I take walks & have pain while walking	☐ I don't enjoy the sport of _____anymore
☐ I no longer take walks	☐ I didn't enjoy the sport of _____for ____weeks
☐ I used to make income at sports	☐ I don't enjoy the sport of _____anymore
☐ I have lost sports income since crash	☐ I didn't enjoy the sport of _____for ____weeks
☐ I am an amateur athlete	☐ I don't enjoy the sport of _____anymore
☐ I am a professional athlete	☐ I didn't enjoy the sport of _____for ____weeks
☐ _____	☐ I don't enjoy the sport of _____anymore
☐ _____	☐ I didn't enjoy the sport of _____for ____weeks

Please check all that apply to your HOBBY Activities because of the accident

☐ My hobbies were affected by accident	☐Hobby #3_____
☐ Hobby #1_____	☐I can't do hobby #3 anymore
☐ I can't do hobby #1 anymore	☐I do hobby #3 but in pain
☐ I do hobby #1 but in pain	☐I have lost money from not doing #3
☐ I have lost money from not doing #1	☐I didn't do hobby #3 for _____ weeks
☐ I didn't do hobby #1 for _____ weeks	☐Hobby #4_____
☐ Hobby #2_____	☐I can't do hobby #4 anymore
☐ I can't do hobby #2 anymore	☐I do hobby #4 but in pain
☐ I do hobby #2 but in pain	☐I have lost money from not doing #4
☐ I have lost money from not doing #2	☐I didn't do hobby #4 for _____ weeks
☐ I didn't do hobby #2 for _____ weeks	☐_____

Please check all that apply to your TRAVEL Activities because of the accident

☐Business travel was affected by crash	☐ Travel Plan #1
☐Pleasure travel was affected by crash	☐ I did not go on travel plan #1
☐I hurt driving in my own car	☐ I went, but did not enjoy #1 as much
☐I am in too much pain to drive	☐ I went and the accident had no effect on #1
☐I hurt when a passenger in a car	☐ Travel Plan #2
☐I am in too much pain to sit in a car	☐ I did not go on travel plan #2
☐I have anxiety when I'm in a car	☐ I went, but did not enjoy #2 as much
☐I hurt when I'm on an airplane	☐ I went and the accident had no effect on #2
☐ I am in too much pain too much pain to travel by plane	☐ I missed time with my family/friends b/c can't travel

Loss of Enjoyment of Sports, Hobbies, Travel, Daily activities, & School

Patient's name_____ Date of Injury_____ Today's date_____

☐ Initial ☐ Update

Please check all the DAILY LIVING activities that cause you pain because of the accident

- ☐ Dressing
- ☐ Putting on pants
- ☐ Putting on shoes
- ☐ Tying my shoes
- ☐ Putting on shirt
- ☐ Drying my hair
- ☐ Combing my hair
- ☐ Washing my hair
- ☐ Taking a shower
- ☐ Taking a bath
- ☐ Leaning forward
- ☐ Laying in bed
- ☐ Sitting in my favorite chair
- ☐ Sleeping
- ☐ Going out with my friends
- ☐ Sitting at a restaurant
- ☐ Shopping
- ☐ Driving to/from work
- ☐ Sitting in Church
- ☐ Playing with my children
- ☐ Caring for my children
- ☐ Bending in a movie theatre
- ☐ Sitting in a movie theatre
- ☐ Exercise
- ☐ Eating
- ☐ Stooping
- ☐ Squatting down
- ☐ Kneeling
- ☐ Brushing my teeth
- ☐ Riding in a car
- ☐ Opening a jar
- ☐ Lifting a pan when cooking
- ☐ Closing the trunk on my car
- ☐ Opening the garage door
- ☐ Using my home computer
- ☐ Climbing stairs
- ☐ Sexual activity
- ☐ Turning my head to left or right
- ☐ Holding my head up all day
- ☐ Watching TV
- ☐ I have pain sitting & doing nothing
- ☐ Talking on the phone
- ☐ Reading
- ☐ Writing
- ☐ Opening doors
- ☐ Drying with a towel after a bath or shower
- ☐ Life has become a chore just to do normal things
- ☐ It is depressing to live like this
- ☐ _____
- ☐ _____
- ☐ _____
- ☐ _____
- ☐ _____
- ☐ _____
- ☐ _____
- ☐ _____

Please check all that apply to your SCHOOL & EDUCATION Activities because of the accident

- ☐ School was affected by the accident
- ☐ I am a student at _____
- ☐ I am in the _____ year/grade
- ☐ I was ☐ full time ☐ part time
- ☐ I am now ☐ full time ☐ part time
- ☐ I had to take fewer classes b/c of crash
- ☐ I missed _____ days of school
- ☐ I had to drop out of school b/c of crash
- ☐ My grades are lower since the crash
- ☐ I have pain carrying my school books
- ☐ I hurt sitting in class more than _____ minutes
- ☐ My neck hurts when I look down to read
- ☐ I don't learn as quickly as before the crash
- ☐ I don't learn things as well as before the crash
- ☐ I have difficulty concentrating in class
- ☐ It takes much longer to study/do my homework
- ☐ _____
- ☐ _____

_____ _____

Signature of Patient Date