VITALITY CHIROPRACTIC
21904 Marine View Dr S, Ste C
Ph: 206-824-5521 / Fax: 206-212-7455

New Patient Registration and Accident Questionnaire

Name: _____ Age: _____Date of birth: _____ Date: _____
LAST FIRST MIDDLE

Address: _____Social Security #: _____ ☐ Male ☐ Female

City, State, Zip: _____Marital Status: ☐ M ☐ S ☐ W ☐ D # of Children_____

Home Phone (_____)_____Work Phone (_____) _____

Cell Phone (_____) _____Email address: _____

Employer: _____ Spouse's Name: _____

Occupation: _____ Spouse's Employer: _____

In case of emergency, notify_____ **Relationship:** _____ **Phone (_____)** _____

Current Symptoms: 1._____ 2._____ 3._____ 4._____

5. _____ 6. _____ 7. _____ 8. _____

When did your symptoms begin? _____

In general what makes your symptoms better? _____

In general what makes your symptoms worse? _____

In general how would you describe your pain? (ache, burn, dull, sharp, throbbing): _____

Are your symptoms local or do they travel to another area? (If they travel, to where?) _____

Are symptoms; ☐Constant >76% ☐Frequent 51-75% ☐Occasional 26-50% ☐Intermittent <25% **of your waking hours**

Were there any symptoms which you had after the crash/accident that have now resolved? (please list)

_____

Please list all medications and dosage: **Frequency** **For What Illness?**

_____

_____

List any allergies to medications, foods or other: _____

Are you pregnant? ☐ Yes ☐ No First day of last menstrual cycle: _____

Do you smoke? ☐ Yes ☐ No; How much? _____ Do you drink alcohol? ☐ Yes ☐ No; How much? _____

Please list all serious illness and serious accidents: **Month and Year** **City, State**

_____

_____

_____

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Patient's Name: _____ Date: _____

Please list any recent x-rays, lab or other tests: **Date** **Facility/Doctor**

_____

_____

Date of Crash/Accident: _____ Hour: _____ ☐ AM ☐ PM

Specific Location of Crash/Accident: _____

Describe in detail, in your own words, how the crash/accident happened: _____

_____

_____

_____

AUTOMOBILE/MOTORCYCLE ONLY

In the crash/accident: Were you the ☐ Driver ☐ Passenger ☐ Pedestrian ☐ Other? _____

Did your vehicle strike the other vehicle? ☐Yes ☐No Did the other vehicle strike your car? ☐Yes ☐No

Your vehicle: ☐ Car ☐ Pick-up Truck ☐ Van ☐ SUV / Other vehicle: ☐ Car ☐ Pick-up Truck ☐ Van ☐ SUV

Were you struck from? ☐ Behind ☐ Front ☐ Driver Side ☐ Passenger Side **Motorcycle Only**: ☐Left Side ☐ Right Side

Were traffic citations issued to? ☐ You ☐ Driver of Your Vehicle ☐ Driver of the Other Vehicle ☐ No Citations Given

Was your vehicle heading? ☐ North ☐ South ☐ East ☐ West on _____ (Street/Highway)

Was the other heading? ☐ North ☐ South ☐ East ☐ West on _____ (Street/Highway)

CHECK ANY OF THE FOLLOWING SYMPTOMS YOU HAVE NOTICED SINCE THE CRASH/ACCIDENT:

☐ *Headache*	☐ Middle Back Pain	☐ Lower Back Pain	☐ *Ears Ring*
☐ Neck Pain	☐ Chest Pain	☐ Lower Back Stiffness	☐ *Buzzing in Ears*
☐ Neck Stiffness	☐ *Bruised Chest*	☐ *Radiating Pain*	☐ *Dizziness*
☐ *Sleep Disruption*	☐ *Bruising Anywhere*	☐ Tingling in Legs	☐ *Loss of Smell*
☐ *Depression*	☐ *Blurred Vision*	☐ Tingling in Arms	☐ *Loss of Taste*
☐ *Anxiety*	☐ *Sensitivity to Light*	☐ *Jaw Pain (TMJ)*	☐ *Any Burns*
☐ *Fainting*	☐ Upper Arm Pain	☐ Upper Leg Pain	☐ *Any Stitches*
☐ *Muscle Spasms*	☐ Lower Arm Pain	☐ Lower Leg Pain	☐ *Any Cuts*

☐ Other Symptoms: _____

Have you lost time from work? ☐ Yes ☐ No: If Yes, Dates: _____ to _____

Where did you go after the crash/accident? ☐ Hospital ☐ Urgent Care ☐ Home ☐ Work ☐ Other _____

Were you taken by ambulance? ☐ Yes ☐ No **To which hospital?** _____

Address: _____ Date of Hospitalization: _____

Attending E.R. Doctor: _____ Treatment Given? _____

Have you done any of the following since the crash/accident?

☐ Ice	☐ Medication (name) _____	☐ Rest
☐ Heat (any kind)	☐ Exercise	☐ Other_____

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Patient's Name: _____ Date: _____

DO YOU HAVE A HISTORY OF ANY OF THE FOLLOWING DISEASES?:

Tuberculosis	☐ Yes	Lung Disease	☐ Yes	Gout	☐ Yes	Diabetes	☐ Yes
Kidney Disease	☐ Yes	Stomach/Ulcer	☐ Yes	Heart Disease	☐ Yes	Hepatitis	☐ Yes
Sciatica	☐ Yes	Blood Pressure	☐ Yes	Transfusion	☐ Yes	Polio / MS	☐ Yes
Colon Disease	☐ Yes	Stroke	☐ Yes	Cancer	☐ Yes	Bleeding	☐ Yes
Paralysis	☐ Yes	Seizures	☐ Yes	Arthritis	☐ Yes	Asthma	☐ Yes
Anemia	☐ Yes	Thyroid Disease	☐ Yes	Drug Dependence	☐ Yes	AIDS	☐ Yes

PLEASE PROVIDE US WITH THE APPROPRIATE INSURANCE INFORMATION:

1) YOUR AUTOMOBILE INSURANCE CARRIER: _____

Address: _____Telephone: (_____) _____Insured: _____

Claim #: _____Policy #: _____

Claim Representative: _____

Telephone: (_____) _____ Fax: (_____) _____

Med-Pay Benefits: _____ Uninsured (UM) Benefits: _____ Underinsured (UIM) Benefits: _____

Have you signed a selection waiver of benefits? ☐ Yes ☐ No ☐ Unsure

Are you a full time Student? ☐ Yes ☐ No Do you reside with a relative? ☐ Yes ☐ No

2) YOUR HEALTH INSURANCE COMPANY: _____

Address: _____ Insured: _____

Date of Birth: _____Policy #: _____ SS#: _____

Telephone: (_____) _____ Fax: (_____) _____

3) ADVERSE OR THIRD PARTY AUTOMOBILE INSURANCE CARRIER: _____

Address: _____ Claims Rep: _____

Claim #: _____Policy #: _____Insured: _____

Telephone: (_____) _____ Fax: (_____) _____

4) ATTORNEY: _____Legal Assistant: _____

Address: _____

Telephone: (_____) _____ Fax: (_____) _____

HIPAA Compliance

Our office is required by law to maintain the HIPAA Notice of Privacy Practices. This notice explains our legal duties and privacy practices with respect to your protected health information. Signature below acknowledges that I have read this Notice of our Privacy Practices. A copy will be provided to me upon request.

Patient Signature: _____ Date:_____

Witness: _____Date: _____

Staff Initials: _____

Neck Index

Patient Name _____ **Date**_____

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

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

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

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

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

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

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

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

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

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

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

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

Neck Index Score ☐

Patient Name: _____ Acct: _____

Loss of Enjoyment & Duties under Duress

Complete the questionnaire as it relates to how your injury/injuries affect your performance of everyday activities and/or work activity. Place a check in front of the **living or work duties that are painful or difficult for you to perform as a result of the injuries**. Also check the appropriate box designating reason for difficulty or limitation.

Work Activity - Reason for the Difficulty/Limitation

☐ **Lifting:** ☐ Increased Pain ☐ Restricted Movement ☐ Weakness ☐ Cannot Perform
☐ **Bending:** ☐ Increased Pain ☐ Restricted Movement ☐ Weakness ☐ Cannot Perform
☐ **Sitting:** ☐ Increased Pain ☐ Restricted Movement ☐ Weakness ☐ Cannot Perform
☐ **Walking:** ☐ Increased Pain ☐ Restricted Movement ☐ Weakness ☐ Cannot Perform
☐ **Computer Duties:** ☐ Increased Pain ☐ Restricted Movement ☐ Fatigue ☐ Cannot Perform
☐ **Other:** _____ ☐ Increased Pain ☐ Restricted Movement ☐ Weakness ☐ Cannot Perform
☐ **Other:** _____ ☐ Increased Pain ☐ Restricted Movement ☐ Weakness ☐ Cannot Perform
☐ **Other:** _____ ☐ Increased Pain ☐ Restricted Movement ☐ Weakness ☐ Cannot Perform

Studies/School - Reason for the Difficulty/Limitation

☐ **Lifting:** ☐ Increased Pain ☐ Restricted Movement ☐ Weakness ☐ Cannot Perform
☐ **Bending:** ☐ Increased Pain ☐ Restricted Movement ☐ Weakness ☐ Cannot Perform
☐ **Sitting:** ☐ Increased Pain ☐ Restricted Movement ☐ Weakness ☐ Cannot Perform
☐ **Walking:** ☐ Increased Pain ☐ Restricted Movement ☐ Weakness ☐ Cannot Perform
☐ **Computer Duties:** ☐ Increased Pain ☐ Restricted Movement ☐ Fatigue ☐ Cannot Perform
☐ **Studying:** ☐ Increased Pain ☐ Restricted Movement ☐ Fatigue ☐ Cannot Perform
☐ **Other:** _____ ☐ Increased Pain ☐ Restricted Movement ☐ Weakness ☐ Cannot Perform
☐ **Other:** _____ ☐ Increased Pain ☐ Restricted Movement ☐ Weakness ☐ Cannot Perform
☐ **Other:** _____ ☐ Increased Pain ☐ Restricted Movement ☐ Weakness ☐ Cannot Perform

Domestic Duties - Reason for the Difficulty/Limitation

☐ **Vacuuming:** ☐ Increased Pain ☐ Restricted Movement ☐ Fatigue ☐ Cannot Perform
☐ **Taking Care of Children/Others:** ☐ Increased Pain ☐ Restricted Movement ☐ Fatigue ☐ Cannot Perform
☐ **Cleaning:** ☐ Increased Pain ☐ Restricted Movement ☐ Fatigue ☐ Cannot Perform
☐ **Laundry:** ☐ Increased Pain ☐ Restricted Movement ☐ Fatigue ☐ Cannot Perform
☐ **Preparing Meals:** Increased Pain Restricted Movement Fatigue Cannot Perform
☐ **Other:** _____ ☐ Increased Pain/Anxiety ☐ Restricted Movement ☐ Fatigue ☐ Cannot Perform
☐ **Other:** _____ ☐ Increased Pain/Anxiety ☐ Restricted Movement ☐ Fatigue ☐ Cannot Perform
☐ **Other:** _____ ☐ Increased Pain/Anxiety ☐ Restricted Movement ☐ Fatigue ☐ Cannot Perform

Household Duties - Reason for the Difficulty/Limitation

☐ **Yardwork:** ☐ Increased Pain ☐ Restricted Movement ☐ Fatigue ☐ Cannot Perform
☐ **Transportation:** ☐ Increased Pain/Anxiety ☐ Restricted Movement ☐ Fatigue ☐ Cannot Perform
☐ **Shopping:** ☐ Increased Pain/Anxiety ☐ Restricted Movement ☐ Fatigue ☐ Cannot Perform
☐ **Taking Out Trash:** ☐ Increased Pain ☐ Restricted Movement ☐ Weakness ☐ Cannot Perform
☐ **Other:** _____ ☐ Increased Pain/Anxiety ☐ Restricted Movement ☐ Fatigue ☐ Cannot Perform
☐ **Other:** _____ ☐ Increased Pain/Anxiety ☐ Restricted Movement ☐ Fatigue ☐ Cannot Perform
☐ **Other:** _____ ☐ Increased Pain/Anxiety ☐ Restricted Movement ☐ Fatigue ☐ Cannot Perform

Sports - Reason for the Difficulty/Limitation

☐ **Sport:** _____ ☐ Increased Pain ☐ Restricted Movement ☐ Weakness ☐ Cannot Perform
Pre-Accident Level of Participation: ☐ Socially ☐ Competitively ☐ Professional
☐ **Sport:** _____ ☐ Increased Pain ☐ Restricted Movement ☐ Weakness ☐ Cannot Perform
Pre-Accident Level of Participation: ☐ Socially ☐ Competitively ☐ Professional
☐ **Sport:** _____ ☐ Increased Pain ☐ Restricted Movement ☐ Weakness ☐ Cannot Perform
Pre-Accident Level of Participation: ☐ Socially ☐ Competitively ☐ Professional

Patient Signature: _____Date: _____/_____/_____

Patient Basic Information

Personal Information:

Last Name:	First Name:		Mid. Init.:
Address:	City, State, Zip:		
Home Phone:	Work Phone:	Social Security No.:	
Date of Birth:	Date of Injury/Onset:		
Dominant Hand: ❑ Right	❑ Left	❑ Both	
Insurance Information: Policy Holder (if different than patient):		Policy No.:	

Special Note: If your injury involved a motor vehicle, skip to page 2. Otherwise, use the spaces below to fully describe your accident, injury or onset, slip and fall, etc.

1. Description of Accident/Injury/Onset

Enter a full description of the accident, injury or onset in the space below.

2. Your condition during and immediately after injury/onset

Enter the details of your condition during and immediately after your injury/onset.

Automobile Accident Description

Please answer the questions below. If you do not know the answer to any of the questions, do not answer that question.

1. Your vehicle type

❑ Car ❑ Station Wagon
❑ Van ❑ Pickup Truck
❑Large Truck ❑Bus
Other_____

2. Your position in vehicle

❑ Driver ❑ Front Passenger
❑ Left Rear Passenger
❑ Right Rear Passenger
Other_____

3. What was your vehicle doing at the time of the accident?

❑Stopped at intersection ❑Stopped in traffic ❑ Stopped at light
❑ Making a right turn ❑ Making a left turn ❑ Parking
❑Proceeding along ❑ Slowing down ❑Accelerating
Other_____

4. Time/Speed/Damage

Time of accident_____
Your vehicle's speed: _____mph
Their vehicle's speed: _____mph
Damage to your vehicle
❑ Mild ❑ Moderate
❑ Totaled

5. Details of Accident

Visibility at time of accident
❑ Poor ❑ Fair ❑ Good

Who hit who/what?
❑ You hit other vehicle
❑ Other vehicle hit you
You hit...(object)
_____

6. Road conditions

Road conditions at time of accident
❑ Icy ❑Wet ❑ Sandy ❑ Dark ❑ Clean and dry

Point of impact
❑ Head-On ❑Left Front ❑ Right Front
❑ Read-End ❑ Left Rear ❑ Right Rear

7. Body Position, etc.

Did you see the accident coming: **Yes❑ ❑ No**
Were you braced for the impact? **Yes❑ ❑ No**
Did you have a seat belt on? **Yes❑ ❑ No**
Did you have a shoulder harness on? **Yes❑ ❑ No**

Does your vehicle have headrests? Yes❑ ❑ No
What was the position of your headrest at the time of the impact?
❑ Even with top of head ❑ Even with bottom of head ❑ Middle of neck
What was the direction of your head at the time of the impact?
❑ Facing straight forward ❑ Turned to the right ❑ Turned to the left

Did driver side air bags deploy? **Yes❑ ❑ No** Did passenger side airbags deploy? **Yes❑ ❑ No** Did side airbags deploy? **Yes❑ ❑ No**

8. Additional accident information

In the case of a motor vehicle accident, enter any additional information here that is not covered by the above check offs.

9. During the accident:

Did your body strike the inside of your vehicle? **Yes❑ ❑ No**
If yes, describe:_____
Did you lose consciousness during the injury? **Yes❑ ❑ No**
If yes, for how long? _____
Your vehicle's estimated damage? _____
Damage to their vehicle: ❑ Mild ❑ Moderate ❑ Totaled
Did police show up at the scene? **Yes❑ ❑ No**
Was an accident report filled out? **Yes❑ ❑ No**

10. After the accident:

Check off your symptoms right after and a few days following:
❑ Headache ❑ Dizziness ❑ Mid back pain ❑ Cold hands
❑ Neck pain ❑ Nausea ❑ Low back pain ❑ Cold feet
❑ Neck stiffnes ❑ Confusion ❑ Nervousness ❑ Diarrhea
❑ Fainting ❑ Fatigue ❑ Loss of taste ❑ Depression
❑ Ringing in ears ❑ Tension ❑ Toe numbness ❑ Anxious
❑ Loss of smell ❑Irritability ❑ Constipation ❑ Chest Pain
❑ Pain behind eyes ❑ Shortness of breath ❑ Sleeping problems
Others:_____

11. Emergency Room?

Where did you go after the accident?
❑ Home ❑ Work ❑ Hospital ER ❑ Private Doctor
How did you get there?
❑ Drove self ❑Somebody else ❑Ambulance ❑ Police
Were X-rays done? Yes❑❑No **Was lab work done?** Yes❑❑No
Body parts X-rayed?_____
What lab work?_____
The X-rays revealed: _____
Treatments: ❑ Cervical Collar ❑ Ice **Other:**_____
Medications:_____
Follow-up instructions:_____
_____

12. Treatment History:

Fill in any other doctor(s) seen prior to your first visit to this office.
1. Dr. _____ First visit date: ____/____/____
Specialty:_____ X-rays done? **Yes❑ ❑ No**
Types of treatments received:_____
How many treatments received? ____ Currently treating? **Yes❑ ❑ No**
Did treatments benefit you? **Yes❑ ❑ No**
Last visit date: ____/____/____
2. Dr. _____ First visit date: ____/____/____
Types of treatments received:_____
How many treatments received? ____ Currently treating: **Yes❑ ❑ No**
Did treatments benefit you? **Yes❑ ❑ No**
Last visit date: ____/____/____

Description of Symptoms (Describe your symptoms in the sections below, in the order of severity, if possible.) PI 4

I. First Current Symptom: (Please check off the boxes below to describe your first symptom. Describe only ONE symptom per Section.

1. Check only one body location below

	L	R	B
❑Headaches	❑	❑	❑
❑Front of Head			
❑Top of Head			
❑Back of Head			
❑Jaw	❑	❑	❑
❑Eye	❑	❑	❑
❑Neck	❑	❑	❑
❑Upper Back	❑	❑	❑
❑Mid Back	❑	❑	❑
❑Low Back	❑	❑	❑
❑Chest	❑	❑	❑
❑Abdomen	❑	❑	❑
❑Ribs	❑	❑	❑
❑Buttocks	❑	❑	❑
❑Shoulder	❑	❑	❑
❑Upper Arm	❑	❑	❑
❑Forearm	❑	❑	❑
❑Hand	❑	❑	❑
❑Hip	❑	❑	❑
❑Leg	❑	❑	❑
❑Foot	❑	❑	❑

Other locations :_____

2. Types of pain

❑ Dull ❑ Sharp ❑ Aching ❑ Cutting
❑Throbbing ❑ Burning ❑ Numbing ❑ Tingling ❑ Cramping
❑Spasm ❑ Stinging ❑ Shooting ❑ Pounding ❑Constricting

Other types of pain:
_____
_____

3. Pain Frequency

❑Up to 1/4 of awake time ❑1/4 to 1/2 of time
❑1/2 to 3/4 of awake time ❑ Most all the time

4. Pain Intensity (How it affects your daily activites)

❑ Doesn't affect ❑ Somewhat affects
❑ Seriously affects ❑ Prevents activities

5. Does this pain radiate into other body parts?

	Left	Right	Both
❑ Head	❑	❑	❑
❑ Neck	❑	❑	❑
❑ Shoulder	❑	❑	❑
❑ Arm	❑	❑	❑
❑ Hand	❑	❑	❑
❑ Hip	❑	❑	❑
❑ Leg	❑	❑	❑
❑ Foot	❑	❑	❑

Other locations of radiation:_____

6. Actions affecting this pain

	Brings On	Aggravates	Relieves
❑ In the A.M.	❑	❑	❑
❑ In the P.M.	❑	❑	❑
❑ Bending forward	❑	❑	❑
❑ Bending back	❑	❑	❑
❑ Bending left	❑	❑	❑
❑ Bending right	❑	❑	❑
❑ Twisting left	❑	❑	❑
❑ Twisting right	❑	❑	❑
❑ Coughing	❑	❑	❑
❑ Sneezing	❑	❑	❑
❑ Straining	❑	❑	❑
❑ Standing	❑	❑	❑
❑ Sitting	❑	❑	❑
❑ Lifting	❑	❑	❑
Other Actions:			
_____	❑	❑	❑
	❑	❑	❑

II. Second Current Symptom: (Please check off the boxes below to describe your next symptom).

1. Check only one body location below

	L	R	B
❑Headaches	❑	❑	❑
❑Front of Head			
❑Top of Head			
❑Back of Head			
❑Jaw	❑	❑	❑
❑Eye	❑	❑	❑
❑Neck	❑	❑	❑
❑Upper Back	❑	❑	❑
❑Mid Back	❑	❑	❑
❑Low Back	❑	❑	❑
❑Chest	❑	❑	❑
❑Abdomen	❑	❑	❑
❑Ribs	❑	❑	❑
❑Buttocks	❑	❑	❑
❑Shoulder	❑	❑	❑
❑Upper Arm	❑	❑	❑
❑Forearm	❑	❑	❑
❑Hand	❑	❑	❑
❑Hip	❑	❑	❑
❑Leg	❑	❑	❑
❑Foot	❑	❑	❑

Other locations :_____

2. Types of pain

❑ Dull ❑ Sharp ❑ Aching ❑ Cutting
❑Throbbing ❑ Burning ❑ Numbing ❑ Tingling ❑ Cramping
❑Spasm ❑ Stinging ❑ Shooting ❑ Pounding ❑Constricting

Other types of pain:
_____
_____

3. Pain Frequency

❑Up to 1/4 of awake time ❑1/4 to 1/2 of time
❑1/2 to 3/4 of awake time ❑ Most all the time

4. Pain Intensity (How it affects your daily activites)

❑ Doesn't affect ❑ Somewhat affects
❑ Seriously affects ❑ Prevents activities

5. Does this pain radiate into other body parts?

	Left	Right	Both
❑ Head	❑	❑	❑
❑ Neck	❑	❑	❑
❑ Shoulder	❑	❑	❑
❑ Arm	❑	❑	❑
❑ Hand	❑	❑	❑
❑ Hip	❑	❑	❑
❑ Leg	❑	❑	❑
❑ Foot	❑	❑	❑

Other locations of radiation:_____

6. Actions affecting this pain

	Brings On	Aggravates	Relieves
❑ In the A.M.	❑	❑	❑
❑ In the P.M.	❑	❑	❑
❑ Bending forward	❑	❑	❑
❑ Bending back	❑	❑	❑
❑ Bending left	❑	❑	❑
❑ Bending right	❑	❑	❑
❑ Twisting left	❑	❑	❑
❑ Twisting right	❑	❑	❑
❑ Coughing	❑	❑	❑
❑ Sneezing	❑	❑	❑
❑ Straining	❑	❑	❑
❑ Standing	❑	❑	❑
❑ Sitting	❑	❑	❑
❑ Lifting	❑	❑	❑
Other Actions:			
_____	❑	❑	❑
	❑	❑	❑

III. Third Current Symptom: (Please check off the boxes below to describe your 3rd symptom).

1. Check only one body location below

	L	R	B
❑Headaches	❑	❑	❑
❑Front of Head			
❑Top of Head			
❑Back of Head			
❑Jaw	❑	❑	❑
❑Eye	❑	❑	❑
❑Neck	❑	❑	❑
❑Upper Back	❑	❑	❑
❑Mid Back	❑	❑	❑
❑Low Back	❑	❑	❑
❑Chest	❑	❑	❑
❑Abdomen	❑	❑	❑
❑Ribs	❑	❑	❑
❑Buttocks	❑	❑	❑
❑Shoulder	❑	❑	❑
❑Upper Arm	❑	❑	❑
❑Forearm	❑	❑	❑
❑Hand	❑	❑	❑
❑Hip	❑	❑	❑
❑Leg	❑	❑	❑
❑Foot	❑	❑	❑

Other locations :_____

2. Types of pain

❑ Dull ❑ Sharp ❑ Aching ❑ Cutting
❑Throbbing ❑ Burning ❑ Numbing ❑ Tingling ❑ Cramping
❑Spasm ❑ Stinging ❑ Shooting ❑ Pounding ❑Constricting

Other types of pain:
_____
_____

3. Pain Frequency

❑Up to 1/4 of awake time ❑1/4 to 1/2 of time
❑1/2 to 3/4 of awake time ❑ Most all the time

4. Pain Intensity (How it affects your daily activites)

❑ Doesn't affect ❑ Somewhat affects
❑ Seriously affects ❑ Prevents activities

5. Does this pain radiate into other body parts?

	Left	Right	Both
❑ Head	❑	❑	❑
❑ Neck	❑	❑	❑
❑ Shoulder	❑	❑	❑
❑ Arm	❑	❑	❑
❑ Hand	❑	❑	❑
❑ Hip	❑	❑	❑
❑ Leg	❑	❑	❑
❑ Foot	❑	❑	❑

Other locations of radiation:_____

6. Actions affecting this pain

	Brings On	Aggravates	Relieves
❑ In the A.M.	❑	❑	❑
❑ In the P.M.	❑	❑	❑
❑ Bending forward	❑	❑	❑
❑ Bending back	❑	❑	❑
❑ Bending left	❑	❑	❑
❑ Bending right	❑	❑	❑
❑ Twisting left	❑	❑	❑
❑ Twisting right	❑	❑	❑
❑ Coughing	❑	❑	❑
❑ Sneezing	❑	❑	❑
❑ Straining	❑	❑	❑
❑ Standing	❑	❑	❑
❑ Sitting	❑	❑	❑
❑ Lifting	❑	❑	❑
Other Actions:			
_____	❑	❑	❑
	❑	❑	❑

Patient Name:_____

Activities/ Daily Living Assessment

Please check all that apply:

Section 1 – Pain Intensity:
- ☐ My pain comes and goes and is mild
- ☐ My pain is mild and does not vary
- ☐ My pain comes and goes and is moderate
- ☐ My pain is moderate and does not vary much
- ☐ My pain comes and goes and is severe
- ☐ My pain is severe and does not vary much

Section 2 – Personal Care:
- ☐ I do not change habits to avoid pain
- ☐ I do not change habits but experience some pain
- ☐ I do not change habits but it increases pain
- ☐ I do change habits due to increased pain
- ☐ I am unable to do some personal care without help
- ☐ I am unable to wash or dress without help

Section 3 – Lifting:
- ☐ I can lift heavy weights with no pain
- ☐ I can lift heavy weights with pain
- ☐ I cannot lift heavy weights off the floor
- ☐ I can lift heavy weight from a table
- ☐ I can lift light weights from a table
- ☐ I can lift only very light weights

Section 4 – Walking
- ☐ My pain does not prevent walking
- ☐ I cannot walk more than 1 mile
- ☐ I cannot walk more than 1/2 mile
- ☐ I cannot walk more than 1/4 mile
- ☐ I can only walk on crutches
- ☐ I am bedridden and must crawl to the toilet

Section 5 – Sitting
- ☐ I can sit in any chair as long as desired
- ☐ I can sit only in certain chair as long as desired
- ☐ I can sit no more than 1 hour
- ☐ I can sit no more than 1/2 hour
- ☐ I can sit no more than 10 minutes
- ☐ I cannot sit at all due to pain

Section 6 – Standing:
- ☐ I can stand for an unlimited time without pain
- ☐ I have some pain standing/ doesn't increase w/time
- ☐ I cannot stand for more than 1 hour
- ☐ I cannot stand for more than 1/2 hour
- ☐ I cannot stand for more than 10 minutes
- ☐ I cannot stand at all

Section 7 – Sleeping:
- ☐ I have no pain in bed
- ☐ I have pain in bed but I sleep well
- ☐ My normal sleep is reduced by 1/4
- ☐ My normal sleep is reduced by 1/2
- ☐ My normal sleep is reduced by 3/4
- ☐ I cannot sleep at all due to pain

Section 8 – Traveling (car, bus, plane, etc.):
- ☐ I can travel without pain
- ☐ Traveling causes some pain, but not made worse
- ☐ Traveling causes extra pain, no change in form
- ☐ Traveling causes pain, uses alternative travel
- ☐ My pain restricts all forms of travel
- ☐ My pain restricts travel except lying down

Section 9 – Social
- ☐ I can socialize normally and it causes no pain
- ☐ I can socialize normally but it causes extra pain
- ☐ My pain limits energetic interests
- ☐ My pain limits activity/ I do not go out as often
- ☐ My pain restricts social life to home
- ☐ My pain restricts all social life

Section 10 – Changing Degree of Pain
- ☐ My pain is rapidly improving
- ☐ My pain fluctuates but is improving
- ☐ My pain improvement is slow
- ☐ My pain level is unchanged
- ☐ My pain is gradually worsening
- ☐ My pain is rapidly worsening

Score: _____ (For Office Use Only)

Patient Name:_____

Terms of Acceptance

When an individual or family seeks and is accepted for chiropractic care, it is essential for all parties to be working toward the same objective.

Chiropractic has only one goal. It is important that everyone understands both the objective, and the method that will be used to achieve it. This will prevent any confusion or disappointment.

Definitions:

Health: A state of optimal physical, mental and social well being, not merely the absence of disease of infirmity.

Subluxation: A disruption in the normal flow of Life Energy in the nerves between the brain and the cells of the body. This causes an alteration of the normal physiology and leads to a state of "dis-ease" (the inability of the body to adapt).

Chiropractic Adjustment: The specific application of gentle force to facilitate the body's correction of subluxation and restore its innate healing processes so as to progressively bring about a state of health and wholeness.

We do not offer to diagnose or treat any disease or condition other than subluxation. However, if during the course of your chiropractic assessment, we encounter non-chiropractic or unusual findings, we will advise you. If you desire advice, diagnosis or treatment for those findings, we will recommend that you seek the services of a health care provider who specializes in that area.

Regardless of what the disease is called, we do not offer to treat it. Nor do we offer advice regarding treatment prescribed by others. **Our Only Practice Objective** is to eliminate a major interference to the full outward expression of your body's Innate Wisdom. Our only method used is specific chiropractic adjusting to correct vertebral subluxations.

I have read and understand the above statement.

Patient/Guardian Signature_____ **Date**_____

Patient Name:_____

Notice of Privacy Practice

This notice describes how health information about you (as a patient of this practice) may be used and disclosed, and how you can get access to your individually identifiable health information. Please review this notice carefully.

Privacy: We are committed to protecting your personal health information against disclosure to unauthorized entities/ persons. With your permission we will share your personal health information only with entities/ persons directly related to your health care and insurance/ payment needs. We will ask for you written permission for any other disclosure of your personal health information.

Access: You have the right to review and amend your personal health care records. Fees for copying your personal health information/ records are set by state regulators annually.

Restrictions: You have to right to restrict certain uses and disclosures of your protected health information.

Communications: You have to right to receive confidential communications from our office. If you would like restricted/ confidential communications from our office, inform our office staff on your first visit and we will make the necessary accommodations.

Consent: I authorize Vitality Chiropractic to share my personal health information only with entities/ persons directly related to my health care and my insurance/ payment needs.

If you have a complaint regarding our privacy notice, our privacy practices or any aspect of our privacy activities you should direct your complaint to Dr. Bonnie Verhunce at (206) 824-5521.

If you would like further information about our privacy policies and practices please contact Dr. Bonnie Verhunce at (206) 824-5521.

This notice is effective as of August 23, 2013. This notice and any alterations or amendments made hereto will expire seven years after the date upon which the record was created. My signature acknowledges that I have received a copy of this notice.

I have read and I understand the above notice.

Patient/Guardian Signature_____ **Date**_____

Patient Name:_____

Patient authorization regarding chiropractic care being provided in an "open adjusting" environment.

It is the practice of this office to provide chiropractic care in an "open adjusting" environment. "Open adjusting" involves several patients being seen in the same adjusting room at the same time. Patients are within sight of one another and some ongoing routine details of care are discussed within earshot of other patients and staff. This environment is used for ongoing care and is NOT the environment used for taking patient histories, performing examinations or presenting reports of findings. These procedures are completed in a private, confidential setting.

We are requesting this authorization of you due to various interpretations under federal law with respect to what is known as an "incidental disclosure" of health information. It is our view that the kinds of matters related in an "open adjusting" environment are incidental matters, in the event you or someone else would not agree with us we are providing this disclosure.

The use of this format is intended to make your experience with our office more efficient and productive as well as to enhance your access to quality health care and health information. If you choose not to be adjusted in an "open adjusting" environment, other arrangements will be made for you. Your decision will have no adverse effect on your care from Vitality Chiropractic.

I have read and I understand the above policy.

Patient/Guardian Signature_____ **Date**_____

You may revoke this authorization at any time. Revocation may be accomplished by advising us in writing of your decision to withdraw your authorization. Please allow a reasonable processing time for the change in our procedures to be completed.

PERSONAL INJURY FINANCIAL AGREEMENT

We would like to take a moment to welcome you to our office and to assure you that you will receive the very best care available for your injury. In order to familiarize you with the financial policy of our office, I would like to explain how your medical bills will be handled.

PARTY RESPONSIBLE:

If you were involved in an auto accident, we will bill the medical payments portion or Personal Injury Protection portion of your insurance policy to cover the treatment charges incurred in our office.

MEDPAY -

If you were a passenger in another vehicle, the insurance company which insures the automobile may be billed for your medical services incurred.

PIP (Personal Injury Protection) -

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.

3rd PARTY -

If another vehicle has caused the accident, we will first bill your automobile MedPay or PIP. It is also to your advantage for our office to bill your own health insurance policy for your medical services, providing your policy does not state otherwise. Once MedPay or PIP is exhausted, we will file a Medical Lien with the 3rd Party insurance to ensure payment to our office.

ATTORNEY/MEDICAL LIENS:

If you do not have PIP insurance, or hire an attorney to represent you, it is our policy to file a Doctor's Lien on your claim. This will guarantee direct payment to our office for any unpaid balance upon the settlement of your claim. We retain the right to first submit all charges to your private 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 the insurance company(ies) 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. If, at any time, you have further questions about your care, please do not hesitate to ask.

I have read and agree to the above.

_____

Patient's Signature Date

_____

Printed Patient Name

21904 Marine View Drive S, Ste C Des Moines, WA 98198
www.vitalitychiropractic.com P:(206) 824-5521 F:(206) 212-7455

Patient Name:_____

Legal Assignment of Benefits and Health Insurance Disclosure Agreement

I, the undersigned patient, affirm that I do have insurance and/ or employee medical benefit coverage with an insurance carrier, and I understand and acknowledge that Vitality Chiropractic will bill my insurance carrier for the medical expenses to be incurred while I'm in treatment. Any and all insurance payments and/or insurance reimbursement will be made payable to Vitality Chiropractic by the carrier. If at any time my insurance carrier makes a payment for my care directly to me (instead of Vitality Chiropractic), I agree to honestly and fully pay Vitality Chiropractic for the services rendered. I understand that I am financially responsible for all charges regardless of any applicable insurance or benefit payments or coverage.

I authorize any plan administrator or fiduciary, insurer, and/ or my attorney to release any and all plan documents, insurance policy and/or settlement information to Vitality Chiropractic upon written request. I authorize the use of this signature on all my insurance and/or employee medical benefits claim submissions.

I, the patient, understand that a certain portion of my care may not be covered by or has not been authorized by my insurance plan. I acknowledge that if any portion of the care provided is not, or may not be, covered by insurance, then I will be responsible for payment, and I will make the necessary financial arrangements with my healthcare provider to pay for these services. I understand that Vitality Chiropractic will make every legal effort to receive payment from the carrier for medically necessary chiropractic treatments and I agree to cooperate with my health care provider in any/ all of these attempts, including, if necessary, bringing suit with my insurance carrier at the cost of my provider.

This assignment will remain in effect until revoked by me in writing. A photocopy of this assignment is to be considered as valid as the original. I have read and fully understand this agreement.

I have read and understand the above statement.

Patient/Guardian Signature_____ **Date**_____

Methods of Communication

Please use this form to let us know of the method you prefer we use in communicating with you. You have the right to request to receive communications about your protected health information from us by alternative means or at alternative locations and we will accommodate reasonable requests.

Name: _____

Date of Birth: _____ Last 4 digits Social Security # XXX-XX- ____ ____ ____ ____

You may change your mind at any time and we will provide you with another copy of this form to request modification of your preferred method of communication. **You do not need to tell us why you are making this request.**

If You Prefer Email or Text Message

You may request that we communicate with you by email or text message. We must warn you there is some level of risk that protected health information transmitted by unencrypted email or unencrypted text message could be intercepted or read by an unauthorized person. In light of this warning, if you still prefer that we communicate with you by unencrypted email or unencrypted text message we will agree to your request. We are not responsible for unauthorized access of your protected health information while in transmission or for safeguarding information that has been delivered to you.

You may check one or more box below or if your preference is not listed please provide specific directions in the space provided following the check boxes.

I request you communicate with me by:

1. Telephone

- ☐ **Call my Home Phone** - Number _____
  - ☐ Leave message with call-back number with family member or voicemail.
  - ☐ Do NOT leave message with call-back number with family member or voicemail.
- ☐ **Do not contact me on my Home Phone.**

- ☐ **Call my Work Phone** - Number _____
  - ☐ Leave message with call-back number with co-worker or on voicemail.
  - ☐ Do NOT leave message with call-back number with co-worker or on voicemail.
- ☐ **Do not contact me on my Work Phone.**

- ☐ **Call my Cell Phone** - Number _____
  - ☐ Leave message with health information and call-back number on voicemail.
  - ☐ Do NOT leave message with health information and call-back number on voicemail.
- ☐ **Do not contact me on my Cell Phone.**

2. E-mail

I understand there is some level of risk that protected health information transmitted by unencrypted email could be read by an unauthorized person but I still prefer you communicate with me by email at this Email Address:

_____

- ☐ **Do Not contact me by e-mail.**

Methods of Communication

3. Text Message

I understand there is some level of risk that protected health information transmitted by unencrypted text message could be read by an unauthorized person but I still prefer you communicate with me by text message at this cell phone number:

_____

☐ **Do Not contact me by text message.**

4. U.S. Mail

We will send mail to you at your Home Address unless you prefer to receive mail at another mailing address.

☐ Instead of my Home Address, please send mail to me at the address below:

_____

5. Online Communication System via DemandForce

We invite you to participate in our patient online system. Features include but not limited to:

- Receiving Appointment Reminders via E-mail and Text Message
- Requesting Appointments Online
- Confirming Appointments via Email or Text

☐ **I prefer to OPT IN the Online Communication System.**

☐ **I prefer to OPT OUT of the Online Communication System**

6. Other Communication Methods

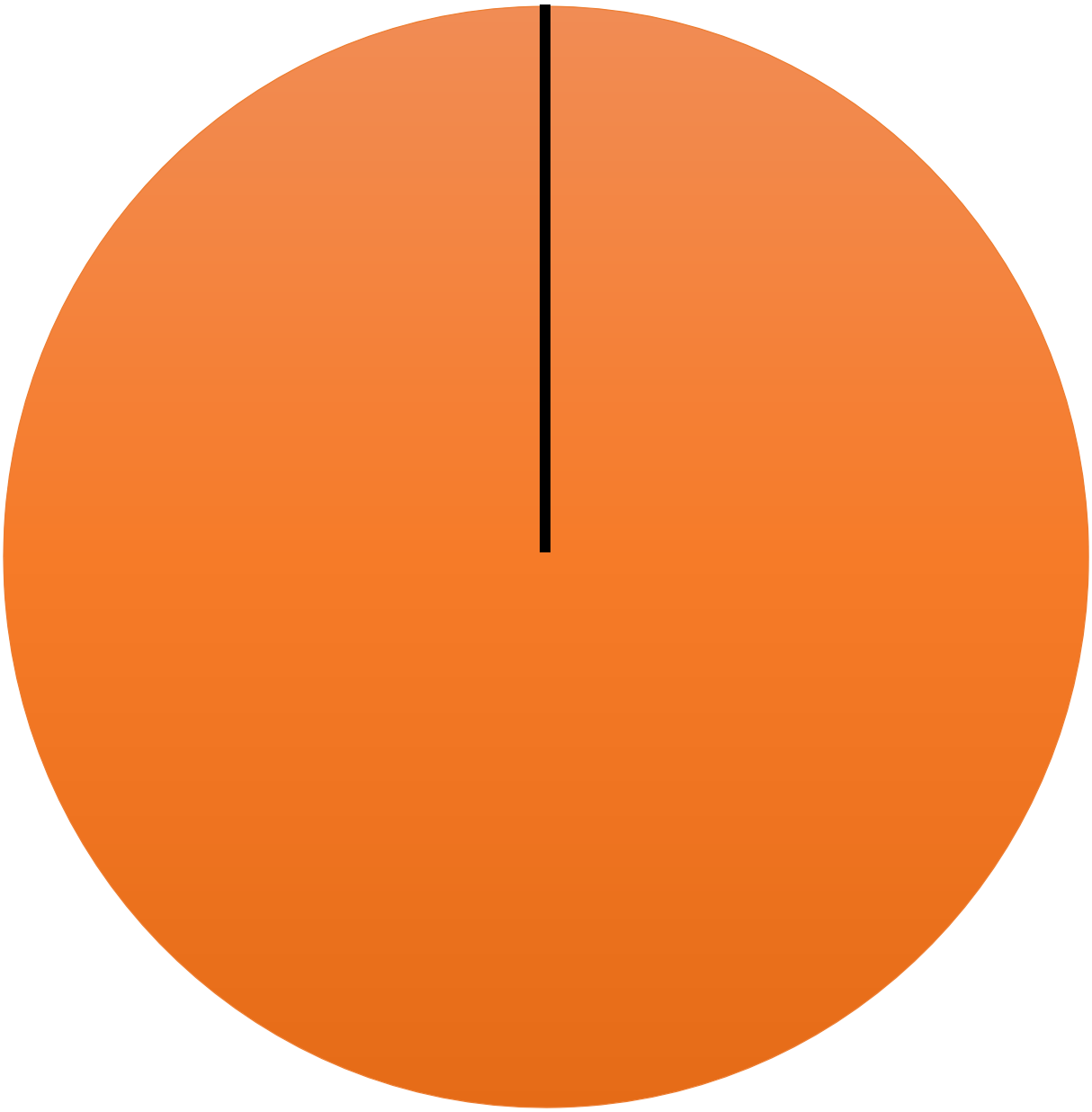
You may communicate with me as follows (please be specific):

Signature:_____ Date: _____

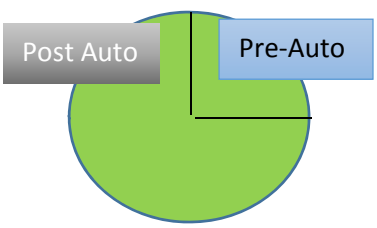
By signing above, I certify that the information provided is correct and true and I understand that I may my request modification of my preferred method of communication at any time.

Pain Scale

Use this graph to show Dr. Bonnie the amount of pain you experienced from before the accident and how much pain is from the auto accident.



Example: Please use this as an example.



Patient name

Date

Vitality Chiropractic
21904 Marine View Dr S, Suite C
Des Moines, WA 98198

Ph: 206-824-5521
www.vitalitychiropractic.com