MVA Intake Paperwork

Instructions:

Please complete this entire packet to the best of your ability. Accurate information is necessary for us to provide the best care possible.

Please give yourself ample time to complete. Typical time spent filling out this paperwork is 45 min to an hour.

All blanks MUST be filled in. If a section does not apply, please write in N/A or none. This ensures that we know a section was not missed in error.

This paperwork needs to be completed prior to your scheduled appointment. You appointment is on ______________________________ at _______________. Please bring this with you to your appointment and arrive 10 minuets before your scheduled appointment to allow our staff to process the paperwork. If the paperwork is not complete by the time of your scheduled appointment, your appointment will be rescheduled.

If you have any questions you can call 206-824-5521 or email katelyn@vitalitychiropractic.com. If it is after hours, you may send an email to cami@vitalitychiropractic.com or text 206-395-5209 and Cami will reach out to you ASAP.

MVA Intake Paperwork

Patient Information

Legal Name ______________________ Date of Birth ______________

Preferred Name ______________________ Preferred Pronouns ______________

Address ____

Home Phone ______________________ Cell Phone ______________________

Email ______________________ SSN ______________

Sex (at birth) ☐ Male ☐ Female Height ______________ Weight ______________

Occupation ______________________ Employer ______________________

Name of Partner/Significant other ______________________

Marital Status: ☐ Minor ☐ Single ☐ Married ☐ Widowed ☐ Divorced

Number of Children: ______________

In case of Emergency, contact

Name ______________________ Relationship: ______________

Contact Phone Number ______________________

Whom may we thank for the referral? ______________________

Insurance & Claims Information

Please provide ALL the following information

Your Auto Insurance Information

Your Auto Insurance Carrier ______________________

Claim Number ______________________ Policy Number ______________

Adjustors Name ______________________ Contact # ______________

Have you signed any waivers? ______________________

3rd Party or Adverse Parties Information

Their Name ______________________ Phone # ______________

Their Auto Insurance Carrier ______________________

Claim Number ______________________ Policy Number ______________

Adjustors Name ______________________ Contact # ______________

*Name*____ *Date of Birth* ____________________

Your Primary Heath Care Insurance Information

Your Heath Insurance Carrier ____

Name of Insured _________________________________ Relationship ____________________

Policy/Member ID ____

Phone # _____________________________

Your Secondary Heath Care Insurance Information

Your Heath Insurance Carrier ____

Name of Insured _________________________________ Relationship ____________________

Policy/Member ID ____

Phone # _____________________________

Attorney's Information

Law Office ____

Name _______________________________________ Phone # _________________________

Address ____

Paralegal ____________________________________ Fax # ____________________________

I understand that if I do not provide all of the above information or provide it accurately it may result in Vitality Chiropractic not being able to bill the appropriate party. If I do not have have Personal Injury Protection (PIP) benefits, Un/Under Insured Motorist benefits, and have not retained an attorney to act on my behalf, I understand I will be responsible for paying for any balance that is accrued during my treatments at Vitality Chiropractic and obtaining reimbursement on my own.

Patient Signature ____ **Date** _________________

Accident Information

Date of Accident __________________________ Time of Accident ____________________ AM PM

Specific Location of Accident ____

Describe in detail, how the accident happened: ____

____

____

____

____

Did the Police Respond? ☐ Yes ☐ No Is there a Police Report? ☐ Yes ☐ No

If yes, what is the report number? ____

*Name*____ *Date of Birth* ______________________

Was a citation given? _____________ If Yes, who was it issued to? _______________________________

In the accident, you were the ☐ Driver ☐ Passenger (front seat) ☐ Passenger (back seat) indicate Driver Side - Middle - Passenger
☐ Pedestrian ☐ Other _________________

Your vehicle is a ☐ Car ☐ Truck ☐ SUV ☐ Van ☐ Other _________________

The other vehicle is a ☐ Car ☐ Truck ☐ SUV ☐ Van ☐ Other _________________

Where did the impact occur? ☐ Front ☐ Back ☐ Drivers Side ☐ Passengers Side

Speed of your vehicle at collision? (approx) ___________ MPH

Speed of their vehicle at collision? (approx) ___________ MPH

Your vehicle was traveling ☐ North ☐ South ☐ East ☐ West on __________________________

The other vehicle was traveling ☐ North ☐ South ☐ East ☐ West on ______________________

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

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

Road Conditions at time of accident ☐ Clean/Dry ☐ Wet ☐ Icy ☐ Dark ☐ Sandy

Weather at time of accident ☐ Clear ☐ Cloudy ☐ Foggy ☐ Drizzling ☐ Raining ☐ Snowing

Was your visability: ☐ Good ☐ Fair ☐ Poor

Have you lost time from work? ☐ Yes ☐ No If yes, from (dates)_______________ to ___________________.

Where did you go immediately after the accident? ____

Have you seen a Medical Provider since the accident? (This includes the ER/Hospital) ☐ Yes ☐ No

If yes, where were you seen and what recommendations were you given? ___________________________
____

Where you taken by ambulance? ☐ Yes ☐ No Were x-rays, CT or an MRI taken? ☐ Yes ☐ No

Did you see the accident coming? ☐ Yes ☐ No Did you brace for the impact? ☐ Yes ☐ No

Were you wearing a seat belt? ☐ Yes ☐ No Did the airbags deploy? ☐ Yes ☐ No

Did you hit your head anywhere inside the vehicle? ☐ Yes ☐ No

If yes, where were did you hit your head? ____

Did you ever lose consciousness? ☐ Yes ☐ No

What is the estimated damage to your vehicle? ☐ Mild ☐ Moderate ☐ Totaled

*Name*_______________________________________ *Date of Birth* ___________________

Have you done any of the following since the accident?

- ☐ Ice
- ☐ Heat (of any kind)
- ☐ Exercise
- ☐ Rest
- ☐ Medication ___________________________________
- ☐ Other ______________________________

Check any/all the following symptoms you have experienced since the accident:

- ☐ Headache
- ☐ Depression
- ☐ Anxiety
- ☐ Muscle Spasms
- ☐ Chest Pain
- ☐ ANY Bruising
- ☐ Sleep Disturbance
- ☐ Blurred Vision
- ☐ Pain in Arms/Hands
- ☐ Pain in Legs/Feet
- ☐ Upper Back Pain
- ☐ Mid Back Pain
- ☐ Lower Back Pain
- ☐ Foot/Ankle Issues
- ☐ Neck Pain
- ☐ Neck Stiffness
- ☐ Migraines
- ☐ Sensitivity to Light
- ☐ Fainting
- ☐ Jaw Pain (TMJ)
- ☐ Radiating Pain
- ☐ Dizziness
- ☐ Tinnitus (ringing in ears)
- ☐ Loss of Smell
- ☐ Loss of Taste
- ☐ Burns
- ☐ Cuts
- ☐ Stiches
- ☐ Other ____

Patient History

From birth to present, please list, describe, and provide the month & year:

Auto Collisions ____

____

____

Falls & Injuries ____

____

____

Sport Injuries ____

____

____

Hospitalizations/Surgeries ____

____

____

X-Rays, MRIs or other imaging____

____

____

Previous Chiropractic Care____

____

Name____ Date of Birth ____________________

Please check all that apply to you

- ☐ AIDS/HIV
- ☐ Alcoholism
- ☐ Anxiety
- ☐ High/Low Blood Pressure
- ☐ Asthma/Allergies
- ☐ Back Pain
- ☐ Heart Issues
- ☐ Cancer
- ☐ Depression
- ☐ Diabetes
- ☐ GI Issues
- ☐ Joint Pain
- ☐ Elbow/Arm/Hand Issues
- ☐ Foot/Ankle Issues
- ☐ Gout
- ☐ Headaches
- ☐ Miagraines
- ☐ Hep A or B
- ☐ Immune Issues
- ☐ Multiple Sclerosis
- ☐ Neck Pain
- ☐ Reproductive issues
- ☐ Tinnitus (ringing in ears)
- ☐ Scoliosis
- ☐ Stroke
- ☐ TMJ Pain
- ☐ Osteoporosis
- ☐ Other ____________

Allergies, Medications & Supplements

Allergies (list)	Medications / RX (list)	Supplements (list)

Family History

Please check all that apply to any immediate blood relative

- ☐ AIDS/HIV
- ☐ Alcoholism
- ☐ Anxiety
- ☐ High/Low Blood Pressure
- ☐ Asthma/Allergies
- ☐ Back Pain
- ☐ Heart Issues
- ☐ Cancer
- ☐ Depression
- ☐ Diabetes
- ☐ GI Issues
- ☐ Joint Pain
- ☐ Elbow/Arm/Hand Issues
- ☐ Foot/Ankle Issues
- ☐ Gout
- ☐ Headaches
- ☐ Miagraines
- ☐ Hep A or B
- ☐ Immune Issues
- ☐ Multiple Sclerosis
- ☐ Neck Pain
- ☐ Reproductive issues
- ☐ Tinnitus (ringing in ears)
- ☐ Scoliosis
- ☐ Stroke
- ☐ TMJ Pain
- ☐ Osteoporosis
- ☐ Other ____________

For the above selections, please provide the blood relative affected [parent, sibling(s) or child(ren)] and the specifics of the condition: ____

____

*Name*____ *Date of Birth* ____________________

How can we help you?

Please list your symptom(s) below and answer the questions.

Symptom #1

Symptom 1 ____

When was the onset on of this symptom? _____/_____/___________

Please mark with an X the area(s) where symptom 1 is located.

What does symptom 1 feel like? (check all that apply)

- ☐ Numbness
- ☐ Tingling
- ☐ Dull
- ☐ Aching
- ☐ Stiffness
- ☐ Cramping
- ☐ Nagging
- ☐ Sharp
- ☐ Shooting
- ☐ Burning
- ☐ Throbbing
- ☐ Stabbing
- ☐ Swollen
- ☐ Other _____________

What is your pain frequency of Symptom #1

- ☐ 0 - 1/4th of the time
- ☐ 1/4th - 1/2th of the time
- ☐ 1/2th - 3/4th of the time
- ☐ almost all of the time

When is Symptom #1 the worst?

- ☐ at night
- ☐ in the morning
- ☐ during the day
- ☐ all of the time

What movement(s) aggravates your symptom #1?

- ☐ Bending
- ☐ Looking Up
- ☐ Looking Dowm
- ☐ Looking over shoulder
- ☐ Lifting
- ☐ Driving
- ☐ Stress
- ☐ Exercising
- ☐ Coughing
- ☐ Straining
- ☐ Stooping
- ☐ Standing
- ☐ Twisting
- ☐ Deep Breathing
- ☐ Sitting
- ☐ Other - __________________

Symptom #1 is (choose all that apply)

- ☐ generalized in __________________________
- ☐ localized to ____________________________
- ☐ radiates to _____________________________
- ☐ shoots to ______________________________
- ☐ Other - ________________________________

*Name*____ *Date of Birth* ____________________

COMPARATIVE PAIN SCALE CHART (Pain Assessment Tool)

0 Pain Free	1 Very Mild	2 Discomforting	3 Tolerable	4 Distressing	5 Very Distressing	6 Intense	7 Very Intense	8 Utterly Horrible	9 Excruciating Unbearable	10 Unimaginable Unspeakable
No Pain	**Minor Pain**			**Moderate Pain**			**Severe Pain**			
Feeling perfectly normal	Nagging, annoying, but doesn't interfere with most daily living activities. Patient able to adapt to pain psychologically and with medication or devices such as cushions.			Interferes significantly with daily living activities. Requires lifestyle changes but patient remains independent. Patient unable to adapt pain.			Disabling; unable to perform daily living activities. Unable to engage in normal activities. Patient is disabled and unable to function independently.			

Using the chart above, how do you rate your pain for Symptom #1? ______________________

Symptom #2

Symptom 2 ____

When was the onset on of this symptom? _____/_____/___________

Please mark with an X the area(s) where symptom 2 is located.

What does symptom 2 feel like? (check all that apply)

- ☐ Numbness
- ☐ Tingling
- ☐ Dull
- ☐ Aching
- ☐ Stiffness
- ☐ Cramping
- ☐ Nagging
- ☐ Sharp
- ☐ Shooting
- ☐ Burning
- ☐ Throbbing
- ☐ Stabbing
- ☐ Swollen
- ☐ Other _____________

What is your pain frequency of Symptom #2

- ☐ 0 - 1/4th of the time
- ☐ 1/4th - 1/2th of the time
- ☐ 1/2th - 3/4th of the time
- ☐ almost all of the time

When is Symptom #2 the worst?

- ☐ at night
- ☐ in the morning
- ☐ during the day
- ☐ all of the time

What movement(s) aggravates your symptom #2?

- ☐ Bending
- ☐ Looking Up
- ☐ Looking Dowm
- ☐ Looking over shoulder
- ☐ Lifting
- ☐ Driving
- ☐ Stress
- ☐ Exercising
- ☐ Coughing
- ☐ Straining
- ☐ Stooping
- ☐ Standing
- ☐ Twisting
- ☐ Deep Breathing
- ☐ Sitting
- ☐ Other - ___________________

*Name*____ *Date of Birth* ____________________

Symptom #2 is (choose all that apply)

- ☐ generalized in _________________________
- ☐ localized to ___________________________
- ☐ radiates to ____________________________
- ☐ shoots to _____________________________
- ☐ Other - _______________________________

COMPARATIVE PAIN SCALE CHART (Pain Assessment Tool)

0 Pain Free	1 Very Mild	2 Discomforting	3 Tolerable	4 Distressing	5 Very Distressing	6 Intense	7 Very Intense	8 Utterly Horrible	9 Excruciating Unbearable	10 Unimaginable Unspeakable
No Pain	Minor Pain			Moderate Pain			Severe Pain			
Feeling perfectly normal	Nagging, annoying, but doesn't interfere with most daily living activities. Patient able to adapt to pain psychologically and with medication or devices such as cushions.			Interferes significantly with daily living activities. Requires lifestyle changes but patient remains independent. Patient unable to adapt pain.			Disabling; unable to perform daily living activities. Unable to engage in normal activities. Patient is disabled and unable to function independently.			

Using the chart above, how do you rate your pain for Symptom #2? _______________________

Symptom #3

Symptom 3 ____

When was the onset on of this symptom? _____/_____/___________

Please mark with an X the area(s) where symptom 3 is located.

What does symptom 3 feel like? (check all that apply)

- ☐ Numbness
- ☐ Tingling
- ☐ Dull
- ☐ Aching
- ☐ Stiffness
- ☐ Cramping
- ☐ Nagging
- ☐ Sharp
- ☐ Shooting
- ☐ Burning
- ☐ Throbbing
- ☐ Stabbing
- ☐ Swollen
- ☐ Other _____________

What is your pain frequency of Symptom #3

- ☐ 0 - 1/4th of the time
- ☐ 1/4th - 1/2th of the time
- ☐ 1/2th - 3/4th of the time
- ☐ almost all of the time

When is Symptom #3 the worst?

- ☐ at night
- ☐ in the morning
- ☐ during the day
- ☐ all of the time

What movement(s) aggravates your symptom #3?

- ☐ Bending
- ☐ Looking Up
- ☐ Looking Dowm
- ☐ Looking over shoulder
- ☐ Lifting
- ☐ Driving
- ☐ Stress
- ☐ Exercising
- ☐ Coughing
- ☐ Straining
- ☐ Stooping
- ☐ Standing
- ☐ Twisting
- ☐ Deep Breathing
- ☐ Sitting
- ☐ Other - __________________

*Name*____ *Date of Birth* ____________________

Symptom #3 is (choose all that apply)

- ☐ generalized in ________________________
- ☐ localized to __________________________
- ☐ radiates to ___________________________
- ☐ shoots to ___________________________
- ☐ Other - _____________________________

COMPARATIVE PAIN SCALE CHART (Pain Assessment Tool)

0	1	2	3	4	5	6	7	8	9	10
Pain Free	Very Mild	Discomforting	Tolerable	Distressing	Very Distressing	Intense	Very Intense	Utterly Horrible	Excruciating Unbearable	Unimaginable Unspeakable
No Pain	Minor Pain			Moderate Pain			Severe Pain			
Feeling perfectly normal	Nagging, annoying, but doesn't interfere with most daily living activities. Patient able to adapt to pain psychologically and with medication or devices such as cushions.			Interferes significantly with daily living activities. Requires lifestyle changes but patient remains independent. Patient unable to adapt pain.			Disabling; unable to perform daily living activities. Unable to engage in normal activities. Patient is disabled and unable to function independently.			

Using the chart above, how do you rate your pain for Symptom #3? ______________________

Are there any other symptoms or concerns you would like to address?_______________________

____

Which Symptom is the worst?____

On a scale of 1 - 10, how do you rate your overall pain today? ____________________________

What daily activities does your pain affect?

- ☐ Personal Hygiene ☐ Sitting ☐ Bending ☐ Driving
- ☐ Household Chores ☐ Lifting ☐ Kneeling ☐ Sleeping
- ☐ Standing ☐ Walking ☐ Exercising ☐ Sports
- ☐ Other - ____

What could you do prior to the collision that you cannot do now? __________________________

____

What are your short term goal(s) with treatment/care? __________________________________

____

What are your long term goal(s) with treatment/care? ___________________________________

____

Have your been treated for this condition before? ______________________________________

If yes,

Where were you seen? ____

What was treatments were provided? ____

____

*Name*____ *Date of Birth* ____________________

Loss of Enjoyment & Duties Under Duress

Complete the following questions as it relates to how your injury/injuries affect your performance of everyday activities and/or work activity. Please circle the living or work duties that are painful or difficult for you to perform as a result of the injuries. Also circle 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

*Name*____ *Date of Birth* ______________________

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

Please continue to the next page.

Name____________________________________ Date of Birth ___________________

Daily Activities/Living Assessment

This questionnaire will give your provider information about how your overall bodily condition affects your everyday life. Please answer every section by marking the statement that most accurately describes how your pain affects your daily life. If two or more statements in a single section apply to you, please mark the ONE that most accurately describes your current situation.

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

Office Use Only - Score: _______________

I attest that, to the best of my knowledge and belief, all information in the above-referenced data reported is accurate and complete

Patient Signature ___________________________________ **Date** ______________

Name____________________________ Date of Birth ____________________

Neck Index Assessment

This questionnaire will give your provider information about how your neck condition affects your everyday life. Please answer every section by marking the one statement that applies to you. If two or more statements in one section apply, 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.

Office Use Only - Score: ______________

I attest that, to the best of my knowledge and belief, all information in the above-referenced data reported is accurate and complete

Patient Signature ________________________________ **Date** ________________

*Name*____ *Date of Birth* ____________________

Preferred Method of Contact

I would like Vitality Chiropractic to communicate with me via:

☐ Text Message ☐ Home Phone ☐ Cell Phone ☐ Mail ☐ eMail

Please note: Vitality Chiropractic uses an automated text message reminder system. The patient can OPT-OUT of these reminders by replying "Stop" or "Cancel". Be aware that if you "opt out" you will no longer receive any appointment reminders and the office will no longer be able to communicate with you via the text messaging system. If you wish to opt out of one type of message, please email info@vitalitychiropractic.com and we can remove you from that specific list. Please be aware that when contacted via phone, text message, or email (or any combination of) that there is a potential for accidental disclosure of my private health information when using these methods.

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.

Vitality Chiropractic recognizes the right of competent patients to decide whether to accept or reject proposed treatment/care and/or to decide on their treatment(s). When a patient is not competent, the right of informed consent is transferred to the person legally authorized medical proxy to make decisions on the patient's behalf. Before exercising this right, we will provide patients with sufficient information to reach an informed decision. By signing you are stating that you are aware that you are agreeing to treatment and are aware that you can revoke consent at any time in writing after this form is signed.

We will conduct some diagnostic and/or examination procedures during the initial visit and if indicated in the future. Any examinations or tests conducted will be carefully performed but may be uncomfortable. Please let us know at any time that the examination is painful or become intolerable.

Chiropractic care involves what is known as chiropractic adjustment. There may be additional supportive procedures or recommendations made. When providing an adjustment, hands or an instrument will be used 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 of a 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, including, but not limited to 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 involves an abnormal change in the wall of an artery that may cause the development of a thrombus (clot) with the potential to lead to a stroke. This occurs 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. As chiropractic can involve manually and/or mechanically adjusting the cervical spine, it has been reported that chiropractic care may be a risk for developing this type of stroke. The association with stroke is exceedingly rare and is estimated to be related in one in one million to one in two million cervical adjustments.

*Name*____ *Date of Birth* _____________________

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. Our standard regarding informed consent is consistent with federal and state laws, rules, and regulations.

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 will have 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 Signature ____ **Date** __________________

Patient Consent for Treatment

I voluntarily consent to treatment and diagnosis procedures provided by Dr. Bonnie Verhunce at Vitality Chiropractic. I am aware that Vitality Chiropractic does not diagnose or treat any disease or condition other than subluxation. However, if during your course of evaluation or treatment non-chiropractic or unusual findings are encountered, Dr. Bonnie will advise you. The only objective at Vitality Chiropractic is to eliminate a major interference to the full outward expression of your body's innate wisdom.

I consent to treatment being provided in an "open adjusting" environment. It is our practice, in this office, to provide chiropractic treatment in an open environment. This involves several patients being seen in the same room at the same time. Patients are within sight and earshot of one another. You acknowledge and consent to treatment in this setting and have been made aware that there is the potential for incidental disclosure of health information to other patients and staff within the adjustment area/office. If there is something that needs to be discussed with Dr. Bonnie in private, we ask that you let her know prior to the conversation so you may talk privately in the exam room.

I authorize Vitality Chiropractic to share my personal health information only with entities/persons directly related to my health care and my insurance and payment needs. Vitality Chiropractic is committed to protecting your personal health information.

I agree to be contacted via phone, text message, or email (or any combination of) with information related to my visits, such as an appointment reminder, check-ins, paperwork links or review requests. I understand that there is a potential for accidental disclosure of my private health information when using these methods. I understand that I can OPT OUT of the text message notifications by replying “Stop” or “Cancel”. Be aware that if you “opt out” you will no longer receive any appointment reminders and the office will no longer be able to communicate with you via the text messaging system. If you wish to opt out of one type of message, please email info@vitalitychiropractic.com and we can remove you from that specific list.

I consent to the use and disclosure of my protected health information for purposes of obtaining payment for services rendered by Dr. Bonnie and Vitality Chiropractic.

I acknowledge that Dr. Bonnie will be submitting claims to my insurance company on my behalf. I understand that any and all changes to my insurance coverage is my responsibility to notify Vitality Chiropractic. Furthermore, I understand the coverage is not a guarantee of payment. Payment is determined by the health plan at the time the claim is received. All patients are responsible for non-covered services and for services rendered after insurance benefits have been exhausted. All patients are responsible for any

deductibles, co-insurance, and copays as determined by your insurance policy. If a patient does not have insurance or their insurance does not cover chiropractic services, I agree to pay in full for my treatment prior to receiving said treatment.

I understand that Vitality Chiropractic is obligated to follow all laws, rules, regulations and policies set in place by the governing bodies that allows Vitality Chiropractic to be contracted with the various insurance companies/programs in which they have a relationship with and that allow Dr. Bonnie to practice chiropractic as a medical professional. This includes but is not limited to the limitations set forth by CMS and the Medial Review Policy that is associated with my insurance coverage.

I agree to place a credit card on file to be stored in a secure and tokenized system. I understand that it is my choice how Vitality Chiropractic processes the card that is placed on file, depending on how I fill out the Credit Card Payment Authorization Form. I understand that payment for treatments rendered is non-refundable.

I understand that there is a $25 cancellation fee, and agree to pay the fee, for any missed, canceled, or rescheduled exam, re-exams, or report of findings appointments where 24-hour notice is not given. This fee will be waived where required by law. This fee does not apply to an appointment where only an adjustment is provided.

Office Financial Policy

It is the intention of this office to assist the patient to make informed decisions about their healthcare and the related costs. This process is accomplished through periodic financial conversations. It is the goal of this office to ensure that lines of communication are open so that every patient is aware of who in the office can assist with questions of a financial nature. This office recognizes that open and clear communication is particularly important for those patients with third-party assistance of any type. This office's goal is to ensure that the financial relationship with our patients never interferes with the treatment relationship. For any questions, please talk with the office manager. If you still have questions, please contact the Practice Manager, Cami Kortz via email at cami@vitalitychiropractic.com and she will be able to further assist you.

For your convenience, this office accepts cash, checks, care credit and the following credit cards: Visa, MasterCard, American Express, Discover.

Should payment be refused by your bank for any check written, this office will charge a fee of $35 to offset the charges we will incur as a result of the returned check.

This office does not turn away any patient due to their ability to not pay. If you feel you might qualify for our financial hardship policy, notify the office manager immediately so we can begin your qualification process. It application can be provided in the office or by emailing info@vitalitychiropractic.com.

It is the policy of this office to clearly communicate with each patient their financial responsibility, regardless of third-party assistance. This office implements this process beginning with the first contact a patient makes with this office. Per the No Surprises Act (NSA) effective January 1, 2022, we begin with verbally offering a Good Faith Estimate (GFE), in writing, for patients that are self-pay, uninsured, or opting not to use their health insurance. We follow the GFE delivery requirements included in this policy upon request. Once a new patient has been evaluated in the clinic, the provider will establish a treatment plan. This plan will be communicated to the patient and to the staff, who will then offer to the patient and deliver a Financial Report of Findings Good Faith Estimate when requested.

*Name*____ *Date of Birth* ____________________

As a courtesy to our patients, this office will bill in-network and out of network insurance companies and wait to be paid for some portion of our patients' financial responsibility.

It is our office policy that payment for services rendered is ultimately the responsibility of the patient, whether or not you have third party assistance (i.e., insurance) with your financial obligation.

All patient copays are to be paid at the time of service.

Patient deductible/coinsurances are to be paid after all remittances are received from the 3rd party payor and allocated to the patient account as such.

This office offers prompt payment discounts. We offer 10% off the actual fee when visits are set up on autopayment plan and 15% off when visits are prepaid by purchasing a package.

Personal balances may not exceed $500 unless on a pre-arranged payment plan. Payment plans are available when balances exceed the patient’s ability to pay in full to ensure you are able to receive all the care you may require.

The privilege of insurance assignment begins when our office receives and verifies your insurance information. Until that time, you are considered a “cash” patient and payment is expected at the time of service. As a courtesy to you, our office will pre-qualify your insurance coverage, in an effort to help you determine what coverage is available to you under your policy. We will help you make the best estimate of your coverage for the recommend services. This service is a courtesy to you and is not a guarantee of coverage or payment by the 3rd party payor.

No one can predict what an insurance company will pay for the usual and customary charges for services rendered. If we participate on your plan, you will not encounter balance billing above the allowed/contracted rate as long as your benefits are effective/available. If we do not participate/are out of network, we can bill the insurance upon your request. If you do not have benefits available for chiropractic care we will work with you to help determine your cost of care.

If your insurance has not paid on an assigned bill within 45 days, our staff looks into the claim for your by contacting the 3rd party payor for resolution. If it remains unpaid within 120 days the balance becomes due and payable immediately. If payment is received from the insurance carrier, resulting in a patient overpayment you will be refunded within 30 days to your original method of payment or via check if the original method was cash or no longer available.

Most 3rd party payors, including most commercial insurance plans, Medicare, and PIP, only over what is medically necessary for a given condition, injury, and diagnosis. We can only bill 3rd party payors for such treatments. For patients who’s treatment is considered as maintenance, wellness or supportive care will be patient responsibility. Our office offers numerous payment options to allow you to continue care/treatment. Should you discontinue care for any reason, other than discharge by the doctor for a completed episode or care, any and all balances will become due and payable at that time. If you are on a predetermined payment plan, that plan will continue to be in effect until your balance is zero.

If you have pre-paid for a package and wish to discontinue treatment/care, you can retain the balance for future care or you can request to be refunded the remaining balance.

Name____ Date of Birth _____________________

If a patient is being seen for a Auto Accident / PIP Claim, we require all information of all insurance parties attached to the claim. If you are not at fault for an accident, and the other party does not have medical coverages on their policy, it is in your best interest to open a claim against your insurance and obtain your benefits through your policy. If neither insurance has PIP/Med Pay benefits available, we are able to bill your health insurance.

For MVA claims that are through Underinsured/Uninsured Motorist Coverage, a medical lien will be placed in effect until payment for full balance is received at the end of care.

For MVA claims that are being held for 3rd party payment, a medical lien will be placed in effect until payment for the full balance is received at the end of care or settlement.

In the event that coverages are not covered, denied, or go unpaid at the determination of the payor, patient will be finically responsible for all care/treatments.

I have read, or have had read to me, the above information. By signing I acknowledge that I understand and consent to the policies and procedures that are explained above.

Patient Signature ____ Date __________________

Last Reviewed/Updated 1/13/2024