PHAM CHIROPRACTIC

MVC

Thank you for choosing our office! In order to serve you better, we need the following information. PLEASE PRINT. ***All information will be confidential.***

Patient's Name: _____ **Date:** _____

Phone: _____ **Email:** _____

Address: _____

Birthdate: _____ **Age:** _____ **Female:** _____ **Male:** _____

Check Appropriate Box: ( ) Married ( ) Single ( ) Minor ( ) Widow ( ) Other
Patient or Guardian's Employer: _____

Work Phone: _____ **Address:** _____

Spouse or Parent / Guardian Name: _____

Person to Contact in Case of Emergency: _____

***INFORMATION REQUIRED**

MOTOR VEHICLE ACCIDENT HISTORY ***(PLEASE FILL OUT THOROUGHLY)***

***DATE OF ACCIDENT** _____ **TIME** _____ **AM / PM**

***LOCATION** _____ **CITY** _____

***AUTO INSURANCE CO.** _____ *** POLICY #** _____

***DO YOU HAVE MEDPAY?** _____ **COVERAGE LIMIT** _____ **CLAIM #** _____

CLAIM ADJUSTER NAME _____ **PHONE #** _____

EMAIL _____ **ADDRESS** _____

Do you currently have legal representation? YES NO
If YES, note name of Attorney and Law Firm _____
Paralegal name and contact information _____
Law Firm phone number _____ **Email** _____

I authorize Pham Chiropractic Services to release any information regarding my examination or treatment for the purposes of obtaining insurance compensation, pre-certification, or medical records. I authorize payment of the chiropractic benefits to Pham Chiropractic Services when claim forms are filed upon my behalf for treatment of extensive office procedures. I also give my permission for treatment to patient, if minor. I understand and agree that regardless of my insurance status, I am ultimately responsible for the balance of my account for any professional services rendered. I have read all the information on this sheet and have completed the above answers. I certify that this information is true and correct to the best of my knowledge. I will notify you of any changes in my health status or updating of this form.

Signed: _____ **Dated:** _____

ACCIDENT DETAILS

Was the accident: Head on _____ Rear end _____ Side impact _____ Other _____

Road Conditions: Wet _____ Dry _____ Snow/Ice _____ Other _____

Where were you seated in the vehicle? Driver seat _____ Passenger seat _____

Back (driver side) _____ Back (passenger side) _____Were you wearing a seatbelt? YES NO Lap belt _____ Shoulder Strap _____

At what speed were you traveling? _____ MPH Other vehicle? _____ MPH

Was your vehicle: Speeding up _____ Slowing down _____ at the time of impact?

Was the other vehicle: Speeding up _____ Slowing down _____ at the time of impact?

Describe, to the best of your ability, what took place during the accident:

_____

Were you prepared for the impact at the time of collision? YES NO
Was your head turned at the time of impact? YES NO If YES: Left Right
Did you hit your head or any other body part on impact? YES NO If YES, where? _____
Did you lose consciousness? YES NO If YES, how long?_____
Do you have any visible bruising? YES NO If YES, take pictures
When did you first notice pain? Immediately_____ Gradually _____Hours/Days after? (circle)
Were you taken to the hospital following the accident? YES NO
Did you have X-rays taken? YES NO If YES, what body parts? _____
Have you had any treatment since the accident? YES NO
Describe:_____
Have you lost time from work as a result of the accident? YES NO How much?_____

Major Complaint: _____

Where specifically does this cause you pain or discomfort? _____

How present are the complaints/pain? ___ Constant 75-100% ___ Frequent 50-75% ___ Occasional 25-49% ___ Intermittent 25% or less

Have you had prior or current treatment for this condition? _____

What helped and what did not help with your pain? _____

Rate your pain on a scale of 1 to 10 with 10 being the max: 1 2 3 4 5 6 7 8 9 10

Is the condition/pain getting worse? _____

Is the condition interfering with your: (circle all that apply)

Work Sleep Daily routine

What activities are you unable to do now that you previously were able to do? _____

_____

Does this condition wake you at night? Yes No Sometimes

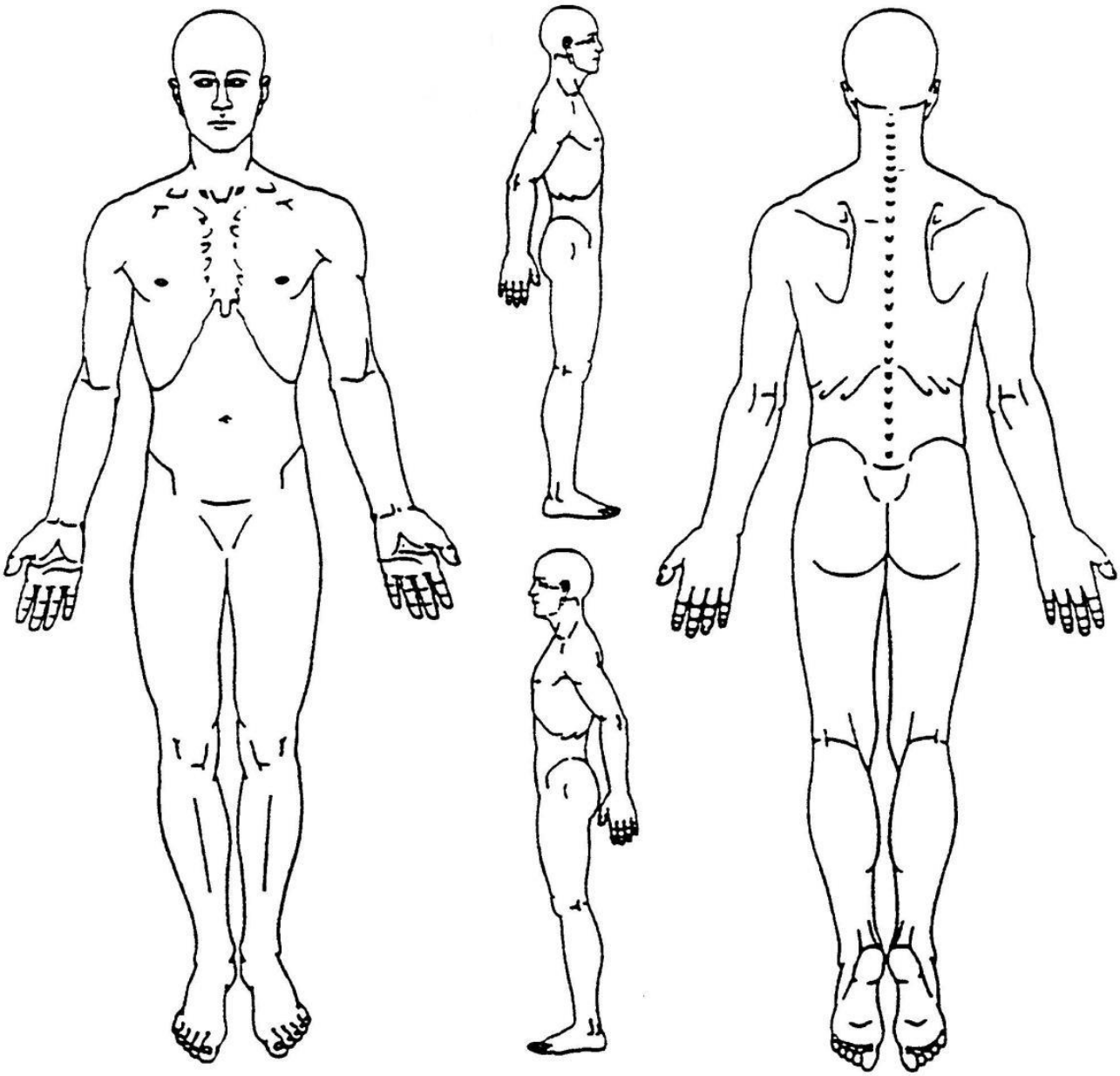
What aggravates your condition? _____

What relieves your condition? _____

PAIN DRAWING ASSESSMENT

Draw the location of your pain on the body outlines using the appropriate symbol. Include all affected areas. Mark the severity of your pain at the bottom of the page.

ACHE	BURNING	NUMBNESS	PINS & NEEDLES	STABBING
ZZZ	BBB	XXX	= = =	////



CIRCLE YOUR PAIN ESTIMATE

NO PAIN 1 2 3 4 5 6 7 8 9 10 INTOLERABLE

I understand and agree that health and accident Insurance policies are an arrangement between and insurance carrier and myself. Furthermore, I understand that the doctor's office will prepare any necessary reports and forms to assist me in making collection from the insurance carrier and that any amount authorized to be paid to the doctor's office will be credited to my account on receipt. However, I clearly understand and agree that all services rendered me are charged directly to me and that I am personally responsible for payment. I also understand that if I suspend or terminate my care at this office, any outstanding charges for professional services rendered me will be immediately due and payable.

Patient's Signature: _____Date: _____

Oswestry Low Back Pain Scale

Please rate the severity of your pain by circling a number below:

No pain | **0 1 2 3 4 5 6 7 8 9 10** | **Unbearable**

NAME _____ **DATE:** _____

Instructions: Please CIRCLE the **ONE NUMBER** in each section which most closely describes your issues.

Section 1 – Pain Intensity

0. Pain comes and goes and is very mild.
1. Pain is mild and does not vary much.
2. Pain comes and goes and is moderate.
3. Pain is moderate and does not vary much.
4. Pain comes and goes and is severe.
5. Pain is severe and does not vary much.

Section 2 – Personal Care (Washing, Dressing. Etc.)

0. Would not have to change my way of washing or dressing to avoid pain.
1. Do not normally change my way of washing or dressing even though it causes some pain.
2. Washing and dressing increases pain but I manage to not change my way of doing so.
3. Washing and dressing increases pain and I find it necessary to change my way of doing so.
4. Due to the pain, I am in need of assistance to do any washing/dressing.

Section 3 – 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.
3. Pain prevents me from lifting heavy weights but I can manage if they are conveniently positioned
4. Pain prevents me from lifting heavy weights but I can manage light to medium weights if they are conveniently positioned.
5. I can only lift light weights for the most part.

Section 4 – Walking

0. I have no pian when walking.
1. I have some pain when walking and it does not increase with distance.
2. I cannot walk more than 1 mile without pain.
3. I cannot walk more than ½ mile without pain.
4. I cannot walk more than ¼ mile without pain.
5. I cannot walk at all without pain.

Section 5 – Sitting

0. I can sit on a chair as long as I like.
1. I can sit on my favorite chair as long as I like.
2. Pain prevents me from sitting for more than 1hr.
3. Pain prevents me from sitting for more than ½ hr.
4. Pain prevents me from sitting more than 10 min.
5. I avoid sitting because it increases pain immediately.

Section 6 – Standing

0. I can stand as long as I want without pain.
1. I have some pain when standing and does not increase with time.
2. I cannot stand for longer than 1hr without pain.
3. I cannot stand for longer than ½ hr without pain.
4. I cannot stand for longer than 10 min without pain.
5. I avoid standing due to increasing pain.

Section 7 – Sleeping

0. I have no pain when in bed.
1. I get pain when in bed but it does not prevent me from sleeping.
2. Due to pain my normal sleep is reduced to less than one quarter.
3. Due to pain my normal sleep is reduced to less than one half.
4. Due to pain my normal sleep is reduced to less than three quarters.
5. Pain prevents me from sleeping at all.

Section 8 – Social Life

0. My Social life is normal with no pain.
1. My social life is normal but it increases pain.
2. Pain has no significant effect on my social life except for my more physical interests, e.g., dancing, etc.
3. Pain has prevented me from going out often.
4. I hardly have a social life due to pain.

Section 9 – Travel

0. I have no pain when traveling.
1. I have some pain when traveling, but not significant.
2. I have extra pain when traveling but no need to consider alternate forms of travel.
3. I have extra pain when traveling and feel the need to consider other forms of travel.
4. Pain restricts me to short trips (under ½ hr)
5. Pain restricts all forms of travel.

Section 10 – Changing Degree of Pain

0. Pain is rapidly improving.
1. Pain fluctuates but is improving.
2. Pain seems to improve but slowly.
3. Pain is neither improving or getting worse.
4. Pain is gradually worsening.
5. Pain is rapidly worsening.

TOTAL _____

Neck Disability Index

This questionnaire is designed to help us better understand how your neck pain affects your ability to manage every day life activities. Please mark in each section the **ONE** box that **MOST CLOSELY** describes your current situation.

Section 1 – Pain Intensity

- I have no pain at the moment.
- Pain is very mild at the moment.
- Pain is moderate at the moment.
- Pain is fairly severe at the moment.
- Pain is very severe at the moment.
- Pain is the worst possible at the moment.

Section 2 – Personal Care

- I can look after myself normally without extra pain.
- I can look after myself normally causing extra pain.
- It is painful to look after myself and I have to be careful.
- I need some help but manage most of my personal care.
- I need help every day in most aspects of self-care.
- I do not get dressed; I was with difficulty & stay in bed.

Section 3 – Lifting

- I can lift heavy weights without extra pain.
- I can lift heavy weights but it causes extra pain.
- Pain prevents me from lifting heavy weights off the floor but I can manage if they are conveniently positioned.
- Pain prevents me from lifting heavy weights but I can manage light weights if they are conveniently positioned.
- I can only lift very light weights.
- I cannot lift or carry anything at all.

Section 4 – Work

- I can do as much work as I want.
- I can only do my usual work, but no more.
- I can do most of my usual work, but no more.
- I can't do my usual work.
- I can hardly do anything at work at all.
- I can't do any work at all.

Section 5 – Headaches

- I have no headaches at all.
- I have slight headaches occasionally.
- I have moderate headaches occasionally.
- I have moderate headaches frequently.
- I have severe headaches frequently.
- I have headaches all the time.

Section 6 – Concentration

- I can concentrate fully without difficulty.
- I can concentrate with slight difficulty.
- I have a fair degree of difficulty concentrating.
- I have a lot of difficulty concentrating.
- I have a great deal of difficulty concentrating.
- I can't concentrate at all.

Section 7 – Sleeping

- I have no trouble sleeping.
- My sleep is slightly disturbed for less than 1 hr.
- My sleep is mildly disturbed for up to 1-2 hrs.
- My sleep is moderately disturbed for up to 2-3 hrs.
- My sleep is greatly disturbed for up to 3-5 hrs.
- My sleep is completely disturbed for up to 5-7 hrs.

Section 8 – Driving

- I can drive my car without neck pain.
- I can drive as long as I want with slight neck pain.
- I can drive as long as I want with moderate neck pain.
- I can't drive for too long due to moderate neck pain.
- I can hardly drive at all due to severe neck pain.
- I can't drive at all due to neck pain.

Section 9 – Reading

- I can read as long as I want with no neck pain.
- I can read as long as I want with slight neck pain.
- I can read as long as I want with moderate neck pain.
- I can't read as long as I want due to moderate neck pain.
- I can't read as long as I want due to severe neck pain.
- I can't read at all.

Section 10 – Recreation

- I have no neck pain during all recreational activities.
- I have some neck pain with all recreational activities.
- I have some neck pain with a few recreational activities.
- I have neck pain with most recreational activities.
- I can hardly do recreational activities due to neck pain.
- I can't do any recreational activities due to neck pain.

Patient Name: _____ Date: _____

Score: _____ (50) Benchmark - *5* = _____

QUADRUPLE VISUAL ANALOGUE SCALE

PATIENT NAME: _____ **DATE:** _____

Instructions: Please circle the number that best describes the question being asked.

Note: If you have more than one complaint. Please answer each question for each individual complaint and indicate the Score for each complaint. Please indicate your pain level right now, average pain, and pain at its best and worst.

1- What is your pain RIGHT NOW?

No pain _____ **Worst possible pain**

0 1 2 3 4 5 6 7 8 9 10

2 – What is your TYPICAL or AVERAGE pain?

No pain _____ **Worst possible pain**

0 1 2 3 4 5 6 7 8 9 10

3 – What is your pain level AT ITS BEST (How close to "0" does your pain get at its best)?

No pain _____ **Worst possible pain**

0 1 2 3 4 5 6 7 8 9 10

4 – What is your pain level AT ITS WORST (How close to "10" does you pain get at its worst)?

No pain _____ **Worst possible pain**

0 1 2 3 4 5 6 7 8 9 10

OTHER COMMENTS:

_____

_____

PATIENT SIGNATURE: _____ **DATE:** _____

Informed consent to Chiropractic Treatment

<u>The nature of Chiropractic treatment:</u> The doctor will use his/her hands or a mechanical device in order to move your joints. You may feel a "click" or "pop, such as the noise when a knuckle is "cracked," and you may feel movement of the joint. Various ancillary procedures, such as hot or cold packs, electric muscle stimulation, therapeutic ultrasound or dry hydrotherapy may also be used.

<u>Possible Risks:</u> As with any health care procedure, complications are possible following a chiropractic manipulation. Complications could include fractures of bone, muscular strain, ligament us sprain dislocations of joints, or injury to intervertebral discs, nerves, or spinal cord. Cerebrovascular injury or stroke could occur upon severe injury to arteries of the neck. A minority of patients may notice stiffness or soreness after the first few days of treatment. The ancillary procedures could produce skin irritation, burns or minor complications.

<u>Possibility of risks occurring:</u> The risk of complications due to chiropractic treatments have been described as "rare" about as often as complications are seen from the taking of a single aspirin tablet. The risks of cerebrovascular injury or stroke, has been estimated at one in one million to one in twenty million and can be even further reduced by screening procedures. The probability of adverse reaction due to ancillary procedures is also considered "rare."

<u>Other treatment options which could be considered may include the following:</u>

• Over-the-counter analgesics. The risk of these medications include: irritation to stomach, liver and kidneys and other side effects in a significant number of cases.

• Medical care, typically anti-inflammatory drugs, tranquilizers, and analgesics. Risks of these drugs include a multitude of undesirable side effects and patient dependence in a significant number of cases.

• Hospitalization in conjunction with medical care adds the risks of exposure to virulent communicable disease in a significant number of cases.

• Surgery in conjunction with medical care adds the risk of adverse reaction to anesthesia, as well an extended convalescent period in a significant number of cases.

<u>Risk of remaining untreated:</u> Delay of treatment allows formation of adhesions, scar tissue and other degenerative changes. These changes can further reduce skeletal mobility, and induce chronic pain cycles. It is quite probable that delay of treatment will complicate the condition and make future rehabilitation more difficult.

<u>Unusual risks:</u> I have had the following unusual risks of my case explained to me. I have read the explanation above of chiropractic treatment. I have had the opportunity to have any questions answered to my satisfaction. I have fully evaluated the risks and benefits of undergoing treatment. I have freely decided to undergo the recommended treatment and hereby give my full consent to treatment.

_____	_____	_____
Printed Name	**Signature**	**Date**