Rocky Mountain Chiropractic & Sports Injury Centers

Doctor's Lien-Insurance Company

I do hereby authorize Rocky Mountain Chiropractic & Sports Injury Centers to furnish you, my insurance company, with a full report of their examination, diagnosis, treatment, prognosis, etc., of myself in regards to the accident in which I was involved.

I hereby authorize and direct you, my insurance company, to pay directly to said doctor such sums as may be due and owing him/her for medical services rendered me both by reason of this accident and by reason of any other bills that are due this office and to withhold such sums from any settlement, judgment or verdicts may be necessary to adequately protect said doctor. I hereby further give a lien on my case to said doctor against any and all proceeds of my settlement , judgment, or verdict which may be paid to you, my insurance company, or myself as the result of the injuries for which I have been treated in connection therewith.

I fully understand that I am directly and fully responsible to said doctor for all medical bills submitted by him/her for services rendered me and that this agreement is made solely for said doctor's additional protection and in consideration of his waiting payment. I further understand that such payment is not contingent on any settlement, judgment or verdict by which I may eventually recover said fee.

Please acknowledge this letter by signing below and returning to the doctor's office. I have been advised that if my insurance company does not wish to cooperate in protecting the doctor's interest, the doctor will not await payment, but will require me to make payments on a current basis.

Date_____

Patient's Name_____

Patient's Signature_____

If Minor, Parent or Guardian Signature_____

Personal Injury History Form

Instructions: Please carefully consider and answer each question as completely as possible.

Name_____ Today's Date (___/___/___) Date of Accident (___/___/___)

Insurance Companies

Your Insurance Company _____ Ins. Adjustor Name:_____ _____
Address_____ City_____ St. ___ Zip_____ Phone_____
Claim #: _____

Who was "at fault" □ You □ Other Driver

Insurance of person responsible for the accident? _____ Ins. Adjustor Name:_____
Address_____ City_____ St. ___ Zip_____ Phone_____
Claim #: _____

Your Attorney

Your Attorney's Firm:_____ Attorney's Name:_____
Address_____ City_____ St. ___ Zip_____ Phone_____

Time of Accident: _____ (A.M.) (P.M.) Weather:_____ Road Conditions:_____

Street(s):_____ Street(s):_____
Patient Headed (N S E W) Other(s) Headed (N S E W)
Patient Speed:_____ Other(s) Speed:_____
Patient Car Type:_____ Other(s) Car Type:_____
Patient Car Hit:_____ Other(s) Car Hit:_____

Impact

Body: (Stright/Bent/Twisted) (Left/Right) Head: (Neutral/Up/Down) (Rt/Lft) Braking: (On/Off) Patient Awarness: (None/Partial/Very)

_____
_____
_____

If this was an auto accident, were you the □ Driver □ Passenger □ Pedestrian.
If auto collision, were you struck from □ Behind □ Right Side □ Left Side □ Front □ Auto was parked.
Other_____
Did your car strike other(s) involved? □Yes □ No. Did the other car strike yours? □ Yes □ No.
Were traffic tickets issued? □Yes □ No. If "yes," to □ You □ The other driver □ The driver of your car.
Did any of your body strike any part of the car? □Yes □No. If "yes," please explain: _____
_____
Did you have a safety belt on? □ Yes □ No. Shoulder Strap? □ Yes □ No.
Does your car have a headrest? □ Yes □ No. Height or Position? □ Shoulder □ Neck □ Head □ Above.
Loss of consciousness? □Yes □ No. If "yes," please explain: _____
_____
Were you stunned? □ Yes □ No. How long? _____
Did you feel or hear popping, tearing, or ripping noise in your neck or back? □Yes □ No.
If "yes," please explain:_____
Did you feel any pain? □Yes □ No. If "yes," where? _____
How long after the accident? _____
Did you find any bruises? □Yes □ No. Where:_____
What is your occupation? _____ What duties are required of you on the job? _____
_____
Have you missed work as a result of this accident? □Yes □ No. If "yes," how many days? _____

Personal Injury Consultation

First Aid

Passenger(s)/ Passer(s) By/ Police/ Aid Car/ Ambulance/ Hospital/ Clinic/ Home Care

Name_____ Location_____ Assistance_____

Comments_____

Name_____ Location_____ Assistance_____

Comments_____

Doctor(s) and Treatment

Did you require post accident care or hospitalization? Yes No. If "yes," where? _____

Were you examined? Yes No. If "yes," by whom? _____

Were you x-rayed? Yes No. Was any treatment given? (medication, supports or recommendations):

_____

Please list any doctors/offices where you have already been evaluated:

1._____ Specialty:_____ Diagnostics:_____

Diagnosis: _____ Treatment:_____ Results:_____

2._____ Specialty:_____ Diagnostics:_____

Diagnosis: _____ Treatment:_____ Results:_____

3._____ Specialty:_____ Diagnostics:_____

Diagnosis: _____ Treatment:_____ Results:_____

Current Disabilities and Restrictions (List activities that are limited as a result of your injuries):

Home: _____

_____

Work: _____

_____

Play: _____

_____

Previous Injurys/Accidents

_____

_____

_____

_____

Headache	Lower back pain	Face Flushed	Constipation
Skull or head pain	Low Back Stiffness	Loss of color	Excessive Perspiration
Neck pain	Hip Pain	Dizziness	Loss of Perspiration
Neck stiffness	Buttock Pain	Fainting	Loss of Taste
Head feels too heavy	Leg Pain	Sinus Trouble	Cold Sweats
Shoulder Pain	Leg Numbness	Loss of smell	Fever
Shoulder Stiffness	Pins and Needles in Legs	Eye Strain	Swelling, if so, where:
Arm Pain	Numbness in Feet/Toes	Difficulty Focusing	Difficulty in:
Arm Numbness	Cold Feet	Pain Behind the Eyes	Prolonged
Pins and Needles in Arms	Depression	Eyes Sensitive to Light	Excessive
Numbness in Hands/ Fingers	Anxiety	Double Vision	Riding in car
Cold Hands	Tension	Buzzing or Ringing in Ears	Bending
Upper Back Pain	Irritability	Loss of Balance	Standing
Upper Back Stiffness	Nervousness	Palpitations	Sitting
Mid Back Pain	Mental Dullness	Shortness of Breath	Walking
Mid Back Stiffness	Loss of Memory	Digestive Problems	Lifting
Chest Pain	Difficulty Sleeping	Nausea	Twisting/turning
Rib Pain	Fatigue	Vomiting	Difficulty rising to walk
Painful Breathing	Tremors	Diarrhea	Pain Doing Occupation

Instructions: Please check the symptoms you have experienced in the last two weeks. Check the box next to the symptoms and then list each of them below. Please state how often you experience the symptom (frequency) and then rate the severity on a scale of 0-10, with 10 being the worse pain imaginable.

Symptoms	Frequency	Intensity

Name:_____ Signed:_____ Date:_____

SENSATION DIAGRAM

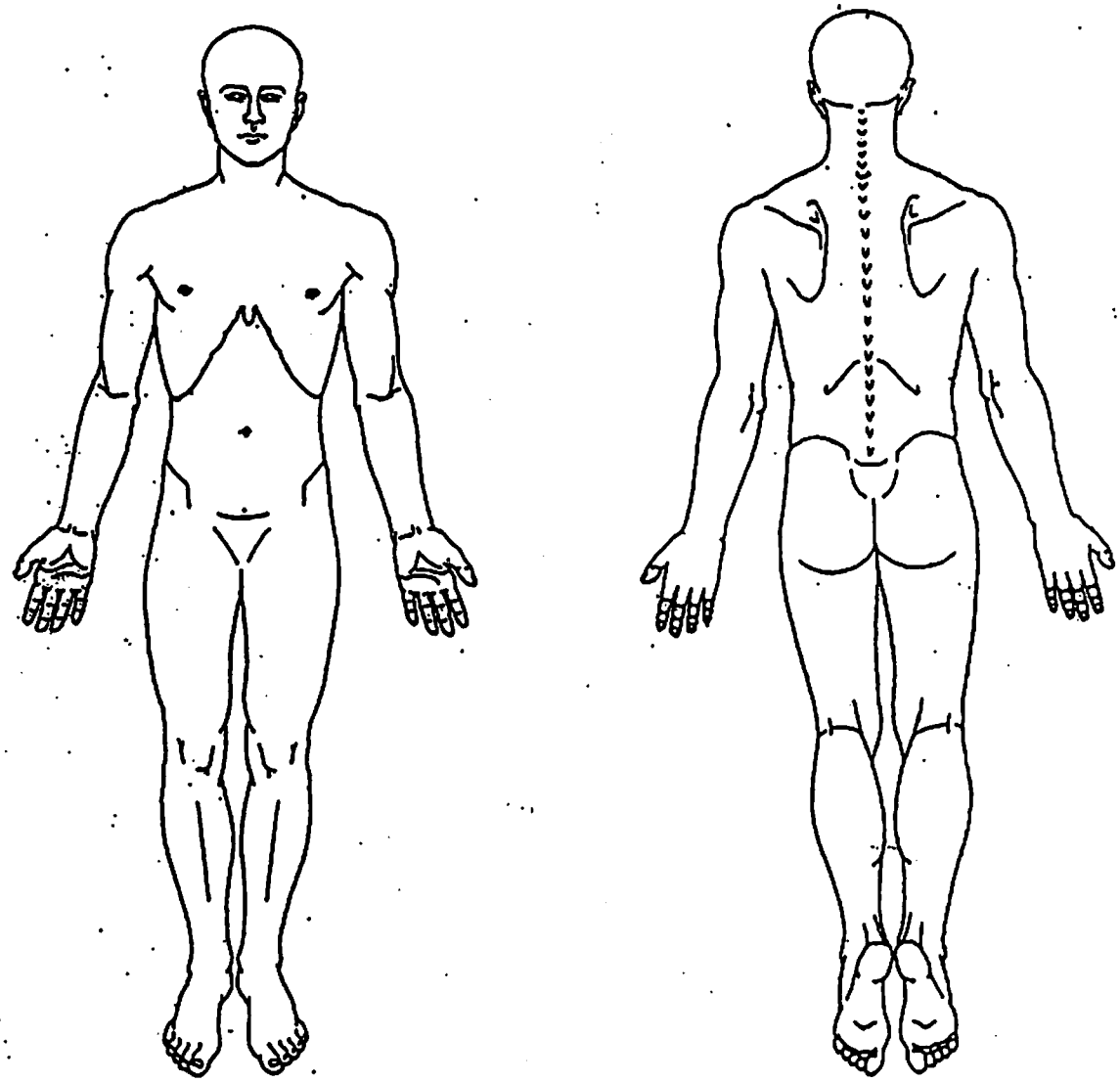
NAME _____ DATE _____

Mark the areas on your body where the described sensations are felt. Use the appropriate symbols. Additional symbols are offered; fill in the blank with the type of sensation you're feeling. Be sure to mark the areas of radiation. Include all affected areas.

Dull/ aching OOOOO Pins & needles ••••• Numbness ≡≡≡

Burning XXXXX Stabbing ///// _____ +++++

_____ ^^^^^ _____ >>>>>>



Neck Index

Form N1-100

rev 3/27/2003

Patient Name _____ ***Date*** _____

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.

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).

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.

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.

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.

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.

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.

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.

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

Neck Index Score

Back Index

Form BI100

rev 3/27/2003

Patient Name _____ ***Date*** _____

This questionnaire will give your provider information about how your back 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 The pain comes and goes and is very mild.
① The pain is mild and does not vary much.
② The pain comes and goes and is moderate.
③ The pain is moderate and does not vary much.
④ The pain comes and goes and is very severe.
⑤ The pain is very severe and does not vary much.

Sleeping

⓪ I get no pain in bed.
① I get pain in bed but it does not prevent me from sleeping well.
② Because of pain my normal sleep is reduced by less than 25%.
③ Because of pain my normal sleep is reduced by less than 50%.
④ Because of pain my normal sleep is reduced by less than 75%.
⑤ Pain prevents me from sleeping at all.

Sitting

⓪ I can sit in any chair as long as I like.
① I can only sit in my favorite chair as long as I like.
② Pain prevents me from sitting more than 1 hour.
③ Pain prevents me from sitting more than 1/2 hour.
④ Pain prevents me from sitting more than 10 minutes.
⑤ I avoid sitting because it increases pain immediately.

Standing

⓪ I can stand as long as I want without pain.
① I have some pain while standing but it does not increase with time.
② I cannot stand for longer than 1 hour without increasing pain.
③ I cannot stand for longer than 1/2 hour without increasing pain.
④ I cannot stand for longer than 10 minutes without increasing pain.
⑤ I avoid standing because it increases pain immediately.

Walking

⓪ I have no pain while walking.
① I have some pain while walking but it doesn't increase with distance.
② I cannot walk more than 1 mile without increasing pain.
③ I cannot walk more than 1/2 mile without increasing pain.
④ I cannot walk more than 1/4 mile without increasing pain.
⑤ I cannot walk at all without increasing pain.

Personal Care

⓪ I do not have to change my way of washing or dressing in order to avoid pain.
① I do not normally change my way of washing or dressing even though it causes some pain.
② Washing and dressing increases the pain but I manage not to change my way of doing it.
③ Washing and dressing increases the pain and I find it necessary to change my way of doing it.
④ Because of the pain I am unable to do some washing and dressing without help.
⑤ Because of the pain I am unable to do any washing and dressing without help.

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.
③ Pain prevents me from lifting heavy weights off the floor, but I can manage if they are conveniently positioned (e.g., on a table).
④ Pain prevents me from lifting heavy weights off the floor, but I can manage light to medium weights if they are conveniently positioned.
⑤ I can only lift very light weights.

Traveling

⓪ I get no pain while traveling.
① I get some pain while traveling but none of my usual forms of travel make it worse.
② I get extra pain while traveling but it does not cause me to seek alternate forms of travel.
③ I get extra pain while traveling which causes me to seek alternate forms of travel.
④ Pain restricts all forms of travel except that done while lying down.
⑤ Pain restricts all forms of travel.

Social Life

⓪ My social life is normal and gives me no extra pain.
① My social life is normal but increases the degree of pain.
② Pain has no significant affect on my social life apart from limiting my more energetic interests (e.g., dancing, etc).
③ Pain has restricted my social life and I do not go out very often.
④ Pain has restricted my social life to my home.
⑤ I have hardly any social life because of the pain.

Changing degree of pain

⓪ My pain is rapidly getting better.
① My pain fluctuates but overall is definitely getting better.
② My pain seems to be getting better but improvement is slow.
③ My pain is neither getting better or worse.
④ My pain is gradually worsening.
⑤ My pain is rapidly worsening.

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

Back Index Score