

# INITIAL PATIENT QUESTIONNAIRE

Name: \_\_\_\_\_ DOB: \_\_\_\_/\_\_\_\_/\_\_\_\_ Age: \_\_\_\_\_ SSN: \_\_\_\_-\_\_\_\_-\_\_\_\_ Sex: M / F

Home Address: \_\_\_\_\_ City/State: \_\_\_\_\_ Zip: \_\_\_\_\_

Phone: (H) \_\_\_\_\_ (C) \_\_\_\_\_ Email: \_\_\_\_\_

Marital Status: \_\_\_\_\_ Occupation: \_\_\_\_\_ Employer: \_\_\_\_\_

Emergency Contact and Relation: \_\_\_\_\_ Phone: \_\_\_\_\_

If you would like to receive text message appointment reminders, please put cell phone provider here: \_\_\_\_\_

## PATIENT INFORMED CONSENT

State law requires offices to obtain your informed consent prior to examination and treatment. The purpose of this form is to inform you. What you're being asked to sign is simply a confirmation that you have been informed of the following:

### EXAMINATIONS

**X-Rays:** This office uses highly sensitive x-ray film, intensifying screens and filters that provide high quality x-rays with the lowest possible x-ray exposure. The only risk with taking x-rays is with pregnancy. If there is any possibility that you are pregnant, inform us prior to any x-ray procedure. If there is no possibility of this condition, the risks are so rare we have no available statistics to qualify their probability.

**Chiropractic adjustment/manipulation:** The doctor will use his hands or a mechanical device upon your body in such a way as to move your joints in various directions. This procedure may cause an audible "pop" or "click" to be heard coming from your joints; this is not a cause for alarm. There are some material risks involved in doing these procedures. They are as follows:

**Pain:** Chiropractic treatments may result in a temporary increase in soreness in the area receiving treatment.

**Rib fractures:** Fractures caused by chiropractic treatments are rare. They occur most frequently in patients with osteoporosis or weakened bones. Evidence of osteoporosis can be noted on your x-rays, and, if detected, the most appropriate and gentle treatments are used, minimizing the possibility of fractures to the ribs.

**Disc Injury:** Chiropractic treatment is appropriate for the treatment of many kinds of back problems, including some disc problems<sup>i</sup>. Occasionally, chiropractic may aggravate or cause a problem if the disc is in a severely weakened state. However, this occurs so rarely that statistics to quantify the probability are unavailable, but estimates place risk of serious injury at about 1 serious complication per 100 million low back manipulations<sup>ii</sup>

**Stroke:** The overall incidence of stroke in the general population is about 2 per 1000 people<sup>iii</sup>. Although chiropractic adjustment/manipulation has been implicated as a possible cause of stroke, this possibility is extremely rare. The best available data suggests that stroke, secondary to chiropractic adjustment/manipulation may occur in 1 per 100,000 patients<sup>iv</sup>, a rate well below the overall average risk in the general population. In comparison, the overall average risk of death from taking non-steroidal anti-inflammatory drugs (aspirin, ibuprofen, naproxen sodium, etc.) is 4 per 100,000 patients<sup>v</sup>. The risk of serious complication or death from spine surgeries of the neck is 1.25 per 1000 patients<sup>vi</sup>. As you can see, the risk of stroke from chiropractic treatments is much lower than other common medical treatments. Even though the risk is small, we have implemental procedures and tests that will likely reduce the potential for stroke even more.

Chiropractic is a system of health care delivery. As with any health delivery system, we cannot promise a cure for any symptom, disease or condition as a result of treatment in this office. We will always give you our best care, and if your results are not acceptable, we will refer you to another health care provider who we feel will assist your situation.

If you have any questions on the above information, please ask the doctor. When you have a clear understanding, please sign and date below.

I HAVE READ, OR HAVE HAD READ TO ME, THIS CONSENT FORM AND I HAVE BEEN INFORMED OF THE MOST LIKELY COMPLICATIONS, OF THE POSSIBLE UNDESIRE RESULTS OF CHIROPRACTIC EXAMINATION AND TREATMENT IN THIS OFFICE AND UNDERSTAND THEM. I HEREBY AUTHORIZE AND DIRECT DR. COBB AND HIS ASSOCIATES OR ASSISTANT TO PROVIDE SUCH ADDITIONAL SERVICES AS THEY MAY DEEM REASONABLE AND NECESSARY.

Patient Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Patient's Printed Name: \_\_\_\_\_ Date: \_\_\_\_\_

Parent's/Guardian's Signature \_\_\_\_\_ Date: \_\_\_\_\_  
(If Patient is less than 18 years of age)

Parent's Guardian's Printed Name \_\_\_\_\_ Date: \_\_\_\_\_

<sup>i</sup> Troyanovich SJ, Harrison DE • Low back pain and the lumbar intervertebral disc. Clinical considerations for the doctor of chiropractic.

<sup>ii</sup> Shekelle PG, Spine update. Spinal Manipulation, Spine 1994, 19,858-86

<sup>iii</sup> Clayman CB, The American Medical Association Home Encyclopedia, New York, Random House: 947-948

<sup>iv</sup> Dabbs v. Lauretti WJ Risk Assessment and Cervical Manipulation vs. NSAIDS for the treatment of neck pain J Manipulative Physiol. THE: 1995; 18•530536

<sup>v</sup> Harwitz PI, Acker PD, Adams AH, Meeker WP, Shekelle PG Manipulation and mobilization of the cervical spine; A systematic review of the literature. Spine, 1996, 21.1746-1760

## HISTORY OF COLLISION

Date of Collision \_\_\_\_ / \_\_\_\_ / \_\_\_\_

Time of Collision \_\_\_\_:\_\_\_\_ AM / PM

Where were you seated? \_\_\_\_\_

Make/Model of vehicle you were occupying: \_\_\_\_\_

Location where the collision occurred: \_\_\_\_\_

Approximately how fast were you traveling when the collision occurred? \_\_\_\_\_ MPH

Make/Model of other vehicle(s) involved: \_\_\_\_\_

In your own words, briefly describe the collision: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

At the time of the collision, which way were you facing? Forward? Turned? \_\_\_\_\_

Were you surprised by the collision? Yes / No

Were you wearing a seat belt? Yes / No

Did the airbags deploy? Yes / No

Were you rendered unconscious? Yes / No

Were the police notified Yes / No

Was a report filed? Yes / No

With whom? \_\_\_\_\_

How did you feel immediately following the collision? \_\_\_\_\_

Is the pain \_\_\_\_ Getting better? \_\_\_\_ No improvement? \_\_\_\_ Getting worse?

Did you go to the hospital? Yes / No      Where? \_\_\_\_\_      How? \_\_\_\_\_

Were any of the following performed? \_\_\_\_ X-rays      \_\_\_\_ CT      \_\_\_\_ MRI

Were you prescribed medication? Yes / No      What was prescribed? \_\_\_\_\_

Have you seen another doctor for this injury? Yes / No      Whom? \_\_\_\_\_

Have you been able to work since the collision? Yes / No      Why or why not? \_\_\_\_\_

What could you do before the collision that you are unable to do now? \_\_\_\_\_

\_\_\_\_\_

Do you have an attorney? Yes / No      Who? \_\_\_\_\_

Patient Signature \_\_\_\_\_      Date \_\_\_\_\_



**OFFICE OF INSURANCE REGULATION**  
**Bureau of Property & Casualty Forms and Rates**

**Standard Disclosure and Acknowledgement Form**  
**Personal Injury Protection - Initial Treatment or Service Provided**

The undersigned insured person (or guardian of such person) affirms:

1. The services or treatment set forth below were **actually rendered**. This means that those services have **already been provided**.

2. I have the right and the **duty to confirm** that the services have already been provided.

3. I was **not solicited** by any person to seek any services from the medical provider of the services described above.

4. The medical provider has **explained** the services to me for which payment is being claimed.

5. If I notify the insurer in writing of a billing error, I may be entitled to a portion of any reduction in the amounts paid by my motor vehicle insurer. If entitled, my share would be at least 20% of the amount of the reduction, up to \$500.

Insured Person (patient receiving treatment or services) or Guardian of Insured Person:

\_\_\_\_\_  
Name (*PRINT or TYPE*)

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Date

The undersigned licensed medical professional or medical director, if applicable, affirms the statement numbered 1 above and also:

A. I have **not solicited** or caused the insured person, who was involved in a motor vehicle accident, to be solicited to make a claim for Personal Injury Protection benefits.

B. The treatment or services rendered were explained to the insured person, or his or her guardian, **sufficiently** for that person to sign this form with informed consent.

C. The accompanying statement or bill is **properly completed** in all material provisions and all relevant information has been provided therein. This means that each request for information has been responded to **truthfully, accurately**, and in a **substantially complete** manner.

D. The coding of procedures on the accompanying statement or bill is proper. This means that **no service has been upcoded, unbundled**, or constitutes an invalid **or not medically necessary diagnostic test** as defined by Section 627.732 (15) and (16), Florida Statutes or Section 627.736(5)(b)6, Florida Statutes.

Licensed Medical Professional Rendering Treatment/Services or Medical Director, if applicable (*Signature by his/ her own hand*):

\_\_\_\_\_  
Name (*PRINT or TYPE*)

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Date

Any person who knowingly and with intent to injure, defraud, or deceive any insurer files a statement of Claim or an application containing any false, incomplete, or misleading information is guilty of a felony of the third degree per Section 817.234(1)(b), Florida Statutes.

Note: The **original** of this form must be furnished to the insurer pursuant to Section 627.736(4)(b), Florida Statutes and may **not** be electronically furnished. Failure to furnish this form may result in non-payment of the claim.

# APPLICATION FOR FLORIDA "NO FAULT" BENEFITS

Date: \_\_\_\_\_

File Number: \_\_\_\_\_

Insurance Company: \_\_\_\_\_

Policy Number: \_\_\_\_\_

Date of Accident: \_\_\_\_\_

TO ENABLE US TO DETERMINE IF YOU ARE ENTITLED TO BENEFITS UNDER THE FLORIDA PERSONAL INJURY PROTECTION LAW, PLEASE COMPLETE THIS FORM AND RETURN IT PROMPTLY. ANY PERSON WHO KNOWINGLY AND WITH INTENT TO INJURE, DEFRAUD OR DECEIVE ANY INSURANCE COMPANY MAKES A STATEMENT OF CLAIM CONTAINING ANY FALSE, INCOMPLETE OR MISLEADING INFORMATION, IS GUILTY OF A FELONY OF THE THIRD DEGREE.

Name: \_\_\_\_\_

Address: \_\_\_\_\_

Phone Number: \_\_\_\_\_

City, State, Zip Code: \_\_\_\_\_

Date of Birth: \_\_\_\_\_

Social Security Number: \_\_\_\_\_

How long have you been a resident of Florida? \_\_\_\_\_

Date of accident: \_\_\_\_\_

Time of accident: \_\_\_\_\_

Location of accident: \_\_\_\_\_

Description of accident: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Make and model of vehicle you were occupying during accident: \_\_\_\_\_

As a result of this accident, were you injured? \_\_\_\_\_ If yes, complete the form. If no, sign below and return to us.

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Date

Description of Injury: \_\_\_\_\_

\_\_\_\_\_

Were you treated by a doctor? \_\_\_\_\_ If yes, name and address: \_\_\_\_\_

Were you treated at a hospital? \_\_\_\_\_ If yes, name and address: \_\_\_\_\_

Amount of medical expenses to date: \$ \_\_\_\_\_ Will you have more expenses? \_\_\_\_\_

At the time of accident, were you employed? \_\_\_\_\_ If yes, did you lose any wages? \_\_\_\_\_

If yes, amount lost? \$ \_\_\_\_\_ Your weekly salary or wage: \$ \_\_\_\_\_

Date disability from work began: \_\_\_\_\_ Date you returned to work: \_\_\_\_\_

Have you received benefits under Worker's Compensation? \_\_\_\_\_ If yes, amount and frequency: \$ \_\_\_\_\_

Name and addresses of employer or previous employer along with occupation and dates of employment: \_\_\_\_\_

\_\_\_\_\_

As a result of this accident, have you had any other expenses? \_\_\_\_\_ If yes, explain below with expense amounts.

\_\_\_\_\_

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Date

## **AUTHORIZATION FOR MEDICAL INFORMATION**

THIS AUTHORIZATION OR PHOTOCOPY HEREOF, WILL AUTHORIZE YOU TO FURNISH ALL INFORMATION YOU MAY HAVE REGARDING MY CONDITION WHILE UNDER YOUR OBSERVATION OR TREATMENT, INCLUDING THE HISTORY OBTAINED, PHYSICAL AND X-RAY FINDINGS, DIAGNOSIS AND PROGNOSIS. YOU ARE AUTHORIZED TO PROVIDE THIS INFORMATION IN ACCORDANCE WITH THE FLORIDA "NO FAULT" AUTO INSURANCE LAW.

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Signature

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Date

## **AUTHORIZATION FOR WAGE AND SALARY INFORMATION**

THIS AUTHORIZATION OR PHOTOCOPY HEREOF, WILL AUTHORIZE YOU TO FURNISH ALL INFORMATION YOU MAY HAVE REGARDING MY WAGES OR SALARY WHILE EMPLOYED BY YOU. YOU ARE AUTHORIZED TO PROVIDE THIS INFORMATION IN ACCORDANCE WITH THE FLORIDA "NO FAULT" AUTO INSURANCE LAW.

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Signature

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Date

**ASSIGNMENT OF BENEFITS, LIENS, DIRECT PAYMENT AUTHORIZATION, AUTHORIZATION TO RELEASE  
INSURANCE INFORMATION, AND AUTHORIZATION TO ESCROW UNPAID MEDICAL & PIP BENEFITS**

**Cobb Rehab & Wellness**

INSURANCE CARRIER: \_\_\_\_\_ POLICY NUMBER: \_\_\_\_\_ DATE OF LOSS: \_\_\_\_\_

For and in consideration of Cobb Rehab & Wellness agreeing to pursue the responsible automobile insurance carrier for payment of benefits due and not requiring prepayment for services, I hereby irrevocably assign all rights and benefits to Cobb Rehab & Wellness for Personal Injury Protection, extended Personal Injury Protection, Medical Payment Coverage, and other benefits which I may have in accordance with Florida Statute §627.736. This includes any benefits from my insurance company and any other entity which may be responsible for medical expenses incurred. I further authorize Cobb Rehab & Wellness to collect payments & prosecute any necessary actions to collect payment for services as they see fit and allowable by law and contract. THIS DOCUMENT CONSTITUTES AN ASSIGNMENT OF RIGHTS AND BENEFITS.

I hereby further give a lien to Cobb Rehab & Wellness against any and all insurance benefits named herein, and any and all proceeds of any settlement, judgment or verdict which may be paid to me as a result of the injuries or illness for which I have been treated by Cobb Rehab & Wellness as a result of the above stated loss date. This document acts as an irrevocable absolute assignment of my rights and benefits to the extent of the charges for services provided. I agree to cooperate with Cobb Rehab & Wellness and their attorney's (at their choosing), and to do all things reasonable to effect payment of the bills by the insurance company or other entity to Cobb Rehab & Wellness including, but not limited to, disclosing my medical condition, being available for factual discovery or other cooperation.

This assignment concerns only the bills for Cobb Rehab & Wellness and those costs including, but not limited to, attorney's fees, other costs, and interest necessary in procuring payment from the above-named insurance company and/or other entities. This assignment is not intended to assign any other causes of action that may belong to the undersigned patient. I agree to pay any applicable deductible or co-payment not covered by any policy of insurance cited above. I understand that as a benefit and convenience to me, Cobb Rehab & Wellness will bill and pursue collection against the insurance company or other responsible entity on my behalf. I hereby instruct and direct my insurance company to pay my benefits directly to Cobb Rehab & Wellness at the address provided on the bill. If my current policy prohibits direct payment to doctors, then I hereby instruct and direct my insurance company or other responsible entity to make the check payable to me and mail it to Cobb Rehab & Wellness at the address on the bill. Cobb Rehab & Wellness' medical care is being provided for a reasonable fee for treatment causally related to the above loss date and is medically necessary. I instruct my insurance carrier or other responsible entity to pay these bills to the full extent of my available benefits under the insurance policy and Florida law. If any portion of the charge for these services is either reduced or denied in whole or in part, my insurance company or other entity is to place funds equal to the amount of the reduced or denied charges into escrow and hold the escrowed funds until agreement or resolution of legal action by Cobb Rehab & Wellness. I further instruct my insurance company to make payment for charges submitted by Cobb Rehab & Wellness in priority to any other requests to escrow benefits, including a request by myself to reserve benefits for pending disability claims. I hereby give Cobb Rehab & Wellness limited power of attorney to endorse and sign my name on any draft for payment to either Cobb Rehab & Wellness or myself if said draft represents payment for charges related to services rendered by Cobb Rehab & Wellness.

I further direct my insurance carrier or responsible other entity to provide information to Cobb Rehab & Wellness which is otherwise available to me including but not limited to a copy of any applicable insurance policy, declaration page, all applicable endorsements, transcripts and/or copies of any recorded statements, examinations under oath and requests for same, independent medical evaluations and requests for same, peer review reports, and a listing of all PIP benefits paid to date which shall include when claims were made, when the claims were received, the payment or denial of each claim, the amount of the deductible and the claims applied thereto, and whether benefits have been exhausted and the amount of PIP benefits available, commonly known as a "PIP log". This request includes the name of other medical providers to whom payments have been under my policy of insurance. This agreement is intended to serve as an assignment of rights and benefits under my policy of insurance in favor of Cobb Rehab & Wellness. If any language within this agreement has the effect of invalidating this agreement, that language shall be deemed void and the remainder of the assignment shall maintain full force and effect. A photocopy of this assignment shall be considered as effective and valid as the original.

\_\_\_\_\_  
Patient Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Patient Name

*If patient is incapacitated or under the age of 18, please indicate the patient name, guardian name and relation to patient, and obtain guardian signature.*

**ACKNOWLEDGMENT OF RECEIPT  
OF NOTICE OF PRIVACY PRACTICES**

I acknowledge that I was provided a copy of the Notice of Privacy Practices and that I have read them or declined the opportunity to read them and understand the Notice of Privacy Practices.

I understand that this form will be placed in my patient chart and maintained for six years.

Patient Name (Please print) \_\_\_\_\_ Date \_\_\_\_\_

Parent, Guardian or Patient's Legal Representative \_\_\_\_\_

Signature \_\_\_\_\_

**THIS FORM WILL BE PLACED IN THE PATIENT'S CHART AND MAINTAINED FOR SIX YEARS.**

Cobb Rehab & Wellness  
Dr. Gregory Cobb  
4205 E. Busch Blvd. Tampa, FL 33617  
Phone: (813) 914-8500 Fax: (813) 914 8511  
www.cobbrehabwellness.com

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**AUTHORIZATION TO RELEASE HEALTHCARE INFORMATION**

Patient's Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

Previous Name: \_\_\_\_\_ Social Security #: \_\_\_\_\_

I request and authorize \_\_\_\_\_ to release  
healthcare information of the patient named above it:

Name: \_\_\_\_\_

Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip Code: \_\_\_\_\_

This request and authorization applies to:

☐ Healthcare information relating to the following treatment, condition, or dates: \_\_\_\_\_

\_\_\_\_\_

☐ All healthcare information

☐ Other: \_\_\_\_\_

\_\_\_\_\_

Patient Signature: \_\_\_\_\_ Date Signed: \_\_\_\_\_



## How did you hear about our clinic?

Sign/Location: \_\_\_\_\_

Friend/Relative/Co-worker \_\_\_\_\_

Attorney: \_\_\_\_\_

PPO/HMO Provider Book: \_\_\_\_\_

Another Doctor/Clinic \_\_\_\_\_

Name: \_\_\_\_\_ Date: \_\_\_\_\_

Thank you for choosing ***Cobb Rehab and Wellness*** for your healthcare needs!

NAME: \_\_\_\_\_

DATE: \_\_\_\_\_

Please be sure to fill this out accurately. Mark the area on your body where you feel the described sensation(s). Use the appropriate symbol(s), mark areas of radiating pain and include all affected areas. You may draw in the face as well.

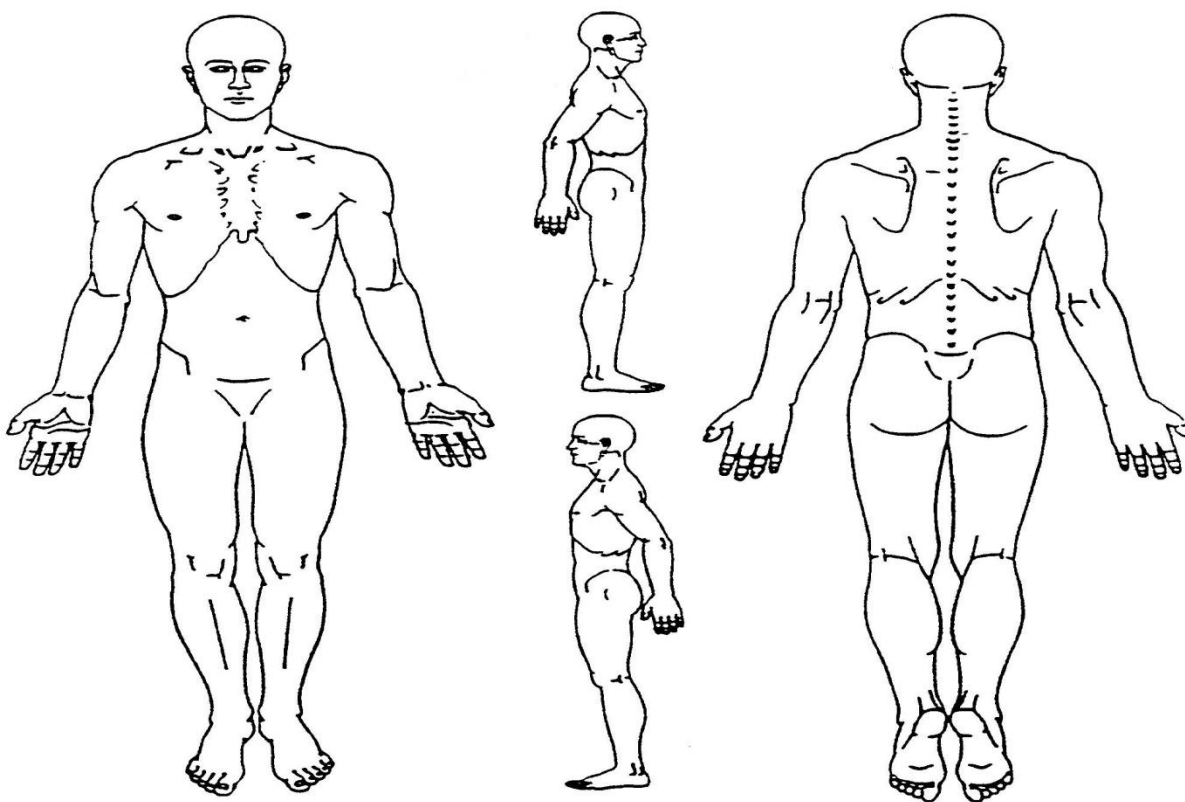
Numbness: -----

Pins & Needles: ooooooo

Burning Pain: xxxxxxxxx

Stabbing Pain: //////////

Aching Pain: ((((((



Please mark on the line the pain level that most accurately represents your pain:

NO PAIN - 0 1 2 3 4 5 6 7 8 9 10 - UNBEARABLE PAIN

A) Right Now:	0	1	2	3	4	5	6	7	8	9	10
B) Average Pain:	0	1	2	3	4	5	6	7	8	9	10
C) At Best:	0	1	2	3	4	5	6	7	8	9	10
D) At Worst:	0	1	2	3	4	5	6	7	8	9	10

## SYMPTOM SURVEY

Please circle all that apply and indicate pain level based on a scale of 1 – 10

L = Left

R = Right

B = Both

### General Symptoms

Nervousness – Irritability – Fatigue

Depression – Loss of Sleep

Tension – PMS

### Head

**Headache:** Mild – Moderate – Severe

Constant – Intermittent – Throbbing

**How Often:** \_\_\_\_\_

**Located:** Back of Head – Forehead

Temples L – R – Behind Eyes

**With:** Lightheaded – Memory Loss

Fainting – Blurred Vision – Double Vision

Sensitivity to Light – Loss of Balance

Hearing Loss – Ringing in Ears

**Scale of 1-10:** \_\_\_\_\_

### Neck

**Pain:** L – R – B \_\_\_\_\_

**Tension:** L – R – B \_\_\_\_\_

**Pain Across Shoulder:** L – R – B \_\_\_\_\_

**Limited Movement:** L – R – B \_\_\_\_\_

### Shoulders

**Pain in Joint:** L – R – B \_\_\_\_\_

**Pain Across Shoulders:** L – R – B \_\_\_\_\_

**Limited Movement:** L – R – B \_\_\_\_\_

**Tension:** L – R – B \_\_\_\_\_

### Arms

**Pain Above Elbow:** L – R – B \_\_\_\_\_

**Pain in Elbow:** L – R – B \_\_\_\_\_

**Pain in Forearm:** L – R – B \_\_\_\_\_

**Pins and Needles(Arm):** L – R – B \_\_\_\_\_

**Numbness in Arm:** L – R – B \_\_\_\_\_

**Numbness in Forearm:** L – R – B \_\_\_\_\_

### Hands

**Pain in Wrist:** L – R – B \_\_\_\_\_

**Pain in Hand:** L – R – B \_\_\_\_\_

**Pins and Needles:** L – R – B \_\_\_\_\_

**Numbness:** L – R – B \_\_\_\_\_

### Chest

**Deep Chest Pain:** L – R – B \_\_\_\_\_

**Pain Level:** Mild – Moderate – Severe

**Pain Around Ribs:** L – R – B \_\_\_\_\_

**With:** Shortness of Breath – Irregular Heartbeat

### Abdominal Symptoms

**Pain:** Mild – Moderate – Severe

**With:** Nervous Stomach – Nausea – Gas

Constipation – Diarrhea – Heartburn

Indigestion – Loss of Appetite

**Scale of 1-10:** \_\_\_\_\_

### Hips and Legs

**Pain:** mild – Moderate – Severe

**Pain in Buttocks:** L – R – B \_\_\_\_\_

**Pain in Hip Joint:** L – R – B \_\_\_\_\_

**Pain Down Leg:** L – R – B \_\_\_\_\_

**Radiating to:** Knee – Calf – Foot

**Numbness in Leg:** L – R – B \_\_\_\_\_

**Pins and Needles:** L – R – B \_\_\_\_\_

**Knee Pain:** L – R – B \_\_\_\_\_

**Leg Cramps:** L – R – B \_\_\_\_\_

### Feet

**Ankle Pain:** L – R – B \_\_\_\_\_

**Swollen Ankles:** L – R – B \_\_\_\_\_

**Foot Pain:** L – R – B \_\_\_\_\_

**Numbness:** L – R – B \_\_\_\_\_

### Back

**Upper Back:** L – R – B \_\_\_\_\_

**Mid Back:** L – R – B \_\_\_\_\_

**Lower Back:** L – R – B \_\_\_\_\_

**Muscle Spasms:** L – R – B \_\_\_\_\_

**Location of Spasms:** \_\_\_\_\_

**Pain Level:** Mild – Moderate – Severe

**Type:** Sharp/Stabbing – Dull Ache

**Other symptoms that you have:** \_\_\_\_\_

Are all of these symptoms directly caused by the accident? YES – NO

\_\_\_\_\_  
PATIENT SIGNATURE

\_\_\_\_\_  
DATE

## PATIENT INTAKE FORM

1. Is today's problem caused by:    ☐ Auto Accident                      ☐ Workman's Compensation
2. How often do you experience your symptoms?  
☐ Constantly (76-100% of the time)                      ☐ Occasionally (26-50% of the time)  
☐ Frequently (51-75% of the time)                      ☐ Intermittently (1-25% of the time)
3. How would you describe the type of pain?  
☐ Sharp                      ☐ Numb  
☐ Dull                      ☐ Tingly  
☐ Diffuse                      ☐ Sharp with motion  
☐ Achy                      ☐ Shooting with motion  
☐ Burning                      ☐ Stabbing with motion  
☐ Shooting                      ☐ Electric like with motion  
☐ Stiff                      ☐ Other: \_\_\_\_\_
4. How are your symptoms changing with time?  
☐ Getting worse                      ☐ Staying the same                      ☐ Getting better
5. Using a scale from 0 – 10 (10 being the worse), how would you rate your problem?  
0            1            2            3            4            5            6            7            8            9            10
6. How much has the problem interfered with your work?  
☐ Not at all            ☐ A little bit            ☐ Moderately            ☐ Quite a bit            ☐ Extremely
7. How much has the problem interfered with your social activities?  
☐ Not at all            ☐ A little bit            ☐ Moderately            ☐ Quite a bit            ☐ Extremely
8. Who else have you seen for your problem?  
☐ Chiropractor            ☐ Neurologist            ☐ Primary Care Physician  
☐ ER Physician            ☐ Orthopedist            ☐ Massage Therapist  
☐ Physical Therapist            ☐ No one            ☐ Other: \_\_\_\_\_
9. How long has this episode been happening? \_\_\_\_\_
10. How do you think your problem began? \_\_\_\_\_  
\_\_\_\_\_
11. Do you consider this problem to be severe?    ☐ Yes    ☐ Yes, at times    ☐ No
12. What aggravates your problem? \_\_\_\_\_  
\_\_\_\_\_
13. What makes it better? \_\_\_\_\_
14. What concerns you the most about your problem; What does it prevent you from doing?  
\_\_\_\_\_
15. What is your:    Height: \_\_\_\_\_                      Weight: \_\_\_\_\_
16. How would you rate your overall health?  
☐ Excellent                      ☐ Very Good                      ☐ Good                      ☐ Fair                      ☐ Poor
17. What type of exercise do you do?  
☐ Strenuous                      ☐ Moderate                      ☐ Light                      ☐ None
18. Indicate if you have any immediate family members with any of the following:  
☐ Rheumatoid Arthritis                      ☐ Diabetes                      ☐ Lupus  
☐ Cancer                      ☐ ALS                      ☐ Heart Problems

PATIENT SIGNATURE: \_\_\_\_\_

DATE: \_\_\_\_\_

**19. For each of the conditions listed below, place a check in the “past” column if you have had the condition in the past. If you presently have the condition, place a check in the “present” column.**

<u>Past</u>	<u>Present</u>	<u>Past</u>	<u>Present</u>	<u>Past</u>	<u>Present</u>
<input type="checkbox"/>	<input type="checkbox"/> Headaches	<input type="checkbox"/>	<input type="checkbox"/> High Blood Pressure	<input type="checkbox"/>	<input type="checkbox"/> Diabetes
<input type="checkbox"/>	<input type="checkbox"/> Neck Pain	<input type="checkbox"/>	<input type="checkbox"/> Heart Attack	<input type="checkbox"/>	<input type="checkbox"/> Excessive Thirst
<input type="checkbox"/>	<input type="checkbox"/> Upper Back Pain	<input type="checkbox"/>	<input type="checkbox"/> Chest Pains	<input type="checkbox"/>	<input type="checkbox"/> Frequent Urination
<input type="checkbox"/>	<input type="checkbox"/> Mid Back Pain	<input type="checkbox"/>	<input type="checkbox"/> Stroke	<input type="checkbox"/>	<input type="checkbox"/> Smoking/Tobacco Use
<input type="checkbox"/>	<input type="checkbox"/> Low Back Pain	<input type="checkbox"/>	<input type="checkbox"/> Angina	<input type="checkbox"/>	<input type="checkbox"/> Drug/Alcohol Dependence
<input type="checkbox"/>	<input type="checkbox"/> Shoulder Pain	<input type="checkbox"/>	<input type="checkbox"/> Kidney Stones	<input type="checkbox"/>	<input type="checkbox"/> Allergies
<input type="checkbox"/>	<input type="checkbox"/> Elbow/Upper Arm Pain	<input type="checkbox"/>	<input type="checkbox"/> Kidney Disorders	<input type="checkbox"/>	<input type="checkbox"/> Depression
<input type="checkbox"/>	<input type="checkbox"/> Wrist Pain	<input type="checkbox"/>	<input type="checkbox"/> Bladder Infection	<input type="checkbox"/>	<input type="checkbox"/> Systemic Lupus
<input type="checkbox"/>	<input type="checkbox"/> Hand Pain	<input type="checkbox"/>	<input type="checkbox"/> Painful Urination	<input type="checkbox"/>	<input type="checkbox"/> Epilepsy
<input type="checkbox"/>	<input type="checkbox"/> Hip Pain	<input type="checkbox"/>	<input type="checkbox"/> Loss of Bladder Control	<input type="checkbox"/>	<input type="checkbox"/> Dermatitis/Eczema/Rash
<input type="checkbox"/>	<input type="checkbox"/> Upper Leg Pain	<input type="checkbox"/>	<input type="checkbox"/> Prostate Problems	<input type="checkbox"/>	<input type="checkbox"/> HIV/AIDS
<input type="checkbox"/>	<input type="checkbox"/> Knee Pain	<input type="checkbox"/>	<input type="checkbox"/> Abdominal Pain		
<input type="checkbox"/>	<input type="checkbox"/> Ankle/Foot Pain	<input type="checkbox"/>	<input type="checkbox"/> Ulcer		
<input type="checkbox"/>	<input type="checkbox"/> Jaw Pain	<input type="checkbox"/>	<input type="checkbox"/> Hepatitis	<input type="checkbox"/>	<b>For Females Only</b> <input type="checkbox"/> Birth Control Pills
<input type="checkbox"/>	<input type="checkbox"/> Joint Pain/Stiffness	<input type="checkbox"/>	<input type="checkbox"/> Dizziness	<input type="checkbox"/>	<input type="checkbox"/> Hormonal Replacement
<input type="checkbox"/>	<input type="checkbox"/> Arthritis	<input type="checkbox"/>	<input type="checkbox"/> General Fatigue	<input type="checkbox"/>	<input type="checkbox"/> Pregnancy
<input type="checkbox"/>	<input type="checkbox"/> Rheumatoid Arthritis	<input type="checkbox"/>	<input type="checkbox"/> Visual Disturbances		
<input type="checkbox"/>	<input type="checkbox"/> Cancer	<input type="checkbox"/>	<input type="checkbox"/> Muscular Incoordination		
<input type="checkbox"/>	<input type="checkbox"/> Tumor	<input type="checkbox"/>	<input type="checkbox"/> Liver/Gallbladder Disorder		
<input type="checkbox"/>	<input type="checkbox"/> Asthma	<input type="checkbox"/>	<input type="checkbox"/> Abnormal Weight Gain/Loss		
<input type="checkbox"/>	<input type="checkbox"/> Chronic Sinusitis	<input type="checkbox"/>	<input type="checkbox"/> Loss of Appetite		
<input type="checkbox"/>	<input type="checkbox"/> Other: _____				

**20. List all prescription medications you are currently taking:** \_\_\_\_\_

**21. List all of the over-the-counter medications you are currently taking:** \_\_\_\_\_

**22. List all supplements you are taking:** \_\_\_\_\_

**23. List all surgical procedures you have had:** \_\_\_\_\_

**24. What is your occupation?** \_\_\_\_\_

**25. What activities do you do at work?**

<input type="checkbox"/> Sit:	<input type="checkbox"/> Most of the day	<input type="checkbox"/> Half of the day	<input type="checkbox"/> A little of the day
<input type="checkbox"/> Stand:	<input type="checkbox"/> Most of the day	<input type="checkbox"/> Half of the day	<input type="checkbox"/> A little of the day
<input type="checkbox"/> Computer Work:	<input type="checkbox"/> Most of the day	<input type="checkbox"/> Half of the day	<input type="checkbox"/> A little of the day
<input type="checkbox"/> On the Phone:	<input type="checkbox"/> Most of the day	<input type="checkbox"/> Half of the day	<input type="checkbox"/> A little of the day

**26. What activities do you do outside of work?** \_\_\_\_\_

**27. Have you ever been hospitalized?** ☐ No ☐ Yes

If yes, why? \_\_\_\_\_

**28. Have you had significant past trauma?** ☐ No ☐ Yes

If yes, why? \_\_\_\_\_

**29. Anything else pertinent to your visit today?** \_\_\_\_\_

**Patient Signature:** \_\_\_\_\_

**Date:** \_\_\_\_\_

# COMMUNICATION LOG

[illegible]