OPTIMAL LIFE
CHIROPRACTIC

AUTOMOBILE/PERSONAL INJURY ACCIDENT QUESTIONNAIRE

PATIENT NAME _____ **DATE OF BIRTH** _____ **FILE#** _____

Dear Patient:
This information is considered confidential. Your answers will help us determine if chiropractic care can help your condition. We will not accept your case if we do not believe your condition will respond satisfactorily to care. For us to understand your condition properly, please be as neat and accurate as possible while completing this form.
Thank you.
Please answer all questions completely.

Please explain in detail how your accident happened: _____

_____

_____

What was the time and date of the injury? _____

Where did you feel pain immediately after the accident? _____

List the extent of your injuries as you know them: _____

_____

_____

Did you require post-accident hospitalization? □ Yes □ No

Check symptoms you have noticed since the accident:

___ Headache	___ Dizziness	___ Depression	___ Fatigue
___ Light Bothers Eyes	___ Buzzing in Ears	___ Diarrhea	___ Neck Pain
___ Head Seems to Heavy	___ Memory Loss	___ Feet Cold	___ Neck Stiff
___ Pins and Needles in Arms	___ Ears Ring	___ Hands Cold	___ Fainting
___ Sleeping Problems	___ Back Pain	___ Face Flushed	___ Loss of Balance
___ Pins and Needles in Legs	___ Constipation	___ Tension	___ Nervousness
___ Numbness in Fingers	___ Loss of Smell	___ Fever	___ Irritability
___ Numbness in Toes	___ Loss of Taste	___ Chest Pain	___ Cold Sweats
___ Shortness of Breath	___ Stomach Upset		

Symptoms other than above: _____

_____

Where were you taken after the accident? _____

Hospitalized? □ Yes □ No If yes, admitted? _____ How long? _____

Name of Hospital: _____

Name of Doctor(s): _____

What treatment was given? _____

Was any other doctor consulted after your accident? □ Yes □ No

If so, what was the doctor's name? _____ D.C., M.D., D.O., D.D.S.

What was the diagnosis? _____

What treatment was given? _____

How **often** did you see the doctor? _____

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How **long** did you see the doctor? _____

Have you ever had any complaints in the involved area before? □ Yes □ No

If so, what were the complaints? _____

Before the injury were you capable of working on an equal basis with others your age? □ Yes □ No

Are your work activities restricted as a result of this accident? □ Yes □ No

Since this injury are your symptoms... □ Improving? □ Getting worse? □ Same?

Driver of other vehicle (if any):

Name _____ Insurance Company _____ Policy No. _____

Driver of vehicle in which you were injured (if applicable):

Name _____ Insurance Company _____ Policy No. _____

Name of your insurance adjuster _____

Have you retained an attorney? □ Yes □ No

If so, his/her name and address_____

You were heading North/ East/ South/ West on _____ (street or highway)

Other vehicle was heading North/ East/ South/ West on _____ (street or highway)

Were the police notified? □ Yes □ No

Were you knocked unconscious? □ Yes □ No If yes, for how long? _____

You were struck from Behind/ Front/ Left Side/Right Side _____

You were Driver/ Passenger/ Front seat/ Back Seat/Using seat belts _____

_____ _____

PATIENT SIGNATURE **DATE**

_____ _____

DOCTOR SIGNATURE **DATE**

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QUADRUPLE VISUAL ANALOGUE SCALE

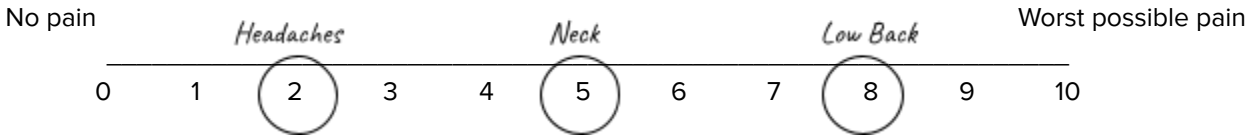
PATIENT NAME: _____ **DATE:** _____

Please read carefully:

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

Note: If you have more than one complaint, please answer each question to 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.

Example:



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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 your pain get at its worst)?

No pain — Worst possible pain

0 1 2 3 4 5 6 7 8 9 10

Other Comments:

_____

_____

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ASSIGNMENT OF BENEFITS, ASSIGNMENT OF RIGHTS TO PURSUE PERSONAL INJURY, WORK COMP, ERISA, AND OTHER LEGAL AND ADMINISTRATIVE CLAIMS ASSOCIATED WITH MY HEALTH INSURANCE AND /OR HEALTH BENEFIT PLAN (INCLUDING BREACH OF FIDUCIARY DUTY) AND DESIGNATION OF AUTHORIZED REPRESENTATIVE

Provider Name: Roger Brady, D.C.
Clinic: Optimal Life Chiropractic
Address: 1051 Helmo Ave N Oakdale, MN 55128

I hereby assign and convey directly to the above-named health care provider, as my designated authorized representative, any and all medical benefits and/or any insurance reimbursement, if any, otherwise payable to me for services, treatments, therapies, and/or medications rendered or provided by the above-named health care provider, regardless of its managed care network participation status. I understand that I am financially responsible for all charges regardless of any applicable insurance or benefit payments. I hereby authorize the above-named health care provider to release all medical information necessary to process my claims. Further, I hereby authorize my plan administrator fiduciary, insurer, and/or attorney to release to the above-named health care provider any and all Plan documents, summary benefit description, insurance policy, and/or settlement information upon written request from the above-named health care provider or its attorneys in order to claim such medical benefits.

In addition to the assignment of all medical benefits and/or insurance reimbursement above, I also assign and/or convey to the above named health care provider any legal or administrative claim or chose an action arising under any group health plan, employee benefits plan, health insurance or tortfeasor insurance concerning medical expenses incurred as a result of the medical services, treatments, therapies, and/or medications I receive from the above-named health care provider (including any right to pursue those legal or administrative claims or chose an action). This constitutes an express and knowing assignment of ERISA breach or fiduciary duty claims and other legal and/or administrative claims.

I intend by this assignment and designation of authorized representative to convey to the above-named provider all of my rights to claim (or place a lien on) the medical benefits related to the services, treatments, therapies, and/or mediations provided by the above-named health care provider, including rights to any settlement, insurance or applicable legal or administrative remedies (including damages arising from ERISA breach of fiduciary duty claims). The assignee and/or designated representative (above-named provider) is given the right by me to (1) obtain information regarding the claim to the same extent as me; (2) submit evidence; (3) make statements about facts or law; (4) make any request including providing or receiving notice of appeal proceedings; (5) participate in any administrative and judicial actions and pursue claims or chose in action or right against any liable party, insurance company, employee benefit plan, health care benefit plan, or plan administrator. The above-named provider as my assignee and my designated authorized representative may bring suit against any such health care benefit plan, employee benefit plan, plan administrator or insurance company in my name with derivative standing at provider's expense.

Unless revoked, this assignment is valid for all administrative and judicial reviews under PPACA (health care reform legislation), ERISA, Medicare and applicable federal and state laws. A photocopy of this assignment is to be considered valid, the same as if it was the original.

I HAVE READ AND FULLY UNDERSTAND THIS AGREEMENT.

_____ _____

PATIENT SIGNATURE **DATE**

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NOTICE OF DOCTOR'S LIEN

Provider Name: Roger Brady, D.C.
Clinic: Optimal Life Chiropractic
Address: 1051 Helmo Ave N Oakdale, MN 55128

I hereby authorize and instruct my attorney &/or insurance carrier, to pay Optimal Life Chiropractic directly for the full amount of services rendered by Optimal Life Chiropractic in relation to my personal injury treatment arising from my accident on or about once a settlement or verdict is reached and those funds are made available or disbursed.

I understand that I am directly and fully responsible for all medical bills incurred at Optimal Life Chiropractic for services rendered to me with respect to any personal injury treatment. Further, I understand that I am responsible for the payment of all services rendered by Optimal Life Chiropractic, regardless of whether or not I receive any proceeds from any insurance company or third party, and that my obligation and liability to Optimal Life Chiropractic is in no way conditioned upon any settlement of verdict.

I agree to promptly notify Optimal Life Chiropractic of any changes in my representation or attorney for this accident.

By signing below, I acknowledge and agree to this lien in favor of Optimal Life Chiropractic the full amount owed for any and all services rendered to me by Optimal Life Chiropractic.

I acknowledge that Optimal Life Chiropractic is not required to permit me the option to postpone or make payments toward services rendered, and that it is being done solely as a courtesy. As such, Optimal Life Chiropractic may, at any time, seek payment for any and all amounts owed by me while this lien is in force. Additionally, if my attorney fails to acknowledge this lien in favor of Optimal Life Chiropractic, the entire balance related to this personal injury treatment is my sole responsibility, and Optimal Life Chiropractic may demand payment immediately.

_____	_____	_____
PATIENT NAME PRINTED	**PATIENT SIGNATURE**	**DATE**

Acknowledged by Attorney this _____ day of _____, 20_____

_____
ATTORNEY SIGNATURE

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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 completely disturbed (5-7 hours sleepless).
4. My sleep is moderately disturbed (2-3 hours sleepless).
5. My sleep is greatly disturbed (3-5 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 at all because of neck pain.
4. I cannot read as much as I want because of moderate neck pain.
5. I can hardly read at all because of severe 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 cannot concentrate at all.
4. I have a lot of difficulty concentrating when I want.
5.I have a great deal of difficulty concentrating when I want.

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 any work at all.
4. I cannot do my usual work.
5. I can hardly 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. I can only lift very light weights.
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 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 at all because of neck pain.
4. I cannot drive my car as long as I want because of moderate neck pain.
5. I can hardly drive at all because of severe 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 cannot do any recreation activities at all.
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 am able to engage in most but not all my usual recreation activities 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 headaches almost all the time.
4. I have moderate headaches which come frequently.
5. I have severe headaches which come

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

SCORE: _____

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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'd like.
1. I can only sit in my favorite chair as long as I'd like.
2. Pain prevents me from sitting more than 1 hour.
3. Pain prevents me from sitting more than ½ 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 ½ 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 ½ mile without increasing pain.
4. I cannot walk more than ¼ mile without increasing pain.
5. I cannot walk at all without increasing pain.

Personal Care
0. I don't have to change my way of washing/dressing to avoid pain.
1. I don't normally change my way of washing/dressing even though it causes some pain.
2. Washing/dressing increases the pain but I manage not to change my way of doing it.
3. Washing/dressing increases the pain and I find it necessary to change my way of doing it.
4. Because of the pain I'm unable to do some washing/dressing without help.
5. Because of the pain I'm unable to do any washing/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 effect 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 **SCORE: _____**

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PATIENT NAME: _____ DATE: _____

This questionnaire will give your provider information about how your **HEADACHES** affect your everyday life.

Please CIRCLE the correct response:

1. I have headache: (1) 1 per month (2) more than 1 but less than 4 per month (3) more than one per week
2. My headache is: (1) mild (2) moderate (3) severe

Please read carefully: The purpose of the scale is to identify difficulties that you may be experiencing because of your headache. Please check off "YES", "SOMETIMES", or "NO" on each item. Answer each question as it pertains to your headache only.

YES	SOMETIMES	NO	
			1. Because of my headaches I feel handicapped.
			2. Because of my headaches I feel restricted in performing my routine daily activities.
			3. No one understands the effect my headaches have on my life.
			4. I restrict my recreational activities (e.g., sports, hobbies) because of my headaches.
			5. My headaches make me angry.
			6. Sometimes I feel that I am going to lose control because of my headaches.
			7. Because of my headaches I am less likely to socialize
			8. My spouse (significant other), or family and friends have no idea what I am going through because of my headaches.
			9. My headaches are so bad that I feel that I am going to go insane
			10. My outlook on the world is affected by my headaches.
			11. I am afraid to go outside when I feel that a headache is starting.
			12. I feel desperate because of my headaches.
			13. I am concerned that I am paying penalties at work or at home because of my headaches.
			14. My headaches place stress on my relationships with family or friends.
			15. I avoid being around people when I have a headache.
			16. I believe my headaches are making it difficult for me to achieve my goals in life.
			17. I am unable to think clearly because of my headaches.
			18. I get tense (e.g., muscle tension) because of my headaches.
			19. I do not enjoy social gatherings because of my headaches.
			20. I feel irritable because of my headaches.
			21. I avoid traveling because of my headaches.
			22. My headaches make me feel confused.
			23. My headaches make me feel frustrated.
			24. I find it difficult to read because of my headaches.
			25. I find it difficult to focus my attention away from my headaches and on other things.

SCORING INSTRUCTIONS: Yes = 4 points Sometimes = 2 points No = 0 points

10-28 is mild disability

30-48 is moderate disability

50-68 is severe disability

72 or more is complete disability

TOTAL SCORE: _____