Dewald Chiropractic
Worker's Comp
Patient Questionnaire

Dear Patient/Injured Worker:

It is important in a workers' compensation case to establish a complete and accurate base of personal and historical information. This information often becomes a critical part of the decision making process in coming to final determinations or conclusions about your case. Therefore, **your help and cooperation in answering this questionnaire as completely and accurately as possible is necessary and appreciated**. This is very important to the people involved in handling your case and for you to receive appropriate and fair compensation.

PLEASE, REVIEW AND COMPLETE THIS PATIENT QUESTIONNAIRE COMPLETELY. WRITE N/A IF THE QUESTION DOES NOT APPLY TO YOU. THANK YOU VERY MUCH!

Patient Information:

Name: _____ Age: _____ Date: _____
Address: (complete mailing address) _____
City:_____ State:_____ Zip:_____
Home Ph: (____)_____ Cell Phone: (_____)_____
Date Of Birth:____/_____/_____ SSN:_____ ____Male ____Female
Are you? ( ) Married ( ) Single ( ) Separated ( ) Divorced ( ) Widowed
Spouse/Parent Name:_____ Occupation:_____
Number of Children: ____ Boys____ Girls____ Ages:_____
Whom May We Thank for Referring You?_____
Name and Phone # to Notify in case of Emergency:_____
Relationship to Patient: Parent ( ) Spouse ( ) Friend ( ) Significant Other ( )
Other:_____ Phone (____)_____

Employer Information: ***(Your Employer At The Time You Were Injured)***

Name Of Business: _____ Phone No.: (____) _____
Address: _____
City:_____ _____ State:_____ Zip_____

Workers' Compensation Insurance Carrier Information:

Name: _____ Phone No.: (____) _____
Address: _____
Claims Representative: _____ Fax No.: (____) _____
Claim No.: _____

Information About Your Work Injury:

Date Of Injury: _____ Time The Injury Occurred: _____ ____ A.M. ____ P.M.
Date You Reported Your Injury To Your Employer/Supervisor: _____
Name Of Person You Reported Your Injury To: _____
Where Did Your Injury Occur? (Address Or Description Of Location): _____
_____

Attorney Information: ( ) Check If None

Name: _____ Phone No.: (____) _____
Address: _____
Fax No.: (____) _____

HISTORY OF THE INJURY:

Please Describe How Your Work Injury Occurred: _____
_____
_____
_____
_____

Please List The Injured Body Parts, **As A Result Of Your Work Injury:**

_____

How Did Your Symptoms Come On? ___ Suddenly ___ Gradually **If 'Gradually'**, Over What Period of Time? _____

When Did You Realize/Know That You Were Injured? Explain: _____

_____

_____

HISTORY OF TREATMENT:

When Did You First Seek Treatment For Your Injury? Date: _____
Did Your Employer Send You For Treatment? ___ YES ___ NO
Did You Seek Treatment On Your Own? ___ YES ___ NO
'INITIALLY', Did You Go To A Hospital/Emergency Room? ___ YES ___ NO **If 'YES',** Answer The Questions Below. **If 'NO',** Go To The ***Name Of Doctor/Facility #1*** On This Page.
Name Of Hospital/ER? _____ City: _____
Were You Admitted To The Hospital? ___ YES ___ NO If 'YES', How Long? _____
Name Of Doctor(s) At The Hospital/ER Who Treated You? _____
Describe The Type Of Treatment &/Or Diagnostic Testing That Was Done: _____

_____

_____
What Did The Hospital Doctor(s) Say Was Wrong With You? _____

_____
Were You Told That You Would Need More Treatment? ___YES ___ NO If 'YES', Explain:

_____

_____
Did The Doctor(s) Restrict Or Modify Your Work Activities? ___ YES ___ NO If 'YES', How?

_____

Please list **ALL** Doctors You Have Seen Regarding Your Work Injury. Please List Them In Chronological Order/***The Order You Saw Them In:***

Name Of Doctor/Facility #1: _____ City/Location:_____
Type Of Doctor (degree or specialty): _____ Number Of Treatments/Visits? _____
Describe Treatment And/Or Tests: _____
What Did This Doctor Say Was Wrong With You? _____
Date When Treatment Started: _____ Date When Treatment Stopped: _____
What Was The Result/Outcome Of The Treatment? _____
Still Treating With This Doctor? ___ YES ___ NO If 'YES', How Often? _____
Did This Doctor Take You Off Work? ___ YES ___ NO If 'YES', Give Dates: _____
Did This Doctor Restrict Or Modify Your Work Activities? ___ YES ___ NO If 'YES', How?

_____
Did This Doctor Refer You Anywhere Else? ___ YES ___ NO If 'YES', Where And Why?

_____

Name Of Doctor/Facility #2: _____ City/Location:_____
Type Of Doctor (degree or specialty): _____ Number Of Treatments/Visits? _____
Describe Treatment And/Or Tests: _____
What Did This Doctor Say Was Wrong With You? _____
Date When Treatment Started: _____ Date When Treatment Stopped: _____
What Was The Result/Outcome Of The Treatment? _____
Still Treating With This Doctor? ___ YES ___ NO If 'YES', How Often? _____
Did This Doctor Take You Off Work? ___ YES ___ NO If 'YES', Give Dates: _____
Did This Doctor Restrict Or Modify Your Work Activities? ___ YES ___ NO If 'YES', How?
_____
Did This Doctor Refer You Anywhere Else? ___ YES ___ NO If 'YES', Where And Why?
_____

Name Of Doctor/Facility #3: _____ City/Location:_____
Type Of Doctor (degree or specialty): _____ Number Of Treatments/Visits? _____
Describe Treatment And/Or Tests: _____
What Did This Doctor Say Was Wrong With You? _____
Date When Treatment Started: _____ Date When Treatment Stopped: _____
What Was The Result/Outcome Of The Treatment? _____
Still Treating With This Doctor? ___ YES ___ NO If 'YES', How Often? _____
Did This Doctor Take You Off Work? ___ YES ___ NO If 'YES', Give Dates: _____
Did This Doctor Restrict Or Modify Your Work Activities? ___ YES ___ NO If 'YES', How?
_____
Did This Doctor Refer You Anywhere Else? ___ YES ___ NO If 'YES', Where And Why?
_____

Name Of Doctor/Facility #4: _____ City/Location:_____
Type Of Doctor (degree or specialty): _____ Number Of Treatments/Visits? _____
Describe Treatment And/Or Tests: _____
What Did This Doctor Say Was Wrong With You? _____
Date When Treatment Started: _____ Date When Treatment Stopped: _____
What Was The Result/Outcome Of The Treatment? _____
Still Treating With This Doctor? ___ YES ___ NO If 'YES', How Often? _____
Did This Doctor Take You Off Work? ___ YES ___ NO If 'YES', Give Dates: _____
Did This Doctor Restrict Or Modify Your Work Activities? ___ YES ___ NO If 'YES', How?
_____
Did This Doctor Refer You Anywhere Else? ___ YES ___ NO If 'YES', Where And Why?
_____

Name Of Doctor/Facility #5: _____ City/Location:_____
Type Of Doctor (degree or specialty): _____ Number Of Treatments/Visits? _____
Describe Treatment And/Or Tests: _____
What Did This Doctor Say Was Wrong With You? _____
Date When Treatment Started: _____ Date When Treatment Stopped: _____
What Was The Result/Outcome Of The Treatment? _____
Still Treating With This Doctor? ___ YES ___ NO If 'YES', How Often? _____
Did This Doctor Take You Off Work? ___ YES ___ NO If 'YES', Give Dates: _____
Did This Doctor Restrict Or Modify Your Work Activities? ___ YES ___ NO If 'YES', How?
_____
Did This Doctor Refer You Anywhere Else? ___ YES ___ NO If 'YES', Where And Why?
_____

Were Any Other Tests, Examinations, Treatments, or Therapy Done That Were Not Described Above? ___ YES ___ NO If 'YES', Please Describe What Was Done And What The Result Was: **(use the back of this page if necessary):** _____

_____

_____

_____

_____

Do You Treat Yourself? __ YES ___ NO If 'YES', Please Explain How: _____

_____

Are You Currently Taking Medication To Relieve The Effects Of This Injury? ___ YES ___ NO If 'YES', Please Describe What You Take, (Prescription or Non-Prescription), How Much It Helps, How Often You Take It, Etc.: _____

_____

Are You Currently Using A Brace, Support, Cane, Crutch(es), Wheelchair, TENS Unit, Or Other Aid Because Of The Effects Of This Injury? ___ YES ___ NO If 'YES', Please Describe Type And How Often It Is Used: _____

_____

What Treatment(s) Offer You The Most Relief, And How Long Do The Benefits Last?

_____

_____

Have There Been Any Recommendations For Diagnostic Testing Or Treatment That You Have Not Received? If 'YES', What Was Recommended, And Who Recommended It?

_____

_____

_____

HISTORY OF OTHER INJURIES:

Have You Ever Experienced The Same Or Similar Symptoms/Problems ***BEFORE*** This Work Injury? ___ YES ___ NO If 'YES', Please Explain In Detail:

_____

_____

_____

Have You Ever Had A ***PRIOR,*** Work Injury(ies)? ___ YES ___ NO If 'YES', Please Explain:

_____

_____

Have You Ever Received a ***PRIOR,*** Workers' Compensation Disability Award? ___ YES ___ NO If 'YES', Please Explain: _____

_____

Have You Ever Served In The **Military**? ___ YES ___ NO If 'YES', Did You Receive A Medical Discharge? ___ YES ___ NO If 'YES', Please Explain Why: _____

_____

Have You Ever Had Any ***PRIOR, NON-WORK RELATED INJURIES?*** (e.g. Sprains/Strains, Slips/Falls, Motor Vehicle Accidents, Cumulative Or Repetitive Traumas, etc.) ___ YES ___ NO
If 'YES', Please Explain: _____

_____

Have You Had Any ***NEW INJURIES*** Since Your Current Work Injury Occurred? ___ YES ___ NO
If 'YES', Please Explain: _____

_____

ACTIVITIES OF DAILY LIVING/CURRENT COMPLAINTS:

1. Self-Care, Personal Hygiene: (**Example** – *Urinating, Defecating, Brushing Teeth, Combing Hair, Bathing, Dressing Oneself, Eating*)
2. Communication: (**Example** – *Writing, Typing, Seeing, Hearing, Speaking*)
3. Physical Activity: (**Example** – *Standing, Sitting, Reclining, Walking, Climbing Stairs*)
4. Sensory Function: (**Example** – *Hearing, Seeing, Tactile Feeling, Tasting, Smelling*)
5. Nonspecialized Hand Activities: (**Example** – *Grasping, Lifting, Tactile Discrimination*)
6. Travel: (**Example** – *Riding, Driving, Flying*)
7. Sexual Function: (**Example** – *Orgasm, Ejaculation, Lubrication, Erection*)
8. Sleep: (**Example** – *Restful, Nocturnal Sleep Pattern*)

Please Indicate Below, Limitations Or Difficulties You Have With Any Of The Above Activities.

1. _____
2. _____
3. _____
4. _____
5. _____
6. _____
7. _____
8. _____

Please list your current symptoms/complaints resulting FROM YOUR WORK INJURY:

Complaint #1: _____
____ % Of Time Felt? 0-10 Pain Scale _____? Symptoms Without Activity? ___ YES ___ NO
What Activities Make This Symptom Worse? _____
What Makes This Symptom Better? _____

Complaint #2: _____
____ % Of Time Felt? 0-10 Pain Scale _____? Symptoms Without Activity? ___ YES ___ NO
What Activities Make This Symptom Worse? _____
What Makes This Symptom Better? _____

Complaint #3: _____
____ % Of Time Felt? 0-10 Pain Scale _____? Symptoms Without Activity? ___ YES ___ NO
What Activities Make This Symptom Worse? _____
What Makes This Symptom Better? _____

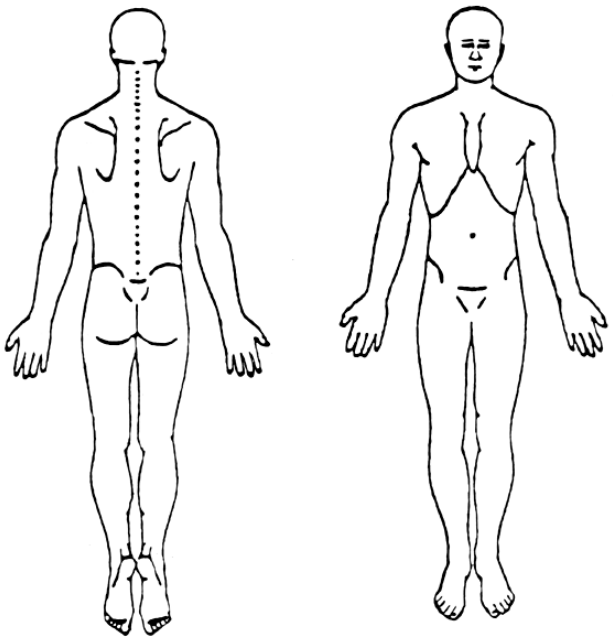
Complaint #4: _____
____ % Of Time Felt? 0-10 Pain Scale _____? Symptoms Without Activity? ___ YES ___ NO
What Activities Make This Symptom Worse? _____
What Makes This Symptom Better? _____

Complaint #5: _____
____ % Of Time Felt? 0-10 Pain Scale _____? Symptoms Without Activity? ___ YES ___ NO
What Activities Make This Symptom Worse? _____
What Makes This Symptom Better? _____

PLEASE USE BACK OF PAGE IF NEEDED

Mark The Areas On Your Body Where You Are Having Symptoms From Your **Work Injury**(ies).

P = Pain **N** = Numbness/Tingling **T** = Tenderness **B** = Burning **R** = Radiating



In The Last **Two Months** Has Your Condition?___ Stayed The Same ___ Improved ___ Worsened
___ Fluctuated But Overall Has Stayed About The Same

If Your Condition Has **Worsened,** Please Explain: _____
_____

If Your Condition **Continues To Improve,** Please Explain: _____
_____

Do You Feel That Your Condition Will Improve With Time? ___ YES ___ NO Please Explain:
_____
_____

Before This Work Injury, How Would You Describe Your Health? ___ Excellent ___ Good ___ Fair
Or ___ Poor If 'Fair' Or 'Poor', Please Explain: _____

JOB DESCRIPTION:

What Is Your Job Title? **(AT THE TIME OF YOUR INJURY)**: _____
Describe The Nature Of Your Work: _____
When Did You Start Working For This Employer? _____
How Many Hours Per Day Do You Normally Work? _____
What Hours Do You Normally Work? _____
How Many Days Per Week Do You Work? _____ How Many Days In A Row? _____
How Long Is Your Lunch Break? _____ How Long Are Your Rest Breaks? _____
How Many Rest Breaks Do You Get In A Normal Work Shift? _____
What Percent Of Your Work Day Do You Work Indoors? _____ % Outdoors? _____ %

At Work, How Many <u>Hours</u> Per Day Do You Do These Activities?

Leave Blank If It Doesn't Apply.

If Done Continuously, Circle.

___ Sit	___ Walk	___ Stand	___ Kneel
___ Squat	___ Climb	___ Bend	___ Twist
___ Reach	___ Crawl	___ Push	___ Pull
___ Keyboard	___ Type	___ Mouse	___ Write
___ Finger	___ Grasp		
___ Work Overhead			
___ Flex/Twist/Side-Bend/Extend Your Neck			

Please List Your Job Duties/Activities At Work: (WHEN YOU WERE INJURED)

_____
_____
_____

What Type Of Surface(s) Do You Work On? _____

	Objects Lifted	Weight In Pounds	Times Per Day	Distance Carried/Feet
1)	_____	_____	_____	_____
2)	_____	_____	_____	_____
3)	_____	_____	_____	_____
4)	_____	_____	_____	_____

Do You Have To Bend Over Or Lean Forward While Lifting? ___ YES ___ NO

Are You Able To Lift The Same Amount Of Weight Now, As Before The Injury? ___ YES ___ NO
If 'NO', Please Explain What You Could Lift Before And What You Can Lift Now: _____
_____

Does Your Job Require You To Reach Below, Above Or At Shoulder Level? ___ YES ___ NO
If 'YES', Please Explain: _____

Are You Required To Move Your Feet In A Repetitive Movement/Activity? ___ YES ___ NO
If 'YES', Please Describe: _____

Are You Required To Use Your Hands For Fine Manipulation, Grasping, Pushing, Pulling, Torquing?
___ YES ___ NO If 'YES', Please Describe: _____

Are You Exposed To Dust, Gas, Fumes, Vapors, Noise, Or Extreme Temperatures Or Humidity?
___ YES ___ NO If 'YES', Please Explain: _____

Are You Required To Work At Heights Or Walk On Uneven Ground? ___ YES ___ NO If 'YES', Please Describe: _____

Are You Required to Drive Vehicles Or Work Near Hazardous Equipment? ___ YES ___ NO
If 'YES', Please Describe: _____

Do You Have Any Special Seeing/Visual Or Hearing Requirements? ___ YES ___ NO If 'YES', Please Describe: _____

Are You Able To Perform Your Normal *Work Duties*? ___ YES ___ NO **If 'NO', Please Explain What Activities You Can't Do, Or Have Difficulty Performing:** _____
_____

WORK HISTORY:

Did You Have **More Than One Employer When You Were Injured?** ___ YES ___ NO
If 'YES', Please List The Employer(s), And The Activities Required At That Employment?
_____
_____

If 'YES', Did The Other Employment/Activities Listed Above **Contribute To, Or Further Worsen Your Condition?** ___ YES ___ NO If 'YES', Please Explain How? _____
_____

Please List All Of **Your Previous Employers:** (i.e., Before Your Current Work Injury Occurred)

	Employer	Dates Of Employment	Job Title/Duties
A)	_____	_____	_____
B)	_____	_____	_____
C)	_____	_____	_____
D)	_____	_____	_____

Are You Still Working For The *Same Employer* Where Your Work Injury Occurred? ___ YES ___ NO
If 'NO', Answer The Questions Below. **If 'YES',** Skip The Following Questions And Go To The Next Section Entitled **'PAST MEDICAL HISTORY.'**

Why Aren't You Working For The Same Employer Now? _____
_____

When Did You Stop Working For The Same Employer? _____

If You Are Not Working For The Same Employer As When You Were Injured, **Please List Your Employment Since Leaving:** ___ I Have Not Worked Since Leaving That Employment

	Employer	Dates Of Employment	Job Title/Duties
A)	_____	_____	_____
B)	_____	_____	_____
C)	_____	_____	_____
D)	_____	_____	_____

Who Is Your **Current Employer(s)**? _____
Are You Doing The Same Type Of Work? ___ YES ___ NO
If 'NO', Describe The Type Of Work You Are Doing Now, Including Details On Physical Activity:
_____
_____

Has Any **NEW** Job Or Employment **Contributed To, Or Further Worsened Your Condition?**
___ YES ___ NO If 'YES', Please Name The Employer(s) And Explain How?
_____
_____

Are You Going To Be **Retrained For Another Job/Occupation** As A Result Of This Work Injury?
___ YES ___ NO ___ I DO NOT KNOW ___ RECOMMENDED Please Describe:
_____

PAST MEDICAL HISTORY:

Please List Information Below With Approximate Dates. **Leave Blank If Denied.**

Childhood Illnesses/Injuries: _____
Allergies: _____ Medications: _____
Surgeries: _____ Adult Illnesses: _____

FAMILY HISTORY:

List Any Health Problems In **Your Immediate Family**: (Mother, Father, Brother, Sister)
_____

REVIEW OF SYSTEMS:

Please List Any Problems That You **Now Have** With The Following Body/Organ Systems:

Ears/Nose/Throat: _____ Eyes: _____
Lungs: _____ Liver: _____
Stomach/Intestines: _____ Kidney/Bladder:_____
Reproductive System: _____ Psychological: _____
Neurological: _____ Heart/Circulation: _____

OFF WORK ACTIVITIES:

Do You Exercise? ___ YES ___ NO If 'YES', Please Describe Type & Frequency. If 'NO', Please Explain Why You Don't: _____
Do You Participate In Any Sports Activities? ___ YES ___ NO If 'YES', Please Describe Type & Frequency: _____
Do You Have Any Hobbies? ___ YES ___ NO If 'YES', Please Describe Type & Frequency:
_____
Are You Able To Perform Your Normal/Regular Household Chores/Activities? ___ YES ___ NO
If 'NO', Please Explain What You Cannot Do & Why: _____
_____

SOCIAL HISTORY:

Are You? ( ) Married ( ) Single ( ) Separated ( ) Divorced ( ) Widowed
How Many Years Of Schooling Have You Had? _____
List Degrees, Diplomas, Licenses, Certifications You Hold: _____
Do You Use Alcohol? ___ YES ___ NO If 'YES', How Many Drinks Per Week? _____
Do You Use Tobacco? ___ YES ___ NO If 'YES', What Kind & Times Per Day Or Week?
_____
Do You Use Recreational Drugs? __ YES ___ NO If 'YES', What Kind & How Many Times Per Day Or Week?_____

Injured Worker's Signature: _____ Date: _____

NECK DISABILITY INDEX QUESTIONNAIRE

NAME_____ **AGE**_____ **DATE**_____ **SCORE**_____

PLEASE READ: This questionnaire is designed to enable us to understand how much your neck pain has affected your ability to manage your everyday activities. Please answer each section by circling the ONE CHOICE that most applies to you. We realize that you may feel that more than one statement may relate to you, but ***PLEASE JUST CIRCLE THE ONE CHOICE THAT MOST CLOSELY DESCRIBES YOUR PROBLEM RIGHT NOW.***

SECTION 1 - Pain Intensity A. I have no pain at the moment. B. The pain is very mild at the moment. C. The pain is moderate at the moment. D. The pain is fairly severe at the moment. E. The pain is very severe at the moment. F. The pain is the worst imaginable at the moment.	*SECTION 6 - Concentration/* A. I can concentrate fully when I want to with no difficulty. B. I can concentrate fully when I want to with slight difficulty. C. I have a fair degree of difficulty in concentrating when I want to. D. I have a lot of difficulty in concentrating when I want to. E. I have a great deal of difficulty in concentrating when I want to. F. I cannot concentrate at all.
SECTION 2 -Personal Care (Washing, Dressing, etc.) A. I can look after myself normally without causing extra pain. B. I can look after myself normally, but it causes extra pain. C. It is painful to look after myself and I am slow and careful. D. I need some help, but manage most of my personal care. E. I need help every day in most aspects of self care. F. I do not get dressed, I wash with difficulty and stay in bed.	*SECTION 7 - Work* A. I can do as much work as I want to. B. I can only do my usual work, but no more. C. I can do most of my usual work, but no more. D. I cannot do my usual work. E. I can hardly do any work at all. F. I cannot do any work at all.
SECTION 3 - Lifting A. I can lift heavy weights without extra pain. B. I can lift heavy weights, but it gives extra pain. C. Pain prevents me from lifting heavy weights off the floor, but I can manage if they are conveniently positioned, for example, on a table. D. Pain prevents me from lifting heavy weights, but I can manage light to medium weights if they are conveniently positioned. E. I can lift very light weights. F. I cannot lift or carry anything at all.	*SECTION 8 – Driving* A. I can drive my car without any neck pain. B. I can drive my car as long as I want with slight pain in my neck. C. I can drive my car as long as I want with moderate pain in my neck. D. I cannot drive my car as long as I want because of moderate pain in my neck. E. I can hardly drive at all because of severe pain in my neck. F. I cannot drive my car at all.
SECTION 4 - Reading A. I can read as much as I want to with no pain in my neck. B. I can read as much as I want to with slight pain in my neck. C. I can read as much as I want to with moderate pain in my neck. D. I cannot read as much as I want because of moderate pain in my neck. E. I cannot read as much as I want because of severe pain in my neck. F. I cannot read at all.	*SECTION 9 – Sleeping* A. I have no trouble sleeping. B. My sleep is slightly disturbed (less than 1 hour sleepless). C .My sleep is mildly disturbed (1-2 hours sleepless). D. My sleep is moderately disturbed (2-3 hours sleepless). E. My sleep is greatly disturbed (3-5 hours sleepless). F. My sleep is completely disturbed (5-7 hours)
SECTION 5 – Headaches A. I have no headaches at all. B. I have slight headaches which come infrequently. C. I have moderate headaches which come infrequently. D. I have moderate headaches which come frequently. E. I have severe headaches which come frequently. F. I have headaches almost all the time.	*SECTION 10 – Recreation* A. I am able to engage in all of my recreational activities with no neck pain at all. B. I am able to engage in all of my recreational activities with some pain in my neck. C. I am able to engage in most, but not all of my recreational activities because of pain in my neck. D. I am able to engage in a few of my recreational activities because of pain in my neck. E. I can hardly do any recreational activities because of pain in my neck. F. I cannot do any recreational activities at all.

COMMENTS: _____

_____

_____

Vernon H, Mior S. The Neck Disability Index: A study of reliability and validity. J Manipulative Physiol Ther 1991;14:409-415.

OSWESTRY DISABILITY INDEX 2.0

NAME_____ **DATE**_____ **SCORE**_____

PLEASE READ: Could you please complete this questionnaire. It is designed to give us information as to how your back (or leg) trouble has affected your ability to manage in everyday life.

Please answer ***every section***. Mark ***one box only*** in each section that most closely describes you ***today***.

SECTION 1 - Pain Intensity
- A ☐ I have no pain at the moment.
- B ☐ The pain is very mild at the moment.
- C ☐ The pain is moderate at the moment.
- D ☐ The pain is fairly severe at the moment.
- E ☐ The pain is very severe at the moment.
- F ☐ The pain is the worst imaginable at the moment.

SECTION 2 - Personal Care (washing, dressing, etc.)
- A ☐ I can look after myself normally without causing extra pain.
- B ☐ I can look after myself normally but it is very painful.
- C ☐ It is painful to look after myself and I am slow and careful.
- D ☐ I need some help but manage most of my personal care.
- E ☐ I need help every day in most aspects of self care.
- F ☐ I do not get dressed, wash with difficulty☐ and stay in bed.

SECTION 3 - Lifting
- A ☐ I can lift heavy weights without extra pain.
- B ☐ I can lift heavy weights, but it causes extra pain.
- C ☐ Pain prevents me from lifting heavy weights off the floor, but I can manage if they are conveniently positioned, e.g. on a table.
- D ☐ Pain prevents me from lifting heavy weights, but I can manage light to medium weights if they are conveniently positioned.
- E ☐ I can only lift very light weights, at the most.
- F ☐ I cannot lift or carry anything at all.

SECTION 4 - Walking
- A ☐ Pain does not prevent me from walking any distance.
- B ☐ Pain prevents me from walking more than one mile.
- C ☐ Pain prevents me from walking more than 1/4 mile.
- D ☐ Pain prevents me from walking more than 100 yards.
- E ☐ I can only walk while using a stick or crutches.
- F ☐ I am in bed most of the time and have to crawl to the toilet.

SECTION 5 - Sitting
- A ☐ I can sit in any chair as long as I like.
- B ☐ I can only sit in my favorite chair as long as I like.
- C ☐ Pain prevents me from sitting more than 1 hour.
- D ☐ Pain prevents me from sitting more than 1/2 hour.
- E ☐ Pain prevents me from sitting more than ten minutes.
- F ☐ Pain prevents me from sitting at all.

SECTION 6 - Standing
- A ☐ I can stand as long as I want without extra pain.
- B ☐ I can stand as long as I want but it gives me extra pain.
- C ☐ Pain prevents me from standing for more than 1 hour.
- D ☐ Pain prevents me from standing for more than 1/2 hour.
- E ☐ Pain prevents me from standing for more than 10 minutes.
- F ☐ Pain prevents me from standing at all.

SECTION 7 - Sleeping
- A ☐ My sleep is never disturbed by pain.
- B ☐ My sleep is occasionally disturbed by pain.
- C ☐ Because of pain I have less than 6 hours' sleep.
- D ☐ Because of pain I have less than 4 hours' sleep.
- E ☐ Because of pain I have less than 2 hours' sleep.
- F ☐ Pain prevents me from sleeping at all.

SECTION 8 - Sex Life (if applicable)
- A ☐ My sex life is normal and causes me no extra pain.
- B ☐ My sex life is normal, but causes some extra pain.
- C ☐ My sex life is nearly normal but is very painful.
- D ☐ My sex life is severely restricted by pain.
- E ☐ My sex life is nearly absent because of pain.
- F ☐ Pain prevents any sex life at all.

SECTION 9 - Social Life
- A ☐ My social life is normal and causes me no extra pain.
- B ☐ My social life is normal, but increases the degree of pain.
- C ☐ Pain has no significant effect on my social life apart from limiting my more energetic interests, e.g., sport, etc.
- D ☐ Pain has restricted my social life and I do not go out as often.
- E ☐ Pain has restricted my social life to my home.
- F ☐ I have no social life because of the pain.

SECTION 10 - Traveling
- A ☐ I can travel anywhere without pain.
- B ☐ I can travel anywhere but I gives extra pain.
- C ☐ Pain is bad but I manage journeys over 2 hours.
- D ☐ Pain restricts me to journeys of less than 1 hour.
- E ☐ Pain restricts me to short necessary journeys under 30 minutes.
- F ☐ Pain prevents me from traveling except to receive treatment.

COMMENTS: _____

_____

_____

_____

_____

Roland, M. and J. Fairbank (2000). "The Roland-Morris Disability Questionnaire and the Oswestry Disability Questionnaire." Spine 25(24): 3115-24.

Cancellation Policy/ Missed Appointment

As stated in our Missed Appointment Policy you signed as part of your New Patient Packet, our policy is to take a credit card as security upon your first appointment.

We kindly ask for the courtesy of a **24-hour notification of cancellation** in the event you are unable to show for your appointment. If we do not receive the timely notice, please understand that a non-waivable fee of $30 per half-hour missed will be charged to your account. If you purchased any packages or are subscribed to our wellness program, please understand that failure to give proper 24-hour notice will result in the forfeiture of that session.

This policy ensures that all of our patients have the best opportunity for appointment choice, and that times are not held for patients who will not be showing up. We do our best to consider each individual case, and rest assured **YOUR CARD WILL NOT BE CHARGED** unless the above occurs without reasonable cause.

By signing below, you agree and accept the above-stated policy.

Name:_____

Signature:_____ Date:_____

Parent/Guardian (if Minor):_____

DC Employee Signature:_____

Credit Card Type: V/MC

Credit Card Number:_____

Expiration Date:_____

Name on Card:_____

NOTE: This form will be destroyed by shredding once processed by Dewald Chiropractic.

NOTICE OF PRIVACY PRACTICES

Dewald Chiropractic Inc.
1037 West Ave N
Suite 101
Palmdale, CA 93551
(661)266-3500

Privacy Officer: Thomas E. Dewald
Effective Date: 4/1/2003

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

We understand that your medical information is private and we strive to protect the confidentiality of your medical records. The new federal regulations require that we issue this official notice of our privacy practices. You have the right to the confidentiality of your medical information, and this practice is required by law to maintain the privacy of that information. The practice is required to abide by the terms of the Notice of Privacy Practices currently in effect and to provide notice of its legal duties and privacy practices with respect to the protected health information.
Prior to making important changes to our privacy practices, we will make available on request a revised Notice of Privacy Practices.
This notice will be followed by any health care professional authorized to enter information in your medical record. All employees, staff, and other personnel at this practice who may need access to your information must abide by this Notice. All subsidiaries, business associates, sites and locations of this practice may share medical information with each other for treatment, payment purposes or health care operations described in this notice. Except where treatment is involved, only the minimum necessary information needed to accomplish the task will be used.

HOW WE MAY USE AND DISCLOSE MEDICAL INFORMATION ABOUT YOU

The following categories describe different ways that we may use and disclose medical information without your specific consent or authorization. Examples are provided for each category of uses or disclosures. Not all possible uses or disclosures are listed.

For Treatment: We may use and disclose medical information about you to provide you with medical treatment or services. Example: In treating you for a specific condition, we may need to know if you are allergic to specific drugs that could influence which medication we prescribe for treatment purpose.

For Payment: We may use and disclose medical information about you so that treatment and services you receive from us may be billed and payment may be collected from you insurance, third party or you. Example: We may need to send your protected health information, such as your name, address, office visit date and codes identifying your diagnosis and treatment to your health insurance company for payment.

Health Care Operations: We may use and disclose medical information about you for health care operations to assure that you receive quality care. Example: We may use medical information to review our treatment and services and evaluate the performance of our staff in caring for you.

Other Uses or Disclosures That Can Be Made Without Consent or Authorization
-As required during an investigation by Law enforcement agencies.
-To avert a serious threat to public health and safety
-As required by military command authorities for their medical records
-To workers' compensation or similar programs for processing of claims
-In response to legal proceeding
-To a coroner or medical examiner for identification of body
-If an inmate, to the correctional institution or law enforcement official
-As required by the US Food and Drug Administration (FDA)
-Other healthcare providers' treatment activities
-Other covered entities' healthcare operations activities (to the extent permitted under HIPPA)
-Uses and disclosures required by law
-Uses and disclosures in domestic violence or neglect situations
-Health Oversight activities
-We may contact you to provide appointment reminders of information about treatment alternatives or other health related benefits and services that may be of interest to you.

(over)

Uses and Disclosures of Protected Health Informational Requiring Your Written Authorization:
Other uses and disclosures of medical information not covered by this notice or the laws that apply to us will be made only with your written authorization. If you give us authorization to use or disclose medical information about you, you may revoke that authorization, in writing, at any time. If you revoke your authorization, we will thereafter no longer use or disclose medical information about you about you for the reasons covered by your written authorization. You understand that we're unable to take back any disclosures we have already made with your authorization, and that we are required to retain our records of the care we have provided you.

YOUR INDIVIDUAL RIGHT REGARDING YOUR MEDICAL INFORMATION

Complaints: If you believe your privacy rights have been violated, you may file a complaint with the Privacy Officer at this practice or with the Secretary of the Department of Health and Human Services.
All complaints must be submitted in writing. You will not be penalized or discriminated against for filing a complaint.

Right to request Restrictions: You have the right to request a restriction or limitation on the medical information we use or disclose about you for your treatment, payment or health care operations or to someone who is involved with or in your care or the payment for your care. We are not required to agree to your request. If we do agree, we will comply with your request unless the information is needed to provide you with emergency treatment. To request restriction you must submit your request in writing to the Privacy Officer at the practice. In your request, you must tell us what information you want limited.

Right to request Confidential Communications: You have the right to request how we should send communications to you about medical matters, and where you would like those communications sent. To request confidential communications, you must make your request in writing to the Privacy Officer at this practice. We will not ask you the reason for your request. We will accommodate all reasonable requests. Your request must specify how or where you wish to be contacted. We reserve the right to deny a request if it imposes an unreasonable burden on the practice.

Right to Inspect and Copy: You have the right to inspect and copy medical information that may be used to make decisions about your care. Usually this includes medical and billing records but does not include psychotherapy notes, information compiled for use in a civil, criminal or administrative action or proceeding and protected health information to which access is prohibited by law. To inspect and copy medical information that may be used to make decisions about you, you must submit your request in writing to the Privacy Officer at this practice. If you request a copy of the information, we reserve the right to charge a fee for he costs of copying, mailing or other supplies associated with your request. We may deny your request to inspect and copy in certain very limited circumstances. If you are denied access to medical information, you may request that denial be reviewed. Another licensed healthcare professional chosen by this practice will review your request and the denial. The person conducting the review will not be the person who denied your request. We will comply with the outcome of the review.

Right to a Paper Copy of This Notice: You have the right to a paper copy of this Notice at any time. Even if you have agreed to receive this notice electronically, you are still entitled to a paper copy. To obtain a paper copy of the current Notice, please request on in writing from the Privacy Officer at this practice.

Right to Amend: If you feel the medical information we have about you is incorrect or incomplete, you may ask us to amend the information. You have the right to request an amendment for as long as the information is kept. To request an amendment, your request must be made in writing and submitted to the Privacy Officer at this practice. In addition you must provide a reason that supports your request. We may deny your request for an amendment if it is not in writing or does not include a reason to support the request. In addition, we may deny your request if the information was not created by us, is not part of the medical information kept at this practice, is not part of the information which you would be permitted to inspect and copy, or which we deem to be accurate and complete. If we deny your request for an amendment, you have the right to file a statement of disagreement with us. We may prepare a rebuttals to your statement and will provide you a copy of any such rebuttal. Statements of disagreement and any corresponding rebuttals will be kept on file and sent out with any future authorized requests for information pertaining to the appropriate portion of your record.

Changes to This Notice: We reserve the right to change this Notice. We reserve the right to make the revised or changed Notice effective for medical information we already have about you as well as any information we receive in the future. We will post a copy of the current notice, with the effective date in the upper right corner of the first page.

I have read the Privacy Notice and understand my rights contained in the above Notice. By way of my signature, I provide Dewald Chiropractic with my authorization and consent to use and disclose my protected health care information as described above.

_____	_____	_____
Patients Name (**Print**)	Patients/Guardian Signature	Date

Dewald Chiropractic
Office Policies & Consent

Thank you for choosing Dewald Chiropractic, Inc. as your healthcare provider. We are committed to your successful treatment and for your experience with us to be second to none. Please thoroughly review the following office policies and areas of consent prior to your first appointment. For us to provide the best treatment possible for all of our patients, we do require that all policies are agreed to prior to your first visit.

INFORMED CONSENT FOR TREATMENT

I understand that, as with any medical treatment, there are possible side effects associated with chiropractic treatment. These may include, but are not limited to: pain, stiffness, headaches, dizziness, or fatigue. I also understand that although the doctor will examine me to rule out any high-risk situations, there is still a remote chance of paralysis, stroke or even death. To help the doctor with his treatment, I certify that I have filled out the "Patient Information/Questionnaire" truthfully and to the best of my ability, and furthermore I am fully responsible for any errors or omissions.

(Initials) _____

MISSED APPOINTMENTS

When you schedule an appointment with Dewald Chiropractic, we will (as a courtesy to you) send you a reminder text message or email; but it is your responsibility to remember when you schedule your appointments regardless of whether you received said reminder. If for any reason you are unable to make your appointment it is your responsibility to cancel or reschedule at least 24 hours in advance. If you fail to do so you will be charged $30 per every 30 minutes you were scheduled for. Upon your first appointment, we will require a credit card to be kept on file to ensure future payment of missed appointments or appointments that are cancelled/rescheduled without 24 hours prior notice.

(Initials) _____

ASSIGNMENT OF BENEFITS

I, the undersigned verify that I, (or my dependent) have insurance coverage, and hereby assign any benefits paid on my behalf for services rendered, to be paid directly to Dewald Chiropractic, Inc. I hereby authorize Dewald Chiropractic to release all information necessary to secure the payment of benefits. I authorize the use of this signature on all insurance submissions. However, I clearly understand and agree that although insurance billing services are provided as a courtesy, all services rendered to me (or my dependent) are my personal and direct responsibility, as well as any and all co-pays or deductibles which may apply.

(Initials) _____

PATIENT CO-INSURANCE/CO-PAY

I understand that Dewald Chiropractic has agreed to accept the discounted rates from my insurance company, and as such copayments, coinsurances, and deductibles are not negotiable and fully my responsibility to be paid to Dewald Chiropractic. I understand that copayments, coinsurances, and deductibles are agreed upon amounts between myself and my insurance company and that Dewald Chiropractic does not have the authority to increase or decrease the patient responsibility assigned by my agreement with my insurance company.

(Initials) _____

THERAPIST REQUESTS

Often, patients may find that they prefer to be seen by specific therapist for their appointments. Our office does allow requests while scheduling, however due to the increased difficulty in scheduling such appointments there is an additional $5 fee for all requests. This fee will be provided to your therapist as gratuity for your visit. You are welcome to tip your therapist in addition to this $5 fee if you would like, however please do not feel as though you are pressured to do so. Due to this policy, please understand that therapist requests are not available to those who are visiting our office under a Personal Injury or Worker's Compensation claim.

(Initials) _____

COLLECTIONS POLICY

I understand that I am responsible for payment of all deductibles, copayments, and upgrade costs related to my care. I understand that if I have a balance for medical services not paid and am unable to pay the balance “in full”, I will agree to a payment plan specified by Dewald Chiropractic. If my balance is not paid "in full" 60 days after I receive my first bill, and I have not set up an auto-debit, then a $20 late fee will be assessed to my account monthly.

After 3 consecutive months of late fees and non-payments I understand that my account will be sent to collections. I acknowledge that I am responsible for paying any and all collection, court, and attorney fees involved in the collection of my account. I further understand that if my treatment is associated with a personal injury or accident claim, all medical bills will be paid at 100% regardless of the outcome of my case (at the sole discretion of Dewald Chiropractic). I understand that if a check or debit is returned for insufficient funds, I will be charged a $25.00 service charge.

(Initials) _____

I have read & fully understand the above policies.

Patient Name (Print) _____

Patient Signature _____ Date_____

Guardian Signature _____ Date_____

DC Staff Signature _____

DEWALD CHIROPRACTIC
EFFECTIVE HEALTH CARE SOLUTIONS

Patient Informed Consent

Patient Name:_____

To the patient: Please read this entire document prior to signing it. It is important that you understand the information contained in this document. Please ask questions before you sign if there is anything that is unclear.

The Nature of the Chiropractic Adjustment

The primary treatment I use as a Doctor of Chiropractic is spinal manipulative therapy. I will use that procedure to treat you. I may use my hands or mechanical instrument upon your body in such a way as to move your joints. That may cause an audible "pop" or "click", much as you have experienced when you "crack" your knuckles. You may feel a sense of movement.

Analysis / Examination / Treatment

As a part of the analysis, examination, and treatment, you are consenting to the following procedures:

Spinal Manipulative Therapy	Palpation	Vital Signs	Myofascial Release
Range of Motion Testing	Orthopedic Testing	Basic Neuro. Testing	Ultrasound
Muscle Strength Testing	Postural Analysis	EMS	
Hot/Cold Therapy			

×_____

The Material Risks Inherent in Chiropractic Adjustment

As with any healthcare procedure, there are certain complications which may arise during chiropractic manipulation and therapy. These complications include but are not limited to: fractures, disc injuries, dislocations, muscle strain, cervical myelopathy, costovertebral strains, and separations, and burns. Some types of manipulation of the neck have been associated with injuries to the arteries of the neck leading to or contributing to serious complications including stroke. Some patients will feel some stiffness and soreness following the first few days of treatment. I will make every reasonable effort during the examination to screen for contraindications to care; however, if you have a condition that would otherwise not come to my attention, it is your responsibility to inform me.

The Probability of Those Risks Occurring

Fractures are rare occurrences and generally result from some underlying weakness of the bone which I check for during the taking of your history and during examination and X-ray. Stroke has been the subject of tremendous disagreement. The incidences of stroke are exceedingly rare and are estimated to occur between one in one million and one in five million cervical adjustments. The other complications are also generally described as rare.

The Availability and Nature of Other Treatment Options

Other treatment options for your condition include:

- Self-administered, over-the-counter analgesics and rest
- Medical care and prescription drugs such as anti-inflammatory, muscle relaxants and pain-killers
- Hospitalization
- Surgery

If you chose one of the above noted "other treatment" options, you should be aware that there are risks and benefits of such options and you may wish to discuss these with your primary medical physician.

The Risks and Dangers Attendant to Remaining Untreated

Remaining untreated may allow the formation of adhesions and reduce mobility which may set up a pain reaction further reducing mobility. Over time this process may complicate treatment making it more difficult and less effective the longer it is postponed.

DO NOT SIGN UNTIL YOU HAVE READ AND UNDERSTAND THE ABOVE. PLEASE CHECK THE APPROPRIATE BLOCK AND SIGN BELOW

I have read [ ] or have read to me [ ] the above explanation of the chiropractic adjustment and related treatment. I have discussed it with Dr. Dewald and have had my questions answered to my satisfaction. By signing below I state that I have weighed the risks involved in undergoing treatment and have decided that it is in my best interest to undergo the treatment recommended. Having been informed of the risks, I hereby give my consent to that Treatment.

Patient's Name _____ **Signature** _____ **Dated:** _____

Parent or Guardian Name _____

Signature of parent or Guardian _____

Dr. Thomas E. Dewald _____ **Dated:** _____