Preparing for Your First Appointment

Documents to Bring:

- ☐ Chiropractic Intake Forms
- ☐ Driver's license or ID
- ☐ Accident Photos – can be emailed to office: Info@CoreChiropracticSolutions.com
- ☐ Accident Report – if available
- ☐ X-Rays / MRI / Medical Records
- ☐ Med-Pay verification
    - Auto Insurance Declaration Statement
    - Auto Adjuster's Phone # and Claim #
- ☐ Attorney Information – if applicable
- ☐ Third Party Insurance Info.

About your Appointment:

- Allow up to 60 minutes for your first appointment. Please arrive 60 minutes early if you have not already completed your initial paperwork.
- Comfortable athletic clothing is highly recommended. This allows the doctor to properly evaluate injured areas.
- Failure to bring in above documents may delay the initiation of treatment.

Thank you for trusting Core Chiropractic Solutions with your health.

We look forward to meeting you soon!

-Core Chiropractic Solutions

INSTRUCTIONS: Please use sections below to help you complete your forms.

[PAGE: 1]

Medical History Section

- ☐ Please include symptoms you are currently experiencing since the accident + before the accident.

[PAGE: 2]

It is HIGHLY important that you list all symptoms you are experiencing since your accident.

- ☐ Please write down symptoms on separate lines. Sections 1-3. Ex: if you are having back pain, please use section 1. Neck pain with Headaches can go together on section 2. Use section 3 to include pain areas: arms, wrists, hands, legs.

Remember use the sections 1, 2, & 3 in the order of most pain to least pain. Always provide a pain score 1-10, 10 means you are in the hospital. Please use the pain scale attached to help you score your pains. Include how often you experience each symptom.

ADL [activities of daily living]

- ☐ Mark one answer for each line, only if it applies. If it does not apply to you, you can skip that line.
- ☐ Sign this form when finished.

Upper Extremity

- ☐ Complete this form, ONLY if you are having pain in areas: arms, hands, wrists...

Lower Extremity

- ☐ Complete this form, ONLY if you are having pain in the legs, knees, or feet.

Release form for medical records

- ☐ Only a signature is required.
- ☐ Leave blank.

Personal Injury Fee Schedule

- ☐ Please provide your insurance declarations page to help you determine if you have medical coverage under your auto insurance policy.
- ☐ Chiropractic treatments will be under a lien; however, supplies may include a small co-pay if no medical coverage is available to cover expenses.

Patient Name:

Please review & use this pain scale to help you score your pain. Use this scale for your "complaints".

0	No Pain
1	Minimal Pain (Annoyance)
2	Constant Minimal to Intermittent Slight Pain
3	Constant Slight Pain (Some Handicap)
4	Constant Slight to Intermittent Moderate Pain
5	Constant Slight to Frequent Moderate Pain
6	Intermittent Moderate Pain (Marked Handicap)
7	Frequent Moderate Pain
8	Constant Moderate Pain
9	Constant Moderate to Intermittent Severe Pain
10	Constant Severe Pain (Incapacitated)

Signature: _____ Date: _____

Patient Intake Form

Today's Date: _____

Welcome to Stamos Chiropractic Inc. Thank you for taking a moment to fill in our Patient Intake Form. Please fill this form completely and to the best of your knowledge. Be sure to sign the consent and authorization form on page 4 and 5.

Patient Information

Personal Information

First Name: _____
Last Name: _____
Gender: ☐ Female ☐ Male

Date of Birth: _____ Age: _____
Social Security #: _____-_____-_____
Height: _____ Feet _____ Inches
Weight: _____

Marital Status: ☐ Married ☐ Single

Preferred Language: English Spanish Other:_____

Occupation: _____

Referred By: _____

Emergency Contact

Contact Name: _____
Relationship: _____
Phone: _____

Contact Information

Email: _____
Home Phone: _____
Cell Phone: _____

Home Address

Address Line 1 _____
Address Line 2 _____
City: _____
State: _____
Zip/Postal Code: _____

If patient is a minor, Parent/Legal Guardian Contact Information

First Name: _____
Last Name: _____
Phone: _____
Address: _____
City, State _____ _____
Zip Code: _____

Insurance Information

Who is the policy holder? _____
Relationship to Patient: _____
Insurance Company: _____
Policy Number: _____
Primary Policy Holder Information
Date of Birth: _____
Social Security #: _____-_____-_____

Accident Information

Is condition due to an accident? ☐ Yes ☐ No
Date of accident: _____
Type of accident: ☐ Work ☐ Auto ☐ Home ☐ Other _____
To whom have you made a report of your accident? ☐ Auto Insurance ☐ Employer ☐ Workman's Comp ☐ Other _____
Attorney's Name: _____

Current Symptoms

Patient Condition:

1. What is your **worst** complaint?_____
   When and **how** did your condition begin?_____

   Rate your pain/ discomfort on a scale (circle) **None = 0 1 2 3 4 5 6 7 8 9 10 = Severe**

   How often do you experience this complaint (circle) Occasionally (0-25% of the day) Intermittently (26-50% of the day) Frequently (51-75% of the day) Constantly (76-100% of the day)

   How are your symptoms changing? **Improving** **Not Changing** **Worsening**

2. What is your **2nd worst** complaint?_____
   When and **how** did your condition begin?_____

   Rate your pain/ discomfort on a scale (circle) **None = 0 1 2 3 4 5 6 7 8 9 10 = Severe**

   How often do you experience this complaint (circle) Occasionally (0-25% of the day) Intermittently (26-50% of the day) Frequently (51-75% of the day) Constantly (76-100% of the day)

   How are your symptoms changing? **Improving** **Not Changing** **Worsening**

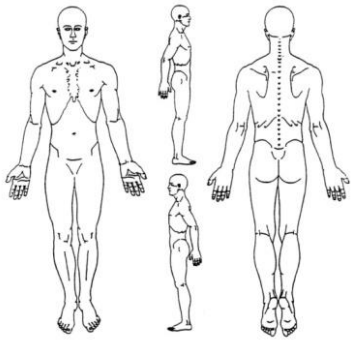
3. Briefly describe any other complaints:_____
   _____

Type of Pain: Circle **Sharp Dull Weakness Numbness Aching Shooting Burning Stiffness Other**

Activities That Are Painful: **Sitting Standing Bending Walking Laying Down**

Does the Pain Interfere with… **Sleep Work School Daily Routine Recreation**

What Treatments Have You Already Received For This Condition? **Medication Surgery Chiropractic Physical Therapy Other_____**



Please indicate on the diagram to the left where you are experecing your symptoms

How were you referred to our office? Flyer( ) Postcard( ) Walk By( ) Other( ) Doctor / Friend( ) Who? _____
Have you ever had chiropractic care before? (YES / NO) If yes, when was your last treatment? _____
Have you ever had a professional massage before? (YES / NO) If yes, when was your last massage? _____
What are your health goals? (Check one of the following)
( ) Reduce symptoms only **( )** Reduce symptoms and show me how to prevent flair-ups **( )** Reduce symptoms, prevent flair-ups and maintenance care

Review of Systems

Name of your family physician _____Last appointment with your physician _____Phone # _____
Do you give us permission to send your medical doctor an updated report on your status? (YES / NO)
Have you been hospitalized in the past? (YES / NO) If yes when and why? _____

Check any of the following symptoms you are currently experiencing or have experienced within the past 6 months.

Musculoskeletal
__Low Back Pain
__Pain Between Shoulders
__Neck Pain
__Headaches
__Arm Pain/Numb/Tingling
__Leg Pain/Numb/Tingling
__Joint Pain/Stiffness
__Walking Problems
__Difficulty Chewing
__Weakness

EENT
__Vision Problems
__Dental Problems
__Sore Throat
__Ear Pain/Ringing
__Hearing Difficulty

General
__Allergies
__Loss of Sleep
__Fever/Night Sweats
__Eczema (skin rash)
__Weight Loss/Gain

Genitourinary
__Bladder Trouble
__Painful Urination
__ Excessive Urination
__Discolored Urine

Male Specific
__Difficulty Urinating
__Impotence
__Sterility

C-V-R
__Chest Pain
__Short of Breath
__Blood Pressure
__Heart Problems
__Wheezing
__Lung Problems
__Varicose Veins
__Arm/Leg Swelling
__Asthma
__High Cholesterol
__Bruise Easily

Female Specific
__Menstrual Irregularity
__Menstrual Cramping
__Sterility
__Breast Pain

ARE YOU PREGNANT? (YES / NO)

Nervous
__Numbness
__Paralysis
__Dizziness
__Forgetfulness
__Confusion
__Depression
__Fainting
__Convulsions
__ADHD/Hyperactivity
__Anxious
__Tremor/Shaking

Gastrointestinal
__Gas/Bloating
__Heartburn
__Poor Appetite
__Excessive Appetite
__Excessive Thirst
__Decreased Appetite
__Colitis
__Vomiting
__Diarrhea
__Constipation
__Black/Bloody Stool
__Liver Problems
__Abdominal Pain
__Frequent Nausea

Past Medical History

Social History

Exercise	Work Activity	Habits	
☐ None	☐ Sitting	☐ Smoking	Packs/Day _____
☐ Moderate	☐ Standing	☐ Alcohol	Drinks/Week _____
☐ Daily	☐ Light Labor	☐ Coffee/Caffeine Drinks	Cups/Day _____
☐ Heavy	☐ Heavy Labor	☐ High Stress Level	Reason _____

Medications	Allergies	Vitamins/Herbs/Minerals
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

Medical History

Car Accidents _____
Falls _____
Head Injuries _____
Broken Bones _____
Surgeries _____
Ongoing Illnesses _____
X-Rays, MRIs & Special Imaging _____

PATIENT SIGNATURE _____ **DATE** _____

Privacy Policy Notice

Consent for the use and/or disclosure of protected health information to carry out treatment, payment and/or health care operations.

Through this consent form, Stamos Chiropratic Inc. is notifying you and you agree that:

1. Protected health information may be used and/or disclosed in order to carry out treatment, payment or health care operations.
2. We will only disclose protected health information with your expressed written authorization.
3. A notice containing the office's privacy practice, including a more complete description of uses and/or disclosure necessary to carry out treatment, payment and/or health care operations, is available for you to read, and you are hereby encouraged to do so prior to signing this consent form.
4. This office reserves their right to change its privacy practices that are described in the above referenced notice, in accordance with applicable law, and will make available to all patients any and all revised and current notices.
5. You have the right to request that this office restrict how protected health information is used and/or disclosed to carry out treatment, payment and/or health operations.
6. You have the right to inspect your records and amend or correct health information.
7. If this office agrees to a requested restriction it will take approximately 30 days to do so.
8. You have the right to revoke this consent, in writing, at any time for all future transactions, with the understanding that any such revocation shall not apply to the extent that this office has already taken action in reliance on this consent.
9. Should you revoke this consent at any time, the office retains the right to refuse treatment based upon the revocation and the future lack of such consent.
10. You will sign and date all consents requested to which you agree.
11. I hereby authorize Stamos Chiropractic Inc./ Dr. Alison Stamos to use and/or disclose health information for the purpose of filing your health insurance claims, consult with other health care providers, and for billling purposes.

I have read and understand the foregoing notice, and all of my questions have been answered to my full satisfaction in a way that I can understand.

_____ _____

Name of Individual (printed) Signature of Individual

_____ _____

Signature of Legal Representative
(Attorney-in-fact, Guardian, Parent of a minor, etc…)

Relationship

Date Signed ____/____/____

_____

Witness – Stamos Chiropractic Inc.

This consent/authorization form will be valid for one year from date of signing.

Consent to Treatment

Chiropractic care, like all forms of health care, while offering considerable benefit may also provide some level of risk. This level of risk is most often very minimal, yet in rare occasions case injury has been associated with chiropractic care. The types of complications that have been reported secondary to chiropractic care include sprain/ strain injuries, irritation of a disk condition and rarely fractures. There are reported cases of stroke associated with visits to medical doctors and chiropractors. Research and scientific evidence does not establish a cause and effect relationship between chiropractic treatment and the occurrence of stroke: rather, recent studies indicate that patients may be consulting medical doctors and chiropractors when they are in the early stages of stroke. In essence, there may be a stroke already in progress. However, you are being informed of this reported association because a stroke may cause serious neurological impairment or even death. The possibility of such injuries occurring in association with an upper cervical adjustment is extremely remote.

If deemed necessary the use of Rock Tape will be used, this may cause skin irritation or even a rash. If you have a skin condition, please notify the doctor.

I understand and agree that health/ accident insurance policies are an arrangement between an insurance carrier and me. I understand that fees for professional services will become immediately due upon suspension or termination of my care or treatment.

Prior to receiving chiropractic care in this office, a health history and physical examination will be completed. These procedures are performed to assess your specific condition, your overall health, and in particular, your spinal health. These procedures will assist us in determining if chiropractic care is needed, or if any further examinations or studies are needed before treatment. In addition, they will help us to determine if there is any reason to modify your care or provide you with a referral to another health care provider.

I understand and agree that all services rendered will be charged to me, and I am responsible for timely payment of such services.

I also understand and accept that there are risks associated with chiropractic care and give my consent to the examinations that the doctor deems necessary, and to the chiropractic care including chiropractic adjustments and other modalities as reported following my assessment.

I certify that I am the patient or legal guardian listed below. I have read/ understand the included information and certify it to be true and accurate to the best of my knowledge.

_____ _____

Patient Name (printed) Signature of Patient or Legal Guardian

_____ _____

Patient's Legal Guardian (printed) Relationship

Date Signed ____/____/____ _____

Witness – Stamos Chiropractic Inc.

OFFICE POLICIES / PROCEDURES AGREEMENT AND CUSTOMARY FEE SCHEDULE

FINANCIAL ARRANGEMENTS

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

INSURANCE BILLING/PAYMENT

Patients are ultimately fully responsible for services provided by our office. For your convenience, our office will make an effort to verify your insurance benefits. However, please note that verification of benefits is not guaranteed. Your insurance company makes the final determination of insurance benefits when they consider the claim. Patients are fully responsible for payment of services not authorized or covered by their insurance company. Patients that are represented by an attorney in PI cases must notify our office the same day if changing or canceling representation.

PAYMENT ARRANGEMENTS

We understand that occasions arise when it may be necessary for you to request to be billed rather than pay at the time of service. This may include setting up a payment plan for those who may require extensive treatments. Payment is due within 30 days of the service rendered. If there are legitimate financial problems, please discuss them with our office manager prior to the 30 days so that we may find a workable solution. If an account is not paid within 30 days and no payment arrangements have been made, you will be responsible for legal fees, collection agency fees, and any other expenses incurred in collecting your account. You will also be charged a monthly interest of 10% based off your principal balance until all fees are paid.

APPOINTMENT SCHEDULING

Canceling or rescheduling appointments requires a 24 hour notice otherwise you will be charged a fee for the missed scheduled service.

NOTICE OF PRIVACY POLICY

We are required by law to make sure your medical information is protected; give you notice describing our legal duties and privacy practices with respect to medical information about you; and follow the terms of the notice that is currently in effect. By signing below you are acknowledging that you have received our Notice of Privacy Policy.

NOTICE OF PRIVATE PRACTICES/ BUSINESSES

There are separate practices/ businesses within this office. Each entity is owned and operated as separate businesses and may have separate fee schedules, different treatment techniques and patient management. I understand that each service offered at this facility are owned and operated as separate businesses and hold each business harmless from any act or omission which may occur by any of the other businesses during the course of my treatment at this facility. Circumstances may arise such as emergencies, or doctor vacation or sick leave and you may request to be treated by another doctor within this office. If you are treated by another doctor you may be charged a different fee. Please consult with our office manager before your treatment if you have any questions.

CURRENT CUSTOMARY FEE SCHEDULE OF OUR MOST COMMON FEES

You may request a statement or receive an insurance explanation of benefits (EOB) which will reflect services provided and the associated insurance billing codes which are shown below. If you have any questions about your EOB or bill please discuss them with our office manager. These fees may change without notice. We will provide a copy of this form if requested.

Initial Exam	99201	Limited	$70.00	**Re-Exam**	99211	Minimal	$30.00	
(New Patient)	99202	Expanded	$120.00	*(Established Patient)*	99212	Limited	$70.00	
	99203	Detailed	$165.00	*(Treated within 3 years)*	99213	Expanded	$115.00	
	99204	Comprehensive	$255.00		99214	Detailed	$170.00	
Range of Motion	95851	$50.00		**Muscle Testing**	95831	$50.00	**Physical Performance Testing**	97750 $50.00
Chiropractic Adjustments	98940	$45.00	1-2 regions	**Manual Therapies**	97140	$50.00		
	98941	$65.00	3-4 regions				**Electrical Muscle Stimulation**	97014 $25.00
	98942	$80.00	5 regions	**Therapeutic Exercises**	97110	$50.00 / Unit		
	98943	$40.00	Extremities					
				Therapeutic Activities	97530	$55.00 / Unit	**Ultrasound**	97035 $20.00
Massage	97124	$40.00 / Unit						
	Ex. 30 min = $80.00			**Mechanical Traction**	97012	$25.00	**Neuromuscular Ed**	972112 $55.00

X-Rays	**Cervical Spine**			**Thoracic Spine**			**Lumbar Spine**	
	72040	$90.00	2-3 views	72070	$90.00	2 views	72100 $100.00	2-3 views
	72050	$125.00	4 views	72072	$105.00	3 views	72110 $125.00	4 views
	72052	$150.00	5 views	All X-ray fees are not listed such as extremities. Ask the front desk for these fees.				

_____ PRINT NAME

_____ SIGNATURE

_____ DATE

Stamos Chiropractic Inc.—4 10 S. Melrose Dr. Ste. 200 Vista, CA 92081—Ph: 760.630.0683 Fax: 760.630.7715

Stamos Chiropractic Inc.

Acknowledgement of Receipt of Notice of Privacy Practices

This form will be retained in your medical record.

NOTICE TO PATIENT

We are required to provide you with a copy of our Notice of Privacy Practices, which states how we may use and/or disclose your health information. Please sign this form to acknowledge receipt of the Notice.

Patient Name:_____ **Date of Birth:**_____

I acknowledge that I have **received and had the opportunity to review** the Notice of Privacy Practices on the date below on behalf of **Stamos Chiropractic Inc.**

I understand that the Notice describes the uses and disclosures of my protected health information by **Stamos Chiropractic Inc.** and informs me of my rights with respect to my protected health information.

Patient's Signature or that of Legal Representative

Printed Name of Patient or that of Legal Representative

Today's Date

If Legal Representative, Indicate Relationship

FOR OFFICE USE ONLY

We have made every effort to obtain written acknowledgment of receipt of our Notice of Privacy from this patient but it could not be obtained because:

- ☐ The patient refused to sign.
- ☐ Due to an emergency situation it was not possible to obtain an acknowledgement
- ☐ Communications barriers prohibited obtaining the acknowledgement
- ☐ Other (please specify):_____

_____

Employee Name

Today's Date

ACCIDENT / INJURY QUESTIONS

Patient: _____ **Date:** _____

Date of Accident: ___ / ___ / ____ **Time of Accident:** ___: ____ **AM / PM** **Place (City/State):** _____

What was the cause of your Accident / Injury? **(Circle)** **Automobile Accident** **Work Injury** **Slip/Fall**

Describe in your own words what happened: _____

_____

_____

How did you feel immediately after the accident? (eg. Confused, dazed, dizzy, nervous, scared, nausea, etc…)

_____

Where did you immediately develop pain following the accident? _____

_____

Are there additional symptoms that developed hours, days or weeks after the accident? (eg. Headaches, tingling…)

_____

EMERGENCY CARE

Did you receive any medical care at the scene of the accident? (eg. Paramedics) **(YES / NO)**

Have you been to the hospital for this accident? **(YES / NO)** If yes, what hospital? _____Date: _____

Were you taken to the hospital by ambulance? **(YES / NO)** Other: _____

Please list the areas of your body where (**X-Rays / CT / MRI)** were taken: _____

Have you been prescribed any medications for this accident? **(YES / NO)** List: _____

List ***any other Doctors' names and specialties with appointment dates*** you have seen for this accident?

_____

AUTOMOBILE ACCIDENT

What ***year and type*** of automobile were you driving? _____Your approximate speed: ____ MPH

What parts of your vehicle were struck during the collision? _____

If struck by another vehicle, what type of vehicle was it? _____Approximate speed: ____ MPH

What was the total damage estimate of your vehicle? **$**_____ Vehicle Totaled: **(YES / NO)**

Did the police arrive at the scene and was a report of the accident taken? **(YES / NO)**

Were you wearing your seatbelt? **(YES / NO)** Did the airbags deploy? **(YES / NO)**

Did you strike your head? **(YES / NO)** If yes, circle what your head hit: **Headrest, Airbag, Steering Wheel, Window, Other**

Did you strike any other body part? (eg. Knees against dashboard, etc…) **(YES / NO)** _____

Did you expect the vehicle was going to hit you? **(YES / NO)** Were you able to brace yourself? **(YES / NO)**

Was your head turned **(Right or Left)**, or looking **(Up or Down)** at the time of the impact? _____

Did you lose consciousness? **(YES / NO)** If yes, how long would you estimate you were out? _____

Patient Signature: _____ **Doctor Signature:** _____

Patient's Name: _____ Date of Injury: _____ Today's Date: _____

Documenting Your Airbag Deployment Injuries

According to the history you have provided us, your recent motor vehicle collision caused your airbag supplemental restraint system to deploy. Because of the potential for serious injuries resulting from such an event, it is important that you complete the following form to the best of your recollection. Thank you for your assistance.

A. Within moments after the time of impact, did you: ***(circle all that apply)***

1. Black-out (lose consciousness)? If so, for approximately how long were you unconscious? _____
2. Become significantly disoriented? If so, for approximately how long were you disoriented? _____
3. Experience any nose bleeds, cuts, abrasions, bruises or burns? If so, please detail: _____
4. Have double-vision and/or blurred vision? If so, for how long? _____
5. Experience hearing loss or ringing in the ears? If so, for how long? _____
6. Experience jaw pain, facial numbness/tingling? If so, for how long? _____

Comments: _____

_____

B. At any point *after* the impact, did you experience any of the following symptoms? (*circle all that apply)*

Suspected Brain Trauma

1. Nausea
2. Vertigo/dizziness/lightheadedness
3. Neck pain/stiffness
4. Headache
5. Photophobia (sensitivity to light)
6. Phonophobia (sensitivity to loud noises)
7. Tinnitus (ringing in the ears)
8. Impaired memory
9. Difficulty concentrating
10. Impaired comprehension or awareness
11. Prolonged, unexplained staring
12. A feeling of having a "brain fog"
13. Forgetfulness
14. Impaired logical thinking
15. Difficulty with new or abstract concepts
16. Insomnia (difficulty sleeping)
17. Fatigue
18. Apathy
19. Outburst of anger
20. Mood swings
21. Depression
22. Loss of libido (sex drive)
23. Personality change
24. Intolerance to alcohol

Suspected TMD

25. Clicking in the jaw
26. Popping in the jaw
27. Locking of the jaw
28. Side shift of the jaw upon maximum opening
29. Inability to open the mouth wide
30. Pain on chewing
31. Facial pain
32. Grinding your teeth
33. Jaw muscles sore upon waking
34. Chewing on one side of your mouth
35. Painful teeth
36. Loose teeth
37. Very tender muscles in the front of the neck
38. Painful swallowing
39. Difficulty swallowing

Misc.

40. Intolerance to strong odors
41. Decreased ability to smell things
42. Decreased ability to taste foods/drinks
43. Vision changes

Comments:

_____

_____

_____

C. If any of the above symptoms were present before the motor vehicle collision, please list them below. Be sure to also identify their intensity, approximate date of onset, and their duration.

_____

_____

_____

_____

_____

_____

BACK BOURNEMOUTH QUESTIONNAIRE

Patient Name _____ Date _____

Instructions: The following scales have been designed to find out about your back pain and how it is affecting you. Please answer ALL the scales, and mark the ONE number on EACH scale that best describes how you feel.

1. Over the past week, on average, how would you rate your back pain?

No pain — Worst pain possible

0 1 2 3 4 5 6 7 8 9 10

2. Over the past week, how much has your back pain interfered with your daily activities (housework, washing, dressing, walking, climbing stairs, getting in/out of bed/chair)?

No interference — Unable to carry out activity

0 1 2 3 4 5 6 7 8 9 10

3. Over the past week, how much has your back pain interfered with your ability to take part in recreational, social, and family activities?

No interference — Unable to carry out activity

0 1 2 3 4 5 6 7 8 9 10

4. Over the past week, how anxious (tense, uptight, irritable, difficulty in concentrating/relaxing) have you been feeling?

Not at all anxious — Extremely anxious

0 1 2 3 4 5 6 7 8 9 10

5. Over the past week, how depressed (down-in-the-dumps, sad, in low spirits, pessimistic, unhappy) have you been feeling?

Not at all depressed — Extremely depressed

0 1 2 3 4 5 6 7 8 9 10

6. Over the past week, how have you felt your work (both inside and outside the home) has affected (or would affect) your back pain?

Have made it no worse — Have made it much worse

0 1 2 3 4 5 6 7 8 9 10

7. Over the past week, how much have you been able to control (reduce/help) your back pain on your own?

Completely control it — No control whatsoever

0 1 2 3 4 5 6 7 8 9 10

_____
Examiner

OTHER COMMENTS: _____

With Permission from: Bolton JE, Breen AC: The Bournemouth Questionnaire: A Short-form Comprehensive Outcome Measure. I. Psychometric Properties in Back Pain Patients. *JMPT* 1999; 22 (9): 503-510.

NECK BOURNEMOUTH QUESTIONNAIRE

Patient Name _____ Date _____

Instructions: The following scales have been designed to find out about your neck pain and how it is affecting you. Please answer ALL the scales, and mark the ONE number on EACH scale that best describes how you feel.

1. Over the past week, on average, how would you rate your neck pain?

No pain — Worst pain possible

0 1 2 3 4 5 6 7 8 9 10

2. Over the past week, how much has your neck pain interfered with your daily activities (housework, washing, dressing, lifting, reading, driving)?

No interference — Unable to carry out activity

0 1 2 3 4 5 6 7 8 9 10

3. Over the past week, how much has your neck pain interfered with your ability to take part in recreational, social, and family activities?

No interference — Unable to carry out activity

0 1 2 3 4 5 6 7 8 9 10

4. Over the past week, how anxious (tense, uptight, irritable, difficulty in concentrating/relaxing) have you been feeling?

Not at all anxious — Extremely anxious

0 1 2 3 4 5 6 7 8 9 10

5. Over the past week, how depressed (down-in-the-dumps, sad, in low spirits, pessimistic, unhappy) have you been feeling?

Not at all depressed — Extremely depressed

0 1 2 3 4 5 6 7 8 9 10

6. Over the past week, how have you felt your work (both inside and outside the home) has affected (or would affect) your neck pain?

Have made it no worse — Have made it much worse

0 1 2 3 4 5 6 7 8 9 10

7. Over the past week, how much have you been able to control (reduce/help) your neck pain on your own?

Completely control it — No control whatsoever

0 1 2 3 4 5 6 7 8 9 10

_____
Examiner

OTHER COMMENTS: _____

With Permission from: Bolton JE, Humphreys BK: The Bournemouth Questionnaire: A Short-form Comprehensive Outcome Measure. II. Psychometric Properties in Neck Pain Patients. *JMPT* 2002; 25 (3): 141-148.

HEADACHE DISABILITY INDEX

Patient Name _____ Date _____

INSTRUCTIONS: 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" to each item. Answer each question as it pertains to your headache only.

YES	SOMETIMES	NO		
____	____	____	E1.	Because of my headaches I feel handicapped.
____	____	____	F2.	Because of my headaches I feel restricted in performing my routine daily activities.
____	____	____	E3.	No one understands the effect my headaches have on my life.
____	____	____	F4.	I restrict my recreational activities (eg, sports, hobbies) because of my headaches.
____	____	____	E5.	My headaches make me angry.
____	____	____	E6.	Sometimes I feel that I am going to lose control because of my headaches.
____	____	____	F7.	Because of my headaches I am less likely to socialize.
____	____	____	E8.	My spouse (significant other), or family and friends have no idea what I am going through because of my headaches.
____	____	____	E9.	My headaches are so bad that I feel that I am going to go insane.
____	____	____	E10.	My outlook on the world is affected by my headaches.
____	____	____	E11.	I am afraid to go outside when I feel that a headaches is starting.
____	____	____	E12.	I feel desperate because of my headaches.
____	____	____	F13.	I am concerned that I am paying penalties at work or at home because of my headaches.
____	____	____	E14.	My headaches place stress on my relationships with family or friends.
____	____	____	F15.	I avoid being around people when I have a headache.
____	____	____	F16.	I believe my headaches are making it difficult for me to achieve my goals in life.
____	____	____	F17.	I am unable to think clearly because of my headaches.
____	____	____	F18.	I get tense (eg, muscle tension) because of my headaches.
____	____	____	F19.	I do not enjoy social gatherings because of my headaches.
____	____	____	E20.	I feel irritable because of my headaches.
____	____	____	F21.	I avoid traveling because of my headaches.
____	____	____	E22.	My headaches make me feel confused.
____	____	____	E23.	My headaches make me feel frustrated.
____	____	____	F24.	I find it difficult to read because of my headaches.
____	____	____	F25.	I find it difficult to focus my attention away from my headaches and on other things.

OTHER COMMENTS: _____

_____
Examiner

With permission from: Jacobson GP, Ramadan NM, et al. *The Henry Ford Hospital headache disability inventory (HDI)*. Neurology 1994;44:837-842.

LOWER EXTREMITY FUNCTIONAL SCALE

We are interested in knowing whether you are having any difficulty at all with the activities listed below because of your lower limb problem for which you are currently seeking attention.

Please Circle an Answer for Each Activity

TODAY, do you or would you have any difficulty at all with:

	ACTIVITIES	Unable to Perform Activity	Severe Difficulty	Moderate Difficulty	Mild Difficulty	No Difficulty
1	Any of your usual work, housework, school activities	4	3	2	1	0
2	Your usual hobbies, recreational or sporting activities	4	3	2	1	0
3	Getting into or out of the bath	4	3	2	1	0
4	Walking between rooms	4	3	2	1	0
5	Putting on your shoes or socks	4	3	2	1	0
6	Squatting	4	3	2	1	0
7	Lifting an object, like a bag of groceries from the floor	4	3	2	1	0
8	Performing light activities around your home	4	3	2	1	0
9	Performing heavy activities around your home	4	3	2	1	0
10	Getting into or out of a car	4	3	2	1	0
11	Walking 2 blocks	4	3	2	1	0
12	Walking a mile	4	3	2	1	0
13	Going up or down 10 stairs (about 1 flight of stairs)	4	3	2	1	0
14	Standing for 1 hour	4	3	2	1	0
15	Sitting for 1 hour	4	3	2	1	0
16	Running on even ground	4	3	2	1	0
17	Running on uneven ground	4	3	2	1	0
18	Making sharp turns while running fast	4	3	2	1	0
19	Hopping	4	3	2	1	0
20	Rolling over in bed	4	3	2	1	0
	Column Totals:					

SCORE: _____/80 = _____

NAME: _____ **DATE:** _____

FOR CLINICIAN: Lower Extremity Functional Scale Measurement Properties
LEFS is scored via summation of all responses (one answer per section) and compared to a total possible score of 80
Error +/- 5 points: an observed score is within 5 points of patients "true" score
Minimum detectable change (MDC); 9 points; change of more than 9 points on the LEFS represents a true change
Minimum clinically important difference (MCID): 9 points; Clinicians can be reasonably confident that a change of greater than 9 points is..a clinically meaningful functional change.

Upper Extremity Functional Scale

We are interested in knowing whether you are having any difficulty at all with the activities listed below because of your upper limb problem for which you are currently seeking attention. Please check (√) an answer for **each** activity.

Today, do you or would you have any difficulty at all with:

Activities	Extreme Difficulty Or Unable to Perform Activity	Quite a Bit of Difficulty	Moderate Difficulty	A Little Bit of Difficulty	No Difficulty
Any of your usual work, household, or school activities					
Your usual hobbies, recreational or sporting activities					
Lifting a bag of groceries to waist level					
Lifting a bag of groceries above your head					
Grooming your hair					
Pushing up on your hands (e.g., from bathtub or chair)					
Preparing food (e.g., peeling, cutting)					
Driving					
Vacuuming, sweeping, or raking					
Dressing					
Doing up buttons					
Using tools or appliances					
Opening doors					
Cleaning					
Tying or lacing shoes					
Sleeping					
Laundering clothes (e.g., washing, ironing, folding)					
Opening a jar					
Throwing a ball					
Carrying a small suitcase with your affected limb)					

Stratford P, Binkley JM, Stratford POW. Development and initial validation of the upper extremity functional index. Physiotherapy Canada Fall 2001;259-266, 281.

Patient name: _____ Signature: _____ Date: _____

Score _____/80 MDC (minimum detectable change) = 9 pts Error +/- 5 scale points

ADL (ACTIVITIES OF DAILY LIVING & FUNCTIONAL ASSESSMENT)

Patient Name: _____ **Date of Injury:** _____ **Date:** _____

Instructions: Please check the activities that currently bother you. Only check one box from each column.

ACTIVITY	ANNOYS ME ONLY	SLOWS ME DOWN	HARD TO PERFORM	UNABLE TO PERFORM
Bending head and neck				
Turning head and neck				
Bending waist – lower back				
Twisting waist – lower back				
Sitting				
Standing				
Walking				
Driving a car				
Riding a bicycle				
Reaching hands over head or shoulder level				
Household chores / cleaning / vacuuming etc.				
Combing / Brushing hair / Bathing				
Typing on a keyboard / Using home computer				
Carrying objects in hand				
Gripping objects or using wrists or hands				
Sleeping / Lying in bed				
Recreational or hobby activities				
Running or jogging				
Sports activities				
Yard work / Gardening etc.				
Using cell phone or tablet				
Crouching or squatting				
Kneeling				
Pushing or pulling with arms /hands				
Reading or Writing				
Dressing myself				
Playing with my children				
Going up or down stairs				
I have pain sitting and doing nothing				
Participating in sexual activity				
SCORE 30 Total Choices				
	(0-25%)	**(26-50%)**	**(51-75%)**	**(76-100%)**

Patient Signature: _____

Office Notes: ADL Total ____ **/ 30** _____

_____

_____ **Doctor Signature:** _____

Symptoms

Patient _____ Date _____ Date of Injury _____

Please fill in all symptoms you currently have <u>that you did not have</u> before the accident.

Orthopedic & Musculoskeletal Symptoms

- ☐ "Clunk" sound with neck movements
- ☐ Neck pain
- ☐ Upper back pain
- ☐ Low back pain
- ☐ Shoulder pain ☐ Left ☐ Right
- ☐ Upper arm pain ☐ Left ☐ Right
- ☐ Elbow pain ☐ Left ☐ Right
- ☐ Forearm pain ☐ Left ☐ Right
- ☐ Wrist pain ☐ Left ☐ Right
- ☐ Hand pain ☐ Left ☐ Right
- ☐ Hip pain ☐ Left ☐ Right
- ☐ Upper leg pain ☐ Left ☐ Right
- ☐ Knee pain ☐ Left ☐ Right
- ☐ Lower leg pain ☐ Left ☐ Right
- ☐ Ankle pain ☐ Left ☐ Right
- ☐ Foot pain ☐ Left ☐ Right
- ☐ Jaw pain
- ☐ Clicking in Jaw
- ☐ Pain when chewing
- ☐ Face pain
- ☐ Chest pain
- ☐ Stomach pain
- ☐ Bruise to _____
- ☐ Scrape/Cut to _____
- ☐ Other Symptom _____
- ☐ Other Symptom _____

Neurological Symptoms

- ☐ Numb/Tingling Arm / Hand L R
- ☐ Numb/Tingling Leg / Foot L R
- ☐ Weakness Arm / Hand L R
- ☐ Weakness Leg / Foot L R

Symptoms Associated with Injuries

- ☐ Stiffness or limited movement in joint(s)
- ☐ Headaches
- ☐ Muscle spasms/sore muscles
- ☐ Dizziness, lightheaded, woozy feeling
- ☐ Visual disturbances or vision change
- ☐ Sleep changes/disruption of patterns
- ☐ Pain radiates from one place to another
- ☐ Anxiety or nervous when driving
- ☐ Irregular Heartbeat or uneven pulse
- ☐ Feeling depressed about things
- ☐ I am taking the following medications _____

_____

Brain/Neuropsych/MTBI/PTSD Symptoms

- ☐ I prefer being alone now (not socializing)
- ☐ I am sleepy, tired during day or doze off easily
- ☐ Upset stomach, nausea, heartburn or vomiting
- ☐ Difficulty concentrating, mind wanders easily
- ☐ I get overwhelmed easily
- ☐ Mood swings, happy one moment then sad
- ☐ Agitation (can't sit still, need to move around)
- ☐ Sadness, tearful episodes, crying easily
- ☐ Blurry vision, had to get or change glasses
- ☐ Asking people to repeat things or hearing problem
- ☐ I make wrong turns driving or can't remember time
- ☐ I get confused easily or cannot multi-task anymore
- ☐ I have difficulty finding some words when talking
- ☐ Bright lights bother me
- ☐ I cannot pay attention as long as before
- ☐ I am eating more or less than normal
- ☐ Room spins, lightheaded or woozy feeling
- ☐ Balance problems
- ☐ I feel like my head is "Foggy"
- ☐ I have forgotten computer passwords or ATM PIN
- ☐ I have to re-read things to understand what I read
- ☐ My thinking is slowed down
- ☐ Difficulty with adding/subtracting numbers
- ☐ Fear I will never be the same again
- ☐ Difficulty learning new things
- ☐ Difficulty understanding what people say to me
- ☐ Difficulty remembering or memory problems
- ☐ Cannot take on any more responsibility
- ☐ I can't make decisions as quickly as before
- ☐ Loss of libido or lack of sexual desire
- ☐ I do not feel as confident of my abilities
- ☐ I get panic attacks, fast heartbeat, nervous
- ☐ I am more irritable than usual
- ☐ Some food or drink tastes "Funny" to me now
- ☐ I get frustrated very easily
- ☐ Difficulty planning my life or organizing my work
- ☐ Flashbacks or frightening thoughts about accident
- ☐ I have had bad dreams about the accident
- ☐ I avoid places & objects that remind me about it
- ☐ I feel emotionally numb-no interest in my hobbies
- ☐ I'm feeling strong guilt, worry or depression
- ☐ I am having trouble remembering the accident
- ☐ I am easily startled since the accident - "jumpy"
- ☐ I feel tense or "on edge" most of the time
- ☐ I am having difficulty sleeping
- ☐ I get angry easily or even yell at people now

Stamos Chiropractic Inc.
410 S Melrose Dr Suite 200
Vista, CA 92081
Office: 760.630.0683 // Fax: 760.630.7715

NOTICE OF DOCTOR LIEN ON PERSONAL INJURY PROCEEDS

I hereby authorize **Dr. Alison Stamos, DC** to furnish you, my attorney, with a full report of the examination, diagnosis, treatment, prognosis, etc. of me in regard to the accident on or about _____, for which you have been retained.

I understand that all bills incurred by me at **Dr. Alison Stamos, DC 's** office are my responsibility to pay and I will either pay them in full at the time of service or make payment arrangements with **Dr. Alison Stamos, DC** . I also understand that, unlike my attorney, **Dr. Alison Stamos, DC** does not work on a contingency fee and I must pay for her services at the time of his rendering of them and that this lien is only to protect her interests in case there is a balance owing when my case is resolved.

I irrevocably instruct my attorney to withhold from my settlement or judgment any amount that, at that time, is owed **Dr. Alison Stamos, DC** for my healthcare in connection with this accident and pay it directly and promptly to **Dr. Alison Stamos, DC** at:

Stamos Chiropractic Inc.
Dr. Alison Stamos, DC
410 S Melrose Dr Suite 200
Vista, CA 92081

I am granting **Dr. Alison Stamos, DC** an irrevocable lien on the proceeds of my legal case and it is my intent that this lien shall be binding on my present attorney and/or any subsequent attorney which either I might hire or to whom my present attorney may assign this case. In the event I have no attorney, I hereby instruct any insurance company from which I may receive a settlement in regard to this accident to add **Dr. Alison Stamos, DC** as a payee on the settlement draft.

_____ _____ _____
Print Name Patient's Signature Date

I, the attorney of record for the above-named signatory in regard to the accident in question, hereby agree to abide by the terms of this lien.

_____ _____ _____
Attorney (Please Print) Attorney's Signature Date

Stamos Chiropractic Inc.
410 S. Melrose Dr. Suite 200
Vista, CA 92081
Office: 760.630.0683

Stamos
Chiropractic Inc.

Auto Insurance Information

Patient Name: _____
Date of Birth: _____

Your Auto Insurance Company

Name of Insurance Company: _____
Name of Insured: _____
Claim Number: _____
Insurance Adjuster's Name: _____
Insurance Adjuster's Phone Number: _____

Third Party Insurance Company (other driver)

Name of Insurance Company: _____
Name of Insured: _____
Claim Number: _____
Insurance Adjuster's Name: _____
Insurance Adjuster's Phone Number: _____

Attorney Information

Name of Attorney: _____
Phone Number: _____
Fax: _____

Stamos Chiropractic Inc.

AUTHORIZATION FOR RELEASE OF RECORDS FROM:

_____

_____

_____

_____

_____

I HEREBY REQUEST AND AUTHORIZE THE RELEASE OF RECORDS TO:

Dr. Alison Stamos, DC
Stamos Chiropractic Inc.
410 S Melrose Dr Suite 200
Vista, CA 92081
PH/ FAX: 760-630-0683

☐ ALL RECORDS

☐ HEALTH RECORDS DATE(S):_____ TO _____

☐ X-RAY, MRI, CT REPORTS

☐ OTHER: _____

PATIENT'S NAME: _____

PATIENT'S SIGNATURE: _____

PATIENT'S DATE OF BIRTH: _____

DOCTOR'S SIGNATURE: _____