Audubon Chiropractic & Wellness Center
Dr. Jim Snyder
2909 W. Northwest Blvd.
Spokane, WA 99205
(509) 327-4049
www.AudubonParkWellness.com

AUTO ACCIDENT HISTORY AND QUESTIONNAIRE

Please print clearly.

Today's date (mm/dd/yyyy)

Name (Last, First, Middle initial) **Gender** ○ Male ○ Female **Social Security number**

Birth date (mm/dd/yy) **Age** **Date and time of the accident** **Where was the accident? (City/State)**

Describe in your own words how the accident occurred

(Cont.)

Was a police report filed? ○ Yes ○ No **How many vehicles were involved in the accident?** **Your vehicle model and make** **Other vehicle(s) model and make**

What direction were you traveling and on which street? **What direction was the other vehicle traveling and on which street?**

Did you anticipate the impact or were you caught by surprise? **Did you have a seat belt on?** ○ Yes ○ No **W/shoulder harness?** ○ Yes ○ No

Did you brace your arms/hands against any part of the vehicle? ○ Yes ○ No **If yes, what part?**

Did you brace your legs against the floorboard? ○ Yes ○ No **Was your foot on the break?** ○ Yes ○ No

At the time of impact were you ○ Looking forward ○ Looking left ○ Looking down ○ Looking right ○ Looking up **What was the position of your torso at the time of impact?** ○ Straight forward ○ Rotated right ○ Rotated left

Did any other part of your body hit the interior of the vehicle? ○ Yes ○ No **If yes, what or where?**

What kind of headrest was in your seat? ○ Moveable (HI pos MED pos LOW pos) ○ Non-moveable ○ None **Did your hat/glasses fall from your head during the accident?** ○ Yes ○ No

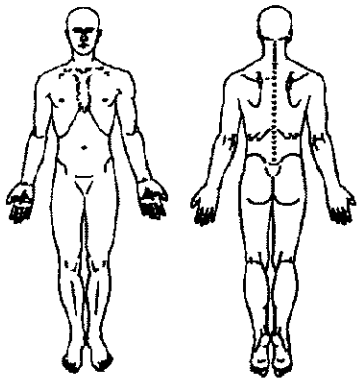
What portion of your car was impacted? ○ Rear ○ Front ○ Right side ○ Left side

During and after the crash, what happened to your vehicle? ○ Kept going straight ○ Kept going straight hitting car in front ○ Was hit by another car ○ Spun around ○ Spun around and hit a stationary object ○ Hit a stationary object ○ Other_____

Your vehicle: ○ In park ○ In gear ○ Stopped ○ In neutral ○ Moving _____ MPH **Other vehicle #1:** ○ In park ○ In gear ○ Stopped ○ In neutral ○ Moving _____ MPH **Other vehicle #2:** ○ In park ○ In gear ○ Stopped ○ In neutral ○ Moving _____ MPH

What are the estimated monetary damages to your vehicle? **Please note any extraordinary damage details**

Where did you immediate notice pain or symptoms? (Please mark with an "x")



Since the accident are your symptoms: ○ Better ○ Worse ○ Same

Where were you located in the vehicle? ○ Driver, ○ Front passenger ○ Rear passenger driver side ○ Rear passenger right side ○ Third seat driver side ○ Third passenger side ○ Center seat

Were you unconscious? ○ Yes ○ No **If yes, for how long?**

Did you go to the hospital/ER after the accident? ○ Yes ○ No

Name/location of hospital/ER

When?

Did you go to hospital by ambulance? ○ Yes ○ No

If yes, did they use: ○ Neck brace ○ Other: ○ Back brace

If no, where did you go?

Did the ambulance workers give you any medications or supplies? ○ Yes ○ No

If you were given medications or supplies, please list them

If you were hospitalized:

Were you there overnight? ○ Yes ○ No

What medications did you receive?

Were x rays taken? ○ Yes ○ No

If yes, what areas?

What diagnosis was given?

What were the treating doctors' recommendations?

Since the accident have you been to any other doctors? ○ Yes ○ No

If yes, name of doctor(s) and location

What was their diagnosis?

Did they recommend any treatment?

What medications or treatments have you received?

Have you ever had similar symptoms in the past? ○ Yes ○ No

If yes, please explain

Have you lost any days from work? ○ Yes ○ No

If so, how many and dates

What is your occupation?

What are your job requirements?

Is there anything else you'd like us to know? Please use the space below.

Signature

Date

AUTO ACCIDENT HISTORY AND QUESTIONNAIRE

CONFIDENTIAL HEALTH INFORMATION

Please allow our staff to photocopy your driver's license and insurance details.
All information you supply is confidential. We comply with all federal privacy standards.
Please print clearly.

Audubon Park Wellness
2909 West Northwest Blvd
Spokane, WA 99205
Office 509-327-4049
audubonparkwellness.com

Today's Date (MM/DD/YYYY)

Have you consulted a chiropractor before?
○ No ○ Yes When?

Patient Number (office use only)

Whom may we thank for referring you?

If so, whom?

Gender
○ Male ○ Female

Your Last Name

Your Social Security Number

Your First Name

Your Middle Name (or Initial)

Birth Date (MM/DD/YYYY)

Age

Marital Status
○ Single ○ Married ○ Divorced
○ Widowed ○ Separated

Address

City

State/Province

ZIP/Postal Code

Home Phone

Spouse's Name

Email Address

Cell Phone

Child's Name and Age

Emergency Contact

Phone

Child's Name and Age

Your Occupation

Child's Name and Age

Your Employer

May we contact you at work?
○ Yes ○ No

Preferred method of contact?
○ Home Phone ○ Cell Phone
○ Work Phone ○ Email

Address

City

State/Province

ZIP/Postal Code

Work Phone

Insurance Carrier

Policy Number

Primary Care Provider's Name

Insured's Last Name

Birth Date (MM/DD/YYYY)

Who carries this policy?
○ Self ○ Spouse ○ Parent

First Name

Middle Name (or Initial)

Insured's Employer

Address

City

State/Province

ZIP/Postal Code

Employer's Phone

1. The symptom(s) that have prompted me to seek care today include: _____

_____

2. And are the result of (darken circle): ○ An accident or injury
○ Work ○ Auto ○ Other _____
○ A worsening long-term problem
○ An interest in: ○ Wellness ○ Other _____

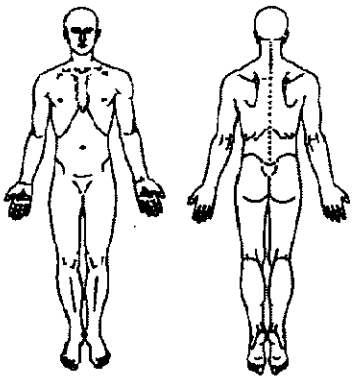
3. Onset (When did you first notice your current symptoms?)
_____

4. Intensity (How extreme are your current symptoms?)
0○-○-○-○-○-○-○-○-○-○10
Absent Uncomfortable Agonizing

5. Duration and Timing (When did it start and how often do you feel it?)
○ Constant ○ Comes and goes. How Often? _____
_____

6. Quality of symptoms (What does it feel like?)
○ Numbness
○ Tingling
○ Stiffness
○ Dull
○ Aching
○ Cramps
○ Nagging
○ Sharp
○ Burning
○ Shooting
○ Throbbing
○ Stabbing
○ Other _____

7. Location (Where does it hurt?)
Circle the area(s) on the illustration.
"0" for current condition
"X" for conditions experienced in the past



8. Radiation (Does it affect other areas of your body? To what areas does the pain radiate, shoot or travel.)
_____

9. Aggravating or relieving factors (What makes it better or worse, such as time of day, movements, certain activities, etc.)
What tends to worsen the problem? _____
What tends to lessen the problem? _____

10. Prior Interventions (What have you done to relieve the symptoms?)
○ Prescription medication ○ Surgery ○ Ice
○ Over-the-counter drugs ○ Acupuncture ○ Heat
○ Homeopathic remedies ○ Chiropractic Other _____
○ Physical therapy ○ Massage _____

11. What else should Audubon Park Wellness know about your current condition? _____

_____

12. How does your current condition interfere with your:

Work or career: _____

Recreational activities: _____

Household responsibilities: _____

Personal relationships: _____

13. Review of Systems
Chiropractic care focuses on the integrity of your nervous system, which controls and regulates your entire body. Please darken the circle beside any condition that you've **Had** or currently **Have** and initial to the right.

a. Musculoskeletal

Had	Have		Had	Have		Had	Have		Had	Have		Had	Have		
○	○	Osteoporosis	○	○	Arthritis	○	○	Scoliosis	○	○	Neck pain	○	○	Back problems	○	○	Hip disorders
○	○	Knee injuries	○	○	Foot/ankle pain	○	○	Shoulder problems	○	○	Elbow/wrist pain	○	○	TMJ issues	○	○	Poor posture

NONE ○ Initials ____

b. Neurological

Had	Have		Had	Have		Had	Have		Had	Have		Had	Have		
○	○	Anxiety	○	○	Depression	○	○	Headache	○	○	Dizziness	○	○	Pins and needles	○	○	Numbness

NONE ○ Initials ____

c. Cardiovascular

Had	Have		Had	Have		Had	Have		Had	Have		Had	Have		
○	○	High blood pressure	○	○	Low blood pressure	○	○	High cholesterol	○	○	Poor circulation	○	○	Angina	○	○	Excessive bruising

NONE ○ Initials ____

d. Respiratory

Had	Have		Had	Have		Had	Have		Had	Have		Had	Have		
○	○	Asthma	○	○	Apnea	○	○	Emphysema	○	○	Hay fever	○	○	Shortness of breath	○	○	Pneumonia

NONE ○ Initials ____

e. Digestive

Had	Have		Had	Have		Had	Have		Had	Have		Had	Have		
○	○	Anorexia/bulimia	○	○	Ulcer	○	○	Food sensitivities	○	○	Heartburn	○	○	Constipation	○	○	Diarrhea

NONE ○ Initials ____

f. Sensory

Had	Have		Had	Have		Had	Have		Had	Have		Had	Have		
○	○	Blurred vision	○	○	Ringing in ears	○	○	Hearing loss	○	○	Chronic ear infection	○	○	Loss of smell	○	○	Loss of taste

NONE ○ Initials ____

g. Skin

Had	Have		Had	Have		Had	Have		Had	Have		Had	Have		
○	○	Skin cancer	○	○	Psoriasis	○	○	Eczema	○	○	Acne	○	○	Hair loss	○	○	Rash

NONE ○ Initials ____

Consultation Notes

Patient name

Patient Number
(office use only)

Doctor's Initials

Audubon Park Wellness

(Continued from previous page)

h. Endocrine

Had	Have		Had	Have		Had	Have		Had	Have		Had	Have		Had	Have		
○	○	Thyroid issues	○	○	Immune disorders	○	○	Hypoglycemia	○	○	Frequent infection	○	○	Swollen glands	○	○	Low energy	NONE ○ Initials ____

i. Genitourinary

Had	Have		Had	Have		Had	Have		Had	Have		Had	Have		Had	Have		
○	○	Kidney stones	○	○	Infertility	○	○	Bedwetting	○	○	Prostate issues	○	○	Erectile dysfunction	○	○	PMS symptoms	NONE ○ Initials ____

j. Constitutional

Had	Have		Had	Have		Had	Have		Had	Have		Had	Have		Had	Have		
○	○	Fainting	○	○	Low libido	○	○	Poor appetite	○	○	Fatigue	○	○	Sudden weight gain/loss (circle one)	○	○	Weakness	NONE ○ Initials ____

Patient name ____________

Patient Number (office use only) ____________

○ All other systems negative

Past Personal, Family and Social History

Please identify your past health history, including accidents, injuries, illnesses and treatments. Please complete each section fully.

PERSONAL

14. Illnesses

Check the illnesses you have **Had** in the past or **Have** now.

Had	Have		Had	Have	
○	○	AIDS	○	○	Tuberculosis
○	○	Alcoholism	○	○	Typhoid fever
○	○	Allergies	○	○	Ulcer
○	○	Arteriosclerosis	○	○	Other: ________
○	○	Cancer			________
○	○	Chicken pox			________
○	○	Diabetes			________
○	○	Epilepsy			________
○	○	Glaucoma			________
○	○	Goiter			________
○	○	Gout			________
○	○	Heart disease			________
○	○	Hepatitis			
○	○	HIV Positive			
○	○	Malaria			
○	○	Measles			
○	○	Multiple Sclerosis			
○	○	Mumps			
○	○	Polio			
○	○	Rheumatic fever			
○	○	Scarlet fever			
○	○	Sexually transmitted disease			
○	○	Stroke			

15. Operations

Surgical interventions, which may or may not have included hospitalization.

- ○ Appendix removal
- ○ Bypass surgery
- ○ Cancer
- ○ Cosmetic surgery
- ○ Elective surgery: ________
- ○ Eye surgery
- ○ Hysterectomy
- ○ Pacemaker
- ○ Spine ________
- ○ Tonsillectomy
- ○ Vasectomy
- ○ Other: ________

16. Treatments

Check the ones you've received in the **Past** or are receiving **Currently**.

Past	Currently	
○	○	Acupuncture
○	○	Antibiotics
○	○	Birth control pills
○	○	Blood transfusions
○	○	Chemotherapy
○	○	Chiropractic care
○	○	Dialysis
○	○	Herbs
○	○	Homeopathy
○	○	Hormone replacement
○	○	Inhaler
○	○	Massage therapy
○	○	Physical therapy
○	○	Nutritional supplements

List ________

○	○	Medications (prescription and over-the-counter): ________

17. Injuries

Have you ever...

- ○ Had a fractured or broken bone
- ○ Had a spine or nerve disorder
- ○ Been knocked unconscious
- ○ Been injured in an accident
- ○ Used a crutch or other support
- ○ Used neck or back bracing
- ○ Received a tattoo
- ○ Had a body piercing

Consultation Notes

18. Family History

Some health issues are hereditary. Tell Audubon Park Wellness about the health of your immediate family members.

FAMILY

Relative	Age (if living)	State of health: Good	Poor	Illnesses	Age at death	Cause of death: Natural	Illness
Mother	____	○	○	________	____	○	○
Father	____	○	○	________	____	○	○
Sister 1	____	○	○	________	____	○	○
Sister 2	____	○	○	________	____	○	○
Brother 1	____	○	○	________	____	○	○
Brother 2	____	○	○	________	____	○	○
____	____	○	○	________	____	○	○

19. Are there any other hereditary health issues that you know about? ________

20. Social History

Tell Audubon Park Wellness about your health habits and stress levels.

SOCIAL

Alcohol use	○ Daily	○ Weekly	How much? ________
Coffee use	○ Daily	○ Weekly	How much? ________
Tobacco use	○ Daily	○ Weekly	How much? ________
Exercising	○ Daily	○ Weekly	How much? ________
Pain relievers	○ Daily	○ Weekly	How much? ________
Soft drinks	○ Daily	○ Weekly	How much? ________
Water intake	○ Daily	○ Weekly	How much? ________

Hobbies: ________

Prayer or meditation?	○ Yes	○ No
Job pressure/stress?	○ Yes	○ No
Financial peace?	○ Yes	○ No
Vaccinated?	○ Yes	○ No
Mercury fillings?	○ Yes	○ No
Recreational drugs?	○ Yes	○ No

Doctor's Initials ____________

Audubon Park Wellness

21. Activities of Daily Living
How does this condition currently interfere with your life and ability to function?

	No Effect	Mild Effect	Moderate Effect	Severe Effect
Sitting	○	○	○	○
Rising out of chair	○	○	○	○
Standing	○	○	○	○
Walking	○	○	○	○
Lying down	○	○	○	○
Bending over	○	○	○	○
Climbing stairs	○	○	○	○
Using a computer	○	○	○	○
Getting in/out of car	○	○	○	○
Driving a car	○	○	○	○
Looking over shoulder	○	○	○	○
Caring for family	○	○	○	○

	No Effect	Mild Effect	Moderate Effect	Severe Effect
Grocery shopping	○	○	○	○
Household chores	○	○	○	○
Lifting objects	○	○	○	○
Reaching overhead	○	○	○	○
Showering or bathing	○	○	○	○
Dressing myself	○	○	○	○
Love life	○	○	○	○
Getting to sleep	○	○	○	○
Staying asleep	○	○	○	○
Concentrating	○	○	○	○
Exercising	○	○	○	○
Yard work	○	○	○	○

Patient name

Patient Number
(office use only)

22. What is the major stressor in your life? ____________ **23. How much sleep do you average per night?** ______ **Hours**

24. What is the type and approximate age of your mattress and pillow? ________ **25. What is your preferred sleeping position?** ________

26. Describe your typical eating habits: ○ Skip breakfast ○ Two meals a day ○ Three meals a day ○ Snacking between meals

27. What would be the most significant thing that you could do to improve your health? ____________

28. In addition to the main reason for your visit today, what additional health goals do you have? ____________

Consultation Notes

Acknowledgements
To set clear expectations, improve communications and help you get the best results in the shortest amount of time, please read each statement and initial your agreement.

Initials ____ **I instruct the chiropractor to deliver the care that, in his or her professional judgement, can best help me in the restoration of my health. I also understand that the chiropractic care offered in this practice is based on the best available evidence and designed to reduce or correct vertebral subluxation. Chiropractic is a separate and distinct healing art from medicine and does not proclaim to cure any named disease or entity.**

Initials ____ **I may request a copy of the Privacy Policy and understand it describes how my personal health information is protected and released on my behalf for seeking reimbursement from any involved third parties.**

Initials ____ **I realize that an X-ray examination may be hazardous to an unborn child and I certify that to the best of my knowledge I am not pregnant. Date of last menstrual period (MM/DD/YYYY):** ____________

Initials ____ **I grant permission to be called to confirm or reschedule an appointment and to be sent occasional cards, letters, emails or health information to me as an extension of my care in this office.**

Initials ____ **I acknowledge that any insurance I may have is an agreement between the carrier and me and that I am responsible for the payment of any covered or non-covered services I receive.**

Initials ____ **To the best of my ability, the information I have supplied is complete and truthful. I have not misrepresented the presence, severity or cause of my health concern.**

If the patient is a minor child, print child's full name: ____________

Doctor's Initials

Audubon Park Wellness

Signature ____________ Date (MM/DD/YYYY) ____________

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 this office uses as Doctors of Chiropractic are spinal manipulative therapy. The doctor will use that procedure to treat you. He/she may use their hands or a 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 part of the treatment you are requesting today, you are consenting to the following procedure(s):

___ spinal manipulative therapy
___ range of motion testing
___ muscle strength testing
___ hot/cold therapy
___ radiographic studies
___ palpation
___ orthopedic testing
___ postural analysis
___ EMS
___ vital signs
___basic neurology

(Patient: initial each procedure you are consenting to)

The material risks inherent in chiropractic adjustment.

As with any health care 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. Some types of manipulation of the neck have been associated with injuries to the arteries in 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. We will make every reasonable effort during the spinal manipulative treatment to screen for contraindications to care; however, if you have a condition that would otherwise not come to our attention, it is your responsibility to inform us.

The probability of those risks occurring.

Fractures are rare occurrences and generally result from some underlying weakness of the bone which is typically checked 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 may 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 choose to use 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 reduced mobility which may set up a pain reaction of 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 APPROPIATE BLOCK AND SIGN BELOW.

I have read [ ] o r have had read to me [ ] the above explanation of the adjustment and related treatment. I have discussed it with Audubon Park Chiropractic and have had my questions 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.

Dated: _____ Dated: _____

_____ _____
Patient's Name Doctors Name

_____ _____
Signature Signature

_____
Signature of Parent or Guardian
(If a minor)

Audubon Park Chiropractic
Auto Accident/ Personal Injury Financial Agreement

For your convenience, we will bill **your** Personal Injury Protection (PIP) coverage for you. Typically, your PIP coverage covers 100% of your injury care through **your** automobile insurance regardless of who was at fault in the accident.

If you were not at fault, your insurance company will be reimbursed by the driver at fault's insurance company. This will occur when you have reached pre-injury or pre-accident status and the claim is settled. Your PIP coverage is specifically designed to protect **YOU** in case of injury, regardless of who is at fault.

If my PIP coverage does not pay, FOR ANY REASON, within 60 days, the balance of the account becomes my responsibility.

I understand my obligation to pay this bill is not contingent on any settlement, claim, judgement or verdict by which I eventually may recover such fee. If my balance is not paid in a timely fashion, I promise to pay any and all collection, court, and attorney fee's in the collection of my account.

I further understand that since my treatment is associated with a personal injury or accident claim, all medical bills will be paid at 100% of Dr. Snyder's fees regardless of the outcome of my case.

I fully understand I am directly, completely and fully responsible to Audubon Park Chiropractic for all chiropractic bills submitted for services rendered me, and that this agreement is primarily for Audubon Park Chiropractic's additional protection beyond any lien being filed or financial responsibility being served.

Moreover, I agree that I will instruct all representatives or attorneys to fully pay the amount owed for Dr. Snyder's services without reduction of any type.

I also understand that if my insurance company declines payment, I authorize Dr. Snyder to file small claims on my behalf against my insurance company as a method of collection. I also understand that I will be present at the court date, if needed.

I have read and fully understand the above financial terms.

Signed_____ Date_____

Witness_____

TERMS OF ACCEPTANCE AND CONSENT FOR CARE

THIS DOCUMENT CONSTITUTES INFORMED CONSENT FOR CHIROPRACTIC CARE

- When a patient seeks Audubon Park Chiropractic health care and we accept a patient for such care, it is essential for both to be working towards the same goal.
- Audubon Park Chiropractic has only one goal. It is important for each patient to understand this goal and the method that will be used to attain it. This will prevent confusion or disappointment.
- "Vertebral subluxations" are mechanical interferences, by spinal bones, to the normal flow of mental impulses traveling over the nerve pathways. The goal of Audubon Park Chiropractic is to locate, analyze and correct these vertebral subluxations.
- Audubon Park Chiropractic's method of correction is by specific adjustments of the spine. These adjustments are intended to reduce vertebral subluxations, thereby allowing the innate healing abilities of the body to work at maximum efficiency.
- With a proper nerve supply restored through Audubon Park Chiropractic adjustments, the body can begin the healing process of repair leading to health. In some patients this happens quickly; in others, more slowly. In some patients the repair and maintenance is complete; in others, only partial.
- Regardless of what the disease is called, we do not offer to treat it. Nor do we offer advice regarding treatment prescribed by others. **OUR ONLY GOAL IS TO ALLOW THE BODY TO DO ITS JOB.** Our only method is the spinal adjustment of the vertebral subluxations.
- If I am a female, I have told the chiropractor whether or not I am pregnant or the possibility of being pregnant as x-rays may be harmful to the fetus.
- I understand that the chiropractor will use his/her hands or a mechanical device upon my body to adjust a joint which may cause an audible "pop" or "click".
- It is my intention to rely on the doctor to exercise professional judgment during the course of any procedures, which he/she feels at the time to be in my best interest.
- Neither the practice of chiropractic or medicine is an exact science, but relies upon information related by the patient, information gathered during examination, and the doctor's interpretation thereof, as well as the doctor's judgment and expertise in working with like cases.
- It is not reasonable to expect the doctor to be able to anticipate, or explain, all possible risks and complications of a given procedure on any particular visit.
- An undesirable result, or side effect, does not necessarily indicate an error in judgment or an improper treatment. As with any health care procedure there are certain complications which may arise during chiropractic adjustment. Some complications include strains/sprains, dislocations, fractures, disc injuries, or CVA's (cerebral vascular accidents). These complications and others are extremely rare occurrences.

I, _____, have read and fully understand the above statements. All questions
(Print Name)
regarding the doctor's objectives pertaining to my care in this office have been answered to my complete satisfaction.

I, therefore, accept chiropractic care on that basis_____, _____
(Signature) (Date)

Complete if patient is a minor child. _____
(Print Child's Name)

I, _____, being the parent or legal guardian of the aforementioned child have read
(Print Parent/Guardian's Name)
and fully understand the above terms and hereby grant permission for my child to receive chiropractic care.

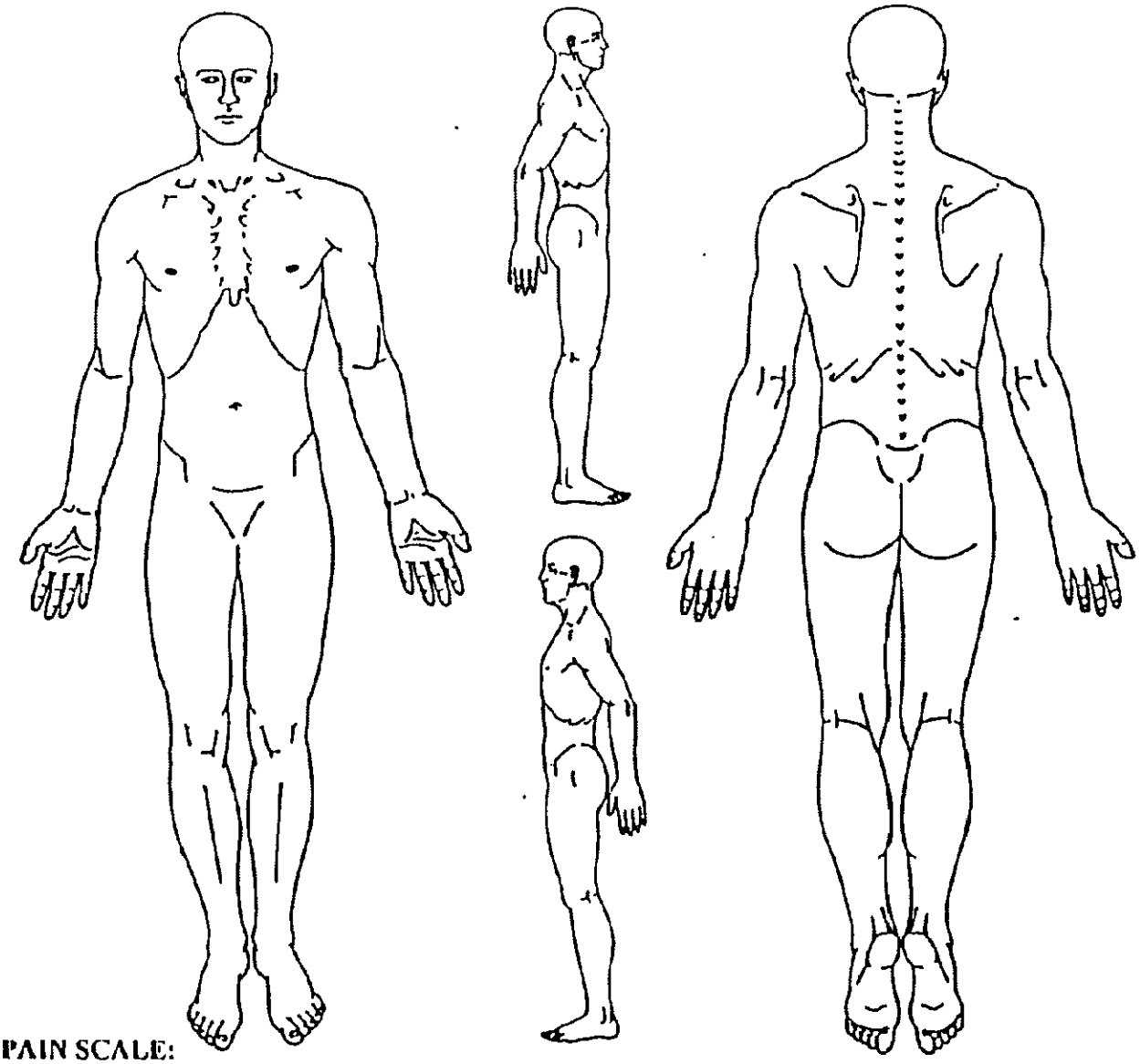
_____, _____
(Signature) (Date)

PAIN DIAGRAM

NAME:_____ DATE:_____

ON THE DIAGRAMS BELOW, **PLEASE MARK WHERE YOU ARE EXPERIENCING PAIN, RIGHT NOW.** USE THE LETTERS BELOW TO INDICATE THE TYPE AND LOCATION OF YOUR SENSATIONS.

KEY:	A-ACHE	B-BURNING	N-NUMBNESS
	P-PINS & NEEDLES	S-STABBING	O-OTHER



PAIN SCALE:

Rate the severity of your pain by checking one box on the following scale.

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

DATE:_____

NECK DISABILITY INDEX

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 WHICH 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 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 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 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 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 at all.

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.

After Vernon & Mior, 1991
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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 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 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 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 sleepless).

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 usual recreational activities because of pain in my neck.
- D I am able to engage in a few of my usual 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.

Revised 10/16/91

Comments:_____

Date_____

THE REVISED OSWESTRY PAIN QUESTIONNAIRE

Please Read: This questionnaire is designed to enable us to understand how much your low back 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 WHICH MOST CLOSELY DESCRIBES YOUR PROBLEM RIGHT NOW.**

SECTION 1 -- Pain Intensity
- A The pain comes and goes and is very mild.
- B The pain is mild and does not vary much.
- C The pain comes and goes and is moderate.
- D The pain is moderate and does not vary much.
- E The pain comes and goes and is severe.
- F The pain is severe and does not vary much.

SECTION 2 -- Personal Care
- A I would not have to change my way of washing or dressing in order to avoid pain.
- B I do not normally change my way of washing or dressing even though it causes some pain.
- C Washing and dressing increase the pain, but I manage not to change my way of doing it.
- D Washing and dressing increase the pain and I find it necessary to change my way of doing it.
- E Because of the pain, I am unable to do some washing and dressing without help.
- F Because of the pain, I am unable to do any washing or dressing without help.

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.
- D Pain prevents me from lifting heavy weights off the floor, but I can manage if they are conveniently positioned, e.g. on a table.
- E Pain prevents me from lifting heavy weights, but I can manage light to medium weights if they are conveniently positioned.
- F I can only lift very light weights, at the most.

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 1/2 mile.
- D Pain prevents me from walking more than 1/4 mile.
- E I can only walk while using a cane or on 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 without pain.
- B I can only sit in my favorite chair as long as I like.
- C Pain prevents me from sitting more than one 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.

From: N.Hudson, K.Torne-Nicholson, A.Breen; 1989

REVISED 9/25/91

SECTION 6 -- Standing
- A I can stand as long as I want without pain.
- B I have some pain while standing, but it does not increase with time.
- C I cannot stand for longer than one hour without increasing pain.
- D I cannot stand for longer than 1/2 hour without increasing pain.
- E I cannot stand for longer than 10 minutes without increasing pain.
- F I avoid standing, because it increases the pain straight away.

SECTION 7 -- Sleeping
- A I get no pain in bed.
- B I get pain in bed, but it does not prevent me from sleeping well.
- C Because of pain, my normal night's sleep is reduced by less than one-quarter.
- D Because of pain, my normal night's sleep is reduced by less than one-half.
- E Because of pain, my normal night's sleep is reduced by less than three-quarters.
- F Pain prevents me from sleeping at all.

SECTION 8 -- Social Life
- A My social life is normal and gives me no pain.
- B My social life is normal, but increases the degree of my pain.
- C Pain has no significant effect on my social life apart from limiting my more energetic interests, e.g., dancing, etc.
- D Pain has restricted my social life and I do not go out very often.
- E Pain has restricted my social life to my home.
- F I have hardly any social life because of the pain.

SECTION 9 -- Traveling
- A I get no pain while traveling.
- B I get some pain while traveling, but none of my usual forms of travel make it any worse.
- C I get extra pain while traveling, but it does not compel me to seek alternative forms of travel.
- D I get extra pain while traveling which compels me to seek alternative forms of travel.
- E Pain restricts all forms of travel.
- F Pain prevents all forms of travel except that done lying down.

SECTION 10 -- Changing Degree of Pain
- A My pain is rapidly getting better.
- B My pain fluctuates, but overall is definitely getting better.
- C My pain seems to be getting better, but improvement is slow at present.
- D My pain is neither getting better nor worse.
- E My pain is gradually worsening.
- F My pain is rapidly worsening.

Comments:_____

_____

ASSIGNMENT AND INSTRUCTION FOR DIRECT PAYMENT TO DOCTOR PRIVATE AND GROUP ACCIDENT AND HEALTH INSURANCE

I hereby instruct and direct the _____ Insurance Company to pay by check made out and mailed directly to:

Audubon Park Chiropractic
2909West Northwest Blvd
Spokane, WA 99205

If my current policy prohibits direct payment to doctor, then I hereby also instruct and direct you to make out the check to me and mail it as follows:

See Above Address

the professional or chiropractic expense benefits allowable, and otherwise payable to me under my current insurance policy as payment toward the total charges for professional services rendered.

THIS IS A DIRECT ASSIGNMENT OF MY RIGHTS AND BENEFITS UNDER THIS POLICY. This payment will not exceed my indebtedness to the above mentioned assignee, and I have agreed to pay, in a current manner, any balance of said professional service charges over and above this insurance payment.

A photo copy of this Assignment shall be considered as effective and valid as the original.

I also authorize the release of any information pertinent to my case to any Insurance company, adjuster, or attorney involved in this case.

Dated _____ this _____ day of _____ 2007.
(day) (day number) (month)

_____ _____
Signature of policyholder Signature of Claimant, if other than Policyholder

*With my signature above, the full deductible or co-payment would be a financial hardship on me.