ADVANCED INTEGRATIVE™ MEDICINE

ACCIDENT PAIN ASSESSMENT

Patient: (Print) _____ **Date:** _____

Welcome to our office. We take great pride in our office and will always do our utmost to provide you the best care. The doctor will be with you shortly. In the meantime, in order to help us determine the extent of your condition, please complete this form. If you have any questions or concerns, please do not hesitate to ask our staff. Thank you for your cooperation.

Please list your crash related symptoms below and the relative intensity (0 – 10) for each symptom using the comparative pain scale.

0 1 2 3 4 5 6 7 8 9 10

Symptoms: (Example: Low back pain – 4)

1) _____ 5) _____

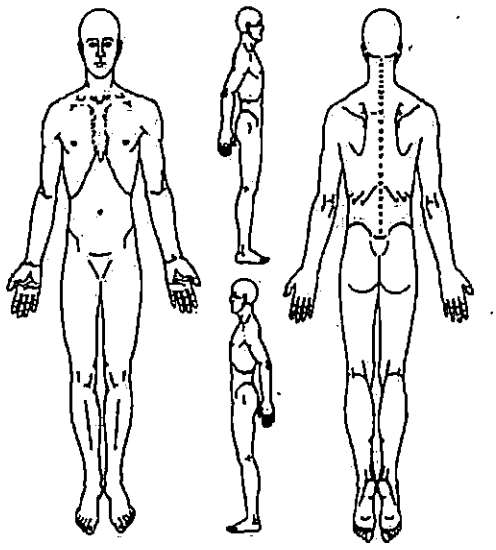
2) _____ 6) _____

3) _____ 7) _____

4) _____ 8) _____

Please mark on the diagram to the right the following symbols as they relate to your symptoms:

SS= spasms BBB= burning ZZZ= dull pain ///= sharp pain
SH= shooting pain TI= tingling xxx = numbness ....= pins/needles



Are symptoms ☐Constant >76% ☐Frequent 51-75% ☐Occasional 26-50% ☐Intermittent <25% of your waking hours

Patient Comments:

_____

_____

_____

_____

_____

_____

By signing below I am indicating that the above information is correct. I also give the doctors of Starman Chiropractic permission to treat my condition as deemed necessary.

Patient Signature: _____ **Date:** _____ **Staff:** _____

Provider Signature _____ **Date** _____

5755 NORTH POINT PARKWAY SUITE 72 • ALPHARETTA, GA • 30022
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ADVANCED INTEGRATIVE™
MEDICINE

IRREVOCABLE ASSIGNMENT, LIEN AND AUTHORIZATION INSURANCE BENEFITS AND ATTORNEY

TO WHOM IT MAY CONCERN:

I hereby authorize and direct you, my insurance carrier and/or attorney to pay directly to Advanced Integrative Medicine such sums as may be due and owing this office for services rendered me, both by reason of accident or illness and by reason of any other bills that are due this office and withhold such sums from any disability benefits, medical payment benefits, no-fault benefits, health and accident, Workers' Compensation benefits, or any other insurance benefits obligated to reimburse me from any settlement, judgment or verdict on my behalf as may be necessary to adequately protect Advanced Integrative Medicine. I hereby further give lien to said office against any and all insurance benefits named herein and any and all proceeds of any settlement, judgment or verdict which may be paid to me as a result of the injuries or illness for which I have been treated for by Advanced Integrative Medicine. This is to act as an assignment of my rights and benefits to the extent of the office's services provided.

I understand that I remain personally responsible for the total amounts due the office for services rendered. I further understand and agree that this Assignment, Lien and Authorization do not constitute any consideration for the office to await payments, and they may demand payments from me immediately upon rendering services at their option.
I authorize the office to release any information pertinent to my case to any insurance carrier, adjuster or attorney to facilitate collection under this Assignment, Lien and Authorization.

I further understand and agree that if Advanced Integrative Medicine must take any action to collect an outstanding balance on this account, I will be responsible for payment of and will reimburse this office for all costs of such collection efforts, including but not limited to all court costs and all attorney fees.

Patient Signature_____ Date:_____ (SEAL) Date: _____

I authorize my Attorney_____to sign this lien to pay the outstanding balance at settlement under NC General Statue 44-50.

Patient Signature _____ (SEAL) Date_____

Please sign this Assignment, Lien and Authorization and return to Advanced Integrative Medicine.

Attorney Signature _____ (SEAL) Date_____

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Advanced Integrative Medicine

Auto Related Accident

Allison Comrie, M.D.

Date and Time of Accident: _____ ❑ A.M. ❑ P.M.

Were you the: ❑ Driver ❑ Front Passenger ❑ Rear Passenger

If a traffic violation was issued, to whom was it issued? _____

Number of people in accident vehicle? _____

❑ Y ❑ N Did the police come to the accident site? ❑ Y ❑ N Were you wearing your seatbelt?

❑ Y ❑ N Was a police report filed? ❑ Y ❑ N Did your vehicle have airbags?

❑ Y ❑ N Were there any witnesses? ❑ Y ❑ N If yes, did it/they inflate?

In relation to the base of your skull, where was the headrest? ❑ Above ❑ Below ❑ At base of skull

What did your vehicle impact? ❑ Another vehicle ❑ Other

If *other*, explain: _____

Did any part of your body strike anything in the vehicle? ❑ Yes ❑ No

If *yes*, please explain: _____

Make & model of the vehicle your were occupying: _____

Name of the location/street on which you were traveling: _____

In which direction were you headed? ❑ North ❑ South ❑ East ❑ West

What was the approximate speed of your vehicle? _____

Did the impact come from: ❑ Front ❑ Rear ❑ Right Side ❑ Left Side ❑ Other

During impact, were you facing: ❑ Right ❑ Left ❑ Forward

Were you ❑ aware ❑ surprised by the accident?

If accident vehicle made impact with another vehicle, list make & model of other vehicle:

_____

Direction other vehicle was headed? ❑ North ❑ South ❑ East ❑ West

Speed of the other vehicle? _____

In your words, please describe the accident: _____

_____

_____

_____

Have you been involved in previous automobile accidents? ❑ Yes ❑ No

If yes, please list type, date, nature of accident and injuries. _____

_____

_____

_____

_____

If necessary, please use the back to continue your explanation.

REVIEW OF SYSTEMS (ROS):

GENERAL
- o Fever
- o Chills
- o Weakness
- o Night Sweats
- o Weight Gain
- o Weight Loss
- o Loss of Appetite

CARDIOVASCULAR
- o Chest Pain
- o Angina
- o Murmur
- o Irregular Heart Beat
- o Palpitations
- o Extremity Swelling
- o Varicose Veins
- o Pain with Walking
- o Cold Hands or Feet

GENITOURINARY
- o Frequent Urination
- o Difficulty Controlling Urination
- o Blood in Urine
- o Pain with Urination
- o Passage of Stones

ENDOCRINE
- o Heat/Cold intolerance
- o Thyroid Disease
- o Decreased Energy

HEAD
- o Headache
- o Trauma
- o Dizziness
- o Vertigo

RESPIRATORY
- o Shortness of Breath
- o Wheezing/Asthma
- o Sputum Production
- o Night Sweats
- o Cough
- o Coughing up Blood
- o COPD/Emphysema
- o Bronchitis

SKIN
- o Rash
- o Pruritis
- o Moles
- o Cancer
- o Dryness

BLOOD/LYMPH
- o Anemia
- o Blood Thinner
- o Easy Bruising
- o Easy Bleeding
- o Lymph Node Swelling
- o Lymph Node Pain

EYES
- o Double Vision
- o Blurred Vision
- o Cataracts
- o Discharge
- o Glaucoma

GASTROINTESTINAL
- o Nausea
- o Vomiting
- o Diarrhea
- o Constipation
- o Ulcer
- o Blood in Stool
- o Abdominal Pain
- o Rectal pain
- o Hernia
- o Hemorrhoids
- o Change in Appetite

MUSCULOSKELETAL
- o Muscle Pain
- o Muscle Spasm
- o Muscle Atrophy
- o Back Pain/Stiffness
- o Neck Pain/Stiffness
- o Joint Pain
- o Joint Stiffness
- o Weakness
- o Fractures

ALLERGY/IMMUNOLOGIC
- o Sinusitis
- o Seasonal Allergies

ENT
- o Loss of Hearing
- o Discharge
- o Loss of Smell
- o Congestion
- o Dentures
- o Sores
- o Gingival Bleeding
- o Hoarseness
- o Sore Throat
- o Difficulty Swallowing
- o Jaw Pain

GYNECOLOGIC
- o Self-Exam
- o Masses/Lumps
- o Pain
- o Nipple Discharge

PSYCHIATRIC
- o Anxiety
- o Depression
- o Hallucinations
- o Sleep Disturbance

NEUROLOGIC
- o Loss of Consciousness
- o Fainting
- o Numbness
- o Weakness
- o Tingling
- o Seizures

FAMILY HISTORY: (Please list all that apply to **blood relatives;** If deceased, please indicate cause and age of death)

____ High Blood Pressure ____ Diabetes ____ Depression/Anxiety

____ Heart Disease ____ Cancer

Other significant family diseases:_____

_____ _____

Signature of Patient or legal Representative Patient or Legal Representative (Please Print)

_____ _____

Allison Comrie MD Date

_____ _____

Julie Abrahamson PA-C Date

Advanced Integrative Medicine

Initial Evaluation Questionnaire
Allison Comrie MD

Name _____ **Age**_____ **DOB**_____ **Gender**_____

CHIEF COMPLAINT: _____

PAST MEDICAL HISTORY: (Please check if you have or have had any of the following)

____ High Blood Pressure	____ Arthritis	____ Ulcer/Reflux Disease
____ Irregular Heartbeat	____ Herniated Disc	____ Degenerative Disc Disease
____ Stroke	____ Spinal Stenosis	____ Peripheral Vascular Disease
____ Back Pain/Neck Pain	____ Diabetes	____ Heart Failure/ Heart Attack
____ Blood Clots	____ Cancer	

Other significant medical history:_____ NA

Do you have a pacemaker? Yes No Do you have a defibrillator? Yes No

Do you have any surgical devices in your body? (e.g. pins, plates, screws, etc?) If yes, please specify and record location_____

PAST SURGICAL HISTORY: Yes No

If yes, please list and their dates:

_____

_____

_____

MEDICATIONS:_____

_____

_____

ALLERGIES (to medications):_____

SOCIAL HISTORY:

Smoking: Y N Alcohol: Y N

Vocation_____

Hobbies and Other Activities: _____

ADVANCED INTEGRATIVE™ MEDICINE

Advanced Integrative Medicine

Neck Pain Disability Questionnaire

NECK PAIN DISABILITY INDEX QUESTIONNAIRE

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

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 causes extra pain.
C Pain prevents me from lifting heavy weights off the floor.
D Pain prevents me from lifting heavy weights, but I can manage light to medium weights if they are conveniently positioned, for example, 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 — 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 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
Reprinted by permission of the Journal of Manipulative and Physiological Therapeutics

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 concentrating when I want to.
D I have a lot of difficulty concentrating when I want to.
E I have a great deal of difficulty 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 hr. sleepless).
C My sleep is mildly disturbed (1-2 hrs. sleepless).
D My sleep is moderately disturbed (2-3 hrs. sleepless).
E My sleep is greatly disturbed (3-5 hrs. sleepless).
F My sleep is completely disturbed (5-7 hrs. 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 January 1, 1995

Comments: _____

Patient Signature: _____ Date: _____

ADVANCED INTEGRATIVE™
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Advanced Integrative Medicine

Neck Pain Disability Questionnaire

NECK PAIN DISABILITY INDEX QUESTIONNAIRE

NAME (please print): _____ Date: _____

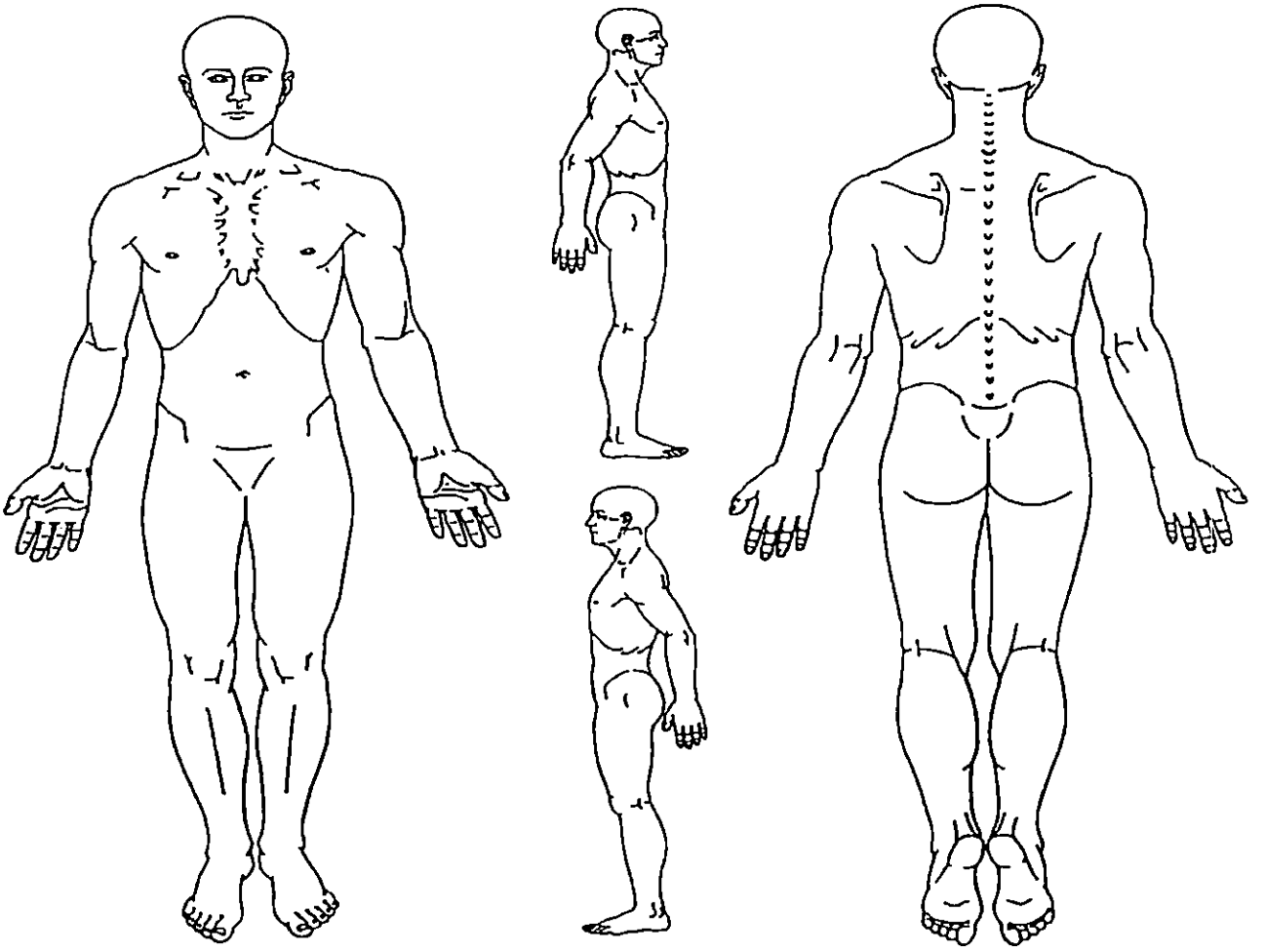
Age: _____ Date of Birth: _____ Occupation: _____

How long have you had neck pain? _____ Years _____ Months _____ Weeks

Is this your first episode of neck pain? _____ Yes _____ No

Use the letters below to indicate the type and location of your sensations right now.
Please remember to complete both sides of this form.

KEY: A= Ache B= Burning N= Numbness
P= Pins & Needles S= Stabbing O= Other



ADVANCED INTEGRATIVE™ MEDICINE

Advanced Integrative Medicine

Patient Health Questionnaire

Patient Name _____ Date _____ ID # _____

If you have ever had a symptom in the past listed below, please check that symptom in the past column. If you are presently troubled by a particular symptom check the symptom in the present column. This is a history of various systems of your body and knowledge of these conditions may influence the type of treatment, therapy, or referral you may receive.

Past	Present	Conditions
____	____	Abdominal Pain
____	____	Abnormal Weight Gain/Loss
____	____	Angina
____	____	Anorexia
____	____	Aortic Aneurysm
____	____	Arthritis
____	____	Asthma
____	____	Bladder Infections
____	____	Blood Disorder
____	____	Breast Soreness/Lump
____	____	Cancer, explain
____	____	Chest Pains
____	____	Chronic Cough
____	____	Chronic Sinusitis
____	____	Colitis
____	____	Constipation/Irregular bowel habits
____	____	Convulsions
____	____	Diabetes
____	____	Depression
____	____	Dermatitis/Eczema/Rash
____	____	Difficulty in Swallowing
____	____	Dizziness
____	____	Emphysema (Chronic Lung Disorders)
____	____	Endometriosis
____	____	Epilepsy
____	____	Excessive Thirst
____	____	Fainting
____	____	Frequent Urination
____	____	General Fatigue
____	____	Hand Pain (R___ L___)
____	____	Headache
____	____	Heart Attack (date_____)
____	____	Heartburn/Indigestion
____	____	Hepatitis
____	____	High Blood Pressure
____	____	Irritable Colon

Past	Present	Conditions
____	____	Loss of Bladder Control
____	____	Low Back Pain
____	____	Mid Back Pain
____	____	Muscular Incoordination
____	____	Neck Pain
____	____	Pain in Ankle or Foot
____	____	Pain in Lower Leg or Knee
____	____	Pain in Upper Arm or Elbow
____	____	Pain in Upper Leg or Hip
____	____	Painful Urination
____	____	PMS
____	____	Profuse Menstrual Flow
____	____	Prostate Problems
____	____	Rapid Heart Beat
____	____	Rheumatoid Arthritis
____	____	Scoliosis
____	____	Shoulder Pain
____	____	Stroke (date_____)
____	____	Swelling, Stiffness of Joint(s)
____	____	Tinnitus (Ear Noises)
____	____	Tumor, Explained _____)
____	____	Ulcer
____	____	Visual Disturbances
____	____	Jaw Pain
____	____	Wrist Pain

FAMILY HISTORY:

If any of your immediate family members have/had the following, please mark the appropriate line.

	MOTHER	FATHER	BROTHER(S)	SISTER(S)
Cancer	____	____	____	____
Retinal Detachment	____	____	____	____
Chronic Back Problems	____	____	____	____
Kidney Failure	____	____	____	____
Cardiovascular Disease	____	____	____	____
Diabetes	____	____	____	____
High Blood Pressure	____	____	____	____
Rheumatoid Arthritis/Lupus	____	____	____	____

Have you ever had surgery or been hospitalized? ___No ___Yes _____

What medications are you currently taking? _____

Do you use tobacco? ___No ___Yes Do you drink alcohol? ___No ___Yes

Do you have or have you had an alcohol, drug, or any other kind of addiction or dependence? ___No ___Yes

In the past 90 days have you had: Doctor's Notes _____

Weight gain or loss of 10 or more pounds:	No	Yes
Any loss of appetite:	No	Yes
Fevers, Chills, or Night Sweats:	No	Yes

X _____

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ADVANCED INTEGRATIVE ™ MEDICINE

Acknowledgement of Receipt of Notice of Privacy Practices

Patient Name: _____

I hereby acknowledge that I have received a copy of **Advanced Integrative Medicine**'s Notice of Privacy Practices. I understand that I have the right to refuse to sign this acknowledgement if I so choose.

_____ _____

Signature of Patient or Legal Representative | Date

_____

PRINTED Name of Patient or Legal Representative

- ☐ Parent or guardian of unemancipated minor
- ☐ Court appointed guardian
- ☐ Executor or administrator of decedent's estate
- ☐ Power of Attorney

FOR OFFICE USE ONLY

We attempted to obtain written acknowledgtement of receipt of our Notice of Privacy Practices on the following date:_____ but acknowledgmenet could not be obtained because:

- ☐ Patient/Representative refused to sign
- ☐ Emergency situation prevented us from obtaining acknowledgement at this time (will attempt at a later date)
- ☐ Communication barriers prohibited obtatining acknowledgement (Explain)

_____

_____

_____

_____

_____

_____

_____

- ☐ Other (Specify)

_____

_____

_____

_____

_____

_____

_____

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ADVANCED INTEGRATIVE™
MEDICINE

Acknowledgment of Financial Responsibility

Your insurance policy is a contract between you and your carrier. Most policies reimburse for at least some chiropractic and wellness care. But coverage varies from policy to policy with constant changes. All liability patients are responsible for keeping their insurance and attorney aware of changes in medical treatment in our facility for the most accurate reimbursement.

Our billing department will work diligently with your insurance company, attorney or any other party involved for reimbursement on your behalf.

I accept financial responsibility for my care. I instruct this office to deliver the care that, in their judgment, can best help me in the restoration of my health.

_____
Print Name

_____ _____
Patient Signature Date

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ADVANCED INTEGRATIVE™ MEDICINE

WELCOME TO ADVANCED INTEGRATIVE MEDICINE

PERSONAL

Patient Name: _____

Address: _____

City/State/Zip: _____

Social Security #: _____

Gender: F / M

Marital Status: _____

Age: _____

Spouse's Name: _____

Patient's Birthdate: ___/___/___

Home Phone: _____

Work Phone: _____

Ext: _____

Cell: _____

Email: _____

Emergency Contact: _____

Phone: _____ Relation: _____

May we ask how you were referred?

GUARANTOR

Policy Holder: _____

Address: _____

City/State/Zip: _____

Social Security #: _____

Gender: F / M Birthdate: ____/____/____

Home Phone: _____

Employer: _____

Address: _____

City/State/Zip: _____

Work Phone:

_____ YES , I have completed/filed the necessary benefits form.

Insurance Co: _____

Call Benefits @ ( ) -

Contact: _____ Ext:

Group Name: _____ Group #

ID/Claim #: _____

Patient is: self spouse child 3rd party

other: _____

CASE

Were you in an Auto Accident? Injury Date:

Were you in a Work related Injury? Injury Date:

Will you be utilizing medical benefits?

NO Insurance	Insurance	_____Fund	Auto/Accident Ins
Medicaid/Medical	Medicare	Government	Work Comp Ins

Attorney Name

Attorney Phone Number

Paralegal You Spoke With

Paralegal Email Address

Do You Have Med Pay? Yes No

If Yes: Claim Number

Adjuster Phone Number

Adjuster Name

Do you have pictures of your accident? Yes No

If Yes: Please email to aimedicine@bellsouth.net

Daily Activity/Occupation:

___ YES, I will pay my portion at the time of service.

___ YES, this office has my permission to copy my driver's license or photo ID for the sole purpose of identification and verification.

AUTHORIZATION & ASSIGNMENT OF BENEFITS

I authorize the staff to perform any necessary services needed during diagnosis and treatment.

I authorize the release of any medical information necessary to process and pay this claim. I authorize payment directly to Advance Integrated Medicine of the "Health Benefits," "Medical Reimbursement" from a Third Party Payor and/or "Government Benefits" otherwise payable to me.

I understand this office only accepts assignment when insurance pays directly.

I fully understand when the insurance company verifies my benefits, it is not a guarantee or authorization to pay on claims submitted. I agree to pay my portion, plus any balance insurance does not reimburse for, at each visit. I agree to pay/settle any denied/unpaid claims. I submitted by this office are my responsibility and require my participation to understand all claims settle regardless of my insurance company or assignment of benefits.

_____

PRINT

Patient/Guarantor -PRINT name

x _____ ___/___/___

Patient/Guarantor - SIGNATURE Date

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