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 _____________

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5755 NORTH POINT PARKWAY SUITE 72 • ALPHARETTA, GA • 30022
TELE: 678-867-7200 • FAX: 770-667-7138

Please Read: This questionnaire is designed to enable us to understand how much your neck pain has affected your ability to manage 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 closely describes your problem *right now*.**

SECTION 1--Pain Intensity

A. I have no pain at the moment
B. The pain is mild at the moment.
C. The pain comes and goes and is moderate.
D. The pain is moderate and does not vary much.
E. The pain is severe but comes and goes.
F. The pain is severe and does not vary much.

SECTION 2--Personal Care (Washing, Dressing etc.)

A. I can look after myself 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 but I can 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 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 as much as I want because of severe pain in my neck.
F. I cannot read at all.

SECTION 5--Headache

A. I have no headaches at all.
B. I have slight headaches which come infrequently.
C. I have moderate headaches which come in-frequently.
D. I have moderate headaches which come frequently.
E. I have severe headaches which come frequently.
F. I have headaches almost all the time.

SECTION 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 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 my car 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 engage in all recreational activities with no pain in my neck at all.
B. I am able engage in all recreational activities with some pain in my neck.
C. I am able engage in most, but not all recreational activities because of pain in my neck.
D. I am able 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 all all

SIGNATURE:____________________**DATE:**________

Vernon H and Hagino C, 1991 (with permission from Fairbank J)

DISABILITY INDEX SCORE: %____________

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 Inte- grative 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' Compen- sation 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 ren- dered. 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___________________

Initial _____

Patient: ____ Age: __________ Birth Date: ________________

Time In: _____________ Time Out: _____________ Date of Accident: ________________________________

Doctor: ____ Date Of Exam: ____

Sex: ☐ M ☐ F Marital Status: _______________ Spouse Name: ________________________ # of Children: ____________________

Occupation: ________________________________Years: _______ Employer: _____________________________________

Are you or have you missed time from work? ☐Yes ☐ No Type of Work: ☐ Office ☐ Clerical ☐ Light ☐ Moderate ☐ Heavy Labor

Describe the type of work performed: ____

Were you on-the-job when the accident occurred? ☐ Yes ☐ No

Were you the: ☐ Driver ☐ Front Seat Passenger ☐ Rear Seat Passenger ☐ Other ____

Vehicle was driven by: ____

Did your vehicle strike another vehicle? ☐ Yes ☐ No Did another vehicle strike your vehicle? ☐ Yes ☐ No

Were you struck from: ☐ Behind ☐ Front ☐ Driver's side ☐ Passenger's side ☐ other ____________________________

Were traffic citations issued? To whom? ☐ You ☐ Driver of your vehicle ☐ Driver of other vehicle ☐ None

Were police at the scene? ☐ Yes ☐ No If yes, was a report made? ☐ Yes ☐ No Did accident occur on ☐ public or ☐ private property

Your vehicle was heading: ☐ North ☐ South ☐ East ☐ West on ____ (Street/highway)

The other car heading: ☐ North ☐ South ☐ East ☐ West on ____ (Street/highway)

Your Vehicle (Year, Make, Model): ____

Your speed at the moment of accident: ☐ Full Stop ☐ Slowing ☐ Accelerating ☐ Legal Limit

The other Vehicle (Year, Make, Model) ____

Time of day: ☐ Daylight ☐ Dawn ☐ Dusk ☐ Dark Road conditions: ☐ Dry ☐ Damp ☐ Wet ☐ Snow ☐ Ice ☐ Other ___________

Head restraints: ☐ None ☐ Integral Type ☐ Adjustable: ☐ Up ☐ Down ☐ Don't know

If adjustable, was the position altered by the accident? ☐ Yes ☐ No

Was the seat back adjustment altered by the accident? ☐ Yes ☐ No

Type of Restraints: ____

Did air bag deploy? ☐ Yes ☐ No If Yes, were you struck by airbag? ☐ Yes ☐ No Were you burned? ☐ Yes ☐ No

Body position: ______________ Head position: ☐ Forward ☐ Left _____° ☐ Right _____° ☐ Up _____° ☐ Down _____°

Position of Hands: ☐ One on steering wheel ☐ Two on steering wheel ☐ N/A Were brakes applied at impact? ☐ Yes ☐ No

Dr. Initials: __________

Initial _____

Oswestry Low Back Pain Scale

Please rate the severity of your pain by circling a number below:

No pain 0 1 2 3 4 5 6 7 8 9 10 ***Unbearable pain***

Name ______________________________ **Date** ____________

Instructions: Please circle the **ONE NUMBER** in each section which most closely describes your problem.

Section 1 – Pain Intensity
0. The pain comes and goes and is very mild.
1. The pain is mild and does not vary much.
2. The pain comes and goes and is moderate.
3. The pain is moderate and does not vary much.
4. The pain comes and goes and is severe.
5. The pain is severe and does not vary much.

Section 2 – Personal Care (Washing, Dressing, etc.)
0. I would not have to change my way of washing or dressing in order to avoid pain.
1. I do not normally change my way of washing or dressing even though it causes some pain.
2. Washing and dressing increase the pain but I manage not to change my way of doing it.
3. Washing and dressing increase the pain and I find it necessary to change my way of doing it.
4. Because of the pain I am unable to do some washing and dressing without help.
5. Because of the pain I am unable to do any washing and dressing without help.

Section 3 – Lifting
0. I can lift heavy weights without extra pain.
1. I can lift heavy weights but it gives extra pain.
2. Pain prevents me lifting heavy weights off the floor.
3. Pain prevents me lifting heavy weights off the floor, but I can manage if they are conveniently positioned, e.g., on a table.
4. Pain prevents me lifting heavy weights but I can manage light to medium weights if they are conveniently positioned.
5. I can only lift very light weights at most.

Section 4 – Walking
0. I have no pain on walking.
1. I have some pain on walking but it does not increase with distance
2. I cannot walk more than 1 mile without increasing pain.
3. I cannot walk more than ½ mile without increasing pain.
4. I cannot walk more than ¼ mile without increasing pain.
5. I cannot walk at all without increasing pain.

Section 5 – Sitting
0. I can sit in any chair as long as I like.
1. I can sit only in my favorite chair as long as I like.
2. Pain prevents me from sitting more than 1 hour.
3. Pain prevents me from sitting more than ½ hour.
4. Pain prevents me from sitting more than 10 minutes.
5. I avoid sitting because it increases pain immediately.

Section 6 – Standing
0. I can stand as long as I want without pain.
1. I have some pain on standing but it does not increase with time.
2. I cannot stand for longer than 1 hour without increasing pain.
3. I cannot stand for longer than ½ hour without increasing pain.
4. I cannot stand for longer than 10 minutes without increasing pain.
5. I avoid standing because it increases the pain immediately.

Section 7 – Sleeping
0. I get no pain in bed.
1. I get pain in bed but it does not prevent me from sleeping well.
2. Because of pain my normal nights sleep is reduced by less than dressing even though it causes some pain.
3. Because of pain my normal nights sleep is reduced by less than
4. Because of pain my normal nights sleep is reduced by less than necessary to change my way of doing it.
5. Pain prevents me from sleeping at all. and dressing without help.

Section 8 – Social Life
0. My social life is normal and gives me no pain.
1. My social life is normal but it increases the degree of pain.
2. Pain has no significant effect on my social life apart from limiting
3. Pain has restricted my social life and I do not go out very often.
4. Pain has restricted my social life to my home.
5. I have hardly any social life because of the pain.

Section 9 – Traveling
0. I get no pain when traveling
1. I get some pain when traveling but none of my usual forms of
2. I get extra pain while traveling but it does not compel me to seek
3. I get extra pain while traveling which compels to seek alternative
4. Pain restricts me to short necessary journeys under ½ hour
5. Pain restricts all forms of travel.

Section 10 – Changing Degree of Pain
0. My pain is rapidly getting better.
1. My pain fluctuates but is definitely getting better.
2. My pain seems to be getting better but improvement is slow.
3. My pain is neither getting better or worse.
4. My pain is gradually worsening
5. My pain is rapidly worsening

Initial _____

WELCOME TO ADVANCED INTEGRATIVE MEDICINE

PERSONAL

PatientName:

Address:

City/State/Zip:

Social Security#:

Gender F/M

Marital Status:

Spouse's Name:

Patient's Birthday: / /
Age:

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 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
Medical	Medicare	Governerment	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			
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 d i agnosis 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.
PRINT

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.

Patient/Guarantor -PRINT name

Patient/Guarantor - SIGNATURE Date / /

Initial _____

Advanced Integrative Medicine

Initial Evaluation Questionaire

Health Complaints You Want Help With (#1 Most Important-#5 Least Important)

1____ When did it start? ____________________

2____ When did it start? ____________________

3____ When did it start? ____________________

4____ When did it start? ____________________

5____ When did it start? ____________________

Referring Physician or Facility ____

Additional Physician(s)

Doctor's Name ____________________________ For What Condition __________________

Doctor's Name ____________________________ For What Condition __________________

Doctor's Name ____________________________ For What Condition __________________

______ Please check here if you ran out of room and continue this section on the back of this page.

Additional Physician(s)

Doctor's Name ____________________________ For What Condition __________________

Doctor's Name ____________________________ For What Condition __________________

Doctor's Name ____________________________ For What Condition __________________

______ Please check here if you ran out of room and continue this section on the back of this page.

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 ____

Initial _____

Family History

(Please list all that apply to **blood relatives** -father, mother, father's parents, mother's parents and siblings)

______ High Blood Pressure ______ Diabetes ______ Heart Disease

______ Anxiety/Depression ______ Cancer - Type?________________________

______ Kidney Disease ______ Thyroid Disease ______ High Cholesterol

______ Stroke ______ Bleeding Disorder ______ Arthritis (RA/OA)

If Blood Relative is Deceased, Please Indicate Cause and Age of Death ____________________

____

____

Other Significant Family Diseases ____

Do You Have a Pacemaker? Yes No Do You Have a Defibrillator? Yes No

Do You Have any Surgical Devices or metal in Your Body? Yes No (Example: Pins, Plates, Screws, etc.)
If Yes, Please Specify Location ______________________________

Past Hospitalizations and/or Surgeries

Procedure or Reason ______________________________ Date of Procedure ____________

Procedure or Reason ______________________________ Date of Procedure ____________

Procedure or Reason ______________________________ Date of Procedure ____________

Procedure or Reason ______________________________ Date of Procedure ____________

______ Please check here if you ran out of room and continue this section on the back of this page.

Social History

Smoking Yes No Alcohol Yes No Occupation ________________________
Hobbies and Other Activities ____

Marital Status: ____

Medications (Please indicate name, for what condition and how often you take it)
If you brought a list of your prescriptions, please indicate by writing, “See Rx Sheet” below

Allergies (Please indicate if allergy is due to medications or other)

______ Please check here if you ran out of room and continue this section on the back of this page.

Current Nutritional Supplements
(Please indicate name, for what condition and how often you take it)

______ Please check here if you ran out of room and continue this section on the back of this page.

Initial _____

Review of Systems

(Please indicate below any symptoms that you've experienced within the last 6 months)

GENERAL
Fever
Chills
Weakness
Night Sweats
Weight Gain
Weight Loss
Loss of Appetite
Fatigue
Loss of Sleep

CARDIOVASCULAR
Chest Pain
Angina
Murmur
Irregular Heart Beat
Palpitations
Extremity Swelling
Varicose Veins
Pain with Walking
Cold Hands or Feet
High Cholesterol
High Triglycerides
High Blood Pressure
Heart Attacks
Congestive Heart Failure
Atherosclerosis

GENITOURINARY
Frequent Urination
Diffculty Controlling Urination
Blood in Urine
Pain with Urination
Passage of Stones

ENDOCRINE
Heat/Cold Intolerance
Thyroid Disease
Thyroid Removed
Goiter
Decreased Energy
Hands/Feet Cold
Diabetes Type I or II
Heat Intolerance
Adrenal Disease
Kidney Disease
Kidney Stones

HEAD
Headache
Trauma
Dizziness
Vertigo

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

SKIN/HAIR
Rash
Pruritus
Moles
Cancer
Dryness
Acne
Eczema
Psoriasis
Hair Loss
Hives

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

ENDOCRINE (MALE)
Erection Issues
Prostate Cancer
Prostate Enlarged
Sexual Desire Diminished
UTI's
Urinary:Dribble Hesitancy, Frequency

EYES
Double Vision
Blurred Vision
Cataracts
Discharge
Glaucoma
Watery Eyes

GASTROINTESTINAL
Nausea
Vomiting
Diarrhea
Constipation
Ulcer
Blood in Stool
Abdominal
Hernia
Hemorrhoids
Change in Appetite
Anal or Rectal pain/itching
Bloating/Belching/Gas
Gall Stones
Reflux
Hepatitis/Liver
IBS
Elevated Liver Enzymes

MUSCULOSKELETAL
Muscle Pain
Muscle Spasm
Muscle Atrophy
Back Pain/Stiffness
Neck Pain/Stiffness
Joint Pain
Joint Stiffness
Weakness
Fractures
Carpal Tunnel Syndrome
Neuropathy
Osteoporosis/Osteopenia
Sciatica

ALLERGY/IMMUNOLOGIC
Sinusitis
Seasonal Allergies
Allergy Shots
Cancer(type:)
Diabetes Type I
Hashimotos Thyroiditis
Grave's Disease
Lupus
Multiple Sclerosis
Rheumatoid Arthritis

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

ENDOGYNECOLOGIC
Self-Exam
Masses/Lump
Vaginal Discharge
Nipple Discharge
Infertility
Menstruation Irregular
Painful Intercourse
PCOS
Premenstrual Syndrome
Painful Menstruation
Fibroid Tumor
Yeast Infections
Recurrent UTI's
Bleeding between Periods
Endometriosis
Hot Flashes
Loss of Sex Drive
Vaginal Dryness

Psychiatric
Anxiety
Depression
Hallucinations
Sleep Disturbance
Body Image Concerns
Cravings
Eat When Nervous
High Stress
Mood Swings
Phobias

Neurologic
Loss of Consciosness
Fainting
Numbness
Weakness
Tingling
Seizures

Date of Last Mammogram or Breast Thermography	N/A
Date of Last Menstrual Period	N/A
Date of Last Pelvic Exam	N/A

How Would You Rate Your Stress Level? 1 2 3 4 5 6 7 8 9 10 (1=very low, 10=very high)

How does stress affect you? 1 2 3 4 5 6 7 8 9 10 (1=doesn't bother me, 10=it really affects

me) How often do you exercise? Never Rarely Sometimes Regularly

Competitively

Is your exercise limited due to any problems with your body? (i.e., pain, fatigue, breathing, etc)
Yes No If Yes, please explain ____

How well do you sleep? (circle all that apply)
Very Well Trouble falling asleep Trouble staying asleep Insomnia Sleep Apnea

How Long has this been happening? ______________________________________

How many hours do you sleep per night on average? ___________

Do you wake up tired, even if you slept several hours? Yes No How long has
this occurred? ________

Do Night Sweats wake you up? Yes No

Do you wake because you have to urinate? Yes No

Do you take sleep aids? Yes No If Yes, how often? __________________________

Have You Had a Bone Density Study? Yes No If Yes, Please Note Findings, Date and
Facility ____

Have You Ever Had Joint Injections or Trigger Point Injections? Yes No If Yes, Please
Specify and Record Location ____

Have You Tried Unsuccessfully to Lose Weight in the Past? Yes No If Yes, What Have
You Tried? ____

Have You Been Told That You Will Need Knee Replacement Surgery? Yes No

Comments

Please use the area below to communicate anything that you think is important for us to know regarding your health and your health goals

____

____

____

____

____

____

Signature

I certify that the information I have provided Advanced Integrative Medicine is answered accurately to the best of my ability. I will not hold any AIM doctors, or members of the staff responsible for any errors or omissions that I may have made in the completion of this form.

____ ______/______/______

Patient or Guardian Signature/Parent or Guardian Signature (if patient is under 18 years of age) Date

____

Printed name