Nowak Chiropractic S.C.
4600 W. Loomis Road Ste. #110
Greenfield WI, 53220
Ph: (414) 481-1021 Fax: (414) 481-3044

PERSONAL INJURY QUESTIONNAIRE

Date:____/____/____ Acct#_____CA_____
Doctor Referred To:_____

Name:_____ Social Security#_____
Email Address:_____
Name of Parent (if under age 18)_____
Street Address:_____City/State/Zip:_____
Cell Phone#:_____ Home Phone#:_____Work Phone#:_____
Birth-date:____/____/____ Age:_____ Sex: M F Married? Yes No
Employed By:_____Occupation:_____

Name of Primary Health Insurance:_____
Name of Secondary Health Insurance:_____

Name of Your Auto Insurance:_____
Your Agent's Name and Phone#:_____

Your Attorney Name:_____
Address of Attorney:_____
Attorney's Phone#:_____

NATURE OF ACCIDENT:

1. **Date of Accident**____/____/____ Time of Day:_____ A.M. P.M.
2. Were you: ( ) Driver ( ) Passenger ( ) Front Seat ( ) Back Seat
3. Number of people in your vehicle?_____ Were you wearing seat belts? ( ) Yes ( ) No
   Which applies: ( ) Shoulder harness with lap OR ( ) Lap only
4. What direction were you headed? ( ) North ( ) East ( ) South ( ) West
   on (name of street)_____
5. What direction was the other vehicle headed? ( ) North ( )East ( ) South ( ) West
6. Were you struck from: ( ) Behind ( ) Front ( )Left Side ( ) Right Side
7. Were the air bags deployed (if applicable)? ( ) Yes ( ) No
8. Approximate speed of your vehicle?_____MPH Other Vehicle?_____MPH
9. Were you knocked unconscious? ( ) Yes ( ) No If yes, for how long?_____
10. Did you strike anything? ( ) Windshield ( ) Seat back ( ) Other_____
11. Road surface: ( ) Dry ( ) Wet
12. Were police notified? ( ) Yes ( ) No
13. Make and year of vehicle you were in:_____
    Make and year of vehicle that was also involved:_____

14. In your own words, please describe the accident:_____

15. Please describe how you felt:
    a. During the accident:_____
    b. Immediately after the accident:_____
    c. Later the day:_____
    d. The next day:_____

16. What are you **PRESENT** complaints and symptoms?_____

17. Where were you taken after the present accident?_____

18. Have you been treated by another doctor since the accident? ( ) Yes ( ) No
    If yes, please list doctor's name and dates treated:_____

19. What type of treatment did you receive?_____

20. Are you taking any medications? ( ) Yes ( ) No
    If yes, please list:_____

21. Did you have any physical complaints **BEFORE THE ACCIDENT?** ( ) Yes ( ) No
    If yes, please describe in detail:_____

22. Do you have any congenital (from birth) factors which relate to this problem?
    ( ) Yes ( ) No

23. Have you ever been involved in an accident before? ( ) Yes ( ) No
    If yes, please describe dates and injuries incurred:_____

24. What **PREVIOUS** illnesses have you had?_____

25. Have you **EVER** had surgery? ( ) Yes ( ) No
    If yes, please give date(s) and condition(s)_____

26. Since **THIS** injury occurred, are your symptoms:
    ( ) Improving ( ) Getting Worse ( ) Same

27. Check the symptoms you have noticed since the accident:

___Headache
___Dizziness
___Buzzing or Ringing in Ears
___Neck Pain/Stiffness
___Upper Back Pain/Stiffness
___Mid Back Pain/Stiffness
___Low Back Pain/Stiffness
___Loss of Balance
___Loss of Memory
___Vision Problems
___Nausea/Vomiting
___Head seems too Heavy
___Depression

28. Do you have pain, numbing, tingling radiating into:

___Base of Skull
___Rt/Lt Shoulder
___Rt/Lt Hand
___Rt/Lt Arm
___Rt/Lt Hip
___Rt/Lt Leg

29. Have you lost time from work as a result of this accident? ( ) Yes ( ) No
    If yes, please complete:
    a. Last day worked: ____/____/____
    b. Present Salary: _____
    c. Are you being compensated for time lost from work? ( ) Yes ( ) No
30. What kind of work do you do? _____
31. Do you notice any activity restrictions as a result of this injury? ( ) Yes ( ) No
    If yes, please describe in detail: _____
32. Other pertinent information: _____

_____
Patient Signature or Legal Guardian

_____
Date

PATIENT REPORT

NAME:_____ DATE:_____

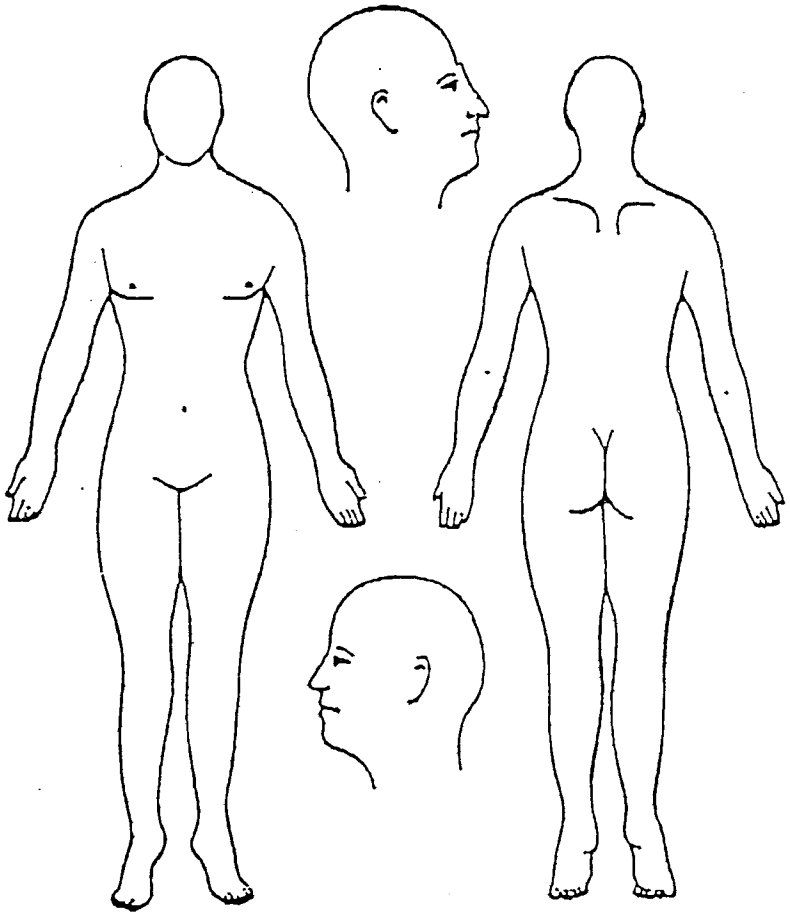
We ask your cooperation in completing the following information.

TELL US WHERE YOU HURT

Please read carefully:

Mark the areas on your body where you feel your pain. Include all affected areas. Mark areas of radiation. If your pain radiates, draw an arrow from where it starts to where it stops. Please extend the arrow as far as the pain travels. Use the appropriate symbols listed below.

Ache >>>> >>>>	Numbness ==== ====	Pins and Needles 0000 0000
Burning xxxx xxxx	Stabbing //// ////	Throbbing ~~~~ ~~~~



SEVERITY OF PAIN

Name region of pain and circle severity number (1=least, 10=greatest, 0=none)

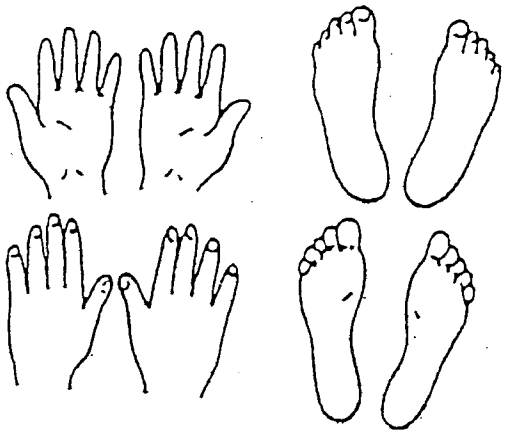
1._____
0 1 2 3 4 5 6 7 8 9 10

2._____
0 1 2 3 4 5 6 7 8 9 10

3._____
0 1 2 3 4 5 6 7 8 9 10

4._____
0 1 2 3 4 5 6 7 8 9 10

5._____
0 1 2 3 4 5 6 7 8 9 10



Comments:_____

_____

PATIENT SIGNATURE:_____

Neck Pain and Disability Index (Vernon-Mior)

Patient Name: _____ **File#** _____ **Date:** _____

Please read instructions:

This questionnaire has been designed to give the doctor information as to how your neck pain has affected your ability to manage in everyday life. Please answer every section and mark in each section only the **ONE** box which applies to you. We realize you may consider that two of the statements in any one section relate to you, but just mark the box which most closely describes your problem.

SECTION 1 - PAIN INTENSITY

- ☐ I have no pain at the moment.
- ☐ The pain is very mild at the moment.
- ☐ The pain is moderate at the moment.
- ☐ The pain is fairly severe at the moment.
- ☐ The pain is very severe at the moment.
- ☐ The pain is the worst imaginable at the moment.

SECTION 2 - PERSONAL CARE (Washing, Dressing, etc)

- ☐ I can look after myself normally without causing extra pain.
- ☐ I can look after myself normally but it causes extra pain.
- ☐ It is painful to look after myself and I am slow and careful.
- ☐ I need some help but manage most of my personal care.
- ☐ I need help every day in most aspects of self care.
- ☐ I do not get dressed, I wash with difficulty and stay in bed.

SECTION 3 - LIFTING

- ☐ I can lift heavy weights without extra pain.
- ☐ I can lift heavy weights but it gives extra pain.
- ☐ Pain prevents me from lifting heavy weights off the floor, but I can manage if they are conveniently positioned, for example on a table.
- ☐ Pain prevents me from lifting heavy weights, but I can manage light to medium weights if they are conveniently positioned.
- ☐ I can lift very light weights.
- ☐ I cannot lift or carry anything at all.

SECTION 4 - READING

- ☐ I can read as much as I want to with no pain in my neck.
- ☐ I can read as much as I want with slight pain in my neck.
- ☐ I can read as much as I want with moderate pain in my neck.
- ☐ I can't read as much as I want because of moderate pain in my neck.
- ☐ I can hardly read at all because of severe pain in my neck.
- ☐ I cannot read at all.

SECTION 5 - HEADACHES

- ☐ I have no headaches at all.
- ☐ I have slight headaches which come infrequently.
- ☐ I have moderate headaches which come infrequently.
- ☐ I have moderate headaches which come frequently.
- ☐ I have severe headaches which come frequently.
- ☐ I have headaches almost all the time.

SECTION 6 - CONCENTRATION

- ☐ I can concentrate fully when I want to with no difficulty.
- ☐ I can concentrate fully when I want to with slight difficulty.
- ☐ I have a fair degree of difficulty in concentrating when I want to.
- ☐ I have a lot of difficulty in concentrating when I want to.
- ☐ I have a great deal of difficulty in concentrating when I want to.
- ☐ I cannot concentrate at all.

SECTION 7 - WORK

- ☐ I can do as much as I want to.
- ☐ I can only do my usual work, but no more.
- ☐ I can do most of my usual work, but no more.
- ☐ I cannot do my usual work.
- ☐ I can hardly do any work at all.
- ☐ I can't do any work at all.

SECTION 8 - DRIVING

- ☐ I can drive my car without any neck pain.
- ☐ I can drive my car as long as I want with slight pain in my neck.
- ☐ I can drive my car as long as I want with moderate pain in my neck.
- ☐ I can't drive my car as long as I want because of moderate pain in my neck.
- ☐ I can hardly drive at all because of severe pain in my neck.
- ☐ I can't drive my car at all.

SECTION 9 - SLEEPING

- ☐ I have no trouble sleeping.
- ☐ My sleep is slightly disturbed (less than 1 hr. sleepless).
- ☐ My sleep is mildly disturbed (1-2 hrs. sleepless).
- ☐ My sleep is moderately disturbed (2-3 hrs. sleepless).
- ☐ My sleep is greatly disturbed (3-5 hrs. sleepless).
- ☐ My sleep is completely disturbed (5-7 hrs. sleepless).

SECTION 10 - RECREATION

- ☐ I am able to engage in all my recreation activities with no neck pain at all.
- ☐ I am able to engage in all my recreation activities, with some pain in my neck.
- ☐ I am able to engage in most, but not all of my usual recreation activities because of pain in my neck.
- ☐ I am able to engage in a few of my usual recreation activities because of pain in my neck.
- ☐ I can hardly do any recreation activities because of pain in my neck.
- ☐ I can't do any recreation activities at all.

Low Back Pain and Disability Questionnaire (Revised Oswestry)

Patient Name: _____ File # _____ Date: _____

This questionnaire has been designed to give the doctor information as to how your back pain has affected your ability to manage everyday life. Please answer every section and mark in each section only the ONE box which applies to you. We realize you may consider that two of the statements in any one section relate to you, but please just mark the box which most closely describes your problem.

SECTION 1- PAIN INTENSITY

- ☐ The pain comes and goes and is very mild.
- ☐ The pain is mild and does not vary much.
- ☐ The pain comes and goes and is moderate.
- ☐ The pain is moderate and does not vary much.
- ☐ The pain comes and goes and is very severe.
- ☐ The pain is severe and does not vary much.

SECTION 2 - PERSONAL CARE

- ☐ I would not have to change my way of washing or dressing in order to avoid pain.
- ☐ I do not normally change my way of washing or dressing even though it causes some pain.
- ☐ Washing and dressing increase the pain but I manage not to change my way of doing it.
- ☐ Washing and dressing increase the pain and I find it necessary to change my way of doing it.
- ☐ Because of the pain I am unable to do some washing and dressing without help.
- ☐ Because of the pain I am unable to do any washing and dressing without help.

SECTION 3 - LIFTING

- ☐ I can lift heavy weights without extra pain.
- ☐ I can lift heavy weights but it causes extra pain.
- ☐ Pain prevents me from lifting heavy weights off the floor.
- ☐ Pain prevents me from lifting heavy weights off the floor, but I manage if they are conveniently positioned (e.g. on a table).
- ☐ Pain prevents me from lifting heavy weights but I can manage light to medium weights if they are conveniently positioned.
- ☐ I can only lift very light weights at the most.

SECTION 4 - WALKING

- ☐ I have no pain on walking.
- ☐ I have some pain on walking but it does not increase with distance.
- ☐ I cannot walk more than one mile without increasing pain.
- ☐ I cannot walk more than 1/2 mile without increasing pain.
- ☐ I cannot walk more than 1/4 mile without increasing pain.
- ☐ I cannot walk at all without increasing pain.

SECTION 5 - SITTING

- ☐ I can sit in any chair as long as I like.
- ☐ I can only sit in my favorite chair as long as I like.
- ☐ Pain prevents me from sitting more than one hour.
- ☐ Pain prevents me from sitting more than half hour.
- ☐ Pain prevents me from sitting more than 10 minutes.
- ☐ I avoid sitting because it increases pain straight away.

SECTION 6 - STANDING

- ☐ I can stand as long as I want without pain.
- ☐ I have some pain on standing but it does not increase with time.
- ☐ I cannot stand for longer than one hour without increasing pain.
- ☐ I cannot stand for longer than 1/2 hour without increasing pain.
- ☐ I cannot stand for longer than 10 minutes without increasing pain.
- ☐ I avoid standing because it increases the pain straight away.

SECTION 7 - SLEEPING

- ☐ I get no pain in bed.
- ☐ I get pain in bed but it does not prevent me from sleeping well.
- ☐ Because of pain my normal night's sleep is reduced by less than 1/4.
- ☐ Because of pain my normal night's sleep is reduced by less than 1/2.
- ☐ Because of pain my normal night's sleep is reduced by less than 3/4.
- ☐ Pain prevents me from sleeping at all.

SECTION 8 - SOCIAL LIFE

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

SECTION 9 - TRAVELLING

- ☐ I get no pain while travelling.
- ☐ I get some pain while travelling but none of my usual forms of travel make it any worse.
- ☐ I get extra pain while travelling but it does not compel me to seek alternative forms of travel.
- ☐ I get extra pain while travelling which compels me to seek alternative forms of travel.
- ☐ Pain restricts all forms of travel.
- ☐ Pain prevents all forms of travel except that done lying down.

SECTION 10 - CHANGING DEGREE OF PAIN

- ☐ My pain is rapidly getting better,
- ☐ My pain fluctuates but overall is definitely getting better.
- ☐ My pain seems to be getting better but improvement is slow at present.
- ☐ My pain is neither getting better nor worse.
- ☐ My pain is gradually worsening.
- ☐ My pain is rapidly worsening.

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Patient Health Information Consent Form

We want you to know how your Patient Health Information (**PHI**) is going to be used in this office and your rights concerning those records. Before we will begin any health care operations we must require you to read and sign this consent form stating that you understand and agree with how your records will be used. If you would like to have a more detailed account of our policies and procedures concerning the privacy of your Patient Health Information we encourage you to read the HIPAA NOTICE that is available to you at the front desk before signing this consent.

1. The patient understands and agrees to allow this chiropractic office to use their Patient Health Information (**PHI**) for the purpose of treatment, payment, healthcare operations, and coordination of care. As an example, the patient agrees to allow this chiropractic office to submit requested PHI to the Health Insurance Company (or companies) provided to us by the patient for the purpose of payment. Be assured that this office will limit the release of all. PHI to the minimum needed for what the insurance companies require for payment.
2. The patient has the right to examine and obtain a copy of his or her own health records at any time and request corrections. The patient may request to know what disclosures have been made and submit in writing any further restrictions on the use of their PHI. Our office is not obligated to agree to those restrictions.
3. A patient's written consent need only be obtained one time for all subsequent care given the patient in this office.
4. The patient may provide a written request to revoke consent at any time during care. This would not effect the use of those records for the care given prior to the written request to revoke consent but would apply to any care given after the request has been presented.
5. For your security and right to privacy, all staff has been trained in the area of patient record privacy and a privacy official has been designated to enforce those procedures in our office. We have taken all precautions that are known by this office to assure that your records are not readily available to those who do not need them.
6. Patients have the right to file a formal complaint with our privacy official about any possible violations of these policies and procedures.
7. If the patient refuses to sign this consent for the purpose of treatment, payment and health care operations, the chiropractic physician has the right to refuse to give care.

I have read and understand how my Patient Health Information will be used and I agree to these policies and procedures.

SIGNATURE _____ DATE _____

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Informed Consent To Chiropractic Treatment

The nature of chiropractic treatment: The doctor will use his/her hands or a mechanical device in order to move your joints. You may feel a "click" or "pop," such as the noise when a knuckle is "cracked," and you may feel movement of the joint. Various ancillary procedures, such as hot or cold packs, electric muscle stimulation, therapeutic ultrasound or traction may also be used.

Possible risks: As with any health care procedure, complications are possible following a chiropractic manipulation. Complications could include fractures of bone, muscular strain, ligamentous sprain, dislocations of joints, or injury to intervertebral discs, nerves or spinal cord. Cerebrovascular injury, or stroke, could occur upon severe injury to arteries of the neck. A minority of patients may notice stiffness or soreness after the first few days of treatment. The ancillary procedures could produce skin irritation, burns or other minor complications.

Probability of risks occurring: The risks of complications due to chiropractic treatment have been described as "rare," about as often as complications are seen from the taking of a single aspirin tablet. The risk of cerebrovascular injury, or stroke, has been estimated at one in one million to one in ten million, and can be even further reduced by screening procedures. The probability of adverse reaction due to ancillary procedures is also considered "rare."

Other treatment options that could be considered may include the following:

- Over-the counter analgesics. The risks of these medications include irritation to stomach, liver and kidneys, and other side effects in a significant number of cases.

- Medical care, typically anti-inflammatory drugs, tranquilizers, and analgesics. Risks of these drugs include a multitude of undesirable side effects and patient dependence in a significant number of cases.

- Hospitalization in conjunction with medical care adds risk of exposure to virulent communicable disease in a significant number of cases.

- Surgery in conjunction with medical care adds the risks of adverse reaction to anesthesia, as well as an extended convalescent period in a significant number of cases.

Risks of remaining untreated: Delay of treatment allows formation of adhesions, scar tissue and other degenerative changes. These changes can further reduce skeletal mobility, an induce chronic pain cycles, It is quite probable that delay of treatment will complicate the condition, and make future rehabilitation more difficult.

I have read the explanation above of chiropractic treatment. I have had the opportunity to have any questions answered to my satisfaction. I have fully evaluated the risks and benefits of undergoing treatment. I have freely decided to undergo the recommended treatment, and hereby give my full consent to treatment.

Printed Name _____ Signature _____ Date _____

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FINANCIAL POLICY OF NOWAK CHIROPRACTIC S.C.

Insurance cards should be presented to our front desk on the first visit. Your chiropractic coverage will be verified by our insurance dept. Your coverage will be explained to you on your second visit. It is understood that you are responsible to obtain any referral that may be necessary to seek chiropractic care.

All copays are to be paid at each visit. You may pay your copays in advance if you wish. We accept cash, checks, Mastercard and Visa as payment.

Payment must be presented for any nuritional supplements, pillows, backhuggers, cervical roll pillows, braces and any other supports your Doctor recommends to you. It is understood that your your insurance carrier will not be billed for these items.

I understand and agree that health and accident insurance policies are an arrangement between my insurance carrier and myself. I understand that this office will submit my claims to my insurance company and that any amount authorized to be paid directly to this office will be credited to my account on receipt.

However, I clearly understand and agree that all services rendered me are charged directly to me and that I am personally responsible for payment for any amount that is not paid and/or covered by my insurance policy.

I have read and understand all of the above:

Patient Signature:_____
Print Your Name:_____

Date:_____