justice family chiropractic

# PATIENT INFORMATION

Name: _____ (Age) _____ Gender: M F

Home Address: _____ Cell Phone: ( ) _____

City, State, Zip: _____ Home Phone: ( ) _____

Email Address: _____ Work Phone: ( ) _____

Birth Date: _____ / _____ / _____ Social Security #: _____ - _____ - _____ Marital Status: S M D W

Names of Children: _____ Ages: _____

Females only: Pregnant: Yes / No Estimated due date: _____

Occupation: _____ Employer Name: _____

Spouse's Name: _____ Cell Phone: ( ) _____ Work Phone: ( ) _____

Spouse's Employer: _____ Occupation: _____

How were you referred to this office? _____

# INSURANCE INFORMATION

Patient's Car Ins. Company: _____ Ins. Phone #: _____

Claim #: _____ Name of policy holder:_____

Adjuster's name:_____ Adjuster's phone number:_____

PIP insurance available: ☐ Yes ☐ No

Insurance company of other vehicle involved: _____ Ins. Phone #: _____

Claim #: _____ Name of policy holder:_____

Adjuster's name:_____ Adjuster's phone number:_____

Policy: _____

# ACCIDENT INFORMATION

Date of accident: _____ Time of accident: _____

Driver of car: _____ Where were you seated:_____

Who owns the car:_____

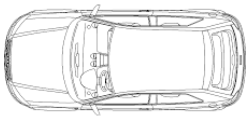
Year and model of your car:_____

Year and model of other car:_____

What was the approximate amount of damage done to your car:_____

Visibility at the time of accident: ☐ Poor ☐ Fair ☐ Good ☐ Other _____

Road conditions at time of accident: ☐ icy ☐ rainy ☐ wet ☐ clear ☐ dry ☐ other: _____

Where was the car struck: FRONT  REAR

In your own words, please describe the accident: _____

_____

_____

Illustrate how the accident happened:

Type of collision: ☐ Head-on ☐ Broad-side ☐ Front impact ☐ Rear end of car in front ☐ Rear impact ☐ Non-collision

At the time of the accident, what part of your head or body parts hit the inside of the car? _____

Did you see the accident coming: ☐ Yes ☐ No Did you brace for impact: ☐ Yes ☐ No

Did you have your seatbelt on: ☐ Yes ☐ No Did your seatbelt have a shoulder harness that was on: ☐ Yes ☐ No

Does your car have headrests: ☐ Yes ☐ No

If yes, what position was the headrest in compared to your head: ☐ Top of headrest even with bottom of head

☐ Top of headrest even with top of head ☐ Top of headrest even with middle of head

Was your car braking: ☐ Yes ☐ No Was your car moving at the time of impact: ☐ Yes ☐ No

If yes, estimate of how fast you were going _____mph The speed of the other car _____ mph

Head/body position at time of accident: ☐ Head turned left or right ☐ Head looking back ☐ Head straight forward

☐ Body straight in sitting position ☐ Body rotated left or right ☐ Other:_____

As a result of the accident were you: ☐ Rendered unconscious ☐ In shock ☐ Dazed, circumstances vague ☐ Other: _____

How was the shoulder harness adjusted: ☐ Loose ☐ Snug

Were you wearing a hat or glasses: ☐ Yes ☐ No

Could you move all parts of your body ☐ Yes ☐ No

If no, what parts could you not move and why: _____

Were you able to get out of the car and walk unaided: ☐ Yes ☐ No If not, why not:_____

Did you get any bleeding cuts: ☐ Yes ☐ No If yes, where:_____

Did you get any bruises: ☐ Yes ☐ No If yes, where:_____

Describe how you felt immediately after the accident:_____

Later that day:_____

The next day:_____

Check the symptoms apparent since the accident:

| | | | | |
|---|---|---|---|---|
| ☐ Headache | ☐ Chest pain | ☐ Neck pain/stiffness | ☐ Mid-back pain | ☐ Light sensitivity |
| ☐ Light sensitivity | ☐ Pain behind ears | ☐ Dizziness | ☐ Low-back pain | ☐ Sleeping problems |
| ☐ Diarrhea | ☐ Loss of smell | ☐ Numbness in toes | ☐ Fainting | ☐Cold feet |
| ☐ Facial pain | ☐ Loss of memory | ☐ Fatigue | ☐ Breath shortness | ☐ Lost of taste |
| ☐ Irritability | ☐ Depression | ☐Ringing/buzzing | ☐ Cold sweats | ☐ Loss of balance |
| ☐ Tension | ☐ Constipation | ☐ Cold hands | ☐ Clicking/popping of jaw | ☐ Numbness in fingers |

☐ Other:_____

Have you missed time from work: ☐ Yes ☐ No

If yes, full time off of work _____ to _____

If yes, part time off of work _____ to _____

Did you seek medical care immediately after accident: ☐ Yes ☐ No

If yes, how did you get there: ☐ Ambulance ☐ Police ☐ Someone drove me ☐ Drove myself ☐ Other:_____

Doctor #1:_____ First visit date:_____

Were you examined: ☐ Yes ☐ No X-rays taken: ☐ Yes ☐ No

Did you receive treatment: ☐ Yes ☐ No ☐ Medication ☐ Braces ☐ Collars

If yes, what kind of treatment did you receive: _____

What benefits did you receive from treatment: _____

Date of last treatment:_____

Doctor #2:_____ First visit date:_____

Were you examined: ☐ Yes ☐ No X-rays taken: ☐ Yes ☐ No

Did you receive treatment: ☐ Yes ☐ No ☐ Medication ☐ Braces ☐ Collars

If yes, what kind of treatment did you receive: _____

What benefits did you receive from treatment: _____

Date of last treatment: _____

Do you have an attorney for this claim: ☐ Yes ☐ No

If yes, name of attorney: _____ Name of firm:_____

Address: _____City/St_____ Zip_____

Phone: _____

# TERMS OF ACCEPTANCE

When a person seeks chiropractic and rehabilitation health care and is accepted for such care, it is essential for both parties to be working towards the same objective. As a Chiropractic facility we have one main goal, to detect and correct/reduce the vertebral subluxation complex. It is important that each person understand both the objective and the method that will be used to attain this goal. This will prevent any confusion or disappointment.

**Adjustment:** An adjustment is the specific application of forces to facilitate the body's correction of vertebral subluxation. Our chiropractic method is by specific adjustments of the spine.

**Health:** A state of optimal physical, mental and social well-being, not merely the absence of disease or infirmity.

**Vertebral Subluxation:** A misalignment of one or more of the 24 vertebra in the spinal column which causes alteration of nerve function and interference to the transmission of mental impulses, resulting in a lessening of the body's innate ability to express it's maximum health potential.

We do not offer to diagnose or treat a disease or condition other than vertebral subluxation. Regardless of what a disease is called, we do not offer to treat it. Nor do we offer advice regarding treatment prescribed by others. **Our Only Practice Objective** is to eliminate a major interference to the expression of the body's innate wisdom and ability to heal. Our only method is specific adjusting to correct vertebral subluxations combined with rehabilitation procedures.

# CONSENT TO CARE

I do hereby authorize the doctors of Justice Family Chiropractic PLLC to administer such care that is necessary for my particular case. This care may include consultation(s), examination(s), spinal adjustments and other chiropractic procedures, including Insight scanning and diagnostic x-rays or any other procedure that is advisable, and necessary for my health care. I understand that all examination procedures, including x-rays, are being performed to locate vertebral subluxation, and not to diagnose or treat any other disease or condition.

Furthermore, I authorize and agree to allow the Daniel Justice D.C. and Lindsay Justice D.C. and/or other licensed doctors of chiropractic who now or in the future treat me while employed by, working or associated with or serving as back-up for the doctor of chiropractic named below, including those working at the clinic or office listed below or any other office or clinic, to work with my spine through the use of spinal adjustments for the sole purpose of postural and structural restoration to allow for normal biomechanical motion and neurological function.

I have had an opportunity to discuss with the doctor(s) of chiropractic named above and/or with other office or clinic personnel the nature and purpose of chiropractic adjustments and other procedures related to my health care. I understand that I am responsible for all fees incurred for the services provided, and agree to ensure full payment of all charges.

I understand and am informed that, as in the practice of medicine, in the practice of chiropractic there are some risks to treatment. I do not expect the doctor to be able to anticipate and explain all risks and complications, and I wish to rely on the doctor to exercise judgment during the course of the procedure which the doctor feels at the time, based upon the facts then known, is in my best interests. The doctor will not be held responsible for any health conditions or diagnoses which are pre-existing, given by another health care practitioner, or are not related to the spinal structural conditions treated at this clinic.

I also clearly understand that if I do not follow the Doctors specific recommendations at this clinic that I will not receive the full benefit from the programs offered, and that if I terminate my care prematurely that all fees incurred will be due and payable at that time. I authorize the assignment of all insurance benefits be directed to the Doctor for all services rendered. I also understand any sum of money paid under assignment by any insurance company shall be credited to my account, and I shall be personally liable for any and all of the unpaid balance to the doctor.

I have read or have had read to me, the above consent. I have also had the opportunity to ask questions about this consent, and by signing below I agree to the above-above named procedures. I intend this consent form to cover the entire course of treatment for my present condition and for any future conditions(s) for which I seek treatment.

Signature_____ Date _____ *(If under age 18: Parent's signature)*

**Pregnancy Release (If Applicable)**

This is to certify that to the best of my knowledge I am not pregnant and the above doctor and his associates have my permission to perform an x-ray evaluation. I have been advised that x-ray can be hazardous to an unborn child.

_____ _____

Signature Date

# FINANCIAL INFORMATION

I understand that all services rendered are my financial responsibility. I clearly understand that all insurance coverage is an arrangement between my insurance carrier and me. If this office chooses to bill any services to my insurance carrier that they are performing these services strictly as a convenience for me. Justice Family Chiropractic will provide any necessary report or required information to aid in insurance reimbursement of services, but I understand that insurance carriers may deny any claim and that I am ultimately held responsible for any unpaid balances. I also understand that if my insurance company requires pre-authorization of services or review of medical notes, that Justice Family Chiropractic will provide required documentation to my insurance company but I am financially responsible if my insurance chooses not to cover rendered services. Any monies received will be credited to my account. I certify that if this office visit is related to any personal injury or worker's compensation case that is active or that has not been closed I have noted this above.

Signature_____ Date _____
*(If under age 18)* Parent's signature

# Acknowledgement of Receipt
# of Notice of Privacy Practices

**I understand and have been provided with the opportunity to review a Notice of Privacy Practices that provides a more complete description of information uses and disclosures. I understand that I have the following rights and privileges:**

1) The right to review the notice prior to signing this consent,
2) The right to object to the use of my health information for directory purposes, and
3) The right to request restrictions as to how my health information may be used or disclosed to carry out treatment, payment or health care operations.

## Appointment Reminders and Health Care Information Authorization

Your chiropractor and members of the practice staff may need to use your name, address, phone number, and your clinical records to contact you with appointment reminders, information about treatment alternatives, or other health related information that may be of interest to you. If this contact is made by phone and you are not at home, a message will be left on our answering machine. By signing this form, you are giving us authorization to contact you with these reminders and information.

Patient Signature: Date:

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I, _____, direct my health care and medical services providers and payers to disclose and release my protected health information to:

Name: _____ Relationship:_____

If not signed by the patient, please indicate relationship.

- ❑ Parent or guardian of minor patient
- ❑ Guardian or conservator of an incompetent patient
- ❑ Beneficiary or personal representative of deceased patient

Name of Patient: _____

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**Patient name:** _____

**Date of form completion:** _____

# *Oswestry Disability Index*

**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 but it is very painful.
- ☐ I can look after myself normally but it is very painful.
- ☐ 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 my personal care.
- ☐ I need help every day in most aspects of self-care.
- ☐ I do not get dressed, 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 (i.e. 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 only very light weights.
- ☐ I cannot lift or carry anything at all.

**Section 4 – Walking**

- ☐ Pain does not prevent me walking any distance.
- ☐ Pain prevents me walking more than 1mile.
- ☐ Pain prevents me walking more than ¼ of a mile.
- ☐ Pain prevents me walking more than 100 yards.
- ☐ I can only walk using a stick or crutches.
- ☐ I am in bed most of the time and have to crawl to the toilet.

**Section 5 – Sitting**

- ☐ I can sit in any chair as long as I like.
- ☐ I can sit in my favorite chair as long as I like.
- ☐ Pain prevents me from sitting for more than 1 hour.
- ☐ Pain prevents me from sitting for more than ½ hour.
- ☐ Pain prevents me from sitting for more than 10 minutes.
- ☐ Pain prevents me from sitting at all.

**Section 6 – Standing**

- ☐ I can stand as long as I want without extra pain.
- ☐ I can stand as long as I want but it gives me extra pain.
- ☐ Pain prevents me from standing more than 1 hour.
- ☐ Pain prevents me from standing for more than ½ an hour.
- ☐ Pain prevents me from standing for more than 10 minutes.
- ☐ Pain prevents me from standing at all.

**Section 7 – Sleeping**

- ☐ My sleep is never disturbed by pain.
- ☐ My sleep is occasionally disturbed by pain.
- ☐ Because of pain, I have less than 6 hours sleep.
- ☐ Because of pain, I have less than 4 hours sleep.
- ☐ Because of pain, I have less than 2 hours sleep.
- ☐ Pain prevents me from sleeping at all.

**Section 8 – Sex life (if applicable)**

- ☐ My sex life is normal and causes no extra pain.
- ☐ My sex life is normal but causes some extra pain.
- ☐ My sex life is nearly normal but is very painful.
- ☐ My sex life is severely restricted by pain.
- ☐ My sex life is nearly absent because of pain.
- ☐ Pain prevents any sex life at all.

**Section 9 – Social Life**

- ☐ My social life is normal and causes me no extra 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, i.e. sports.
- ☐ Pain has restricted my social life and I do not go out as often.
- ☐ Pain has restricted social life to my home.
- ☐ I have no social life because of pain.

**Section 10 – Traveling**

- ☐ I can travel anywhere without pain.
- ☐ I can travel anywhere but it gives extra pain.
- ☐ Pain is bad but I manage journeys of over two hours.
- ☐ Pain restricts me to short necessary journeys under 30 minutes.
- ☐ Pain prevents me from traveling except to receive treatment.

**Section 11 - Previous Treatment**

Over the past three months have you received treatment, tablets or medications of any kind for your back or leg pain? Please check the appropriate box. □ No □ Yes

If yes, please state the type of treatment you have received):_____

_____

_____

_____

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**Patient name:** _____

**Date of form completion:** _____

# *Neck Disability Index*

**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 but it is very painful.
- ☐ I can look after myself normally but it is very painful.
- ☐ 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 my personal care.
- ☐ I need help every day in most aspects of self-care.
- ☐ I do not get dressed, 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 (i.e. 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 only 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 to with slight pain in my neck.
- ☐ I can read as much as I want with moderate pain in my neck.
- ☐ I cannot 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 that 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 work as I want to.
- ☐ I can 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 cannot 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 cannot 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 cannot drive my car at all.

**Section 9 – Sleeping**

- ☐ I have no trouble sleeping.
- ☐ My sleep is slightly disturbed (less than 1 hour sleepless).
- ☐ My sleep is mildly disturbed (1-2 hours sleepless).
- ☐ My sleep is moderately disturbed (2-3 hours sleepless).
- ☐ My sleep is greatly disturbed (3-5 hours sleepless).
- ☐ My sleep is completely disturbed (5-7 hours 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 cannot do any recreation activities at all.