Account # _____
(for office use only)

PATIENT INFORMATION

FAMILYFIRST CHIROPRACTIC

Name: _____ Date: _____

Address | City | State |Zip Code: _____

Phone: _____ Email: _____

DOB: _____ ☐ Male ☐ Female Preferred Pronoun: _____

☐ Married ☐ Single ☐ Partnered Significant Other's Name: _____

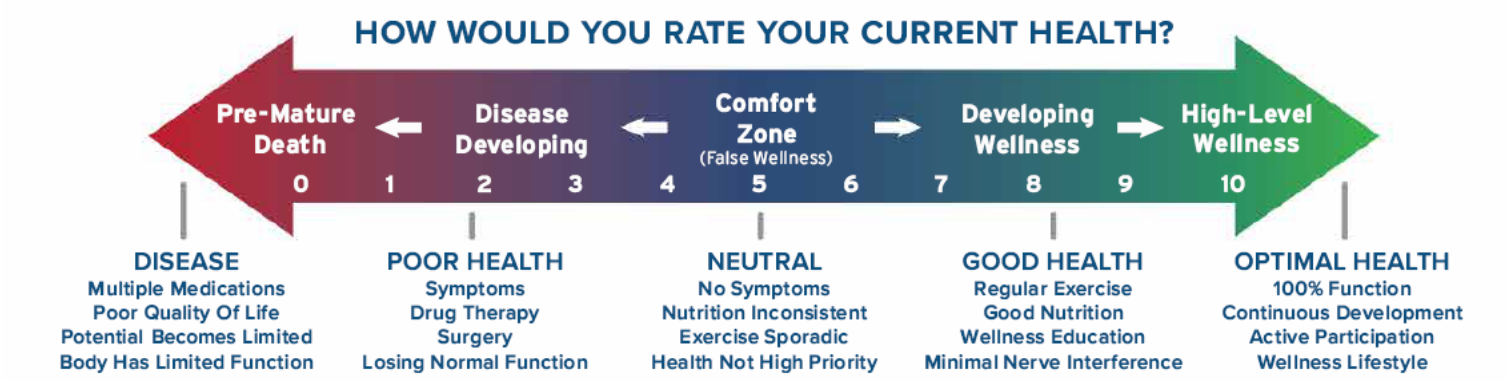
Employer / School: _____ Occupation: _____

Emergency Contact Name | Relationship | Phone: _____

Have you had Chiropractic Care before? Y / N Date of last Adjustment: _____

Who may we thank for referring you to our practice? _____

Have you or your spouse served in the U.S. Military? Y / N



What number do you think represents your health today? (1 - 10 scale as seen above) _____

.....

4 PILLARS OF HEALTH

(check any that apply to you and fill in your own)

EAT WELL: What does your diet mostly consist of?

☐ Organic/Grass Fed ☐ Home cooked ☐ Processed Foods ☐ Eating Out ☐ _____

MOVE WELL: What are your daily movement habits?

☐ Hiking/Outdoors ☐ Yoga ☐ Sedentary ☐ Strength ☐ Walking ☐ Other: _____

THINK WELL: What are your daily mental health strategies?

☐ Meditation ☐ Gratitude ☐ Journaling ☐ Creative Activity ☐ Other: _____

RECOVER WELL: What recovery strategies do you incorporate into your life?

☐ 7+ Hours of Sleep ☐ Time in Nature ☐ Breathwork ☐ Other: _____

Rank these in order (1 - 4) of needing improvement for your life at this time (1 - highest priority)

_____ Eat Well _____ Move Well _____ Think Well _____ Recover Well

Name: _____DOB: _____ Account # _____
(for office use only)

REASON FOR SEEKING CHIROPRACTIC CARE

- ☐ To experience a new level of health and healing
- ☐ To be more connected to my body
- ☐ To relieve symptoms - (please mark areas on the diagram to the right)
- ☐ Healthy Pregnancy - due date: _____
- ☐ Other: _____

Current Health Concern:

_____

_____

_____

How long have you been suffering from this?
_____ Days | Weeks | Months | Years

How do you think this began?

_____

What have you done to make it better?

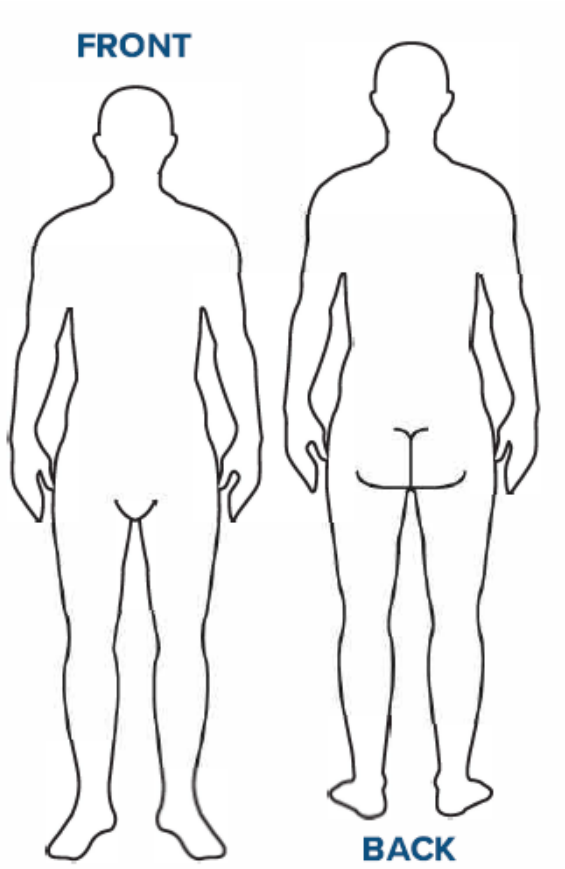
_____

What makes it worse?

_____

What is the severity of these concerns?
1 2 3 4 5 6 7 8 9 10

How often do you experience these concerns?
☐ Constantly ☐ Frequently ☐ Occasionally ☐ Intermittently



KEY:

X Numb/Tingling
^ Ache/Dull/Stiff
O Burning
– Swelling
> Sharp

Other signs of interference (check any that apply to you)

- ☐ Headache
- ☐ Dizziness
- ☐ Balance Issues
- ☐ Double Vision
- ☐ Speech Difficulty
- ☐ Allergies
- ☐ Jaw Pain
- ☐ High Blood Pressure
- ☐ Sleep Concerns
- ☐ Seizures/Epilepsy
- ☐ Heartburn
- ☐ Acid Reflux
- ☐ Gall Stones
- ☐ Kidney Stones
- ☐ Bladder Infections / UTI
- ☐ Loss of Bladder Control
- ☐ Constipation
- ☐ Diarrhea
- ☐ Ulcers
- ☐ Irritable Bowel
- ☐ Heart Disease
- ☐ Diabetes
- ☐ Cancer
- ☐ HIV / AIDS
- ☐ Autoimmune Disease
- ☐ Arthritis
- ☐ Infertility
- ☐ Other Health Concerns

_____

_____

Name: _____DOB: _____ Account # _____
(for office use only)

THE BODY'S INABILITY TO EXPRESS HEALTH FULLY

The following can contribute to the nerve interference process.
Please check any that apply to your health history.

PHYSICAL STRESS

- ☐ Birth Trauma
- ☐ Surgeries
- ☐ Hospitalizations
- ☐ Slip / Fall
- ☐ Motor Vehicle Accident
- ☐ Sports Injury
- ☐ Concussion
- ☐ Physical Abuse
- ☐ Heavy Physical Labor
- ☐ Poor Posture
- ☐ Heavy Computer Use
- ☐ Repetitive Movements
- ☐ Prolonged Sitting / Standing
- ☐ Poor Sleep Habits

EMOTIONAL STRESS

- ☐ Relationships / Family
- ☐ Career
- ☐ Financial
- ☐ Pace of Life
- ☐ Anxiety
- ☐ Depression
- ☐ Quick Temper
- ☐ Overwhelm
- ☐ Emotional Suppression
- ☐ Perfectionism
- ☐ Procrastination
- ☐ Extreme Loss
- ☐ Unworthiness
- ☐ Self Doubt

CHEMICAL STRESS

- ☐ Painkillers
- ☐ Smoke / Tobacco
- ☐ Muscle Relaxers
- ☐ 2nd Hand Smoke
- ☐ Caffeine
- ☐ Alcohol
- ☐ Soda
- ☐ "Diet / Sugar Free"
- ☐ Prescription Meds
- ☐ Birth Control / HRT
- ☐ Drugs
- ☐ Processed Foods
- ☐ Antibiotics
- ☐ Hormones

Add any additional information from the check boxes above:

_____

_____

_____

_____

_____

What are the 3 BIGGEST stressors in your life currently?

_____ _____ _____

ALLERGIES

_____

_____

_____

_____

_____

_____

MEDICATIONS / PURPOSE

_____

_____

_____

_____

_____

_____

SUPPLEMENTS

_____

_____

_____

_____

_____

_____

Name: _____ DOB: _____ Account # _____
(for office use only)

Children's Names | Ages: _____

BIRTH HISTORY:

☐ OBGYN ☐ Midwife ☐ Hospital ☐ Homebirth ☐ Birthing Center ☐ Natural ☐ Cesarean ☐ Induced

☐ Breech ☐ Sunny Side Up ☐ Vacuum ☐ Forceps ☐ Breastfed ☐ Formula ☐ Vaccines ☐ Antibiotics

☐ Miscarriage ☐ Fertility Concerns

Has your child experienced any of the following?

☐ Reflux ☐ Colic ☐ Constipation ☐ Ear Infections ☐ Behavioral ☐ Sleep Concerns ☐ Torticollis

☐ Other: _____

_____

What activities are important to your quality of life?

_____

_____

_____

_____

How is your current health concern interfering with your quality of life?

☐ Work
☐ Excercise / Recreation
☐ Relationships
☐ Sleep
☐ Self-care
☐ Energy
☐ Attitude
☐ Patience
☐ Productivity

What are your HEALTH GOALS?

1. _____
2. _____
3. _____

What is your level of commitment to yourself and your well-being?

1 2 3 4 5 6 7 8 9 10

Signature: _____ Date: _____

Name: _____ DOB: _____ Account # _____
(for office use only)

TOXICITY QUESTIONNAIRE

Designed to aid the practitioner in assessing a patient's potential for nutritional needs.
Rate each of the following based upon your health profile for the past 90 days.

CIRCLE THE CORRESPONDING NUMBER

0 - Rarely or Never
1 - Occasionally Experience the Symptoms - Effect is NOT Severe
2 - Occasionally Experience the Symptoms - Effect IS Severe
3 - Frequently Experience the Symptoms - Effect is NOT Severe
4 - Frequently Experience the Symptoms - Effect IS Severe

DIGESTIVE

Nausea and/or Vomiting	0	1	2	3	4
Diarrhea	0	1	2	3	4
Constipation	0	1	2	3	4
Bloated Feeling	0	1	2	3	4
Belching and/or passing gas	0	1	2	3	4
Heartburn	0	1	2	3	4

TOTAL: _____

EARS

Itchy Ears	0	1	2	3	4
Earaches and/or ear infections	0	1	2	3	4
Drainage from ear	0	1	2	3	4
Ringing in ears and/or hearing loss	0	1	2	3	4

TOTAL: _____

EMOTIONS

Mood Swings	0	1	2	3	4
Anxiety/Fear/Nervousness	0	1	2	3	4
Anger/Irragility	0	1	2	3	4
Depression	0	1	2	3	4
Sense of despair	0	1	2	3	4
Uncaring/Disinterested	0	1	2	3	4

TOTAL: _____

ENERGY / ACTIVITY

Fatigue and/or sluggishness	0	1	2	3	4
Hyperactivity	0	1	2	3	4
Restlessness	0	1	2	3	4
Insomnia	0	1	2	3	4
Startled awake at night	0	1	2	3	4

TOTAL: _____

EYES

Water and/or itchy eyes	0	1	2	3	4
Swollen/reddened/sticky eyelids	0	1	2	3	4
Dark circles under eyes	0	1	2	3	4
Blurred or tunnel vision	0	1	2	3	4

TOTAL: _____

HEAD

Headaches	0	1	2	3	4
Faintness	0	1	2	3	4
Dizziness	0	1	2	3	4
Pressure	0	1	2	3	4

TOTAL: _____

LUNGS

Chest Congestion	0	1	2	3	4
Asthma and/or bronchitis	0	1	2	3	4
Shortness or breath	0	1	2	3	4
Difficulty breathing	0	1	2	3	4

TOTAL: _____

WEIGHT

Binge eating/drinking	0	1	2	3	4
Craving certain foods	0	1	2	3	4
Excessive weight	0	1	2	3	4
Compulsive weight	0	1	2	3	4
Water retention	0	1	2	3	4
Underweight	0	1	2	3	4

TOTAL: _____

MIND

Poor Memory	0	1	2	3	4
Confusion	0	1	2	3	4
Poor Concentration	0	1	2	3	4
Poor Coordination	0	1	2	3	4
Difficulty making decisions	0	1	2	3	4
Stuttering/Stammering	0	1	2	3	4
Slurred Speech	0	1	2	3	4
Learning Disabilities	0	1	2	3	4

TOTAL: _____

MOUTH / THROAT

Chronic coughing	0	1	2	3	4
Gagging/frequent need to clear throat	0	1	2	3	4
Swollen and/or discolored	0	1	2	3	4
Canker sores	0	1	2	3	4

TOTAL: _____

NOSE

Stuffy nose	0	1	2	3	4
Sinus problems	0	1	2	3	4
Hay Fever	0	1	2	3	4
Sneezing attacks	0	1	2	3	4
Excessive mucous	0	1	2	3	4

TOTAL: _____

SKIN

Acne	0	1	2	3	4
Hives/rashes/dry skin	0	1	2	3	4
Hair loss	0	1	2	3	4
Flushing	0	1	2	3	4
Excessive sweating	0	1	2	3	4

TOTAL: _____

JOINTS / MUSCLES

Pain and/or aches in joints	0	1	2	3	4
Rheumatoid arthritis	0	1	2	3	4
Osteoarthritis	0	1	2	3	4
Stiffness and/or limited movement	0	1	2	3	4
Pain and/or aches in muscles	0	1	2	3	4
Recurrent back aches	0	1	2	3	4
Weakness and/or tiredness	0	1	2	3	4

TOTAL: _____

HEART

Skipped heartbeat	0	1	2	3	4
Rapid heartbeats	0	1	2	3	4
Chest pain	0	1	2	3	4

TOTAL: _____

OTHER

Frequent illness/sickness	0	1	2	3	4
Frequent/urgent urination	0	1	2	3	4
Leaky bladder	0	1	2	3	4
Genital itch/discharge	0	1	2	3	4

TOTAL: _____

TOTAL: _____

Signature: _____ Date: _____

FAMILYFIRST CHIROPRACTIC

ELECTRONIC HEALTH RECORDS INTAKE FORM

In compliance with requirements for the government EHR incentive program.

First Name: _____Last Name: _____

Preferred Language: _____DOB:_____/_____/_____

Sex:_____ Sex at Birth:_____

Smoking Status (Circle One): Every Day Smoker / Occasional Smoker / Former Smoker / Never

If yes, start date: _____

CMS requires providers to report both race and ethnicity.

Race (Circle One):

American Indian or Alaska Native / Asian / Black or African American / White (Caucasian) / Native Hawaiian or Pacific Islander / Other / Decline to Answer

Ethnicity (Circle One): Hispanic or Latino / Not Hispanic or Latino / Decline to Answer

☐ I choose to decline receipt of my clinical summary after every visit.

Signature: _____Date:_____

FOR OFFICE USE ONLY

Height: _____ Weight: _____ Blood Pressure: _____/_____ Pulse: _____

CONSENT FOR CARE

FAMILYFIRST CHIROPRACTIC

Name: _____DOB: _____ Account # _____
(for office use only)

The process of determining suitability of Chiropractic Services involves answering fully and truthfully all questions presented to you either written or spoken regarding your past and present health conditions during the Consultation.

If warranted, a physical examination will be performed that can include but is not limited to: vitals measurement, systems evaluation, orthopedic tests and maneuvers (tests that move and stress joints of the body), neurological test (tests using sharp or dull instruments, smells or sounds, gently tapping tendons) as well as physical touching. These test and maneuvers will help the Chiropractor determine what may be causing your complaints. Occasionally some temporary soreness and/or stiffness may occur due to the examination; less frequently aggravation of presenting symptoms or initiation of new symptoms.

Radiographs (X Rays) may be taken or ordered to further the Chiropractor's understanding of the underlying condition, positions and alignment of the spine and associated structures. There is limited but present risk to radiation exposure. If you are or think you may be pregnant alert the Chiropractor and/or X ray lab technician; X Rays are not allowed to pregnant women in any trimester.

PRIVACY NOTICE ACKNOWLEDGEMENT

We are concerned with protecting your privacy, especially in matters that concern your personal health information. In accordance with the Health Insurance Portability and Accountability Act of 1996 (HIPAA), we are required to supply you with a copy of our privacy policies and procedures. We encourage you to read this document carefully, for it outlines the use and limitations of the disclosure of your health information and your rights as a patient. If you ever have any questions or concerns regarding the use or dissemination of your personal health information, we would be happy to address them.

I consent to the performance of the above-mentioned procedures performed by the doctor involved in my case:
_____ YES _____ NO

I acknowledge that I have been offered a copy of Family First Chiropractic's Notice of Privacy Practices for Protected Health Information.

Signature: _____Date:_____

Witness Signature: _____Date:_____

Account # _____
(for office use only)

AUTO ACCIDENT INTAKE

FAMILYFIRST CHIROPRACTIC

Name: _____DOB: _____/_____/_____Date:_____

ACCIDENT / DRIVER(S) INFORMATION

Date of Accident: _____ Location (State): _____

Please give a brief description of the accident:

_____

_____

_____

_____

Your car insurance company: _____

Adjuster Name: _____ Phone Number: _____

Claim Number: _____ Policy Number: _____

Medical payments coverage amount: _____ Uninsured motorist coverage amount: _____

Third party insurance company: _____

Name of other driver involved: _____

What law firm represents you: _____

Your lawyers name: _____ Phone: _____Fax: _____

Address: _____ City | State | Zip: _____

Have you had any other medical care since the accident? If so, describe:

_____

Have you lost any work time since the accident? _____ No _____ Yes, on these dates: _____

Your MD's name: _____ Phone Number: _____

EMPLOYMENT

Occupation at time of the crash: _____Employer: _____

Current Occupation: _____ Employer: _____

If unemployed, is unemployment due to crash? _____ Yes _____ No

Type of work: _____ Office / Cervical _____ Light Labor _____ Moderate Labor _____ Heavy Labor

AUTO ACCIDENT INTAKE

FAMILYFIRST CHIROPRACTIC

Name: _____DOB: _____/_____/_____Date:_____

MEDICAL HISTORY - PRIOR TO CRASH

Surgeries (dates and residuals): _____

Fractures (dates and residuals): _____

Serious illness (dates and residuals): _____

Workers' comp. injuries (date, TX, awards, residuals): _____

Personal injuries (date, TX, awards, residuals): _____

Sports or other injuries to head, neck or back: _____

Any prior episodes of current complaints:

1._____

2._____

3._____

DURING THE CRASH

Location of the crash (street, intersection, city, state):

_____

INJURY HISTORY

Date of crash injury/injuries: _____ Were you aware of the impending crash? Yes / No

Were you the: _____ Driver _____ Passenger (Front) _____Passenger (Rear - L / R)

_____ Motorcycle operator _____ Motorcycle passenger _____ Other:_____

Name of Vehicle Driver: _____

YOUR vehicle (year, make, model): _____

Is there a trailer hitch? _____ Yes _____ No _____ Not Sure

Estimated speed at time of accident: _____ MPH _____ Slowing _____ Accelerating _____ Stopped

OTHER vehicle (year, make, model): _____

Estimated speed at time of accident: _____ MPH _____ Slowing _____ Accelerating _____ Stopped

Road conditions: _____ Dry _____ Damp _____ Wet _____ Snowy _____ Icy _____ Other: _____

Your head rest: _____ None _____ Integral _____ Adjustable: up/down _____ Not Sure

Was your seat back position altered by the crash? _____ Yes _____ No

Was the seat broken? _____ Yes _____ No

Were you wearing lap belt? _____ Yes _____ No - Shoulder Belt? _____ Yes _____ No

Did an airbag deploy? _____ Yes _____ No - If yes, were you truck by it? _____ Yes _____ No

Body position: _____ Straight forward _____ Leaning forward _____ Twisted _____ Other: _____

Head position: _____ Forward _____ Left _____ Right _____ Up _____ Down

Hands: _____ One on the wheel (L / R) _____ Two on wheel _____ Not sure _____ Not driving

AUTO ACCIDENT INTAKE

FAMILYFIRST CHIROPRACTIC

Name: _____DOB: _____/_____/_____Date:_____

AFTER CRASH

Symptoms: _____ Headache _____ Dizziness _____ Nausea _____ Confusion/disorientation _____ Neck Pain
_____ Back Pain

Numbness / tingling / paresthesia(s) - If yes, where? _____

Arm and / or leg pain - If yes, where? _____

Other symptoms? _____

Where did you go after the crash? _____ Home _____ Work _____ Hospital
_____ Private doctor _____

Mode of transportation? _____ Drove self _____ Other drove _____ Emergency transport

TREATMENT HISTORY - FOR ACCIDENT

Prior to this office, have you been evaluated / treated for these injuries? _____ No _____ Yes (list below)

Date: _____ Doctor / Provider: _____

Specialty: _____

Treatment: _____

Date: _____ Doctor / Provider: _____

Specialty: _____

Treatment: _____

Signature: _____Date:_____

Account # _____
(for office use only)

NECK DISABILITY INDEX

FAMILYFIRST CHIROPRACTIC

Name: _____DOB: _____/_____/_____Date:_____

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

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

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

SECTION 1 - PAIN INTENSITY
0 - I have no pain at the moment.
1 - The pain is very mild at the moment.
2 - The pain is moderate at the moment.
3 - The pain is fairly severe at the moment.
4 - The pain is very severe at the moment.
5 - The pain is the worst imaginable at the moment.

SECTION 2 - PERSONAL CARE (Washing, Dressing, etc.)
0 - I can look after myself normally, without causing extra pain.
1 - I can look after myself normally, but it causes extra pain.
2 - It is painful to look after myself and I am slow and careful.
3 - I need some help, but manage most of my personal care.
4 - I need help every day in most aspects of self care.
5 - I do not get dressed; I wash with difficulty and stay in bed.

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 from lifting heavy weights off the floor, but I can manage if they are conveniently positioned, for example, on a table.
3 - Pain prevents me from lifting heavy weights off the floor, but I can manage light to medium weights if they are conveniently positioned.
4 - I can lift very light weights.
5 - I cannot lift or carry anything at all.

SECTION 4 - READING
0 - I can read as much as I want to, with no neck pain.
1 - I can read as much as I want to, with slight neck pain.
2 - I can read as much as I want to, with moderate neck pain.
3 - I can't read as much as I want, because of moderate neck pain.
4 - I can hardly read at all, because of severe neck pain.
5 - I cannot read at all.

SECTION 5 - HEADACHES
0 - I have no headaches at all.
1 - I have slight headaches that come infrequently.
2 - I have moderate headaches that come infrequently.
3 - I have moderate headaches that come frequently.
4 - I have severe headaches that come frequently.
5 - I have headaches almost all the time.

SECTION 6 - CONCENTRATION
0 - I can concentrate fully when I want to, with no difficulty.
1 - I can concentrate fully when I want to, with slight difficulty.
2 - I have a fair degree of difficulty concentrating when I want to.
3 - I have a lot of difficulty in concentrating when I want to.
4 - I have a great deal of difficulty in concentrating when I want to.
5 - I cannot concentrate at all.

SECTION 7 - WORK
0 - I can do as much work as I want to.
1 - I can do my usual work, but no more.
2 - I can do most of my usual work, but no more.
3 - I cannot do my usual work.
4 - I can hardly do any work at all.
5 - I can't do any work at all.

SECTION 8 - DRIVING
0 - I can drive my car without any neck pain.
1 - I can drive my car as long as I want, with slight neck pain.
2 - I can drive my car as long as I want, with moderate neck pain.
3 - I can't drive my car as long as I want, because of moderate neck pain.
4 - I can hardly drive at all, because of severe neck pain.
5 - I can't drive my car at all.

SECTION 9 - SLEEPING
0 - I have no trouble sleeping.
1 - My sleep is slightly disturbed (less than 1 hr sleepless).
2 - My sleep is mildly disturbed (1-2 hrs sleepless).
3 - My sleep is moderately disturbed (2-3 hrs sleepless).
4 - My sleep is greatly disturbed (3-5 hrs sleepless).
5 - My sleep is completely disturbed (5-7 hrs sleepless).

SECTION 10 - RECREATION
0 - I am able to engage in all my recreation activities, with no neck pain at all.
1 - I am able to engage in all my recreation activities, with some neck pain.
2 - I am able to engage in most, but not all, of my usual recreation activities, because of neck pain.
3 - I am able to engage in few of my recreation activities, because of neck pain.
4 - I can hardly do any recreation activities, because of neck pain.
5 - I can't do any recreation activities at all.

Instructions: Using this system, a score of 10-28% (i.e., 5-14 points) is considered by the authors to constitute mild disability; 30-48% is moderate; 50-68% is severe; 72% or more is complete.

TOTAL: _____

Account # _____
(for office use only)

OSWESTRY LOW BACK PAIN SCALE

FAMILYFIRST CHIROPRACTIC

Name: _____DOB: _____/_____/_____Date:_____

Please rate the severity of your low back pain by circling a number below.

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

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

SECTION 1 – PAIN INTENSITY

0 - The pain comes and goes and is very mild.
1 - The pain comes and goes and is moderate.
2 - The pain is moderate and does not vary much.
3 - The pain comes and goes and is severe.
4 - 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 and I find it necessary to change my way of doing it.
3 - I need some help, but manage most of my personal care.
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 from lifting heavy weights off the floor.
3 - Pain prevents me from lifting heavy weights off the floor, but I can manage if they are conveniently positioned, e.g. on a table.
4 - Pain prevents me me from lifting heave 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 1/2 mile without increasing pain.
4 - I cannot walk more than 1/4 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 1/2 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 1/2 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 one-quarter.
3 - Because of pain my normal nights sleep is reduced by less than one-half.
4 - Because of pain my normal nights sleep is reduced by less than three-quarters.
5 - Pain prevents me from sleeping at all.

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 my more energetic interests, e.g., dancing, etc.
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 travel make it any worse.
2 - I get extra pain while traveling, but it does not compel me to seek alternate forms of travel.
3 - I get extra pain while traveling which compels me to seek alternative forms of travel.
4 - Pain restricts me to short necessary journeys under 1/2 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.

Instructions: Using this system, a score of 10-28% (i.e., 5-14 points) is considered by the authors to constitute mild disability; 30-48% is moderate; 50-68% is severe; 72% or more is complete.

TOTAL: _____

PERSONAL INJURY FINANCIAL AGREEMENT

FAMILYFIRST CHIROPRACTIC

Name: _____DOB: _____ Account # _____
(for office use only)

Welcome to our office. We assure you that you will receive our very best care for your injury. It's important to familiarize you with our financial policies and we would like to explain the 3 options to handle the cost of your personal injury care.

OPTION 1: MED PAY

Medical Payments (Med Pay) is a coverage option available with auto insurance policies that covers medical expenses for the policyholder, passengers, and family members traveling in the insured vehicle at the time of an accident. This coverage will pay up to policy limits and regardless of fault. Use of Med Pay does not affect policy premiums. We will bill the Med Pay portion of the auto insurance policy covering the vehicle you were injured in. If the Med Pay benefit is exhausted, you are responsible for payment at that point unless an attorney is representing you.

OPTION 2: ATTORNEY LIENS

If you have hired an attorney to represent you during your personal injury case, it is our policy to have you and your attorney sign a Chiropractic Lien. This will guarantee direct payment to our office for any unpaid balance upon the settlement of your case in exchange for delaying required payment. Please note that we retain the right to first submit and receive payment from available Med Pay coverage. The amount not covered by Med Pay will be held on the Chiropractic Lien until the case is settled. Further, this office does not discount or reduce the amount of your balance based upon the outcome of your settlement.

OPTION 3: SELF PAY - THIRD PARTY RECOVERY

If you are solely relying on the "at fault" vehicle's insurance to pay your medical expenses, this is termed a "Third-Party" claim. The Third Party insurance is not obligated to pay our office directly and typically will only reimburse the claimant (you) directly for your medical expenses. Therefore, we do not bill Third Party insurers. In these cases, if you do not have legal representation, you will need to pay for your services (care) at time of service and be reimbursed by the at-fault third party. We will provide you with any needed records and receipts. The third party should make any appropriate payment directly to you.

RESPONSIBILITY FOR PAYMENT

We will gladly submit records and charges, with your approval and direction, to insurance companies and/or attorneys to help settle your case. However, understand that all services rendered by this office are charged ultimately to you. You are personally responsible for the cost of all services rendered, regardless of any insurance reimbursement or settlement you may or may not receive. Personal health insurance is not billed in personal injury claims, it is not a responsible payer in personal injury claims. We will not bill your personal health insurance.

VOLUNTARY TERMINATION OF CARE

If you suspend or terminate your care at any time, your portion of all charges for professional services provided becomes immediately due and payable to this office.

I HAVE READ AND UNDERSTAND THE ABOVE.

Signature: _____Date:_____

Account # _____
(for office use only)

ATTORNEY LIEN

FAMILYFIRST CHIROPRACTIC

Name: _____ Date: _____

Date of Birth: _____ Date of Accident: _____

I do hereby authorize FAMILY FIRST CHIROPRACTIC and associated Doctors, to furnish you, my attorney, with a full report of the Doctor examination, diagnosis, treatment, prognosis, etc., of myself in regard to the accident in which I was recently involved.

I hereby authorize and direct you, my attorney, to pay directly to said doctor/facility such sums as may be due and owing him/them for medical services rendered me both by reason of this accident and by reason of any other bills that are due his office/facility and to withhold such sums from any settlement, judgment or verdict as may be necessary to adequately protect and fully compensate said doctor. And I hereby further give a Lien on my case to said doctor/facility against any and all proceeds of my settlement, judgment or verdict which may be paid to you, my attorney, or myself, as the result of the injuries for which I have been treated or injuries in connection therewith.

I fully understand that I am directly and fully responsible to said doctor and facility for all medical bills submitted by him/them for service rendered me and that this agreement is made solely for said doctor's/facility's additional protection and in consideration of his/their awaiting payment. And I further understand that such payment is not contingent on any settlement, judgment or verdict by which I may eventually recover said fee.

I agree to promptly notify said doctor/facility of any change or addition of attorney(s) used by me in connection with this accident, and I instruct my attorney to do the same and to promptly deliver a copy of this lien to any such substituted or added attorney(s).

Please acknowledge this letter by signing below and returning to the doctor's office. I have been advised that if my attorney does not wish to cooperate in protecting the doctor's/facility's interest, the doctor/facility will not await payment but may declare the entire balance due and payable.

Patient Signature: _____Date:_____

The undersigned, being attorney of record for the above patient, does hereby agree to observe all terms of the above and agrees to withhold such sums for any settlement, judgment, or verdict, as may be necessary to adequately protect Family First Chiropractic in consideration for one copy of records at no expense.

Attorney Signature: _____Date:_____