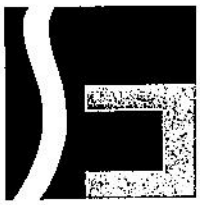

Fitterer
Chiropractic

Dr. Dennis J. Fitterer
112 East Maple Street
Palmyra, PA 17078
Phone: (717) 838-2071
Fax: (717) 838-6116

CONSENT FOR RELEASE OF PERSONAL INJURY PROTECTION INFORMATION (PIP)

I _____ (Print Name), give permission to _____, my insurance company, to release information to Fitterer Chiropractic pertaining to the amount of Personal Injury Protection (PIP) I have on my policy.

Sincerely,

_____ _____

(Patient Signature) (Date)

_____ _____

(Witness Signature) (Date)

Insurance Company Name: _____

Policy #: _____

Effective Date: _____

Claim Representative: _____

Claim #: _____

Date of Incident: _____

PIP Coverage Amount / Remaining: _____

Working together for a healthier tomorrow

FITTERER CHIROPRACTIC
112 EAST MAPLE STREET, POB 109, PALMYRA PA 17078
Phone: (717) 838-2071 Fax: (717) 838-6116 Email: drfitterer@verizon.net

Date: _____
Acct: _____

PATIENT INFORMATION

Name: _____ Social Security #: _____
(Last) (First) (Middle)
Address: _____ City: _____ State: ___ Zip: _____

Sex: M / F Birthdate: ____/____/____ Age: ___ Marital Status: S / M / W / D / O Spouse Name: _____

Parent/Guardian (If patient is under 18): _____ Email Address: _____

Home #: ( )_____ Work#: ( )_____ Cell#: ( )_____ Prefer? _____

Employer Name: _____ Job Title: _____ Full-Time / Part-Time

Employer Address: _____ City: _____ State:___ Zip: _____

Who may we thank for referring you? _____

In case of emergency, who should we call? _____ Relationship: _____ Phone: ( )_____

Is your visit due to: ☐Auto Accident ☐Work Injury ☐Other Party Liability ☐Home Accident ☐Unsure How Started

INSURANCE INFORMATION

Insurance Company Name: _____ Effective: ____/____/____

ID#: _____ Group: _____ Phone: ( ) _____

Name of Policyholder: _____ Birthdate: ____/____/____ Social Security: _____

Policyholder Employer: _____ Job Title: _____ Phone: ( ) _____

Employer Address: _____ City: _____ State: ___ Zip: _____

If patient is a college student, name of school they attend: _____

Other family members covered under policy: _____

Release of Information / Insurance Payment Authorization / Medical Records Release

This authorization, or photocopy hereof, will authorize Fitterer Chiropractic to furnish all information they may have regarding my condition while under care, including the history obtained, X-ray and physical findings, diagnosis and prognosis, to the responsible insurance carrier or other health care provider. Necessary information may be given to my employer concerning my condition. I also assign insurance benefits to Fitterer Chiropractic. I permit this office to endorse remittance for conveyance of credit to my account. HOWEVER, I CLEARLY UNDERSTAND AND AGREE THAT ALL SERVICES RENDERED TO ME ARE CHARGED DIRECTLY TO ME THAT I AM PERSONALLY RESPONSIBLE FOR PAYMENT.

Patient or Parent/Guardian
Signature: _____ Date: ____/____/____ Witness: _____

Consent for Treatment

I authorize the doctors of Fitterer Chiropractic and whoever he/she may designate as his/her assistant(s) to examine, perform diagnostic tests, including but not limited to radiographs, and to administer treatment as necessary. I understand that the doctors of Fitterer Chiropractic will do their best to obtain a positive result for my condition; however I certify that no guarantee or assurance is implied or made as to the results that may be obtained from treatment. If the patient is a minor, as parent/guardian, I give consent for treatment to be administered.

Patient or Parent/Guardian
Signature: _____ Date: ____/____/____ Witness: _____

FITTERER CHIROPRACTIC
112 EAST MAPLE STREET
PALMYRA PA 17078-2435
(717) 838-2071

TERMS OF ACCEPTANCE

When a patient seeks chiropractic health care and we accept a patient for such care, it is essential for both to be working for the same objective.

Chiropractic has only one goal. It is important that each patient understands both the objective and the method that will be use to attain it. This will prevent any confusion or disappointment.

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

HEALTH: The 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 its maximum health potential.

We do not offer diagnose or treat any disease. We only offer to diagnose either vertebral subluxations or neuro-musculoskeletal conditions. However, if during the course of a chiropractic spinal examination we encounter non-chiropractic or unusual findings, we will advise you. If you desire advice, diagnosis or treatment for those findings, we will recommend that you seek the services of another health care provider.

Regardless of what the 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 major interference to the expression of the body's innate wisdom. Our only method is specific adjusting to correct vertebral subluxations. However, we may use other procedures to help your body hold the adjustments.

I, _____ have read and fully understand the above statements.
(Print Name)

All questions regarding the doctor's objective pertaining to my care in this office have been answered to my complete satisfaction.

I therefore accept chiropractic care on this basis.

_____ _____
(Signature) (Date

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES FOR PROTECTED HEALTH INFORMATION

By signing below, I acknowledge that I have received a copy of Dr. Fitterer's Notice of Privacy Practices.

_____ _____

Signature of Patient/Personal Representative Date

_____

Relationship to patient

Office Use Only:

Our organization has made a good faith effort to obtain a written acknowledgement of receipt of the Notice provided to the individual named below.

- ☐ Refused to sign
- ☐ Physically unable to sign
- ☐ Other (explain in detail)

_____

_____

_____

Employee Signature: _____ Date: _____

FINANCIAL RESPONSIBILITY FORM

1. **INDIVIDUAL'S FINANCIAL RESPONSIBILITY**

- I understand that I am financially responsible for my health insurance deductible, coinsurance or non-covered service.
- Co-payments are due at time of service.
- If my plan requires a referral, I must obtain it prior to my visit.
- In the event that my health plan determines a service to be "not payable", I will be responsible for the complete charge and agree to pay the costs of all services provided.
- If I am uninsured, I agree to pay for the medical services rendered to me at time of service.

2. **INSURANCE AUTHORIZATION FOR ASSIGNMENT OF BENEFITS**

I hereby authorize and direct payment of my medical benefits to **Fitterer Chiropractic** on my behalf for any services furnished to me by the providers.

3. **AUTHORIZATION TO RELEASE RECORDS**

I hereby authorize **Fitterer Chiropractic** to release to my insurer, governmental agencies, or any other entity financially responsible for my medical care, all information, including diagnosis and the records of any treatment or examination rendered to me needed to substantiate payment for such medical services as well as information required for precertification, authorization or referral to another medical provider.

4. **MEDICARE REQUEST FOR PAYMENT**

I request payment of authorized Medicare benefits to me or on my behalf for any services furnished me by or in **Fitterer Chiropractic**. I authorize any holder of medical or other information about me to release to Medicare and its agents any information needed to determine these benefits or benefits for related services.

_____ _____

Signature of Patient, Authorized Representative or Responsible Party Date

_____ _____

Print Name of Patient, Authorized Representative or Responsible Party Relationship to Patient

Acct #: _____
Today's Date: _____

Confidential Patient Data

IF YOU NEED ANY ASSISTANCE COMPLETING THIS FORM, PLEASE ASK THE RECEPTIONIST

PATIENT INFORMATION:

Name:_____ Date of Birth: _____ Age: _____
Address: _____ City: _____ State: _____ Zip: _____
Home Phone: _____ Work Phone: _____ Cell: _____
Social Security #: _____ Email: _____ Marital Status: S/ M/ W/ D/ Other
Number of Children: _____ Ages of Children: _____
Referred to this office by: ☐ Friend/Family Member - Name: _____
☐ Yellow pages, which book: _____ ☐ Mail ☐ Clinic Location
Employer: _____ Occupation: _____ ☐ FT ☐ PT
Emergency Contact: _____ Phone: _____ Relationship: _____
Name of person responsible for payment: _____

PLEASE DESCRIBE PRESENT MAJOR COMPLAINTS:
Please Rate Your symptoms (1-10, with 1 being least serious)

	SYMPTOMS	RATING (1-10)
1.	_____	_____
2.	_____	_____
3.	_____	_____
4.	_____	_____

Are your symptoms:

☐ Improving
☐ About the same
☐ Getting Worse
☐ Intermittent (come and go)
☐ Worse in Morning
☐ Worse in the Afternoon
☐ Worse in the Night

Are you able to sleep with the pain? ☐ Yes ☐ No

When did the Pain Begin? _____
What Caused the Pain? _____

Did symptoms develop from:

☐ Job Related Injury
☐ Auto Accident
☐ Fall
☐ Accident
☐ Illness
☐ Unknown Cause
☐ Gradual Onset
☐ Date Occurred: _____

_____

Doctors Notes:

Acct #: _____
Today's Date: _____

Symptoms Have Persisted for (number)

☐ Hours _____
☐ Days _____
☐ Weeks _____
☐ Months _____
☐ Years _____

Have You Had These Symptoms Before? ☐ No ☐ Yes **When?** _____

Please Check the Following Activities that <u>Aggravate</u> Your Condition:

☐ Bending
☐ Reaching
☐ Straining at Stool
☐ Walking
☐ Walking after ___ minutes
☐ Exercising
☐ Getting Up and Down
☐ Coughing
☐ Sitting
☐ Sitting after ___ minutes
☐ Turning Head
☐ Lifting
☐ Sneezing
☐ Overhead Activities
☐ Twisting Injured Area
☐ Lying Down
☐ Standing
☐ Standing after ___ minutes
☐ Standing Straight

Please Check the Following Activities that Relieve Your Condition:

☐ Bending
☐ Sitting
☐ Lifting
☐ Standing
☐ Lying Down
☐ Turning head
☐ Reaching
☐ Walking
☐ Medication
☐ Stretching

Please Check any <u>Additional</u> Symptoms You May Be Experiencing:

☐ Blurred Vision
☐ Buzzing in Ears
☐ Cold Feet
☐ Cold Hands
☐ Cold Sweats
☐ Concentration Loss/Confusion
☐ Constipation
☐ Depression/Weeping Spells
☐ Diarrhea
☐ Dizziness
☐ Face Flushed
☐ Fainting
☐ Fatigue
☐ Fever
☐ Head Seems Too Heavy
☐ Headaches
☐ Insomnia
☐ Light Bothers Eyes
☐ Loss of Balance
☐ Loss of Smell
☐ Loss of Taste
☐ Low Resistance to Colds
☐ Muscle Jerking
☐ Numbness in Fingers
☐ Numbness in Toes
☐ Pins and Needles in Arms
☐ Pins and Needles in Legs
☐ Ringing in Ears
☐ Shortness of Breath
☐ Stiff Neck
☐ Stomach Upset

Who is your family medical doctor? _____ **Phone:** _____

Have you been treated by a Medical Physician for any health condition in the last year? ☐ Yes ☐ No

Describe Condition: _____

Date of last visit: _____

Doctors Notes:

Acct #: _____
Today's Date: _____

Have you ever been treated by a doctor of Chiropractic previously? ☐ Yes ☐ No
Describe Condition: _____
Date of last visit: _____

List all surgical operations: _____
_____
_____

List all Prescription Drugs: _____
_____
_____

List all Non-Prescription Drugs: _____
_____
_____

Social Habits:	**Exercise Activities:**	**Stress Levels:**	**Physical Activities:**
☐ Tobacco	☐ No exercise program	☐ Little or no	☐ Sitting 50% or more
☐ Alcohol	☐ Light exercise	☐ Minimal	☐ Light labor
☐ Coffee	☐ Moderate exercise	☐ Moderate	☐ Manual labor
	☐ Strenuous exercise	☐ Greatly stressed	☐ Heavy labor
			☐ Repeated motion

Are you allergic to any Medications? ☐ No ☐ Yes Which? _____
Are you Pregnant? ☐ No ☐ Yes Date of last period: _____
Have you ever had a metal implant? ☐ No ☐ Yes
Have you ever been gun shot? ☐ No ☐ Yes
What is your dominant hand? ☐ Right ☐ Left ☐ Ambidextrous

Doctors Notes:

Acct #: _____
Today's Date: _____

MEDICAL/FAMILY HISTORY:

S=Self M=Mother F=Father

(Please indicate which conditions have been experienced by the above by marking appropriate boxes)

S	M	F		S	M	F		S	M	F	
☐	☐	☐	AIDS	☐	☐	☐	dislocated joints	☐	☐	☐	neck pain
☐	☐	☐	anemia	☐	☐	☐	epilepsy	☐	☐	☐	nervousness
☐	☐	☐	arthritis	☐	☐	☐	German measles	☐	☐	☐	numbness
☐	☐	☐	asthma	☐	☐	☐	headaches	☐	☐	☐	polio
☐	☐	☐	back pain	☐	☐	☐	heart trouble	☐	☐	☐	poor circulation
☐	☐	☐	bladder trouble	☐	☐	☐	reproductive disorders	☐	☐	☐	hepatitis
☐	☐	☐	bone fracture	☐	☐	☐	high blood pressure	☐	☐	☐	rheumatic fever
☐	☐	☐	cancer	☐	☐	☐	HIV/ARC	☐	☐	☐	rheumatism
☐	☐	☐	chest pain	☐	☐	☐	kidney disorder	☐	☐	☐	scarlet fever
☐	☐	☐	concussion	☐	☐	☐	bowel control loss	☐	☐	☐	serious injury
☐	☐	☐	convulsions	☐	☐	☐	menstrual cramps	☐	☐	☐	sinus trouble
☐	☐	☐	diabetes	☐	☐	☐	multiple sclerosis	☐	☐	☐	tuberculosis
☐	☐	☐	indigestion	☐	☐	☐	muscular dystrophy	☐	☐	☐	venereal disease

Please indicate which of these *additional* conditions <u>you</u> have experienced by marking the appropriate boxes.

☐ Heart Disease	☐ Pneumonia	☐ Hiatal Hernia
☐ Heart Murmurs	☐ Kidney Stones	☐ Gas/Bloating
☐ Bronchitis	☐ Gastric Ulcers	☐ Jaw Pain
☐ Pulmonary disease	☐ Colitis/Spastic Colon	☐ Shoulder Pain
☐ Emphysema	☐ Acid Reflux	☐ Sexual Disfunction

ACCIDENT HISTORY:

Please list all automobile & work related accidents here. Use back of form if you need more space.

☐ Job ☐ Auto ☐ Other 1. _____ Date: _____
☐ Job ☐ Auto ☐ Other 2. _____ Date: _____
☐ Job ☐ Auto ☐ Other 3. _____ Date: _____
☐ Job ☐ Auto ☐ Other 4. _____ Date: _____

Patient's Signature: _____ **Date:** _____

Doctors Notes:

Acct #: _____
Today's Date: _____

Automobile Accident Questionnaire

IF YOU NEED ANY ASSISTANCE COMPLETING THIS FORM, PLEASE ASK THE RECEPTIONIST

PATIENT INFORMATION:

Name: _____

Date of Accident: _____

THE FOLLOWING QUESTIONS PERTAIN TO YOU AND THE VEHICLE YOU WERE IN:

Vehicle type:

- ❑ Car
- ❑ Truck
- ❑ Van
- ❑ Bus
- ❑ Station Wagon
- ❑ Other: _____
- ❑ Pickup

Vehicle size:

- ❑ Subcompact
- ❑ Full-Size
- ❑ Compact
- ❑ Mini
- ❑ Mid-Size
- ❑ Light
- ❑ Heavy
- ❑ Other: _____

Your position in the vehicle:

- ❑ Driver
- ❑ Passenger
- ❑ Other: _____

If Passenger, What was your location?

- ❑ Left
- ❑ Middle
- ❑ Right
- ❑ Front
- ❑ Rear
- ❑ Third Seat (rear)

Speed of your vehicle:

- ❑ Stopped
- ❑ Moving Moderately
- ❑ Parked
- ❑ Moving Fast
- ❑ Slowing
- ❑ Moving at approx _____ MPH
- ❑ Moving Slowly

Why Vehicle was slowed or stopped:

- ❑ Traffic Signal
- ❑ Parking
- ❑ Pedestrian
- ❑ Traffic
- ❑ Stop Sign
- ❑ Busy Intersection

Collision Type:

- ❑ Driver Side Impact
- ❑ Head On Collision
- ❑ Passenger Side Impact
- ❑ Rear Impact
- ❑ Front Impact
- ❑ Pedestrian Incident

THE FOLLOWING QUESTIONS CONCERN THE OTHER VEHICLE INVOLVED IN THE ACCIDENT:

Vehicle type:

- ❑ Car
- ❑ Truck
- ❑ Van
- ❑ Bus
- ❑ Station Wagon
- ❑ Other: _____
- ❑ Pickup

Vehicle size:

- ❑ Subcompact
- ❑ Full-Size
- ❑ Compact
- ❑ Mini
- ❑ Mid-Size
- ❑ Light
- ❑ Heavy
- ❑ Other: _____

Doctors Notes:

Acct #: _____
Today's Date: _____

CONDITIONS AT THE TIME OF THE ACCIDENT:

Time of day:
- ❑ Full Daylight
- ❑ Dawn
- ❑ Dusk
- ❑ Night

Road Conditions:
- ❑ Dry
- ❑ Damp
- ❑ Wet
- ❑ Snow Covered
- ❑ Ice Covered
- ❑ Patchy Ice/Snow

Visibility:
- ❑ Excellent
- ❑ Good
- ❑ Fair
- ❑ Poor

Visibility compromised by:
- ❑ Brightness
- ❑ Darkness
- ❑ Rain
- ❑ Snow
- ❑ Fog
- ❑ Traffic

THE FOLLOWING QUESTIONS CONCERN THE MOMENT OF IMPACT OF THE ACCIDENT:

Were you...
- ❑ Totally unaware that the accident was impending
- ❑ Aware that the accident was impending
- ❑ Aware that the accident was impending and braced for it

Restraints: (check all that apply)
- ❑ Seat belt
- ❑ Shoulder harness
- ❑ No restraints

If you were the driver of the vehicle, was your foot on the brake pedal? ❑ Yes ❑ No ❑ Knocked off by impact

Was the air bag deployed?
- ❑ Car not equipped with air bag
- ❑ Air bag deployed
- ❑ Air bag not deployed

What position was YOUR headrest in?
- ❑ High position
- ❑ Middle position
- ❑ Low position

Position of <u>YOUR</u> head at time of impact?
- ❑ Facing straight ahead
- ❑ Tilted forward
- ❑ Rotated to the left
- ❑ Rotated to the right

Was your head thrown...?
- ❑ Backward and then forward
- ❑ Forward then backward
- ❑ To the left ❑ To the left then the right
- ❑ To the right ❑ To the right, then the left

Position of <u>YOUR</u> body at time of impact?
- ❑ Straight
- ❑ Tilted forward
- ❑ Rotated to the left
- ❑ Rotated to the right

Was your body thrown...?
- ❑ Backward and then forward
- ❑ Forward then backward
- ❑ To the left ❑ To the left then the right
- ❑ To the right ❑ To the right, then the left
- ❑ Across the vehicle
- ❑ Outside the vehicle ❑ Under the vehicle

Doctors Notes:

Acct #: _____
Today's Date: _____

Damage to vehicle YOU were in:

- ❑ Incurred minimal damage
- ❑ Incurred moderate damage
- ❑ Incurred severe damage
- ❑ Was totaled
- ❑ Not known

Citations:

- ❑ None issued
- ❑ Yourself
- ❑ Driver of vehicle patient was a passenger of
- ❑ Driver of other vehicle
- ❑ Not sure

AS A RESULT OF THE FORCE OF THE COLLISION, WHICH OBJECTS IN THE VEHICLE DID YOUR BODY STRIKE?

Head

- ❑ Steering Wheel
- ❑ Dashboard
- ❑ Windshield
- ❑ Armrest
- ❑ Headrest
- ❑ Rear view mirror
- ❑ Left door
- ❑ Right door
- ❑ Left window
- ❑ Right window
- ❑ Console
- ❑ Gear shift
- ❑ Front seat
- ❑ Back seat

Left Arm

- ❑ Steering Wheel
- ❑ Dashboard
- ❑ Windshield
- ❑ Armrest
- ❑ Headrest
- ❑ Rear view mirror
- ❑ Left door
- ❑ Right door
- ❑ Left window
- ❑ Right window
- ❑ Console
- ❑ Gear shift
- ❑ Front seat
- ❑ Back seat

Right Arm

- ❑ Steering Wheel
- ❑ Dashboard
- ❑ Windshield
- ❑ Armrest
- ❑ Headrest
- ❑ Rear view mirror
- ❑ Left door
- ❑ Right door
- ❑ Left window
- ❑ Right window
- ❑ Console
- ❑ Gear shift
- ❑ Front seat
- ❑ Back seat

Torso

- ❑ Steering Wheel
- ❑ Dashboard
- ❑ Windshield
- ❑ Armrest
- ❑ Headrest
- ❑ Rear view mirror
- ❑ Left door
- ❑ Right door
- ❑ Left window
- ❑ Right window
- ❑ Console
- ❑ Gear shift
- ❑ Front seat
- ❑ Back seat

Left Leg

- ❑ Steering Wheel
- ❑ Dashboard
- ❑ Windshield
- ❑ Armrest
- ❑ Headrest
- ❑ Rear view mirror
- ❑ Left door
- ❑ Right door
- ❑ Left window
- ❑ Right window
- ❑ Console
- ❑ Gear shift
- ❑ Front seat
- ❑ Back seat

Right Leg

- ❑ Steering Wheel
- ❑ Dashboard
- ❑ Windshield
- ❑ Armrest
- ❑ Headrest
- ❑ Rear view mirror
- ❑ Left door
- ❑ Right door
- ❑ Left window
- ❑ Right window
- ❑ Console
- ❑ Gear shift
- ❑ Front seat
- ❑ Back seat

Doctors Notes:

Acct #: _____
Today's Date: _____

THE FOLLOWING QUESTIONS CONCERN THE TIME PERIOD IMMEDIATELY FOLLOWING THE ACCIDENT:

Did you lose consciousness?

- ❑ Yes
- ❑ No

Immediately following the accident, did you feel...?

- ❑ Dizzy
- ❑ Dazed
- ❑ Disoriented
- ❑ Weak
- ❑ Nervous
- ❑ Nauseated

Were you able to walk unaided?

- ❑ Yes
- ❑ No

Where did you go...?

- ❑ Drove home
- ❑ Was driven home
- ❑ Drove to hospital
- ❑ Was driven to hospital
- ❑ Taken to hospital via ambulance
- ❑ Drove to work
- ❑ Was driven to work
- ❑ Drove to school
- ❑ Was driven to school

Next day discomfort...?

- ❑ Increased
- ❑ Decreased
- ❑ Same

Did your major complaints exist before the accident?

- ❑ Yes
- ❑ No

In what areas did you <u>IMMEDIATELY</u> feel pain?

❑ Head	Shoulder	❑ Left	❑ Right	Hip	❑ Left	❑ Right
❑ Neck	Arm	❑ Left	❑ Right	Thigh	❑ Left	❑ Right
❑ Upper Back	Elbow	❑ Left	❑ Right	Knee	❑ Left	❑ Right
❑ Mid Back	Wrist	❑ Left	❑ Right	Calf	❑ Left	❑ Right
❑ Ribs	Hand	❑ Left	❑ Right	Ankle	❑ Left	❑ Right
❑ Chest	Fingers	❑ Left	❑ Right	Foot	❑ Left	❑ Right
❑ Abdomen	Buttock	❑ Left	❑ Right	Toes	❑ Left	❑ Right
❑ Low Back						
❑ Pelvis						

In what areas did you experience lacerations (cuts)?

❑ Head	Shoulder	❑ Left	❑ Right	Hip	❑ Left	❑ Right
❑ Neck	Arm	❑ Left	❑ Right	Thigh	❑ Left	❑ Right
❑ Upper Back	Elbow	❑ Left	❑ Right	Knee	❑ Left	❑ Right
❑ Mid Back	Wrist	❑ Left	❑ Right	Calf	❑ Left	❑ Right
❑ Ribs	Hand	❑ Left	❑ Right	Ankle	❑ Left	❑ Right
❑ Chest	Fingers	❑ Left	❑ Right	Foot	❑ Left	❑ Right
❑ Abdomen	Buttock	❑ Left	❑ Right	Toes	❑ Left	❑ Right
❑ Low Back						
❑ Pelvis						

Doctors Notes:

Acct #: _____
Today's Date: _____

At the hospital, what areas were x-rayed? **Which hospital?** _____

❑ Head	Shoulder	❑ Left	❑ Right	Hip	❑ Left	❑ Right
❑ Neck	Arm	❑ Left	❑ Right	Thigh	❑ Left	❑ Right
❑ Upper Back	Elbow	❑ Left	❑ Right	Knee	❑ Left	❑ Right
❑ Mid Back	Wrist	❑ Left	❑ Right	Calf	❑ Left	❑ Right
❑ Ribs	Hand	❑ Left	❑ Right	Ankle	❑ Left	❑ Right
❑ Chest	Fingers	❑ Left	❑ Right	Foot	❑ Left	❑ Right
❑ Abdomen	Buttock	❑ Left	❑ Right	Toes	❑ Left	❑ Right
❑ Low Back						
❑ Pelvis						

Where did you experience pain on the day <u>FOLLOWING</u> the accident?

❑ Head	Shoulder	❑ Left	❑ Right	Hip	❑ Left	❑ Right
❑ Neck	Arm	❑ Left	❑ Right	Thigh	❑ Left	❑ Right
❑ Upper Back	Elbow	❑ Left	❑ Right	Knee	❑ Left	❑ Right
❑ Mid Back	Wrist	❑ Left	❑ Right	Calf	❑ Left	❑ Right
❑ Ribs	Hand	❑ Left	❑ Right	Ankle	❑ Left	❑ Right
❑ Chest	Fingers	❑ Left	❑ Right	Foot	❑ Left	❑ Right
❑ Abdomen	Buttock	❑ Left	❑ Right	Toes	❑ Left	❑ Right
❑ Low Back						
❑ Pelvis						

Patient's Signature: _____

Doctors Notes:

Patient Name: _____

Acct #: _____

Today's Date: _____

DIFFICULTY IN PERFORMING ACTIVITIES OF DAILY LIVING

HOUSEWORK

_____ Doing Laundry
_____ Making Beds
_____ Vacuuming
_____ Washing Dishes
_____ Ironing
_____ Carrying Groceries
_____ Caring for pets
_____ Cooking
_____ Other: _____

YARD WORK

_____ Mowing lawn
_____ Shoveling Snow
_____ Raking leaves
_____ Gardening

PERSONAL GROOMING

_____ Combing Hair
_____ Shaving
_____ In/Out of bathtub
_____ Brushing teeth
_____ Other: _____

TRAVEL

_____ Driving
_____ Riding (Passenger)
_____ Getting in/out of auto

Minutes per day traveling

Type of Vehicle

Auto _____
Train _____
Bus _____
Truck _____
Airplane _____

GENERAL

_____ Walking
_____ Standing
_____ Running
_____ Sitting
_____ Lifting children
_____ Bending
_____ Climbing Stairs
_____ Reading
_____ Lying in bed
_____ Chewing
_____ Swimming
_____ Sports: _____
_____ Playing instrument
_____ Using typewriter/computer
_____ Kneeling
_____ Sexual Intercourse
_____ Exercising
_____ Sleeping
_____ Using Telephone
_____ Sitting in recliner

OTHER

Please list any other difficulties you are experiencing with activities you have engaged in since your condition arose:

_____

_____

_____

_____

_____

_____

_____

_____

_____ _____

Patient Signature Date

Doctors Notes:

FITTERER CHIROPRACTIC
112 E. Maple Street, Palmyra, PA 17078

Revised Oswestry Low Back Pain Disability Questionnaire

From N. Hudson, K. Tome-Nicholson, A. Breen; 1989 rev. 09/11/92

Name_____ **Date**_____

Please mark the ONE choice from EACH group that best describes you.

PAIN INTENSITY

❑A. The pain comes and goes and is very mild.
❑B. The pain is mild and does not very much.
❑C. The pain comes and goes and is moderate.
❑D. The pain is moderate and does not very much.
❑E. The pain comes and goes and is severe.
❑F. The pain is severe and does not very much.

PERSONAL CARE

❑A. I would not have to change my way of washing or dressing in order to avoid pain.
❑B. I do not normally change my way of washing or dressing even though it causes some pain.
❑C. Washing and dressing increases the pain, but I manage not to change my way of doing it.
❑D. Washing and dressing increases the pain and I find it necessary to change my way of doing it.
❑E. Because of the pain, I am unable to do some washing and dressing without help.
❑F. Because of the pain, I am unable to do any washing or dressing without help.

LIFTING

❑A. I can lift heavy weights without extra pain.
❑B. I can lift heavy weights, but it causes extra pain.
❑C. Pain prevents me from lifting heavy weights off the floor.
❑D. Pain prevents me from lifting heavy weights off the floor, but I can manage if they are conveniently positioned, e.g., on a table.
❑E. Pain prevents me from lifting heavy weights, but I can manage light to medium weights if they are conveniently positioned.
❑F. I can only lift very light weights, at the most.

WALKING

❑A. Pain does not prevent me from walking any distance.
❑B. Pain prevents me from walking more than one mile.
❑C. Pain prevents me from walking more than ½ mile.
❑D. Pain prevents me from walking more than 1/4 mile.
❑E. I can only walk while using a cane or on crutches.
❑F. I am in bed most of the time and have to crawl to the toilet.

SITTING

❑A. I can sit in any chair as long as I like without pain.
❑B. I can only sit in my favorite chair as long as I like.
❑C. Pain prevents me from sitting more than one hour.
❑D. Pain prevents me from sitting more than ½ hour.
❑E. Pain prevents me from sitting more than ten minutes.
❑F. Pain prevents me from sitting at all.

STANDING

❑A. I can stand as long as I want without pain.
❑B. I have some pain while standing, but it does not increase with time.
❑C. I cannot stand for longer than one hour without increasing pain.
❑D. I cannot stand for longer than ½ hour without increasing pain.
❑E. I cannot stand for longer than ten minutes without increasing pain.
❑F. I avoid standing, because it increases the pain straight away.

SLEEPING

❑A. I get no pain in bed.
❑B. I get pain in bed, but it does not prevent me from sleeping well.
❑C. Because of pain, my normal night's sleep is reduced by less than one-quarter.
❑D. Because of pain, my normal night's sleep is reduced by less than one-half.
❑E. Because of pain, my normal night's sleep is reduced by less than three-quarters.
❑F. Pain prevents me from sleeping at all.

SOCIAL LIFE

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

TRAVELING

❑A. I get no pain while traveling.
❑B. I get some pain while traveling, but none of my usual forms of travel make it any worse.
❑C. I get extra pain while traveling, but it does not compel me to seek alternative forms of travel.
❑D. I get extra pain while traveling which compels me to seek alternative forms of travel.
❑E. Pain restricts all forms of travel.
❑F. Pain prevents all forms of travel except that done lying down.

CHANGING DEGREE OF PAIN

❑A. My pain is rapidly getting better.
❑B. My pain fluctuates, but overall is definitely getting better.
❑C. My pain seems to be getting better, but improvement is slow at present.
❑D. My pain is neither getting better nor worse.
❑E. My pain is gradually worsening.
❑F. My pain is rapidly worsening.

Patient Signature _____ **Date**_____

Neck Pain Disability Questionnaire

After Vernon & Mior, 1991, rev. 1/1/95

Name_____

Date_____

Please mark the ONE choice from EACH group that best describes you.

PAIN INTENSITY

- ☐A. I have no pain at the moment.
- ☐B. The pain is very mild at the moment.
- ☐C. The pain is moderate at the moment.
- ☐D. The pain is fairly severe at the moment.
- ☐E. The pain is very severe at the moment.
- ☐F. The pain is worst imaginable at the moment.

PERSONAL CARE

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

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 manage 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 only lift very light weights.
- ☐F. I cannot lift or carry anything at all.

READING

- ☐A. I can read as much as I want to with no pain in my neck.
- ☐B. I can read as much as I want to with slight pain in my neck.
- ☐C. I can read as much as I want 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.

HEADACHES

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

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 concentrating when I want to.
❑F. I cannot concentrate at all.

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.

DRIVING

❑A. I can drive my car without any neck pain.
❑B. I can drive my car as long as I want with slight pain in my neck.
❑C. I can drive my car as long as I want with moderate pain in my neck.
❑D. I cannot drive my car as long as I want because of moderate pain in my neck.
❑E. I can hardly drive at all because of severe pain in my neck.
❑F. I cannot drive my car at all.

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).

RECREATION

❑A. I am able to engage in all of my recreational activities, with no neck pain at all.
❑B. I am able to engage in all of my recreational activities, with some neck pain at all.
❑C. I am able to engage in most, but not all of my usual recreational activities because of pain in my neck.
❑D. I am able to engage in a few of my usual recreational activities because of pain in my neck.
❑E. I can hardly do any recreational activities because of pain in my neck.
❑F. I cannot do any recreational activities at all.

Patient Signature

_____ **Date** _____