

MOTOR VEHICLE CRASH FORM (Page 1)

Patient Name: _____ Date: _____
 Date of crash: _____ Time of collision: _____ AM PM
 City where crash occurred: _____ Was the street wet or dry? Wet Dry
 Street (location) where crash occurred: _____
 Who owns the vehicle in which you were hit? _____
 What is the estimated repair damage to your vehicle? \$ _____
 Who made damage estimates on your vehicle? _____
 Yes, No Did the police come to the accident scene?
 Yes, No Did the police make a written report?
 Yes, No Were any photographs taken of the vehicle? If yes, who took them?

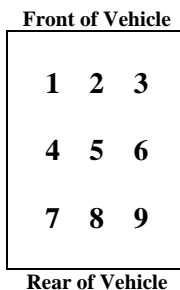
DESCRIBE HOW THE CRASH HAPPENED

COLLISION DESCRIPTION-TYPE

Check all that apply to you. Indicate which type of automobile crash you were involved in:

<input type="checkbox"/> Single-vehicle crash	<input type="checkbox"/> Two-vehicle crash	<input type="checkbox"/> Three-or-more vehicles
<input type="checkbox"/> Rear-end crash	<input type="checkbox"/> Side crash	<input type="checkbox"/> Rollover
<input type="checkbox"/> Head-on crash	<input type="checkbox"/> Hit guard rail, tree, or object	<input type="checkbox"/> Ran off the road
<input type="checkbox"/> Other (Describe): _____		

CIRCLE YOUR SEATING POSITION (The number's 1-9 indicate where you were seated at the time of the crash. The #1 spot is the driver. Seating numbers 7-9 are for a third row seat.)



DESCRIBE THE VEHICLE YOU WERE IN (If not certain, check unknown):

Model, Make, and Year: _____ Unknown

DESCRIBE THE OTHER VEHICLE (If not certain, check unknown):

Model, Make, and Year: _____ Unknown

MOTOR VEHICLE CRASH FORM (Page 2)

AT THE TIME OF IMPACT YOUR VEHICLE WAS:

<input type="checkbox"/> Slowing down	<input type="checkbox"/> Gaining speed
<input type="checkbox"/> Stopped	<input type="checkbox"/> Moving at a constant or steady speed

AT THE TIME OF IMPACT THE OTHER VEHICLE WAS:

<input type="checkbox"/> Slowing down	<input type="checkbox"/> Gaining Speed	<input type="checkbox"/> Unknown speed
<input type="checkbox"/> Stopped	<input type="checkbox"/> Moving at steady speed	<input type="checkbox"/> Other:

DURING AND AFTER THE CRASH, YOUR VEHICLE:

<input type="checkbox"/> Kept going straight, not hitting anything	<input type="checkbox"/> Spun around, not hitting anything
<input type="checkbox"/> Kept going straight, hitting car in front	<input type="checkbox"/> Spun around, hitting another car
<input type="checkbox"/> Was hit by another vehicle	<input type="checkbox"/> Spun around, hitting object other than car

INDICATE IF YOUR BODY HIT SOMETHING OR WAS HIT BY ANY OF THE FOLLOWING: Please draw lines from the body regions on the left side and match to the right side.

BODY REGION	OBJECT YOU HAD CONTACT WITH
Head	Windshield or side window
Face	Steering wheel
Shoulder	Side of door
Arm/hand	Dashboard
Front chest wall	Knee bolster/glove compartment
Side chest wall	Seatbelt (lap belt or shoulder harness)
Hip/abdomen	Frame of car near windows
Knee	Roof or top part of vehicle
Leg	Another occupant/animal
Foot	Other

CHECK IF ANY OF THE FOLLOWING VEHICLE PARTS BROKE, BENT, OR WERE DAMAGED IN YOUR CAR:

<input type="checkbox"/> Windshield	<input type="checkbox"/> Seat frame bent or damaged	<input type="checkbox"/> Knee bolster
<input type="checkbox"/> Steering wheel	<input type="checkbox"/> Side-rear window broken	<input type="checkbox"/> Other
<input type="checkbox"/> Dash	<input type="checkbox"/> Mirror	<input type="checkbox"/> Other

ALL TYPES OF COLLISIONS Indicate those relevant to your case.

YES NO

<input type="checkbox"/>	<input type="checkbox"/>	Did any of the interior front or side structures within your vehicle, such as the side door, dashboard, steering wheel, or floorboard of your car dent inward during the crash?
<input type="checkbox"/>	<input type="checkbox"/>	Did the side door, dash, or interior of your vehicle touch or hit your body during the crash?
<input type="checkbox"/>	<input type="checkbox"/>	Did your body slide under the seatbelt?
<input type="checkbox"/>	<input type="checkbox"/>	Was the door(s) of your vehicle damaged to a point where you could not open the door?
<input type="checkbox"/>	<input type="checkbox"/>	Did an airbag deploy in your vehicle during the crash? If yes, circle (side air bag/front air bag)
<input type="checkbox"/>	<input type="checkbox"/>	Were you intoxicated (alcohol) at the time of crash?

MOTOR VEHICLE CRASH FORM (Page 3)

SEATBELT USAGE AND STEERING WHEEL HAND PLACEMENT:

YES NO

<input type="checkbox"/>	<input type="checkbox"/>	Were you wearing a seatbelt? If yes, does your seatbelt have a: <input type="checkbox"/> Lap and Shoulder Strap, <input type="checkbox"/> Lap belt only
<input type="checkbox"/>	<input type="checkbox"/>	Did you have any portion of your seatbelt positioned behind your chest, back or shoulder.
<input type="checkbox"/>	<input type="checkbox"/>	Were you holding onto the steering wheel (driver only) at the time of impact? If yes, Indicate where each hand was positioned (<i>Use time clock face as your reference point</i>) Left hand: <input type="checkbox"/> Not on wheel, <input type="checkbox"/> Yes, hand at ____ o'clock, <input type="checkbox"/> Hand elsewhere Right hand: <input type="checkbox"/> Not on wheel, <input type="checkbox"/> Yes, hand at ____ o'clock, <input type="checkbox"/> Hand elsewhere

REAR-END COLLISIONS ONLY Answer this section only if you were hit from the rear.

Describe your vehicle's head restraint system:

- | | |
|--|--|
| <input type="checkbox"/> Movable/adjustable head restraint | <input type="checkbox"/> Fixed, non-moveable head restraint |
| <input type="checkbox"/> No headrests in my vehicle | <input type="checkbox"/> Bench seat in your vehicle without head restraint |

Please indicate how your head restraint was positioned at the time of crash (if present):

- | | |
|--|---|
| <input type="checkbox"/> At the top of the back of your head | <input type="checkbox"/> Midway height of the back of your head |
| <input type="checkbox"/> Lower height of the back of your head | <input type="checkbox"/> Located at the level of your neck |
| <input type="checkbox"/> Level of your shoulder blades | |

BRUISING AFTER THE CRASH?

YES NO

<input type="checkbox"/>	<input type="checkbox"/>	Did your body have any bruising (areas that were visibly black, red, and/or blue) after the crash? If yes, indicate where bruising was located on your body and what caused the bruising:
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AWARENESS AND BODY POSITION DESCRIPTIONS: *Check all areas that apply to you.*

<input type="checkbox"/>	You were unaware of the impending collision. You did not see or hear brakes prior to the impact.
<input type="checkbox"/>	You were aware of the impending crash and relaxed before the collision.
<input type="checkbox"/>	You were aware of the impending crash and braced yourself.
<input type="checkbox"/>	Your body, torso, and head were facing straight ahead.
<input type="checkbox"/>	You had your head and/or torso turned at the time of collision: <input type="checkbox"/> Turned to left, <input type="checkbox"/> Turned to right Describe how far you were turned/twisted and why you were turned/what were you doing?
<input type="checkbox"/>	You were leaning forward at the time of impact resulting in a gap between your body and the seatback. If yes, indicate how far you were leaning and why you were leaning forward?
<input type="checkbox"/>	Your torso/body were positioned normally against the seatback with no gaps due to leaning/twisting.

HOW SOON DID YOU FIRST NOTICE ANY PAIN/SORENESS AFTER THE CRASH?

Form 1610

MOTOR VEHICLE COLLISION INJURY REPORT

Patient Name:		Address:		Home Telephone:	
Claim No:		Date of Injury:		Date of First Treatment:	
Patient Date of Birth:		Name of Employer:		Job Title:	
Patient's Description of Motor Vehicle Collision:					
Prior Injuries or Illness: List Complicating Factors:					
Prior Treatment for Injury:		<input type="checkbox"/> No, <input type="checkbox"/> Yes If yes, indicate where:			
Present Symptoms: (Severity and Frequency)					
Physical Exam Findings:					
Diagnosis:					
Diagnosis:					
X-Ray: (Indicate date/findings)		<input type="checkbox"/> No X-rays Taken Date <input type="checkbox"/> Yes X-rays Taken		Findings	
Other Testing: (MRI, EMG, CT, etc)		<input type="checkbox"/> None Name of Test Date <input type="checkbox"/> Yes		Findings	
Types of Treatment Given: (List Modalities, etc)					
Current Treatment Status: (If Discharged give Date)		<input type="checkbox"/> Discharged From Care <input type="checkbox"/> Currently Under Care		Date of Discharge:	
Response to Therapy:					
Disability Dates:		<input type="checkbox"/> None, <input type="checkbox"/> Yes Indicate Dates:			
Prognosis: (If unknown, indicate why)		<input type="checkbox"/> Good, <input type="checkbox"/> Unknown, <input type="checkbox"/> Guarded If guarded, Describe:			
Permanent Impairment or Disability:		<input type="checkbox"/> None, <input type="checkbox"/> Unknown, <input type="checkbox"/> Yes If yes, Describe:			
Present Work Restrictions:		<input type="checkbox"/> None, <input type="checkbox"/> Yes If yes, Describe:			
Misc Notes:					
Date of Report:		Physician's License Number:		Physician's Tax ID No:	Physician's Telephone:
Physician's Address (Street, Suite, City, State, Zip):					
Physician's Name:			Signature of Physician:		

GENERAL HEALTH HISTORY (PAGE 1)

Check only those conditions that apply to you and indicate if you have had in the past or presently have.

YES	GENERAL QUESTIONS	PAST	PRESENT
<input type="checkbox"/>	History of poor healing or told that you have a healing disorder?	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	Smoke cigarettes or use tobacco products?	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	Diabetes, hypoglycemia, thyroid, kidney, liver disease, or other endocrine disorder?	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	Heart attack, heart disease or have a heart pacemaker or neck or chest shunt?	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	History of any disease such as AIDS, Tuberculosis, Meningitis, etc.?	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	Do you have difficulties or intolerance to heat packs or ice packs on your skin?	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	Do you have problems with dizziness, blacking out, balance, fainting, or tripping?	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	Epilepsy-Seizure-Convulsion history or any other neurological disease?	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	History of multiple sclerosis, lupus, psoriasis, paralysis, or any disease affecting nerves/brain?	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	Cancer history or cancer treatment of any type?	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	Stroke history (Indicate any suspected strokes or transient ischemic attacks)?	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	Told that you have scoliosis, spondylolisthesis, spina bifida, or fused/abnormal vertebrae?	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	Told that you have a bulging/herniated disc or disc degeneration in the spine?	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	Have you ever been hospitalized? Why/When:	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	Blood clots, bleeding or vascular disorder, or told you have an abdominal aneurysm?	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	Hypertension or high blood pressure? If yes, name of MD seeing:	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	Told you have weak bones, osteoporosis, osteopenia, or ankylosing spondylitis?	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	Told you have arthritis, degeneration, or rheumatoid arthritis in your spine or joints?	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	Do you have any type of chest or breast implants presently (males & females)?	N/A	<input type="checkbox"/>
<input type="checkbox"/>	Women only: Check box to left if there any chance that you are currently pregnant		

PRIOR INJURY AND/OR PREVIOUS PAIN (I have never had any injuries or pain) If yes, check below:

<input type="checkbox"/> Work Injury	<input type="checkbox"/> Fall	<input type="checkbox"/> Sports Injury	<input type="checkbox"/> Lifting Injury	<input type="checkbox"/> Car Accident
<input type="checkbox"/> Motorcycle Injury	<input type="checkbox"/> Head Injury	<input type="checkbox"/> Pedestrian Injury	<input type="checkbox"/> Military Injury	<input type="checkbox"/> Other Injury
<input type="checkbox"/> Headaches	<input type="checkbox"/> Neck Pain	<input type="checkbox"/> Middle Back Pain	<input type="checkbox"/> Low Back Pain	<input type="checkbox"/> Shoulder Pain
<input type="checkbox"/> arm numb/tingling	<input type="checkbox"/> Arm Pain	<input type="checkbox"/> Leg Pain/Tingling	<input type="checkbox"/> Other Pain:	

Describe:

FRACTURES/BROKEN BONES HISTORY

(I have never had any broken bones). If you have broken/fractured any bones, indicate where and when below:

Region	Year	Region	Year
<input type="checkbox"/> Spinal Vertebra		<input type="checkbox"/> Skull	
<input type="checkbox"/> Collar bone (clavicle)		<input type="checkbox"/> Rib(s) or sternum chest bone	
<input type="checkbox"/> Arm or hand bones		<input type="checkbox"/> Leg or foot bones	
<input type="checkbox"/> Pelvis or hip bones		<input type="checkbox"/> Other: List	

PREVIOUS SURGERIES

(I have never had any surgical procedure). If you have had any previous surgery, indicate type and when:

Surgery	Year	Surgery	Year
<input type="checkbox"/> Spine Surgery (neck, back, or pelvis)		<input type="checkbox"/> Abdominal/chest Surgery or Appendix	
<input type="checkbox"/> Disc surgery in neck or back		<input type="checkbox"/> Gallbladder/Liver/Stomach/Kidney	
<input type="checkbox"/> Heart		<input type="checkbox"/> Cancer (any type)	
<input type="checkbox"/> Head/Brain/Spinal Cord/Nerve		<input type="checkbox"/> Hernia (inguinal or hiatal)	
<input type="checkbox"/> Shoulder/Arm/Hip/Leg		<input type="checkbox"/> Other	

When did you have your last physical examination by a medical doctor? Year: _____ Name MD: _____

Doctor's Name: Lawrence Nordhoff DC	Patient Name: Sally Jones
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Form 1010

GENERAL HEALTH HISTORY (PAGE 2)

No, Yes **Do you have a family history** of high blood pressure, stroke, heart attacks, scoliosis, spina bifida, genetic conditions of the spine, spinal cord, brain, nerves, or other diseases? If yes, please describe: _____

No, Yes **Have you ever been to a Chiropractor before for any condition?**

If yes, Chiropractor's Name/City : _____ Year: _____

List Problem(s) that the Chiropractor treated you for: _____

No, Yes **Do you have any problems laying face down on an examination table**, including tender chest/breast, level of pain, etc? If yes, why: _____

ARE YOU TAKING ANY MEDICATIONS PRESENTLY?

I am not taking any medications currently. Check the following that you are taking or have taken recently.

<input type="checkbox"/> Muscle Relaxants	<input type="checkbox"/> Blood pressure/Stroke prevention medications	<input type="checkbox"/> Cortisone/Epidural injections
<input type="checkbox"/> Pain/Anti-inflammatory meds	<input type="checkbox"/> Osteoporosis (bone strengthening) medications	<input type="checkbox"/> Other:
<input type="checkbox"/> Cholesterol Drugs	<input type="checkbox"/> Heart medications	<input type="checkbox"/> Other

WHEN IS YOUR PAIN WORSE & WHAT ACTIVITIES INCREASE YOUR PAIN?

<input type="checkbox"/> Morning is when pain is worse	<input type="checkbox"/> Bending your back increases pain	<input type="checkbox"/> Walking increases pain
<input type="checkbox"/> Afternoon/evening pain worse	<input type="checkbox"/> Lying down flat increases pain	<input type="checkbox"/> Standing increases pain
<input type="checkbox"/> During sleep hours pain worse	<input type="checkbox"/> Sitting increases pain	<input type="checkbox"/> Exercise/Stretching increases pain
<input type="checkbox"/> Standing up from sitting	<input type="checkbox"/> Poor posture increases pain	<input type="checkbox"/> Other:

WHAT ACTIVITIES LESSEN YOUR PAIN?

<input type="checkbox"/> Walking	<input type="checkbox"/> Being flat on your back	<input type="checkbox"/> Exercise/Stretching
<input type="checkbox"/> Sitting	<input type="checkbox"/> Standing	<input type="checkbox"/> Other:

DO YOU EXERCISE?

<input type="checkbox"/> I do no regular exercise	<input type="checkbox"/> I exercise 1-2 times a week	<input type="checkbox"/> I exercise 3-5 times a week
<input type="checkbox"/> I stretch regularly	<input type="checkbox"/> I do weight lifting at gym/home	<input type="checkbox"/> I do cardiovascular work outs
<input type="checkbox"/> I am willing to do exercise	<input type="checkbox"/> I am not willing to do exercises	<input type="checkbox"/> I do regular sports activities

HAS YOUR PAIN BEEN ASSOCIATED WITH ANY OF THE FOLLOWING?

<input type="checkbox"/> Excessive fatigue-malaise	<input type="checkbox"/> Bowel or bladder disorders	<input type="checkbox"/> Night pain or night time sweats
<input type="checkbox"/> Weight loss	<input type="checkbox"/> Ovarian pain	<input type="checkbox"/> Abdominal pain
<input type="checkbox"/> Low grade fever	<input type="checkbox"/> Kidney pain/painful urination	<input type="checkbox"/> Balance problems

Since the injury did your pain and other symptoms come on? Suddenly, Gradually

Doctor's Name: Lawrence Nordhoff, DC	Patient Name: Sally Jones
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NECK, MIDDLE BACK, AND EXTREMITY QUESTIONNAIRE (PAGE 3)

Please answer the following sections that apply to you. If some of the questions are unclear to you, skip ahead to the next question. Your doctor will be going over this questionnaire with you during your consultation, and you can ask questions or clarify your answers at that time.

YES NO

NECK REGION

<input type="checkbox"/>	<input type="checkbox"/>	Does neck and head movement cause your neck pain to intensify?
<input type="checkbox"/>	<input type="checkbox"/>	Do you get dizzy when you look up or twist your head? If yes, how often:
<input type="checkbox"/>	<input type="checkbox"/>	Do you black out or lose your balance when you look up or twist your head? If yes, how often:
<input type="checkbox"/>	<input type="checkbox"/>	Do you have to support your head with your hand or grasp your mouth or hair to be able to lift your head up when you are lying down and attempting to sit up? If your difficulty/inability to lift your head without support is injury related, indicate how soon this occurred after injury? (_____ min/hrs)
<input type="checkbox"/>	<input type="checkbox"/>	Do you feel your neck pain sends pain downwards between your shoulders?
<input type="checkbox"/>	<input type="checkbox"/>	Do you feel your neck pain sending pain downwards to the front of your chest?
<input type="checkbox"/>	<input type="checkbox"/>	Have you noticed your head leaning or tilting to one side recently?
<input type="checkbox"/>	<input type="checkbox"/>	Have you ever been diagnosed as having a disc bulge or disc herniation in your neck previously?
<input type="checkbox"/>	<input type="checkbox"/>	Does your neck make a "clunk" sound when you move it?

YES NO

SHOULDER, ARM, HAND, OR FINGER REGION

<input type="checkbox"/>	<input type="checkbox"/>	Do you have pain, numbness, or tingling in your shoulder, elbow, forearm, or hand ? Circle areas
<input type="checkbox"/>	<input type="checkbox"/>	Do you have pain, numbness, or tingling in your fingers? If Yes, circle finger(s) that are involved: Thumb, Index finger, Middle finger, Ring finger, Little finger
<input type="checkbox"/>	<input type="checkbox"/>	Do you get increased arm numbness when lying flat on your back or sleeping on your side?
<input type="checkbox"/>	<input type="checkbox"/>	Does changing your sitting posture increase your arm/hand symptom intensity?
<input type="checkbox"/>	<input type="checkbox"/>	If you sit and slouch forward for several minutes, do your arm symptoms intensify?
<input type="checkbox"/>	<input type="checkbox"/>	If you have arm symptoms, do they improve when you lift your arms over your head?
<input type="checkbox"/>	<input type="checkbox"/>	If you have arm symptoms, do they worsen when you lift your arms over your head?
<input type="checkbox"/>	<input type="checkbox"/>	If you have hand or arm pain/numbness at night, does it help to shake and massage them?
<input type="checkbox"/>	<input type="checkbox"/>	Do your hands feel tender when you grasp objects?
<input type="checkbox"/>	<input type="checkbox"/>	Do you feel weakness in your grip strength?
<input type="checkbox"/>	<input type="checkbox"/>	Do you drop objects from your hand?
<input type="checkbox"/>	<input type="checkbox"/>	Do you have difficulty writing or doing small motions with your fingers recently?
<input type="checkbox"/>	<input type="checkbox"/>	Do your hand(s) or wrist swell?
<input type="checkbox"/>	<input type="checkbox"/>	Do your hands burn?
<input type="checkbox"/>	<input type="checkbox"/>	Are your fingers or hands frequently cold?
<input type="checkbox"/>	<input type="checkbox"/>	Have you been diagnosed as having Carpal Tunnel Syndrome or Raynaud's syndrome in your past?

YES NO

MIDDLE BACK AND CHEST WALL REGION

<input type="checkbox"/>	<input type="checkbox"/>	Do you have pain that shoots or radiates outward along your rib cage?
<input type="checkbox"/>	<input type="checkbox"/>	Does your middle back or chest wall pain intensify when you take in a deep breath or cough?
<input type="checkbox"/>	<input type="checkbox"/>	Does your middle back or chest wall pain intensify when you twist your torso, bend, or stoop forward?
<input type="checkbox"/>	<input type="checkbox"/>	When you move your neck around, does your middle back pain or chest pain increase?
<input type="checkbox"/>	<input type="checkbox"/>	Have you been diagnosed as having angina before?
<input type="checkbox"/>	<input type="checkbox"/>	Do you have a tight band-like feeling sometimes around your chest?
<input type="checkbox"/>	<input type="checkbox"/>	Do you recently have any associated unusual indigestion, chest pressure, or pain down your left arm?
<input type="checkbox"/>	<input type="checkbox"/>	Does your middle back pain mostly bother you during sleep?

Doctor's Name: Lawrence Nordhoff, DC	Patient Name: Sally Jones
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Form 1030

PATIENT INTRODUCTION FORM

Today's Date: _____

Last Name:		MI:	First Name:	
Home Address:		City:	State:	Zip:
Date Birth:	Age:	Social Security Number:		
Height:	Weight:	Who Referred You to Our Office:		
Employer's Name:		Marital Status (Circle): Single, Married, Divorced, Widowed		
Occupation:		Name of Family Physician:		

IS THIS VISIT RELATED TO A:

- | | | |
|---|---|---|
| <input type="checkbox"/> Work Related Injury/Symptoms | <input type="checkbox"/> Motorcycle-Bicycle Injury | <input type="checkbox"/> Non-Injury Pain/Symptoms |
| <input type="checkbox"/> Sport or Recreational Injury | <input type="checkbox"/> Home Injury Symptoms | <input type="checkbox"/> Check-up Only |
| <input type="checkbox"/> Motor Vehicle Crash Injury | <input type="checkbox"/> School/Employment Physical | <input type="checkbox"/> Other (Describe): |

HEALTH-MEDICAL INSURANCE INFORMATION

Does your insurance plan cover Chiropractic treatment?	<input type="checkbox"/> Yes, <input type="checkbox"/> No If yes, we need a copy of the card
If yes, indicate Insurance Company Name (Need copy of card).	Insurance Name: _____ Address: _____ Telephone: _____
Are you the insured person or dependent (wife/husband/child)?	<input type="checkbox"/> Insured, <input type="checkbox"/> Dependent
If you are the insured person's dependent (spouse or child), we need the insured person's name, date of birth, social security number, and the company/business name of the insured employer in order to do billing.	Name of Insured Person: _____ Social Security Number: _____ Insured Date of Birth: _____ Name of Insured Employer: _____
What is your co-payment amount for each visit?	Amount: \$ _____ Percentage: %
Do you have a health insurance deductible for chiropractic?	<input type="checkbox"/> Yes, <input type="checkbox"/> No Deductible \$ _____ Have you met deductible yet?
Specific chiropractic health insurance benefits	Number visits per year # _____ . Amount per year: \$ _____

Name, Address, Relationship, and Telephone Number of your nearest adult relative (for emergencies):

OUR OFFICE WILL PROVIDE INSURANCE BILLING SERVICES FOR AS A COURTESY. HOWEVER, IN ORDER TO KEEP OUR OFFICE OVERHEAD DOWN AND KEEP OUR PATIENT FEES REASONABLE, WE EXPECT PAYMENT AT THE CONCLUSION OF EACH TREATMENT FOR CASH PATIENTS AND THE CO-PAYMENT AND/OR DEDUCTIBLE FOR REGULAR HEALTH INSURANCE PATIENTS.

Patient Signature and Date	I am a responsible party and agree to pay for any outstanding bills incurred in this office. It is my responsibility to pay any deductible, co-insurance, and/or any other balances not paid by my health insurance carrier. Minors must have parent's signature.
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Form 1000

POST-TRAUMATIC SYMPTOM QUESTIONNAIRE

PATIENT INSTRUCTIONS: *It is important for this section to be filled out in detail. Look at each symptom listed in the left column and make a single check mark or several check marks in the appropriate columns for the specific symptom which applies to you. Be certain to indicate when you had the beginning of any of the following symptoms. Leave the row blank if the symptom listed below does not apply to you.*

SYMPTOM LIST (Check all that apply to you)	BEGAN IN LESS THAN 24 HOURS AFTER INJURY	BEGAN 1 TO 7 DAYS AFTER INJURY	YOU HAVE SYMPTOMS RECENTLY	HAD SIMILAR SYMPTOMS ONE YEAR BEFORE THIS INJURY
Headache/migraine				
Dizziness				
Tinnitus (ear ringing)				
Blurry vision				
Memory problems				
Poor concentration				
Nausea or vomiting				
Balance problems				
Loss of coordination				
Sensitivity to sound				
Sensitivity to light				
Fatigue				
Loss of smell				
Pain/difficulty swallowing				
Jaw pain/soreness				
Neck pain/soreness/aching/stiff				
Shoulder pain/stiffness				
Arm pain/tingling/numbness				
Wrist/hand/finger pain/numbness				
Weakness in arms/legs				
Upper/middle back pain/soreness				
Chest pain or bruising				
Rib cage pain or bruising				
Abdominal-Pelvic pain or bruising				
Low back pain/soreness/aching				
Hip pain or bruising				
Upper leg or thigh pain				
Leg numbness/tingling				
Pain radiating down leg(s)				
Lower leg or calf pain				
Knee pain				
Ankle/foot/toe pain				
Other				

Doctor's Name: Lawrence Nordhoff, DC	Patient Name: Sally Jones
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CONCUSSION QUESTIONNAIRE

PATIENT: _____ DATE: _____

Please check any of the following boxes that correspond to any symptom(s) or other problems that you have had or observed since your injury.

YES	SYMPTOM DESCRIPTION	YES	SYMPTOM DESCRIPTION
<input type="checkbox"/>	Headaches or migraines	<input type="checkbox"/>	Blurry vision or other visual symptoms
<input type="checkbox"/>	Dazed or lightheaded right after the accident	<input type="checkbox"/>	Loss of smell or taste
<input type="checkbox"/>	Reduced drive/motivation	<input type="checkbox"/>	Difficulty handling multiple tasks
<input type="checkbox"/>	Poor memory or forgetful	<input type="checkbox"/>	More assertive
<input type="checkbox"/>	Difficulty finishing tasks	<input type="checkbox"/>	Loss of smell
<input type="checkbox"/>	Sleep disorders or insomnia	<input type="checkbox"/>	Personality change
<input type="checkbox"/>	Abnormal levels of anxiety	<input type="checkbox"/>	Hand tremors
<input type="checkbox"/>	Seizure	<input type="checkbox"/>	Ringing or buzzing sounds in your ears
<input type="checkbox"/>	Dizziness	<input type="checkbox"/>	Less diplomatic than normal with other people
<input type="checkbox"/>	Loss of coordination or balance	<input type="checkbox"/>	Mood swings
<input type="checkbox"/>	Irritability, anger outbursts or temper problems	<input type="checkbox"/>	Reduced attention span
<input type="checkbox"/>	Depression	<input type="checkbox"/>	Blackouts
<input type="checkbox"/>	Fatigue	<input type="checkbox"/>	Indifference to other people
<input type="checkbox"/>	Difficulty or absence of ability to anticipate others	<input type="checkbox"/>	More shallow relationships
<input type="checkbox"/>	Mental inflexibility	<input type="checkbox"/>	Difficulty with problem solving
<input type="checkbox"/>	Impaired sexual function	<input type="checkbox"/>	Less mental stamina
<input type="checkbox"/>	Language difficulty	<input type="checkbox"/>	Performance inconsistencies
<input type="checkbox"/>	Impaired judgment	<input type="checkbox"/>	Verbal learning problems
<input type="checkbox"/>	Need daytimer to remember appointments/activities	<input type="checkbox"/>	Slower reaction times
<input type="checkbox"/>	Other:	<input type="checkbox"/>	Other:

PHYSICIAN SUMMARY AS PATIENT HAS REACHED MMI STATUS

PATIENT NAME: _____ DATE: _____

Date Patient reached MMI status:	Date MMI was determined:
Patient reached pre-injury level:	<input type="checkbox"/> Yes, <input type="checkbox"/> No If no, summarize residual symptoms below.
Is supportive care indicated?	<input type="checkbox"/> Yes, <input type="checkbox"/> No If yes, summarize why supportive care is needed below.
Is apportionment indicated?	<input type="checkbox"/> Yes, <input type="checkbox"/> No If yes, define percentages for each area of body below.

OVERALL RESPONSE TO TREATMENT

SUMMARY OF RESIDUAL COMPLAINTS AND EXAM FINDINGS

YES, NO IS SUPPORTIVE CARE NECESSARY? IF YES, SEE BELOW.

Supportive care is defined as treatment rendered to keep the patient at the discharge level. The patient only calls for appointments (as needed) when he/she has a significant flare-up of pain.

Reasons for this patient needing supportive care include the following:

SUMMARY OF ANY WORK/HOME/RECREATIONAL RESTRICTIONS

(Doctor's Name, Address, & Telephone)

--

TRAVEL CARD (FRONT SIDE. PRINTS 8.5 x 11 inch size)

NAME:

DATE:

X-Ray Date/Views/Findings:	Age: _____ M S W D, Children	TRAVEL CARD (Front) WC, PI, CASH, INS, Medicare, Medicaid
	Occupation:	
	Home Phone:	
	Work Phone:	
	Address:	
	DOB:	
		LIST OF COMPLAINTS
	Disability Dates: <input type="checkbox"/> Total, <input type="checkbox"/> Partial	Onset:
	From: _____ To: _____	1.
	From: _____ To: _____	2.
	Extended to: _____	3.
	Extended to: _____	4.
		5.
		Prior Treatment:
	PATIENT PRECAUTIONS/NOTES:	Prior Episodes:
		Prior Illnesses:
		Prior Surgeries:
		Prior Fractures:
		Prior MVA/Injuries:

TRAVEL CARD (BACK SIDE)

PROBLEM LIST	PROBABLE ETIOLOGY	TREATMENT RENDERED
<input type="checkbox"/> Headaches/Migraines <input type="checkbox"/> Neck pain/soreness/stiffness <input type="checkbox"/> Middle back pain/soreness <input type="checkbox"/> Chest wall pain <input type="checkbox"/> Low back pain/soreness <input type="checkbox"/> Hip/Sacroiliac joint pain <input type="checkbox"/> Knee pain <input type="checkbox"/> Calf/ankle/foot pain <input type="checkbox"/> Rotator Cuff Syndrome <input type="checkbox"/> Shoulder pain <input type="checkbox"/> Elbow/forearm/wrist pain <input type="checkbox"/> Upper extremity pain/paresthesia <input type="checkbox"/> Lower extremity pain/paresthesia <input type="checkbox"/> Radiculopathy <input type="checkbox"/> Biomechanically weak area <input type="checkbox"/> Thoracic Outlet Syndrome <input type="checkbox"/> Carpal Tunnel Syndrome <input type="checkbox"/> Strain _____ <input type="checkbox"/> Sprain _____ <input type="checkbox"/> Strain/Sprain _____ <input type="checkbox"/>	<input type="checkbox"/> Recent trauma _____ <input type="checkbox"/> Old trauma _____ <input type="checkbox"/> Joint dysfunction <input type="checkbox"/> Post-traumatic inflammation/swelling <input type="checkbox"/> Zygapophyseal joint/capsule irritation <input type="checkbox"/> Facet Joint/Capsule Inflammation <input type="checkbox"/> Spinal stenosis <input type="checkbox"/> Myofascial scar tissue-post traumatic <input type="checkbox"/> Myofascial adhesions, nontraumatic <input type="checkbox"/> Shortening-contracture of muscle <input type="checkbox"/> Active trigger points <input type="checkbox"/> Postural-Ergonomic muscle tension <input type="checkbox"/> Meniscoid entrapment (synovial fold) <input type="checkbox"/> Disc Annular fiber injury <input type="checkbox"/> Bulging/herniated cervical disc <input type="checkbox"/> Bulging/herniated lumbar disc <input type="checkbox"/> Peripheral nerve root compression <input type="checkbox"/> Degeneration of discs <input type="checkbox"/> Degeneration of joints (osteoarthritis) <input type="checkbox"/> Scapular winging, dorsal weakness <input type="checkbox"/> Weak low back/abdominal muscles <input type="checkbox"/>	<input type="checkbox"/> Spinal adjustments <input type="checkbox"/> Extremity adjustments <input type="checkbox"/> Joint mobilization <input type="checkbox"/> Myotherapy (gentle/deep) <input type="checkbox"/> Myofascial release <input type="checkbox"/> Trigger Point Therapy <input type="checkbox"/> Therapeutic exercises <input type="checkbox"/> Cervical/Lumbar traction ___ lbs, ___ min <input type="checkbox"/> Ultrasound ___ setting for ___ min <input type="checkbox"/> Muscle Stim ___ setting for ___ min <input type="checkbox"/> Ice packs/ Moist heat packs (home/office) <input type="checkbox"/> Exercises (home/gym/office) ___ x week <input type="checkbox"/> Stretching (home/gym/office) ___ x week <input type="checkbox"/> Dietary/Nutritional advice _____ <input type="checkbox"/> Posture modifications _____ <input type="checkbox"/> Ergonomic modifications _____ <input type="checkbox"/> Cervical collar <input type="checkbox"/> Cervical pillow <input type="checkbox"/> Brace (wrist etc) _____ <input type="checkbox"/> Lumbar brace <input type="checkbox"/> Orthotics _____ <input type="checkbox"/>

TREATMENT OBJECTIVES

<input type="checkbox"/> Decrease pain/paresthesias <input type="checkbox"/> Enhance and improve repair <input type="checkbox"/> Decrease swelling/inflammation <input type="checkbox"/> Improve and normalize joint motion <input type="checkbox"/> Improve circulation to joint	<input type="checkbox"/> Break up myofascial adhesions <input type="checkbox"/> Neutralize active trigger points <input type="checkbox"/> Lessen impingement <input type="checkbox"/> Strengthen weak areas <input type="checkbox"/> Get pt reliant on self-management <input type="checkbox"/>	<input type="checkbox"/> Stabilize condition <input type="checkbox"/> Improve body-joint function <input type="checkbox"/> Improve posture/ergonomics <input type="checkbox"/> Prevent or lessen risk of chronicity <input type="checkbox"/> Avoid surgery
---	--	--

NOTES: _____

X-ray necessity:	<input type="checkbox"/> Yes, indicated, <input type="checkbox"/> Not indicated. Will wait and observe response first before ordering x-rays.
Complicating factors:	<input type="checkbox"/> None noted, <input type="checkbox"/> Yes:
Referral for testing or to a MD:	<input type="checkbox"/> None noted, <input type="checkbox"/> Yes, indicated:

INITIAL OFFICE VISIT FREQUENCY (ESTIMATE)	<input type="checkbox"/> Daily, <input type="checkbox"/> 4-5x wk, <input type="checkbox"/> 3x wk, <input type="checkbox"/> 2x wk, <input type="checkbox"/> 1x wk for ____ week(s), then patient will be re-evaluated. Based on exam findings and response to treatment, the visit frequency will then be determined. Will re-evaluate pt in ____ weeks.
--	---

<input type="checkbox"/> Condition outlined to patient	<input type="checkbox"/> Treatment objectives explained	<input type="checkbox"/> Pt willing to do home recommendations.
--	---	---

Travel Card-Progress Notes Abbreviations: adj = adjustment, MH = moist heat, Elect Stim = Electrical Stimulation, US = Ultrasound, mm = muscle, H/A = headache, Nk pn = neck pain, MB pn = middle back pain, UB pn = upper back pain, SI = Sacroiliac, Sh = shoulder, cerv tract = cervical traction, TP = trigger point, Tx = treatment, ThEx = Therapeutic exercises, MT = manual therapy, Flex-Dist = Flexion-Distract, Int traction = intersegmental traction, mm = muscle, wk = week.

Patient Name:	Doctor's Name/Address:

Form 1501

PATIENT PROGRESS NOTES

DATE	S	See pain drawing. <input type="checkbox"/> H/A, <input type="checkbox"/> Nk pn, <input type="checkbox"/> MB pn, <input type="checkbox"/> LBP, <input type="checkbox"/> SI pn, <input type="checkbox"/> <input type="checkbox"/> No recent flare-ups, <input type="checkbox"/> Flare-up noted:
	O	<input type="checkbox"/> Clinical Findings (ROM/Testing/Etc): <input type="checkbox"/> Myofascial adhesions/Fibrotic muscles/Hypertonicity/TP:
	A	<input type="checkbox"/> Responding (Normally/Slowly/No improvement).
	P	<input type="checkbox"/> See ____ times a week/mo. <input type="checkbox"/> See PRN. <input type="checkbox"/> Cerv tract, <input type="checkbox"/> Flex-Dist, <input type="checkbox"/> Ice, <input type="checkbox"/> MH, <input type="checkbox"/> Elect Stim, <input type="checkbox"/> US, <input type="checkbox"/> Int traction, <input type="checkbox"/> <input type="checkbox"/> Adjust: <input type="checkbox"/> Myotherapy (gentle/deep) to hypertonic/fibrotic areas noted in objectives <input type="checkbox"/> Mobilization <input type="checkbox"/> Nk, <input type="checkbox"/> MB, <input type="checkbox"/> LB, <input type="checkbox"/> SI, Other:
DATE	S	See pain drawing. <input type="checkbox"/> H/A, <input type="checkbox"/> Nk pn, <input type="checkbox"/> MB pn, <input type="checkbox"/> LBP, <input type="checkbox"/> SI pn, <input type="checkbox"/> <input type="checkbox"/> No recent flare-ups, <input type="checkbox"/> Flare-up noted:
	O	<input type="checkbox"/> Clinical Findings (ROM/Testing/Etc): <input type="checkbox"/> Myofascial adhesions/Fibrotic muscles/Hypertonicity/TP:
	A	<input type="checkbox"/> Responding (Normally/Slowly/No improvement).

	P	<input type="checkbox"/> See ____ times a week/mo. <input type="checkbox"/> See PRN. <input type="checkbox"/> Cerv tract, <input type="checkbox"/> Flex-Dist, <input type="checkbox"/> Ice, <input type="checkbox"/> MH, <input type="checkbox"/> Elect Stim, <input type="checkbox"/> US, <input type="checkbox"/> Int traction, <input type="checkbox"/> <input type="checkbox"/> Adjust: <input type="checkbox"/> Myotherapy (gentle/deep) to hypertonic/fibrotic areas noted in objectives <input type="checkbox"/> Mobilization: <input type="checkbox"/> Nk, <input type="checkbox"/> MB, <input type="checkbox"/> LB, <input type="checkbox"/> SI, Other:
DATE	S	See pain drawing. <input type="checkbox"/> H/A, <input type="checkbox"/> Nk pn, <input type="checkbox"/> MB pn, <input type="checkbox"/> LBP, <input type="checkbox"/> SI pn, <input type="checkbox"/> <input type="checkbox"/> No recent flare-ups, <input type="checkbox"/> Flare-up noted:
	O	<input type="checkbox"/> Clinical Findings (ROM/Testing/Etc): <input type="checkbox"/> Myofascial adhesions/Fibrotic muscles/ Hypertonicity/TP:
	A	<input type="checkbox"/> Responding (Normally/Slowly/No improvement).
	P	<input type="checkbox"/> See ____ times a week/mo. <input type="checkbox"/> See PRN. <input type="checkbox"/> Cerv tract, <input type="checkbox"/> Flex-Dist, <input type="checkbox"/> Ice, <input type="checkbox"/> MH, <input type="checkbox"/> Elect Stim, <input type="checkbox"/> US, <input type="checkbox"/> Int traction, <input type="checkbox"/> <input type="checkbox"/> Adjust: <input type="checkbox"/> Myotherapy (gentle/deep) to hypertonic/fibrotic areas noted in objectives <input type="checkbox"/> Mobilization: <input type="checkbox"/> Nk, <input type="checkbox"/> MB, <input type="checkbox"/> LB, <input type="checkbox"/> SI, Other:
DATE	S	See pain drawing. <input type="checkbox"/> H/A, <input type="checkbox"/> Nk pn, <input type="checkbox"/> MB pn, <input type="checkbox"/> LBP, <input type="checkbox"/> SI pn, <input type="checkbox"/> <input type="checkbox"/> No recent flare-ups, <input type="checkbox"/> Flare-up noted:
	O	<input type="checkbox"/> Clinical Findings (ROM/Testing/Etc): <input type="checkbox"/> Myofascial adhesions/Fibrotic muscles/ Hypertonicity/TP:
	A	<input type="checkbox"/> Responding (Normally/Slowly/No improvement). <input type="checkbox"/> Yes, <input type="checkbox"/> No Complying with treatment
	P	<input type="checkbox"/> See ____ times a week/mo. <input type="checkbox"/> See PRN. <input type="checkbox"/> Yes, <input type="checkbox"/> No Referral/testing indicated. <input type="checkbox"/> Cerv tract, <input type="checkbox"/> Flex-Dist, <input type="checkbox"/> Ice, <input type="checkbox"/> MH, <input type="checkbox"/> Elect Stim, <input type="checkbox"/> US, <input type="checkbox"/> Int traction, <input type="checkbox"/> <input type="checkbox"/> Adjust: <input type="checkbox"/> Myotherapy (gentle/deep) to hypertonic/fibrotic areas noted in objectives <input type="checkbox"/> Mobilization: <input type="checkbox"/> Nk, <input type="checkbox"/> MB, <input type="checkbox"/> LB, <input type="checkbox"/> SI, Other:

Patient:	Doctor:
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Form 1520

RADIOLOGY REPORT

PATIENT NAME: _____ **DATE:** _____

X-rays taken with patient: Standing, Supine

Reason for taking radiographs: _____

CERVICAL SPINE

Check Views taken: AP-LAT. AP, LAT, APOM. Flexion-Extension. Obliques. Davis series. _____

THORACIC SPINE, CHEST AND RIB CAGE X-RAYS

Check Views taken: AP-LAT. Chest. Sternal. Rib. Other: _____

LUMBOSACRAL, PELVIS, AND HIP X-RAYS

Check Views taken: AP-LAT Lumbosacral. AP Sacral Base Tilt-up. Hip. Other: _____

SKULL, FACE, AND TMJ X-RAYS (Indicate specific region): _____

Check Views taken: AP-LAT. Other: _____

SHOULDER X-RAYS (Indicate specific region): _____

Check Views taken: AP-LAT. Weighted distraction. Other: _____

EXTREMITY X-RAYS (Indicate specific region): _____

Check Views taken: AP-LAT. Other _____

FINDINGS

- No pathology noted on films. No evidence of fracture, tumor, or other pathological conditions.
- The following genetic conditions were noted: _____
- Evidence of fracture(s) noted at: _____
- Schmorl's nodes noted at: _____
- Osteopenia noted: _____
- Degeneration noted at: _____
- IVF narrowing or facet imbrication noted at: _____
- Lordotic/Kyphotic observations: _____
- Lateral curvature or scoliosis noted on AP films at: _____
- Spondylosis or spondylolisthesis noted at level(s): _____ Grade: _____
- Spinal instability (describe) noted at levels: _____
- Break in George's lines noted at levels: _____
- Flexion-Extension views show abnormal motion at levels: _____
- Subluxation(s) noted at following: _____
- Incidental findings: _____

NOTES (Indicate pertinent issues relating to x-ray findings i.e. lab work or referral): _____

Signature of Physician: _____

Lawrence Nordhoff, DC
4133 Mohr Ave, Ste F, Pleasanton, CA 94566

PROVIDERS SEEN SINCE INJURY OR WHEN CONDITION BEGAN

Start with the first doctor that you went to after your injury or your condition began and list all providers (all types of doctors or therapists), up to your last provider seen, and check all that apply for each. Be certain to list these in sequence from first to last.

① Name Emergency Room, hospital/doctor/therapist/center: _____
 Address: _____ Date _____

Indicate what was done:

<input type="checkbox"/> Exam-consultation	<input type="checkbox"/> Rehabilitation	<input type="checkbox"/> Exercises
<input type="checkbox"/> Exam or consult only (no treatment)	<input type="checkbox"/> Ultrasound	<input type="checkbox"/> Acupuncture
<input type="checkbox"/> X-ray of neck or head	<input type="checkbox"/> Spinal adjustments	<input type="checkbox"/> Injection(s)
<input type="checkbox"/> X-ray of chest/ribs/middle back	<input type="checkbox"/> Muscle massage/myotherapy	<input type="checkbox"/> Wrist brace-splint
<input type="checkbox"/> X-ray of low back/ pelvis/hips	<input type="checkbox"/> Muscle stimulation	<input type="checkbox"/> Neck collar (brace)
<input type="checkbox"/> X-ray of shoulder/arms/legs	<input type="checkbox"/> Physical therapy	<input type="checkbox"/> Low back brace
<input type="checkbox"/> MRI/CT scan	<input type="checkbox"/> Anti-inflammatory medications	<input type="checkbox"/> Heat packs
<input type="checkbox"/> EMG/Nerve conduction study	<input type="checkbox"/> Pain medications	<input type="checkbox"/> Ice packs
<input type="checkbox"/> Other tests	<input type="checkbox"/> Muscle relaxants	<input type="checkbox"/> Other: _____

Indicate if treatment with this provider: Helped, Did not help, Made condition worse

② Name hospital/doctor/therapist/center seen: _____
 Address: _____ Date _____

Indicate what was done:

<input type="checkbox"/> Exam-consultation	<input type="checkbox"/> Rehabilitation	<input type="checkbox"/> Exercises
<input type="checkbox"/> Exam or consult only (no treatment)	<input type="checkbox"/> Ultrasound	<input type="checkbox"/> Acupuncture
<input type="checkbox"/> X-ray of neck or head	<input type="checkbox"/> Spinal adjustments	<input type="checkbox"/> Injection(s)
<input type="checkbox"/> X-ray of chest/ribs/middle back	<input type="checkbox"/> Muscle massage/myotherapy	<input type="checkbox"/> Wrist brace-splint
<input type="checkbox"/> X-ray of low back/pelvis/hips	<input type="checkbox"/> Muscle stimulation	<input type="checkbox"/> Neck collar (brace)
<input type="checkbox"/> X-ray of shoulder/arm/leg	<input type="checkbox"/> Physical therapy	<input type="checkbox"/> Low back brace
<input type="checkbox"/> MRI/CT scan	<input type="checkbox"/> Anti-inflammatory medications	<input type="checkbox"/> Heat packs
<input type="checkbox"/> EMG/Nerve conduction study	<input type="checkbox"/> Pain medications	<input type="checkbox"/> Ice packs
<input type="checkbox"/> Other tests: _____	<input type="checkbox"/> Muscle relaxants	<input type="checkbox"/> Other: _____

Indicate if treatment with this provider: Helped, Did not help, Made condition worse

DISABILITY FORM

EMPLOYEE NAME: _____ DATE: _____

This letter/form certifies that this patient is under my care for the following:

<input type="checkbox"/>	Neck or back pain	<input type="checkbox"/>	Automobile crash injury Date: _____
<input type="checkbox"/>	Knee, leg, or foot pain	<input type="checkbox"/>	Work related injury Date: _____
<input type="checkbox"/>	Arm pain	<input type="checkbox"/>	Sports/Home related injury and/or pain
<input type="checkbox"/>	Disc pain	<input type="checkbox"/>	Other: _____

HE/SHE IS PRESCRIBED:

<input type="checkbox"/>	Temporary Partial Disability	<input type="checkbox"/>	Temporary Total	<input type="checkbox"/>	Permanent Partial Disability	<input type="checkbox"/>	Permanent Total
--------------------------	-------------------------------------	--------------------------	------------------------	--------------------------	-------------------------------------	--------------------------	------------------------

(See Modifications)	Disability	(See Modifications)	Disability
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Modifications/Restrictions include the following:

<input type="checkbox"/>	Single lifting limited to _____ pounds	<input type="checkbox"/>	(No/Limited) fingering/handling/grasping
<input type="checkbox"/>	No repeated lifting over _____ pounds	<input type="checkbox"/>	(No/Limited) bending head-neck
<input type="checkbox"/>	Lifting restricted to _____ times per hour	<input type="checkbox"/>	Keyboarding limited to _____ (minutes/hours) per day
<input type="checkbox"/>	No lifting above (waist/shoulder/head) level	<input type="checkbox"/>	Sitting limited to _____ (minutes/hours) per day
<input type="checkbox"/>	No raising/lowering objects to other levels	<input type="checkbox"/>	(No/Limited) carrying activity
<input type="checkbox"/>	(No/Limited) bending/stooping waist	<input type="checkbox"/>	To take a _____ minute break every _____ hours
<input type="checkbox"/>	(No/Limited) crouching/squatting	<input type="checkbox"/>	Allow worker to move about when needed for pain
<input type="checkbox"/>	(No/Limited) twisting/pushing/pulling	<input type="checkbox"/>	Limited to _____ hours of work per day
<input type="checkbox"/>	(No/Limited) climbing/crawling	<input type="checkbox"/>	To wear a _____ (support/brace) at work
<input type="checkbox"/>	No (walking/standing)	<input type="checkbox"/>	
<input type="checkbox"/>	No prolonged walking/standing	<input type="checkbox"/>	

DISABILITY DATES	FROM:	TO:
-------------------------	--------------	------------

Discussion: _____

(Treating Physician's Signature)

"I declare under penalty of perjury that this report is true and correct to the best of my knowledge and I have not violated any labor codes."

(Doctor's Name, Address, and Telephone Number)

FORMULARIO DE INTRODUCCION DEL PACIENTE

Nombre del Paciente:	Fecha de Hoy:
Direccion:	Teléfono de la Casa:
Ciudad/Codigo Postal:	Teléfono del Trabajo:
Fecha de Nacimiento:	Edad:
Estatura:	Ocupacion:
Peso:	Empleo:
Licencia de Manejar Num.:	Seguro Social Num.:

LA VISITA ESTA RELACIONADA CON:

- | | |
|--|---|
| <input type="checkbox"/> Lesion Relacionada con el Trabajo | <input type="checkbox"/> Lesion de Accidente Automovilístico |
| <input type="checkbox"/> Lesion Relacionada con la Casa | <input type="checkbox"/> Lesion por un Deporte |
| <input type="checkbox"/> Síntomas Sin Lesiones | <input type="checkbox"/> Revision General Solamente |
| <input type="checkbox"/> Lesion por Caída o por Resbalar | <input type="checkbox"/> Exámen Físico requerido por la Escuela |

MUJERES SOLAMENTE

Sí, No ¿Hay posibilidad que esté embarazada ahora o sospeche estar embarazada?

INFORMACION DEL SEGURO MEDICO

Sí, No ¿Tiene usted seguro que cubra un tratamiento Quiropráctico?

Nombre y Direccion de la Compañía de Seguro: _____

¿Es usted el asegurado, o dependiente?

¿Cuál es el porcentaje que pagan? _____

¿Cuál es la cantidad del deducible? _____

¿Limitan la cantidad de pago por cada visita? _____

¿Limitan el numero de visitas? _____

Nuestra oficina mandará como cortesía la factura a su compañía aseguradora. Si usted tiene una poliza de seguro secundaria, es su responsabilidad mandarles la factura. Tendrá que pagar por todo lo que su compañía de seguros principal no pague. Su segunda compañía aseguradora le pagará después, basado en los beneficios de su poliza.

Si usted lo desea, nuestra oficina le proveerá los servicios para mandar las facturas. *Recuerde que usted es responsable por cualquier cargo incurrido en esta oficina. Es su responsabilidad pagar cualquier deducible, y cualquier otro balance que no sea pagado por su compañía de seguros.*

PARA DE MANTENER BAJOS LOS GASTOS EN NUESTRA OFICINA Y LAS CUOTAS RAZONABLES, SE REQUIERE EL PAGO AL FINAL DE CADA TRATAMIENTO PARA NUESTROS PACIENTES QUE PAGUEN EN EFECTIVO Y LA PARTE DE PAGO CORRESPONDIENTE PARA LOS PACIENTES REGULARES CON SEGURO MEDICO.

Firma de la parte responsable (Paciente o Padres): _____ Fecha _____

(Doctor's Name/Address/Telephone)

INFORMED CONSENT

I hereby consent to the performance of chiropractic adjustments and other chiropractic procedures, on myself, (or on the patient named below, for whom I am legally responsible) by **Lawrence Nordhoff, DC**, and/or other licensed doctors of chiropractic who now or in the future provide chiropractic adjustments and other types of treatment for me. This consent includes other doctors of chiropractic that are employed by, associated with, or serve as back-up for **Lawrence Nordhoff, DC**, whether or not their names are listed on this form.

I understand and consent to the following procedures: examination, x-rays (if needed), neck and spine/extremity adjustments, joint mobilization, electrical therapies, traction, and/or other procedures recommended for my condition(s).

I have had an opportunity to discuss with **Lawrence Nordhoff, DC**, the various types of treatment, including spinal adjustments, that have been proposed to me for my condition, and the purpose and objectives of these chiropractic procedures. I understand that the results from the chiropractic treatment are not guaranteed for my condition.

I have been informed about the risks and benefits of chiropractic adjustments and other chiropractic procedures, and understand that, there are some uncommon potential serious risks to chiropractic adjustments and procedures, including, but not limited to, sprains, fractures, disc injuries, dislocations, nerve injuries, and strokes specifically from neck adjustments. I understand and have had the opportunity to ask about the risks and benefits of the proposed treatment and of other alternative types of treatment for my condition.

I have had the opportunity to read this form and understand the above statements, accept the risks mentioned, and hereby consent and agree to chiropractic treatment over the entire course of treatment for my present condition and any future conditions for which I seek treatment.

PATIENT NAME (PRINT): _____ **DATE:** _____

X _____
SIGNATURE OF PATIENT OR RESPONSIBLE PARTY

NAME: _____ RELATIONSHIP: _____

Indicate your name and relationship (parent/guardian/personal representative) if signing for patient (minor):

OFFICE/WITNESS SIGNATURE: _____ DATE: _____

(Doctor/Clinic Name and Address)