ORIGINAL

APPLICATION FOR TREATMENT
AUTO PERSONAL INJURY

Date _____

Name _____ Age _____ Birthday _____
Address _____ City _____ State _____ Zip _____
Home Phone _____ Work Phone _____ Cell Phone _____
Social Security Number _____ Email _____

Whom should we thank for the referral? _____
Circle if you are: Married Single Widowed Divorced Separated
Employer _____ Occupation _____

Please describe the main reason(s) for which you came to this office: _____
_____

On a scale from 0-10, with 10 being unbearable pain, how severe is your pain? 0 1 2 3 4 5 6 7 8 9 10

When and how did symptoms first occur? _____
_____
_____

List any other doctors seen for these problems. _____
_____

List diagnosis and types of treatment(s) _____
_____

Does this interfere with your normal living and work? Yes No If yes, in what way? _____
_____

Have you lost any days of work? Yes No Dates _____

Have you had similar symptoms or injuries before? Yes No If yes, explain. _____
_____

List the names of any relatives that have or have had a similar problem. _____
_____

Who is responsible for your bill (please circle)? Self Spouse Employer Insurance Other _____

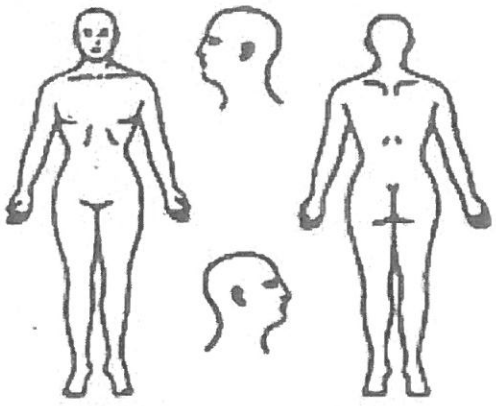
PAST HISTORY

Has a physician treated you for any health condition in the last year? Yes No If yes, explain. _____
_____
Have you or any relative received chiropractic treatment previously? Yes No If yes, explain. _____
_____
List the approximate dates of any operations, unusual diseases, serious illnesses or accidents you have had (include any broken bones). _____
List all drugs or medications that you have used recently. _____
_____

EMERGENCY CONTACT

Name of emergency contact(s) _____
Address _____
Home Phone _____ Work Phone _____ Cell Phone _____
Email Address _____

Please mark your areas of pain on the figures below.



List the condition that you are most interested in getting corrected. List in order of importance:

1. _____
2. _____
3. _____
4. _____

What functions are you unable to perform or induce pain upon performance? List in order of severity. (Exm: Sitting, walking, bending)

1. _____
2. _____
3. _____
4. _____

ACCIDENT INJURY INFORMATION

Date of Accident: _____ Time _____ am pm Location of accident_____
Were you the: ( ) Driver ( ) Passenger ( ) Pedestrian
Where was the impact? ( ) Behind ( ) Right Side ( ) Left Side ( ) Front ( ) Parked
Did your car strike the other(s) involved? ( ) Yes ( ) No ( ) Undetermined
Did the other car strike yours? ( ) Yes ( ) No ( ) Undetermined
As a result of the accident, were traffic citations issued to you? ( ) Yes ( ) No

Check symptoms you have noticed since the accident:

( ) Headache	( ) Sleeping problems	( ) Lights bother eyes	( ) Diarrhea
( ) Neck pain	( ) Head too heavy	( ) Loss of memory	( ) Feet cold
( ) Neck stiff	( ) Pins & needles in arms	( ) Ears ringing	( ) Hands cold
( ) Dizziness	( ) Pins & needles in legs	( ) Face flushed	( ) Stomach upset
( ) Back pain	( ) Numbness in fingers	( ) Buzzing in ears	( ) Constipation
( ) Nervousness	( ) Numbness in toes	( ) Loss of balance	( ) Cold sweats
( ) Tension	( ) Shortness of breath	( ) Fainting	( ) Fever
( ) Irritability	( ) Fatigue	( ) Loss of smell	( ) Chest pain
( ) Loss of taste	( ) Other _____		

Did you require post-accident hospitalization? ( ) Yes ( ) No
Have you lost any days of work? ( ) Yes ( ) No If yes, what dates? _____

Insurance Information: (Please fill out this section in its entirety)
At-Fault Insurance Company Name _____ Phone Number _____
Claims Mailing Address _____
Adjustor Name _____ Is there medical payment coverage on this claim? ( ) Yes ( ) No
Your Insurance Company Name _____ Phone Number _____
Do you have medical payments coverage on your auto policy? ( ) Yes ( ) No
Do you have an attorney that has advised you in this case: ( ) Yes ( ) No
If yes, attorneys name _____ Phone Number _____

PATIENT NAME _____ DATE _____

NECK PAIN DISABILITY INDEX (NPDI)

This questionnaire has been designed to give the doctor information as to how your neck pain has affected your activities daily living. Please mark in each section the **one box** that applies to you. Although you may consider that two of the statements in any one section relate to you, please mark the box that **most closely** describes your present - day situation.

SECTION 1 - PAIN INTENSITY

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

SECTION 2 - PERSONAL CARE

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

SECTION 3 – LIFTING

- ❑ I can lift heavy weights without causing extra pain.
- ❑ I can lift heavy weights, but it gives me extra pain.
- ❑ Pain prevents me from lifting heavy weights off the floor, but I can manage if items are conveniently positioned, ie. on a table.
- ❑ Pain prevents me from lifting heavy weights, but I can manage light weights if they are conveniently positioned.
- ❑ I can lift only very light weights.
- ❑ I cannot lift or carry anything at all.

SECTION 4 – READING

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

SECTION 5 – HEADACHES

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

SECTION 6 – CONCENTRATION

- ❑ I can concentrate fully with no difficulty.
- ❑ I can concentrate fully with slight difficulty.
- ❑ I can concentrate fully with moderate difficulty.
- ❑ I have a moderate degree of difficulty in concentrating fully.
- ❑ I have a great deal of difficulty in concentrating.
- ❑ I cannot concentrate at all.

SECTION 7 – WORK

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

SECTION 8 - DRIVING

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

SECTION 9 - SLEEPING

- ❑ I have no trouble sleeping.
- ❑ My sleep is slightly disturbed for less than 1 hour.
- ❑ My sleep is mildly disturbed for up to 1-2 hours.
- ❑ My sleep is moderately disturbed for up to 2-3 hours.
- ❑ My sleep is greatly disturbed for up to 3-5 hours.
- ❑ My sleep is completely disturbed for up to 5-7 hours.

SECTION 10 – RECREATION

- ❑ I have no neck pain during all recreational activities.
- ❑ I have some neck pain with few recreational activities.
- ❑ I have neck pain with most recreational activities.
- ❑ I have some neck pain with all recreational activities.
- ❑ I can hardly do recreational activities due to neck pain.
- ❑ I can't do any recreational activities due to neck pain.

SCORE _____ [50]

PATIENT NAME _____ DATE _____

OSWESTRY BACK PAIN INDEX QUESTIONNAIRE

This questionnaire is designed to help us better understand how your back pain affects your ability to manage everyday -life activities. Please mark in each section the **one box** that applies to you. Although you may consider that two of the statements in any one section relate to you, please mark the box that **most closely** describes your present -day situation.

SECTION 1 - PAIN INTENSITY

- ☐ My pain is mild to moderate. I do not need pain killers.
- ☐ The pain is bad, but I manage without taking pain killers.
- ☐ Pain killers give complete relief from pain.
- ☐ Pain killers give moderate relief from pain.
- ☐ ain killers give very little relief from pain.
- ☐ Pain killers have no effect on the pain.

SECTION 2 - PERSONAL CARE

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

SECTION 3 – LIFTING

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

SECTION 4 – WALKING

- ☐ I can walk as far as I wish.
- ☐ Pain prevents me from walking more than 1 mile.
- ☐ Pain prevents me from walking more than 1/2 mile.
- ☐ Pain prevents me from walking more than 1/4 mile.
- ☐ I can walk only if I use a cane or crutches.
- ☐ I am in bed or in a chair for most of every day.

SECTION 5 – SITTING

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

SECTION 6 – STANDING

- ☐ I can stand as long as I want without extra pain.
- ☐ I can stand as long as I want, but it gives me extra pain.
- ☐ Pain prevents me from standing for more than 1 hour.
- ☐ Pain prevents me from standing more than 1/2 hour.
- ☐ Pain prevents me from standing more than 10 minutes.
- ☐ Pain prevents me from standing at all.

SECTION 7 – SLEEPING

- ☐ Pain does not prevent me from sleeping well.
- ☐ I sleep well but only when taking medication.
- ☐ Even when I take medication, I sleep less than 6 hours.
- ☐ Even when I take medication, I sleep less than 4 hours.
- ☐ Even when I take medication, I sleep less than 2 hours.
- ☐ Pain prevents me from sleeping at all.

SECTION 8 - SOCIAL LIFE

- ☐ Social life is normal and causes me no extra pain.
- ☐ Social life is normal, but increases the degree of pain.
- ☐ Pain affects my social life by limiting only my more energetic interests, such as dancing, sports, etc.
- ☐ Pain has restricted my social life, and I do not go out as often.
- ☐ Pain has restricted my social life to my home.
- ☐ I have no social life because of pain.

SECTION 9 - SEXUAL ACTIVITY

- ☐ Sexual activity is normal and causes no extra pain.
- ☐ Sexual activity is normal, but causes some extra pain.
- ☐ Sexual activity is nearly normal, but is very painful.
- ☐ Sexual activity is severely restricted by pain.
- ☐ Sexual activity is nearly absent because of pain.
- ☐ Pain prevents any sexual activity at all.

SECTION 10 – TRAVELING

- ☐ I can travel anywhere without extra pain.
- ☐ I can travel anywhere, but it gives me extra pain.
- ☐ Pain is bad, but I manage journeys over 2 hours.
- ☐ Pain restricts me to journeys of less than 1 hour.
- ☐ Pain restricts me to necessary journeys under ½ hr.
- ☐ Pain prevents traveling except to the doctor/hospital.

SCORE _____ [50]

AUTO AUTHORIZATION FORM

CONSENT TO RECEIVE TREATMENT

FEES ARE PAYABLE AT THE TIME X-RAYS, EXAMINATIONS AND TREATMENTS ARE RECEIVED UNLESS OTHER ARRANGEMENTS ARE MADE IN ADVANCE. X-RAYS REMAIN THE PROPERTY OF THIS CLINIC. I HEREBY GIVE PERMISSION FOR TREATMENT.

Signature of Patient _____ Social Security Number _____ Date _____

RELEASE OF INFORMATION

Patient's or Authorized Person's Signature: I authorize the release of any medical or other information necessary to process my insurance claim. This is to serve as a long-term authorization card. I authorize payment of medical benefits to Boutwell Chiropractic Group for the services described on the insurance form. This authorization is to apply to all occasions of service until it is revoked in writing.

Signature_____ Date_____

AUTO INSURANCE DISCLAIMER

The following policies with regards to auto insurance claims are currently being enforced:

1. It is your responsibility to provide the office with the company responsible for payment of services to include the name, claims mailing address, phone number, name of adjustor, and claim number.
2. We can file towards medical payments coverage on yours or the at-fault parties auto insurance, if the policy has this. Medical payments (med pay) is an optional benefit on auto insurance policies. If you are filing on your medical payments coverage you will have to make a separate claim with your insurance company and provide us with this information.
3. We **do not** accept third party billing unless special arrangements are made. Third party billing is when there is no medical payments coverage on either policy. It is your responsibility to pay for services rendered at the time of service and wait for reimbursement upon settlement with the at-fault auto insurance company. If special arrangements are made and the doctor agrees to wait for settlement from the at-fault party it is your responsibility to immediately pay for services rendered at the office upon settlement. In the event that settlement is not reached within 6 months of your release of care we will require that you pay the balance in full and we will provide you with documentation to submit to the responsible payer for reimbursement.
4. All accounts must be kept current on a weekly basis. There will be a missed appointment fee of $25.00 charged for all missed or cancelled appointments without 24 hours prior notice.

I have been notified by Boutwell Chiropractic Group that if my auto insurance or the at-fault parties auto insurance does not cover the services rendered, I am to be personally and fully responsible for the payment to Boutwell Chiropractic Group.

Signature_____ Date_____

NOTICE OF DOCTOR LIEN

To: _____
_____
_____
_____

Patient: _____ Date of Accident: _____
Address: _____ Date of Birth: _____
_____

I do hereby authorize Boutwell Chiropractic Group to furnish you, my attorney, with a full report of treatment 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 such sums as may be due owning for chiropractic services rendered me both by reason of this accident and by reason of any other bills that are due this office 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 against any and all proceeds of my settlement, judgment or verdict which may be paid to connection therewith.

I fully understand that I am directly and fully responsible to said doctor for all medical bills submitted by Boutwell Chiropractic Group for service rendered me and that this agreement is made solely for said doctor to give additional protection and in consideration of 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 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 promptly deliver a copy of this lien to any substituted or added attorney(s).

Please acknowledge this letter by signing below and returning to Boutwell Chiropractic Group. I have been advised that if my attorney does not wish to cooperate in protecting said doctor's interest, the doctor will not await payment but may declare the entire balance due and payable. I further understand the cost of my chiropractic treatment and believe his charges to be a reasonable and necessary expense. I also direct my attorney to pay said doctor the full cost of treatment in my case.

_____ _____
Patient Signature Date

Pursuant to GA code 44-14-361 and 361.1 Boutwell Chiropractic Group hereby asserts and gives notice of a lien upon any sums recovered in damages for personal injury in any civil action and also upon all funds paid to the above-named patients in compensation for or settlements of injuries sustained, whether in litigation or otherwise.

Received by Boutwell Chiropractic Group by:

_____ _____

Boutwell Chiropractic Group

Boutwell Chiropractic Group
3665 Wheeler Road, Suite 2A
Augusta, GA 30909

Electronic Health Records Intake Form

In compliance with requirements for the government EHR incentive program

First Name:_____ **Last Name:**_____

Email address: _____@_____

Preferred method of communication for patient reminders (Circle one): Email / Phone / Mail

DOB: __/__/____ **Gender (Circle one):** Male / Female **Preferred Language:** _____

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

Smoking Start Date (Optional): _____

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 / I Decline to Answer

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

Are you currently taking any medications? (Please include regularly used over the counter medications)

Medication Name	Dosage and Frequency (i.e. 5mg once a day, etc.)

Do you have any medication allergies?

Medication Name	Reaction	Onset Date	Additional Comments

☐ **I choose to decline receipt of my clinical summary after every visit** *(These summaries are often blank because of the nature and frequency of chiropractic care.)*

Patient Signature: _____ Date: _____

For office use only

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