Patient Name:_____ **Boutwell Chiropractic Group P.C.** Date: _____

Patient Name: _____ Birthdate: _____ Sex: M/F
Address: _____ City: _____ State: _____ Zip: _____
Telephone: _____ SSN: _____
Email: _____ Referral: _____
Marital Status: _____ Spouse Name: _____
Occupation: _____ Employer: _____ Work #: _____
Address: _____ City: _____ State: _____ Zip: _____

Health Plan: _____ Subscriber: _____

ID#: _____ Group #: _____

Primary Care Physician: _____ PCP phone #: _____

Emergency Contact: _____
Relationship: _____ Phone #: _____

Health History:
Please check all the following that apply to you:

No	Yes	Condition
☐	☐	History of Recent Infection
☐	☐	Recent Fever
☐	☐	HIV/AIDS
☐	☐	Diabetes
☐	☐	Corticosteroid Use
☐	☐	Birth Control
☐	☐	High Blood Pressure
☐	☐	Stroke (date) _____
☐	☐	Dizziness/Fainting
☐	☐	Numbness in the Groin/Buttocks
☐	☐	Urinary Retention
☐	☐	Aortic Aneurysm
☐	☐	Cancer/Tumor
☐	☐	Osteoporosis
☐	☐	Recent Trauma
☐	☐	Autoimmune Disease

None Apply

No	Yes	Condition
☐	☐	Prostate Problems
☐	☐	Frequent Urination
☐	☐	Pregnancy, # of births _____
☐	☐	Abnormal Weight ☐ Gain ☐ Loss
☐	☐	Epilepsy/seizures
☐	☐	Visual Disturbances
☐	☐	History of Low/Mid Back Pain
☐	☐	History of Neck Pain
☐	☐	Arthritis
☐	☐	History of Alcohol Use
☐	☐	History of Tobacco Use

Surgeries:_____
_____
_____
_____

Family History: ☐ Cancer ☐ Diabetes ☐ High Blood Pressure ☐ Cardiovascular Problems/Stroke

Patient Name:_____ Boutwell Chiropractic Group P.C. Date: _____

List of all medications & dosages (Include OTC & Supplements)

Medication:	**Dosages:**	**Frequency:**

Recent Covid Diagnosis or Vaccination: _____

If patient is a minor, Parent/Guardian Permission to treat: Yes No
Name: _____ Signature:_____

For Office Use:

Describe your current problem and how it began:

_____
_____
_____
_____
_____

Is this? Work Related Auto Related N/A Date
Problem Began: _____

Current complaint (how you feel today):

_____

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

How often are your symptoms present? 0-25% 26-50% 51-75% 76-100%
Can you perform your daily activities? Yes No (Describe) _____

_____

HAVE YOU HAD SPINAL X-RAYS, MRI, XT SCAN? No Yes **Date(s) Taken:** _____
REGIONS TAKEN: _____

Patient Name:_____ Boutwell Chiropractic Group P.C. Date: _____

Auto Accident, Workers Comp, or Personal Injury (Please circle the correct answer)

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	☐ Ear 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? _____

Since the accident have your symptoms: IMPROVED STEYED THE SAME. WORSENED

What type of vehicle were you driving: S M L CAR/TRUCK/SUV

What type of vehicle was the other vehicle involved: S M L CAR/TRUCK/SUV

Were you wearing a seatbelt: Yes No

Which direction were you looking at time of impact: AHEAD LEFT RIGHT DOWN UNCERTAIN

Did any part of your body contact the interior of the car? Y/N If yes: Your _____ hit the _____.

Did you lose consciousness? Y/N

Patient vehicle movement: BACKING UP MOVING FORWARD STOPPED TURNING RIGHT/LEFT

Estimated speed of patient vehicle: <0 < 15 MPH 15-25 MPH 25-40 MPH 40-65 MPH >65 MPH

Damage to patient vehicle: HEAVY MODERATE SLIGHT NONE TOTALED UNKNOWN

Other vehicle movement: BACKING UP MOVING FORWARD STOPPED TURNING RIGHT/LEFT

Other vehicle estimated speed: <0 < 15 MPH 15-25 MPH 25-40 MPH 40-65 MPH >65 MPH

Damage to other vehicle: HEAVY MODERATE SLIGHT NONE TOTALED UNKNOWN

Was your vehicle towed: Y/N Police Report: Y/N Accident Report: Y/N EMS on Scene: Y/N

Have you received any tickets since the accident: Y/N If yes explain: _____

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 _____

OSWESTRY LOW BACK DISABILITY QUESTIONNAIRE

Instructions: this questionnaire has been designed to give us information as to how your back pain has affected your ability to manage everyday life. Please answer every section and mark in each section only the ONE box which applies to you at this time. We realize you may consider 2 of the statements in any section may relate to you, but please mark the box which most closely describes your current condition.

1. PAIN INTENSITY
- ☐ I can tolerate the pain I have without having to use 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
- ☐ Pain killers give very little relief from pain
- ☐ Pain killers have no effect on the pain and I do not use them

2. PERSONAL CARE (e.g. Washing, Dressing)
- ☐ 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 don't get dressed, I was with difficulty and stay in bed

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

4. WALKING
- ☐ Pain does not prevent me walking any distance
- ☐ Pain prevents me walking more than one mile
- ☐ Pain prevents me walking more than ½ mile
- ☐ Pain prevents me walking more than ¼ mile
- ☐ I can only walk using a stick or crutches
- ☐ I am in bed most of the time and have to crawl to the toilet

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

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 one hour
- ☐ Pain prevents me from standing for more than 30 minutes
- ☐ Pain prevents me from standing for more than 10 minutes
- ☐ Pain prevents me from standing at all

7. SLEEPING
- ☐ Pain does not prevent me from sleeping well
- ☐ I can sleep well only by using medication
- ☐ Even when I take medication, I have less than 6 hrs sleep
- ☐ Even when I take medication, I have less than 4 hrs sleep
- ☐ Even when I take medication, I have less than 2 hrs sleep
- ☐ Pain prevents me from sleeping at all

8. SOCIAL LIFE
- ☐ My social life is normal and gives me no extra pain
- ☐ My social life is normal but increases the degree of pain
- ☐ Pain has no significant effect on my social life apart from limiting my more energetic interests, i.e. dancing, 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

9. TRAVELLING
- ☐ 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 short necessary journeys under 30 minutes
- ☐ Pain prevents me from traveling except to the doctor or hospital

10. EMPLOYMENT/ HOMEMAKING
- ☐ My normal homemaking/ job activities do not cause pain.
- ☐ My normal homemaking/ job activities increase my pain, but I can still perform all that is required of me.
- ☐ I can perform most of my homemaking/ job duties, but pain prevents me from performing more physically stressful activities (e.g. lifting, vacuuming)
- ☐ Pain prevents me from doing anything but light duties.
- ☐ Pain prevents me from doing even light duties.
- ☐ Pain prevents me from performing any job or homemaking chores.

Neck Disability Index

This questionnaire is designed to help us better understand how your neck 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

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

Section 2 - Personal Care

- ☐ 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 – Work

- ☐ I can do as much work 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 can't do my usual work.
- ☐ I can hardly do any work at all.
- ☐ I can't do any work at all.

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 moderate headaches that come frequently.
- ☐ I have severe headaches that come frequently.
- ☐ I have headaches almost all the time.

Section 6 – Concentration

- ☐ I can concentrate fully without difficulty.
- ☐ I can concentrate fully with slight difficulty.
- ☐ I have a fair degree of difficulty concentrating.
- ☐ I have a lot of difficulty concentrating.
- ☐ I have a great deal of difficulty concentrating.
- ☐ I can't concentrate at all.

Section 7 – 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 8 – Driving

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

Section 9 – 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't read as much as I want because of severe neck pain.
- ☐ I can't read at all.

Section 10 – Recreation

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

Patient Name _____ Date _____

Score _____ [50] Benchmark -5 = _____

Boutwell Chiropractic Group, P.C. 3665 Wheeler Road Augusta, GA 30909
Office: (706) 860-8717 Fax: (706) 860-1341

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES (NPP)

I, _____, have received a copy of Boutwell Chiropractic Groups' Notice of Privacy Practices (NPP) either in paper form, laminated copy, downloaded and printed from another source, or viewed electronically on a personal computer, smart phone, etc.

_____
Print Patient's Name

_____
Signature of Patient or Parent/Guardian

_____
Date

_____
Name and Birthdate of individual we have permission to release information to

Or:

_____ *I refuse to sign this acknowledgement.*
(Initial)

For office use only: _____

We attempted to obtain written acknowledgement of receipt of our Notice of Privacy Practices (NPP), but acknowledgement could not be obtained because:

( ) Individual refused to sign

( ) Communication barriers prohibited obtaining the acknowledgement

( ) An emergency situation prevented us from obtaining acknowledgement

( ) Other (Please Specify) _____

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, P.C.

AUTO/PERSONAL INJURY/ WORK COMP AUTHORIZATION FORM

CONSENT TO TREATMENT

Initial:____ I hereby request and consent to chiropractic adjustments and other chiropractic procedures, including various modes of physical therapy and diagnostic x-rays on me by licensed Doctors of Chiropractic or those working at the clinic or office who now or in the future provide treatment while employed by, working or associated with, or serving as a backup at Boutwell Chiropractic Group, PC. I intend this consent to cover the entire course of treatment for my present condition and for any future condition(s) for which I seek treatment.

RELEASE OF INFORMATION

Initial:____ 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. If deemed necessary, x-rays may be sent out to be read by a DACBR radiologist and a report will be provided to the doctor.

AUTO/PERSONAL INJURY/ WORK COMP DISCLAIMER

The following policies 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 of the insurance company, 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 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 for all missed appointments.

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

PATIENT SIGNATURE: _____ DATE: _____