SPORT & SPINAL
REHAB
Chiropractic | Physical Therapy | Massage

Please Print

Last Name _____ First Name _____ Birth Date _____

Address _____ City _____ State _____ Zip_____

Home Phone _____ Cell Phone _____ Email _____

What is your preferred method of contact? □ Home □ Cell □ E-mail

How do you prefer to receive appointment reminders? □ Phone □ Text □ E-mail

Employer _____ Occupation _____

Primary Physician _____ May we contact them? _____

Emergency Contact _____ Phone _____ Relation_____

Who may we thank for referring you to us? _____

Do you have any medication allergies?

□ No known medication allergies

□ Yes. What?

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

Are you currently taking any medications?

□ Not currently prescribed any medications

□ Yes. What?

1. _____ _____ mg / mcg / g / other ___
2. _____ _____ mg / mcg / g / other ___
3. _____ _____ mg / mcg / g / other ___
4. _____ _____ mg / mcg / g / other ___
5. _____ _____ mg / mcg / g / other ___
6. _____ _____ mg / mcg / g / other ___

Patient Name: _____ Signature: _____ Date: _____

Parent or Guardian: _____ Signature: _____ Date: _____

SPORT & SPINAL
REHAB
Chiropractic | Physical Therapy | Massage

Informed Consent to Care

You are the decision maker for your health care. Part of our role is to provide you with information to assist you in making informed choices. This process is often referred to as "informed consent" and involves your understanding and agreement regarding the care we recommend, the benefits and risks associated with the care, alternatives, and the potential effect on your health if you choose not to receive the care. We may conduct some diagnostic or examination procedures if indicated. Any examinations or tests conducted will be carefully performed but may be uncomfortable.

Chiropractic care centrally involves what is known as a chiropractic adjustment. There may be additional supportive procedures or recommendations as well. When providing an adjustment, we use our hands or an instrument to reposition anatomical structures, such as vertebrae. Potential benefits of an adjustment include restoring normal joint motion, reducing swelling and inflammation in a joint, reducing pain in the joint, and improving neurological functioning and overall well-being.

It is important that you understand, as with all health care approaches, results are not guaranteed, and there is no promise to cure. As with all types of health care interventions, there are some risks to care, including, but not limited to: muscle spasms, aggravating and/or temporary increase in symptoms, lack of improvement of symptoms, burns and/or scarring from electrical stimulation and from hot or cold therapies, including but not limited to hot packs and ice, fractures (broken bones), disc injuries, strokes, dislocations, strains, and sprains.

With respect to strokes, there is a rare but serious condition known as an "arterial dissection" that typically is caused by a tear in the inner layer of the artery that may cause the development of a thrombus (clot) with the potential to lead to a stroke. The best available scientific evidence supports the understanding that chiropractic adjustment does not cause a dissection in a normal, healthy artery. Disease processes, genetic disorders, medications, and vessel abnormalities may cause an artery to be more susceptible to dissection. Strokes caused by arterial dissections have been associated with over 72 everyday activities such as sneezing, driving, and playing tennis.

Arterial dissections occur in 3-4 of every 100,000 people whether they are receiving health care or not. Patients who experience this condition often, but not always, present to their medical doctor or chiropractor with neck pain and headache. Unfortunately, a percentage of these patients will experience a stroke.

The reported association between chiropractic visits and stroke is exceedingly rare and is estimated to be related in one in one million to one in two million cervical adjustments. For comparison, the incidence of hospital admission attributed to aspirin use from major GI events of the entire (upper and lower) GI tract was 1219 events/ per one million persons/year and risk of death has been estimated as 104 per one million users.

It is also important that you understand there are treatment options available for your condition other than chiropractic procedures. Likely, you have tried many of these approaches already. These options may include, but are not limited to self-administered care, over-the-counter pain relievers, physical measures and rest, medical care with prescription drugs, physical therapy, bracing, injections, and surgery. Lastly, you have the right to a second opinion and to secure other opinions about your circumstances and health care as you see fit.

I have read, or have had read to me, the above consent. I appreciate that it is not possible to consider every possible complication to care. I have also had an opportunity to ask questions about its content, and by signing below, I agree with the current or future recommendation to receive chiropractic care as is deemed appropriate for my circumstance. I intend this consent to cover the entire course of care from all providers, including doctors who are serving as coverage/back-up doctors in place of Dr. Brandon T. Nevel in this office for my present condition and for any future condition(s) for which I seek chiropractic care.

Patient Name: _____ Signature: _____ Date: _____

Parent or Guardian: _____ Signature: _____ Date: _____

Witness Name: _____ Signature: _____ Date: _____

SPORT & SPINAL
REHAB
Chiropractic | Physical Therapy | Massage

OFFICE POLICIES AND PROCEDURES / CANCELATION AGREEMENT

Appointments / Urgent Need or Sudden Illness: Patients are normally seen by appointment only. Same day appointments and walk-ins are welcome but are usually only available for urgent or sudden cases. We have a limited number of same day or "work-in" appointments available every day. Please call ahead, as these spots fill up quickly.

Cancelations: Your appointment time is held exclusively for you. If you need to cancel or reschedule your appointment, **PLEASE notify our office at least 24 hours in advance.** This allows us to provide that time slot to another patient**. Any missed appointments and cancelations with fewer than 24 hours' notice will be subject to a $50 fee.**

Treatment of Minors: Patients under the age of 18 must be accompanied by a responsible adult or have written permission for treatment from a parent or guardian.

No Insurance: Payment will be due at the time of service. If you are unable to pay your balance in full, you will need to make prior arrangements with our Office Manager.

Insurance: Although we are contracted with several insurance companies, it is your responsibility to make sure that our physician is on your plan. It is also your responsibility to know your insurance benefits.
At the time of service, you will be responsible for all fees that are not covered by your insurance, including co-pays, co-insurance, deductibles and non-covered services or items received. The co-pay cannot be waived by our practice, as it is a requirement placed on you by your insurance carrier. We strive to be as accurate as possible in calculating your responsibility but, with so many variations with policies and fee schedules, we are not always exact. You may receive a statement from our office for any balance due. For your convenience, we accept cash, checks, credit cards (Visa, MasterCard, Amex, and Discover). Payments are also accepted by phone.

Billing: If you receive a bill from us, it is because we believe that the balance is your responsibility. If you think it could be an error, please contact your insurance company first. If you have any questions about your bill or cannot pay the full balance, please call our office with any questions or to make payment arrangements. Accounts that are not paid within 60 days begin our in-house collection process.

***Acknowledgement:* I acknowledge that I have read and received a copy of the Sport & Spinal Rehab Office Policies and Procedures / Cancellation Agreement.**

Patient Name: _____ Signature: _____ Date: _____

Parent or Guardian: _____ Signature: _____ Date: _____

SPORT & SPINAL
REHAB
Chiropractic | Physical Therapy | Massage

ASSIGNMENT OF INSURANCE BENEFITS, RELEASE, & DEMAND

I, the undersigned patient/insured knowingly, voluntarily, and intentionally assign the rights and benefits of my **Medical payments policy of insurance** to the above health care provider. I understand it is the intention of the provider to accept this assignment of benefits in lieu of demanding payment at the time services are rendered. I understand this document will allow the provider to file suit against an insurer for payment of the insurance benefits or an explanation of benefits and to seek §627.428 damages from the insurer. If the provider's bills are applied to a deductible, I agree this will serve as a benefit to me. This assignment of benefits includes the cost of transportation, medications, supplies, overdue interest and any potential claim for common law or statutory bad faith/unfair claims handling. If the insurer disputes the validity of this assignment of benefits, then the insurer is instructed to notify the provider in writing within five days of receipt of this document. Failure to inform the provider shall result in a waiver by the insurer to contest the validity of this document. The undersigned directs the insurer to pay the health care provider the maximum amount directly without any reductions & without including the patient's name on the check. To the extent, the PIP insurer contends there is a material misrepresentation on the application for insurance resulting in the policy of insurance is declared voided, rescinded, or canceled, I, as the named insured under said policy of insurance, hereby assign the right to receive the premiums paid for my PIP insurance to this provider and to file suit for recovery of the premiums. The insurer is directed to issue such a refund check payable to this provider only. Should the medical bills not exceed the premium refunded, then the provider is directed to mail the patient/named insured a check which represents the difference between the medical bills and the premiums paid. The patient agrees before the services are provided that the provider's charges for services are reasonable, usual and customary.

Disputes: The insurer is directed by the provider and the undersigned to not issue any checks or drafts in partial settlement of a claim that contain or are accompanied by language releasing the insurer or its insured/patient from liability unless there has been a prior written settlement agreed to by the health provider (specifically the office manager) and the insurer as to the amount payable under the insurance policy. The insured and the provider hereby contest and objects to any reductions or partial payments. Any partial or reduced payment, regardless of the accompanying language, issued by the insurer and deposited by the provider shall be done so under protest, at the risk of the insurer, and the deposit shall not be deemed a waiver, accord, satisfaction, discharge, settlement, or agreement by the provider to accept a reduced amount as payment in full. The insurer is hereby placed on notice that this provider reserves the right to seek the full amount of the bills submitted. If the PIP insurer states it can pay claims at 200% of Medicare, then the insurer is instructed & directed to provide this provider with a copy of the policy of insurance within 10 days**. Any effort by the insurer to pay a disputed debt as full satisfaction must be mailed to the address above, after speaking with the office manager, and mailed to the specific attention of the Office Manager. See Fla. Stat. §673.3111.**

EUOs and IMEs: If the insurer schedules a defense examination or examination under oath (hereinafter "EUO") the insurer is hereby INSTRUCTED to send a copy of said notification to this provider. The provider or the provider's attorney is expressly authorized to appear at any EUO or IME set by the insurer. The health care provider is not the agent of the insurer or the patient for any purpose. This assignment applies to both past and future medical expenses and is valid even if undated. A photocopy of this assignment is to be considered as valid as the original. I agree to pay any applicable deductible, co-payments, for services rendered after the policy of insurance exhausts and for any other services unrelated to the automobile accident. The health care provider is

given the power of attorney to: endorse my name on any check for services rendered by the above provider and to request a copy of any statements or examinations under oath given by patient.

Express Consent and Release of information: I authorize this provider to: furnish an insurer, an insurer's intermediary, the patient's other medical providers, and the patient's attorney and hired experts via mail, fax, or email, with any and all information that may be contained in the medical records; to obtain insurance coverage information (declaration sheet & policy of insurance) in writing and telephonically from the insurer; request from any insurer all explanation of benefits (EOBs) for all providers and non-redacted PIP payout sheets; obtain any written and verbal statements the patient or anyone else provided to the insurer; obtain copies of the entire claim file, the property damage file, and all medical records, including but not limited to, documents, reports, scans, notes, bills, opinions, X-rays, IMEs, and MRIs, from any other medical provider or any insurer. The provider is permitted to produce my medical records to its attorney and experts in connection with any pending lawsuits. The patient's other medical providers are authorized to sign affidavits and testify justifying the patient's care and treatment. The insurer is directed to keep the patient's medical records from this provider private and confidential. The insurer is not authorized to provide the patient's medical records to anyone without the patient's and the provider's prior express written permission.

Demand: Demand is hereby made for the insurer to pay all bills within 30 days without reductions and to mail the latest non-redacted PIP payout sheet and the insurance coverage declaration sheet to the above provider within 15 days. The insurer is directed to pay the bills in the order they are received. However, if a bill from this provider and a claim from anyone else is received by the insurer on the same day the insurer is directed to not apply this provider's bill to the deductible. If a bill from this provider and claim from anyone else is received by the insurer on the same day, then the insurer is directed to pay this provider first before the policy is exhausted. In the event the provider's medical bills are disputed or reduced by the insurer for any reason, or amount, the insurer is to: set aside the entire amount disputed or reduced; escrow the full amount at issue; and not pay the disputed amount to anyone or any entity, including myself, until the dispute is resolved by a Court. Do not exhaust the policy. The insurer is instructed to inform, in writing, the provider of any dispute and when the policy is exhausted.

Certification: I certify that: I have read and agree to the above; I have not been solicited or promised anything in exchange for receiving health care. I have not received any promises or guarantees from anyone as to the results that may be obtained by any treatment or service; and I agree the provider's prices for medical services, treatment and supplies are reasonable, usual and customary.

Caution: Please read before signing. **If you do not completely understand this document, please ask us to explain it to you.**

Patient Name: _____ Signature: _____ Date: _____

Parent or Guardian: _____ Signature: _____ Date: _____

SPORT & SPINAL
REHAB
Chiropractic | Physical Therapy | Massage

Release of Patient Records Authorization

I hereby authorize you to release confidential health information about me by releasing a copy of my medical records, or a summary or narrative of my protected health information to Sport & Spinal Rehab/Dr. Brandon Nevel, D.C. This authorization is a given pursuant to Florida Statue 456.057 and HIPAA Regulations. I understand that Florida Statue 456.057 (10) makes clear that any third party to whom records are disclosed is prohibited from further disclosing any information in this medical record without the expressed written consent of the patient or the patient's legal representative.

Patient Name: _____ Date of Birth: _____

Please release my protected health information to the following physician/person/facility/entity and/or those directly associated in my medical care:

Name: Sport & Spinal Rehab / Brandon T. Nevel, D.C.
Address: 103 S US HWY 1 Suite B-4, Jupiter FL, 33477
Phone: 561.406.6905
Fax: 561.406.6913

The information you may release subject to this signed release form is as follows:

□ Complete Records	□ History & Physical	□ Progress Notes
□ Care Plan	□ Lab Reports	□ Radiology Reports
□ Pathology Reports	□ Treatment Records	□ Operative Reports
□ Hospital Reports	□ Medication Records	□ Other: _____

Patient Name: _____ Signature: _____ Date: _____

Parent or Guardian: _____ Signature: _____ Date: _____

SPORT & SPINAL
REHAB
Chiropractic | Physical Therapy | Massage

INITIAL EVALUATION ACCIDENT RELATED

LAST NAME: _____ FIRST NAME: _____ DATE: _____

Date of Accident: _____

What was your position in the vehicle?

☐ Driver ☐ Front Passenger ☐ Left Rear Passenger
☐ Middle Front Passenger ☐ Middle Rear Passenger ☐ Right Rear Passenger

Time of the accident: _____ AM/PM
Location of accident: _____
Patient's vehicle speed: _____ mph
Other vehicle's speed: _____ mph

What was the damage to the vehicle? ☐ Mild ☐ Moderate ☐ Extensive ☐ Totaled
How was the visibility on the road? ☐ Poor ☐ Fair ☐ Good
And the weather was: ☐ Snowing ☐ Raining ☐ Windy ☐ Foggy ☐ Clear
How did the accident happen? ☐ I hit another vehicle ☐ Another vehicle hit me ☐ I hit an object

What was the point of impact on our vehicle?

☐ Left ☐ Front End ☐ Rear End ☐ Right
☐ Left Front ☐ Left Rear ☐ Right Front ☐ Right Rear

Were you wearing a seatbelt? ☐ Yes ☐ No
If yes, does the seatbelt have a shoulder strap? ☐ Yes ☐ No

Does your vehicle have an airbag? ☐ Yes ☐ No
Was the airbag deployed? ☐ Yes ☐ No

Did you strike anything inside the vehicle? ☐ Yes ☐ No
What inside your vehicle did you strike?

☐ Gear shift lever/knob ☐ Seatback
☐ Airbag ☐ Headrest ☐ Side door
☐ Armrest ☐ Rearview mirror ☐ Side window
☐ Center Console ☐ Roof ☐ Wheel
☐ Dashboard ☐ Rear window ☐ Windshield
☐ Other: _____

Did you see the accident coming? ☐ Yes ☐ No
Does your vehicle have headrests? ☐ Yes ☐ No
What is the position of the headrest?
☐ Even with top of head
☐ Even with bottom of head
☐ Middle of neck

Were you braced for impact? ☐ Yes ☐ No
Immediately after the accident, did you feel dazed? ☐ Yes ☐ No
Did you lose consciousness? ☐ Yes ☐ No
Which way was you head turned during the accident?

☐ Facing forward ☐ Turned to the right ☐ Turned to the left

Was your head injured? ☐ Yes ☐ No

Was anything else injured? _____

Immediately after the accident, did you experience: ☐ Headache ☐ Neck Pain ☐ Low back pain

Did you see another doctor before coming here? ☐ Yes ☐ No

Did you go to a hospital after the accident? ☐ Yes ☐ No

If yes, where? _____

How did you get to the hospital? ☐ Ambulance ☐ Drove Self ☐ Somebody else ☐ Police

Were any of the following tests performed at the hospital?

☐ X-rays ☐ MRI ☐ CT Scan ☐ Labs

Have you seen any prior doctor for this accident? ☐ Yes ☐ No

If yes:

1. Who? _____

Did they perform any tests? ☐ Yes ☐ No

If yes, what? _____

_____

2. Who? _____

Did they perform any tests? ☐ Yes ☐ No

If yes, what? _____

_____

3. Who? _____

Did they perform any tests? ☐ Yes ☐ No

If yes, what? _____

_____

4. Who? _____

Did they perform any tests? ☐ Yes ☐ No

If yes, what? _____

_____

Have you been in any previous auto accidents? ☐ Yes ☐ No

If yes:

1. Date: _____

Details of Accident: _____

_____

2. Date: _____

Details of Accident: _____

_____

3. Date: _____

Details of Accident: _____

_____

Date: _____

Details of Accident: _____

_____

Do you feel your condition is: ☐ Improving ☐ Staying the same ☐ Getting worse

Have you lost time from work? ☐ Yes ☐ No

Can you perform physical work activities? ☐ Yes ☐ No

If no, because of: ☐ Pain ☐ Weakness ☐ Stress ☐ Other: _____

ACTIVITIES OF DAILY LIVING Please select all activities in which you are currently experiencing problems:

☐ Seeing	☐ Tasting	☐ Smelling	☐ Eating
☐ Hearing	☐ Bathing	☐ Grooming	☐ Dressing
☐ Reading	☐ Typing	☐ Writing	☐ Grasping
☐ Holding	☐ Pinching	☐ Standing	☐ Leaning
☐ Walking	☐ Stooping	☐ Squatting	☐ Climbing
☐ Kneeling	☐ Bending	☐ Twisting	☐ Carrying
☐ Lifting	☐ Pushing	☐ Pulling	☐ Reaching
☐ Sitting	☐ Driving	☐ Riding car	☐ Air travel
☐ Sports	☐ Exercising	☐ Loss of sexual drive	☐ Reclining
☐ Restful sleeping	☐ Insomnia	☐ Using the toilet	☐ Loss of concentration
☐ Nervous	☐ Irritable	☐ Change in personality	☐ Tactile feeling

Can you go to sleep without problems? ☐ Yes ☐ No

Do you awaken because of pain? ☐ Yes ☐ No

If yes, where? (body part) _____

Did you have sleep problems before? ☐ Yes ☐ No

PAST MEDICAL HISTORY **Please check all that apply:**

☐ None	☐ Abdominal Pain	☐ Angina	☐ Anorexia
☐ Anxiety	☐ Aortic aneurysm	☐ Arthritis	☐ Asthma
☐ Bladder Infection	☐ Blood Disorder	☐ Breast Lumps	☐ Breast Soreness
☐ Bronchitis	☐ Cancer/Tumors	☐ Cardiovascular	☐ Chest Pain
☐ Chronic Cough	☐ Chronic Sinusitis	☐ Colitis	☐ Constipation
☐ Convulsions	☐ COPD	☐ Depression	☐ Dermatitis/Eczema/Rash
☐ Diabetes	☐ Difficulty Swallowing	☐ Dizziness	☐ Emphysema
☐ Endometriosis	☐ Epilepsy	☐ Excessive Thirst	☐ Fainting
☐ Frequent Urination	☐ General Fatigue	☐ Gout	☐ Hand Pain
☐ Headache	☐ Heart Attack	☐ Heart Disease	☐ Heartburn
☐ Hepatitis	☐ High Blood Pressure	☐ High Cholesterol	☐ High PSA
☐ High Triglycerides	☐ HIV/AIDS/STD	☐ Irritable Colon	☐ Jaw Pain
☐ Kidney Disorders	☐ Kidney Stones	☐ Liver/Gallbladder	☐ Loss of appetite
☐ Loss of bladder control	☐ Low Back Pain	☐ Lung Disease	☐ Mental Disease
☐ Mid Back Pain	☐ Muscular incoordination	☐ Neck Pain	☐ Osteoarthritis
☐ Pain ankle/foot	☐ Pain lower leg/knee	☐ Pain upper arm/elbow	☐ Pain upper leg/hip
☐ Painful urination	☐ PMS	☐ Pneumonia	☐ Profuse/Irregular menstrual flow
☐ Prostate problems	☐ Rapid heartbeat	☐ Renal disease	☐ Rheumatoid arthritis
☐ Scoliosis	☐ Shoulder Pain	☐ Stroke	☐ Swelling/Stiffness Joints
☐ Thyroid Disease	☐ Tinnitus/Ear noises	☐ Tuberculosis	☐ Ulcer
☐ Visual Disturbances	☐ Weight gain/loss	☐ Wrist Pain	

FAMILY HISTORY **Please check all that apply:**

☐ None	☐ Abdominal Pain	☐ Angina	☐ Anorexia
☐ Anxiety	☐ Aortic aneurysm	☐ Arthritis	☐ Asthma
☐ Bladder Infection	☐ Blood Disorder	☐ Breast Lumps	☐ Breast Soreness
☐ Bronchitis	☐ Cancer/Tumors	☐ Cardiovascular	☐ Chest Pain
☐ Chronic Cough	☐ Chronic Sinusitis	☐ Colitis	☐ Constipation
☐ Convulsions	☐ COPD	☐ Depression	☐ Dermatitis/Eczema/Rash
☐ Diabetes	☐ Difficulty Swallowing	☐ Dizziness	☐ Emphysema
☐ Endometriosis	☐ Epilepsy	☐ Excessive Thirst	☐ Fainting
☐ Frequent Urination	☐ General Fatigue	☐ Gout	☐ Hand Pain
☐ Headache	☐ Heart Attack	☐ Heart Disease	☐ Heartburn
☐ Hepatitis	☐ High Blood Pressure	☐ High Cholesterol	☐ High PSA
☐ High Triglycerides	☐ HIV/AIDS/STD	☐ Irritable Colon	☐ Jaw Pain
☐ Kidney Disorders	☐ Kidney Stones	☐ Liver/Gallbladder	☐ Loss of appetite
☐ Loss of bladder control	☐ Low Back Pain	☐ Lung Disease	☐ Mental Disease
☐ Mid Back Pain	☐ Muscular incoordination	☐ Neck Pain	☐ Osteoarthritis
☐ Pain ankle/foot	☐ Pain lower leg/knee	☐ Pain upper arm/elbow	☐ Pain upper leg/hip
☐ Painful urination	☐ PMS	☐ Pneumonia	☐ Profuse/Irregular menstrual flow
☐ Prostate problems	☐ Rapid heartbeat	☐ Renal disease	☐ Rheumatoid arthritis
☐ Scoliosis	☐ Shoulder Pain	☐ Stroke	☐ Swelling/Stiffness Joints
☐ Thyroid Disease	☐ Tinnitus/Ear noises	☐ Tuberculosis	☐ Ulcer
☐ Visual Disturbances	☐ Weight gain/loss	☐ Wrist Pain	

SURGICAL HISTORY **Please check all that apply:**

☐ None	☐ Other	☐ Abdominal Exploration	☐ Abdominoplasty
☐ Abortion	☐ ACL Reconstruction	☐ Adenoid Removal	☐ Angioplasty
☐ Appendectomy	☐ Bone Fracture Repair	☐ Breast Lump Removal	☐ Bunion Removal
☐ Carotid Artery Surgery	☐ Cataract Surgery	☐ Cervical Spine Surgery	☐ Cholecystectomy
☐ Cosmetic Breast Surgery	☐ C-Section	☐ Facelift	☐ Gallbladder Removal
☐ Gastric Bypass Surgery	☐ Heart Bypass Surgery	☐ Heart Surgery	☐ Hemorrhoid Surgery
☐ Hernia Repair	☐ Hip Joint Replacement	☐ Hysterectomy	☐ Kidney Transplant
☐ Knee Arthroscopy	☐ Knee Joint Replacement	☐ Knee Surgery	☐ LASIK Eye Surgery
☐ Liposuction	☐ Lumbar Spine Surgery	☐ Mastectomy	☐ Prostate Removal
☐ Rotator Cuff Surgery	☐ TMJ Surgery	☐ Tonsillectomy	☐ Vasectomy

Surgical History was reviewed:

☐ Not contributory

MEDICATIONS **Please check all that apply:**

☐ None	☐ Other	☐ Analgesics	☐ Antacids	☐ Antibiotics
☐ Antihistamines	☐ Anti-Inflammatory	☐ Arthritis	☐ Aspirin	☐ Birth Control
☐ Blood Pressure	☐ Bone Density	☐ Cancer	☐ Cholesterol	☐ Daily Vitamins
☐ Diabetes	☐ Digestion	☐ Heart	☐ Muscle Relaxers	☐ OTC
☐ Pain	☐ Steroids	☐ Thyroid		

ALLERGIES **Please check all that apply:**

☐ None	☐ Other	☐ Chemical	☐ Environmental	☐ Food
☐ Medication	☐ Seasonal			

SOCIAL HISTORY **Please check all that apply:**

☐ Married ☐ Single		☐ Widowed	☐ Divorced	☐ Separated
Do you have any children?		☐ Yes ☐ No	If yes, how many? _____	
Are you pregnant? (FEMALES)		☐ Yes ☐ No	If yes, how far along? _____ Due Date: _____	
Do you use:		☐ Tobacco	☐ Alcohol	☐ Coffee

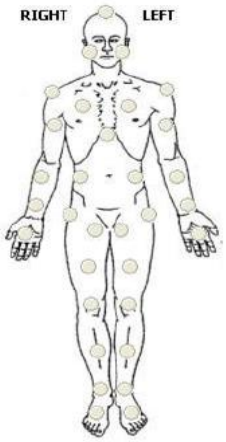
Smoking Status:

☐ Current every day smoker	☐ Current some day smoker	☐ Former smoker
☐ Never smoker	☐ Heavy tobacco smoker	☐ Light tobacco smoker

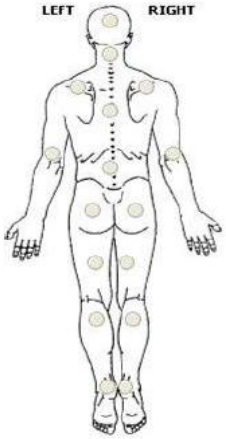
Complaint Form
(Initial Exam, Follow-Up/Final Exam, Daily Note)

Place an X the part(s) of the body where you are experiencing pain or discomfort and grade your pain level on a scale of 0-10 with 10 being the worst.

Please grade pain 0-10 (10 is the highest) ⓿ ❶ ❷ ❸ ❹ ❺ ❻ ❼ ❽ ❾ ❿



Other: _____



This complaint came on:	☐ Gradually	☐ Immediately		
It is getting:	☐ Better	☐ Same	☐ Worse	
The intensity is:	☐ Minimal	☐ Slight	☐ Moderate	☐ Severe
The frequency is:	☐ Occasional	☐ Frequent	☐ Constant	
The pain is:	☐ Dull	☐ Sharp	☐ Aching	☐ Shooting
	☐ Spasm	☐ Throbbing	☐ Burning	☐ Numb
	☐ Tingling	☐ Other: _____		
The pain is on the:	☐ Left side	☐ Right Side	☐ Bilateral	

Please mark the actions affecting your complaint(s): ***Other: _____***

Morning	☐ Brings on	☐ Aggravates	☐ Relieves
Afternoon	☐ Brings on	☐ Aggravates	☐ Relieves
Bending forward	☐ Brings on	☐ Aggravates	☐ Relieves
Bending back	☐ Brings on	☐ Aggravates	☐ Relieves
Bending left	☐ Brings on	☐ Aggravates	☐ Relieves
Bending right	☐ Brings on	☐ Aggravates	☐ Relieves
Twisting left	☐ Brings on	☐ Aggravates	☐ Relieves
Twisting right	☐ Brings on	☐ Aggravates	☐ Relieves
Coughing	☐ Brings on	☐ Aggravates	☐ Relieves
Sneezing	☐ Brings on	☐ Aggravates	☐ Relieves
Straining	☐ Brings on	☐ Aggravates	☐ Relieves
Standing	☐ Brings on	☐ Aggravates	☐ Relieves
Lifting	☐ Brings on	☐ Aggravates	☐ Relieves
Sitting	☐ Brings on	☐ Aggravates	☐ Relieves
Heat	☐ Brings on	☐ Aggravates	☐ Relieves
Cold	☐ Brings on	☐ Aggravates	☐ Relieves
Rest	☐ Brings on	☐ Aggravates	☐ Relieves
Laying down	☐ Brings on	☐ Aggravates	☐ Relieves
Medications	☐ Brings on	☐ Aggravates	☐ Relieves

PAIN DISABILITY QUESTIONNAIRE

LAST NAME: _____ FIRST NAME:_____ MI:_____ DATE:_____

Complete this questionnaire if you're experiencing any pain/discomfort. Rate the degree to which your symptoms over the past month have negatively affected your ability to perform the following functions. Rate each function as follows: 0 not at all, 1 – 3 slightly, 4 – 6 moderately, 7 – 10 severely.

1. Does your pain interfere with your normal work inside and outside the home?

Work Normally — Unable to work at all

0 1 2 3 4 5 6 7 8 9 10

2. Does your pain interfere with personal care (such as washing, dressing, etc.)?

Take care of myself completely — Need help with all my personal care

0 1 2 3 4 5 6 7 8 9 10

3. **Does your pain interfere with traveling**?

Travel anywhere I like — Only travel to see doctors

0 1 2 3 4 5 6 7 8 9 10

4. Does your pain affect your ability to sit or stand?

No problems — Not sit/stand at all

0 1 2 3 4 5 6 7 8 9 10

5. Does your pain affect your ability to lift overhead, grasp objects, or reach for things?

No problems — Cannot do at all

0 1 2 3 4 5 6 7 8 9 10

6. Does your pain affect your ability to lift objects off the floor, bend, stoop, or squat?

No problems — Cannot do at all

0 1 2 3 4 5 6 7 8 9 10

7. Does your pain affect your ability to walk or run?

No problems — Cannot walk/run at all

0 1 2 3 4 5 6 7 8 9 10

8. Has your income decreased since your pain began?

No decline — Lost all income

0 1 2 3 4 5 6 7 8 9 10

9. Do you have to take pain medication every day to control your pain?

No medication needed — On pain medication throughout the day

0 1 2 3 4 5 6 7 8 9 10

10. Does your pain force you to see doctors much more than before your pain began?

Never see doctors — See doctors weekly

0 1 2 3 4 5 6 7 8 9 10

11. Does your pain interfere with your ability to see people who are important to you as much as you would like?

No problems — Never see them

0 1 2 3 4 5 6 7 8 9 10

12. Does your pain interfere with recreational activities and hobbies that are important to you?

No interference — Total interference

0 1 2 3 4 5 6 7 8 9 10

13. Do you need help of your family and friends to complete everyday tasks (including both work outside home and housework) because of your pain?

Never need help — Need help all the time

0 1 2 3 4 5 6 7 8 9 10

14. Do you feel now more depressed, tense, or anxious than before your pain began?

No depression/tension — Severe depression/tension

0 1 2 3 4 5 6 7 8 9 10

15. Are there emotional problems caused by your pain that interfere with your family, social, and/or work activities?

No problems — Severe problems

0 1 2 3 4 5 6 7 8 9 10

Revised Oswestry Questionnaire

Name:_____ Date: _____/_____/_____

Please Read:

This questionnaire has been designed to give your doctor/therapist information as to how your pain has affected your ability to manage everyday life. Please answer every section, and mark in each section only the **one box** that best describes your condition today.

We realize you may feel that two of the statements in any one section relate to you, but please just mark the box which most closely describes your current condition

Section 1 – Pain Intensity

- ☐ The pain comes and goes and is very mild.
- ☐ The pain is mild and does not vary much.
- ☐ The pain comes and goes and is moderate.
- ☐ The pain is moderate and does not vary much.
- ☐ The pain comes and goes and is very severe.
- ☐ The pain is severe and does not vary much.

Section 2 – Personal Care (Washing, Dressing, etc.)

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

Section 3 – Lifting

- ☐ I can lift heavy weights without extra pain.
- ☐ I can lift heavy weights, but it causes extra pain.
- ☐ Pain prevents me from lifting heavy weights off the floor, but I can manage if they are conveniently positioned (e.g. on a table.)
- ☐ Pain prevents me from lifting heavy weights off the floor.
- ☐ Pain prevents me from lifting heavy weights, but I can manage light to medium weights if they are conveniently positioned.
- ☐ I can only lift very light weights at the most.

Section 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 cane or crutches.
- ☐ I am in bed most of the time and have to crawl to the toilet.

Section 5 - Sitting

- ☐ I can it in any chair as long as I like without pain.
- ☐ I can only sit in my favorite chair as long as I like.
- ☐ Pain prevents me sitting more than 1 hour.
- ☐ Pain prevents me from sitting more than ½ hour.
- ☐ Pain prevents me from sitting more than 10 mins.
- ☐ Pain prevents me from sitting.

Section 6 – Standing

- ☐ I can stand as long as I want without pain.
- ☐ I have some pain while standing, but it does not increase with time.
- ☐ I cannot stand for longer than 1 hour without increasing pain.
- ☐ I cannot stand for longer than ½ hour without increasing pain.
- ☐ I cannot stand for longer than 10 minutes without increasing pain.
- ☐ I avoid standing because it increases the pain straight away.

Section 7 – Sleeping

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

Section 8 – Social Life

- ☐ My social life is normal and gives me no pain.
- ☐ My social life is normal, but it increases the degree of pain.
- ☐ Pain has no significant effect on my social life apart from limiting my more energetic interests, e.g. 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 hardly have any social life because of pain.

Section 9 – Traveling

- ☐ I get no pain while traveling.
- ☐ I get some pain while traveling, but none of usual forms of travel make it any worse.
- ☐ I get extra pain while traveling, but it does not compel me to seek alternative forms of travel.
- ☐ I get extra pain while traveling, which compels me to seek alternative forms of travel.
- ☐ Pain restricts all forms of travel.
- ☐ Pain prevents all forms of travel except if lying down.

Section 10 – Changing Degree of Pain

- ☐ My pain is rapidly getting better.
- ☐ My pain fluctuates but overall is definitely getting better.
- ☐ My pain seems to be getting better but improvement is slow at present.
- ☐ My pain is neither getting better nor worse.
- ☐ My pain is gradually worsening.
- ☐ My pain is rapidly worsening.

OFFICE OF INSURANCE REGULATION
Bureau of Property & Casualty Forms and Rates

Standard Disclosure and Acknowledgement Form
Personal Injury Protection - Initial Treatment or Service Provided

The undersigned insured person (or guardian of such person) affirms:

1. The services or treatment set forth below were **actually rendered.** This means that those services have **already been provided.**

_____

_____

2. I have the right and the **duty to confirm** that the services have already been provided.
3. I was **not solicited** by any person to seek any services from the medical provider of the services described above.
4. The medical provider has **explained** the services to me for which payment is being claimed.
5. If I notify the insurer in writing of a billing error, I may be entitled to a portion of any reduction in the amounts paid by my motor vehicle insurer. If entitled, my share would be at least 20% of the amount of the reduction, up to $500.

Insured Person (patient receiving treatment or services) or Guardian of Insured Person:

_____	_____	_____
Name *(PRINT or TYPE)*	Signature	Date

The undersigned licensed medical professional or medical director, if applicable, affirms the statement numbered 1 above and also:

A. I have **not solicited** or caused the insured person, who was involved in a motor vehicle accident, to be solicited to make a claim for Personal Injury Protection benefits.

B. The treatment or services rendered were explained to the insured person, or his or her guardian, **sufficiently** for that person to sign this form with informed consent.

C. The accompanying statement or bill is **properly completed** in all material provisions and all relevant information has been provided therein. This means that each request for information has been responded to **truthfully, accurately**, and in a **substantially complete** manner.

D. The coding of procedures on the accompanying statement or bill is proper. This means that **no service has been upcoded, unbundled**, or constitutes an invalid **or not medically necessary diagnostic test** as defined by Section 627.732 (15) and (16), Florida Statutes or Section 627.736(5)(b)6, Florida Statutes.

Licensed Medical Professional Rendering Treatment/Services or Medical Director, if applicable *(Signature by his/ her **own hand**)*:

_____	_____	_____
Name *(PRINT or TYPE)*	Signature	Date

Any person who knowingly and with intent to injure, defraud, or deceive any insurer files a statement of Claim or an application containing any false, incomplete, or misleading information is guilty of a felony of the third degree per Section 817.234(1)(b), Florida Statutes.

Note: The **original** of this form must be furnished to the insurer pursuant to Section 627.736(4)(b), Florida Statutes and may **not** be electronically furnished. Failure to furnish this form may result in non-payment of the claim.

OIR-B1-1571
Pub. 1/2004