PERSONAL INJURY QUESTIONNAIRE

Name:_____ Date:_____

INSURANCE:
Your Auto Insurance & Agent's Name_____
Policy #_____
Driver's Auto Insurance & Agent's Name_____
Policy #_____

ATTORNEY:
Name_____Phone_____
Address_____City_____State_____Zip_____
Were there any witnesses: ☐ Yes ☐ No Name(s)_____

NATURE OF ACCIDENT:

1. Date of Accident:_____ Time of Day_____
2. Were you: ☐ Driver ☐ Passenger ☐ Front Seat ☐ Back Seat
3. Number of people in your vehicle?_____Were you wearing seat belts?_____
4. What direction were you headed? ☐ North ☐ East ☐ South ☐ West
   on (name of street)_____
5. What direction was other vehicle heading? ☐ North ☐ East ☐ South ☐ West
   on (name of street)_____
6. Struck from: ☐ Behind ☐ Front ☐ Left Side ☐ Right Side
   Check All That Apply: ☐ Braced for impact ☐ Not braced for impact
   ☐ Both hands on steering wheel ☐ One hand on steering wheel
   ☐ Looking straight ahead on impact ☐ Looking left on impact ☐ Looking right on impact
7. Approximate speed of your car?_____mph Other car_____mph
8. Were you knocked unconscious? ☐ Yes ☐ No If yes for how long?_____
9. Were the police notified? ☐ Yes ☐ No If yes, can you supply us with a copy of the police report? ☐ Yes ☐ No
10. Where were you taken after the accident?_____
11. Check symptoms you have noticed since accident:

☐ Headache	☐ Tension	☐ Shortness of Breath	☐ Pins & Needles in: Arms, Legs
☐ Sleeping Problem	☐ Stomach Upset	☐ Head Seems to Heavy	☐ Numbness in:
☐ Diarrhea	☐ Sinus Trouble	☐ Cold Sweats / Fever	☐ Arms ☐ Legs
☐ Constipation	☐ Loss of Balance	☐ Nausea, Vomiting	☐ Fingers ☐ Toes
☐ Chest Pain	☐ Loss of Smell	☐ Lights Bother Eyes	☐ Swelling (where)_____
☐ Fainting	☐ Loss of Taste	☐ Pain Behind Eyes	☐ Difficulty in:
☐ Dizziness	☐ Loss of Memory	☐ Vision Problems	☐ Walking ☐ Standing ☐ Lifting
☐ Tremors	☐ Buzzing in Ears	☐ Heart Palpitations	☐ Bending ☐ Riding ☐ Sitting
☐ Irritability	☐ Ears Ring	☐ Neck (Pain; Stiffness)	☐ Pain Radiating into:
☐ Nervousness	☐ Feet Cold	☐ Upper Back (Pain; Stiffness)	☐ Base of skull ☐ Arm (Rt Lt)
☐ Fatigue	☐ Hands Cold	☐ Mid Back (Pain; Stiffness)	☐ Shoulder (Rt Lt) ☐ Hip (Rt Lt)
☐ Depression	☐ Face Flushed	☐ Low Back (Pain; Stiffness)	☐ Head (Rt Lt) ☐ Leg (Rt Lt)

Symptoms Other Than Above_____
_____

12. Do you notice any activity restrictions as a result of this injury? ☐ Yes ☐ No If yes please describe in detail:_____
    _____
    _____
    _____
13. Other pertinent information:_____
    _____

Patient Signature_____ Date_____

Patient Information Sheet

Patient Name_____M. I.____Social Security_____
Street Address_____City/State/Zip_____
Home Phone_____Cell Phone_____
Work Phone_____Ext. _____E-mail_____
Birthdate _____Age ___ Sex ☐ M ☐ F Employed By_____
☐ Single ☐ Married ☐ Widowed ☐ Separated ☐ Divorced Occupation_____
Emergency Contact_____Phone_____
Name of Insurance _____
Is the primary insurance through ☐ Yourself ☐ Spouse ☐ Parent ☐ Significant Other
Name of Policy Holder_____Birth Date of Policy Holder_____
Social Security # of Policy Holder_____
Place of Employment of Policy Holder_____
Is the secondary insurance through ☐ Yourself ☐ Spouse ☐ Parent ☐ Significant Other
Name of Policy Holder_____Birth Date of Policy Holder_____
Social Security # of Policy Holder_____
Place of Employment of Policy Holder _____
Who can we thank for referring you to our office?_____

I AUTHORIZE PAYMENT OF MEDICAL BENEFITS TO MY DOCTOR FOR ALL SERVICES RENDERED

Signed_____Date_____
(Insured or authorized person)

Patient Informed Consent

I hereby request and/or consent to the performance of chiropractic adjustments and/or other chiropractic procedures on me (or the patient named above for whom I am legally responsible) by Dr. Scott Newcomer or Dr. Thomas Zastrow who now and/or in the future may care for me in this office.

I understand and am informed that, as in the practice of medicine, in the practice of chiropractic there are some risks to chiropractic care, including but not limited to sprain and strain, fractures, dislocations, and general aggravations of inflammatory conditions. I understand that I will have an opportunity to discuss with the doctor and/or other office personnel the nature and purpose of the chiropractic procedures I will receive. I understand that the doctor will perform an examination in order to minimize any risk of care, however, I do except the doctor to be able to anticipate and explain all risks and complications. I therefore wish to rely on how the doctor feels at the time, based upon the facts as they are then known, which are in my best interest.

I have read, or have had read to me, the above consent. I have also had an opportunity to ask questions about its content, and by signing below, I agree to the procedures. I intend for this consent form to cover the entire course of care for my present condition(s) and for any future condition(s) for which I may seek care in this office.

_____ _____
Patient/Guardian Signature Date

_____ _____
Doctor's Signature Date

Female's Only: I do hereby state that, to the best of my knowledge I am not pregnant, nor is pregnancy suspected or confirmed at this particular time. Initial_____

Zastrow Chiropractic Clinic * 4811 S. 76th Street, Suite 204 *** Greenfield, WI 53220**
Phone: 414-281-5266 Fax 414-281-9772

Patient Health Questionnaire - PHQ

ACN Group, Inc. - Form PHQ-202

ACN Group Use Only rev 9/11/2002

Patient Name _____ *Date* _____

1. Describe your symptoms _____

_____

a. When did your symptoms start? _____

b. How did your symptoms begin? _____

2. How often do you experience your symptoms?

① Constantly (76-100% of the day)
② Frequently (51-75% of the day)
③ Occasionally (26-50% of the day)
④ Intermittently (0-25% of the day)

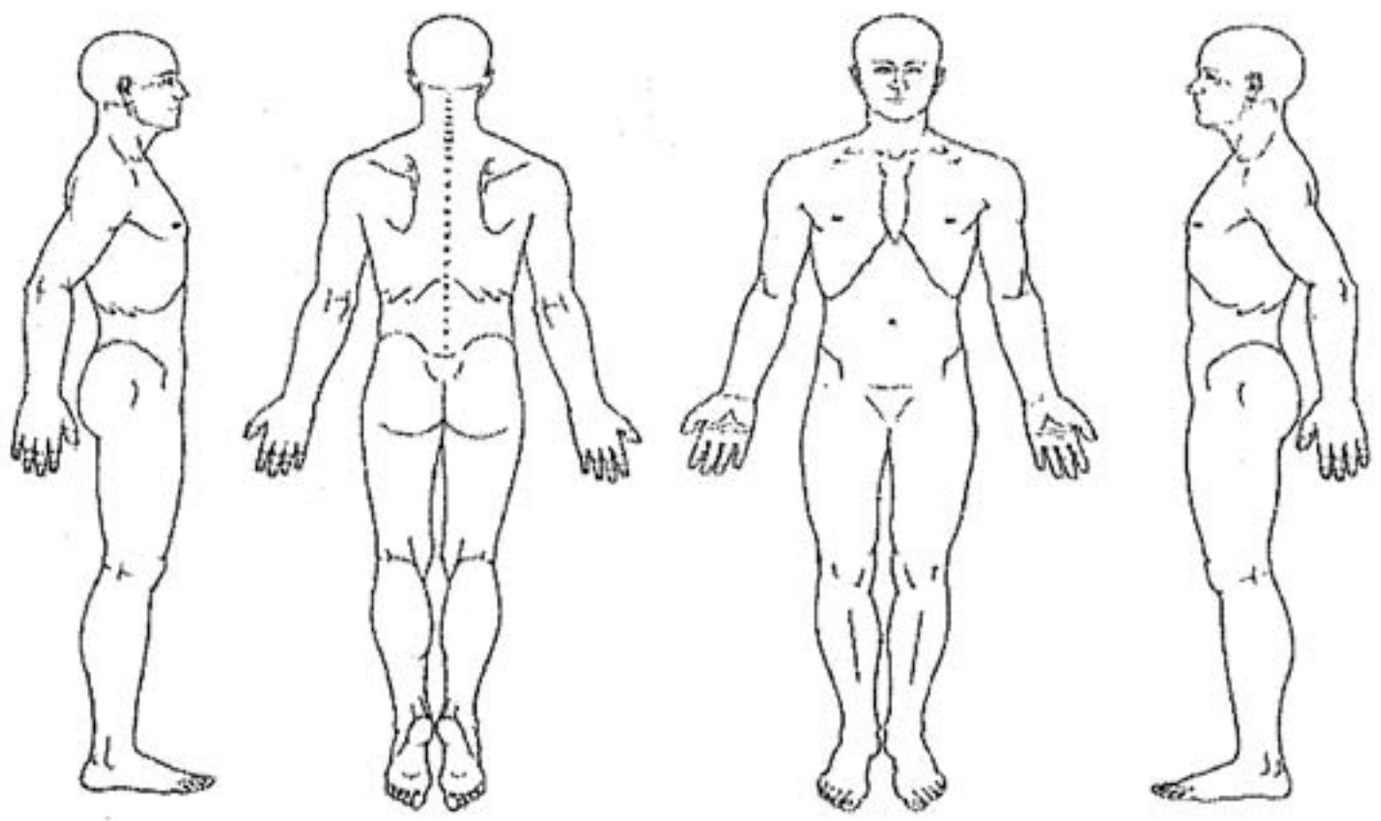
3. What describes the nature of your symptoms?

① Sharp ④ Shooting
② Dull ache ⑤ Burning
③ Numb ⑥ Tingling

4. How are your symptoms changing?

① Getting Better
② Not Changing
③ Getting Worse

Indicate where you have pain or other symptoms



None Unbearable

5. During the <u>past 4 weeks:</u>

a. Indicate the average intensity of your symptoms ⓪ ① ② ③ ④ ⑤ ⑥ ⑦ ⑧ ⑨ ⑩

b. How much has pain interfered with your normal work (including both work outside the home, and housework)

① Not at all ② A little bit ③ Moderately ④ Quite a bit ⑤ Extremely

6. During the <u>past 4 weeks</u> how much of the time has your condition interfered with your social activities?
(like visiting with friends, relatives, etc)

① All of the time ② Most of the time ③ Some of the time ④ A little of the time ⑤ None of the time

7. In general would you say your overall health right now is...

① Excellent ② Very Good ③ Good ④ Fair ⑤ Poor

---

8. Who have you seen for your symptoms?

① No One
② Other Chiropractor
③ Medical Doctor
④ Physical Therapist
⑤ Other

a. What treatment did you receive and when? _____

b. What tests have you had for your symptoms and when were they performed?

① Xrays *date:* _____ ③ CT Scan *date:* _____
② MRI *date:* _____ ④ Other *date:* _____

9. Have you had similar symptoms in the past? ① Yes ② No

a. If you have received treatment in the past for the same or similar symptoms, who did you see?

① This Office
② Other Chiropractor
③ Medical Doctor
④ Physical Therapist
⑤ Other

10. What is your occupation?

_____

① Professional/Executive
② White Collar/Secretarial
③ Tradesperson
④ Laborer
⑤ Homemaker
⑥ FT Student
⑦ Retired
⑧ Other

a. If you are not retired, a homemaker, or a student, what is your current work status?

① Full-time
② Part-time
③ Self-employed
④ Unemployed
⑤ Off work
⑥ Other

Patient Signature _____ ***Date*** _____

Patient Health Questionnaire - page 2

American Chiropractic Network

ACN Use Only rev 4/23/99

Patient Name _____ *Date* _____

What type of regular exercise do you perform? ① None ② Light ③ Moderate ④ Strenuous

What is your height and weight? Height [ ][ ][ ] *Feet Inches* Weight [ ][ ][ ] lbs.

For each of the conditions listed below, place a check in the Past column if you have had the condition in the past. If you presently have a condition listed below, place a check in the Present column.

Past	Present		Past	Present		Past	Present	
○	○	Headaches	○	○	High Blood Pressure	○	○	Diabetes
○	○	Neck Pain	○	○	Heart Attack	○	○	Excessive Thirst
○	○	Upper Back Pain	○	○	Chest Pains	○	○	Frequent Urination
○	○	Mid Back Pain	○	○	Stroke			
○	○	Low Back Pain	○	○	Angina	○	○	Smoking/Use Tobacco Products
			○	○	Kidney Stones	○	○	Drug/Alcohol Dependence
○	○	Shoulder Pain	○	○	Kidney Disorders			
○	○	Elbow/Upper Arm Pain	○	○	Bladder Infection	○	○	Allergies
○	○	Wrist Pain	○	○	Painful Urination	○	○	Depression
○	○	Hand Pain	○	○	Loss of Bladder Control	○	○	Systemic Lupus
			○	○	Prostate Problems	○	○	Epilepsy
○	○	Hip/Upper Leg Pain				○	○	Dermatitis/Eczema/Rash
○	○	Knee/Lower Leg Pain	○	○	Abnormal Weight Gain/Loss	○	○	HIV/AIDS
○	○	Ankle/Foot Pain	○	○	Loss of Appetite			
○	○	Jaw Pain	○	○	Abdominal Pain	*Females Only*		
			○	○	Ulcer	○	○	Birth Control Pills
○	○	Joint Swelling/Stiffness	○	○	Hepatitis	○	○	Hormonal Replacement
○	○	Arthritis	○	○	Liver/Gall Bladder Disorder	○	○	Pregnancy
○	○	Rheumatoid Arthritis				○	○	
			○	○	Cancer	*Other Health Problems/Issues*		
○	○	General Fatigue	○	○	Tumor	○	○	
○	○	Muscular Incoordination				○	○	
○	○	Visual Disturbances	○	○	Asthma	○	○	
○	○	Dizziness	○	○	Chronic Sinusitis			

Indicate if an immediate family member has had any of the following:

○ Rheumatoid Arthritis ○ Heart Problems ○ Diabetes ○ Cancer ○ Lupus ○ _____

List all prescription and over-the-counter medications, and nutritional/herbal supplements you are taking:

_____ _____ _____

_____ _____ _____

List all the surgical procedures you have had and times you have been hospitalized:

_____ _____ _____

_____ _____ _____

Patient Signature _____ *Date* _____

Doctor's Additional Comments

_____

_____

_____

Doctors Signature _____ *Date* _____

Neck Index

ACN Group, Inc. - Form NI-100

ACN Group, Inc. Use Only rev 11/13/02

Patient Name _____ **Date** _____

This questionnaire will give your provider information about how your neck condition affects your everyday life. Please answer every section by marking the one statement that applies to you. If two or more statements in one section apply, please mark the one statement that most closely describes your problem.

Pain Intensity

⓪ I have no pain at the moment.
① The pain is very mild at the moment.
② The pain comes and goes and is moderate.
③ The pain is fairly severe at the moment.
④ The pain is very severe at the moment.
⑤ The pain is the worst imaginable at the moment.

Personal Care

⓪ I can look after myself normally without causing extra pain.
① I can look after myself normally but it causes extra pain.
② It is painful to look after myself and I am slow and careful.
③ I need some help but I manage most of my personal care.
④ I need help every day in most aspects of self care.
⑤ I do not get dressed, I wash with difficulty and stay in bed.

Sleeping

⓪ I have no trouble sleeping.
① My sleep is slightly disturbed (less than 1 hour sleepless).
② My sleep is mildly disturbed (1-2 hours sleepless).
③ My sleep is moderately disturbed (2-3 hours sleepless).
④ My sleep is greatly disturbed (3-5 hours sleepless).
⑤ My sleep is completely disturbed (5-7 hours sleepless).

Lifting

⓪ I can lift heavy weights without extra pain.
① I can lift heavy weights but it causes extra pain.
② Pain prevents me from lifting heavy weights off the floor, but I can manage if they are conveniently positioned (e.g., on a table).
③ Pain prevents me from lifting heavy weights off the floor, but I can manage light to medium weights if they are conveniently positioned.
④ I can only lift very light weights.
⑤ I cannot lift or carry anything at all.

Reading

⓪ I can read as much as I want with no neck pain.
① I can read as much as I want with slight neck pain.
② I can read as much as I want with moderate neck pain.
③ I cannot read as much as I want because of moderate neck pain.
④ I can hardly read at all because of severe neck pain.
⑤ I cannot read at all because of neck pain.

Driving

⓪ I can drive my car without any neck pain.
① I can drive my car as long as I want with slight neck pain.
② I can drive my care as long as I want with moderate neck pain.
③ I cannot drive my car as long as I want because of moderate neck pain.
④ I can hardly drive at all because of severe neck pain.
⑤ I cannot drive my car at all because of neck pain.

Concentration

⓪ I can concentrate fully when I want with no difficulty.
① I can concentrate fully when I want with slight difficulty.
② I have a fair degree of difficulty concentrating when I want.
③ I have a lot of difficulty concentrating when I want.
④ I have a great deal of difficulty concentrating when I want.
⑤ I cannot concentrate at all.

Recreation

⓪ I am able to engage in all my recreation activities without neck pain.
① I am able to engage in all my usual recreation activities with some neck pain.
② I am able to engage in most but not all my usual recreation activities because of neck pain.
③ I am only able to engage in a few of my usual recreation activities because of neck pain.
④ I can hardly do any recreation activities because of neck pain.
⑤ I cannot do any recreation activities at all.

Work

⓪ I can do as much work as I want.
① I can only do my usual work but no more.
② I can only do most of my usual work but no more.
③ I cannot do my usual work.
④ I can hardly do any work at all.
⑤ I cannot do any work at all.

Headaches

⓪ I have no headaches at all.
① I have slight headaches which come infrequently.
② I have moderate headaches which come infrequently.
③ I have moderate headaches which come frequently.
④ I have severe headaches which come frequently.
⑤ I have headaches almost all the time.

Neck Index Score _____

Back Index

ACN Group, Inc. - Form BI-100

ACN Group, Inc. Use Only rev 11/13/02

Patient Name _____ *Date* _____

This questionnaire will give your provider information about how your back condition affects your everyday life. Please answer every section by marking the one statement that applies to you. If two or more statements in one section apply, please mark the one statement that most closely describes your problem.

Pain Intensity

⓪ The pain comes and goes and is very mild.
① The pain is mild and does not vary much.
② The pain comes and goes and is moderate.
③ The pain is moderate and does not vary much.
④ The pain comes and goes and is very severe.
⑤ The pain is very severe and does not vary much.

Sleeping

⓪ I get no pain in bed.
① I get pain in bed but it does not prevent me from sleeping well.
② Because of pain my normal sleep is reduced by less than 25%.
③ Because of pain my normal sleep is reduced by less than 50%.
④ Because of pain my normal sleep is reduced by less than 75%.
⑤ Pain prevents me from sleeping at all.

Sitting

⓪ I can sit in any chair as long as I like.
① I can only sit in my favorite chair as long as I like.
② Pain prevents me from sitting more than 1 hour.
③ Pain prevents me from sitting more than 1/2 hour.
④ Pain prevents me from sitting more than 10 minutes.
⑤ I avoid sitting because it increases pain immediately.

Standing

⓪ I can stand as long as I want without pain.
① I have some pain while standing but it does not increase with time.
② I cannot stand for longer than 1 hour without increasing pain.
③ I cannot stand for longer than 1/2 hour without increasing pain.
④ I cannot stand for longer than 10 minutes without increasing pain.
⑤ I avoid standing because it increases pain immediately.

Walking

⓪ I have no pain while walking.
① I have some pain while walking but it doesn't increase with distance.
② I cannot walk more than 1 mile without increasing pain.
③ I cannot walk more than 1/2 mile without increasing pain.
④ I cannot walk more than 1/4 mile without increasing pain.
⑤ I cannot walk at all without increasing pain.

Personal Care

⓪ I do not have to change my way of washing or dressing in order to avoid pain.
① I do not normally change my way of washing or dressing even though it causes some pain.
② Washing and dressing increases the pain but I manage not to change my way of doing it.
③ Washing and dressing increases the pain and I find it necessary to change my way of doing it.
④ Because of the pain I am unable to do some washing and dressing without help.
⑤ Because of the pain I am unable to do any washing and dressing without help.

Lifting

⓪ I can lift heavy weights without extra pain.
① I can lift heavy weights but it causes extra pain.
② Pain prevents me from lifting heavy weights off the floor.
③ Pain prevents me from lifting heavy weights off the floor, but I can manage if they are conveniently positioned (e.g., on a table).
④ Pain prevents me from lifting heavy weights off the floor, but I can manage light to medium weights if they are conveniently positioned.
⑤ I can only lift very light weights.

Traveling

⓪ I get no pain while traveling.
① I get some pain while traveling but none of my usual forms of travel make it worse.
② I get extra pain while traveling but it does not cause me to seek alternate forms of travel.
③ I get extra pain while traveling which causes me to seek alternate forms of travel.
④ Pain restricts all forms of travel except that done while lying down.
⑤ Pain restricts all forms of travel.

Social Life

⓪ My social life is normal and gives me no extra pain.
① My social life is normal but increases the degree of pain.
② Pain has no significant affect on my social life apart from limiting my more energetic interests (e.g., dancing, etc).
③ Pain has restricted my social life and I do not go out very often.
④ Pain has restricted my social life to my home.
⑤ I have hardly any social life because of the pain.

Changing degree of pain

⓪ My pain is rapidly getting better.
① My pain fluctuates but overall is definitely getting better.
② My pain seems to be getting better but improvement is slow.
③ My pain is neither getting better or worse.
④ My pain is gradually worsening.
⑤ My pain is rapidly worsening.

Back Index Score _____

ZASTROW CHIROPRACTIC CLINIC S.C.

Patient Health Information Consent Form

We want you to know how your Patient Health Information (**PHI**) is going to be used in this office and your rights concerning those records. Before we will begin any health care operations we must require you to read and sign this consent form stating that you understand and agree with how your records will be used. If you would like to have a more detailed account of our policies and procedures concerning the privacy of you Patient Health Information we encourage you to read the HIPAA NOTICE that is available to you at the front desk before signing this consent.

1. The patient understands and agrees to allow this chiropractic office to use their Patient Health Information (**PHI**) for the purpose of treatment, payment, healthcare operations, and coordination of care. As an example, the patient agrees to allow this chiropractic office to submit requested PHI to the Health Insurance Company (or companies) provided to us by the patient for the purpose of payment. Be assured that this office will limit the release of all. PHI to the minimum needed for what the insurance companies require for payment.
2. The patient has the right to examine and obtain a copy of his or her own health records at any time and request corrections. The patient may request to know what disclosures have been made and submit in writing any further restrictions on the use of their PHI. Our office is not obligated to agree to those restrictions.
3. A patient's written consent need only be obtained one time for all subsequent care given the patient in this office.
4. The patient may provide a written request to revoke consent at any time during care. This would not effect the use of those records for the care given prior to the written request to revoke consent but would apply to any care given after the request has been presented.
5. For your security and right to privacy, all staff has been trained in the area of patient record privacy and a privacy official has been designated to enforce those procedures in our office. We have taken all precautions that are known by this office to assure that your records are not readily available to those who do not need them.
6. Patients have the right to file a formal complaint with our privacy official about any possible violations of these policies and proccdures.
7. If the patient refuses to sign this consent for the purpose of treatment, payment and health care operations, the chiropractic physician has the right to refuse to give care.

I have read and understand how my Patient Health Information will be and I agree to these policies and proccdures.

Name of Patient Date Witness

4811 South 76th Street ■ Edgewood Plaza ■ Suite 204 ■ Greenfield, Wisconsin 53220 ■ (414) 281-5266

FINANCIAL POLICY OF ZASTROW CHIROPRACTIC CLINIC, S.C.

Insurance cards should be presented to our front desk on the first visit. Your chiropractic coverage will be verified by our billing department. It is understood that you are responsible to obtain any referral that may be necessary to seek chiropractic care.

All copays are to be paid at each visit. You may pay your copays in advance if you wish. We accept cash, checks, debit cards, MasterCard and Visa as payment.

Payment must be presented for any nutritional supplements, pillows, back huggers, lumbosacral belts, foot orthotics, braces and any other supports your Doctor recommends to you. It is understood that your insurance carrier will not be billed for these items.

I understand and agree that health and accident insurance policies are an arrangement between my insurance carrier and myself. I understand that this office will submit my claims to my insurance company and that any amount authorized to be paid directly to this office will be credited to my account on receipt.

However, I clearly understand and agree that all services rendered to me are charged directly to me and that I am personally responsible for payment for any amount that is not paid and/or covered by my insurance policy

I have read and understood all of the above.

Patient Signature: _____

Print Your Name: _____

Date: _____