CHECKLIST FOR PERSONAL INJURY (for office use)

(REQUIRED DOCUMENTATION)

Patient Name: _____ **Date:** _____ D.O.I._____

_____ **1. Personal Injury Packet** (Plus copies of DL and Ins Cards)

_____ **2. Personal Auto Insurance Information** (Medical Payments and Claim#)

_____ **3. Major Medical Insurance** (example: Aetna, Anthem, UHC, etc.)

_____ **4. Liability Party Information** (Person's Name, Insurance Co Name & Claim#)

_____ **5. Attorney Information** (Name, Address & Phone #)

_____ **6. Copy of Police Report** (Available 10 days after accident)

_____ **7. Signed Lien** (Must be sent to pts attorney, Liab Party & Liab Ins Co)

_____ **8. Signed Assignment of Benefits (**Must be sent to Med Pay)

_____ **9. Eggleston Forms, including Dr's Diagnosis (DX) & Treatment Plan (TX) Forms**

Entry in Case Tab -

Dr Name, PI, Pts Ins Co name/Major Med Co Name/Liability Ins Co name
Assigned Provider:
Managed Care Profile: Personal Injury

Entry Into Guarantor Tab –

Guarantor 1: Med Pay (Pts Auto Ins) Be sure to enter Claim#/Policy#
Guarantor 2: Major Medical (Pts Health Ins)
Guarantor 3: Liability Ins (Be sure to enter Person's name & Claim#/Policy#)

Entry Into Condition Tab -

DATES: Check 1st, 3rd & 4th boxes, (4th box should be the date of the Accident)
Assigned Guarantor: Who are we billing?
Was Pt in an Accident?: Auto & MO (Do not worry about Time)

To Mail out 1st bill, **if Med Pay**, send the following by Certified Mail:

1. Claim Form (IF USAA, Send Daily Notes/Exams/Tx Plans with every claim)
2. Lien
3. Assignment of Benefits
4. Eggleston Form
5. DX and TX Plan Forms, from Dr.

Patient Name: _____ **Date:** _____
DOB: _____ **SSN:** _____ **Patient ID:** _____
Address: _____ **City:** _____ **State:** _____ **Zip:** _____
Home Phone: _____**Cell Phone:** _____**Email Address:** _____
*****Cell Phone Carrier:**_____

PLEASE PROVIDE US WITH YOUR CURRENT HEALTH INSURANCE CARD AND DRIVERS LICENSE.

Nickname: (preferred to be called) _____
Race/Ethnicity: White ___; African American ___; Native American___; Asian ___; Pacific Islander___
Preferred language: English_____; Spanish_____; Other _____

Have you been diagnosed with: Asthma/COPD Diabetes Hypertension

Person ultimately responsible for this account?

Name: _____

Relation: _____

Billing Address: _____

SSN: _____

Drivers license #: _____

Work phone: _____

In the event of an emergency, who should we contact?

Name: _____

Relationship: _____

Cell phone: _____

Work phone: _____

Home phone: _____

Who is your Medical Doctor:_____

Medical Doctors Phone #: _____

I understand that if x-rays are necessary, there is a separate radiology fee of $40 that I must pay to Crosby Chiropractic and Acupuncture Centre at the time of service.

Acknowledgement of receipt of Notice of Privacy Practices:

I hereby consent and state my preference to have my physician, [Physician Name], and other staff at [Practice Name] communicate with me by email or standard SMS/text messaging, in addition to or to replace leaving phone messages, regarding various aspects of my health care, which may include, but shall not be limited to, test results, appointments, and billing. I understand that email and standard SMS/text messaging are not confidential methods of communication and may be insecure. I further understand that, because of this, there is a risk that email and standard SMS/text messaging regarding my medical care might be intercepted and read by a third party.

Signature: _____

If Legal Representative for the Patient please indicate relationship here:_____

I authorize Crosby Chiropractic & Acupuncture Centre to release to the following people access to my health record and financial record: _____

Assignment of Benefits:

I request that payment of insurance benefits for services provided to me by Jenny L Wiemann, D.C., P.C dba Crosby Chiropractic & Acupuncture Centre, be made directly to the Service Provider as appropriate. I assign any and all rights to payment of insurance benefits to the Service Provider. I acknowledge and agree that I am financially responsible for all charges relating to the services rendered to me or my dependent. If, for any reason, my insurance carrier does not pay for a portion of this bill, I understand that I am responsible for prompt (within 30 days) payment arrangements. , I understand that I am responsible for prompt (within 30 days) payment arrangements. I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits to this office which accepts assignment.

Signature:_____**Date/time:**_____
Patient, parent or guardian

Patient Name:_____ **Date:**_____

ABN (excluding Medicare):

Jenny L Wiemann, D.C., P.C, dba Crosby Chiropractic & Acupuncture Centre, will file a claim on your behalf with your health insurance carrier(s) based on information that you provided during your registration process. Your carrier may not pay for part of all of the services listed below as they may determine it to be "not medically necessary." It is important that you understand your coverage as Crosby Chiropractic & Acupuncture Centre will bill you in the event that the service(s) are not covered by your insurance carrier(s) or there is a balance due after payment by your insurance carrier that is determined to be patient responsibility. Services this may apply to include: Out of network chiropractic and acupuncture care, chiropractic after 26 visits, chiropractic for self-funded or federal plans, chiropractic for maintenance/supportive care, chiropractic for minor children, acupuncture, therapy modalities, xrays, examinations, supplements.

I have read and reviewed these terms with a representative of the provider and I understand that my treatment(s) may not be covered by my health insurance carrier. I agree that I am financially responsible for the amount billed to me by Crosby Chiropractic & Acupuncture and will pay any balance due in a timely manner (less than 45 days). , I understand that I am responsible for prompt (within 30 days) payment arrangements. I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits to this office which accepts assignment.

Signature:_____
Patient, parent or guardian

Informed Consent:

I request and consent to any diagnostic testing or treatment from the Doctors/staff of Crosby Chiropractic. I understand that the practice of chiropractic, acupuncture and massage are not exact sciences and I acknowledge that no guarantees have been made to me as a results of medical treatments, diagnostic procedures or examinations that occur within this facility. I further understand that, as in the practice of medicine, there are some risks to treatment including fracture, disc injury, stroke, dislocation and sprains although these are very rare (1 in 4 million). I do not expect the doctor to be able to anticipate and explain all risks and complications and wish to rely on the doctor to exercise those procedures that the doctor feels, at the time are in my best interest.

In the event I need x-rays I authorize them **1)** to be taken, and **2)** to be sent to Radiology Consultants Midwest, to be read.(initial) _____ and state that to the best of my knowledge I am not pregnant (female only)_____(initial).

Signature: _____
Patient, parent or guardian

CONSENT TO TREAT A MINOR
I hereby authorize the doctors at Croby Chiropractic & Acupuncture Centre to administer treatment as they so deem necessary to my son/daughter _____

Parent/Guardian Signature: _____

I have read or have had read to me, the above and have had opportunities to ask about the content. By signing below I agree to care for this condition and for any future conditions for which I seek treatment.

- Our policy requires payment in full for all services rendered at the time of each visit unless other arrangements have been made. If insurance has not paid within 90 days of the date of service, you will be responsible for the bill. Any legal fees, collection agency, attorney fees, interest fees and any other fees incurred attempting to recoup your account balance are your responsibility.
- I authorize the staff to perform any necessary services needed during my diagnosis and treatment including x-rays and I understand there is an associated radiology fee of $40,that I am personally responsible for. I also authorize the provider to release any information required to ensure payment of insurance claims.
- I hereby appoint Jenny L Wiemann, D.C., P.C., including its authorized agents, as my attorney in fact to collect any and all data required to satisfy my financial obligations to this office. I hereby give and grant to my said attorney full power and authority to do and perform all and every act and thing whatsoever to be done. In order to fully carry out and affectuate the authority granted herein, as fully to all intents and purposes as I might or could do if personally present and personally acting and I hereby ratify and confirm all that my said attorney may do pursuant to this power.
- I understand the above information and guarantee that my information, provided electronically and on paper was completed correctly to the best of my knowledge and I know it is my responsibility to inform this office of any changes in the information I have provided

Signature: _____ **Date/time:**_____

Witness: _____ **Date:** _____

"In the event this matter is placed for collection, the patient shall be responsible for collection fees equal to 45%, reasonable attorneys' fees and court costs." In addition, I hereby agree to pay interest in the amount of 1% per month upon the outstanding balance.

CROSBY CHIROPRACTIC & ACUPUNCTURE CENTRE

PATIENT HISTORY FORM

Date: _____/_____/_____

NAME: _____ Birthdate: _____/_____/_____
Last First M. I.

Age:_____ Sex: ❑ F ❑ M

How did you hear about this clinic?

Describe briefly your present symptoms:

Please list the names of other practitioners you have seen for this problem:

Orthotics: Y/N Mattress age: Comfortable? Last Spinal Xrays?

Hospitalizations:

CURRENT MEDICATIONS

Drug allergies: ❑ No ❑ Yes To what?

Please list any medications that you are now taking. Include non-prescription medications & vitamins or supplements:

Name of drug	**Dose (include strength & number of pills per day)**	**How long have you been taking this?**
1.		
2.		
3.		
4.		
5.		
6.		

Living status: alone /not alone

Smoking status:

Alcohol use:

Caffeine use:

Soda consumption:

Exercise:

Patient Name: _____**Date:**_____

PAST MEDICAL HISTORY

Do you now or have you ever had:

❑ Diabetes	❑ Gout	❑ Crohn's disease
❑ High/low blood pressure	❑ Pneumonia	❑ Colitis
❑ High cholesterol	❑ Pulmonary embolism	❑ Anemia
❑ Hypothyroidism/hyperthyroidism	❑ Asthma/bronchitis	❑ Jaundice
❑ Goiter	❑ Emphysema	❑ Hepatitis
❑ Cancer (type) _____	❑ Stroke	❑ Stomach or peptic ulcer
❑ Leukemia	❑ Epilepsy (seizures)	❑ Rheumatic fever
❑ Psoriasis	❑ Celiac/Crohn's	❑ Tuberculosis
❑ Angina	❑ Kidney disease/stones	❑ HIV/AIDS
❑ Heart problems/disease/murmur	❑ Arteriosclerosis	❑ Chicken Pox

Other medical conditions (please list):

_____

FAMILY HISTORY

	IF LIVING		IF DECEASED	
	Age (s)	Health & Psychiatric	Age(s) at death	Cause
Father				
Mother				
Siblings				
Children				

Female: ❑ BCP/IUD/ ❑ miscarriages

Male: ❑ Impotency ❑ Pain on erection/ejaculation

Do any of the following apply to you today:

- ___Open Cuts ___Injury ___Cold/Flu ___Anything Contagious?
- Have you had a fever in the last 24 hours of 100°F or above? _____
- Do you now, or have you recently had, any respiratory or flu symptoms, sore throat, or shortness of breath?_____
- Have you been in contact with anyone in the last 14 days who has been diagnosed with COVID-19 or has coronavirus-type symptoms? _____
- Have you travelled out of state in the last 14 days? _____

I understand that, because chiropractic, acupuncture and passive modality therapies involve touch and close physical proximity over an extended period of time, there may be an elevated risk of disease transmission, including COVID-19. By signing this form, I acknowledge that I am aware of the risks involved and give consent to receive treatment from this clinic and its employees.

Signature_____ Date_____

Patient Name: _____ **Date:**_____

Current Medications: (Provide Front Desk with your list, if available)

Medication Name i.e. Lipitor	**# of MD Refills Issued**	**Quantity of Pills**	**Strength i.e. 10mg**	**Dose Form i.e Capsule**	**MD's Instruction i.e. 1 per day**
1.					
2.					
3.					
4.					
5.					

Medicine Allergies

Name of Drug: i.e. Penicillin	**Symptoms: i.e. headache**
1.	
2.	

Family History of Cancer, Diabetes, Heart Disease, Autoimmune disease etc.

Mother_____

Father_____

Siblings_____

Vehicle Accident Information:

Date of the accident: _____ Time of the accident: _____AM/PM Speed you were traveling:_____

Driving conditions: __ dry ___wet __icy/snow packed ___other Estimated speed of other vehicle:_____

Make and Model of Your Vehicle:_____Make and Model of Other Vehicle:_____

Location of accident: Road/Street name:_____City/State:_____

Which direction were you headed?:_____ Was the impact ____front _____rear____left_____right___ other

Did your car hit another car or structure? if yes, please explain:_____

Were you the Driver____Front Passenger___Rear Passenger___Pedestrian Were both hands on the steering wheel?___Yes____No

Did any part of your body strike any part of the vehicle (explain)?_____ Were you unconscious? ___Yes ___ No if yes, how long?_____

Were you ___looking ahead___looking left____looking right___looking down____Looking in the mirror

Was your foot on the brake? ___Yes____No Were you ____surprised by the impact? ____braced for the impact?

Did your seat have a headrest?: ____Yes_____No Was the headrest position ___Low ___ Med____High

Were you wearing a seatbelt?: ___Yes____No Lapbelt or shoulder belt?_____ Did airbags deploy?___Yes ___No

Please describe the accident and how you felt immediately after the accident in your words:_____

_____

_____

_____

Patient Name:_____ Date:_____

Who was at fault: ____ You _____ other driver

SECTION I (Medpay)YOUR AUTO INSURANCE

Do you have medpay/auto insurance? ____Y____N

Did you file a claim with your insurance? ___Y ____N

YOUR INSURANCE _____

ADDRESS _____

PHONE # _____

NAME ON POLICY _____

POLICY # _____

MEDICAL PAY COVERAGE _____

CLAIM # _____ADJUSTOR _____

Were the police notified? _____ Yes _____ No

SECTION II (Liability) AUTO INSURANCE

THEIR INSURANCE _____

ADDRESS _____

PHONE # _____

NAME ON POLICY _____

POLICY # _____

MEDICAL PAY COVERAGE _____

CLAIM # _____ADJUSTOR _____

Was a report filed? _____Yes _____ No

Report Number:_____ Municipality:_____Did you go to the hospital or urgent care?____Yes ____No. If yes, when did you go?_____ How did you go? _____Ambulance _____Your Car_____Another Vehicle

Name of facility? _____ Xrays/CT/MRI/other testing imaging?_____

SECTION III YOUR ATTORNEY INFORMATION

NAME OF YOUR ATTORNEY _____

ATTORNEY'S ADDRESS _____

ATTORNEY'S PHONE # _____

Party Responsibility

If you were involved in an auto accident and are the owner of the vehicle, we will bill the medical portion of your own automobile insurance policy. If you were a passenger in someone else's car, we will bill the driver's auto insurance company on your behalf.

Insurance Rates

It is important to remember that when a medical claim is submitted to the" Medical payments" portions of your insurance policy. Your standing with the insurance company should not be affected, and your rates should not normally be increased, unless the accident is determined to be your fault.

Billing Other Insurance Policies

It is also to your advantage for our office to bill your own health insurance policy and or automobile medical policy for your medical bills, providing your policy does not state otherwise. Any money received above and beyond your total bill in the office will be refunded to you.

Injury Case Proceeds

Should you choose to utilize your health insurance on an injury case, we are still entitled to receive full payment of our fees from any injury case proceeds over and above any health insurance payments.

Crosby Chiropractic & Acupuncture Centre
331 Jungermann Road
St. Peters, MO 63376
Telephone (636) 928-5588 Fax (636) 922-0071

Re: Medical Reports and Medical Provider's Lien

I hereby authorize **Jenny L. Wiemann, D.C., P.C. d/b/a Crosby Chiropractic Centre,** as my medical provider, to furnish to you, my attorney, a full report of my examinations, treatment, prognosis, etc., with regard to the accident in which I was involved.

I hereby authorize, irrevocably instruct, and direct you, my attorney, to pay directly to said medical provider, such sums as may be due and owing him or her for medical or chiropractic services rendered to me both by reason of this accident and by reason of any other bills that are due his or her office relating thereto, and to withhold such sums from any settlement, judgement or verdict as may be necessary to adequately protect said medical provider a lien on my case, against andy and all proceeds of my settlement, judgement or verdict which may be paid to you, my attorney, or myself as the result of the injuries for which I have been treated or injuries in connection herewith.

I fully understand that I am directly and fully responsible to said medical provider for all medical or chiropractic bills or the like, submitted by him/her for services rendered to me and that this agreement is made solely for said medical provider's additional protection and in consideration of his/her waiting for payment. I further understand that such payment is not contingent on any settlement, judgement or verdict by which I may eventually recover said fee and that if I do not recover any sums to pay the medical provider, I am solely responsible for the bills relating to my treatment.

I hereby agree to pay the attorney's fees and court costs incurred by medical provider as a result of my failure to pay medical provider in full. In addition, I hereby agree to pay interest in the amount of 1% per month upon the outstanding balance owed to the medical provider.

Patient's Signature _____ **Date:** _____
Patient's Address:_____ **City:**_____ **State:**_____ **Zip:**_____

Lien Amount: $_____ **Date of Accident:** ___/___/20__

Liability Party Name: _____

Liability Party Insurance: _____

The undersigned, being attorney of record for the above patient, does hereby agree to observe all the terms of the above and agree to follow my clients\'s irrevocable escrow instructions herein, to withhold such sums from any settlement, judgement or verdict as may be necessary to adequately protect said medical provider above named.

Attorney's Signature: _____ **Date:** _____/_____/20___

Please sign date and return one copy to medical provider's office. Keep one copy for your records.

Crosby Chiropractic & Acupuncture Centre
331 Jungermann Road
St. Peters, MO 63376
Telephone (636) 928-5588 Fax (636) 922-0071

I, the undersigned, hereby nominate and appoint as my attorney-in-fact for the specific purpose as set forth here-in **Jenny L. Wiemann, D.C., P.C. d/b/a Crosby Chiropractic Centre**.

I authorize and direct my appointed attorney-in-fact, the above named provider, to make in my behalf any and all claims against my insurance carrier and/or my attorney, for any sum or sums that may be due and owing to me as a result of any policy of insurance wherein I am the beneficiary.

That the aforesaid attorney-in-fact shall have the power of attorney to institute claims in my name individually, and the name of my attorney-in-fact named herein, to recover any sums that may be owed to me as a result of coverage with my insurance company under Medical Pay or any other benefit for services rendered to me, or to my dependents as a result of an accident or illness, and to make said claim for the total of said bills as they come due from the aforesaid insurance company, and to make demand upon the insurance company for payment directly to my power of attorney for the joint benefit of my power of attorney, and me or at his election, to make claim for the payments directly to the provider listed above.

I further authorize my power of attorney named herein to withhold such sums from any disability_benefits, includingmedical payment benefits, no-fault benefits, health and accident benefits, or any other insurance benefits obligated to reimburse the undersigned or from any settlement, judgment, or verdict, on my behalf as may be necessary to adequately provide for any financial obligation owed to my attorney-in-fact for services rendered by him individually or by his office, directly to me. It is my understanding that this document assigns directly to my attorney in-fact, the powers to collect all sums due said attorney-in-fact as a result of treatment to me the same as if I myself, were making such claims.

I agree that the above-mentioned office be given full power of attorney to endorse/sign my name on any and all checks for payment of any indebtedness owed the provider listed above and assignee, including the use of my credit card for the payment of benefits that are paid to me, that are owed to the provider listed above and my past due account, if thirty (30) days old; also my accident account if past three (3) months old that is owed to the provider listed above.

The provider listed above, my attorney-in-fact named herein, is additionally assigned the right to commence any action, whether at law or in equity, for enforcement of any right or collection of any sums assigned hereby, or hereby, including the right to seek any available statutory remedies or penalties for non–payment against the insurer, including the right to file a lawsuit in the name of the undersigned or in its own name, individually, in the name of my attorney-in-fact named herein and the undersigned together or separately, at my attorney-in-fact's discretion.

It is understood and agreed that this assignment shall neither release nor extinguish the undersigned's responsibility for full payment of the aforesaid chiropractic services, which shall be payable to the provider listed above, to the extent such sums are not paid by the insurance company and/or the attorney. I understand that these fees are not negotiable since they are not payable at the time of service, but held as a courtesy.

I further understand and agree that if I file a claim against my personal health insurance plan for the physician's medical services for injuries arising out of an automobile accident, and my insurance plan discounts the physician's regular fee and will only pay the discounted fee, I will allow the physician to bill me for the difference between the physician's regular fee and the discounted fee, or the fee allowed by the insurance carrier. This sum, will be remitted from the monies recovered by settlement, judgment or verdict.

Dated: _____

Patient's Signature: _____

Patient Name:_____

Patient's Address: _____

City/St/ Zip:_____

Date of Accident (If Applicable): _____

Symptoms

Patient:_____ **Date:**_____

Please fill in all symptoms you currently have <u>that you did not have</u> before the accident.

Date of Accident:

Orthopedic & Musculoskeletal Symptoms

- ☐ "Clunk" Sound with Neck Movements
- ☐ Neck Pain
- ☐ Upper Back Pain
- ☐ Low Back Pain
- ☐ Shoulder Pain ☐ Left ☐ Right
- ☐ Upper Arm Pain ☐ Left ☐ Right
- ☐ Elbow Pain ☐ Left ☐ Right
- ☐ Forearm Pain ☐ Left ☐ Right
- ☐ Wrist Pain ☐ Left ☐ Right
- ☐ Hand Pain ☐ Left ☐ Right
- ☐ Hip Pain ☐ Left ☐ Right
- ☐ Upper Leg Pain ☐ Left ☐ Right
- ☐ Knee Pain ☐ Left ☐ Right
- ☐ Lower Leg Pain ☐ Left ☐ Right
- ☐ Ankle Pain ☐ Left ☐ Right
- ☐ Foot Pain ☐ Left ☐ Right
- ☐ Jaw Pain
- ☐ Clicking in Jaw
- ☐ Pain when Chewing
- ☐ Face Pain
- ☐ Chest Pain
- ☐ Stomach Pain
- ☐ Bruise/Contusion to
- ☐ Abrasion/Scrape to
- ☐ Other Symptom
- ☐ Other Symptom

Neurological Symptoms

- ☐ Numb/Tingling Arm / Hand L R
- ☐ Numb/Tingling Leg / Foot L R
- ☐ Weakness Arm / Hand L R
- ☐ Weakness Leg / Foot L R

Symptoms Associated with Injuries

- ☐ Range of Motion Problems
- ☐ Headaches
- ☐ Muscle Spasms
- ☐ Dizziness
- ☐ Visual Disturbances
- ☐ Sleep Disruption
- ☐ Radiating Pain
- ☐ Anxiety
- ☐ Depression
- ☐ I am taking over-the-counter pain meds

Brain/Neuropsych/MTBI Symptoms

- ☐ Wanting to be Alone
- ☐ Sleepiness
- ☐ Nausea/vomiting
- ☐ Difficulty Concentrating
- ☐ Day Dreaming/Staring Mindless Staring
- ☐ Mood Swings
- ☐ Agitation
- ☐ Sadness or tearful
- ☐ Blurry Vision
- ☐ Double Vision
- ☐ Disoriented
- ☐ Confused
- ☐ Difficulty Speaking
- ☐ Feelings of Isolation from Others
- ☐ Attention Problems
- ☐ Appetite Change
- ☐ Pupils Different Sizes
- ☐ Room Spins/ Woozy Feeling
- ☐ Balance Problems
- ☐ Difficulty Walking
- ☐ Difficulty Focusing/Easily Distracted
- ☐ Very Tired
- ☐ Dozing During The Day
- ☐ Personality Change
- ☐ Can't Remember Numbers
- ☐ Reading Problems
- ☐ Writing Problems
- ☐ Difficulty with Adding/Subtracting
- ☐ Poor Attention
- ☐ Difficulty Learning New Things
- ☐ Difficulty Understanding
- ☐ Difficulty Remembering Things
- ☐ Re-reading Things to Understand It
- ☐ Anger
- ☐ Difficulty Making Decisions
- ☐ Change in Sexual Functioning
- ☐ Reduced Confidence
- ☐ Helplessness
- ☐ Apathy (Don't Care)
- ☐ Irritable
- ☐ Change in Sense of Taste or Smell
- ☐ Flashbacks to Accident
- ☐ Impatience
- ☐ Frustration
- ☐ Hearing Problems
- ☐ Difficulty Planning or Organizing

NEW PATIENT INSTRUCTIONS

Thank you for your confidence in our office. You have placed your health problems in the hands of Crosby Chiropractic and Acupuncture. Please read and follow these instructions:

- Explain every change in your symptoms to the Doctor.
- **Plan your schedule so that you will be able to keep your appointments. This is extremely important in your treatment plan.**
- After your first treatment, you may notice some soreness. This is to be expected. We are making changes to your spine and the body needs to adapt to these changes.
- Do NOT take your neighbors' and friends' advice for a "quick cure." Their suggestions cost you nothing and usually worth just that.
- Don't become discouraged if you see little improvement at the beginning of your treatment.
    - Some patients respond faster than others and your doctor will be honest with you about what you can anticipate.
- Don't use home remedies of self medications without informing your doctor.
- As you begin to feel better, share your joy with friends. The highest compliment the Doctor can receive is a referral from you.
- Read the Chiropractic literature you are given. It will help you understand your recovery process and you will be able to help friends determine whether or not chiropractic care can be advised for them.
- During your treatment, your doctor may give you some at home therapeutic exercises. These are an integral part of your treatment program and you should do them as instructed. Failure to do so can slow down your healing and may jeopardize your ultimate healing.
- Following your release, it is recommended that you schedule periodic appointments for a spinal check-up. It is wise to make sure your spine and nervous system are properly aligned.
- Do bring your children in for spinal check-ups. Many spinal conditions are hereditary and when detected early, can result in no problems later in life.
- Resist the urge to "pop" your own spine or allow your friends to "crack your back." You are paying for the expertise and knowledge of the doctor. You deserve no less for yourself. Let her locate the problem and make the proper corrections.
- Regardless of your health problems or concerns, consult with your doctor first. If the problem is not a chiropractic one, they will refer you to the correct health care provider for your concerns.
- If you have any questions, please do not hesitate to discuss them with your doctor.

The Doctors and Staff at Crosby Chiropractic & Acupuncture Centre
331 Jungermann Rd, St Peters, MO 63376
(636)928-5588
www.crosbychiropractic.com

The Rivermead Post-Concussion Symptoms Questionnaire*

Patient _____ DOI: _____ Today's Date: _____

After a head injury or accident some people experience symptoms which can cause worry or nuisance. We would like to know if you now suffer any of the symptoms given below. As many of these symptoms occur normally, we would like you to *compare yourself now with before the accident*. For each one please circle the number closest to your answer.

0=Not experienced at all
1=no more of a problem now than before the accident
2=a mild problem now
3=a moderate problem now
4=a severe problem now

Compared with before the accident, do you now (i.e. over the last 24 hours) suffer from:

Headaches	0	1	2	3	4
Feelings of dizziness	0	1	2	3	4
Nausea and/or vomiting	0	1	2	3	4
Noise sensitivity, or easily upset by loud noise	0	1	2	3	4
Sleep disturbance	0	1	2	3	4
Fatigue, tiring more easily	0	1	2	3	4
Being irritable, easily angered	0	1	2	3	4
Feeling depressed or tearful	0	1	2	3	4
Feeling frustrated or impatient	0	1	2	3	4
Forgetfulness, poor memory	0	1	2	3	4
Poor Concentration	0	1	2	3	4
Taking longer to think	0	1	2	3	4
Blurred Vision	0	1	2	3	4
Light sensitivity, or easily upset or irritated by bright light	0	1	2	3	4
Double Vision	0	1	2	3	4
Restlessness	0	1	2	3	4

Are you experiencing any other difficulties?
Please specify, and rate as above.

1_____	0	1	2	3	4
2._____	0	1	2	3	4

*King, N., Crawford S., Wenden F., Moss, N., and Wade, D. (1995) J. Neurology 242: 587-592

THE EPWORTH SLEEPINESS SCALE

Patient:_____
DOI: _____ Today's Date:_____

How likely are you to doze off or fall asleep in the following situations, in contrast to feeling just tired? This refers to your usual way of life in recent times. Even if you have not done some of these things recently try to work out how they would have affected you. Use the following scale to choose the most appropriate number for each situation:

0 = no chance of dozing
1 = slight chance of dozing
2 = moderate chance of dozing
3 = high chance of dozing

Situation	Chance of Dozing
Sitting and reading	_____
Watching TV	_____
Sitting inactive in a public place (e.g. a theater or a meeting)	_____
As a passenger in a car for an hour without a break	_____
Lying down to rest in the afternoon when circumstances permit	_____
Sitting and talking to someone	_____
Sitting quietly after a lunch without alcohol	_____
In a car, while stopped for a few minutes in traffic	_____

Modified Oswestry Low Back Pain Disability Questionnaire

Patient Name: _____ **Date:** _____

Please Read:

This questionnaire has been designed to give your doctor/therapist 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 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

0 I can tolerate the pain I have without having to use pain medication.
1 The pain is bad but I manage without having to take pain medication.
2 Pain medication provides me complete relief from pain.
3 Pain medication provides me moderate relief from pain.
4 Pain medication provides me little relief from pain.
5 Pain medication has no effect on the pain

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

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

Section 3 – Lifting

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

Section 4 - Walking

0 Pain does not prevent me walking any distance.
1 Pain prevents me walking more than 1 mile.
2 Pain prevents me walking more than ½ mile
3 Pain prevents me walking more than ¼ mile
4 I can only walk using crutches or a cane.
5 I am in bed most of the time and have to crawl to the toilet.

Section 5 - Sitting

0 I can it 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 sitting more than 1 hour.
3 Pain prevents me from sitting more than ½ hour.
4 Pain prevents me from sitting more than 10 mins.
5 Pain prevents me from sitting at all.

Score _____ (50) **Benchmark -5=_____**

Section 6 – Standing

0 I can stand as long as I want without increased pain.
1 I can stand as long as I want but increases my pain.
2 Pain prevents me from standing for more than 1 hour.
3 Pain prevents me from standing for more than ½ hour.
4 Pain prevents me from standing for more than 10 mins.
5 Pain prevents me from standing at all.

Section 7 – Sleeping

0 Pain does not prevent me from sleeping well.
1 I can sleep well only by using pain medication.
2 Even when I take pain medication, I sleep less than 6 hours.
3 Even when I take pain medication, I sleep less than 4 hours.
4 Even when I take pain medication, I sleep less than 2 hours.
5 Pain prevents me from sleeping at all

Section 8 – Social Life

0 My social life is normal and does not increase my pain.
1 My social life is normal, but it increases my level of pain.
2 Pain prevents me from participating in more energetic activities (ex sports, dancing, etc.
3 Pain prevents me from going out very often.
4 Pain has restricted my social life to my home.
5 I have hardly any social life because of my pain.

Section 9 – Traveling

0 I can travel anywhere without increased pain.
1 I can travel anywhere but it increases my pain.
2 Pain restricts travel over 2 hours.
3 Pain restricts travel over 1 hour.
4 Pain restricts my travel to short necessary journeys under ½ hour.
5 Pain prevents all travel except for visits to the doctor/therapist or hospital.

Section 10 – Employment/Homemaking

0 My normal homemaking/job activities do not cause pain.
1 My normal homemaking/job activities increase my pain, but I can still perform all that is required of me.
2 I can perform most of my homemaking/job duties, but pain prevents me from performing more physically stressful activities (ex. Lifting, vacuuming).
3 Pain prevents me from doing anything but light duties.
4 Pain prevents me from doing even light duties.
5 Pain prevents me from performing any job/homemaking chores.

CROSBY CHIROPRACTIC & ACUPUNCTURE CENTRE

Patient Name: _____Date: _____

OSWESTRY NECK DISABILITY INDEX

SECTION 1: Pain Intensity

A. 0 I have no pain at the moment.
B. 1 The pain is mild at the moment.
C. 2 The pain comes & goes & is moderate
D. 3 The pain is moderate & does not vary much.
E. 4 The pain is severe but comes & goes.
F. 5 The pain is severe & does not vary much.

SECTION 2: Personal Care (Washing, Dressing etc.)

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

SECTION 3: Lifting

A. 0 I can lift heavy weights without extra pain.
B. 1 I can lift heavy weights, but it causes extra pain.
C. 2 Pain prevents me from lifing heavy weights off the floor, but I can if they are conveniently positioned, for example on a table.
D. 3 Pain prevents me from lifting heavy weights, but I can manage light to medium weights if they are conveniently positioned.
E. 4 I can only lift very light weights.
F. 5 I cannot lift or carry anything at all.

SECTION 4: Reading

A. 0 I can read as much as I want to with no pain in my neck.
B. 1 I can read as much as I want with slight pain in my neck.
C. 2 I can read as much as I want with moderate pain in my neck.
D. 3 I cannot read as much as I want because of moderate pain in my neck.
E. 4 I cannot read as much as I want because of severe pain in my neck.
F. 5 I can not read at all because of neck pain.

SECTION 5: Headache

A. 0 I have no headaches at all.
B. 1 I have slight headaches that come infrequently.
C. 2 I have moderate headaches that come in-frequently.
D. 3 I have moderate headaches that come frequently.
E. 4 I have severe headaches that come frequently.
F. 5 I have headaches almost all the time.

Score _____ (50) Benchmark -5=_____

SECTION 6: Concentration

A. 0 I can concentrate fully when I want to with no difficulty.
B. 1 I can concentrate fully when I want to with slight difficulty.
C. 2 I have a fair degree of difficulty in concentrating when I want to.
D. 3 I have a lot of difficulty in concentrating when I want to.
E. 4 I have a great deal of difficulty in concentrating when I want to.
F. 5 I cannot concentrate at all.

SECTION 7: Work

A. 0 I can do as much work as I want to.
B. 1 I can only do my usual work but no more.
C. 2 I can don most of my usual work but no more.
D. 3 I cannot do my usual work.
E. 4 I can hardly do any work at all.
F. 5 I cannot do any work at all.

SECTION 8: Driving

A. 0 I can drive my car without neck pain.
B. 1 I can drive my car as long as I want with slight pain in my neck.
C. 2 I can drive my car as long as I want with moderate pain in my neck.
D. 3 I cannot drive my car as long as I want because of moderate pain in my neck.
E. 4 I can hardly drive my car at all because of severe pain in my neck.
F. 5 I cannot drive my car at all.

SECTION 9: Sleeping

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

SECTION 10: Recreation

A. 0 I am able to engage in all recreational activities with no pain in my neck at all.
B. 1 A am able to engage in all recreational activities with some pain in my neck.
C. 2 I am able to engage in most, but not all, recreational activities because of pain in myneck.
D. 3 I am able to engage in only a few of my usual recreational activities because of pain in my neck.
E. 4 I can hardly do any recreational activiites because of pain in my neck.
F. 5 I cannot do any recreational activities at all.

Revise Date 11/20/2019

These Forms are Doctors Discretion based on Post-Concussive Needs:

Pittsburg

ACE

Assessment of Reaction to a Stressful Car Accident

Name_____ Date_____

Sleep Quality Assessment (PSQI)

What is PSQI, and what is it measuring?

The Pittsburgh Sleep Quality Index (PSQI) is an effective instrument used to measure the quality and patterns of sleep in adults. It differentiates "poor" from "good" sleep quality by measuring seven areas (components): subjective sleep quality, sleep latency, sleep duration, habitual sleep efficiency, sleep disturbances, use of sleeping medications, and daytime dysfunction over the last month.

INSTRUCTIONS:

The following questions relate to your usual sleep habits during the past month only. Your answers should indicate the most accurate reply for the majority of days and nights in the past month. Please answer all questions.

During the past month,

1. When have you usually gone to bed? _____
2. How long (in minutes) has it taken you to fall asleep each night? _____
3. What time have you usually gotten up in the morning? _____
4. A. How many hours of actual sleep did you get at night? _____
   B. How many hours were you in bed? _____

5. During the past month, how often have you had trouble sleeping because you	Not during the past month (0)	Less than once a week (1)	Once or twice a week (2)	Three or more times a week (3)
A. Cannot get to sleep within 30 minutes				
B. Wake up in the middle of the night or early morning				
C. Have to get up to use the bathroom				
D. Cannot breathe comfortably				
E. Cough or snore loudly				
F. Feel too cold				
G. Feel too hot				
H. Have bad dreams				
I. Have pain				
J. Other reason (s), please describe, including how often you have had trouble sleeping because of this reason (s):				
6. During the past month, how often have you taken medicine (prescribed or "over the counter") to help you sleep?				
7. During the past month, how often have you had trouble staying awake while driving, eating meals, or engaging in social activity?				
8. During the past month, how much of a problem has it been for you to keep up enthusiasm to get things done?				
9. During the past month, how would you rate your sleep quality overall?	Very good (0)	Fairly good (1)	Fairly bad (2)	Very bad (3)

Scoring

Component 1	#9 Score	C1 _____
Component 2	#2 Score (<15min (0), 16-30min (1), 31-60 min (2), >60min (3)) + #5a Score (if sum is equal 0=0; 1-2=1; 3-4=2; 5-6=3)	C2 _____
Component 3	#4 Score (>7(0), 6-7 (1), 5-6 (2), <5 (3)	C3 _____
Component 4	(total # of hours asleep) / (total # of hours in bed) x 100 >85%=0, 75%-84%=!, 65%-74%=2, <65%=3	C4 _____
Component 5	# sum of scores 5b to 5j (0=0; 1-9=1; 10-18=2; 19-27=3)	C5 _____
Component 6	#6 Score	C6 _____
Component 7	#7 Score + #8 score (0=0; 1-2=1; 3-4=2; 5-6=3)	C7 _____

Add the seven component scores together _____ ***Global PSQI*** _____

A total score of "5" or greater is indicative of poor sleep quality.
If you scored "5" or more it is suggested that you discuss your sleep habits with a healthcare provider

Assessment of Reactions to a Stressful Car Accident

Name _____ Date of Injury _____ Date Today _____

INSTRUCTIONS: Below is a list of problems and complaints that people sometimes have in response to stressful life experiences. Please read each one carefully, then circle one of the numbers to the right to indicate how much you have been bothered by that problem in the past month.

		Not at all	A little bit	Moderately	Quite a bit	Extremely
1.	Repeated, disturbing *memories, thoughts,* or *images* of a stressful experience from the past?	1	2	3	4	5
2.	Repeated, disturbing *dreams* of a stressful experience from the past?	1	2	3	4	5
3.	Suddenly *acting* or *feeling* as if a stressful experience *were happening again* (as if you were reliving it)?	1	2	3	4	5
4.	Feeling *very upset* when *something reminded you* of a stressful experience from the past?	1	2	3	4	5
5.	Having *physical reactions* (e.g., heart pounding, trouble breathing, sweating) when *something reminded you* of a stressful experience from the past?	1	2	3	4	5
6.	Avoiding *thinking about* or *talking about* a stressful experience from the past or avoiding *having feelings* related to it?	1	2	3	4	5
7.	Avoiding *activities* or *situations* because *they reminded you* of a stressful experience from the past?	1	2	3	4	5
8.	Trouble *remembering important parts* of a stressful experience from the past?	1	2	3	4	5
9.	*Loss of interest* in activities that you used to enjoy?	1	2	3	4	5
10.	Feeling *distant* or *cut off* from other people?	1	2	3	4	5
11.	Feeling *emotionally numb* or being unable to have loving feelings for those close to you?	1	2	3	4	5
12.	Feeling as if your *future* will somehow be *cut short*?	1	2	3	4	5
13.	Trouble *falling* or *staying asleep*?	1	2	3	4	5
14.	Feeling *irritable* or having *angry outbursts*?	1	2	3	4	5
15.	Having *difficulty concentrating*?	1	2	3	4	5
16.	Being "*super-alert*" or watchful or on guard?	1	2	3	4	5
17.	Feeling *jumpy* or easily startled?	1	2	3	4	5