## CHECKLIST FOR WORKER'S COMPENSATION PACKET

(REQUIRED DOCUMENTATION)

_____ **1. WC NP Packet** (Plus copies of DL and Ins Cards)

_____ **2. PERMISSION TO TREAT FROM EMPLOYER/ATTORNEY**

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

_____ **4. EMPLOYER INFORMATION** (Person's Name, WC Insurance Co Name & Claim#)

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

_____ **6. ACCIDENT DESCRIPTION** (Available 10 days after accident)

_____ **7. Signed Lien** (Must be sent to pts attorney)

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

**Patient Name:** _____ **Date:** _____

**DOB:** _____ **SSN:**_____ **Patient ID:** _____

**Address:** _____ **City:** _____**State:** _____ **Zip:** _____

**Home Phone:** _____**Cell Phone:** _____**Email Address:** _____

## PLEASE PROVIDE US WITH YOUR CURRENT AUTO INSURANCE CARD, HEALTH INSURANCE CARD, DRIVERS LICENSE AND A COPY OF THE POLICE REPORT **(If available).**

**IF YOU ARE NOT CURRENTLY ABLE TO OBTAIN EMPLOYER AUTHORIZATION FOR CARE AND DO NOT HAVE AN ATTORNEY OR HEALTH INSURANCE, ASK ABOUT CHIROHEALTH USA ( A $49 A YEAR DISCOUNT PLAN), CARE CREDIT OR OUR IN-HOUSE AUTOPAY PROGRAMS.**

**Nickname:** (preferred to be called) _____

**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 $30 that I must pay to Crosby Chiropractic and Acupuncture Centre at the time of service.

**Acknowledgement of receipt of Notice of Privacy Practices:**

We are required to provide you with a copy of our Notice of Privacy Practices, which states how we may use and/or disclose your health information. Signing this form is your acknowledgement that you received and had the opportunity to review the notice and that you understand your rights with respect to your protected health information as defined by Crosby Chiropractic & Acupuncture Centre.

I consent and state my preference to have my physician], and other staff 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. Once you have been dismissed from care for which a third party may be responsible, we allow up to three months (90 days) for you to reach a settlement and pay all medical expenses in our office. If a settlement is not made within the time allowed, you will be billed and payment will be expected immediately.

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

Patient, parent or guardian

**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, x-rays, 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).

**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 Crosby 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 $30, 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:** _____

**SECTION I YOUR WORK COMP INSURANCE**

**INSURANCE NAME** _____

ADDRESS _____

PHONE # _____

NAME ON POLICY _____

POLICY # _____

CLAIM # _____ADJUSTOR _____

**SECTION II HEALTH INSURANCE**

**INSURANCE** _____

ADDRESS _____

PHONE # _____

NAME ON POLICY _____

POLICY # _____

CLAIM # _____ADJUSTOR _____

**SECTION III YOUR ATTORNEY INFORMATION**

NAME OF YOUR ATTORNEY _____

ATTORNEY'S ADDRESS _____

ATTORNEY'S PHONE # _____

**Party Responsibility**

If you were have employer authorization to treat, we will bill the medical portion to the worker's compensation insurance company on your behalf.

**Insurance Rates**

Your standing with the insurance company should be full coverage, unless the accident is determined to be your fault and is not considered a worker's compensation case.

**Billing Other Insurance Policies**

In the event the injury is determined not to be a worker's compensation case, we will bill your health insurance policy and you may incur a bill for deductibles/copays/co-insurance.

**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

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:

**PAST MEDICAL HISTORY**

Do you now or have you ever had:

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

## SYSTEMS REVIEW

**In the past month, have you had any of the following problems?**

**GENERAL**
- ❑ Loss/gain of weight
- ❑ Low back pain
- ❑ Fatigue
- ❑ Weakness
- ❑ Polio/Rheumatic Fever/Scarlet fever
- ❑ Night sweats

**MUSCLE/JOINTS/BONES**
- ❑ Numbness
- ❑ Joint pain/numbness
- ❑ Muscle weakness
- ❑ Joint swelling

Where?

**EARS**
- ❑ Ringing in ears/Ear pain
- ❑ Loss of hearing

**EYES**
- ❑ Pain
- ❑ Redness
- ❑ Loss of vision
- ❑ Double or blurred vision
- ❑ Dryness

**THROAT**
- ❑ Frequent sore throats
- ❑ Hoarseness
- ❑ Difficulty in swallowing
- ❑ Pain in jaw

**HEART AND LUNGS**
- ❑ Chest pain
- ❑ Palpitations
- ❑ Shortness of breath
- ❑ Asthma/Bronchitis/wheezing
- ❑ Swollen legs or feet
- ❑ Cough (chronic)

**NERVOUS SYSTEM**
- ❑ Headaches
- ❑ Dizziness
- ❑ Fainting or loss of consciousness
- ❑ Numbness or tingling
- ❑ Memory loss
- ❑ Multiple sclerosis

**STOMACH AND INTESTINES**
- ❑ Nausea/vomiting
- ❑ Heartburn/GERD
- ❑ Stomach pain/abdominal pain
- ❑ Gas/belching/difficult digestion
- ❑ Liver trouble/jaundice
- ❑ Increasing constipation
- ❑ Persistent diarrhea/colitis
- ❑ Blood in stools/black stools
- ❑ Ulcers
- ❑ Hemorrhoids

**SKIN**
- ❑ Redness/rash
- ❑ Bruise easily
- ❑ Nodules/bumps/sores
- ❑ Hair loss
- ❑ Color changes of hands or feet

**BLOOD**
- ❑ Anemia
- ❑ Clots/phlebitis
- ❑ Poor circulation/Reynauds

**KIDNEY/URINE/BLADDER**
- ❑ Frequent or painful urination
- ❑ Blood in urine
- ❑ Bed wetting
- ❑ Urinary tract infection
- ❑ Nighttime urination
- ❑ PMS

**CHIROPRACTIC**
- ❑ Headaches
- ❑ Excessive worries
- ❑ Difficulty falling asleep
- ❑ Difficulty staying asleep
- ❑ Difficulties with sexual arousal
- ❑ Poor appetite
- ❑ Food cravings
- ❑ Muscle or Ligament Tears
- ❑ Neck Pain/Stiffness
- ❑ Pain between shoulder blades
- ❑ Pain with coughing/sneezing
- ❑ Pain on swallowing
- ❑ Poor concentration
- ❑ Arthritis/Bursitis
- ❑ Sciatica
- ❑ Jaw pain/TMJ issues
- ❑ Foot issues
- ❑ Hernia
- ❑ Mood swings
- ❑ Anxiety/Nervousness
- ❑ Sinus issues
- ❑ Depression
- ❑ Irritability/Stress

**OTHER PROBLEMS:**
- ❑ get sick easily
- ❑ loss of smell
- ❑ no appetite
- ❑ gall bladder troubles

**Women Only:**
- ❑ Abnormal Pap smear
- ❑ Irregular periods
- ❑ Bleeding between periods
- ❑ PMS
- ❑ Excess flow/vaginal discharge

**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 settlememt, 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.

*Revised Date 05/06/16*

**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, including medical 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's Address: _____

City/St/ Zip: _____

Date of Accident (If Applicable): _____

*Revised Date 05/06/16*

# Symptoms

**Patient:** _____ **Date:**_____ **Date of Injury:** _____

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

**<u>Orthopedic & Musculoskeletal Symptoms</u>**

- ☐ "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

**<u>Neurological Symptoms</u>**

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

**<u>Symptoms Associated with Injuries</u>**

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

**<u>Brain/Neuropsych/MTBI Symptoms</u>**

- ☐ 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

# 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 | _____ |

**REVISED OSWESTRY BACK PAIN DISABILITY QUESTIONNAIRE**

**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**

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

**Personal Care**

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

**Lifting**

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

**Walking**

- o Pain does not prevent me from walking any distance.
- o Pain prevents me from walking more than 1 mile.
- o Pain prevents me from walking more than 1/2 mile.
- o Pain prevents me from walking more than 1/4 mile.
- o I can only walk using a stick or crutches.
- o I am in bed most of the time and have to crawl to the toilet.

**Sitting**

- o I can sit in any chair as long as I like without pain.
- o I can only sit in my favorite chair as long as I like.
- o Pain prevents me from sitting more than 1 hour.
- o Pain prevents me from sitting more than 1/2 hour.
- o Pain prevents me from sitting more than 10 minutes.
- o Pain prevents me from sitting at all.

**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 1/2 hour without increasing pain.
- I cannot stand for longer than 10 minutes without increasing pain.
- Pain prevents me from standing at all.

**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.

**Social Life**

- My social life is normal and gives me no pain.
- My social life is normal but increases the degree of my pain.
- Pain has no significant effect on my social life apart from limiting my more energetic interests, eg, dancing, etc.
- Pain has restricted my social life and I do not go out very often.
- Pain has restricted my social life to my home.
- I have hardly any social life because of the pain.

**Traveling**

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

**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 or worse.
- My pain is gradually worsening.
- My pain is rapidly worsening.

| Back Index Score |
| --- |
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**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.

*Revised Date 05/06/16*