

PERSONAL INJURY INTRODUCTION FORM

Today's Date: _____

First Name:	MI:	Last Name:
Home Address:		City: State: Zip:
Date of Birth: Age:		Home Telephone:
Height: Weight:		Work Telephone:
Social Security No:		Employer's Name:
Drivers License No:		Marital Status (Circle): Single, Married, Divorced, Widowed

Please list the name, address, relationship and telephone number of your nearest adult relative (for emergency use only).

AUTOMOBILE INSURANCE INFORMATION

Does anyone have insurance coverage for the vehicle you were in?	<input type="checkbox"/> I do <input type="checkbox"/> someone else has coverage. Indicate name of person policy is under:
How is this person related to you?	<input type="checkbox"/> Self <input type="checkbox"/> Parent <input type="checkbox"/> Spouse <input type="checkbox"/> Other:
Your automobile insurance carrier:	
Your automobile insurance carrier's address:	
Claim adjuster's name:	
Claim adjuster's telephone number:	
Claim number:	
Do you have an insurance deductible?	<input type="checkbox"/> Yes <input type="checkbox"/> No Deductible: \$
Do you know your Policy Limits for medical bills?	<input type="checkbox"/> Yes <input type="checkbox"/> No Limit: \$
Did you report this injury to your insurance carrier?	<input type="checkbox"/> Yes <input type="checkbox"/> No

Our office will provide insurance billing services for you, if you so desire, as a courtesy. *Remember that you are ultimately responsible for any charges incurred in this office. It is your responsibility to pay any deductible amount, co-insurance, and or any other balances not paid by your insurance carrier. Your signature on this document indicates that you agree to pay Douglas F. Cancel, D.C. for all charges incurred in this office.*

It is essential that if your insurance carrier sends you forms that need to be signed for authorization for records that you sign these documents and send the completed forms back to the carrier as soon as possible.

Do you have an attorney representing you?	Attorney's name: _____
<input type="checkbox"/> Yes, <input type="checkbox"/> No If yes, indicate name and address:	Address: _____
	Telephone: _____

Signature of responsible party (Patient or Parent) _____ **Date** _____

MOTOR VEHICLE CRASH FORM

Patient's Name: _____ Date: _____
 Date of injury: _____ Time of injury _____ AM PM
 City where crash occurred: _____ Was the street wet or dry? Wet Dry
 Street (location) where crash occurred: _____
 What is the estimated damage to your vehicle? \$ _____
 Who made damage estimates on your vehicle? _____
 Who owns the vehicle you were involved in: _____
 Yes No Did the police come to the accident scene?
 Yes No Did the police make a written report?
 Yes No Were photographs taken of your vehicle? If yes, who took them: _____

DESCRIBE HOW THE CRASH HAPPENED

COLLISION DESCRIPTION-TYPE

Check all that apply to you. Indicate which type of vehicle crash you were involved in.

<input type="checkbox"/> Single-car crash	<input type="checkbox"/> Two-vehicle crash	<input type="checkbox"/> Three or more vehicles
<input type="checkbox"/> Rear-end crash	<input type="checkbox"/> Side crash	<input type="checkbox"/> Rollover
<input type="checkbox"/> Head-on crash	<input type="checkbox"/> Hit guard rail, tree, or object	<input type="checkbox"/> Ran off the road
<input type="checkbox"/> Other (Describe): _____		

INDICATE YOUR SEATING POSITION

<input type="checkbox"/> Driver	<input type="checkbox"/> Front passenger	<input type="checkbox"/> Left rear passenger	<input type="checkbox"/> Right rear passenger
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DESCRIBE THE VEHICLE YOU WERE IN

Model, Make, and Year: _____		
<input type="checkbox"/> Small-sized car	<input type="checkbox"/> Mid-sized car	<input type="checkbox"/> Large-sized car
<input type="checkbox"/> Pick-up truck	<input type="checkbox"/> Van	<input type="checkbox"/> Sport Utility Vehicle
<input type="checkbox"/> 2 Door vehicle	<input type="checkbox"/> 4 Door vehicle	<input type="checkbox"/> Large truck, bus, or semi-truck
<input type="checkbox"/> Sedan	<input type="checkbox"/> Hatchback	<input type="checkbox"/> Station wagon
<input type="checkbox"/> Other (Describe): _____		

DESCRIBE THE OTHER VEHICLE (If not certain, leave blank)

Model, Make and Year: _____		<input type="checkbox"/> Unknown
<input type="checkbox"/> Small passenger car	<input type="checkbox"/> Mid-sized passenger car	<input type="checkbox"/> Van
<input type="checkbox"/> Pick-up truck/sports utility	<input type="checkbox"/> Large-sized passenger car	<input type="checkbox"/> Large truck, bus, or semi-truck

MOTOR VEHICLE CRASH FORM

AT THE TIME OF IMPACT YOUR VEHICLE WAS:

<input type="checkbox"/> Slowing down	<input type="checkbox"/> Gaining speed
<input type="checkbox"/> Stopped	<input type="checkbox"/> Moving at steady speed

AT THE TIME OF IMPACT THE OTHER VEHICLE WAS:

<input type="checkbox"/> Slowing down	<input type="checkbox"/> Gaining Speed	<input type="checkbox"/> Unknown speed
<input type="checkbox"/> Stopped	<input type="checkbox"/> Moving at steady speed	<input type="checkbox"/> Other:

DURING AND AFTER THE CRASH, YOUR VEHICLE:

<input type="checkbox"/> Kept going straight, not hitting anything	<input type="checkbox"/> Spun around, not hitting anything
<input type="checkbox"/> Kept going straight, hitting car in front	<input type="checkbox"/> Spun around, hitting another car
<input type="checkbox"/> Was hit by another vehicle	<input type="checkbox"/> Spun around, hitting object other than car

INDICATE IF YOUR BODY HIT SOMETHING OR WAS HIT BY ANY OF THE FOLLOWING: (Please draw lines from the body regions on the left side and match to the right side.)

BODY REGION	OBJECT YOU HAD CONTACT WITH
Head	Windshield or side window
Face	Steering wheel
Shoulder	Side door
Arm/hand	Dashboard
Front chest wall	Knee bolster/glove compartment
Side chest wall	Seatbelt
Hip/abdomen	Frame of car near windows or doors
Knee	Roof of vehicle
Leg	Another occupant/animal
Foot	Other

CHECK IF ANY OF THE FOLLOWING VEHICLE PARTS BROKE, BENT, OR WERE DAMAGED IN YOUR CAR:

<input type="checkbox"/> Windshield	<input type="checkbox"/> Seat frame	<input type="checkbox"/> Knee bolster
<input type="checkbox"/> Steering wheel	<input type="checkbox"/> Side-rear window	<input type="checkbox"/> Other
<input type="checkbox"/> Dash	<input type="checkbox"/> Mirror	<input type="checkbox"/> Other

TYPE OF COLLISION (Indicate those relevant to your case.)

YES NO

<input type="checkbox"/>	<input type="checkbox"/>	Did any of the front or side structures, such as the side door, dashboard, or floorboard of your car dent inward during the crash?
<input type="checkbox"/>	<input type="checkbox"/>	Did the side door touch your body during the crash?
<input type="checkbox"/>	<input type="checkbox"/>	Did your body slide under the seatbelt?
<input type="checkbox"/>	<input type="checkbox"/>	Was the door(s) of your vehicle damaged to point where you could not open the door?
<input type="checkbox"/>	<input type="checkbox"/>	Did an airbag deploy in your vehicle during the crash? If yes, circle (side air bag/front air bag)
<input type="checkbox"/>	<input type="checkbox"/>	Were you intoxicated (alcohol) at the time of crash?

MOTOR VEHICLE CRASH FORM

SEATBELT USAGE AND STEERING WHEEL HAND PLACEMENT

YES NO

<input type="checkbox"/>	<input type="checkbox"/>	Were you wearing a seatbelt? If yes, does your seatbelt have <input type="checkbox"/> a Lap and Shoulder Strap, <input type="checkbox"/> a Lap belt only
<input type="checkbox"/>	<input type="checkbox"/>	Indicate if you had any portion of your seatbelt positioned behind your back or shoulder.
<input type="checkbox"/>	<input type="checkbox"/>	Were you holding onto the steering wheel (driver only) at the time of impact? If yes, indicate where each hand was positioned (Use a time clock face as your reference point) Left hand: <input type="checkbox"/> Not on wheel <input type="checkbox"/> Yes, hand at ____ o'clock, <input type="checkbox"/> Hand elsewhere Right hand: <input type="checkbox"/> Not on wheel <input type="checkbox"/> Yes, hand at ____ o'clock, <input type="checkbox"/> Hand elsewhere

REAR-END COLLISIONS ONLY (Please answer this section **only** if you were hit from the rear.)

Describe your vehicle's head restraint system:

- | | |
|--|--|
| <input type="checkbox"/> Movable/adjustable head restraint | <input type="checkbox"/> Fixed, non-moveable head restraint |
| <input type="checkbox"/> No headrests in my vehicle | <input type="checkbox"/> Bench seat in your vehicle without head restraint |

Please indicate how your head restraint was positioned at the time of crash (if present):

- | | |
|--|---|
| <input type="checkbox"/> At the top of the back of your head | <input type="checkbox"/> Midway height of the back of your head |
| <input type="checkbox"/> Lower height of the back of your head | <input type="checkbox"/> Located at the level of your neck |
| <input type="checkbox"/> Level of your shoulder blades | |

BRUISING AFTER THE CRASH

YES NO

<input type="checkbox"/>	<input type="checkbox"/>	Did your body have any bruising (areas that were visibly black and blue) after the crash? If yes, indicate where: _____
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CRASH AWARENESS AND YOUR BODY POSITION (Please check all areas that apply to you.)

<input type="checkbox"/>	You were unaware of the impending collision. You did not see or hear brakes prior to the impact.
<input type="checkbox"/>	You were aware of the impending crash and consciously relaxed your body before the collision.
<input type="checkbox"/>	You were aware of the impending crash and consciously tightened and braced yourself.
<input type="checkbox"/>	You were aware of the impending crash but did not consciously brace yourself.
<input type="checkbox"/>	Your body, torso, and head were facing straight ahead at the time of the crash.
<input type="checkbox"/>	You had your head and/or torso turned at the time of collision: <input type="checkbox"/> Turned to left, <input type="checkbox"/> Turned to right If yes, describe how far you were turned/twisted and why?
<input type="checkbox"/>	You were leaning forward at the time of impact, resulting in a gap between your body and the seatback. If yes, describe how far you were leaning forward and indicate why you were leaning forward:
<input type="checkbox"/>	Your torso and body were positioned normally against the seatback with no gaps due to leaning/twisting

PAST AND PRESENT GENERAL HEALTH HISTORY

GENERAL QUESTIONS (Please check only those that apply and indicate if you have had them in the past and/or are having them in the present.)

YES		PAST	PRESENT
<input type="checkbox"/>	I bruise easily	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	I heal slowly	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	My body temperature is normally low (feel cold)*	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	Smoke cigarettes or use tobacco products	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	Diabetic-Hypoglycemic or need to have dialysis.	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	Do you have a pacemaker or any other mechanical/electronic device in your body?	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	Heart Attack	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	Do you have difficulties or intolerance to heat packs or ice packs on your skin?	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	Dizziness, blacked out, or fainting spell history	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	Epilepsy-Seizure-Convulsion history	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	History of gout, lupus, psoriasis, temporary paralysis, or spinal meningitis	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	Cancer history or treatment of any type	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	Stroke history (Indicate any suspected strokes or transient ischemic attacks)	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	Told that you have scoliosis, spondylolisthesis, disc degeneration, or herniated disc	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	Told that you have spina bifida, abdominal aneurysm, or vascular conditions	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	Have you ever been hospitalized? Why:	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	Thyroid disorders	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	Coma from head injury or other problem	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	Told you have osteoporosis of your spine or osteopenia (weak bones)	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	Told you have osteoarthritis or rheumatoid arthritis of your spine or joints	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	Women only: Check this box if you currently have any type of breast implants	N/A	N/A
<input type="checkbox"/>	Women only: Check this box if there any chance that you are currently pregnant	N/A	N/A

PRIOR INJURY OR MUSCULOSKELETAL PAIN HISTORY

I do not have a previous history of painful injury or pain. If you do, please check below:

<input type="checkbox"/> Work Injury	<input type="checkbox"/> Fall	<input type="checkbox"/> Sports Injury	<input type="checkbox"/> Lifting Injury	<input type="checkbox"/> Car accident
<input type="checkbox"/> Motorcycle Injury	<input type="checkbox"/> Bicycle Injury	<input type="checkbox"/> Pedestrian Injury	<input type="checkbox"/> Military Injury	<input type="checkbox"/> Other Injury
<input type="checkbox"/> Headaches/Migraines	<input type="checkbox"/> Neck Pain or Arm Pain	<input type="checkbox"/> Middle Back Pain	<input type="checkbox"/> Low Back/Leg Pain	<input type="checkbox"/> Other Pain

FRACTURES/BROKEN BONES

I have never had broken bones. If you have broken bones, please indicate which and when:

REGION	YEAR	REGION	YEAR
<input type="checkbox"/> Spinal Vertebra		<input type="checkbox"/> Skull	
<input type="checkbox"/> Collar bone (clavicle)		<input type="checkbox"/> Rib bone	
<input type="checkbox"/> Arm or hand bone		<input type="checkbox"/> Leg or foot bone	
<input type="checkbox"/> Pelvis bone		<input type="checkbox"/> Other	

PAST AND PRESENT GENERAL HEALTH HISTORY

PREVIOUS SURGERIES

I've never had a surgical procedure. If you have, please list what and when:

SURGERY	YEAR	SURGERY	YEAR
<input type="checkbox"/> Spine Surgery (neck or back)		<input type="checkbox"/> Appendix	
<input type="checkbox"/> Disc surgery in neck or back		<input type="checkbox"/> Gallbladder/Stomach/Kidney	
<input type="checkbox"/> Heart		<input type="checkbox"/> Cancer (any type)	
<input type="checkbox"/> Tonsillectomy		<input type="checkbox"/> Rib/Collar bone	
<input type="checkbox"/> Head/Brain		<input type="checkbox"/> Hernia	
<input type="checkbox"/> Shoulder/Arm/Leg		<input type="checkbox"/> Other	

CHECK RECENT OR CURRENT SYMPTOMS

SYMPTOM	HOW LONG	SYMPTOM	HOW LONG
<input type="checkbox"/> Headaches/Migraines		<input type="checkbox"/> Upper Back Pain, Soreness, or Stiffness	
<input type="checkbox"/> Neck Pain, Soreness, or Stiffness		<input type="checkbox"/> Hip Pain	
<input type="checkbox"/> Low Back Pain, Soreness, Stiffness		<input type="checkbox"/> Leg or Foot Pain, Numbness, or Tingling	
<input type="checkbox"/> Arm/Hand Pain, Numbness, or Tingling		<input type="checkbox"/> Other:	

SYMPTOMS/PAIN DESCRIPTION

Please circle any word/words that best describe how your symptoms currently feel to you.

Pain	Pinching	Spreading	Vicious	Unbearable
Ache	Pricking	Shooting	Sickening	Soreness
Cutting	Tingling	Stabbing	Miserable	Pins and Needles
Tearing	Gnawing	Dull	Troublesome	Radiating
Crushing	Nagging	Bony	Pressing	Weakness
Pulling	Boring	Terrifying	Deep pain	Falls asleep
Irritating	Burning-Hot	Dreadful	Superficial pain	Suffocating
Annoying	Drill like	Fearful	Stinging	Punishing
Stiff or tight	Heavy	Unhappy	Throbbing	Crawling
Exhausting	Numbness	Torturing	Sharp	Tender

HAVE YOU BEEN TO A CHIROPRACTOR FOR ANY PRIOR CONDITION?

No Yes. Chiropractor's Name: _____ Year: _____

Problem seen for: _____

Do you have problems laying facedown on an examination table? No Yes. Why? _____

ARE YOU UNDER ANY OTHER MEDICAL/PSYCHIATRIC TREATMENT?

If yes, please explain: _____

PAST AND PRESENT GENERAL HEALTH HISTORY

LIST ANY MEDICATIONS THAT YOU ARE CURRENTLY TAKING

I am not taking medications. If you are, please check any medications that you are currently taking.

- | | | |
|---|--|--|
| <input type="checkbox"/> Muscle Relaxants | <input type="checkbox"/> Aspirin | <input type="checkbox"/> Statin Drugs |
| <input type="checkbox"/> Anti-inflammatory | <input type="checkbox"/> Tylenol | <input type="checkbox"/> Diuretic/Hypertension Drugs |
| <input type="checkbox"/> Narcotics for Pain | <input type="checkbox"/> Advil/Motrin | <input type="checkbox"/> Stroke prevention meds |
| <input type="checkbox"/> Heart medications | <input type="checkbox"/> Birth control medications | <input type="checkbox"/> Other |

WHEN IS YOUR PAIN USUALLY BETTER?

- | | | |
|--|--|--|
| <input type="checkbox"/> Morning | <input type="checkbox"/> Afternoon | <input type="checkbox"/> Evening |
| <input type="checkbox"/> During sleep hours | <input type="checkbox"/> Lying down flat | <input type="checkbox"/> Standing |
| <input type="checkbox"/> Walking | <input type="checkbox"/> Sitting | <input type="checkbox"/> Rest |
| <input type="checkbox"/> Stress (mental) is less | <input type="checkbox"/> Good posture | <input type="checkbox"/> Exercise/Stretching |

HAS YOUR PAIN BEEN ASSOCIATED WITH THE FOLLOWING?

- | | | |
|--|--|--|
| <input type="checkbox"/> Excessive fatigue-malaise | <input type="checkbox"/> Bowel or bladder disorders | <input type="checkbox"/> Night pain or night time sweats |
| <input type="checkbox"/> Weight loss | <input type="checkbox"/> Ovarian pain | <input type="checkbox"/> Abdominal pain |
| <input type="checkbox"/> Low grade fever | <input type="checkbox"/> Kidney pain/painful urination | <input type="checkbox"/> Balance problems |

DO YOU EXERCISE?

- | | | |
|--|---|---|
| <input type="checkbox"/> I do no regular exercise | <input type="checkbox"/> I exercise 1-2 times a week | <input type="checkbox"/> I exercise 3-5 times a week |
| <input type="checkbox"/> I stretch regularly | <input type="checkbox"/> I do weight lifting at gym/home | <input type="checkbox"/> I do cardiovascular work outs |
| <input type="checkbox"/> I am willing to do exercise | <input type="checkbox"/> I am not willing to do exercises | <input type="checkbox"/> I do regular sports activities |

WHAT ARE YOUR SLEEPING PATTERNS?

Please check either Yes or No

Y N

- | | | |
|--------------------------|--------------------------|--|
| <input type="checkbox"/> | <input type="checkbox"/> | Do you sleep poorly at night recently? |
| <input type="checkbox"/> | <input type="checkbox"/> | Do you sleep on your stomach? |
| <input type="checkbox"/> | <input type="checkbox"/> | Do you consistently feel extremely tired when you wake up in the morning recently? |

SYMPTOMS QUESTIONNAIRE

Please fill out only the sections that apply to you. Skip sections that do not relate to your condition.

NECK REGION

Y	N	
<input type="checkbox"/>	<input type="checkbox"/>	Do neck and head movements cause your neck pain to intensify?
<input type="checkbox"/>	<input type="checkbox"/>	Do you get dizzy when you look up or twist your head? If yes, how often:
<input type="checkbox"/>	<input type="checkbox"/>	Do you black out or lose your balance when you look up or twist your head? If yes, how often:
<input type="checkbox"/>	<input type="checkbox"/>	Do you have to support your head with your hand or grasp your mouth or hair to be able to lift your head up when you are lying down and attempting to sit up? If your difficulty/inability to lift your head without support is injury related, indicate how soon this occurred after injury? (_____ min/hrs)
<input type="checkbox"/>	<input type="checkbox"/>	Do you feel your neck pain sends pain downwards between your shoulders?
<input type="checkbox"/>	<input type="checkbox"/>	Do you feel your neck pain sending pain downwards to the front of your chest?
<input type="checkbox"/>	<input type="checkbox"/>	Have you noticed your head leaning or tilting to one side recently?
<input type="checkbox"/>	<input type="checkbox"/>	Have you ever been diagnosed as having a disc bulge or herniation in your neck?

ARM, HAND OR FINGER REGION

Y	N	
<input type="checkbox"/>	<input type="checkbox"/>	Do you have pain, numbness, or tingling in your shoulder, upper arm, lower arm, or hand? Circle areas
<input type="checkbox"/>	<input type="checkbox"/>	Do you have pain, numbness, or tingling in your fingers? If Yes, circle which finger(s) are involved: Thumb, Index finger, Middle finger, Ring finger, Little finger
<input type="checkbox"/>	<input type="checkbox"/>	Do you get increased arm numbness when lying flat on your back* or sleeping on your side recently?*
<input type="checkbox"/>	<input type="checkbox"/>	Does changing your sitting posture increase your arm/hand symptom intensity?
<input type="checkbox"/>	<input type="checkbox"/>	If you sit and slouch forward for several minutes, do your arm symptoms intensify?
<input type="checkbox"/>	<input type="checkbox"/>	If you have arm symptoms, do they improve when you lift your arms over your head? *
<input type="checkbox"/>	<input type="checkbox"/>	If you have arm symptoms, do they worsen when you lift your arms over your head? *
<input type="checkbox"/>	<input type="checkbox"/>	If you have night time hand or arm pain, does it help to shake and massage them?
<input type="checkbox"/>	<input type="checkbox"/>	Do your hands feel tender when you grasp objects recently?
<input type="checkbox"/>	<input type="checkbox"/>	Do you feel weakness in your grip strength recently?
<input type="checkbox"/>	<input type="checkbox"/>	Do you drop objects in your hand recently?
<input type="checkbox"/>	<input type="checkbox"/>	Do you have difficulty writing or doing small motions with your fingers recently?
<input type="checkbox"/>	<input type="checkbox"/>	Do your hand(s) or wrist get swollen recently?
<input type="checkbox"/>	<input type="checkbox"/>	Do your hands burn recently?
<input type="checkbox"/>	<input type="checkbox"/>	Are your fingers frequently cold?
<input type="checkbox"/>	<input type="checkbox"/>	Have you been diagnosed as having Raynaud's syndrome in your past?

MID-BACK AND CHEST WALL REGION

Y	N	
<input type="checkbox"/>	<input type="checkbox"/>	Do you have pain that shoots or radiates outward along your rib cage?
<input type="checkbox"/>	<input type="checkbox"/>	Does your mid back or chest wall pain intensify when you take a deep breath in or cough recently?
<input type="checkbox"/>	<input type="checkbox"/>	Does your mid back or chest wall pain intensify when you twist your torso, bend, or stoop forward?
<input type="checkbox"/>	<input type="checkbox"/>	When you bend your mid back to the left or right side, does your mid back pain or chest pain increase?
<input type="checkbox"/>	<input type="checkbox"/>	Have you been diagnosed as having angina before?
<input type="checkbox"/>	<input type="checkbox"/>	Do you have a tight band-like chest feeling recently?
<input type="checkbox"/>	<input type="checkbox"/>	Do you recently have any associated unusual indigestion, chest pressure, or pain down your left arm?
<input type="checkbox"/>	<input type="checkbox"/>	Does your mid back pain mostly bother you during sleep?
<input type="checkbox"/>	<input type="checkbox"/>	Does your upper-middle back pain radiate inwards or upwards into your neck?

SYMPTOMS QUESTIONNAIRE

Please fill out only the sections that apply to you. Skip sections that do not relate to your condition.

LOW BACK, HIP AND LEG/FOOT REGION

Check any of the following body movements that intensify your low back pain or leg symptoms

<input type="checkbox"/>	Sitting	<input type="checkbox"/>	Bending forwards	<input type="checkbox"/>	Standing up	<input type="checkbox"/>	Walking
<input type="checkbox"/>	Standing still	<input type="checkbox"/>	Bending backwards	<input type="checkbox"/>	Lying on your back	<input type="checkbox"/>	Putting on shoes

Check all locations of any current leg pain, numbness, or tingling

<input type="checkbox"/>	Hip	<input type="checkbox"/>	Buttock	<input type="checkbox"/>	Back of thigh	<input type="checkbox"/>	Calf
<input type="checkbox"/>	Groin area	<input type="checkbox"/>	Knee	<input type="checkbox"/>	Front of thigh	<input type="checkbox"/>	Foot/toes

Please check either Yes or No

Y N

<input type="checkbox"/>	<input type="checkbox"/>	When you cough, sneeze, or bear down to have a bowel movement, does your low back pain or leg pain get worse recently?
<input type="checkbox"/>	<input type="checkbox"/>	Do you have a consistent pattern of getting severe leg pain after walking for similar distances that is relieved by resting or sitting? This pain resumes after walking for the same distance again, *
<input type="checkbox"/>	<input type="checkbox"/>	Do you get leg cramping while walking that is relieved by resting, leaning against an object, or sitting? This pain is worse at nighttime and relieved by walking around for a couple of minutes. *
<input type="checkbox"/>	<input type="checkbox"/>	Do you get leg pain or hip pain while walking that is consistently relieved by sitting down or lying down? This pain doesn't bother you at night time or while sitting. *
<input type="checkbox"/>	<input type="checkbox"/>	Does your leg or foot drag on the floor recently?
<input type="checkbox"/>	<input type="checkbox"/>	Do you get a lot of leg cramps at night time recently?
<input type="checkbox"/>	<input type="checkbox"/>	Have you had any urinary or bowel incontinence recently or had difficulty urinating or having bowel movements during the same time as your having low back pain or leg pain?
<input type="checkbox"/>	<input type="checkbox"/>	Have you had abdominal pain, indigestion, colicky symptoms with your low back pain?
<input type="checkbox"/>	<input type="checkbox"/>	Have you observed that your low back pain is not relieved by any type of postural change?
<input type="checkbox"/>	<input type="checkbox"/>	Do your feet feel cold recently? If yes, indicate which feet:
<input type="checkbox"/>	<input type="checkbox"/>	Have you ever been diagnosed as having a herniated or bulging disc in your low back in the past?
<input type="checkbox"/>	<input type="checkbox"/>	Have you ever had an injection of Chymopapain into your discs in your back or neck?
<input type="checkbox"/>	<input type="checkbox"/>	Have you recently noticed that either of your legs occasionally give out on you when you walk? *
<input type="checkbox"/>	<input type="checkbox"/>	Have one or both of your legs felt weak recently?
<input type="checkbox"/>	<input type="checkbox"/>	Have you ever been diagnosed as having a spondylolisthesis in your low back region?
<input type="checkbox"/>	<input type="checkbox"/>	Have you or either of your parents ever been diagnosed as having an abdominal aneurysm?
<input type="checkbox"/>	<input type="checkbox"/>	If you have radiating leg or foot pain, did you notice low back pain or soreness before your leg symptoms became noticeable?
<input type="checkbox"/>	<input type="checkbox"/>	If you have leg pain, is your leg pain primarily focused in the front of your thigh(s)?*
<input type="checkbox"/>	<input type="checkbox"/>	Has your anal-rectal region been completely numb recently?
<input type="checkbox"/>	<input type="checkbox"/>	Men Only. Do you have any recent prostate or urinary problems?
<input type="checkbox"/>	<input type="checkbox"/>	Women Only. Do you have any recent ovarian, uterine, or bladder problems?

Office Use Only
 1
 2-5
 >5
 WLTSE et. al.

Patient #: _____

PAIN DRAWING

Name: _____ Todays Date: _____

Date of Birth: _____ Examiner: _____

TELL US WHERE YOU HURT.

Please read carefully:

Mark the areas on your body where you feel your pain. Include all affected areas. Mark areas of radiation. If your pain radiates, draw an arrow from where it starts to where it stops. Please extend the arrow as far as the pain travels. Use the appropriate symbols(s) listed below.

Ache >>>>
 >>>>

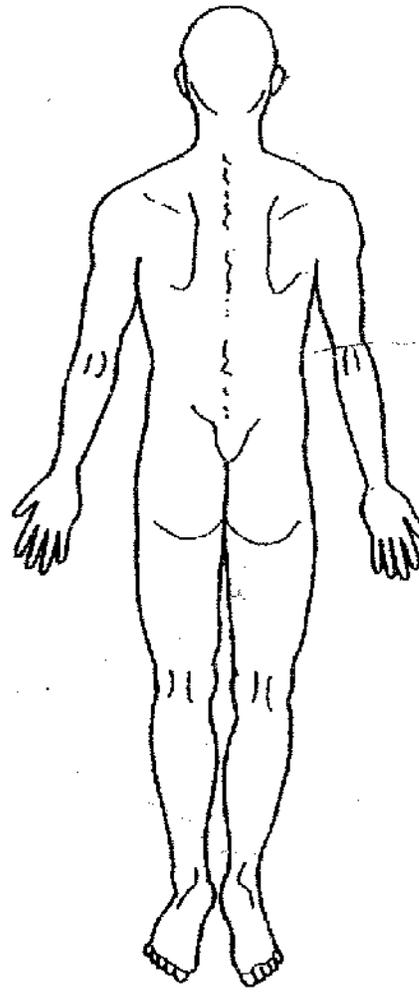
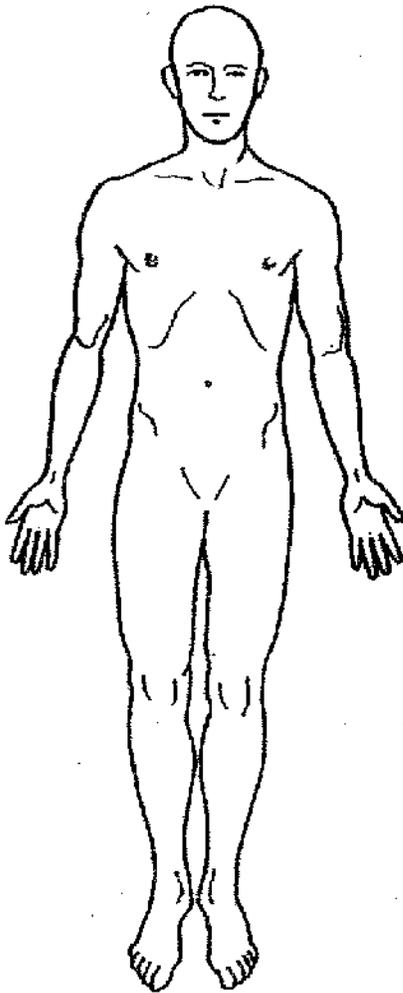
Numbness =====
 =====

Pins and Needles o o o o
 o o o o

Burning x x x x
 x x x x

Stabbing / / / /
 / / / /

Throbbing ~ ~ ~ ~
 ~ ~ ~ ~



DOUGLAS F. CANCEL, D.C./PERFORMANCE SPORT-CARE

P.O. Box 3915, Walnut Creek, CA 94598

1. Authorization to Release Medical Records
2. Authorization to Release Information
3. Assignment of Benefits and Payment Policy
4. Authorization for Treatment

I hereby authorize Douglas F. Cancel, D.C., to release my clinical records and radiological films directly to other caregivers for the purpose of my further diagnosis or treatment. This excludes the release of drug, alcohol, psychiatric or HIV records which require separate, written authorization.

I hereby authorize Douglas F. Cancel, D.C., to furnish to my insurance company's/companies' attorney or legal representative all information which said parties may request concerning my illness or injury. I hereby assign Douglas F. Cancel, D.C., all money which may be recovered from any source in connection with the accident or illness for which I am being treated by Douglas F. Cancel, D.C., not to exceed my indebtedness to him. I further agree and accept as follows:

That insurance is a contract between the patient or guarantor and the insurance company. Douglas F. Cancel, D.C., only bills insurance as a courtesy to patients and I am financially responsible to Douglas F. Cancel, D.C., for ALL charges for services rendered. (If you are an HMO patient, you are only responsible for any amount attributed to co pay, deductible and non-covered services should that apply to your plan.)

I recognize that Douglas F. Cancel, D.C., will bill and attempt to collect from my insurance company/companies as a courtesy. I fully understand that Douglas F. Cancel, D.C., may not accept my insurance company's usual and customary fees (UCR) as payment in full. This may lead to my receiving a bill for deductibles, co-payments, co-insurance and non-covered items. I agree to pay for any such balance. I understand that it is my responsibility to obtain all necessary referrals from other doctors and my insurance company/companies as required by my insurance company/companies, and this must be done before I can consult Douglas F. Cancel, D.C. In the event that services are rendered and later denied by my insurance company/companies for lack of referral or pre-authorization, I understand that it shall be my responsibility to pay Douglas F. Cancel, D.C., for all services rendered. I also understand that I am responsible for understanding my individual insurance policy and benefits prior to seeking services.

Although I may be represented by an attorney on matters related to the illness or injury for which Douglas F. Cancel, D.C. my have rendered services to me, I must still keep my account current and paid in full.

If my account becomes delinquent and is referred to an attorney or collection agency for collections, I agree to pay a 33% attorney's or collection fee, any court costs incurred by Douglas F. Cancel, D.C., and interest at the rate of 1.5% per month (or the maximum permitted by State Law, if less) on the unpaid balance from the date that payment was first due, in addition to the outstanding balance of the account.

I fully understand that while Douglas F. Cancel, D.C. is willing to send an insurance claim to my insurance company/companies, Douglas F. Cancel, D.C. will not be responsible for lost claims or claims which did not arrive at my insurance company/companies. I understand that if payment from my insurance company/companies has not been received by Douglas F. Cancel, D.C. within 75 days from the date of service, the TOTAL balance will become my responsibility and will be due immediately. All accounts that are 90 days old will be sent to collection. Patients are encouraged to stay in touch with their insurance company/companies as to the status of their claim.

This agreement is in addition to any other agreement which I may have with Douglas F. Cancel, D.C. I have read this document, understand it fully, have been provided an opportunity to ask questions and have them answered to my satisfaction, and I agree fully to the terms and conditions.

Print Name _____

Signature _____ Date _____

(Patient or authorized representative)