PERSONAL INJURY INTRODUCTION FORM

PATIENT INFORMATION

Today's Date: / / **Date of Incident:** / /	Marital Status (Circle): Single-Married-Divorced-Widowed-Other
Patient Name: Gender: M / F	Location of Incident (City/State):
Date of Birth: / / Age: SS#: / /	Height: Weight:
Street Address:	Employer's Name:
City/State/Zip:	Employer's Address:
Cell Phone: Cell Carrier:	Job Title:
Home Phone: Work Phone:	Emergency Contact:
E-mail Address:	Emergency Contact Phone:

AUTOMOBILE INSURANCE/ATTORNEY INFORMATION

Do you or someone else have insurance coverage for the vehicle you were in?	☐ **Yes** ☐ **Self** ☐ **No** ☐ **Someone Else (please write their name below)** **Policyholder's name:**_____ _____
Name of automobile insurance carrier for this vehicle:	
Have you reported this injury to this insurance carrier?	☐ Yes ☐ No *(Required before treatment begins)*
Is there Personal Injury Protection (PIP) or Medical Pay?	☐ Yes ☐ No *(See Declarations Page)*
What are the PIP or Med Pay limits for medical bills?	$ _____
Claim number for *this* incident:	_____ *(Required before treatment begins)*
Claim adjuster's name *(NOT agent)*:	
Claim adjuster's phone #::	Phone: ext:
Claims address of *this* automobile insurance carrier:	

Name of *other driver (REQUIRED, see police report):*	
Address of *other driver (REQUIRED, see police report):*	
Name of *other driver's* automobile insurance carrier - *(REQUIRED, see police report)*:	
Phone/Fax of *other driver's* automobile insurance carrier:	Phone: Fax:
Other driver's claim number for *this* incident:	

Do you have an attorney representing you?	☐ Yes ☐ No
Attorney's name:	
Attorney's address:	
Attorney's phone/fax:	Phone: Fax:

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 for any outstanding bills 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.

RELEASE OF INFORMATION AUTHORIZATION: I hereby authorize Northwest Injury & Rehab Center, P.S. to furnish my insurance company or attorney with reports regarding examination, diagnosis, treatment, prognosis, etc., of myself in reference to the condition described above.

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

MOTOR VEHICLE COLLISION INJURY QUESTIONNAIRE

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

Circumstances of the Collision

Patient Location:

Were you the driver? ☐ Yes ☐ No

If no, what section of the vehicle were you in? ☐ Front ☐ Middle ☐ Rear

Were you on the right, left or center of your section? ☐ Right ☐ Left ☐ Center

Other Occupants:

Were you alone in the vehicle? ☐ Yes ☐ No

If no, please name all of the other occupants: _____

_____

Collision Environment:

What was the time? _____☐ AM☐PM ☐ Day ☐ Night ☐ Dawn (sunrise) ☐ Dusk (sunset)

What was the weather:☐ Wet ☐ Dry ☐ Raining ☐Snowing☐ Hailing ☐ Windy☐ Other:_____

Were the headlights on or off? ☐ On ☐ Off ☐ Don't know

Were the windshield wipers on or off? ☐On ☐ Off ☐ Don't know

What was the road surface made of? ☐ Asphalt ☐ Concrete ☐ Gravel ☐ Dirt

What was the road design? ☐Straight ☐Curved ☐ Intersection

What was the road terrain? ☐ Level ☐ Upward slope ☐ Downward slope

Was there traffic control? ☐None ☐ Stop sign ☐ Traffic lights ☐ Other: _____

Collision Report:

Was a motor vehicle collision report made? ☐ Yes ☐ No

To what agency was it made? _____

Patient's Vehicle Information

Vehicle Type:

Make (Ford, Toyota): _____ Model (Focus, Camry) _____ Year: _____

Body Type: ☐ 2 door ☐ 4 door ☐ Convertible ☐ S.U.V. ☐ Pick-up ☐ Van ☐ Other: _____

If a pick-up, S.U.V or van, describe any visible weight load: _____

Was it an automatic transmission? ☐ Yes ☐ No

Damage to Vehicle:

Was there visible damage to your vehicle? ☐ Yes ☐ No

Describe Damage: _____

Where is your vehicle now? _____

MOTOR VEHICLE COLLISION INJURY QUESTIONNAIRE (continued)

What is the estimated cost of repair? _____$ ☐ Totaled ☐ Don't Know
Were pictures taken of the vehicle? ☐ Yes ☐ No
Do you have photos? ☐ Yes ☐ No

Seat Belt:

What was the type of seat belt? ☐ Lap belt only ☐ Lap belt and shoulder strap
Were you using your seat belt? ☐ Yes ☐ No
If no, indicate why? _____
If using a shoulder strap, how was it positioned? ☐ Over neck ☐ Over chest ☐ Other:_____

Head Restraint:

What type of head rest was behind your head? ☐ Adjustable ☐ Non-adjustable ☐ Don't know
Where was the head rest positioned from the center of your head? ☐ Below ☐ Above ☐ Don't know
How far behind your head was the head rest? ☐ In contact ☐ Less than one inch ☐ More than one inch
Was the head rest position changed by the collision? ☐ Knocked down ☐ Broken ☐ No change

Seat Position:

What was the seat position at the time of impact? ☐ Tilted forward ☐ Tilted backward ☐ Straight up ☐ Don't know
Did the seat position change upon impact? ☐ No Change ☐ Tilted Forward ☐ Tilted backward ☐ Straight up ☐ Don't know
Was there damage to the seat back? ☐ Broke ☐ Bent ☐ Release failed to hold ☐ No change ☐ Don't know

Airbag(s):

Did the airbag(s) deploy as a result of the collision? ☐ Deployed ☐ Did not deploy ☐ No airbags in vehicle
If deployed, were you struck by the airbag(s)? ☐ Face ☐ Body/arms ☐ Other:_____
If struck, did the airbag(s) cause injury to you? ☐ Yes ☐ No ☐ Don't know

Other Vehicle's Information

Other Vehicle's Type:

Make (Ford, Toyota)_____ Model(Focus, Camry)_____ Year: _____
Body type of other vehicle: ☐ 2 door ☐ 4 door ☐ Convertible ☐ S.U.V. ☐ Pick-up ☐ Van ☐ Other:
If a pick-up, S.U.V. or van, describe any weight load: _____

Other Vehicle's Damage:

Was there visible damage to the other vehicle? ☐ Yes ☐ No ☐ Don't know
Describe the damage: _____
Was a picture taken of the other vehicle? ☐ Yes ☐ No
Do you have photos? ☐ Yes ☐ No

Collision Dynamics

Direction of Impact:

From which direction were you struck? ☐ Front ☐ Rear ☐ Left side ☐ Right side

Was the impact direct or at an angle? ☐ Direct ☐ Angle
If impacted on an angle, specify direction _____

Movement of the vehicle at impact:
Was your vehicle moving at impact? ☐ Yes ☐ No
What was your estimated speed? _____

Movement of the vehicle after impact:
Did your vehicle move as a result of the impact? ☐ Yes ☐ No ☐ Don't know
Describe movement: _____
How far apart were the vehicles after impact? ☐ In contact ☐ Several feet ☐ Over 10 feet

Secondary Collisions:
Did your vehicle strike any objects, such as a guard rail, tree, or an additional vehicle? ☐ Yes ☐ No
Describe: _____

Body Position and Impact

Patient Position:
How was your head positioned at the moment of impact? ☐ Looking straight ☐ Turned to the right ☐ Turned to the left ☐ Tilted up ☐ Tilted down
How were you sitting? ☐ Upright ☐ Leaning forward ☐ Leaning left ☐ Leaning right ☐ Leaning backward
Were you holding the steering wheel at impact? ☐ Yes ☐ No ☐ Not the driver
If the driver, where was your left hand? ☐ Steering wheel ☐ Other: _____
If the driver, where was your right hand? ☐ Steering wheel ☐ Other: _____
If the driver, where was your left foot? ☐ Clutch ☐ Floor
If the driver, where was your right foot? ☐ Brake ☐ Gas pedal ☐ Floor

Impact Awareness:
Were you aware that the collision was about to occur? ☐ Yes ☐ No
Did you have time to brace? ☐ Yes ☐ No
What did you hear immediately before and during the collision? _____
_____

Impact on Objects and Structures in the Vehicle:
Were you wearing glasses? ☐ Yes ☐ No
Was there damage to your glasses as a result of the collision? ☐ Yes ☐ no
Where were your glasses immediately after the collision? _____
Were you wearing a hat? ☐ Yes ☐ No
Where was your hat after the collision? _____
Did any object within the vehicle (including the trunk) move? ☐ Yes ☐ No
Describe the object(s) and what happened? _____
Did your body strike anything inside the vehicle? ☐ Seat belt/shoulder harness ☐ Head-rest ☐ Rear-view mirror ☐ Steering wheel ☐ Windshield ☐ Dashboard ☐ Side door
Did any of the vehicle windows break? ☐ Yes ☐ No

MOTOR VEHICLE COLLISION INJURY QUESTIONNAIRE (continued)

Were you cut as a result? ☐ Yes ☐ No

Injuries and Treatment

Injuries Sustained:

When did you first become aware that you were injured? ☐ Immediately ☐ Within minutes ☐ Within hours ☐ Within days ☐ Within weeks

What was the first injury that you noticed? _____

Did you lose consciousness? ☐ Yes ☐ No

Do you know how long? ☐ Seconds ☐ Minutes ☐ Greater than 3 minutes ☐ Don't know

What is the last thing you remember prior to the collision? _____

What is the first thing you remember after the collision? _____

Did you suffer any cuts, bruises, scrapes or swelling? ☐ Yes ☐ No

Where were you injured? ☐ Head ☐ Face ☐ Neck ☐ Chest ☐ Abdomen ☐ Right shoulder ☐ Right arm ☐ Right wrist ☐ Right leg ☐ Right ankle ☐ Left shoulder ☐ Left arm ☐ Left wrist ☐ Left leg ☐ Left ankle

Have you had arm or leg pain, numbness or tingling since the collision? ☐ Yes ☐ No

Describe the location: _____

Have you had dizziness or balance problems since the collision? ☐ Yes ☐ No

Describe: _____

Have you had any trouble reading or recalling words since the collision? ☐ Yes ☐ No

Have you had neck pain since the collision? ☐ Yes ☐ No

Have you had back pain since the collision? ☐ Yes ☐ No

Effect of Injuries on Daily Activities:

What is your type of work? ☐ Office ☐ Light labor ☐ Moderate labor ☐ Heavy labor ☐ Stay at home

Have you been unable to work as a result of your injuries? ☐ Yes ☐ No

Do you have a doctor's release from work? ☐ Yes ☐ No

What is the doctor's name? _____

Have you been on light-duty since the collision as a result of your injuries? ☐ Yes ☐ No

What leisure or home restrictions have you noticed as a result of the collision? _____

_____

Treatment Received:

Were you treated at the scene? ☐ Yes ☐ No

Who treated you at the scene? ☐ Ambulance crew ☐ Paramedics ☐ Other: _____

For what injuries were you treated? _____

Were you transported to a hospital emergency room? ☐ Yes ☐ No

How were you transported? ☐ Ambulance ☐ Other: _____

Where were you taken? _____

For what injuries were you treated? _____

Were x-rays, MRI's or CT scans performed? ☐ Yes ☐ No

Did you see a Doctor within 20 days of the injury? ☐ Yes ☐ No

If no, indicate why: _____

MOTOR VEHICLE COLLISION INJURY QUESTIONNAIRE (continued)

Past Health History

Injuries:

Have you suffered an injury to your head, neck or back prior to your current injury? ☐ Yes ☐ No

Approximately what year were you injured? _____

What body part(s) were injured? _____

How were you injured? ☐ Motor vehicle collision ☐ Work injury ☐ Other: _____

Claims:

Have you made a personal injury or workers compensation claim in the past? ☐ Yes ☐ No

When was the claim? _____

What body part(s) was injured? _____

Treatment:

Have you been treated by a medical doctor, chiropractor or other health care professional for head, neck or Back pain prior to your current injury? ☐ Yes ☐ No

Describe the treatment you received? _____

Have you ever received physical therapy for any condition? ☐ Yes ☐ No

What were your complaints? _____

Dr. Comments: _____

_____

_____

Patient's Signature: _____ **Date:** _____

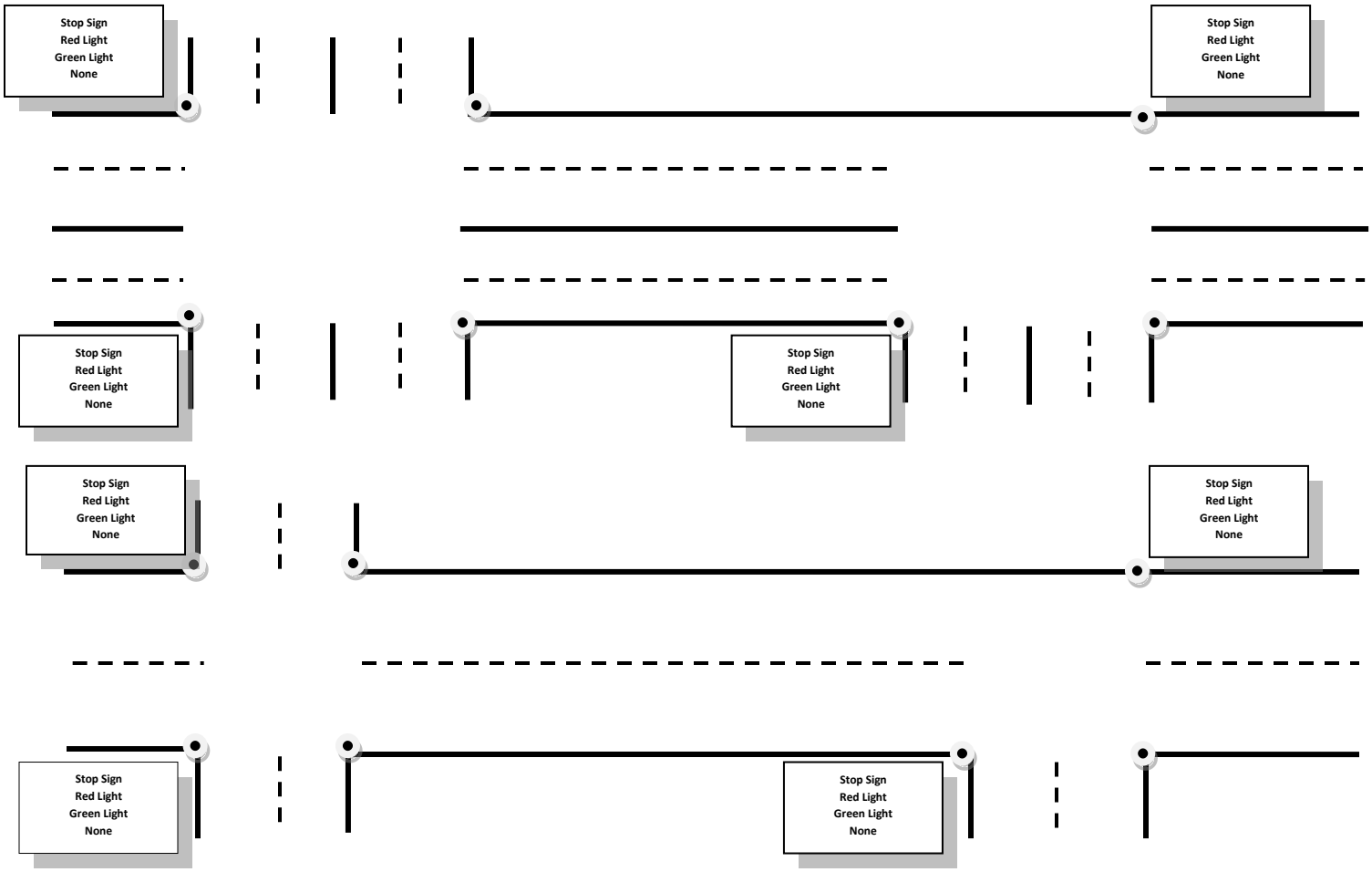
Reviewed by: _____ **Date Reviewed:** _____

MOTOR VEHICLE DAMAGE DRAWING

Please shade in the section of each vehicle that was damaged.

MINE	**OTHER 1**	**OTHER 2**
Front	Front	Front
Rear	Rear	Rear

MOTOR VEHICLE COLLISION DRAWING



Location of accident: _____

_____

_____

DOCTORS/THERAPISTS SEEN AND ALL TESTS DONE SINCE INJURY

(Start with the emergency room (if you went), the first doctor you saw after your injury and list in order all doctors, therapists, massage therapists up to your last doctor/therapist seen and check all that apply for each)

PATIENT NAME: **DATE:**

1. Name hospital/doctor/therapist/center: _____

Address: _____ Date: _____

Indicate what was done:

☐ Exam-consultation	☐ Rehabilitation	☐ Exercises
☐ IME exam or consult only	☐ Ultrasound	☐ Suturing laceration
☐ X-ray of neck	☐ Spinal Adjustments	☐ Cast
☐ X-ray of chest/mid back	☐ Muscle massage/myotherapy	☐ Wrist brace-splint
☐ X-ray of low back	☐ Ultrasound/muscle stimulation	☐ Neck collar (brace)
☐ Other x-rays	☐ Physical Therapy	☐ Low back brace
☐ MRI/CT scan	☐ Over-the-counter medications	☐ Heat packs
☐ Nerve Conduction Study	☐ Pain Medications	☐ Ice packs
☐ Other Tests	☐ Muscle Relaxants	☐ Other

Indicate if treatment: ☐ Made condition worse ☐ Did not help ☐ Helped

2. Name hospital/doctor/therapist/center: _____

Address: _____ Date: _____

Indicate what was done:

☐ Exam-consultation	☐ Rehabilitation	☐ Exercises
☐ IME exam or consult only	☐ Ultrasound	☐ Suturing laceration
☐ X-ray of neck	☐ Spinal Adjustments	☐ Cast
☐ X-ray of chest/mid back	☐ Muscle massage/myotherapy	☐ Wrist brace-splint
☐ X-ray of low back	☐ Ultrasound/muscle stimulation	☐ Neck collar (brace)
☐ Other x-rays	☐ Physical Therapy	☐ Low back brace
☐ MRI/CT scan	☐ Over-the-counter medications	☐ Heat packs
☐ Nerve Conduction Study	☐ Pain Medications	☐ Ice packs
☐ Other Tests	☐ Muscle Relaxants	☐ Other

Indicate if treatment: ☐ Made condition worse ☐ Did not help ☐ Helped

3. Name hospital/doctor/therapist/center: _____

Address: _____ Date: _____

Indicate what was done:

☐ Exam-consultation	☐ Rehabilitation	☐ Exercises
☐ IME exam or consult only	☐ Ultrasound	☐ Suturing laceration
☐ X-ray of neck	☐ Spinal Adjustments	☐ Cast
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☐ MRI/CT scan	☐ Over-the-counter medications	☐ Heat packs
☐ Nerve Conduction Study	☐ Pain Medications	☐ Ice packs
☐ Other Tests	☐ Muscle Relaxants	☐ Other

Indicate if treatment: ☐ Made condition worse ☐ Did not help ☐ Helped

NW Injury & Rehab Center, P.S. • 9618 NE Fourth Plain Blvd, WA 98662
Office (360) 573-1933 • Fax (360) 571-0143

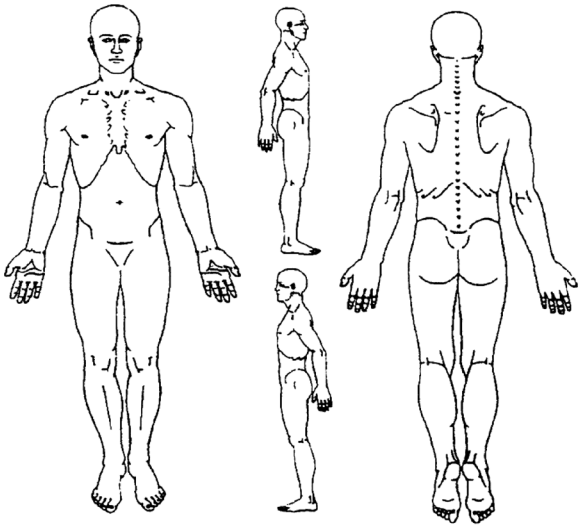
HISTORY QUESTIONNAIRE

PATIENT NAME: **D.O.B.:** **DATE:**

Please mark areas of current pain on the figures below.

Neck Pain
How Long?
_____ day(s)
_____week(s)
_____ month(s)
_____ year(s)
☐ Worsening
☐ Staying the Same

Arm Pain
☐ Numbness
☐ Tingling
☐ Weakness
☐ Sharp ☐ Dull



Lower Back Pain
How Long?
_____ day(s)
_____ week(s)
_____ month(s)
_____ year(s)
☐ Worsening
☐ Staying the Same

Leg Pain
☐ Numbness
☐ Tingling
☐ Weakness
☐ Sharp ☐ Dull

Dr. Comments: _____

_____

_____

_____

_____

_____

_____

Please circle yes or no and fill in the appropriate blank spaces

Previous Motor Vehicle Collision(s) Yes/No List Year(s) _____
Broken Bone(s) (Fractures) Yes/No When and what bone(s)? _____
Surgeries Yes/No List year(s) and surgery(s): _____
Hospitalizations Yes/No When and for what? _____
Neck and/or Back X-rays, MRI's and/or CT Scans Yes / No When and for what? _____
Neck and/or Back Injuries (in sports, on-the-job, in the military or otherwise which have required medical attention) Yes/No
Old injuries that have left you with Permanent Complaints Yes/ No Where? _____
Childhood Illnesses (such as polio, rheumatic fever or scarlet fever) Yes/No What? _____

Current Medications (such as Ibuprofen, Flexeril or Vicodin) Yes/No List them: _____

_____

Medication Allergies or Sensitivities Yes/No List them: _____
Chiropractic Treatment Yes/No When was your last adjustment? _____ By whom? _____
Satisfactory/Unsatisfactory (Circle)
Various Health Conditions Cancer, Heart, Lung, Diabetes, Thyroid, High Blood Pressure, Genitourinary, Gastrointestinal, Skin, Ear, Nose, Throat, Blood, Lymph and/or Glandular Condition (please circle all that apply to you)
Smoke: No / Yes (____ packs a day / week for ____ months / years) I quit smoking for _____ months / years
Drink: No / Yes (____ drinks a day / week / month / year) I quit drinking for _____ months / years
Married: Yes / No Children's ages: _____ **if female are you pregnant?** Yes / No
Occupational Title: _____ Part Time / Full Time ____ % Sitting, ____% Standing/Walking
Work Hours: ____ hours a day and ____ days a week. Heaviest lift _____ pounds, _____ times per shift / week.
Mother's Age: ____ Current Health Condition(s): _____
Father's Age: ____ Current Health Condition(s):_____

SYMPTOM SURVEY

PATIENT NAME: **D.O.B.** **DATE:**

Please check the box of all the symptoms that you are currently or have been recently experiencing. Please also circle the appropriate side of complaint (R / L / Both) and pain level (mild / moderate / significant)

Example:
- ☒ Below the Shoulder Blades to the Lower Ribs (R) / L / Both
- ☐ Above the Belt Line R / L / Both
- ☒ At the Belt Line R / L / (Both)
- ☐ Below the Belt Line R / L / Both
- ☒ Mild / (Moderate) / Significant

VARIOUS SYMPTOMS:
- ☐ Unexplained Recent Weight Loss/ Fever
- ☐ Visual Disturbances
- ☐ Blurred Vision
- ☐ Double Vision
- ☐ Nausea
- ☐ Vomiting
- ☐ Loss of sleep due to pain
- ☐ Short Term Memory Loss
- ☐ Sensitivity to Light
- ☐ Dizziness (Daily / ____ Times a Day / Week / Month)
- ☐ Balance Difficulties
- ☐ Light Headedness
- ☐ Sensation of Spinning / Moving Inside Room
- ☐ Sensation of Room Spinning / Moving Around

HEADACHE PAIN:
- ☐ Back of the Head R / L / Both
- ☐ Side of the Head (above ears) R / L / Both
- ☐ Forehead R / L / Both
- ☐ Behind the Eyes R / L / Both
- ☐ Mild / Moderate / Significant
- ☐ Worsening
- ☐ Daily (at least once per day)/4-5 x a Week/ 3-4x a Week/2-3x a Week/1-2x a Week/ 1x a Week)
- ☐ Headache Pain Causes Sleep Disturbances
- ☐ Medication Offers Pain Relief (Complete / Moderate / Slight / None)

JAW PAIN:
- ☐ Chewing Hard Foods R / L / Both
- ☐ Wide Yawning R / L / Both
- ☐ Prolonged Phone Conversations R / L / Both
- ☐ Side Sleeping Positions R / L / Both
- ☐ Ringing in the Ears R / L / Both
- ☐ Ear Pain or Fullness R / L / Both
- ☐ Facial Pain / Numbness R / L / Both

NECK AND UPPER BACK PAIN:
- ☐ Upper Neck R / L / Both
- ☐ Side of the Neck R / L / Both
- ☐ Lower Neck R / L / Both
- ☐ Upper Back R / L / Both
- ☐ Mild / Moderate / Significant

PAIN BETWEEN THE SHOULDER BLADES:
- ☐ Causes Difficulty Taking a Deep Breath R / L / Both
- ☐ Mild / Moderate / Significant R / L / Both

LOWER BACK PAIN:
- ☐ Below the Shoulder Blades to the Lower Ribs R / L / Both
- ☐ Above the Belt Line R / L / Both
- ☐ At the Belt Line R / L / Both
- ☐ Below the Belt Line R / L / Both
- ☐ Mild / Moderate / Significant

SHOULDER BLADE PAIN:
- ☐ Mild / Moderate / Significant R / L / Both

SHOULDER PAIN:
- ☐ Mild / Moderate / Significant R / L / Both

ARM AND HAND PAIN:
- ☐ Pain in Hand R / L / Both
- ☐ Pain in the Wrist R / L / Both
- ☐ Pain in the Forearm R / L / Both
- ☐ Pain in the Elbow R / L / Both
- ☐ Pain in the Upper Arm R / L / Both

LEG, FOOT AND ANKLE PAIN:
- ☐ Pain in the Foot R / L / Both
- ☐ Pain in the Ankle R / L / Both
- ☐ Pain in the Calf/Shin R/ L / Both
- ☐ Pain in the Upper Leg R / L / Both
- ☐ Pain in the Hip / Gluteal Region R / L / Both

CHEST REGION PAIN:
- ☐ Upper Chest wall R / L / Both
- ☐ Breast Bone R / L / Both
- ☐ Vehicle's Shoulder Strap Region R / L / Both

RIB CAGE PAIN:
- ☐ Front R / L / Both
- ☐ Side R / L / Both
- ☐ Back R / L / Both

ABDOMINAL REGION PAIN:
- ☐ Upper Chest Wall R / L / Both
- ☐ Breast Bone R / L / Both
- ☐ Vehicle's Shoulder Strap Region R / L / Both

Dr's Comments:

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The Neck Disability Index

Patient name: _____ File# _____ Date: _____

Please read instructions:

This questionnaire has been designed to give the doctor information as to how your neck pain has affected your ability to manage everyday life. Please answer every section and mark in each section only the ONE box that applies to you. We realize that you may consider that two of the statements in any one section relate to you, but please just mark the box that most closely describes your problem.

SECTION 1-PAIN INTENSITY

- ☐ I have no pain at the moment.
- ☐ The pain is very mild at the moment.
- ☐ The pain is moderate at the moment.
- ☐ The pain is fairly severe at the moment.
- ☐ The pain is very severe at the moment.
- ☐ The pain is the worst imaginable at the moment.

SECTION 2-PERSONAL CARE (Washing, Dressing, etc.)

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

SECTION 3-LIFTING

- ☐ I can lift heavy weights without extra pain.
- ☐ I can lift heavy weights, but it gives extra pain.
- ☐ Pain prevents me from lifting heavy weights off the floor, but I can manage if they are conveniently positioned, for example, on a table.
- ☐ Pain prevents me from lifting heavy weights off the floor, but I can manage light to medium weights if they are conveniently positioned.
- ☐ I can lift very light weights.
- ☐ I cannot lift or carry anything at all.

SECTION 4-READING

- ☐ I can read as much as I want to, with no pain in my neck.
- ☐ I can read as much as I want to, with slight pain in my neck.
- ☐ I can read as much as I want to, with moderate pain in my neck.
- ☐ I can't read as much as I want, because of moderate pain in my neck.
- ☐ I can hardly read at all, because of severe pain in my neck.
- ☐ I cannot read at all.

SECTION 5-HEADACHES

- ☐ I have no headaches at all.
- ☐ I have slight headaches that come infrequently.
- ☐ I have moderate headaches that come infrequently.
- ☐ I have moderate headaches that come frequently.
- ☐ I have severe headaches that come frequently.
- ☐ I have headaches almost all the time.

SECTION 6-CONCENTRATION

- ☐ I can concentrate fully when I want to, with no difficulty.
- ☐ I can concentrate fully when I want to, with slight difficulty.
- ☐ I have a fair degree of difficulty in concentrating when I want to.
- ☐ I have a lot of difficulty in concentrating when I want to.
- ☐ I have a great deal of difficulty in concentrating when I want to.
- ☐ I cannot concentrate at all.

SECTION 7-WORK

- ☐ I can do as much work as I want to.
- ☐ I can do my usual work, but no more.
- ☐ I can do most of my usual work, but no more.
- ☐ I cannot do my usual work.
- ☐ I can hardly do any work at all.
- ☐ I can't do any work at all.

SECTION 8-DRIVING

- ☐ I can drive my car without any neck pain.
- ☐ I can drive my car as long as I want, with slight pain in my neck.
- ☐ I can drive my car as long as I want, with moderate pain in my neck.
- ☐ I can't drive my car as long as I want, because of moderate pain in my neck.
- ☐ I can hardly drive at all, because of severe pain in my neck.
- ☐ I can't drive my car at all.

SECTION 9-SLEEPING

- ☐ I have no trouble sleeping.
- ☐ My sleep is slightly disturbed (less than 1 hr sleepless).
- ☐ My sleep is mildly disturbed (1-2 hrs sleepless).
- ☐ My sleep is moderately disturbed (2-3 hrs sleepless).
- ☐ My sleep is greatly disturbed (3-5 hrs sleepless).
- ☐ My sleep is completely disturbed (5-7 hrs sleepless).

SECTION 10-RECREATION

- ☐ I am able to engage in all my recreation activities, with no neck pain at all.
- ☐ I am able to engage in all my recreation activities, with some neck.
- ☐ I am able to engage in most, but not all, of my usual recreation activities, because of pain in my neck.
- ☐ I am able to engage in few of my recreation activities, because of pain in my neck.
- ☐ I can hardly do any recreation activities, because of pain in my neck.
- ☐ I can't do any recreation activities at all.

Instructions:

1. The NDI is scored in the same way as the Oswestry Disability Index.

2. Using this system, a score of 10-28% (*i.e.*, 5-14 points) is considered by the authors to constitute mild disability; 30-48% is moderate; 50-68% is severe; 72% or more is complete.

The Revised Oswestry Disability Index (for low back pain/dysfunction)

Patient name: _____ File #_____ Date: _____

This questionnaire has been designed to give the doctor 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 applies to you. We realize that you may consider that two of the statements in any one section relate to you, but please just mark the box that most closely describes your problem.

SECTION 1-PAIN INTENSITY

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

SECTION 2-PERSONAL CARE

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

SECTION 3-LIFTING

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

SECTION 4-WALKING

- ☐ I have no pain on walking.
- ☐ I have some pain on walking, but it does not increase with distance.
- ☐ I cannot walk more than one mile without increasing pain.
- ☐ I cannot walk more than 1/2 mile without increasing pain.
- ☐ I cannot walk more than 1/4 mile without increasing pain.
- ☐ I cannot walk at all without increasing pain.

SECTION 5-SITTING

- ☐ I can sit in any chair as long as I like.
- ☐ I can only sit in my favorite chair as long as I like.
- ☐ Pain prevents me from sitting more than one hour.
- ☐ Pain prevents me from sitting more than 1/2 hour.
- ☐ Pain prevents me from sitting more 10 minutes.
- ☐ I avoid sitting because it increases pain right away.

SECTION 6-STANDING

- ☐ I can stand as long as I want without pain.
- ☐ I have some pain on standing, but it does not increase with time.
- ☐ I cannot stand for longer than one 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.
- ☐ I avoid standing because it increases the pain right away.

SECTION 7-SLEEPING

- ☐ I get no pain in bed.
- ☐ I get pain in bed, but it does not prevent me from sleeping well.
- ☐ Because of pain, my normal night's sleep is reduced by less than 1/4.
- ☐ Because of pain, my normal night's sleep is reduced by less than 1/2.
- ☐ Because of pain, my normal night's sleep is reduced by less than 3/4.
- ☐ Pain prevents me from sleeping at all.

SECTION 8-SOCIAL LIFE

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

SECTION 9-TRAVELLING

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

SECTION 10-CHANGING DEGREE OF PAIN

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

Instructions:

1. This is a self-report questionnaire: the patient is instructed to fill it out.

2. The patient follows the general instructions given at the top of the questionnaire.

3. Each section must be completed. If the patient leaves one blank, instruct them to complete the form. It must be completed in one sitting.

4. Each section has 6 possible answers. Statement 1 is graded as 0 points; statement 6 is graded as 5 points. A total score of 50 is thus possible and would indicate 100% disability. So, for example, a total score of 10 of a possible 50 would constitute a 20% disability.

5. The following interpretation of disability scores is excerpted from the developers of the Oswestry system (457):

0%-20%: Minimal disability

This group can cope with most living activities. Usually no treatment is indicated, apart from advice on lifting, sitting posture, physical fitness, and diet. In this group some patients have particular difficulty with sitting, and this may be important if their occupation is sedentary, e.g., a typist or lorry [truck] driver.

20%-40% Moderate disability

This group experiences more pain and problems with sitting, lifting, and standing. Travel and social life are more difficult and they may well be off work. Personal care, sexual activity*, and sleeping are not grossly affected, and the back condition can usually be managed by conservative means.

40%-60%: Severe disability

Pain remains the main problem in this group of patients, but travel, personal care, social life, sexual activity*, and sleep are also affected. These patients require detailed investigation.

60%-80%: Crippled

Back pain impinges on all aspects of these patients' lives—both at home and at work—and positive intervention is required.

80%-100%

These patients are either bed-bound or exaggerating their symptoms. This can be evaluated by careful observation of the patient during medical examination.

6. It is recommended that clinicians focus their discussions of the results with patients in positive terms, rather than reporting disability scores. For example, point out the 10% improvement on a subsequent test.

* Note: in the revised Oswestry, sex life questions were replaced with recreation questions.

NW Injury
& Rehab Center P.S.

Informed Consent for Examination and Treatment

I (we) herby consent to the performance of examination and treatment on me or on _____, by the licensed doctors of chiropractic, medical doctors, licensed physical therapists, chiropractic assistants, and/or licensed massage therapists who may be employed by or engaged in practice in this clinic.

I have had an opportunity to discuss with the doctor(s) or other clinic personnel the nature and purpose of the different physical therapy procedures, massage therapy and chiropractic treatment (manipulation/adjustment). I understand that neither chiropractic nor medical treatment is an exact science and that my care may involve judgments based upon facts and information known to the doctor. The doctor uses this judgment to attempt to anticipate or explain risk and complications and an undesirable result does not necessarily indicate an error in judgment. No guarantee for results can be made or expected but rather I wish to rely on the doctor to choose and recommend a best course of treatment based upon facts known that is in my best interest.

I further understand that there are certain degrees of risk associated with chiropractic health care, massage therapy and physical therapy, which includes rarely, but not limited to fractures, disc injuries, strokes, and strain/sprains and am therefore willing to accept and consent to the risk associated with the care that I am about to receive.

I have read, or the above information has been explained regarding consent. I have had an opportunity to ask questions about my examination and treatment. By signing below, I agree and intend this consent form to cover the procedures prescribed for my condition and for any future conditions for which I seek treatment.

Female Patients: By my signature on this form I do hereby state that to the best of my knowledge, I am not pregnant, nor is pregnancy suspected or confirmed at this particular time.
Date of last menstrual period: _____

_____ _____
Patient's Name (Print) Patient's Signature

_____ _____
Date Relationship or authority if not signed
By patient

_____
Witness

PRIVACY PRACTICES ACKNOWLEDGEMENT FORM

I have received the Notice of Privacy Practices and I have been provided an opportunity to review it.

Name:_____ Birthdate:_____

Signature:_____ Date:_____