FOLLETO DE INFORMACION

(Patient Information Sheet)

FECHA DE HOY: _____ *(Today's Date)* **SEXO: M ( ) F ( )** **FECHA DE LESSION:** _____ *(Date of Injury)*

APELLIDO: _____ *(Last Name)* **NOMBRE:** _____ *(First Name)*

DOMICILIO: _____ *(Address)* **Apt. #** _____

Ciudad *(City)* _____ **Estado** *(State)* _____ **Codigo Postal** *(Zip)* _____

 # TEL. CASA: ( ) _____ *(Home #)* **# TEL. TRABAJO:** ( ) _____ *(Work #)* **CELULAR:** ( ) _____ *(Cell#)*

 # SEGURO SOCIAL *(S.S. #)*: _____ **FECHA DE NACIEMENTO** *(D.O.B.)*: _____

 # LICENSIA: _____ *(Driver's license)* **ESTADO CIVIL:** *(Marital Status)* **( ) Casado** *(Married)* **( ) Soltero** *(Single)* **( ) Viudo** *(Widow)* **( ) Divorciado** *(Divorced)*

NOMBRE DE CONYUGE O TUTOR: _____ *(Spouse/Guardian Name)* **DOMICILIO:** _____ *(Address)*

ENCASO DE EMERGENCIA POR FAVOR NOTIFIQUE A : *(In case of an emergency please notify person not living in your household)*

APELLIDO: _____ *(Last Name)* **NOMBRE:** _____ *(First Name)* **TEL:** ( ) _____

_____

SEGURO DE SALUD PRIVADO: _____
(Private Health Insurance Co. / must include name AND address)

DOMICILIO *(Address)*: _____

NUMERO DE POLISA *(policy #)*: _____ **GRUPO** *(Group)*: _____

RELACION CON EL SUSCRIPTOR *(Subscriber/Relationship)*: _____

COBERTURA DE SEGURO DE AUTO: _____ **TEL:** ( ) _____
(Auto Insurance Coverage)

NUMERO DE POLISA *(policy #)*: _____ **RELACION CON EL SUSCRIPTOR** *(Subscriber/Relationship)*: _____

Favor de leer y firmar:

Cession y Divulgacion

Certifico que yo y/a mi(s) persona(s) a cargo contamos con cobertura de seguro de _____
Nombre de la(s) Compañia(s) de seguro

y cedemos directamente al Dr._____ todos los beneficios del seguro, si los hubiere, de otro modo pagaderos a mi por servicios prestados. Comprendo que soy responsable desde el punto de vista financiero por todos los cargos, sean o no pagados por el seguro. Autorizo el uso de mi firma en todos los documentos del seguro.

_____ _____

Firma del Paciente, padre/madre, tutor o representante personal Fecha

_____

Indicar nombre del Paciente, padre/madre, tutor o representante personal

_____

Relacion con el Paciente

OCUPACION *(Occupation)*:_____ DESCRIPCION DE TRABAJO *(Brief Job Description)*:_____

( ) Mano Derecha *(Right-handed)* ( ) Mano Izquierda *(Left-handed)*

Historia Del Daño *(History of Injury)*

TIPO DE ACCIDENTE *(Nature of Accident)*:

( ) Vehiculo *(Auto)* ( ) Caida *(Slip and fall)* ( ) Peaton *(Pedestrian)* ( ) Trabajo *(Work Related)* ( ) Asalto *(Assault)* ( ) Otro (Explicar)_____ *(Other, Explain)*

Si no fue accidente de Auto, describa lo que paso. *(If non-motor vehicle accident, describe the injury)*: _____

_____

_____

Informacion sobre el Accidente de AUTO solamente: *(Motor Vehicle Information Only)*:

circule o marque una

Paciente era el: *Patient was the:* ( ) Chofer *(driver)* ( ) El pasajero y estaba... *(passenger in the...)* ( )adelante *(front seat)* ( )detras *(rear)* (medio, izquierda, derecha) *(middle, left, right seat)* ( )cajuela de la camioneta *(bed of pickup)*

Paciente: *Patient was* ( ) tenia el cinturon puesto *(Wearing seatbelt)* ( ) no tenia el cinturon puesto *(Not wearing seatbelt)*

Auto del Paciente: *Patient's Vechicle* ( ) Auto *(Car)* ( ) Van *(Van)* ( ) Camioneta *(Pick-Up Truck)* ( )Motocicleta *(Motorcycle)* ( ) Bicicleta *(Bicycle)* ( ) Otro (Explicar)_____ *(Other, Explain)*

Contra: *Versus:* ( ) Auto *(Car)* ( ) Van *(Van)* ( ) Camioneta *(Pick-Up Truck)* ( ) Motocicleta *(Motorcycle)* ( ) Bicicleta *(Bicycle)* ( ) Otro (Explicar)_____ *(Other, Explain)*

Vehiculo Del Paciente estaba: *Patient's vehicle was* ( ) Parado *(At a stop)* ( ) Empesando a mover *(Starting to move)* ( ) Bajando la velocidad *(Slowing down)* ( ) Moviendo *(Moving)*

Donde fue el golpe? *Where was it struck?*

( ) POR DETRAS *(From behind)*	( ) Guardabarros derecha *(Right fender)*	( ) Guardabarros izquierda *(Left fender)*
( ) ADELANTE *(Head on)*	( ) Guardabarros derecha *(Right fender)*	( ) Guardabarros izquierda *(Left fender)*
( ) EN LADO *(Sideswiped)*	( ) Derecha *(Right side)*	( ) Izquierda *(Left side)*

El Paciente estaba: *The patient was:* ( )Desprevenido *(unprepared)* ( ) Tenia la cabesa volteada: a la derecha *(right)* izquierda *(left)* detras *(rear)* ( ) Apoyado contra el Porta Brasos *(leaning on armrest)*

Al momento del impacto, el paciente: *(On impact, the patient)* ( ) Refuerzo el cuerpo para el impacto *(Braced for impact)* ( ) Pizo los frenos *(Stepped hard on brakes)* ( ) Detubo fuerte el volante *(Forcibly held on to steering wheel)*

Al momento, su cuerpo fue: *(Thereafter, the patient's body was)* ( ) Sacudido de enfrente a atras *(Jolted back and forth)* ( ) Sacudido de lado a lado *(Jolted from side to side)* ( ) Otra_____ *(Other, Explain)*

Despues Del Impacto *(Following the Impact)*:

El Paciente indica: *Patient Indicates* ( ) No perdio el conocimiento *(Denied loss of consciousness)* ( ) Perdio el conocimiento *(Lost consciousness)* ( ) por segundos *(Momentarily)* ( ) por minutos *(Several minutes)*

Despues del accidente se sintio: *Thereafter felt*

( ) Nervioso/*Nervous*	( ) Sobresaltado/*Surprised*	( ) Aturdido/*Stunned or Dazed*
( ) Panico/Panicky	( ) Confundido/*Confused*	( ) Desorientado /*Disoriented*
( ) Asustado/Scared	( ) Ganas de vomitar /*Nauseated*	( ) Mareado/*Lightheaded or Dizzy*
( ) Otra/*Other* _____		

El paciente experimento: *(The Patient experienced)* ( ) Vomito *(Vomiting)* ( ) Convulsiones *(Convulsions)* ( ) No recuerdo los eventos de el accidente *(Poor recollection of events)*

Paciente Sufrio: *Patient sustained:* ( ) Golpe(s) a la cabesa *(Head injuries)* ( ) Sangrando / Heridas a la cabesa *(Scalp bleeding / lacerations)* ( ) Cortadas / Moretes en _____ *(Cuts / Bruises on...)*

Paciente sintio dolor: ( ) **Inmediatamente despues del accidente** ( ) **Horas despues** ( ) **Al siguente dia** ( ) **Dias despues**
Patient noted pain: *(Immediately following the accident)* *(Hours later)* *(The next morning)* *(Over the next few days)*

Sintio Dolor en: *(Pain located):* ( ) **Cabeza**/*Head* ( ) **Pecho**/*Chest* ( ) **Abdomen**/*Abdomen*

( ) **Cuello**/*Neck* ( ) **Espalda Superior**/*Upper back* ( ) **Espalda Media**/*Mid Back* ( ) **Cintura**/*Lower Back*

( ) **Hombro**/*Shoulder* ( ) **derecha**/*right* ( ) **izquierda**/*left* ( ) **Pierna**/*Leg...* ( ) **derecha**/*right* ( ) **izquerda**/*left*

( ) **Brazo**/*Arm* ( ) **derecha**/*right* ( ) **izquierda**/*left* ( ) **Muslo**/*Thigh...* ( ) **derecha**/*right* ( ) **izquerda**/*left*

( ) **Codo**/*Elbow...* ( ) **derecha**/*right* ( ) **izquierda**/*left* ( ) **Rodilla**/*Knee...* ( ) **derecha**/*right* ( ) **izquierda**/*left*

( ) **Mano**/*Hand...* ( ) **derecha**/*right* ( ) **izquierda**/*left* ( ) **Pie**/*Foot...* ( ) **derecha**/*right* ( ) **izquierda**/*left*

( ) **Muñeca**/*Wrist...* ( ) **derecha**/*right* ( ) **izquierda**/*left* ( ) **Tobillo**/*Ankle...* ( ) **derecha**/*right* ( ) **izquierda**/*left*

( ) **Dedos**/*Fingers...* ( ) **derecha**/*right* ( ) **izquierda**/*left* ( ) **Dedos del Pie**/*Toes...* ( ) **derecha**/*right* ( ) **izquierda**/*left*

Despues Del Accidente (*After the Accident*):

Paciente fue a: ( ) **Casa** ( ) **Trabajo/Escuela** ( ) **Al Hospital, via...** ( ) **Paramedicos** ( ) **Usted mismo**
Patient went *(Home)* *(Back to work/school)* *(To hospital via...* *(Paramedics)* *(Self)*

Nombre Del Hospital/Clinica Medica *(Hospital Name/Medical Center)* _____

Fue internado, Fecha *(Date admitted)* _____ **Fecha de Alta** *(Released)* _____

Tratamiento que recibio en Hospital/Clinica *(Treatment rendered at hospital/center)*_____

_____

Lista de otros doctores que ha visto por causa de ESTE ACCIDENTE *(List any other physicians seen as a result of THIS ACCIDENT):*

_____

_____

Que medicamento, fisioterapia o tratamiento quiropractico ha recibido por causa de ESTE ACCIDENTE? *(To date, what medication(s). physical therapy or chiropractic treatment has the patient undergone or received as a result of THIS ACCIDENT)?* _____

_____

_____

Sigue recibiendo tratamiento? ( ) **No** ( ) **Si**/*Yes* **Fecha de ultimo tratamiento:** _____
(Is the patient still being treated)? *(Date of Last Treatment)*

Dolores Actuales *(Current Complaints)*

DOLORES DE CABEZA *(Headaches):*

Frequencia/*Frequency*: ( ) **Constante**/*Constant* *OIOR* ( ) **Viene o se va**/*Intermittent(comes and goes)*

Intensidad/*Intensity*: ( ) **Minimo** *(Minimal)* ( ) **Ligeramente** *(Slight)* ( ) **Moderado** *(Moderate)* ( ) **Severo** *(Severe)*

Como/*Nature*: ( ) **Agudo** *(Sharp)* ( ) **Pulsante** *(Pulsating/throbbing)* ( ) **Con Presion** *(Pressure-type)* ( ) **Punzante** *(Sharp stabbing)* ( ) **Partiendo** *(Splitting)*

Donde esta localisado el dolor: ( ) **Toda la Cabeza** *(All over the head)* ( ) **Area de Frente** *(Frontal are)* ( ) **Detras** *(Back)* ( ) **Lado Derecho** *(Right side)* ( ) **Lado Izquierdo** *(Left side)*
(location of pain)

DOLORES ACTUALES (CONTINUACION)/*CURRENT COMPLAINTS (CONTINUED)*

( ) Dolor de Pecho/*Chest pain*	( ) Hombro/*Shoulder*	( ) D/R ( ) I/L	( ) Cadera/*Hip*	( ) D/R ( ) I/L
( ) Abdominal/*Abdominal pain*	( ) Brazo/*Upper arm*	( ) D/R ( ) I/L	( ) Pierna/*Leg*	( ) D/R ( ) I/L
( ) Enfrente del Cuello/*Neck front*	( ) Codo/*Elbow*	( ) D/R ( ) I/L	( ) Muslo/*Thigh*	( ) D/R ( ) I/L
( ) Cuello/Nuca /*Neck back*	( ) Ante brazo/*Forearm*	( ) D/R ( ) I/L	( ) Rodilla/*Knee*	( ) D/R ( ) I/L
( ) Costado/*Upper /mid back*	( ) Muñeca/*Wrist*	( ) D/R ( ) I/L	( ) Tobillo/*Ankle*	( ) D/R ( ) I/L
( ) Cintura/*Lower back*	( ) Mano/*Hand*	( ) D/R ( ) I/L	( ) Pie/*Feet*	( ) D/R ( ) I/L

Tiene moretes, inflamacion,, raspones, o cortadas? Explique en detalle *(Any bruises, swelling, abrasions, lacerations? If so, explain in detail)*:

_____

_____

_____

Marque las quejas relacionadas *(Mark any of the following associated complaints)*:

( ) Vision Borroso/*Blurred Vision* ( ) Nausea/vomito/*Nausea/Vomiting* ( ) Perdida de Balance/*Loss of Balance* ( ) Mareos/*Dizziness*
( ) Perdida de Memoria/*Memory Loss* ( ) Problemas de Dijestion/*Digestion Problems* ( ) Perdida de Apetito/*Loss of Appetite*
( ) Problemas Recordando/*Absent Mindedness* ( ) Nerviosismo/*Nervousness* ( ) Confusion/*Confusion* ( ) Ansiedad/*Anxiety*
( ) Sumbido de Oidos /*Ringing Noise in the Ears* ( ) Insomnio/*Insomnia* ( ) Tension/*Tension* ( ) Inquietud/*Restlessness*
( ) Ganas de Llorar/*Crying Spell* ( ) Depresion/*Depression* ( ) Problemas de la Vejiga/*Bladder Problems*

( ) Cojear a causa de dolor en /*Limping due to pain in* ... ( ) derecha/*right* ( ) izquierda/*left extremity*

Describe algun dolor que extende, entumido o piquetes/*Describe any radiating pain; numbness or tingling sensations*:

_____

Describe partes de su cuerpo que truenan con movimiento/*Describe any locking, snapping, crackling, popping)*:_____

_____

Actividades que Aumentan el dolor *(Activities that increase pain)*:

( ) Agachando /*Bending* ( ) Cargando/ *Carrying* ( ) Extenderse/*Extending* ( ) Caminando/ *Walking*
( ) Empujando/*Pushing* ( ) Sentando /*Sitting* ( ) Sentadillas /*Squatting* ( ) Torsiendo/*Twisting*
( ) Volteando/*Turning* ( ) Parado/*Standing* ( ) Jalando/*Pulling* ( ) Manejando /*Driving*
( ) Levantando algo/*Lifting* ( ) Alsando las Manos/*Reaching Overhead* ( ) Tosiendo/*Coughing* ( ) Estornudado/*Sneezing*
( ) Caminar en piso disparejo/*Walking on uneven ground* ( ) Cambios de clima /*Climate changes* ( ) Otro/*Other* _____

( ) Tiene problemas buscando una posición confortable al dormir por el dolor? (Su cama es... ( ) Suave ( ) Dura ( ) Firme
(Unable to find a comfortable position in bed due to pain...) *(Patients bed is... (Soft) (Hard) (Firm)*

Cuanto tiempo puede durar sentado, de pie o caminando antes de cambiar de posicion por el dolor? _____
(How long can patient sit, stand, or walk before changing positions?)

_____

Antes de el accidente, describe la capacidad de levanter cosas: _____
(Describe patient's pre-injury capacity for lifting)

Los sintomas originales han *Have original symptoms* ( ) Mejorado *(Improved)* ( ) Permanesen igual *(Remained the same)* ( ) Empeoraron *(Worsened)*

Usando la escala, circule la intensidad de dolor que siente/*Using the following scale, circle the patient's average pain level:*

No tiene Dolor (*No Pain)* Pequeño *(Minimal)* Poco *(Slight)* Moderado *(Moderate)* Severo *(Severo)*

0 1 2 3 4 5 6 7 8 9 10

ACCIDENTES ANTERIORES/ ANTECEDENTES MEDICOS, *(Past medical history/Prior Accidents)*

Alergias *(Allergies)*: ( ) NO ( ) SI De Que *(To what)*? _____

Trauma Abdominal *(Abdominal Trauma)*	( )NO	( )SI	**SE RECUPERO?** *(If yes, did you fully recover?)*	( )NO	( )SI
Trauma al Pecho *(Chest Trauma)*	( )NO	( )SI	**SE RECUPERO?** *(If yes, did you fully recover?)*	( )NO	( )SI
Fracturas *(Fractures)*	( )NO	( )SI	**SE RECUPERO?** *(If yes, did you fully recover?)*	( )NO	( )SI
Trauma de Cabesa *(Head Trauma)*	( )NO	( )SI	**SE RECUPERO?** *(If yes, did you fully recover?)*	( )NO	( )SI
Otro*(Other)*	( )NO	( )SI	**SE RECUPERO?** *(If yes, did you fully recover?)*	( )NO	( )SI

SIDA/VIH *(AIDS/HIV)*	( )NO	( )SI	**Tratamiento** *(Treatment)* _____
Artritis *(Arthritis)*	( )NO	( )SI	**Tratamiento** *(Treatment)* _____
Asma *(Asthma)*	( )NO	( )SI	**Tratamiento** *(Treatment)* _____
Bronquitis *(Bronchitis)*	( )NO	( )SI	**Tratamiento** *(Treatment)* _____
Cancer *(Cancer)*	( )NO	( )SI	**Tratamiento** *(Treatment)* _____
Diabetes *(Diabetes)*	( )NO	( )SI	**Tratamiento** *(Treatment)* _____
Enfermedad cardiaca *(Heart Disease)*	( )NO	( )SI	**Tratamiento** *(Treatment)* _____
Hepatitis *(Hepatitis)*	( )NO	( )SI	**Tratamiento** *(Treatment)* _____
Alta Presion Sanguinea*(High Blood Pressure)*	( )NO	( )SI	**Tratamiento** *(Treatment)* _____
Neumonia *(Pneumonia)*	( )NO	( )SI	**Tratamiento** *(Treatment)* _____
Problemas psiquiatricos *(Psychiatric Problems)*	( )NO	( )SI	**Tratamiento** *(Treatment)* _____
Tuberculosis *(Tuberculosis)*	( )NO	( )SI	**Tratamiento** *(Treatment)* _____
Otro *(Other)*_____	( )NO	( )SI	**Tratamiento** *(Treatment)* _____

ANTECEDENTES QUIRURGICOS. *(Surgical History)*

Apendicectomia *(Appendectomy)*	( )NO	( )SI,	**Fecha** *(Date):* _____
Vesicula biliar *(Gallbladder)*	( )NO	( )SI,	**Fecha** *(Date):* _____
Hernia *(Herniotomy)*	( )NO	( )SI,	**Fecha** *(Date):* _____
Histerectomia*(Hysterectomy)*	( )NO	( )SI,	**Fecha** *(Date):* _____
De Corazon Abierto *(Open Heart/Bypass)*	( )NO	( )SI,	**Fecha** *(Date):* _____
Tonsillectomy *(Tonsillectomy)*	( )NO	( )SI,	**Fecha** *(Date):* _____
Tubal Ligation *(Tubal ligation)*	( )NO	( )SI,	**Fecha** *(Date):* _____
Otro (explicar)*/other (specify)*	( )NO	( )SI,	**Fecha** *(Date):* _____

Que medicamento esta tomamdo: *(Medications currently taking):*

Nombre/Medicamento *(Medication Name)*	**Fuerza** *(Strength) (mg/gm)*	**Dosis por dia** *(Daily Dosage)*	**Por quanto tiempo** *(Length taken)*

Accidentes o Heridas Anteriores: *(Previous Accidents/Injuries)*

( ) **Accidente de Auto**/*Car accident* ( ) **Caida y resbalo** /*Slip and Fall* ( ) **DeTrabajo**/*Work-related*

( ) **Otro/ (Explicar)**/*Other (Explain)*_____

Fecha Y Descripcion de accidente(s): _____
(Date & Description of prior accident(s))

HISTORIA SOCIAL/*SOCIAL HISTORY*

Consumo de Alcol: ( ) **Diario** ( ) **Cada Semana** ( ) **De vez en cuando** ( ) **Socialmente** ( ) **Raramente** ( ) **Nunca**
(Alcohol Intake :) *(Daily)* *(Weekly)* *(Occasionally)* *(Socially)* *(Seldom)* *(Never)*

Consumo de Tabacco: ( ) **No Fumo** ( ) **Fumo** ____ **paquete(s) por/** ( ) **Dia** ( ) **Semana** ( ) **Mes** ( ) **POR** ____ **Años**
(Tobacco Use :) *(Non-Smoker)* *(Smoker packs per...)* *(Day)* *(Week)* *(Month)* *(for/years).*

MUJERES SOLAMENTE: **Embarazada?** ( ) **NO** ( ) **SI**/*yes* **(Si, quanto tiempo?** _____)
(FOR WOMEN ONLY): *(Pregnant?)* *(Yes, How long?)*

Fecha de la ultima Menstruacion/ *Date of last menstrual period*_____

Neck Index

ACN Group, Inc. Form NI-100

ACN Group, Inc. Use Only rev 3/27/2003

Patient Name _____ **Date** _____

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

Pain Intensity

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

Sleeping

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

Reading

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

Concentration

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

Work

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

Personal Care

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

Lifting

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

Driving

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

Recreation

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

Headaches

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

Index Score = [Sum of all statements selected / (# of sections with a statement selected x 5)] x 100

Neck Index Score _____

Back Index

ACN Group, Inc. Form BI-100

ACN Group, Inc. Use Only rev 3/27/2003

Patient Name _____ ***Date*** _____

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

Pain Intensity

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

Sleeping

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

Sitting

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

Standing

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

Walking

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

Personal Care

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

Lifting

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

Traveling

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

Social Life

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

Changing degree of pain

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

Index Score = [Sum of all statements selected / (# of sections with a statement selected x 5)] x 100

Back Index Score _____

SAN PEDRO CHIROPRACTIC CLINIC

1534 W 25th St • San Pedro, CA 90732 •T:(310) 548-5656 •F: (310) 382- 2085

NOTICE OF DOCTORS LIEN

Patient: _____ Date of Accident: _____

I do hereby authorize the doctors practicing at San Pedro Chiropractic Clinic to furnish you, my attorney, with a full report of his/her examination, diagnosis, treatment, prognosis, etc., of myself in regard to the accident in which I was recently involved.

I hereby authorize and direct you, my attorney, to pay directly to said doctor such sums as may be due and owing him/her for the medical service rendered me both by reason of this accident and by reason of any other bills that are due his/her office and to withhold such sums from any settlement, judgment, or verdict as may be necessary to adequately protect and fully compensate said doctor. And I hereby further give a lien on my case to said doctor against any and all proceeds of my settlement, judgment, or verdict which be paid to you, my attorney, or myself, as the result of the injuries for which I have been treated or injuries in connection therewith.

I fully understand that I am directly and fully responsible to said doctor for all medical bills submitted by him/her for service rendered me and that this agreement is made solely for said doctor's additional protection and in consideration of his awaiting payment, and I further understand that such payment is not contingent on any settlement, judgment, or verdict by which I may eventually recover said fee.

I agree to promptly notify said doctor of any change or addition of attorney(s) used by me in connection with this accident, and I instruct my attorney to do the same and to promptly deliver a copy of this lien to any such substituted attorney(s).

Please acknowledge this letter by signing below and returning to the doctor's office. I have been advised that if my attorney does not wish to cooperate in protecting the doctor's interest, the doctor will not await payment and may declare the entire balance due and payable.

_____ _____

DATED PATIENT'S SIGNATURE

The undersigned being attorney of record for the above patient does hereby agree to observe all the terms of the above and agrees to withhold such sums from any settlement, judgment, or verdict, as may be necessary to adequately protect and fully compensate said doctor above-named. Attorney further agrees that in the event this lien is litigated, that the prevailing party will be awarded attorney fees and costs.

_____ _____

DATED ATTORNEY SIGNATURE

Informed Consent for Care

Please read and sign below:

I, as a patient coming to *San Pedro Chiropractic Clinic*, give the doctors permission and consent to care for myself in accordance with appropriate testing, diagnosis, and treatment. The clinical procedures in this office are typically beneficial and rarely cause problems. However, although rare, medical treatments, chiropractic, physical therapy and more do carry a small risk with treatment, including but not limited to: swelling, disc injuries, stroke, and sprains/strains.

I do not expect the doctor to be able to anticipate and explain all risk and complications. I wish to rely on the doctor to exercise judgment during the course of the procedures, which the doctors feel at the time, based on the facts then known, are in my best interest. We use all precautions (exams, x-rays) and gentle treatment procedures to mitigate risk. We cater the care plans to your individual needs.

This office does not perform breast, pelvic, prostate, rectal, or full skin evaluations. We also do not provide care for conditions (such as high blood pressure, diabetes, high cholesterol, etc.) other than those addressed in your treatment care plan. Treatment for conditions other those being addressed in our office should be performed by your family physician, or other specialist/provider. We do not prescribe or refill any controlled substances, this aspect should be taken care of by your primary care physician or the original prescriber.

The patient assumes all responsibility/liability if the patient does not report on any health forms any past medical history, illnesses, medications, or allergies.

I have read, or have had read to me, the above consent. By signing below I agree to the above, and allow the doctors affiliated with *San Pedro Chiropractic Clinic* to perform treatment procedures and protocols. I intend for this consent to cover the entire course of treatment for my present condition and any further condition(s) for which I seek treatment for in this office.

_____ _____

Patient name (Print) Date

_____

Patient (or guardian) signature

Privacy Policy Statement

By signing this document, I acknowledge that I have received/read a copy of San Pedro Chiropractic Clinic's privacy policy. I also acknowledge that I can request a copy of the privacy policy at any time, as well as read the one posted in this office.

_____ _____

Patient name (Print) Date

Personal Medical Information Consent Form

The Health Insurance Portability Accountability Act of 1996 (HIPAA) requires that we receive your permission before we use the personal information in your medical records for any reason.

This consent form gives us permission to use your Protected Health Information (PHI) to carry out treatment, receive and/or as part of health care operations of our practice.

HIPPA also requires us to have a written notice of our privacy policy describing how medical information about you may be used and disclosed. If you so desire, this written notice is available at the front desk for you to read.

You have the right to revoke, in writing, this consent form at the time, although any services performed prior to the revocation of this consent are covered by this consent.

Patient Signature: _____ **Date:** _____

Restrictions:

Right to revise Privacy Practices: As permitted by law, we reserve the right to amend or modify our privacy policies and practices. These changes in our office's and practice may be required by changes in federal and state laws and regulations. Upon receipt, we will provide you with the most recent notice on an office visit. The revised policies and practices will be applied to all protected health information we maintain.

Doctor/Staff Signature: _____ **Date:** _____

San Pedro Chiropractic Clinic Record Release

1534 W 25th St. San Pedro, CA 90732
phone: (310) 548-5656 fax: (310) 382-2083

Dr. Ramin Eshghi, DC. Dr. Tyler Clark, DC

AUTHORIZATION TO RELEASE MEDICAL RECORDS

To: _____

Address: _____

I, _____ Birth Date: _____request the following information:

X-Rays History Records Diagnosis Reports Treatment

Concerning my: Illness Accident Injury Other_____

D.O.I:_____

To be released to: San Pedro Chiropractic Clinic. at the above address.

For the purpose of: Review and Treatment

I understand that I have a right to receive a copy of this authorization upon my request.

Signature: _____ Date: _____

Patient Spouse Parent Guardian