



Time _____ RM _____
_____ T 1 2 3

Name _____ Date of Birth ____/____/____ Age _____ Male / Female

Address _____ City _____ State _____ Zip _____

Full SSN _____ Phone # _____

Email Address _____

Occupation _____ Employer's Name _____

Single / Married / Divorced / Widowed Spouse's Name _____

Number of Children _____ Names, Ages & Gender _____

Who may we thank for referring you? _____

Office Only _____

LIST YOUR HEALTH CONCERNS BELOW:

Health Concerns: List according to severity	Rate of Severity 1 = mild 10 = unbearable	When did this episode start?	If you had the condition before, when?	Did the problem begin with an injury?	Are symptoms constant or intermittent?
1. _____	_____	_____	_____	_____	_____
2. _____	_____	_____	_____	_____	_____
3. _____	_____	_____	_____	_____	_____
4. _____	_____	_____	_____	_____	_____
5. _____	_____	_____	_____	_____	_____

HAVE YOU EVER SEEN OTHER DOCTORS FOR THESE CONDITIONS? YES / NO

Chiropractor? _____ Medical Doctor? _____ Other _____

Name and Date of Providers _____

Result of Care _____

CIRCLE ALL CURRENT PROBLEMS YOU HAVE:

- | | | | | |
|----------------|-------------------|------------------|--------------------|--------------|
| DIZZINESS | THROAT ISSUES | KIDNEY PROBLEMS | LIVER DISEASE | DISC PROBLEM |
| HEADACHES | THYROID PROBLEMS | MID BACK PAIN | SHOULDER PAIN | INFERTILITY |
| VERTIGO | ASTHMA | IRRITABLE BOWEL | CHRONIC FATIGUE | LUPUS |
| EAR INFECTIONS | ULCERS | SCIATICA | FIBROMYALGIA | OTHER _____ |
| NAUSEA | NUMBNESS IN ARMS | NUMBNESS IN LEGS | GASTRIC REFLUX | _____ |
| TMJ | NUMBNESS IN HANDS | NUMBNESS IN FEET | CHEST PAIN | _____ |
| NECK PAIN | LOW BACK PAIN | ARM PAIN | MENSTRUAL DISORDER | _____ |
| MIGRAINES | HEART DISORDERS | HIP PAIN | ADD/ADHD | _____ |
| ANXIETY | STOMACH DISORDERS | LEG PAIN | NERVOUSNESS | _____ |
| CHRONIC SINUS | BLADDER PROBLEMS | KNEE PAIN | EPILEPSY | _____ |

CIRCLE ANY CONDITION YOU HAVE NOW and/or HAVE HAD:

STROKE CANCER HEART DISEASE SPINAL SURGERY SEIZURES SPINAL BONE FRACTURE SCOLIOSIS DIABETES

List ALL surgical operations and years _____

List all over the counter & prescription medications you are on _____

Have you ever been knocked unconscious? YES / NO Fractured a bone? YES / NO
If yes, please describe _____

Other major traumas _____

Have you had previous chiropractic care? YES / NO
If you have, Dr. & date _____

Social History

1. **Tobacco:** ___Cigars ___Pipe ___Cigarettes ___Chew
How often? ___Daily ___Weekends ___Socially ___Occasionally ___Never

2. **Exercise: How often?** ___Daily ___Several Days per Week ___Weekends ___Occasionally ___Never

3. **How does your present problem affect the following: Hobbies --- Recreational Activities --- Exercise**

4. **What daily activities are being restricted by your current health problems:**

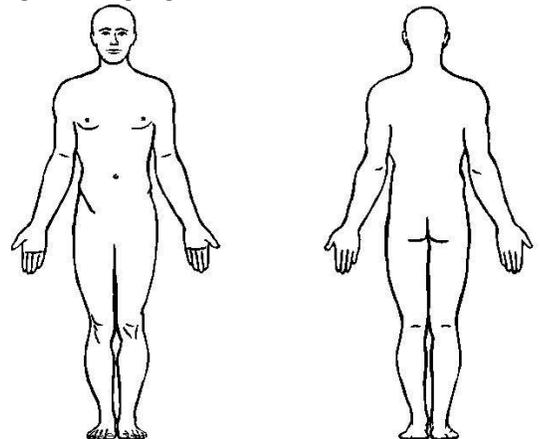
5. **What could you do or would like to do if you weren't restricted by your current health problems:**

***Please Mark** the areas on the Diagram with the following **letters** to describe your symptoms:

R=Radiating **B**=Burning **D**=Dull **A**=Aching **N**=Numbness **S**=Sharp/Stabbing **T**=Tingling

What relieves your symptoms? _____

What makes them feel worse? _____



Terms of Acceptance

In order to provide for the most effective healing environment, the most effective application of chiropractic procedures, and the strongest possible doctor-patient relationship, it is our wish to provide each practice member with a set of parameters and declarations that will facilitate the goal of optimum health through chiropractic.

To that end, we ask that you acknowledge the following point regarding chiropractic care and the services that are offered through this clinic:

- A. Chiropractic is a very specific science, authorized by law to address spinal health concerns and needs. Chiropractic is a separate and distinct science, art, and practice. It is not the practice of medicine.
- B. Chiropractic seeks to maximize the inherent healing power of the human body by restoring normal nerve functions through the adjustment of spinal subluxation(s). Subluxations are deviations from normal spinal structures and configurations that interfere with normal nerve processes.
- C. The chiropractic adjustment process, as defined in the law of this jurisdiction, involves the application of a specific directional thrust to a region or regions of the spine with the specific intent of re-positioning misaligned spinal segments. This is a safe, effective procedure applied over one million times each day by Doctor of Chiropractic in the United States alone.
- D. A thorough chiropractic examination and evaluation is part of the standard chiropractic procedure. The goal of this process is to identify any spinal health problems and chiropractic needs. If during this process, any condition or question outside the scope of chiropractic is identified, you will receive a prompt referral to an appropriate provider or specialist, according to the initial indications of the need.
- E. Chiropractic does not seek to replace or compete with your medical, dental or other type(s) of health professionals. They retain responsibility for care and management of medical conditions. We do not offer advice regarding treatment prescribed by others.
- F. Your compliance with care plans, home and self-care, etc., is essential to maximum healing and optimal health through chiropractic.
- G. We invite you to speak frankly to the doctor on any matter related to your care at this facility, its nature, duration, or cost, in what we work to maintain as a supporting, open environment.

By my signature below, I have read and fully understand the above statements.

All questions regarding the doctor's objectives pertaining to my care in this office have been answered to my satisfaction. I therefore accept chiropractic care on this basis.

_____ / / _____
Signature Date

Auto Injury Questionnaire

Practice Member Name _____	Make/Model of your car _____
Auto Insurance Company _____	Make/Model of other involved vehicle _____
Name on policy (if other than yourself) _____	Amount of damage to your car \$ _____

Attorney Information

Attorney's Name _____ Firm _____

Phone (____) _____

Address _____ City _____ State _____ Zip _____

Nature of Accident

1. Date of accident _____ Time of Day _____
2. Were you in: *Driver seat* *Passenger seat* *Backseat Driver Side* *Backseat Passenger Side* *Middle seat*
3. Did the airbags deploy? *Yes / No*
4. Were you wearing a seatbelt? *Yes / No*
5. Were you struck from: *Behind* *Front* *Driver Side* *Passenger Side*
6. Were you aware of the impending accident or were you taken by surprise? *Aware / Surprised*
7. Speed of your vehicle? _____ mph Other vehicle _____ mph
8. In your own words, please describe the accident: _____

9. Were you knocked unconscious? *Yes / No*
10. Did you have any physical complaints/injuries/problems BEFORE the accident? *Yes / No*
11. Please describe what you felt:
 - a. During the accident _____
 - b. Immediately after the accident _____
 - c. Later that day _____
 - d. The next day _____
12. Were you taken to receive medical evaluation or care after the accident? _____
List treatment/procedures you received _____
13. What other Dr's have treated you for injury since the accident _____
14. Since the accident, your symptoms are: *Improving* *Getting Worse* *Same*
15. Was an accident report filed? *Yes / No*

Activities of Daily Living Assessment

Rate your current difficulties resulting from your accident/illness with regard to the various activities listed below. Use the following 0 to 4 scale and WRITE IN THE APPROPRIATE NUMBER that most closely describes your current degree of difficulty: (" 0 " if activity does not apply to you)

0 = "I can do it without any difficulty" 1 = "I can do it without much difficulty, despite some pain" 2 = "I can manage to do it by myself, despite marked pain" 3 = "I manage to do it, despite the pain, but only if I have help" 4 = "I cannot do it at all because of the pain" *Only in areas affected by accident.*

Difficulties with Self Care and Personal Hygiene Activities

Bathing.....	_____	Drying hair.....	_____	Brushing teeth.....	_____	Putting on shoes.....	_____
Preparing meals.....	_____	Showering.....	_____	Combing hair.....	_____	Making bed.....	_____
Tying shoes.....	_____	Eating.....	_____	Doing Laundry.....	_____	Washing hair.....	_____
Washing face.....	_____	Putting on pants.....	_____	Cleaning dishes.....	_____	Going to toilet.....	_____

Difficulties with Physical Activities

Standing.....	_____	Walking.....	_____	Kneeling.....	_____	Reaching.....	_____
Twisting left	_____	Twisting right.....	_____	Stooping.....	_____	Leaning back.....	_____
Leaning forward.....	_____	Leaning left.....	_____	Leaning right.....	_____	Bending left.....	_____
Bending right.....	_____	Bending back.....	_____	Bending forward.....	_____	Reclining.....	_____
Squatting.....	_____	Sitting for long periods.	_____	Standing for long periods.	_____	Walking for long periods	_____
Kneeling for long periods.....	_____						_____

Difficulties with Functional Activities

Carrying small objects.....	_____	Carrying large objects.....	_____	Carrying briefcase.....	_____
Carrying large purse.....	_____	Lifting weights off floor.....	_____	Lifting weights off table.....	_____
Climbing stairs.....	_____	Climbing inclines.....	_____	Pushing things while seated.....	_____
Pushing things while standing.....	_____	Pulling things while seated.....	_____	Pulling things while seated.....	_____
Exercising upper body.....	_____	Exercising lower body.....	_____	Exercising arms.....	_____

Difficulties with Social and Recreational Activities

Bowling.....	_____	Fishing.....	_____	Jogging.....	_____	Biking.....	_____	Competitive sports....	_____
Dating.....	_____	Golfing.....	_____	Swimming...	_____	Skiing.....	_____	Roller skating.....	_____
Hobbies.....	_____	Dining out.....	_____	Dancing.....	_____	Boating.....	_____	Other (describe below)	_____

Difficulties with Traveling

Driving in a motor vehicle.....	_____	Driving for long periods of time.....	_____
Riding as a passenger.....	_____	Riding as a passenger on an airplane.....	_____
Riding as a passenger on a train.....	_____	Riding as a passenger for long periods.....	_____

Use the following 0 to 4 scale to describe the difficulties below:

0 = "This area is not affected by my condition" 1 = "This area is slightly affected by my condition" 2 = "My condition moderately restricts my ability in the area" 3 = "My condition seriously limits my ability in this area" 4 = "My condition prevents me from using the ability"

Difficulties with Different Forms of Communication

Concentrating...	_____	Hearing.....	_____	Reading...	_____	Using a keyboard.....	_____
Writing.....	_____	Listening.....	_____	Speaking.....	_____		

Difficulties with Senses

Seeing.....	_____	Hearing.....	_____	Sense of touch.....	_____	Tasting.....	_____	Smelling.....	_____
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Difficulties with Hand Functions

Grasping..	_____	Holding..	_____	Pinching...	_____	Percussive movements...	_____	Sensory discrimination....	_____
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Difficulties with Sleep and Sexual Function

Able to have normal, restful night's sleep.....	_____	Able to participate in desired sexual activity.....	_____
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Please write in below any additional information regarding your Activities of Daily Living (that was not covered above)

Practice Member Name _____ Eval Date _____ / 368 Score _____

PI Practice Member-Provider Contract and Promissory Note

Enter This Day between Dr. Gabriel Waterman (hereafter 'Provider') and _____ (hereafter 'Practice Member'). Provider hereby agrees to establish an active account for the Practice Member and to provide essential services for the purposes of benefiting and improving Practice Member's current health condition. Practice Member hereby agrees to pay Provider in full for services performed by Provider. Practice Member and Provider acknowledge that Practice Member retains any and all rights to suit to procure payment for and benefit Practice Member may be entitled.

In Consideration of and for Provider rendering essential chiropractic and/or medical services to Practice Member, and for the temporary suspension of any collection activity by Provider by the maintenance of an active account while not receiving payment at the point of service. Practice Member hereby authorizes and directs the following actions be taken on Practice Member's behalf.

- I. PRACTICE MEMBER AUTHORIZATION TO LIABILITY INSURANCE CARRIER: In consideration of the services to be rendered to Practice Member by Provider are privy of contact, and in lieu of Provider sending direct billing to liability insurance carrier Practice Member authorizes and directs liability insurance company to disclose the settlement status of Practice Member's claim to Provider upon request, including settlement amounts thereof. After such time that the Practice Member has settled the claim with the liability carrier, in consideration that Provider has not demanded payment at the point of service. Practice Member directs the liability carrier to include the name of Provider on any check to Practice Member upon such settlement. In the event payment is made to Practice Member's attorney after settlement of the claim. Practice Member further authorizes and directs the liability company to issue a check to Provider for the full amount owed for chiropractic and/or medical services rendered to fully satisfy Practice Member's obligation to Provider.
- II. PRACTICE MEMBER AUTHORIZATIONS TO ATTORNEY IF REPRESENTED: If Practice Member hires an attorney; Practice Member acknowledges that Practice Member is represented by _____ Attorney at Law. Practice Member and Provider stipulate that representation by the above-named attorney prior to settlement, judgment, or verdict in the Practice Member's claim. Provider shall have the option to terminate this agreement and immediately collect from Practice Member the full amount then owed to Provider. Practice Member directs attorney to disclose to Provider upon request the settlement status and amount of Practice Member claim to include amount of all outstanding medical bill, dollar amount of any offers and counteroffers as well as date and reason of termination or dismissal, Practice Member's last address, telephone number and place of employment known to attorney. Practice Member further directs attorney to honor this agreement and to deduct medical expenses from total settlement prior to contingency fee being deducted and to pay Provider for services rendered after any settlement, judgment or verdict rendered in Practice Member's claim. Practice Member acknowledges and agrees to remain personally liable to Provider for any unpaid account balance to Provider for any unpaid account balance to Provider. This agreement survives this attorney-client relationship and all others that may follow in reference to this claim.
- III. BINDING ARBITRATION: In the event the liability insurance carrier or Practice Member's attorney do not honor this agreement, both parties agree to submit to binding arbitration prior to the insurance with any funds after settlement is reached. Both parties shall be entitled to legal representation at such hearing, with Practice Member's attorney the likely representative for Practice Member.
- IV. PROMISSORY NOTE: For the consideration stated above; Practice Member promises to pay Provider the full balance in Practice Member's account for services rendered to Practice Member. Payment shall be due and payable within 30 days of the last date of services or within 3 (three) days of settlement with liability carrier for injuries sustained by Practice Member and treated by Provider, whichever event occurs first, provided agreement has not been terminated by parties prior to these events, in which case the account balance will be due in full 3 (three) days after termination. Further, Practice Member agrees to the following:

IN THE EVENT PRACTICE MEMBER'S ACCOUNT IS NOT PAID IN FULL WITHIN 30 DAYS OF THE LAST DATE OF SERVICE OR WITHIN 3 (THREE) DAYS OF SETTLEMENT WITH LIABILITY CARRIER OR ATTORNEY FOR INJURIES SUSTAINED BY PRACTICE MEMBER AND TREATED BY PROVIDER, OR WITHIN 3 (THREE) DAYS OF TERMINATION, WHICHEVER EVENT OCCURS FIRST, PRACTICE MEMBER ACCOUNTS SHALL BECOME DELINQUENT. IF PRACTICE MEMBER'S ACCOUNT BECOMES DELINQUENT, PRACTICE MEMBER AGREES TO PAY COLLECTION AGENCY FEES AT 18% OF THE PRACTICE MEMBER ACCOUNT BALANCE AS OF THE LAST DATE OF SERVICES. PRACTICE MEMBER FURTHER AGREES TO PAY ALL COSTS AND ATTORNEY FEES SHOULD THOSE EFFORTS BE UNDERTAKEN BY THE PROVIDER.

Either party may terminate this agreement at any time, provided Practice Member's account remains in active status. It is agreed that, in the event Practice Member terminates this agreement, Practice Member shall pay full balance of Practice Member's account within 3 (three) days of termination, or the account shall be in default. Practice Member and Provider acknowledge that this document contains full final and entire agreement between the parties. There are no other terms to this agreement. Practice Member has read and fully understands the terms of this agreement. In the event any portion of this agreement is rendered null or void, it is expressly agreed by the parties that all remaining provisions shall remain in full force.

Print Name	Signature	_____/_____/_____ Date of Agreement
Witness Signature	Provider	