

Patient Name: _____

Claim #: _____

State your Emotions and Physical State *immediately following* the accident:

Other Doctors Seen:

- Orthopedist
- Psychiatrist
- Massage Therapist
- None
- Neurologist
- Physical Therapist
- Chiropractor

State your Emotions & Physical State *after the first few days:* _____

The Road was:

- Dry
- Wet w/ _____
- Icy
- Snowy

The Weather Conditions were:

- Sunny
- Cloudy
- Foggy
- Light rain
- Heavy rain
- Snowing

Time of Day: Dawn Day Dusk Night Unknown

SYMPTOMATOLOGY (Pain Characteristics for Major Area of Complaint):

The pain started _____

The pain is made better by _____

and worse by _____

The pain has the following qualities: _____

There is There is not radiation into _____

There is There is not referred pain into _____

There is There is not parasthesia (tingling/numbness) into: _____

The pain is located _____

The pain is (as far as timing is concerned: i.e. comes & goes, constant, etc.) _____

DAILY ACTIVITIES

How many days out of an average week do you have pain? _____

How much time out of an average day are you in pain? _____

What are the worst times of day for the pain? _____

What are the best times of day for the pain? _____

How do the following activities affect your pain?

	No Change	Relieves	Increased	Duration
Sitting	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Walking	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Standing	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Lying Down	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Looking up	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Looking Down	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Lifting	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____

What do you do to relieve the pain? _____

PAIN RATING

On a scale of 1- 10, rate your pain

No Pain Severe Pain

0 1 2 3 4 5 6 7 8 9 10

Describe the overall severity of the pain

- Mild Nuisance
- Mild to moderate but can live with it
- Moderate, having trouble coping with it
- Severe, it is ruining my quality of life

Progression

How is your pain compared to when the pain episode first started?

- Much improved
- A little worse
- Somewhat improved
- Much worse
- No Change

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Please mark each that apply to your Daily Activities:

- Has difficulty climbing stairs.
- Stays at home most of the time due to the problem.
- Changes position frequently to try and get comfortable.
- Walks more slowly than usual because of the problem.
- Does not do jobs around the house because of the problem.
- Has to use handrails to get up stairs, etc.
- Has to lie down and rest frequently due to the problem.
- Has to hold onto something to sit or stand from a chair.
- Has to get other people to do things for you.
- Has difficulty getting dressed due to the problem.
- Can only stand for short periods due to the problem.
- Has difficulty bending or kneeling due to the problem.
- Has difficulty turning over in bed due to the problem.
- Has a loss of appetite due to the problem.
- Can only walk short distances because of the problem.
- Has difficulty sleeping because of the problem.
- Has to get dressed with someone's help.
- Has to sit most of the day because of the problem.
- Is more irritable because of the problem.
- Stays in bed most of the day because of the problem.

What are some recreational activities that you participated in before this current problem and which ones cannot be performed now to the same extent as before? _____

How often do you have to stop activities and sit or lie down to control your symptoms?

- Several times a day
- Occasionally
- Approximately once per day
- Never
- All Day

List your Hobbies & Exercise Activities _____

Social History

- Single
- Married
- Divorced
- Number of Children: _____
- Smoker
- Non-Smoker
- Drink Alcohol
- Do not drink Alcohol
- Take Drugs
- Do not take Drugs

Occupational History

Your Employer _____

Job Title _____

Are your Job Duties physically demanding for you? Yes No

Have you had any disability time? Yes No

If you are currently working, which are you performing?

- Regular Duties
- Limited – Light Duties

What is your current job satisfaction:

- Very Satisfied
- Satisfied
- Dissatisfied
- Very Dissatisfied

Your highest level of education attained? _____

Medical History

List the Physicians and other practitioners your have seen for this problem:

List the Medications you are currently taking:

List the treatments you have had for your problem.

- Hot packs / Ultrasound
- Massage
- Electrical Stimulation
- TENS Unit
- Body Mechanics Training
- Strengthening Exercises
- Aerobics
- Gravity Inversion – Traction
- Bed Rest
- Chiropractic
- Osteopathy
- Biofeedback
- Trigger Point Injections
- Epidural Injections
- Back Brace
- Acupuncture
- Naturopathy

List Past Surgeries: None

List the types of Diagnostic Testing that has been performed for this problem.

- X-rays
- CT Scan
- Myelogram
- MRI Scan
- Discogram
- Bone Scan
- EMG

List Past Hospitalizations: None

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List previous back, neck and musculoskeletal problems _____

Medical History

Mark if you have had any of the following symptoms in the past 5 years.

- | | |
|--|--|
| <input type="checkbox"/> Unexplained fevers | <input type="checkbox"/> Swollen ankles |
| <input type="checkbox"/> Night sweats | <input type="checkbox"/> Stomach pain |
| <input type="checkbox"/> Weight loss of 10 lbs or more | <input type="checkbox"/> Change in bowel habits |
| <input type="checkbox"/> Loss of appetite | <input type="checkbox"/> Persistent diarrhea |
| <input type="checkbox"/> Excessive fatigue | <input type="checkbox"/> Excessive constipation |
| <input type="checkbox"/> Problems with depression | <input type="checkbox"/> Dark black stools |
| <input type="checkbox"/> Difficulty sleeping | <input type="checkbox"/> Blood in stools |
| <input type="checkbox"/> Unusual stress at work | <input type="checkbox"/> Pain-burning when urinating |
| <input type="checkbox"/> Unusual stress at home | <input type="checkbox"/> Difficulty urinating – start / stop |
| <input type="checkbox"/> Easy bruising | <input type="checkbox"/> Blood in urine |
| <input type="checkbox"/> Excessive bleeding | <input type="checkbox"/> Need to urinate more at night |
| <input type="checkbox"/> Lumps in neck, armpit or groin | <input type="checkbox"/> Morning stiffness |
| <input type="checkbox"/> Chest pain or tightness | <input type="checkbox"/> Persistent eye redness |
| <input type="checkbox"/> Persistent or unusual cough | <input type="checkbox"/> Muscle tenderness |
| <input type="checkbox"/> Trouble breathing with exercise | <input type="checkbox"/> Dry eyes or mouth |
| <input type="checkbox"/> Trouble breathing lying flat | <input type="checkbox"/> Skin rashes |
| <input type="checkbox"/> Coughing up blood | <input type="checkbox"/> Joint pain or swelling |

Females – Mark if have the following:

- Vaginal bleeding other than period
- Pap smear within last two years
- Painful menstrual periods
- Back pain with menstrual periods
- Other menstrual problems

Do you have any current problem with:

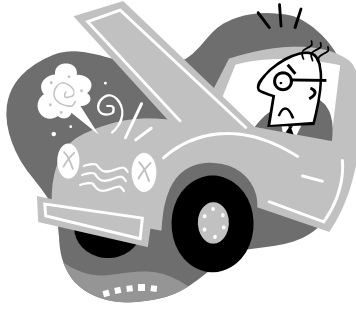
- anxiety
- depression
- irritability

Do you have a home exercise program that you follow on a regular basis?

- Yes No

NOTES:

Assignment of Benefits Personal Injury Cases



I authorize **Dr. Lindon W. Keeler, DC** to receive lien payment from all liable insurance companies, attorneys, or myself for all monies due on my account. I understand that all coverage in effect at the time of my injury will be billed. Any overpayments will be promptly returned to me. In the event that there is no valid coverage or that I have exceeded my insurance limit, I will remain responsible for charges incurred.

Further, I hereby authorize **Advanced Health Center** or any of their employees to sign my name on the back of any draft or check which they receive from my insurance company for services rendered, whether pursuant to medical payments coverage or health insurance coverage, as long as I have an outstanding balance with them. Said amount shall be credited against my account and shall reduce my outstanding balance accordingly.

All fees are based upon individual services rendered, and may vary from visit to visit depending upon the doctor's specific recommendations. A complete list is available at the front desk.

Initial Consultation: This is an opportunity to discuss with the doctor your concerns and their suggestions. There is no charge for this consultation. (The initial consultation does not include any exams, therapy or X-rays).

Note: Unless all proper claim and insurance information is provided, the patient will be responsible for payment of care received after the first visit until the necessary information can be validated.

A charge of \$45.00 will be assessed for a missed appointment. This fee will require payment at the next visit. We require a 24-hour notice for cancellations.

If the case is not settled within 120 days of being released from active care, the patient will be responsible to begin making monthly payments until the balance is paid by the insurance company.

I agree to the terms above, and acknowledge that in the event that there is an outstanding balance, which fails to be paid within sixty (60) days, my account with **Advanced Health Center** will be turned over to collection. I understand that should this happen, I will remain responsible for any and all additional collection fees and/or attorney and court costs. (Please initial to show your agreement.)

Name

Signature

Date

Notice of Doctor's Lien

Patient's Name: _____

Healthcare Provider: **Advanced Health Center / Dr. Lindon W Keeler, D.C.**
2406 Iron Street
Bellingham, WA 98225
(360) 715-9010 Clinic (360) 715-9005 Fax

I hereby authorize the above healthcare provider to furnish the above-mentioned attorney with a full report of his/her examination, diagnosis, treatments records, etc., of myself in regard to the accident in which I was involved.

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

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

Name

Signature

Date

(Patient, please do not write below this line.)

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 the said healthcare provider named above.

Attorney Name: _____

Attorney Address: _____

Date: _____ Attorney's Signature: _____

Please return to: **Advanced Health Center / Dr. Lindon W. Keeler, D.C.**
2406 Iron Street
Bellingham, WA 98225
(360) 715-9010 clinic (360) 715-9005 fax

Please maintain a copy for your records.