Bailey Chiropractic

9500 Brooktree Rd. Suite 305, Wexford, PA 15090
724 – 934 – 0899

PERSONAL INJURY

PATIENT INFORMATION

Please present your insurance card(s) so we can put a copy in your file.

Date Patient #

☐Mr. ☐Mrs. ☐ Ms. _____
(First) (Initial) (Last) (Nickname)

Address _____

City_____ State_____ Zip_____ Birthday_____ Age:_____ ☐ Male ☐ Female

Employer _____Occupation _____

Address _____ City_____ State_____ Zip_____

Insurance Company_____

Is patient covered by **Spouse's** insurance? ☐ No ☐ Yes Is patient covered by additional insurance? ☐ No ☐ Yes

Subscriber Name _____ Birthday_____
(First) (Initial) (Last)

Employer_____ Insurance Company_____

Please present insurance card(s) so we can put a copy in your file.

CONTACT INFORMATION

Best way to reach you ☐ Home ☐ Cell ☐ Work ☐ Email **Home phone** _____

Cell phone _____Work phone _____ Ext _____ Email_____

In Case of Emergency

Name_____ Relationship_____ Home Phone _____ Cell_____

If someone referred you to Dr. Bailey's office would you please tell us their name & address so we can send them a coupon to thank them.

Name_____ ☐ Ad ☐ Friend ☐ Relative ☐ Neighbor ☐ Doctor

Address_____ City_____ State _____ ZIP_____

Is your present pain due to an injury? ☐ No ☐ Yes ☐ On the job ☐ Auto Accident ☐ Other_____

Has the accident been reported? ☐ No ☐ Yes ☐ To Employer ☐ Workmen's s Compensation ☐Auto Carrier ☐ Other

Have you had any surgeries? If yes, please list ----

Surgery _____ Date_____

Surgery_____ Date _____

X-Ray Exam ☐No ☐Yes Date _____	MRI ☐No ☐Yes Date _____	CAT SCAN ☐No ☐Yes Date _____

PLEASE LIST ANY ACCIDENTS OR FALLS		DATES
Auto	☐ No ☐ Yes	
Sports or Other	☐ No ☐ Yes	
Other	☐ No ☐ Yes	
Broken Bones or dislocations (fractures)	☐ No ☐ Yes	
Have you ever had any spinal taps or spinal injections?	☐ No ☐ Yes	
Were you ever knocked unconscious or had a lapse of memory?	☐ No ☐ Yes	
Have you ever had a lapse of memory?	☐ No ☐ Yes	
Are you presently taking any medications - prescribed or patent?	☐ No ☐ Yes	If yes list below
What medications?		

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Personal Injury Patient Questionnaire

Please present your insurance card so we can put a copy in your file.

Name_____ Patient #_____

Your Auto Ins Co. _____Policy #_____Claim #_____

Name on policy_____ Ins Agent's name_____

Responsible party's name_____

Address _____City_____ State_____ Zip_____

Responsible party's policy holder's name_____ Policy #_____

Attorney's name_____Phone #_____

Address _____ City_____ State_____ Zip_____

Were there any witnesses? ☐ No ☐ Yes Names _____

Date of Accident _____Time of Day_____ Number of people in your vehicle _____

Were you: ☐ Driver ☐ Passenger ☐ Front Seat ☐Back Seat Were you wearing seat belts ☐Yes ☐ No

Approximate speed of your vehicle_____mph. What direction were you going? ☐North ☐ South ☐ East ☐ West

on name of street _____

Speed of other vehicle_____mph. What direction was the other vehicle going? ☐North ☐ South ☐ East ☐ West

on name of street _____

How many vehicles were involved in this accident_____Were you struck from ☐ Behind ☐ Front ☐ Left side ☐ Right side

Were you knocked unconscious? ☐ No ☐ Yes If yes, for how long?_____

Were the police notified? ☐ No ☐ Yes Where were you taken after the accident? _____

_____

In your own words, please describe the accident:_____

_____

Did you have any physical complaints BEFORE THE ACCIDENT? ☐ No ☐ Yes If yes please describe in detail below

_____

_____

_____

Please describe how you felt:
DURING the accident:_____

IMMEDIATELY AFTER the accident: _____

LATER THAT DAY: _____

THE NEXT DAY: _____

What are your PRESENT complaints and symptoms? _____

_____

_____

_____

Name Personal Injury Questionnaire P2

Do you have any congenital (from birth) factors which relate to this problem? ☐ No ☐ Yes IF Yes, please describe here_____

_____

Do you have any previous illnesses which relate to this case? ☐ No ☐ Yes Yes IF Yes, please describe here_____

_____

Have you ever been involved in an accident before ☐ No ☐ Yes IF Yes describe type(s) of accidents, as well as injury (ies) received_____

_____

How did you hear about our office? ☐ Ad ☐ Friend / Relative ☐ Doctor - Please tell us their name & address so we can thank them.

Name_____ Are they a patient of Dr. Bailey's ☐ No ☐ Yes

Address_____ State_____City_____ ZIP_____

Since this injury occurred, are you symptoms Improving Getting Worse Same

From the list below--PLEASE CHECK SYMPTOMS YOU HAVE NOTICED SINCE THE ACCIDENT

neck pain	dizziness	numbness in fingers	sleeping problems
neck stiff	fainting	numbness in toes	nervousness
back pain	loss of balance	pins & needles in arms	stomach upset
chest pain	loss of memory	pins & needles in legs	depression
headache	buzzing in ears	shortness of breath	constipation
fatigue	loss of smell	lights bother eyes	diarrhea
fever	head seems too heavy	feet cold	loss of taste
tension	ears ring	hands cold	cold sweats
irritability	face flushed		

Symptoms other than above_____

_____

Have you lost time from work as a result of this accident? ☐ No ☐ Yes **If yes please enter information below**

Last day worked _____ Present salary _____

Type of employment _____

Are you being compensated for time lost from work ☐ No ☐ Yes If yes, what type of compensation are you receiving?_____

Do you notice any activity restrictions as a result of this injury? ☐ No ☐ Yes If yes, please describe _____

_____

_____

Other pertinent information_____

_____

_____

Date_____ Patient's Signature_____

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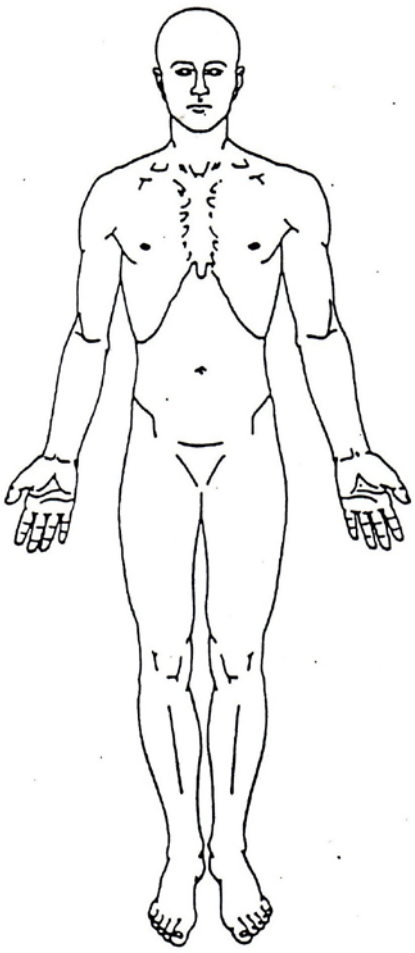
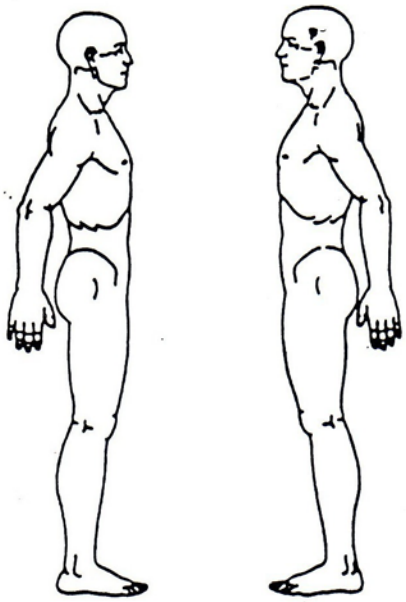
DIAGRAM OF PATIENT'S DISCOMFORT

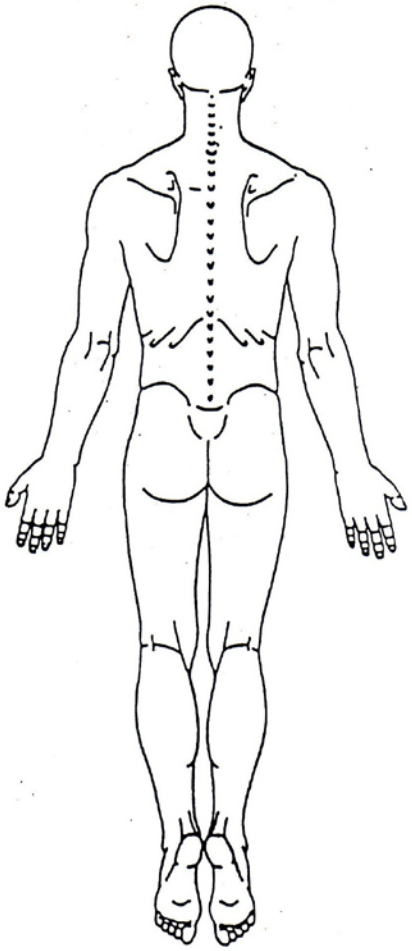
Name		Date
Habits		
☐ Smoke - packs /day	☐ Coffee - Cups/day	☐Alcohol - Amount/day
Exercise		
☐ None ☐ Moderate ☐ Daily	Type of Exercise?	
Do you currently take any vitamins and or supplements?		☐ Yes ☐ No
☐ Over the counter	☐ From my doctor	☐ I send away for them
Please list type you take		

LIST PRESENT COMPLAINTS WITH RATINGS OF 1 - 10 (10 being unbearable Pain)										
1	**1**	**2**	**3**	**4**	**5**	**6**	**7**	**8**	**9**	**10**
2	**1**	**2**	**3**	**4**	**5**	**6**	**7**	**8**	**9**	**10**
3	**1**	**2**	**3**	**4**	**5**	**6**	**7**	**8**	**9**	**10**

Use these figures to mark your pain







Mark with
A for Ache
B for Burning sensations
M for pain with Movement
N for Numbness
P for Pins & needles
S for Sharp/Stabbing pain
T for Tingling sensations
O for Other

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BACK AND NECK PAIN

BACK PAIN

Currently, I have pain in my			☐ low back	☐ mid back	☐ upper back		
My pain began			☐ gradually	☐ suddenly			
I have pain			☐ sometimes	☐ all of the time			
My pain goes into my			☐ right leg	☐ left leg	☐ both		
I have tingling and/or numbness In my			☐ right leg	☐ left leg	☐ both		
My pain is worse when I:							
cough/sneeze	☐ No	☐ Yes	walk	☐ No	☐ Yes		
sit	☐ No	☐ Yes	lift	☐ No	☐ Yes		
bend	☐ No	☐ Yes	push	☐ No	☐ Yes		
use a computer	☐ No	☐ Yes	pull	☐ No	☐ Yes		
My back is worse with sexual activity				☐ No	☐ Yes		
My pain wakes me up during the night				☐ No	☐ Yes		
Changes in the weather affect my pain				☐ No	☐ Yes		

NECK PAIN

My neck pain began			☐ gradually	☐ suddenly			
I have pain			☐ sometimes	☐ all of the time			
My pain goes into my			☐ right arm	☐ left arm	☐ both		
I have tingling and / or numbness in my			☐ right arm	☐ left arm	☐ both		
My pain is worse when I:			cough/sneeze	☐ No	☐ Yes		
lift	☐ No	☐ Yes	bend forward	☐ No	☐ Yes		
push	☐ No	☐ Yes	turn my head	☐ No	☐ Yes		
pull	☐ No	☐ Yes	use a computer	☐ No	☐ Yes		
My pain wakes me up during the night				☐ No	☐ Yes		
Changes In the weather affect my pain				☐ No	☐ Yes		
I have neck stiffness				☐ No	☐ Yes		
I have headaches				☐ No	☐ Yes		
If I do get headaches, they occur		☐ sometimes		☐ all of the time			

OTHER PAIN

Please describe any current medical complaints which you are experiencing and were not previously covered on this questionnaire, or list any additional comments you wish to make regarding your condition

NECK DISABILITY INDEX

Name_____ Date _____ Patient # _____

This questionnaire is designed to give the doctor information as to how your neck pain has affected your ability to manage in everyday life. **Please answer every section and mark in each section only the ONE BOX** which most closely applies to you.

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

2 PERSONAL CARE (WASHING AND DRESSING)

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 is most aspects of self care.

I do not get dressed, wash with difficulty, and stay in bed.

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 but I can manage if they are conveniently positioned.

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

I cannot lift or carry anything at all.

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.

5 SITTING

I have no headaches at all

I have slight headaches which come infrequently.

I have moderate headaches which come infrequently.

I have severe headaches which come frequently.

I have headaches almost all the time

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 with 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.

7 WORK

I can do as much work as I want to

I can only 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

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.

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)

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 pain in my 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 a few of my usual 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.

MODIFIED OSWESTRY DISABILITY QUESTIONNAIRE

Name _____ Date _____ Patient #_____

The purpose of this questionnaire is to measure your perceived disability from your condition. The selections you choose will give your doctor information about how your pain has affected your ability to manage in everyday life.

INSTRUCTIONS: In each section, mark with an "X" ONLY ONE BOX WHICH MOST CLOSELY APPLIES TO YOU. PLEASE ANSWER EVERY SECTION:

20	**PAIN INTENSITY**	**70**	**STANDING**
0	I have no pain.	0	I can stand as long as I want without extra pain.
1	Pain comes and goes and is very mild.	1	I can stand as long as I want but it gives me extra pain.
2	Pain is constant and is very mild.	2	Pain prevents me from standing for more than 1 hour.
3	Pain comes and goes and is moderate.	3	Pain prevents me from standing for more than 1/2 hour.
4	Pain is constant and is moderate.	4	Pain prevents me from standing for more than 10 minutes.
5	Pain is constant and is severe.	5	Pain prevents me from standing at all.
30	**PERSONAL CARE (WASHING AND DRESSING)**	**80**	**SLEEPING**
0	I can look after myself normally without causing extra pain.	0	I have no trouble sleeping
1	I can look after myself normally but it causes extra pain.	1	I can only sleep well by taking medications.
2	It is painful to look after myself and I am slow and careful.	2	I get less than six hours sleep before the pain wakes me up.
3	I need some help but manage most of my personal care.	3	I get less than four hours sleep before the pain wakes me up.
4	I need help every day is most aspects of self care.	4	I get less than two hours sleep before the pain wakes me up.
5	I do not get dressed, wash with difficulty, and stay in bed.	5	Pain prevents me from sleeping at all.
40	**LIFTING**	**90**	**CHANGING DEGREE OF PAIN**
0	I can lift heavy weights without extra pain.	0	My pain is rapidly decreasing and I am getting better.
1	I can lift heavy weights but it gives extra pain.	1	My pain fluctuates but I am gradually getting better
2	Pain prevents me from lifting heavy weights but I can manage if they are conveniently positioned.	2	My pain is decreasing and my improvement is slow.
3	Pain prevents me from lifting heavy weights but I can manage light to medium weights if they are conveniently positioned.	3	My pain is not changing -- I am not getting better or worse.
4	I can only lift very light weights	4	My pain is increasing and I am gradually getting worse.
5	I cannot lift or carry anything at all.	5	My pain is rapidly increasing -- I am getting worse.
50	**WALKING**	**100**	**SOCIAL LIFE**
0	Pain does not prevent me from walking any distance.	0	My social life is normal and gives me no extra pain.
1	Pain prevents me from walking more than one mile.	1	My social life is normal but increases the degree of pain.
2	Pain prevents me from walking more than 1/2 mile.	2	Pain has no significant effect on my social life apart from limiting my more energetic interests (e.g. dancing, etc.).
3	Pain prevents me from walking more than 1/4mile.	3	Pain has restricted my social life, I don't go out as often.
4	I can only walk using a can or crutches.	4	Pain has restricted my social life to my home.
5	I am in bed most of the time and have to crawl to the toilet.	5	I have no social life because of pain.
60	**SITTING**	**110**	**TRAVELING**
0	I can sit in any chair as long as I like.	0	I can travel anywhere without extra pain.
1	I can only sit in my favorite chair as long as I like.	1	I can travel anywhere but it gives me extra pain.
2	Pain prevents me from sitting for more than 1 hour.	2	Pain is bad but I manage journeys over two hours.
3	Pain prevents me from sitting for more than 1/2 hour.	3	Pain restricts me to journeys of less than one hour.
4	Pain prevents me from sitting for more than 10 minutes.	4	Pain restricts me to short, necessary journeys under 1/2 hour.
5	I avoid sitting since it increases my pain straight away.	5	Pain prevents me from traveling except to my doctor.

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HIPAA PATIENT PRIVACY FORM

IN ORDER TO BE COMPLIANT WITH HIPAA REGULATIONS WE REQUEST THAT EACH PATIENT COMPLETE THIS FORM. THIS FORM WILL BECOME A PERMANENT PART OF YOUR MEDICAL RECORDS. THE HIPAA PRIVACY RULES GIVE INDIVIDUALS THE RIGHT TO REQUEST A RESTRICTION ON USES AND DISCLOSURES OF THEIR PROTECTED HEALTH INFORMATION. IN LAYMANS TERMS, WE ARE ASKING FOR YOUR PERMISSION TO SEND ANY PERTANANT HEALTH INFORMATION TO ANOTHER PHYSICIAN, HOSPITAL, LAB, INSURANCE COMPANY OR ANY OTHER ENTITY THAT REQUESTS YOUR INFORMATION FOR REASONS OF CONDUCTING BUSINESS WITH REGARDS TO YOUR CARE. THE TYPES OF INFORMATION THAT ARE TYPICALLY SENT TO ANOTHER ENTITY INCLUDE: MEDICAL RECORDS, LABORATORY OR PATHOLOGY REPORTS, MEDICATIONS LIST, CONSULTATION NOTES, SURGERY NOTES AND PHOTOS AND INSURANCE INFORMATION.

I understand that I have the right to revoke this authorization at any time and that I must put that request in writing and present it to the Privacy Officer at this office I understand that the revocation will not apply to the information that has already been released or to information that is required by law or by my insurance company.

I understand that authorizing the disclosure of this health information is voluntary. I can refuse to sign this authorization and my treatment will not be altered. I understand that I may view or receive a copy of the information to be used or disclosed.

OUR OFFICE IS COMMITED TO PROTECTING YOUR PRIVACY.
PLEASE LET US KNOW HOW WE CAN CONTACT YOU.

CHECK ALL THAT APPLY

☐ HOME TELEPHONE: _____

☐ YES, YOU ARE PERMITTED TO LEAVE A MESSAGE WITH DETAILED INFORMATION ON MY MACHINE.

☐ YES, YOU ARE PERMITTED TO LEAVE A MESSAGE WITH ANOTHER ADULT.

OR

☐ N0, DO NOT LEAVE A MESSAGE ON MY MACHINE OR WITH ANOTHER ADULT.

☐ If necessary may we call you at work? If yes, list number_____

Signature of patient_____ Date _____/____/_____
or legal proxy

Office Policy – Insurance Assignment

I understand and agree that health and accident insurance policies are an arrangement between an insurance carrier and myself.

I understand that the Doctor's Office will prepare any necessary reports and forms to assist me in making collection from the insurance company and that any amount authorized to be paid directly to the Doctor's Office will be credited to my account on receipt.

This office DOES NOT promise that an insurance company will pay, nor does the office promise that an insurance company will or should pay the fees as charged

The office will not enter into a dispute with an insurance company over reimbursements or the amount of reimbursement. This is the patient's obligation.

I clearly understand and agree that all services rendered me are charged directly to me and that I am personally responsible for payment.

The patient also agrees that he/she is responsible for all bills incurred at this office

---

.All deductible amounts must be paid prior to insurance submittals

The patient must stay current with their percentage of responsibility (e.g. insurance pays 80% of the bill, and the patient pays 20%). Bills must be paid each visit unless other arrangements have been made.

I also understand that if I suspend or terminate my care and treatment, any fees for professional services rendered will be immediately due and payable.

If the patient discontinues care for any reason other than discharge by the doctor-the bill is due and payable in full-immediately, regardless of any claims submitted.

If patient fails to keep regular appointments they will be discharged. The bill is then due and payable in full-immediately.

If I fail to keep an appointment I maybe charged a no show fee of $10.00 per missed appointment.

It is understood and agreed the amount paid the Doctor for x-rays is for examination only and the x-ray negatives will remain the property of this office, being on file where they may be seen at any time while a patient at this office.

The Doctor will not be held responsible for any pre-existing medically diagnosed conditions nor for any medical diagnosis.

I hereby authorize the Doctor to examine and treat my conditions he deems appropriate through the use of Chiropractic Health Care, and I give authority for these procedures to be performed.

THERE CAN BE NO EXCEPTIONS TO THE ABOVE WE ARE ONLY TOO HAPPY TO ANSWER QUESTIONS YOU MAY HAVE.

Patient Signature_____ Date _____/_____/_____