CONFIDENTIAL
HEALTH INFORMATION

Afford A Care Chiropractic, Inc.
1223 Brookfield Rd.
P.O. Box 233
Hubbard, OH 44425
Phone 330.448.0111
Fax 330.448.0544

Please provide your driver's license and insurance card(s) for us to copy
We comply with all HIPPA & all federal privacy standards.
All information supplied is strictly confidential.

_____ **Full name including middle initial** | _____-_____-_____ **SS#** | ○ Male ○ Female **Gender** | _____/_____/_____ **Birth date**

_____ **Address** | _____ **City** | _____ **State** | _____ **Zip**

○ Single ○ Married ○ Divorced ○ Widowed **Marital status** | ( ) _____ **Home phone** | ( ) _____ **Cell phone** | ( ) _____ **Work phone**

_____ **Email address** | ○ Yes ○ No **Okay to contact me with this info**

_____ **Emergency contact – name** | _____ **Relation** | _____ **Cell** | _____ **Home** | _____ **Work**

○ Home phone ○ Cell ○ Work ○ Email **Preferred method of contact** | ○ Insurance ○ Self-pay ○ Other _____ **Who is responsible for this bill** | *If work or auto related – inform front desk*

○ Caucasian ○ African American ○ Asian ○ Native American ○ Latin American ○ Other _____ **Race**

○ Hispanic ○ Latino ○ Non-Hispanic/Non-Latino ○ Other _____ **Ethnicity**

_____ **Who may we thank for referring you to our office?** | _____ **Primary Care Physician's Name** | _____ **Primary Care Physician's City & State**

○ Employed full time ○ Employed part time ○ Unemployed ○ Retired ○ Full time student ○ Part time student _____ **Your employment status**

○ Yes ○ No **Ever involved in an auto accident?** | _____/_____/_____ **When?** | ○ Yes ○ No **Any Injuries? If yes, describe** _____

○ Yes ○ No **Any problems remaining from the above accident? If yes, describe** _____

_____ **Patient employed by** | _____ **Occupation** | ○ Yes ○ No **Have you missed work due to this problem? If yes, list dates** _____

_____ **Address of patient's employer** | _____ **City** | _____ **State** | _____ **Zip**

_____ **Name of spouse** | _____ **Spouse employed by** | _____ **Occupation** | _____/_____/_____ **DOB of spouse**

○ **I have NO insurance** | _____ **Insurance Carrier** | _____ **Insured's name** | _____/_____/_____ **DOB of insured**

How important is your health to you (1 = very little; 10 = extremely important): 1 2 3 4 5 6 7 8 9 10

*Please read each statement and **initial** your agreement to the following:*

_____ I hereby authorize Afford A Care Chiropractic, Inc., to furnish information concerning my present illness and DIRECT the insurer to pay without equivocation, directly to them, any and all benefits due him as a result of this claim. I hereby authorize this office to release all information necessary, including diagnosis and the records of any exam or treatment rendered to me, in order to secure the payment of benefits. I am also aware that I am personally responsible for charges &/or balances not covered by my insurance. I understand that it is my personal responsibility to know the coverage of my insurance and if there are any special requirements, such as but not limited to: referral by a primary physician or prior authorization. A copy or scan of this form is as legally acceptable as the original.

_____ I authorize Afford A Care Chiropractic, Inc/Clarence L. Wray, Jr., D.C.., to send copies of my records to my family physician stated on this form (or later informed to them) as they see fit.

_____ To the best of my knowledge, the information I have supplied is complete and truthful. I have not misrepresented the presence, severity, or cause of my concern.

_____ ***If the patient is a child, print the child's full name*** | _____ ***Signature of patient / parent / legal guardian*** | _____/_____/_____ ***Date***

Informed Consent to Care

A patient coming to the doctor gives him/her permission and authority to care for them in accordance with appropriate test, diagnosis, and analysis. The clinical procedures performed are usually beneficial and seldom cause any problem. In rare case, underlying physical defects, deformities or pathologies may render the patient susceptible for injury. The doctor, of course, will not provide specific healthcare, if he/she is aware that such care may be contraindicated. It is the responsibility of the patient to make it known or to learn through health care procedures from whatever he/she is suffering from: latent pathological defects, illnesses, or deformities, which would otherwise not come to the attention of the physician. This office does not perform breast, pelvic, prostate, rectal, or full skin evaluations. These examinations should be performed by your family physician, GYN, and dermatologist to exclude cancers, abnormal skin lesions that should undergo biopsy/removal or other treatments. This clinic does not provide care for any condition (such as high blood pressure, diabetes, high cholesterol) other than those addressed in your physical medicine care plan. We also do not prescribe or refill ANY controlled substances. All prescriptions should be refilled by your original prescriber and any new prescriptions should be issued by your primary care provider.

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

I agree to settle any claim or dispute I may against or with any of these persons or entities, whether related to the prescribed care or otherwise, will be resolved by binding arbitration under the current malpractice terms which can be obtained by written request.

_____ _____/_____/_____
Patient's Signature *Date*

Chiropractic care, like all forms of health care, while offering considerable benefit may also provide some level of risk. This level of risk is most often very minimal, yet in rare cases injury has been associated with chiropractic care. The types of complications that have been reported secondary to chiropractic care include sprain/strain injuries, irritation of a disc condition, and rarely, fractures. One of the rarest complications associated with chiropractic care, occurring at a rate between one instance per one million to one per two million cervical spine (neck) adjustments may be a vertebral artery injury that could lead to stroke.

Prior to receiving chiropractic care in this Chiropractic office, a health history and physical examination will be completed. These procedures are performed to assess your specific condition, your overall health and, in particular, your spine health. These procedures will assist us in determining if chiropractic care is needed, or if any further examinations or studies needed. In addition, they will help us determine if there is any reason to modify your care or provide you with a referral to another health care provider. All relevant findings will be reported to you along with a care plan prior to beginning care. I understand and accept that there are risks associated with chiropractic care and give consent to the examinations that the doctor deems necessary, and to the chiropractic care including spinal adjustments, as reported following my assessment.

This notice is effective as of the date it is signed and will expire seven years after the date on which you last received services from us.

_____ _____/_____/_____
Patient's Signature *Date*

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

I acknowledge that I have reviewed the Notice of Privacy Practices of Jones Integrated Physical Medicine & Afford A Care Chiropractic, Inc.
(Please initial one of the following options and sign below.)

_____ I wish to receive a paper copy of Privacy Notice.

_____ I do not request a copy of the Privacy Notice at this time. I acknowledge that I can request a copy at any time and the Privacy Notice is posted in the office. If I should have a problem or question in regard to my rights, I may speak with the Privacy Officer about my concerns.

I acknowledge that it is the policy of this office to leave reminder messages on my answering machine or with another person in my home. I may make a request of an alternative means of communication (within reason) in writing.

X_____ _____
Signature of Patient/Guardian Date

_____ _____
Witness (Office Staff) Date

Motor Vehicle Accident Information

Last Name:	Social Security no.:
First Name:	Middle:

Describe the accident

General Information

Date of Accident:			**Number of people in your vehicle :**
Your Location (*circle one*)	**Driver**		
	Passenger	Location (circle one)	Front / Middle / Rear
		Position (circle one)	Left / Middle / Right

Work from Left to Right and Circle One

Patient's Vehicle	**Type :**	Car / Van / Pickup / Truck / Bus / SUV / M. Cycle / Other:		
	Size :	Mini / Sub Comp / compact / Mid Size / Full Size		
	Action :	Stopped / Slowing / Acceleration / Cruising		
	Impact Location	○ Frontal driver corner ○ Frontal ○ Front passenger corner ○ Side swipe passenger side	○ Impact passenger side ○ Rear passenger corner ○ Rear-ended	○ Rear passenger corner ○ Side swipe driver's side ○ Impact driver's side ○ Other:
	Speed : (MPH**)**	**Damage to your vehicle:** Minimal / Moderate / Extensive / Totaled / Unsure		
	Time of Accident :	Day Light / Dawn / Dusk / Dark		
	Road Condition :	Dry / Damp / Wet / Snow / Ice		
	Visibility :	Good / Fair / Poor		

Enter impact Information for up to three Vehicles or Objects

Impact Information: Vehicle or Object (I)

(Select one) ☐ **Vehicle** ☐ **Object**	**Name Object :**		**Number of people in their vehicle :**
	Vehicle Type :	Car / Van / Pickup / Truck / Bus / SUV / M. Cycle	
	Speed : (MPH**)**		
	Size :	Mini / Sub Comp / compact / Mid Size / Full Size / Other:	
	Damage to Veh.:	Minimal / Moderate / Extensive / Totaled / Unsure	
Impact Location	○ Frontal driver corner ○ Frontal ○ Front passenger corner ○ Side swipe passenger side	○ Impact passenger side ○ Rear passenger corner ○ Rear-ended	○ Rear passenger corner ○ Side swipe driver's side ○ Impact driver's side ○ Other:

Impact Information: Vehicle or Object (II)

(Select one) ☐ Vehicle ☐ Object	**Name Object :**		**Number of people in their vehicle :**
	Vehicle Type :	Car / Van / Pickup / Truck / Bus / SUV / M. Cycle / Other:	
	Size :	Mini / Sub Comp / compact / Mid Size / Full Size / Other:	
	Speed : (MPH**)**		
	Damage to Veh.:	Minimal / Moderate / Extensive / Totaled / Unsure	
Impact Location	○ Frontal driver corner ○ Frontal ○ Front passenger corner ○ Side swipe passenger side	○ Impact passenger side ○ Rear passenger corner ○ Rear-ended	○ Rear passenger corner ○ Side swipe driver's side ○ Impact driver's side ○ Other:

Impact Information: Vehicle or Object (III)

(Select one) ☐ Vehicle ☐ Object	**Name Object :**		**Number of people in their vehicle :**
	Vehicle Type :	Car / Van / Pickup / Truck / Bus / SUV / M. Cycle / Other:	
	Size :	Mini / Sub Comp / compact / Mid Size / Full Size / Other:	
	Speed : (MPH**)**		
	Damage to Veh.:	Minimal / Moderate / Extensive / Totaled / Unsure	
Impact Location	○ Frontal driver corner ○ Frontal ○ Front passenger corner ○ Side swipe passenger side	○ Impact passenger side ○ Rear passenger corner ○ Rear-ended	○ Rear passenger corner ○ Side swipe driver's side ○ Impact driver's side ○ Other:

During Impact Information:

Seat Belt?	☐ Yes	☐ No	Brakes Applied ?	☐ Yes	☐ No
Air Bag Deployed?	☐ Yes	☐ No	Seat Broken ?	☐ Yes	☐ No
Seat Back position Changed?	☐ Yes	☐ No			

Head Rest : (Circle one)	Low / Mid / High / None
Prepare for Accident : (Circle one)	Un-expected / Expected / Expected and Braced
Body Position : (Circle one)	Straight / Rotated Left / Rotated Right / Unsure / Other:
Body Thrown?	☐ Yes / ☐ No
Direction of Throw : (Circle one)	Backwards / Forward / Outside / Unsure / Other:

(Circle one)

Head Position :	Straight / Rotated Left / Rotated Right / Forward / Unsure / Other:
Head Motion :	Forward Backwards / Backwards Forward / Right Left / Left Right / Unsure / Other:

Body Impact (Indicate any parts of your body that were struck during the impact)

☐ Head	☐ Upper Back	☐ Right hand	☐ Lower Back
☐ Left Shoulder	☐ Left Leg	☐ Mid Torso	☐ Right Foot
☐ Left Arm	☐ Right Leg	☐ Mid Back	☐ Left Foot
☐ Left Elbow	☐ Right Shoulder	☐ Right Knee	☐ Other :
☐ Left hand	☐ Right Arm	☐ Left Knee	
☐ Upper Front Torso	☐ Right Elbow	☐ Lower Front Torso	

After Accident Information:

Immediately After Accident:	☐ Dizzy/dazed ☐ Upset ☐ Weak ☐ Nervous ☐ Headache ☐ Disoriented ☐ Unconscious ☐/Other:

Pain (Indicate if you experienced any pain **immediately following the accident**)

☐ Head	☐ Left foot	☐ Right foot	☐ Left Knee
☐ Left Hand	☐ Left Shoulder	☐ Right Shoulder	☐ Right knee
☐ Right Arm	☐ Left Elbow	☐ Left Arm	☐ Neck :
☐ Upper Front Torso	☐ Mid Torso	☐ Right elbow	☐ Other:
☐ Upper Back	☐ Mid back	☐ Lower Front Torso	
☐ Left Leg	☐ Right Leg	☐ Lower Back	

Numbness:	☐Left Hand ☐ Right Hand ☐ Left Leg ☐ Right Leg ☐ Left Upper Arm ☐ Right Upper Arm ☐ Left Foot ☐ Right Foot ☐ Other:

Medical Information (Did you get medical care for this accident before coming to our office)

Medical Care?	☐ Yes	☐ No

Time of care	Next day / At time of Accident / Later that Day / Days Later: (Specify)
Transported	Drove Self / Ambulance / Other
Went To	ER (Name, City & State)
	MD or DO (Name, City & State)
	Chiropractor (Name, City & State)
	Specialist (Name, City & State)
	Other (Name, City & State)
Admitted to Hospital?	☐ Yes ☐ No Days Spent in Hospital:
Tests:	☐ X-ray – Where performed and results?
	☐ MRI – Where performed and results?
	☐ CT Scan – Where performed and results?
	☐ Lab work – Where performed and results?
	☐ Other: (Specify) –– Where performed and results?
Treatment:	☐ Ice Pack ☐ Hot Pack ☐ None ☐ Cervical Collar
	☐ Medication (list):
	☐ Other:(Specify)

Previous Injuries

Previous Injuries / Accidents	☐ No ☐ Yes, Specify:
Residual pain from Previous Injuries/Accidents?	☐ No ☐ Yes, Specify:

Later Symptoms (Please note any symptoms that started **AFTER THE ACCIDENT** occurred)

HEAD

☐ No head symptoms

☐ Headache ☐ Dizziness ☐ Blurred Vision ☐ Light Headed ☐ Loss of Vision
☐ Fainting ☐ Loss of Memory ☐ Pain in Ear ☐ Double Vision ☐ Ringing of Ears
☐ Other Specify

Location of pain: ☐ Left ☐ Right ☐ Both sides ☐ Centered ☐ Frontal ☐ Back of head
☐ Temples ☐ Eyes ☐ Other: _____
Rate the pain: ☐ Mild ☐ Mild to moderate ☐ Moderate ☐ Moderate to severe ☐ Severe
Rate your pain: 0 1 2 3 4 5 6 7 8 9 10 (10 = excruciating)
Frequency: ☐ Intermittent <25% ☐ Occasional 25-50% ☐ Frequent 50-75% ☐ Constant >75%
Better with: ☐ Nothing ☐ Inactivity ☐ Medication (list): _____
☐ Chiropractic treatment ☐ Lying down ☐ Resting ☐ Exercise ☐ Laying on left side
☐ Laying on right side ☐ Sitting ☐ Heat ☐ Ice ☐ Stretching ☐ Massage ☐ Walking
☐ Other (list): _____
Worse with: ☐ Nothing ☐ Bright lights ☐ Working ☐ Stress ☐ Chewing ☐ Neck movement
☐ Bending ☐ Certain foods ☐ Coughing ☐ Watching TV ☐ Lifting ☐ Physical activity
☐ Daily living activities ☐ Reading ☐ Sneezing ☐ Temperature change ☐ Loud noises
☐ Housework ☐ Laying down ☐ Computer ☐ Other (list) _____
Quality: ☐ Aching ☐ Dull ☐ Burning ☐ Deep ☐ Electric ☐ Numbness/tingling
☐ Sharp ☐ Shooting ☐ Stabbing ☐ Throbbing ☐ Other (describe): _____
Radiating: ☐ Left arm ☐ Right arm ☐ Left elbow ☐ Right elbow ☐ Eyes ☐ Ears
☐ Left forearm ☐ Right forearm ☐ Left hand ☐ Right hand ☐ Left fingers ☐ Right fingers
☐ Left shoulder ☐ Right shoulder ☐ Left shoulder blade ☐ Right shoulder blade ☐ Jaw
☐ Back of head ☐ Both sides of head ☐ Upper back ☐ Other (list): _____
Timing (worse in or with): ☐ Morning ☐ Afternoon ☐ Evening ☐ During night ☐ Same all day
☐ Increases as day goes on ☐ Light activities ☐ Moderate activities
Side effects: ☐ Nausea ☐ Vomiting ☐ Sensitive to bright light ☐ Visual problems ☐ Dizziness
☐ Loss of balance ☐ Ringing of ears ☐ Tightness ☐ Fatigue ☐ Other (list) _____

NECK

☐ No neck symptoms

☐ Pain in Neck ☐ Muscle Spasms ☐ Popping in neck ☐ Other (list) _____

Location of neck pain: ☐ Left ☐ Right ☐ Both sides ☐ Centered
Rate the pain: ☐ Mild ☐ Mild to moderate ☐ Moderate ☐ Moderate to severe ☐ Severe
Rate your pain: 0 1 2 3 4 5 6 7 8 9 10 (10 = excruciating)
Frequency: ☐ Intermittent <25% ☐ Occasional 25-50% ☐ Frequent 50-75% ☐ Constant >75%
Better with: ☐ Nothing ☐ Inactivity ☐ Medication (list): _____
☐ Chiropractic treatment ☐ Lying down ☐ Resting ☐ Exercise ☐ Laying on left side
☐ Laying on right side ☐ Sitting ☐ Heat ☐ Ice ☐ Stretching ☐ Massage ☐ Walking
☐ Other (list): _____
Worse with: ☐ Nothing ☐ Neck flexion ☐ Neck extension ☐ Neck movement ☐ chewing
☐ Lateral flexion left ☐ Lateral flexion right ☐ Rotation left ☐ Rotation right ☐ Reaching
☐ Lifting ☐ Reading ☐ Sitting ☐ Sneezing ☐ Watching TV ☐ Driving ☐ Working
☐ Laying down ☐ Coughing ☐ Daily living activities ☐ Other (list): _____
Quality: ☐ Aching ☐ Dull ☐ Burning ☐ Deep ☐ Electric ☐ Numbness/tingling
☐ Sharp ☐ Shooting ☐ Stabbing ☐ Throbbing ☐ Other (describe): _____
Radiating: ☐ Left arm ☐ Right arm ☐ Left elbow ☐ Right elbow ☐ Eyes ☐ Ears
☐ Left forearm ☐ Right forearm ☐ Left hand ☐ Right hand ☐ Left fingers ☐ Right fingers
☐ Left shoulder ☐ Right shoulder ☐ Left shoulder blade ☐ Right shoulder blade ☐ Jaw
☐ Back of head ☐ Both sides of head ☐ Upper back ☐ Other (list): _____
Timing (worse in or with): ☐ Morning ☐ Afternoon ☐ Evening ☐ During night ☐ Same all day
☐ Increases as day goes on ☐ Light activities ☐ Moderate activities
Side effects: ☐ Increased sensitivity ☐ Numbness ☐ Tingling ☐ Stiffness ☐ Tightness

SHOULDERS

☐ No shoulder symptoms

☐ Pain in Shoulder Joint ☐ Tension in Shoulders ☐ Can't raise arms above:
☐ Pain Across Shoulder ☐ Muscles Spasms in Shoulder [ ] Shoulder level
☐ Other Specify [ ] Over head

Location of pain: ☐ Left ☐ Right ☐ Both sides ☐ Centered
Rate the pain: ☐ Mild ☐ Mild to moderate ☐ Moderate ☐ Moderate to severe ☐ Severe
Rate your pain: 0 1 2 3 4 5 6 7 8 9 10 (10 = excruciating)
Frequency: ☐ Intermittent <25% ☐ Occasional 25-50% ☐ Frequent 50-75% ☐ Constant >75%
Better with: ☐ Nothing ☐ Lying down ☐ Standing ☐ Resting ☐ Stretching ☐ Sitting
☐ Chiropractic treatment ☐ Range of motion ☐ Heat ☐ Ice
☐ Medication (list): _____ ☐ Other (list): _____
Worse with: ☐ Nothing ☐ Driving ☐ Neck rotation left ☐ Neck rotation right ☐ Reaching
☐ Pulling ☐ Shoulder range of motion ☐ Housework ☐ Working ☐ Lifting
☐ Other (list): _____
Quality: ☐ Aching ☐ Dull ☐ Burning ☐ Deep ☐ Electric ☐ Numbness/tingling
☐ Sharp ☐ Shooting ☐ Stabbing ☐ Throbbing ☐ Other (describe): _____

SHOULDER CONTINUED – *Radiating:* ☐ Neck ☐ Chest ☐ Left arm ☐ Left elbow
☐ Left forearm ☐ Left wrist ☐ Left hand ☐ Left fingers ☐ Right arm ☐ Right elbow
☐ Right forearm ☐ Right wrist ☐ Right hand ☐ Right fingers
Timing (worse in or with): ☐ Morning ☐ Afternoon ☐ Evening ☐ During night ☐ Same all day
☐ Increases as day goes on ☐ Light activities ☐ Moderate activities
Side effects: ☐ Decreased range of motion ☐ Increased sensitivity ☐ Numbness ☐ Tingling
☐ Weakness ☐ Other (list): _____

ARMS AND HANDS

☐ No arm or hand symptoms

☐ Pain in Fingers ☐ Numbness in Left Arm ☐ Hands Cold
☐ Pins & Needles in Hands ☐ Numbness in Right Arm ☐ Loss of Grip Strength
☐ Pins & Needles in Fingers ☐ Swollen Joints in Fingers
☐ Other Specify
Location of pain: ☐ Left ☐ Right ☐ Both sides ☐ Centered
Rate the pain: ☐ Mild ☐ Mild to moderate ☐ Moderate ☐ Moderate to severe ☐ Severe
Rate your pain: 0 1 2 3 4 5 6 7 8 9 10 (10 = excruciating)
Frequency: ☐ Intermittent <25% ☐ Occasional 25-50% ☐ Frequent 50-75% ☐ Constant >75%
Better with: ☐ Nothing ☐ Lying down ☐ Heat ☐ Ice ☐ Stretching ☐ Chiropractic treatment
☐ Other (list): _____
Worse with: ☐ Nothing ☐ Driving ☐ Daily living activities ☐ Housework ☐ Lifting
☐ Movement ☐ Working ☐ Laying down ☐ ☐ Wrist flexion ☐ Wrist extension
☐ Other (list): _____
Quality: ☐ Aching ☐ Dull ☐ Burning ☐ Deep ☐ Electric ☐ Numbness/tingling
☐ Sharp ☐ Shooting ☐ Stabbing ☐ Throbbing ☐ Other (describe): _____
Radiating: ☐ Left fingers ☐ Left forearm ☐ Left elbow ☐ Left arm ☐ Right fingers
☐ Right forearm ☐ Right elbow ☐ Right arm ☐ Other (list): _____
Timing (worse in or with): ☐ Morning ☐ Afternoon ☐ Evening ☐ During the night
☐ Increases as the day goes on ☐ Light activities ☐ Moderate activities ☐ Same all day
Side effects: ☐ Decreased range of motion ☐ Numbness ☐ Stiffness ☐ Swelling ☐ Tingling

CHEST

☐ No chest symptoms

☐ Chest Pain ☐ Pain Around Ribs ☐ Shortness of breath
☐ Other Specify ☐ Breast Pain
Location of pain: ☐ Left ☐ Right ☐ Both sides ☐ Centered
Rate the pain: ☐ Mild ☐ Mild to moderate ☐ Moderate ☐ Moderate to severe ☐ Severe
Rate your pain: 0 1 2 3 4 5 6 7 8 9 10 (10 = excruciating)
Frequency: ☐ Intermittent <25% ☐ Occasional 25-50% ☐ Frequent 50-75% ☐ Constant >75%
Better with: ☐ Nothing ☐ Lying down ☐ Chiropractic treatment ☐ Heat ☐ Ice
☐ Range of motion ☐ Resting ☐ Inactivity ☐ Stretching ☐ Medication (list): _____
Worse with: ☐ Nothing ☐ Coughing ☐ Deep breathing ☐ Lying down ☐ Lifting ☐ Movement
☐ Daily living activities ☐ Left lateral flexion ☐ Right lateral flexion ☐ Left rotation
☐ Right rotation ☐ Laying to sitting ☐ Laying to standing ☐ Sitting to laying
☐ Sitting to standing ☐ Standing to laying ☐ Standing to sitting ☐ Bending backward
☐ Bending forward ☐ Housework ☐ Working ☐ Other (list): _____
Quality: ☐ Aching ☐ Dull ☐ Burning ☐ Deep ☐ Electric ☐ Numbness/tingling
☐ Sharp ☐ Shooting ☐ Stabbing ☐ Throbbing ☐ Other (describe): _____
Radiating: ☐ Left ribs ☐ Right ribs ☐ Low back ☐ Upper back ☐ Other (list): _____
Timing (worse in or with): ☐ Morning ☐ Afternoon ☐ Evening ☐ During the night
☐ Increases as the day goes on ☐ Light activities ☐ Moderate activities ☐ Same all day
Side effects: ☐ Increased sensitivity ☐ Numbness ☐ Shallow breathing ☐ Tingling
☐ Other (list): _____

ABDOMEN
☐ No symptoms

☐ Nervous Stomach ☐ Nausea ☐ Gas ☐ Diarrhea
☐ Other Specify ☐ Constipation

MID BACK

☐ No mid back symptoms

☐ Sharp Stabbing ☐ Mid Back Pain ☐ Pain from Front to Back ☐ Dull Ache
☐ Pain in Kidney area ☐ Muscle Spasms ☐ Pain Between Shoulders
☐ Other Specify
Location of pain: ☐ Left ☐ Right ☐ Both sides ☐ Centered
Rate the pain: ☐ Mild ☐ Mild to moderate ☐ Moderate ☐ Moderate to severe ☐ Severe
Rate your pain: 0 1 2 3 4 5 6 7 8 9 10 (10 = excruciating)
Frequency: ☐ Intermittent <25% ☐ Occasional 25-50% ☐ Frequent 50-75% ☐ Constant >75%
Better with: ☐ Nothing ☐ Chiropractic treatment ☐ Exercise ☐ Heat ☐ Ice ☐ Inactivity
☐ Lying down ☐ Laying on left side ☐ laying on right side ☐ Massage ☐ Resting ☐ Sitting
☐ Stretching ☐ Walking ☐ Medication (list): _____ ☐ Other (list): _____
Worse with: ☐ Nothing ☐ Neck extension ☐ Lifting ☐ Reaching ☐ Chewing ☐ Flexion
☐ Neck movement ☐ Sitting ☐ Coughing ☐ Left lateral flexion ☐ Left rotation ☐ Sneezing
☐ Daily living activities ☐ Right lateral flexion ☐ Right rotation ☐ Watching TV ☐ Driving
☐ Laying down ☐ Reading ☐ Working ☐ Other (list): _____

MID BACK CONTINUED

Quality: ☐ Aching ☐ Dull ☐ Burning ☐ Deep ☐ Electric ☐ Numbness/tingling ☐ Sharp
☐ Shooting ☐ Stabbing ☐ Throbbing ☐ Other (describe): _____
Radiating: ☐ Left shoulder blade ☐ Left shoulder ☐ Left arm ☐ Left elbow ☐ Left forearm
☐ Left hand ☐ Left fingers ☐ Right shoulder blade ☐ Right shoulder ☐ Right arm
☐ Right elbow ☐ Right forearm ☐ Right hand ☐ Right fingers ☐ Back of head
☐ Other (list): _____
Timing (worse in or with): ☐ Morning ☐ Afternoon ☐ Evening ☐ During the night
☐ Increases as the day goes on ☐ Light activities ☐ Moderate activities ☐ Same all day
Side effects: ☐ Increased sensitivity ☐ Numbness ☐ Stiffness ☐ Tightness ☐ Tingling

LOWER BACK

☐ No lower back symptoms

☐ Low Back Pain
Low back pain is worse when:
☐ Working ☐ Lifting ☐ Stooping ☐ Standing
☐ Sitting ☐ Bending ☐ Coughing ☐ Lying Down ☐ Muscle Spasms
☐ Other Specify:
Location of pain: ☐ Left ☐ Right ☐ Both sides ☐ Centered
Rate the pain: ☐ Mild ☐ Mild to moderate ☐ Moderate ☐ Moderate to severe ☐ Severe
Rate your pain: 0 1 2 3 4 5 6 7 8 9 10 (10 = excruciating)
Frequency: ☐ Intermittent <25% ☐ Occasional 25-50% ☐ Frequent 50-75% ☐ Constant >75%
Better with: ☐ Nothing ☐ Chiropractic treatment ☐ Exercise ☐ Heat ☐ Ice ☐ Inactivity
☐ Lying down ☐ Laying on left side ☐ laying on right side ☐ Resting ☐ Sitting ☐ Standing
☐ Stretching ☐ Walking ☐ Leaning left ☐ Leaning right ☐ Inactivity ☐ Bending backwards
☐ Bending forwards ☐ Movement ☐ Medication (list): _____
☐ Other (list): _____
Worse with: ☐ Nothing ☐ Bending backward ☐ Bending forward ☐ Bending left or right
☐ Bowel movements ☐ Coughing ☐ Daily living activities ☐ Lifting ☐ Laying down
☐ Laying to sitting ☐ Sitting ☐ Sitting to standing ☐ Sitting to laying ☐ Sneezing
☐ Twisting right or left ☐ Standing to laying ☐ Standing to sitting ☐ Walking
☐ Walking up or down steps ☐ Working ☐ Other (list): _____
Quality: ☐ Aching ☐ Dull ☐ Burning ☐ Deep ☐ Electric ☐ Numbness/tingling ☐ Sharp
☐ Shooting ☐ Stabbing ☐ Throbbing ☐ Other (describe): _____
Radiating: ☐ Left buttock ☐ Right buttock ☐ Left calf ☐ Right calf ☐ Left foot ☐ Right foot
☐ Left groin ☐ Right groin ☐ Left knee ☐ Right knee ☐ Front left thigh ☐ Front right thigh
☐ Left toes ☐ Right toes ☐ Other (List): _____
Timing (worse in or with): ☐ Morning ☐ Afternoon ☐ Evening ☐ During the night
☐ Increases as the day goes on ☐ Light activities ☐ Moderate activities ☐ Same all day
Side effects: ☐ Increased sensitivity ☐ Numbness ☐ Stiffness ☐ Tightness ☐ Tingling

HIPS, LEGS & FEET

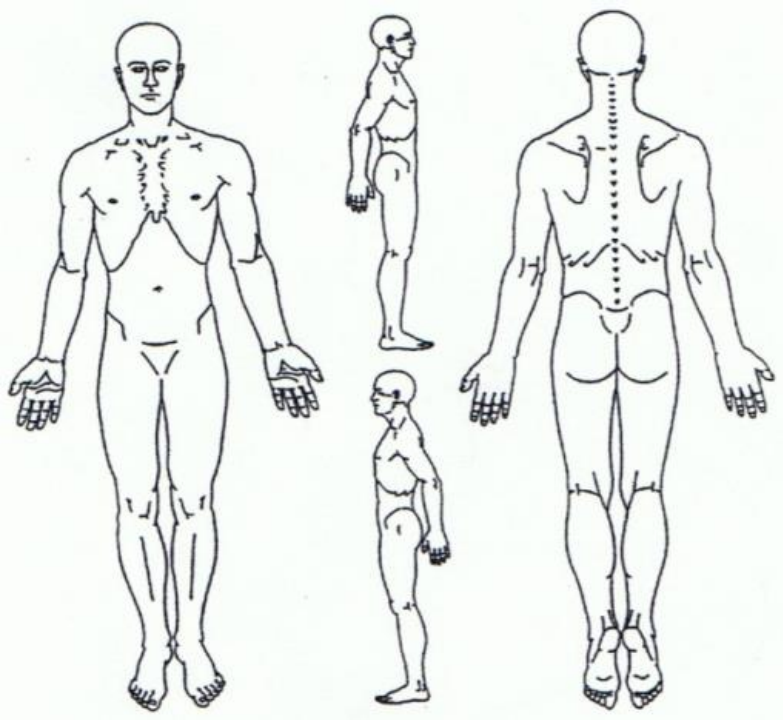
☐ No hip, leg or feet symptoms

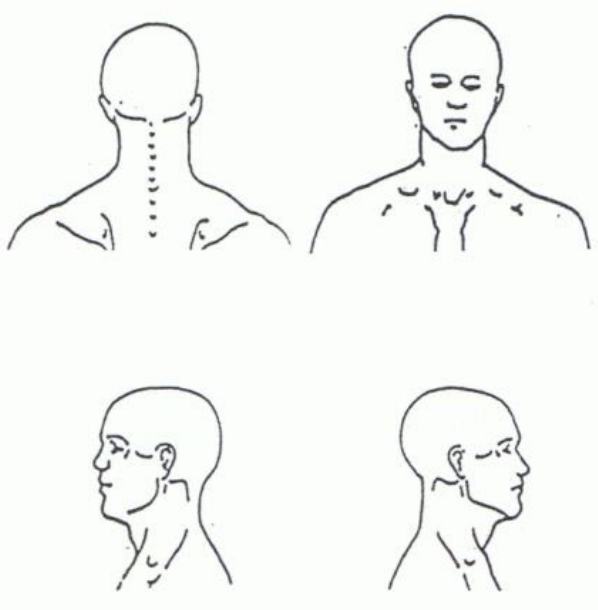
☐ Pain in Buttocks ☐ Pain and needles in Legs ☐ Pain down leg
☐ Pain in hip joint ☐ Feet feel Cold ☐ Swollen Feet
☐ Numbness in Toes ☐ Numbness of Leg ☐ Knee pain
☐ Leg cramps ☐ Cramps in Feet
☐ Other Specify:_____
Location of pain: ☐ Left ☐ Right ☐ Both sides ☐ Centered
Rate the pain: ☐ Mild ☐ Mild to moderate ☐ Moderate ☐ Moderate to severe ☐ Severe
Rate your pain: 0 1 2 3 4 5 6 7 8 9 10 (10 = excruciating)
Frequency: ☐ Intermittent <25% ☐ Occasional 25-50% ☐ Frequent 50-75% ☐ Constant >75%
Better with: ☐ Nothing ☐ Lying down ☐ Heat ☐ Ice ☐ Stretching ☐ Chiropractic treatment
☐ Sitting ☐ Standing ☐ Resting ☐ Lying on left side ☐ Lying on right side ☐ Leaning left
☐ Leaning right ☐ Exercise ☐ Inactivity ☐ Movement
☐ Medication (list): _____ ☐ Other (list): _____
Worse with: ☐ Driving ☐ Extension ☐ Lifting ☐ Movement ☐ Prolonged sitting
☐ Prolonged standing ☐ Walking ☐ Daily living activities ☐ Left lateral flexion
☐ Right lateral flexion ☐ Left rotation ☐ Right rotation ☐ Laying to sitting ☐ Laying to standing
☐ Sitting to laying ☐ Sitting to standing ☐ Standing to laying ☐ Standing to sitting
☐ Other (list): _____
Quality: ☐ Aching ☐ Dull ☐ Burning ☐ Deep ☐ Electric ☐ Numbness/tingling ☐ Sharp
☐ Shooting ☐ Stabbing ☐ Throbbing ☐ Other (describe): _____
Radiating: ☐ Left buttock ☐ Left calf ☐ Left knee ☐ Left foot ☐ Left lower back
☐ Left groin ☐ Right buttock ☐ Right calf ☐ Right knee ☐ Right foot ☐ Right lower back
☐ Right groin ☐ Other (list): _____
Timing (worse in or with): ☐ Morning ☐ Afternoon ☐ Evening ☐ During the night
☐ Increases as the day goes on ☐ Light activities ☐ Moderate activities ☐ Same all day
Side effects: ☐ Decreased range of motion ☐ Increased sensitivity ☐ Numbness ☐ Stiffness
☐ Tightness ☐ Tingling

GENERAL ☐ No general symptoms	☐ Nervousness ☐ Fatigue ☐ Irritable ☐ Depressed ☐ Generally Feel Rundown ☐ Prostate Pain/Swelling ☐ Difficulty Urinating ☐ Night Urination ☐ Cramping ☐ Irregularity Loss of Sleep : [_____] hrs per night Loss of weight : [_____] lbs Gain weight : [_____] lbs Other:

Use the following symbols to show where and what type of symptoms you are experiencing:

Pain	Numbness	Pins & Needles	Stabbing	Burning
XXXX	- - - -	0 0 0 0	/ / / /	\ \ \ \





Additional Comments:

_____

_____

_____

I hereby authorize Afford A Care Chiropractic, Inc./Clarence L. Wray, Jr., D.C., to furnish information concerning my present illness and DIRECT the insurer to pay without equivocation, directly to Afford A Care Chiropractic, Inc./Clarence L. Wray, Jr., D.C, any and all benefits due him as a result of this claim. I am also aware that I am personally responsible for charges and/or balances not covered by my insurance. I understand that it is my personal responsibility to know what the coverage is of my insurance and if there are special requirements, such as but not limited to: referral by a primary physician or prior authorization. I also authorize Dr. Wray to send copies of my records to my family physician on this form (or later informed by Dr. Wray) as he sees fit. I hereby state that a photocopy of this document will be deemed as valid on all parties as the original. This assignment is valid indefinitely unless I notify Dr. Wray in writing that it is to be terminated.

Signature: _____ Date: _____/_____/_____

All questions contained in this questionnaire are strictly confidential and will become part of your medical record.

RED FLAG QUESTIONNAIRE

Name _____ DATE _____/_____/_____ Age _____

Please check the appropriate response. If "yes", please explain. If you are not sure, check the "?" box. **Thank You!**

NO	YES	?	
❑	❑	❑	Do you have a past history of cancer?
❑	❑	❑	Have you had any unexplained weight loss?
❑	❑	❑	Does your pain improve with rest?
❑	❑	❑	Are you over 50 years old?
❑	❑	❑	Failure to respond to a course of conservative care (4-6 weeks)?
❑	❑	❑	Have you had spinal pain greater than 4 weeks?

NO	YES	?	
❑	❑	❑	Prolonged use of corticosteroids (such as organ transplant Rx)?
❑	❑	❑	Intravenous drug use?
❑	❑	❑	Current or recent urinary tract, respiratory tract or other infection
❑	❑	❑	Immunosuppression medication &/or condition

NO	YES	?	
❑	❑	❑	History of significant trauma?
❑	❑	❑	Minor trauma in person > 50 years old?
❑	❑	❑	Do you have osteoporosis (weak bones)?
❑	❑	❑	Are you over 70 years old?
❑	❑	❑	Any history of prolonged use of corticosteroids?

NO	YES	?	
❑	❑	❑	Acute onset urinary retention or overflow incontinence (wet underwear)
❑	❑	❑	Loss of anal sphincter tone or fecal incontinence (bowel accidents)
❑	❑	❑	Saddle anesthesia (numbness in the groin region)
❑	❑	❑	Global or progressive muscle weakness in the legs (legs give out)

COMMENTS:

_____

_____

_____

_____

Current Conditions:

❑ Aids	❑ Cancer	❑ Multiple Sclerosis	❑ Spinal Disc Disease	❑ STD's	❑ Ulcer
❑ Allergies	❑ Bone Fracture	❑ Heart Problem	❑ Low Blood Pressure	❑ Sinus Trouble	❑ Polio
❑ Anemia	❑ Cirrhosis/Hepatitis	❑ HIV/ARC	❑ Mental/Emotional Difficulty	❑ Epilepsy	❑ Scoliosis
❑ Arthritis	❑ Diabetes	❑ High Blood Pressure	❑ Prostate Trouble	❑ Thyroid Trouble	❑ Diverticulitis
❑ Asthma	❑ Dislocated Joints	❑ Kidney Trouble	❑ Rheumatic Fever	❑ Tuberculosis	

❑ Other – list: _____

Family History of Illness: *Please check the box if you have a family member with one of the following. In the comment section at the bottom, list the condition and put **M** for mother, **F** for father, or **S** for sibling.*

❑ Aids	❑ Cancer	❑ Multiple Sclerosis	❑ Spinal Disc Disease	❑ STD's	❑ Ulcer
❑ Allergies	❑ Bone Fracture	❑ Heart Problem	❑ Low Blood Pressure	❑ Sinus Trouble	❑ Polio
❑ Anemia	❑ Cirrhosis/Hepatitis	❑ HIV/ARC	❑ Mental/Emotional Difficulty	❑ Epilepsy	❑ Scoliosis
❑ Arthritis	❑ Diabetes	❑ High Blood Pressure	❑ Prostate Trouble	❑ Thyroid Trouble	❑ Diverticulitis
❑ Asthma	❑ Dislocated Joints	❑ Kidney Trouble	❑ Rheumatic Fever	❑ Tuberculosis	

❑ Other – list: _____

List any past tests and diagnosis for the condition(s) you have come this office for: ❑ None
Past treatments (list doctors and hospitals) for this condition and your response: ❑ None
List current medications & over-the-counter drugs and dosage *(or include a copy)*: ❑ None
List all vitamins/herbs/minerals you are taking: ❑ None
List all surgeries and dates: ❑ None
List allergies: ❑ None

Do you drink alcohol? ❑ No ❑ Yes **Drinks per week _____**	**Cigarettes?** ❑ Current every day smoker ❑ Former smoker ❑ Current some days smoker ❑ Never smoked ❑ Heavy tobacco smoker ❑ Light tobacco smoker
Caffeine? ❑ No ❑ Yes **Drinks per day? _____**	**Exercise?** ❑ No ❑ Yes ❑ Light ❑ Moderate ❑ Strenuous **Hours per week? _____**
Additional Comments:	

Signature _____ *Date* _____/_____/_____

All questions in this questionnaire are strictly confidential and will become a part of your medical record

Review of Systems

Name _____ Date _____/_____/_____

CONSTITUTIONAL ○ **NONE OF BELOW**
○ Appetite change ○ Fever ○ Weight loss ○ Night sweats ○ Weight gain
○ Fatigue ○ Weakness ○ Trouble Sleeping ○ Chills ○ Restlessness

EYES ○ **NONE OF BELOW**
○ Blurry ○ Double vision ○ Vision loss ○ Tearing ○ Redness
○ Pain ○ Sensitivity to light ○ Glaucoma ○ Flashing lights ○ Specks
○ Cataracts Other _____

EAR/NOSE/THROAT ○**NONE OF BELOW**
○ Ringing in ears ○ Ear pain ○ Nasal congestion ○ Nasal drainage ○ Nose bleeds
○ Mouth/throat irritation ○ Tooth problem ○ Sinus pain ○ Sore tongue ○ Dry mouth
○ Sore throat ○ Hoarseness ○ Decreased hearing ○ Bleeding gums ○ Bad breath
○ Altered taste/smell ○ Voice change ○ Swollen glands in neck ○ Earaches ○ Ear drainage
○ Thrush ○ Neck lumps Other _____

CARDIOVASCULAR ○ **NONE OF BELOW**
○ Chest pain/pressure ○ Heart racing ○ Palpitations ○ Sweating ○ Leg swelling
○ High blood pressure ○ Low blood pressure ○ Tightness ○ Shortness of breath ○ Anemia
○ Swelling ○ Difficulty breathing lying down ○ Sudden awakening shortness of breath Other _____

RESPIRATORY ○ **NONE OF BELOW**
○ Cough ○ Yellow/green sputum ○ Blood in sputum ○ Shortness of breath ○ Wheezing
○ Painful breathing ○ Asthma ○ Recurrent respiratory infection Other _____

GASTROINTESTINAL ○ **NONE OF BELOW**
○ Swallowing difficulties ○ Nausea ○ Vomiting ○ Diarrhea ○ Constipation
○ Pain ○ Blood in stool ○ Blood in vomitus ○ Heartburn ○ Change in appetite
○ Change in bowel Habits ○ Rectal bleeding ○ Stomach pain or Cramping Other _____

GENITOURINARY ○ **NONE OF BELOW**
○ Incontinence ○ Abnormal bleeding ○ Abnormal discharge ○ Urinary frequency ○ Urinary hesitancy
○ Pain ○ Impotence ○ Sexual problem ○ Infection ○ Urinary retention
○ Urgency ○ Uterine fibroids ○ Ovarian cysts ○ Cancer ○ Prostate problems
○ Change in urinary strength Other _____

MUSCULOSKELETAL ○ **NONE OF BELOW**
○ Muscle or joint pain ○ Stiffness ○ Back pain ○ Redness of joints ○ Swelling of joints
○ Trauma ○ Arthritis ○ Weakness ○ Muscle wasting ○ Sprain/fracture
○ Rheumatoid arthritis ○ Chronic pain Other _____

INTEGUMENTARY ○ **NONE OF BELOW**
○ Rashes ○ Lumps ○ Itching ○ Dryness ○ Color changes
○ Hair and nail changes ○ Eczema ○ Excessive sweating ○ Easy bruising ○ Increased bleeding
Other _____

NEUROLOGICAL ○ **NONE OF BELOW**
○ Headache ○ Dizziness ○ Change in voice ○ Change in taste ○ Change in vision
○ Change in hearing ○ Loss/change sensation ○ Trouble walking ○ Balance problem ○ Coordination problem
○ Shaking ○ Speech problem ○ Seizures ○ Migraines Other _____

MENTAL ○ **NONE OF BELOW**
○ Nervousness ○ Stress ○ Depression ○ Memory loss ○ Mood swings
○ Irritability ○ Confusion Other _____

ENDOCRINE ○ **NONE OF BELOW**
○ Cold intolerance ○ Heat intolerance ○ Blood sugar problem ○ Weight gain ○ Missed periods
○ hot flashes/sweats ○ Change in body hair ○ Change in libido ○ Increased thirst ○ Increased urination
○ Change in appetite ○ Inability to lose weight ○ Weight loss for no reason Other _____

HEMATOLOGIC ○ **NONE OF BELOW**
○ Bruising easily ○ Bleed easily ○ Swelling ○ Anemia ○ Enlarge lymph node
Other _____

ALLERGIC/IMMUNOLOGIC ○ **NONE OF BELOW**
○ Itch ○ Post-nasal drip ○ Watery/itchy eyes ○ Nasal drainage ○ Immunosuppressed
Other _____

BACK INDEX

Patient Name _____ **Date** ____/____/____

*This questionnaire will give your provider information about how your back condition affects your everyday life. Please answer every section by **circling** the number for the one statement that applies to you. If two or more statements apply, circle 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

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 or 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

Walking
0 I have not 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

Sitting
0 I can sit in any chair for as long as I like
1 I can only sit in my favorite chair for 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

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

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

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

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

If you have been involved in an accident or if you have had something happen (example: you lifted something or slipped) please tell the doctor

NECK INDEX

Patient Name _____ **Date** ____/____/____

*This questionnaire will give your provider information about how your back condition affects your everyday life. Please answer every section by **circling** the number for the one statement that applies to you. If two or more statements apply, circle 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

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

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

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

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

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 severe 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

Sleeping
0 I have no difficulty sleeping
1 My sleep is slight 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)

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 of my usual recreation activities because of neck pain
3 I am only able to engage in a few of my usual recreating 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

If you have been involved in an accident or if you have had something happen (example: you lifted something or slipped) please tell the doctor

Modern Chiropractic with Old Time Caring

AFFORD A CARE CHIROPRACTIC, INC.
Clarence L. Wray, Jr., D.C.
1223 Brookfield Rd. PO Box 233 Hubbard, OH 44425
Phone 330.448.0111 Fax 330.448.0544
Docdcwray@gmail.com www.wraydc.com

Doctor's Assignment/Lien

Provider: Afford A Care Chiropractic, Inc. ~ Clarence L. Wray, Jr., D.C.

To: Attorney or Insurance Carrier _____

Patient/Client _____

I hereby authorize the above Afford A Care Chiropractic/Clarence L. Wray, Jr., D.C., to furnish you, my attorney(s)/insurance carrier, with a full report of the case history, examination, diagnosis, treatment, and prognosis in regards to the accident in which I was involved on _____/_____/_____
(Date of Loss)

I hereby authorize and direct you, my attorney(s)/insurance company, to pay directly to said Afford A Care Chiropractic, Inc./Clarence L. Wray, Jr., D.C., such sums as may be due and owing Afford A Care Chiropractic, Inc./ Clarence L. Wray, Jr., D.C., for professional services rendered to me both by reason of the aforesaid accident and by reason of any other bills that are due and owing to Afford A Care Chiropractic, Inc./ Clarence L. Wray, Jr., D.C. and to withhold the sum of _____ for services rendered by Afford A Care Chiropractic, Inc./Clarence L. Wray, Jr., D.C. from any insurance settlement, judgment, or verdict, as may be necessary to adequately compensate Afford A Care Chiropractic, Inc./Clarence L. Wray, Jr., D.C. for its services. I hereby further give a lien on my case to Afford A Care Chiropractic, Inc./Clarence L. Wray, Jr., D.C. against any and all proceeds of any settlement, judgment, or verdict which may be paid to you, my attorney(s)/insurance company, on my behalf as the result of the injuries for which I have been treated, as a result of my accident.

This assignment/lien is for services rendered in compliance with the Ohio Supreme Court's decision of *West Broad Chiropractic v. American Family Insurance (122 Ohio St.3d 497, 912 N.E.2d 1093(*. I hereby state and affirm that a claim has been made with the applicable insurance carrier.

I also give Afford A Care Chiropractic, Inc./Clarence L. Wray, Jr., D.C., as a lien on any med-pay claim that may be filed under my personal auto insurance policy or any med-pay claim to which I am afforded coverage pursuant to a third-party auto policy for any unpaid balances on my account. I understand that med-pay is a contractual right under an applicable auto-insurance policy and that said med-pay proceeds like health insurance benefits are intended to be paid directly to my medical provider, specifically Afford A Care Chiropractic, Inc./Clarence L. Wray, Jr., D.C. Said med-pay proceeds should not be subject to the payment of attorney fees prior to payments being made to Afford A Care Chiropractic, Inc./Clarence L. Wray, Jr., D.C. and other health care providers.

I understand that I am directly and fully responsible to Afford A Care Chiropractic, Inc./Clarence L. Wray, Jr., D.C. for all professional bills submitted by Afford A Care Chiropractic, Inc./Clarence L. Wray, Jr., D.C. for services rendered to me. This agreement is made solely for Afford A Care Chiropractic, Inc./Clarence L. Wray, Jr., D.C. as additional protection and in consideration for payment for services rendered to me by Afford A Care Chiropractic, Inc./Clarence L. Wray, Jr., D.C. I further understand that such payment is not contingent on any settlement, judgment, or verdict and that I am personally liable for said services and bills.

Patient Signature: _____ Date: _____

Patient's Address: _____

City: _____ State _____ Zip _____

Telephone: ( ) _____-_____

IMPORTANT NOTICE TO PATIENT WHO HAS SIGNED A PERSONAL INJURY ASSIGNMENT

_____
Patient Initials

I understand this Assignment, and how it will affect my Prospective settlement proceeds. I <u>know</u> that the Clinic is starting treatment <u>in reliance</u> that I understand the Assignment.

_____
Patient Initials

I understand that I cannot cancel or terminate the Assignment, and will not permit any attorney for me to attempt to do this.

_____
Patient Initials

I will not settle My Claim unless the settlement covers <u>at least</u> my own damages (pain and suffering, lost wages, etc.) <u>and</u> this Clinics treatment fees. I understand that this Clinic is entitled to its treatment fees <u>first</u> out of <u>any</u> and <u>all</u> settlement proceeds.

_____
Patient Initials

If I believe the prospective settlement from any insurance company will <u>not</u> be enough to cover my damages <u>and</u> this Clinic's treatment fees, I realize that I will owe any balance to this Clinic for my treatment. I <u>can</u> choose to continue treatment, <u>or</u> can consult with my chiropractic physician at this Clinic about decreasing or terminating treatment prior to reaching Maximum Medical Improvement.

_____
Patient Initials

I state that I am not currently a debtor in a pending Chapter 7 or Chapter 13 Bankruptcy Proceeding.

_____ ____/____/____
Signature *Date*

PATIENT VERIFICATION

I have been advised by this Clinic that the preferred method of payment for treatment fees is for the fees to be paid directly by me as I receive treatment. **Check EVERY box that is true:**

- ❑ I do not choose to pay for treatment fees as received, for financial reasons.
- ❑ I do not have health insurance that will cover my treatment for my injuries.
- ❑ I do not want my health insurance to be billed for treatment of my injuries, except in the case that my own liability insurer requires it as a condition to qualifying for medical payments coverage. **I have chosen to not seek and not authorize health insurance reimbursement for this Clinic's treatment fees knowingly, and after considering my alternatives. I do not want to pay health insurance co-payments and/or do not want the potential obligations to have to pay this Clinic for treatment which is not covered by my health insurance. "My health insurance" means Medicaid and Medicare reimbursement programs and every other type of private or government sponsored health insurance.**

I authorize this Clinic to bill my own liability insurer for treatment fees I incur. I authorize this Clinic to send notice of the Assignment to my own liability insurer, to the liability insurer of the person I claimed caused my injuries, and to the attorney representing me for My Claim. This document is made part of the Assignment I have signed in favor of the Clinic.

_____ _____

Name of Liability Insurer for Person at Fault Name of My Liability Insurer

_____

Name of My Attorney

I have received a copy of an Assignment which I have signed in favor of this Clinic and Schedule of Treatment Fees.

_____ _____

(Signature of Patient, Parent or Legal Guardian (Date)

_____ _____

(Print or Type Above Name) (Staff Witness)

Payment For Treatment When Patient's Health Insurance Will Not be Billed

I have been injured. If my automobile insurance will cover my treatment fees, I authorize this Clinic to bill this insurer. Even if no other person is at fault for my injuries caused by an accident, I agree to sign this Clinic's *Assignment* and related documents, and will provide any information required by the Clinic. I realize that any money which I receive from my automobile insurer for this Clinic's treatment fees must be immediately paid over to this Clinic.

If I believe that one or more persons are at fault for causing my injuries in an accident, I agree to sign this Clinic's *Assignment* and related documents, and will provide any information required by the Clinic.

I understand that my automobile insurer, or an insurer representing someone I believe to be at fault for causing my injuries, or that person's attorney, or an attorney representing me in claim for injuries, may request reports, copies of records, may require a physician from this Clinic to provide deposition testimony or testimony in court, or other information. I understand and agree that I am financially responsible to this Clinic to pay the Clinic's costs for these items, and that the Clinic may request payment in advance for some or all of these items, even if the Clinic's *Assignment* states otherwise.

I understand and agree that all of my records, including my x-rays, are permanent records of this Clinic. I authorize the release of any information relevant to my treatment, including information regarding treatment fees, to insurers and attorneys who are involved with my claim and their respective representatives.
(*Except if required by patient's automobile insurance)

I HAVE READ THIS DOCUMENT AND FULLY UNDERSTAND IT.

THIS DOCUMENT IS MADE A PART OF THE ASSIGNMENT.

I HAVE SIGNED IN FAVOR OF THE CLINIC.

I HAVE RECEIVED A COPY OF THIS DOCUMENT.

_____ _____/_____/_____
(Signature of patient) *(Date)*

_____ _____
(Print or type patient name) *(Signature of Parent or Legal Guardian)*

Modern Chiropractic with Old Time Caring

AFFORD A CARE CHIROPRACTIC, INC.
Clarence L. Wray, Jr., D.C.
1223 Brookfield Rd PO Box 233 Hubbard, OH 44425
Phone 330.448.0111 Fax 330.448.0544
Docdcwray@gmail.com www.wraydc.com

SCHEDULE OF TREATMENT FEES

The following is a brief listing of the most common fees utilized in this office in treating patients who have suffered from auto injuries / PI / Slip & Fall. Some fees are given in ranges as the exact cost would depend on the exact level of service provided that day. If you have a treatment that is not included in this list and you would like to know the charge, please ask at the front desk. NOTE: Prices will be subject to change without notification.

SERVICE	**FEE**
First Visit Examination	$90 - $150
Re-examinations	$50 - $110
X-rays	$50 - 130 per region depending on area and views
Adjustment	$40 - $58
Ultrasound	$15
Electric Stimulation	$15
Traction	$15
Manual Therapy	$45
Rehab / Therapeutic Exercises	$40 - 80 per session
Equipment / Supplement Purchases	Prices will be given at time of purchase

*I have received a copy of the above **Schedule of Treatment Fees**. I understand that if I have any questions regarding any fees in the office, I am to discuss it with the assistant at the front desk.*

_____ _____/_____/_____

(Signature of Patient / Legal Guardian) *Date*

To: _____
ATTN: _____
FAX: _____
PH: _____
Date: _____
Pages: _____
RE: _____

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Hubbard OH 44425

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NOTICE OF CONFIDENTIAL INFORMATION:

We have double checked the recipient's fax number before pressing the send key. The documents accompanying this transmission contain confidential health information that is privileged. This information is intended only for the use of the individual or entity named below. The authorized recipient of this information is prohibited from disclosing this information to any other party unless required to do so by law or regulation and is required to destroy the information after its stated need has been fulfilled.

If you are not the intended recipient, you are hereby notified that any disclosure, copying, distribution, or action taken in reliance on the contents of these documents is strictly prohibited. If you have received this information in error, please notify the sender immediately and arrange for the return or destruction of these documents.

AUTHORIZATION FOR RELEASE OF PROTECTED HEALTH INFORMATION - REQUESTING RECORDS

Patient Name (print): _____ Date of Birth: _____/_____/_____

Previous/Maiden Name (if applicable): _____ Phone: ( ) _____

Facility/Provider Authorized to Disclose (Releasing Entity):

Name: _____

Address: _____

Facility/Provider Authorized to Receive or Use (Receiving Entity):

Afford A Care Chiropractic, Inc. Clarence L. Wray, Jr., D.C. 1223 State Route 7 NE PO Box 233 Hubbard, OH 44425

Information to be disclosed includes copies of: ___ **Entire Record OR** ___ **Partial Record, including:**

___ Patient intake forms (History) ___ Physical examination forms ___ X-ray films

___ Daily chart notes from _____ to _____ ___ Consultation/Report of Findings ___ X-ray report

___ Plan of treatment forms ___ Discharge summary

___ Other (specify): _____

Purpose for Disclosure: ___ Treatment, Payment or Operations ___ Other (specify): _____

Expiration (select one): ___ This authorization will expire on: _____/_____/_____

___ Transfer of records is for Treatment purposes, expiration not applicable

___ On the occurrence of the following event: _____

Right to Revoke: I understand that I have the right to revoke this authorization in writing by presenting the revocation to the manager at Afford A Care Chiropractic. I understand that revocation will not apply to information that has already been released prior to the written revocation.

Signature: I understand that the facility cannot condition treatment on whether I sign this authorization. I understand that authorizing the disclosure of this health information is voluntary and I may refuse to sign the authorization. A copy of this authorization is as valid as the original.

Patient Signature: _____ Date: _____/_____/_____

Legal Representative (if applicable) Name (print) _____

Relationship to Patient: _____

Legal Representative Signature: _____ Date: _____/_____/_____

If signing for a minor patient, I hereby state that my parental rights have not been revoked by a court of law.

AUTHORIZATION FOR TREATMENT OF A MINOR

(I) (WE), the undersigned, parent(s) / person having legal custody / legal guardianship of:

(Name of minor) _____,

do hereby authorize and give consent to any x-ray examination and chiropractic diagnosis or treatment, which is deemed advisable by a licensed chiropractor, be rendered under the general or special supervision of any licensed chiropractor.

It is understood that this authorization is given in advance of any specific diagnosis or treatment being required but is given to provide consent to any and all such diagnosis and treatment which chiropractor, meeting the requirements of this authorization, may, in the exercise of his/her best judgment, deem advisable.

These authorizations shall remain in effect until such time as the minor becomes a legal adult, unless sooner revoked in writing delivered to Afford-A-Care Chiropractic, Inc. - Clarence L. Wray, Jr., D.C.

I hereby authorize Dr. Clarence L. Wray, Jr., to furnish information concerning my present illness and DIRECT the insurer to pay without equivocation, directly to Dr. Wray, any and all benefits due him as a result of this claim. I am also aware that I am personally responsible for charges and/or balances not covered by my insurance. I understand that is my personal responsibility to know what the coverage is of my insurance and if there are special requirements, such as but not limited to: referral by a primary care physician.

I also authorize Dr. Wray to send copies of my records to my family physician stated in my records or to discuss the health condition of this patient with the doctor as he sees fit for proper management of the health problem.

I hereby state and agree that a photocopy of this document will be deemed as valid and binding on all parties as the original. This assignment is valid indefinitely unless I notify Dr. Wray in writing that it is to be terminated.

_____

Patient's name

_____ _____/_____/_____

Signature of parent or authorized guardian *Date*