



# Personal Injury Form

Name: \_\_\_\_\_ Date: \_\_\_\_/\_\_\_\_/\_\_\_\_

Date of Birth: \_\_\_\_/\_\_\_\_/\_\_\_\_ (age \_\_\_\_) M / F Social Security Number \_\_\_\_/\_\_\_\_/\_\_\_\_

Address \_\_\_\_\_ State \_\_\_\_\_ Zip Code \_\_\_\_\_

Phone Number: (\_\_\_\_)-\_\_\_\_-\_\_\_\_ Cell: (\_\_\_\_)-\_\_\_\_-\_\_\_\_ E-Mail: \_\_\_\_\_

Emergency Contact Person: \_\_\_\_\_ Contact Number: (\_\_\_\_)-\_\_\_\_-\_\_\_\_

Marital Status: S M D W Who can we thank for referring you? \_\_\_\_\_

Employer: \_\_\_\_\_ Occupation: \_\_\_\_\_

Address: \_\_\_\_\_ Phone Number: \_\_\_\_\_

Are you taking any medication? Please Circle

Nerve Pill Pain Meds Muscle Relaxer Stimulant Blood Thinner Insulin Aspirin

Other: \_\_\_\_\_ Do you smoke? Y / N Are you pregnant? Y / N

Date of Injury: \_\_\_\_/\_\_\_\_/\_\_\_\_ Time of Injury: \_\_\_\_ am/pm Date of 1st Treatment: \_\_\_\_/\_\_\_\_/\_\_\_\_

Primary Complaint: \_\_\_\_\_ Secondary Complaint: \_\_\_\_\_

Describe Accident: \_\_\_\_\_

What was your position in the vehicle? Driver Front Passenger Rear Passenger In Rear Car Seat

What is the vehicles type, make and model: \_\_\_\_\_

What speed were you traveling at the time of the accident? \_\_\_\_\_

Who Hit Whom? \_\_\_\_\_ Your Vehicles Point of Impact: \_\_\_\_\_

What speed was the other vehicle traveling at the time of the accident? \_\_\_\_\_

Their Point of Impact? \_\_\_\_\_ Were you wearing seat restraints? Y / N

Did the air bag deploy? Y / N Were you prepared for the impact? Y / N

What was your mental/emotional state following the accident? \_\_\_\_\_

Did you receive medical attention at the scene of the accident? Y / N

If yes, describe: \_\_\_\_\_

Where did you go immediately following the accident? \_\_\_\_\_

List each body part that struck the following vehicle parts during the accident:

Dashboard _____	Windshield _____
Steering Wheel _____	Other _____
Left Door/Window _____	Right Door/Window _____

Car Damage? Y / N      Tow? Y / N      Totaled? Y / N

Road Condition \_\_\_\_\_ Weather at the time of accident? \_\_\_\_\_

Any physical complaints BEFORE the accident? \_\_\_\_\_

Auto Insurance Company: \_\_\_\_\_ Contact: \_\_\_\_\_

Address: \_\_\_\_\_ Phone: \_\_\_\_\_

Policy Number: \_\_\_\_\_ Claim Number: \_\_\_\_\_

By signing below I, \_\_\_\_\_ understand the above information and guarantee this form was completed correctly to the best of my knowledge and understand it is my responsibility to inform Blau Family Chiropractic of any changes in my medical status.

I authorize Blau Family Chiropractic to perform any necessary services needed during diagnosis and treatment. I also authorize Blau Family Chiropractic to release any information requested and required to process insurance claims, this includes releasing records to lawyers.

\_\_\_\_\_  
Signature

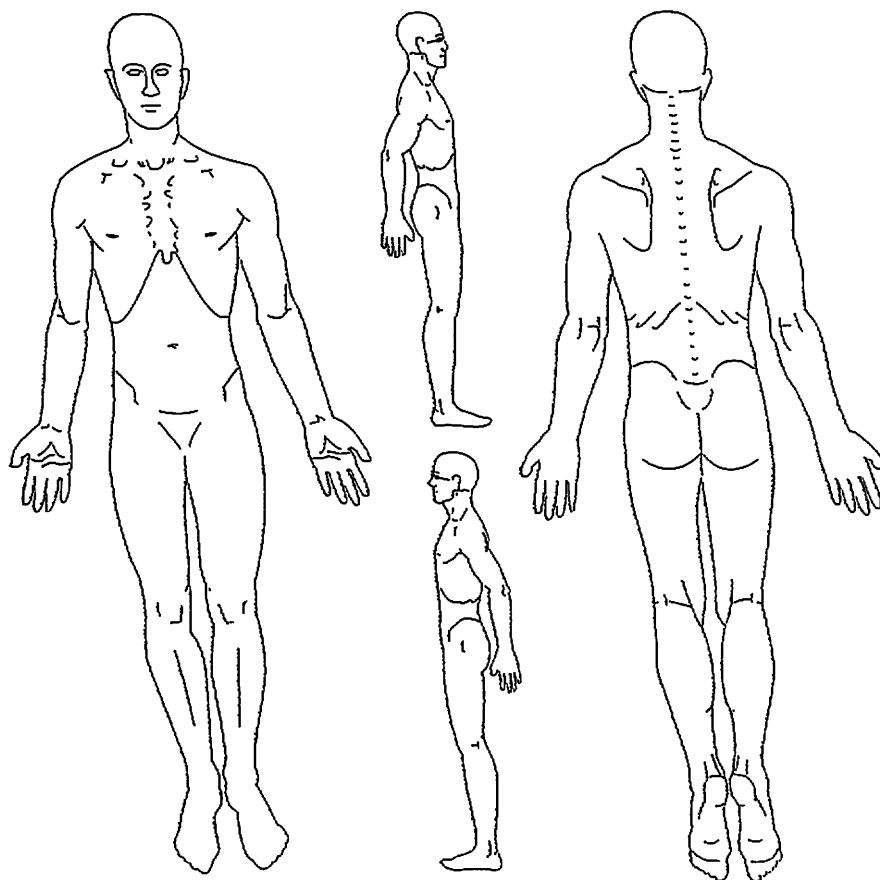
\_\_\_\_\_  
Date

## Location of your discomfort

Name \_\_\_\_\_ Date: \_\_\_\_\_

Please locate the area of discomfort on the image below by using the letters shown:

- |                |              |             |               |
|----------------|--------------|-------------|---------------|
| D = Dull       | S = Stabbing | B = Burning | T = Tingling  |
| N = Numbness   | C = Cramping | A = Aching  | SH = Shooting |
| TH = Throbbing |              |             |               |



Frequency of discomfort:      Continuous      Intermittent      Occasional      Frequent

Pain (choose one) decreases / stays the same / increases with movement.

Intensity: Please Circle

1 (no pain)    2    3    4    5    6    7    8    9    10 (unbearable)

Amount of time in discomfort: Please Circle

10%    20%    30%    40%    50%    60%    70%    80%    90%    100%

# REVISED OSWESTRY DISABILITY

Name \_\_\_\_\_ Date \_\_\_\_/\_\_\_\_/\_\_\_\_ File # \_\_\_\_\_

(Please Print)

This questionnaire helps us to understand how much your low back pain has affected your ability to perform everyday activities. Please check the one box in each section that most clearly describes your problem right now.

## SECTION 1 - Pain Intensity

- The pain comes and goes and is very mild.
- The pain is mild and does not vary much.
- The pain comes and goes and is moderate.
- The pain is moderate and does not vary much.
- The pain comes and goes and is severe.
- The pain is severe and does not vary much.

## SECTION 2 - Personal Care (Washing, Dressing, etc.)

- I would not have to change my way of washing or dressing in order to avoid pain.
- I do not normally change my way of washing or dressing even though it causes some pain.
- Washing and dressing increase the pain, but I manage not to change my way of doing it.
- Washing and dressing increase the pain and I find it necessary to change my way of doing it.
- Because of the pain, I am unable to do some washing and dressing without help.
- Because of the pain, I am unable to do any washing and dressing without help.

## SECTION 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 off the floor.
- Pain prevents me from lifting heavy weights off the floor, but I can manage if they are conveniently positioned, e.g., on a table.
- 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 at the most.

## SECTION 4 - Walking

- I have no pain on walking.
- I have some pain on walking but it does not increase with distance.
- I cannot walk more than one mile without increasing pain.
- I cannot walk more than 1/2 mile without increasing pain.
- I cannot walk more than 1/4 mile without increasing pain.
- I cannot walk at all without increasing pain.

## SECTION 5 - Sitting

- I can sit in any chair as long as I like without pain.
- I can sit only in my favorite chair as long as I like.
- Pain prevents me from sitting more than 1 hour.
- Pain prevents me from sitting more than 1/2 hour.
- Pain prevents me from sitting for more than 10 minutes.
- I avoid sitting because it increases pain immediately.

## SECTION 6 - Standing

- I can stand as long as I want without pain.
- I have some pain on standing, but it does not, increase with time.
- I cannot stand for longer than one hour without increasing pain.
- I cannot stand for longer than 1/2 hour without increasing pain.
- I cannot stand for longer than 10 minutes without increasing pain.
- I avoid standing, because it increases the pain immediately.

## SECTION 7 - Sleeping

- I get no pain in bed.
- I get pain in bed but it does not prevent me from sleeping well.
- Because of pain, my normal night's sleep is reduced by less than 1/4.
- Because of pain, my normal night's sleep is reduced by less than 1/2.
- Because of pain, my normal nights sleep is reduced by less than 3/4.
- Pain prevents me from sleeping at all.

## SECTION 8 - Social Life

- My social life is normal and gives me no pain.
- My social life is normal, but increases the degree of pain.
- Pain has no significant effect on my social life apart from limiting my more energetic interests, e.g., dancing, etc.
- Pain has restricted my social life and I do not go out very often.
- Pain has restricted my social life to my home.
- I have hardly any social life because of the pain.

## SECTION 9 - Traveling

- I get no pain while traveling.
- I get some pain while traveling, but none of my usual forms of travel make it any worse.
- I get extra pain while traveling, but it does not compel me to seek alternative forms of travel.
- I get extra pain while traveling which compels me to seek alternative forms of travel.
- Pain restricts all forms of travel.
- Pain prevents all forms of travel except that done lying down.

## SECTION 10 - Changing Degree of Pain

- My pain is rapidly getting better.
- My pain fluctuates, but overall is definitely getting better.
- My pain seems to be getting better, but improvement is slow.
- My pain is neither getting better nor getting worse.
- My pain is gradually worsening.
- My pain is rapidly worsening.

# NECK DISABILITY INDEX

Name \_\_\_\_\_ Date \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_ File # \_\_\_\_\_

(Please Print)

This questionnaire helps us to understand how much your neck pain has affected your ability to perform everyday activities. Please check the one box in each section that most clearly describes your problem right now.

## SECTION 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.

## SECTION 2 - Personal Care ( Washing, Dressing etc.)

- 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 in most aspects of self care.
- I do not get dressed, I wash with difficulty and stay in bed.

## SECTION 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 off the floor, but I can manage if they are conveniently positioned, for example on a table.
- Pain prevents me from lifting heavy weights, but I can manage light to medium weights if they are conveniently positioned.
- I can lift very light weights.
- I cannot lift or carry anything at all.

## SECTION 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 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.

## SECTION 5 - Headaches

- I have no headaches at all.
- I have slight headaches which come infrequently.
- I have moderate headaches which come infrequently.
- I have moderate headaches which come frequently.
- I have severe headaches which come frequently.
- I have headaches almost all the time.

## SECTION 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 in 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.

## SECTION 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 cannot do any work at all.

## SECTION 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.

## SECTION 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).

## SECTION 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.

## TERMS OF ACCEPTANCE

When a patient seeks chiropractic health care and we accept a patient for such care, it is essential for both to be working towards the same objective.

Chiropractic has only one goal. It is important that each patient understand both the objective and the method that will be able to attain it. This will prevent any confusion or disappointment.

**Adjustment:** An adjustment is the specific application of forces to facilitate the body's correction of vertebral subluxation. Our chiropractic method of correction is by specific adjustments of the spine.

**Health:** A state of optimal physical, mental and social well-being, not merely the absence of disease or infirmity.

**Vertebral Subluxation:** A misalignment of one or more of the 24 vertebra in the spinal column which causes alteration of nerve function and interference to the transmission of mental impulses, resulting in a lessening of the body's innate ability to express its maximum health potential.

We do not offer to diagnose or treat any disease or condition other than vertebral subluxation. However, if during the course of a chiropractic spinal evaluation, we encounter non-chiropractic or unusual findings, we will advise you. If you desire advice, diagnosis or treatment for those findings, we will recommend that you seek the services of a health care provider who specializes in that area.

Regardless of what the disease is called, we do not offer to treat it. Nor do we offer advice regarding treatment prescribed by others. **OUR ONLY PRACTICE OBJECTIVE** is to eliminate a major interference to the expression of the body's innate wisdom. Our only method is specific adjusting to correct vertebral subluxations.

I, \_\_\_\_\_ have read and fully understand the above statements.  
( print name )

All questions regarding the doctor's objectives pertaining to my care in this office have been answered to my complete satisfaction.

I therefore accept chiropractic care on this basis.

\_\_\_\_\_  
( signature )

\_\_\_\_\_  
( date )

# INFORMED CONSENT TO CHIROPRACTIC TREATMENT

The State of Wisconsin requires that every patient be informed of the risks of treatment and the alternatives to treatment prior to the beginning of treatment. The following is Blau Family Chiropractic's informed consent. We intend this consent form to cover the entire course of treatment for your present condition, and for any future conditions for which you seek treatment at this office.

The nature of chiropractic treatment: The doctor will use his/her hands or a mechanical device in order to adjust your joints. You may hear a "click or pop," similar to when a joint is "cracked," and you may feel movement of the joint. Various ancillary procedures, such as hot or cold packs, light therapy, electric muscle stimulation, therapeutic ultrasound, or traction, as well as exercise instruction.

Possible risks and probability: There are inherent risks in any and all treatment delivered by any health care provider, ranging from taking a single aspirin to complicated brain surgery. Chiropractic is no exception. Although we take every precaution, there are indeed some slight risks to chiropractic adjustment. The risk is very minor to almost nonexistent in any treatment of extremities. The risks involved in treatment to the spine excluding the neck are several. A list from the least to the most serious would include: muscular strain (rare), ligamentous sprain (rare), fractures (rare), and injury to intervertebral discs, nerves, or spinal cord (very rare). The risks involved in the treatment of the neck would include any on the preceding list but also include the remote possibility of cerebrovascular injury, or stroke (very very rare chances are one in one million to one in ten million.) A minority of patients may notice stiffness or soreness after the first few days of treatment (common). The ancillary physical therapy procedures could produce skin irritation, burns, or other minor complications (rare).

## Other treatment options that could be considered may include the following:

Over the counter analgesics: The risks of these medications include irritation to stomach, liver, kidneys, and other side effects in a significant number of cases.

Medical Care: Typically anti-inflammatory drugs, tranquilizers, and analgesics. Risks of these drugs include numerous undesirable effects, usually more serious than those listed above, and the patient dependence in a significant number of cases.

Surgery: In conjunction with medical care adds the risks of adverse reaction to anesthesia (which includes death) as well as an extended convalescent period in a significant number of cases.

## Risks of remaining untreated

Delay of treatment allows formation of adhesions, scar tissue and other degenerative changes. These changes can further reduce skeletal mobility and include chronic pain cycles. It is probable that delay of treatment will complicate the condition, and make future rehabilitation more difficult.

## Concerns or Questions

Please ask your Doctor of Chiropractic. Be assured Blau Family Chiropractic has gone to great lengths to make your health and safety our top priority. We will be glad to explain any concern about treatment. We will only recommend treatment for you that we would feel comfortable having performed on ourselves.

I have read the above explanation of Chiropractic Treatment. I also had the opportunity to ask questions and have them answered to my satisfaction. I have fully evaluated the risks and benefits of undergoing treatment, I have freely decided to undergo treatment, and hereby give my full consent to treatment.

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Date

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Signature of Patient or Parent

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Printed Patient Name