# 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: ________________

*641 Latton Lane Suite A * Portage, WI 53901 * 608-742-1300 * www.blauchiropractic.com*

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

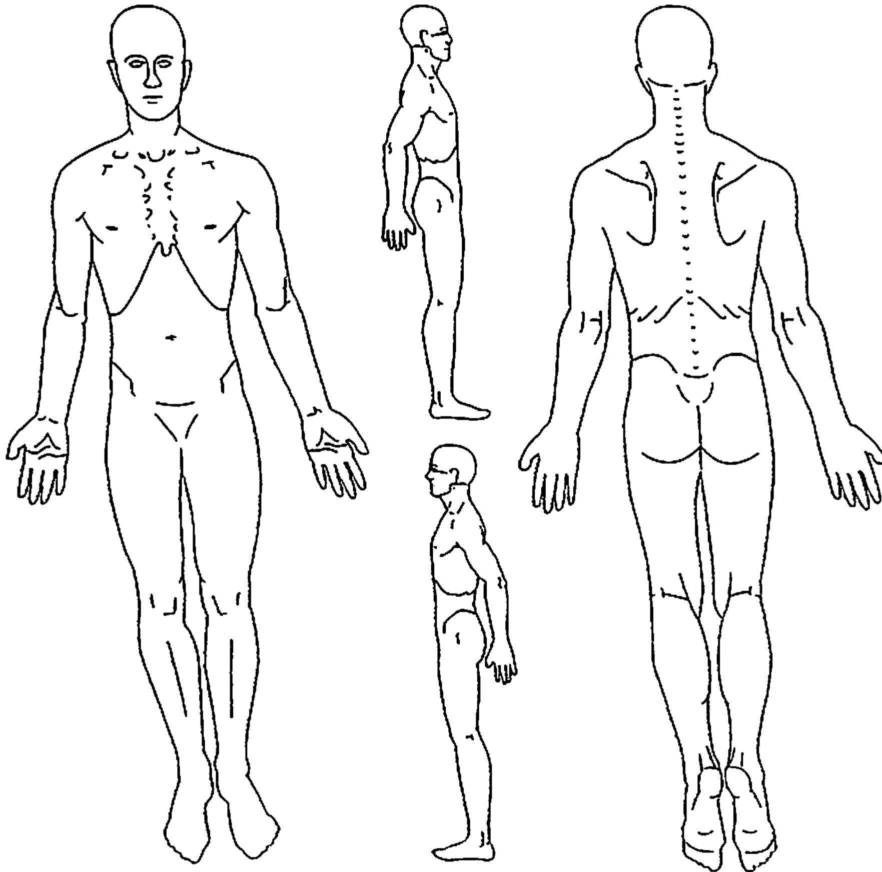
Blau Family
CHIROPRACTIC

# 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 immediatley.

**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.

Form by N. Hudson- Cook, K. Tomes-Nicholson, A. Breen. In Roland MO, Jenner JR. Eds. Back Pain. Manchester University Press 1989: 187-204

# 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 coveniently 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.

From Vernon H, Mior S. JMPT 1991; 14(7): 409-415

# Office Fee Schedule and Financial Policy

| Service | Insurance Coverage | Paid At Time of Service |
|---|---|---|
| Consultation | N/C | N/C |
| Initial Exam/Computer Scans | $72 | $50 |
| Dynamic Exam/Computer Scans | $65 | $35 |
| X-Rays (per view) | $60 | $40 |
| Adjustment | $60 | $37 |
| Light Therapy | N/A | $35 |
| Wellness Adjustment Plans | N/A | Varies per persons needs |

## Financial Policy and Chiropractic Active Life Plans

We are committed to providing you with the best chiropractic care possible in a caring environment and have established financial policies to achieve that goal. You will be expected to pay for your chiropractic care at the time of service, unless you are participating in an Active Life Plan. These are Active Life Plans are designed to be the most cost effective way to keep you and your family as healthy as possible. Details of these plans will be discussed with you during your Chiropractic Report. Balances with no payment over 30 days will be charged a $5.00 statement fee, this charge will occur each month until arrangements have been made or balance is paid in full. Patient balances over 60 days will be forwarded to a collection agency with any accrued interest.

- ☐ Cash Policy: Payment is due at time of service or according to the plan of your choice.

- ☐ Health Insurance: If you have Insurance that covers chiropractic care, we will send in your claims for you. Deductibles and co-pays are paid at time of service, or paid according to the plan of your choice. Remember, your agreement with your insurance company is between you and them. Please submit any requested information to them as quickly as possible. Any balance due to denied or reduced claims will be your responsibility. Having Insurance does not always guarantee payment.

If you acquire insurance for a special situation such as an auto accident or worker's compensation please let us know immediately. Once a claim is complete, you can return to your original Active Life Plan.

I have read and I understand the above policies. I have initialed the one that applies to me.

Patient Signature ______________________ Date __________

# 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, 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), ligamenous 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 proceeding list but also include the remote possibility of cervebrovascular injury, or stroke (very 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 quite probable that delay of treatment will complicate the condition, and make future rehabilitation more difficult.

Concerns or Questions

Please ask your Doctor of Chiropractic. We at Blau Family Chiropractic's have 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.

________________________
Date

________________________ ________________________
Signature of Patient or Parent Printed Patient Name