INFORMED CONSENT FOR CHIROPRACTIC CARE

By beginning chiropractic care at Compass Chiropractic LLC, I acknowledge that the objective of the chiropractor is to identify and correct vertebral subluxations through a chiropractic adjustment. This is a specific manual force applied to the spine by hand or instrument, in which a controlled thrust or impulse is delivered to the involved area. The doctor may need to touch sensitive areas of the body to properly deliver an adjustment or analyze my spine. I acknowledge that techniques may require the body to be placed into awkward positions to better receive treatment. I request and consent to receiving chiropractic care, diagnostic X-rays, and other related therapies, on myself (or on the patient for whom I am legally responsible) by any licensed doctor of chiropractic employed at Compass Chiropractic LLC.

Many patients report benefits while under chiropractic care including increased range of motion and pain relief. Although most people respond positively to care, no guarantees of cure have been implied or given. As with any health care procedure, there are some associated risks which your doctor is required to bring to your attention. Though uncommon, you should note the possibility of fracture, disc injury, muscle strain, ligament sprain, dislocation, and costovertebral separation. Strokes have been reported following chiropractic manipulation. The probability of this is exceedingly rare, estimated at one in two million and can be further reduced by screening procedures. Complications generally result from underlying other pre-existing conditions. I understand that a risk exists.

I am ultimately responsible for my health and therefore may seek care from other related health care fields. Common alternatives to chiropractic treatment consist of acupuncture, massage therapy, physical therapy, and orthopedic evaluation. Each of these have their own risks and benefits. I am free to discuss any questions or concerns with the doctor as the need arises, especially during my first visit. Based this information, I understand the nature of treatment, its risks/benefits, and that other alternatives exist for me to pursue.

I have read this document and give my consent to receive chiropractic treatment. I intend this document to cover the entire course of care, now and in the future, and agree to its provisions.

Patient Name (Printed): _____

Patient or Guardian Signature: _____ Date:_____

Females Only - Regarding Possibility of Pregnancy

X-rays, particularly those involving the lumbopelvic region, can be hazardous to an unborn child. It is advisable that, in women of child-bearing potential, X-rays be taken only in the first ten (10) days following the onset of a menstrual cycle, as this is generally considered to be safe for X-ray exams. With this in mind, I certify that to the best of my knowledge I am NOT pregnant, and the doctor has permission to perform diagnostic X-rays. It it my responsibility to update the treating doctor if this status changes.

Initial:_____

HIPAA - Notice of Privacy Policy

Our Notice of Privacy Practices provides information about how we may use and disclose “protected health information” (PHI) about you. A summary is below, and our full privacy statement is made available on the practice website: www.CompassChiroVA.com.

* Our office does not distribute or make available to any outside source your PHI except in cases of treatment or referrals, claims submission to third party insurance carriers for the purposes of payment, and other health care operations (subpoena of records).
* A family member may be present during your visit, but your PHI will not be available to them without your written authorization.
* Our office may utilize, text, phone, or email reminders to confirm or reschedule an appointment.
* We may leave a voicemail at the phone number provided unless you have specifically instructed us to the contrary.
* You have the right to withdraw consent and terminate care at any time for any reason. Withdrawals of consent must be in writing.

Patient or Guardian Signature: _____ Date:_____

Compass Chiropractic LLC
13146 Midlothian Turnpike
Midlothian, VA 23113
Phone: 804.499.6020
Fax: 804.499.6030

Assignment of Insurance Benefits

I, _____, assign and direct that payment be made directly to:
(Printed Name)

COMPASS CHIROPRACTIC LLC
13146 MIDLOTHIAN TURNPIKE
MIDLOTHIAN, VA 23113

for any and all insurance benefits or reimbursement of services rendered by Compass Chiropractic LLC which amounts would otherwise be payable to me under my insurance or pre-paid health plan.

I further understand that if my insurance carrier mistakenly sends payment to me for services incurred in this office, I agree to surrender those payments upon receipt.

Patient or Guardian Signature: _____ Date:_____

Financial Policy

There is no guarantee that your insurance company or pre-paid health plan will cover or pay for charges you incur. In the event of denied claims, reduction of benefits, or failure of my insurance company to pay for any reason, you are responsible for all remaining charges. This is so even if the results of your treatment are not as expected.

General Information:
All deductibles, co-insurances, and copayments are due at the time of service.
It is your responsibility to notify us of any changes to your health insurance.
Our office will provide whatever treatment is necessary to help your condition or complaint, regardless of what your insurance coverage is or what they consider to be medically necessary. You are responsible for these balances.

Collection Fees: In the event that your account is turned over to a collection agency, you will be responsible for any and all collection costs, include reasonable attorney's fees.

Missed Appointments: Unless cancelled at least 24 hours in advance, our policy assesses a $15 fee for missed appointments and a $30 fee for missed new patient appointments. We strive to have little to no wait time for all visits, and this can only be accomplished if you keep your appointments or provide notice of changes.

I have read, understand, and agree to this financial policy.

Patient or Guardian Signature: _____ Date:_____

Read and Sign

Compass Chiropractic LLC
13146 Midlothian Turnpike
Midlothian, VA 23113
Phone: 804.499.6020
Fax: 804.499.6030

To any insurance company with coverage applicable to my claim(s) and to any attorney representing me:

Assignment of Benefits

IN CONSIDERATION of the willingness of Compass Chiropractic LLC to treat me on credit without demand for payment at the time services are rendered, I hereby agree and stipulate as follows:

I irrevocably assign to Compass Chiropractic LLC any proceeds of compensation that I am or may become entitled to receive as a result of injuries that occurred on _____ to the extent of the chiropractic services rendered. I make this agreement without prejudice to any rights I may have to prosecute legal claims against any party who may be liable for my injuries, but I hereby authorize and instruct you to pay directly to Compass Chiropractic LLC from any disability benefits, medical payment benefits, liability benefits, health and accident benefits, workers compensation benefits, judgments, settlements, or proceeds of any kind that would otherwise be payable to me, such sums as are due to Compass Chiropractic LLC for its services rendered.

I appoint Compass Chiropractic LLC as my attorney in fact to affix my name as an endorsement upon the reverse of any check or draft upon which I am named payee and to deposit said check or draft and apply the proceeds to any unpaid balance I may have with Compass Chiropractic LLC. If I received payment directly from the covering insurance party for treatment at this facility, I must surrender these funds to Compass Chiropractic within 15 days. Failing to do so results in a 3% monthly fee of any unpaid balance, beginning after the 15 day mark.

I authorize Compass Chiropractic LLC to release to any insurer with applicable coverage or to my attorney or successor attorney any information regarding my injuries, prior medical history, or treatment as may be necessary to facilitate collection of proceeds under this assignment.

I acknowledge that I remain personally liable for the total amount due to Compass Chiropractic LLC for services rendered, including any balance remaining after the application of insurance payments and settlement or judgment proceeds. If Compass Chiropractic LLC is required to take legal action against me to recover any unpaid balance on my account, I agree to reimburse Compass Chiropractic LLC for its costs of recovery, including reasonable attorney's fees.

I further agree this assignment of benefits (AOB) cannot be revoked and the right to receive payment cannot be transferred to any other party or re-asserted by me in any way.

Patient Name: _____ DOB: _____

Patient Signature: _____ Date: _____

NOTICE OF LIEN

Pursuant to Virginia Codes §8.01-66.2 and §8.01-66.9, Compass Chiropractic LLC hereby asserts and gives notice of a lien upon any sums recovered in damages for personal injury in any civil action and also upon all funds paid to the above-named patient in compensation for or settlement of injuries sustained, whether in litigation or otherwise. Compass Chiropractic LLC hereby requests that if its claim is not paid in full from the foregoing proceeds, a full disclosure and accounting of proceeds be provided in conformity with Codes §8.01-66.2 and §8.01-66.9. Compass Chiropractic LLC agrees to be bound by any confidentiality agreements regarding the contents of the accounting.

Patient Signature: _____ Date: _____

Complete Front and Back

Compass Chiropractic LLC
13146 Midlothian Turnpike
Midlothian, VA 23113
Phone: 804.499.6020
Fax: 804.499.6030

Personal Injury / Motor Vehicle Accident Form

We need the following information to determine how we can help you. If we do not believe your injury will respond satisfactorily, we will refer you to someone who can help. Please answer as neatly and as accurately as possible.

Patient Name: _____ Today's Date: _____

Time of Accident: _____:_____ AM/PM Date of Loss: _____

Briefly explain what happened: _____

_____

_____

Make/model of your vehicle: _____ Your speed at impact: _____mph

Make/model of other vehicle: _____ Their speed at impact: _____mph

Were you: ❑ Driver ❑ Passenger ❑ Pedestrian

Were you struck from: ❑ Behind ❑ Front ❑ Right side ❑ Left side ❑ Parked

What was your first symptom following the accident? _____

Since the injury, are your symptoms: ❑ Improving ❑ No change ❑ Getting worse

	Yes	No
Are you now (or do you expect to be) in litigation for this accident?	❑	❑
Were the police notified of the accident?	❑	❑
Were you issued a traffic citation?	❑	❑
Were you wearing a seatbelt?	❑	❑
Did you see the collision coming and brace for impact?	❑	❑
Was your head turned at all at the moment of impact?	❑	❑
Were there any secondary impacts (another vehicle, guardrail, tree, etc.)?	❑	❑
Did anything in your car hit you (i.e. something from the back seat)?	❑	❑
Did your head hit anything (dashboard, steering wheel, window, etc.)?	❑	❑
Did the airbags in your vehicle deploy?	❑	❑
Did your headrest or windshield break?	❑	❑
Were you ejected from the vehicle?	❑	❑
Did you lose consciousness at any point?	❑	❑
Did you go to the hospital, emergency, or urgent care?	❑	❑
If yes, were you transported by ambulance?	❑	❑
Was any treatment provided?	❑	❑
Have you seen any other health care professionals for this injury?	❑	❑
Did you feel any pain immediately after the accident?	❑	❑
Did you feel any pain later that night or on the next day?	❑	❑
Is your ability to work impaired or restricted as a result of this accident?	❑	❑
Before the accident, have you ever had any complaints in the involved area?	❑	❑
Before the accident, were you able to work on an equal basis with others your age?	❑	❑

[over]

Additional Symptoms and Complaints

Please check any and all symptoms that you have noticed since the time of the accident.
* Do **not** check the box for symptoms you were already experiencing before the accident *

❑ Loss of Balance	❑ Ringing in Ears	❑ Headache	❑ Pins & Needles	❑ Back Pain
❑ Dizziness	❑ Loss of Taste	❑ Light Sensitivity	❑ Weakened Grip	❑ Chest Pain
❑ Fainting	❑ Loss of Smell	❑ Neck Pain	❑ Numb Fingers	❑ Shortness of Breath
❑ Memory Loss	❑ Face Flushed	❑ Neck Stiffness	❑ Numb Feet	❑ Diarrhea/Constipation
❑ Cold Sweats	❑ Nervousness	❑ Head too Heavy	❑ Cold Hands	❑ Bowel incontinence
❑ Sleeping Problems	❑ Depression	❑ Fatigue	❑ Cold Feet	❑ Urinary incontinence

❑ Other: _____

_____

_____

Please describe how you felt:

a) Before the accident: _____

b) Immediately after the accident: _____

c) Later that night: _____

d) The next day: _____

Have you had to miss any days of work due to your injuries? ❑ Yes ❑ No

If yes, list the date(s): _____ through _____

By signing below, I certify that the above information, on this page and the previous, is complete and true to the best of my current knowledge. I understand that fabricating symptoms will result in immediate termination of my care in this office, and all bills will be immediately due and payable.

Patient Signature: _____ Date: _____

Complete Pages 1-4

Compass Chiropractic LLC: Health Profile

Please fill out this form to the best of your ability. All of your information is strictly confidential.

Legal Name: _____ Date: _____

Mailing Address: _____ Occupation: _____

_____ (If retired/unemployed, list former occupation)

Email: _____ Height: _____

Weight: _____lbs

How did you hear about us? _____

Emergency Contact (Required)

Have you been to a chiropractor before? ❑ Yes ❑ No Name: _____

If Yes, was it a good experience? ❑ Yes ❑ No Relationship: _____

Are you nervous about being adjusted? ❑ Yes ❑ No Phone: _____

1. Lifestyle:

Smoking: ❑ 0 Cigarettes/day (non-smoker) ❑ 1-3 Cigarettes/day
❑ 0 Cigarettes/day (former-smoker) ❑ 1-2packs/day ❑ 2+ packs/day

Alcohol: ❑ Abstainer (none at all) ❑ Heavy drinker
❑ Light/Moderate drinker ❑ Former Alcoholic (sober since: _____)

Activity Level: ❑ Sedentary (none) ❑ Moderate activity (jogging)
❑ Light activity (i.e. walking) ❑ Vigorous activity (max exertion)

Any hobbies/sports you participate in regularly? _____

_____

2. Medical History:

Hospitalizations/Surgeries: please check the boxes if you have had any of these particular surgeries.

❑ Spine ❑ Shoulder (R/L) ❑ Brain ❑ Lung ❑ Gallbladder
❑ Hip (R/L) ❑ Knee (R/L) ❑ Heart ❑ Breast ❑ Appendix

Year: _____ Area/reason: _____ Procedure: _____
Year: _____ Area/reason: _____ Procedure: _____
Year: _____ Area/reason: _____ Procedure: _____

Prior Accidents/Injuries: includes car accidents, falls, sports injuries, etc.

Year: _____ Area injured: _____ How? _____
Year: _____ Area injured: _____ How? _____
Year: _____ Area injured: _____ How? _____

Ongoing Condition(s)? ❑ No ❑ Yes, please list: _____

Allergies? ❑ No ❑ Yes, please list: _____

Prescription Medications: If you have a medication list, please give us a copy and skip this section.

Medication	Reason	Date Started

Family History: this pertains to your direct siblings, parents, and grandparents **only**

❑ Cancer ❑ Stroke ❑ RA ❑ Seizures ❑ Diabetes
❑ Thyroid ❑ Heart Attack ❑ Osteoporosis ❑ Blood clots ❑ Kidney Disease

❑ Other: _____

Were there any deaths directly related to the above conditions? ❑ No ❑ Yes (fill in below)

Who _____ Condition _____ Age _____
Who _____ Condition _____ Age _____

Review of Systems: have **you** had a problem, whether now or in the past, with any of the following?

❑ Lethargy/Weakness
❑ Recurring Fever
❑ Recent Weight Loss/Gain
❑ Dizziness/Vertigo
❑ Chills
❑ Headaches
❑ Night Sweats

❑ Cancer
❑ Diabetes (Type I/II)
❑ Excessive Thirst
❑ Frequent Urination
❑ Thyroid Disorders
❑ Heart attack/disease
❑ Blood clots/DVT
❑ Ringing in ears
❑ Asthma/Allergies

❑ Migraines
❑ Memory Loss
❑ Poor Balance
❑ Numbness/Tingling
❑ Seizures
❑ Stroke/TIA
❑ Tremors
❑ Head Trauma
❑ Anxiety
❑ Depression
❑ Sleep Problems
❑ Weak Muscles
❑ Loss of Taste/Vision
❑ Double Vision
❑ Difficulty concentrating
❑ Difficulty controlling urination
❑ Incontinence of bowels

❑ Arthritis
❑ Joint Pain/Swelling
❑ Neck Pain
❑ Back Pain
❑ Trauma
❑ Osteoporosis
❑ Scoliosis
❑ Cramping
❑ Fractures
❑ Implants/Screws/Pins
❑ Hip Disorders
❑ Knee Injuries
❑ Foot/Ankle Pain
❑ Shoulder Problems
❑ Elbow/Wrist Pain
❑ Poor Posture
❑ Gout

Other Medical History:

Any steroid/epidural injections? ❑ No ❑ Yes, part of body: _____ Date: _____

Recent infections/immunizations? ❑ No ❑ Yes, please list: _____

Recent unintentional weight loss? ❑ No ❑ Yes, I've lost about _____ pounds in the last _____

FEMALES ONLY: is there any possibility that you are pregnant? ❑ No ❑ Yes ❑ Unsure

3. Primary Complaint: Please fill out this section in regards to your **primary** complaint only.

List the #1 reason you are here: _____

When did this start? _____ ❑ This is a recurring problem for me

How did this happen? _____ ❑ Started suddenly ❑ Started gradually

This problem is:	❑ Right-sided only	❑ Left-sided only	❑ Both	❑ In the middle
This problem is:	❑ Constant	❑ Frequent	❑ On/Off	❑ Occasional
When present, it lasts:	❑ Days	❑ Hours	❑ Minutes	❑ Seconds

On **average**, the severity of the complaint is: _____ /10 At its **worst**: _____ /10

Describe how it feels: (check all that apply)	❑ Aching	❑ Burning	❑ Dull	❑ Sharp	❑ Stabbing
	❑ Throbbing	❑ Stiffness	❑ Weakness	❑ Numbness	❑ Tingling

This problem is worsened by:			This problem is improved by:		
❑ Activity	❑ Twisting	❑ Lying Down	❑ Cold	❑ Rx Meds	❑ Morning
❑ Bending	❑ Getting Up	❑ Morning	❑ Heat	❑ Rest	❑ Night
❑ Lifting	❑ Everything	❑ Night	❑ Activity	❑ Stretching	❑ Standing
❑ Standing	❑ Ice	❑ Overhead Reach	❑ Lying down	❑ Support brace	❑ Standing
❑ Stress	❑ Job	❑ Sitting	❑ OTC Meds	❑ Chiropractic	❑ TENS Unit
❑ Temp change	❑ Kneeling	❑ Touch/Pressure	❑ Posture change	❑ Massage	❑ Time off Work

Overall, this problem has been: ❑ Improving ❑ Staying the same ❑ Worsening

Which of these apply to your job? ❑ Prolonged standing ❑ Prolonged sitting ❑ Heavy lifting

Check the box if there is more to your problem than this, and the doctor will ask you about it: ❑ There is more

4. Secondary Complaint: Please fill out this section only if you have a **secondary** complaint.

List the #2 reason you are here: _____

When did this start? _____

How did this happen? _____ ❑ Started suddenly ❑ Started gradually

This problem is:	❑ Right-sided only	❑ Left-sided only	❑ Both	❑ In the middle
This problem is:	❑ Constant	❑ Frequent	❑ On/Off	❑ Occasional
When present, it lasts:	❑ Days	❑ Hours	❑ Minutes	❑ Seconds

On **average**, the severity of the complaint is: _____ /10 At its **worst**: _____ /10

Describe how it feels: (check all that apply)	❑ Aching	❑ Burning	❑ Dull	❑ Sharp	❑ Stabbing
	❑ Throbbing	❑ Stiffness	❑ Weakness	❑ Numbness	❑ Tingling

This problem is worsened by:			This problem is improved by:		
❑ Activity	❑ Twisting	❑ Lying Down	❑ Cold	❑ Rx Meds	❑ Morning
❑ Bending	❑ Getting Up	❑ Morning	❑ Heat	❑ Rest	❑ Night
❑ Lifting	❑ Everything	❑ Night	❑ Activity	❑ Stretching	❑ Standing
❑ Standing	❑ Ice	❑ Overhead Reach	❑ Lying down	❑ Support brace	❑ Standing
❑ Stress	❑ Job	❑ Sitting	❑ OTC Meds	❑ Chiropractic	❑ TENS Unit
❑ Temp change	❑ Kneeling	❑ Touch/Pressure	❑ Posture change	❑ Massage	❑ Time off Work

Overall, this problem has been: ❑ Improving ❑ Staying the same ❑ Worsening

Which of these apply to your job? ❑ Prolonged standing ❑ Prolonged sitting ❑ Heavy lifting

Check the box if there is more to your problem than this, and the doctor will ask you about it: ❑ There is more

5. Other:

Optional: Describe any goal, expectations, or reservations you have at this time.

_____

_____

_____

I have read and completed the above information and certify it to be true to the best of my knowledge. I hereby permit this office to use my responses to provide me with chiropractic care, according to the state's regulations.

Patient Name (printed): _____

Signature of Patient/Guardian: _____ Date: _____

6. Doctor's Notes: Patients Leave Blank

BP: _____ Pulse: _____

1° _____ MOI: _____ 2° _____ MOI: _____

Notes: _____

_____

_____

❑ Painful SST ❑ Normal CLC ❑ Normal NSM

Codes: ❑ 98940 ❑ 98941 ❑ 98943 ❑ 72040 ❑ 72100 ❑ 72110 ❑ 99202 ❑ 99203 ❑ 97012 ❑ 97014

TP: ❑ 8 ❑ 16 ❑ 24 ❑ PPV ❑ MWP ❑ CNB12 ❑ Actiflex

Read Only

Compass Chiropractic LLC
13146 Midlothian Turnpike
Midlothian, VA 23113
Phone: 804.499.6020
Fax: 804.499.6030

Coverage Options

We understand this process can be confusing. This form has been created for the sole purpose of explaining your options. You do not need to do anything with this form other than read it, so you can make an informed decision in choosing which party you would like us to bill.

Our office requires all patients to provide their own auto insurance information so we can check if you have MedPay on your policy. This does not necessarily mean they will be billed; it simply gives this office a back-up entity to whom we *can* bill, if payment for services is not properly received. The alternative, if auto insurance is not provided, is that the bill then becomes your personal responsibility. The MedPay component of your auto insurance is to protect you from getting billed.

Medical Payments

"Medical Payments" or "MedPay" is part of your auto insurance policy which will immediately cover the costs of your medical expenses, given by a licensed health care provider and those of any passengers in your car, up to a certain limit, **regardless of fault**. Senate Bill 08-011, effective January 1, 2009, made MedPay benefits mandatory on all auto insurance policies unless specifically rejected in writing or declined during the application process. Your auto insurance rates are not impacted by using your MedPay, even if another party is at-fault. We highly recommend you to use your MedPay if it is available on your policy.

Liability Insurance of Third Party

Virginia is currently an "at-fault" state regarding payment of claims resulting from an auto accident or personal injury. This means the responsible party, or his or her insurance, should cover the cost of medically necessary treatment given by a licensed health care provider. Such claims are considered for payment when all treatment is complete and a settlement is reached with the third party. We discourage patients from selecting this option because it increases the probability that they will be left with the medical bills if payments are not properly received or settlement does not occur as expect.

Attorney Representation

If you have acquired legal representation, your bills will be forwarded directly to the attorney's office. We cannot and will not bill your MedPay or the third party’s insurance. When settlement is made, your attorney’s office will typically disperse the funds directly to our office on your behalf.

Personal Health Insurance

Your individual health insurance plan may be used to cover your auto-related medical expenses only if you are not using an attorney AND your auto insurance does not have MedPay. We assist you in verifying your coverage, but you are still responsible for the usual co-payments or deductibles your policy requires.

Read Only

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ADDITIONAL MEDPAY INFORMATION

Most people have benefits, such as MedPay, included in their automobile policies, and don't even realize it. Our office highly recommends that you use your MedPay coverage, if you have it, in the event you've been injured in an automobile accident, regardless of who is at fault.

We recommend filing with your MedPay for the following 3 reasons:

1. MedPay is similar to health insurance – using it does not cause your rates to increase. If your rates increase, it is not because you filed your MedPay, it is most likely because:

a) it was determined that you were at fault, or
b) you reported multiple auto accidents within a brief period of time and therefore are now considered to be "high risk" by your automobile insurance carrier

2. Filing your MedPay doesn't relieve the other party from having to pay for your loss. On the contrary, by filing your MedPay, when you collect from the other driver's liability insurance, a greater amount of the settlement may go directly to you because your bill in our office is already covered by your MedPay. If the other party's insurance refuses to settle or make a payment on your behalf, filing your MedPay ensures you are not stuck with all the medical bills.

3. If you have MedPay coverage and choose not to file it, then you are paying for an option but not receiving any benefit. MedPay is often included in the cost of your auto insurance premiums and specifically exists to cover you these types of cases. Since you pay for this included coverage, opting not to use it means you paid for this service needlessly.

Choose coverage based on previous 2 pages

Compass Chiropractic LLC
13146 Midlothian Turnpike
Midlothian, VA 23113
Phone: 804.499.6020
Fax: 804.499.6030

Personal Injury/Auto Accident Coverage Selection

Patient Name: _____ Today's Date: _____

Date of Accident/Loss: _____

NOTE: Even if the accident was not your fault, and another party's insurance will be covering your medical costs, **we still require information about your insurance policy and coverage**.

- **Medical Payments (MedPay): your automobile insurance information is required**
  Insurance Company: _____
  Phone Number: _____
  Mailing Address: _____
  Name of Insured: _____
  Policy Number: _____
  Claim Number: _____
  Claim Adjuster: _____

NOTE: we also require that you provide ***at least one*** of the following to us:

- **Personal Health Insurance: a copy of your health insurance card is required**
  Insurance Company: _____
  Phone Number: _____
  Name of Insured: _____
  Policy Number: _____

- **Liability Insurance: insurance information of the other (at-fault) party is required**
  Insurance Company: _____
  Phone Number: _____
  Mailing Address: _____
  Name of Insured: _____
  Policy Number: _____
  Claim Number: _____
  Claim Adjuster: _____

- **Representation by an Attorney: must have letter of representation by the third visit**
  Law Firm: _____ Phone: _____
  Name of Attorney/Case Manager: _____
  Mailing Address: _____

NECK BOURNEMOUTH QUESTIONNAIRE

Patient Name _____ Date _____

Instructions: The following scales have been designed to find out about your neck pain and how it is affecting you. Please answer ALL the scales, and mark the ONE number on EACH scale that best describes how you feel.

1. Over the past week, on average, how would you rate your neck pain?

No pain Worst pain possible

0 1 2 3 4 5 6 7 8 9 10

2. Over the past week, how much has your neck pain interfered with your daily activities (housework, washing, dressing, lifting, reading, driving)?

No interference Unable to carry out activity

0 1 2 3 4 5 6 7 8 9 10

3. Over the past week, how much has your neck pain interfered with your ability to take part in recreational, social, and family activities?

No interference Unable to carry out activity

0 1 2 3 4 5 6 7 8 9 10

4. Over the past week, how anxious (tense, uptight, irritable, difficulty in concentrating/relaxing) have you been feeling?

Not at all anxious Extremely anxious

0 1 2 3 4 5 6 7 8 9 10

5. Over the past week, how depressed (down-in-the-dumps, sad, in low spirits, pessimistic, unhappy) have you been feeling?

Not at all depressed Extremely depressed

0 1 2 3 4 5 6 7 8 9 10

6. Over the past week, how have you felt your work (both inside and outside the home) has affected (or would affect) your neck pain?

Have made it no worse Have made it much worse

0 1 2 3 4 5 6 7 8 9 10

7. Over the past week, how much have you been able to control (reduce/help) your neck pain on your own?

Completely control it No control whatsoever

0 1 2 3 4 5 6 7 8 9 10

Examiner

OTHER COMMENTS: _____

With Permission from: Bolton JE, Humphreys BK: The Bournemouth Questionnaire: A Short-form Comprehensive Outcome Measure. II. Psychometric Properties in Neck Pain Patients. *JMPT* 2002; 25 (3): 141-148.

BACK BOURNEMOUTH QUESTIONNAIRE

Patient Name _____ Date _____

Instructions: The following scales have been designed to find out about your back pain and how it is affecting you. Please answer ALL the scales, and mark the ONE number on EACH scale that best describes how you feel.

1. Over the past week, on average, how would you rate your back pain?

No pain Worst pain possible

0 1 2 3 4 5 6 7 8 9 10

2. Over the past week, how much has your back pain interfered with your daily activities (housework, washing, dressing, walking, climbing stairs, getting in/out of bed/chair)?

No interference Unable to carry out activity

0 1 2 3 4 5 6 7 8 9 10

3. Over the past week, how much has your back pain interfered with your ability to take part in recreational, social, and family activities?

No interference Unable to carry out activity

0 1 2 3 4 5 6 7 8 9 10

4. Over the past week, how anxious (tense, uptight, irritable, difficulty in concentrating/relaxing) have you been feeling?

Not at all anxious Extremely anxious

0 1 2 3 4 5 6 7 8 9 10

5. Over the past week, how depressed (down-in-the-dumps, sad, in low spirits, pessimistic, unhappy) have you been feeling?

Not at all depressed Extremely depressed

0 1 2 3 4 5 6 7 8 9 10

6. Over the past week, how have you felt your work (both inside and outside the home) has affected (or would affect) your back pain?

Have made it no worse Have made it much worse

0 1 2 3 4 5 6 7 8 9 10

7. Over the past week, how much have you been able to control (reduce/help) your back pain on your own?

Completely control it No control whatsoever

0 1 2 3 4 5 6 7 8 9 10

Examiner

OTHER COMMENTS: _____

With Permission from: Bolton JE, Breen AC: The Bournemouth Questionnaire: A Short -form Comprehensive Outcome Measure. I. Psychometric Properties in Back Pain Patients. *JMPT* 1999; 22 (9): 503-510.