

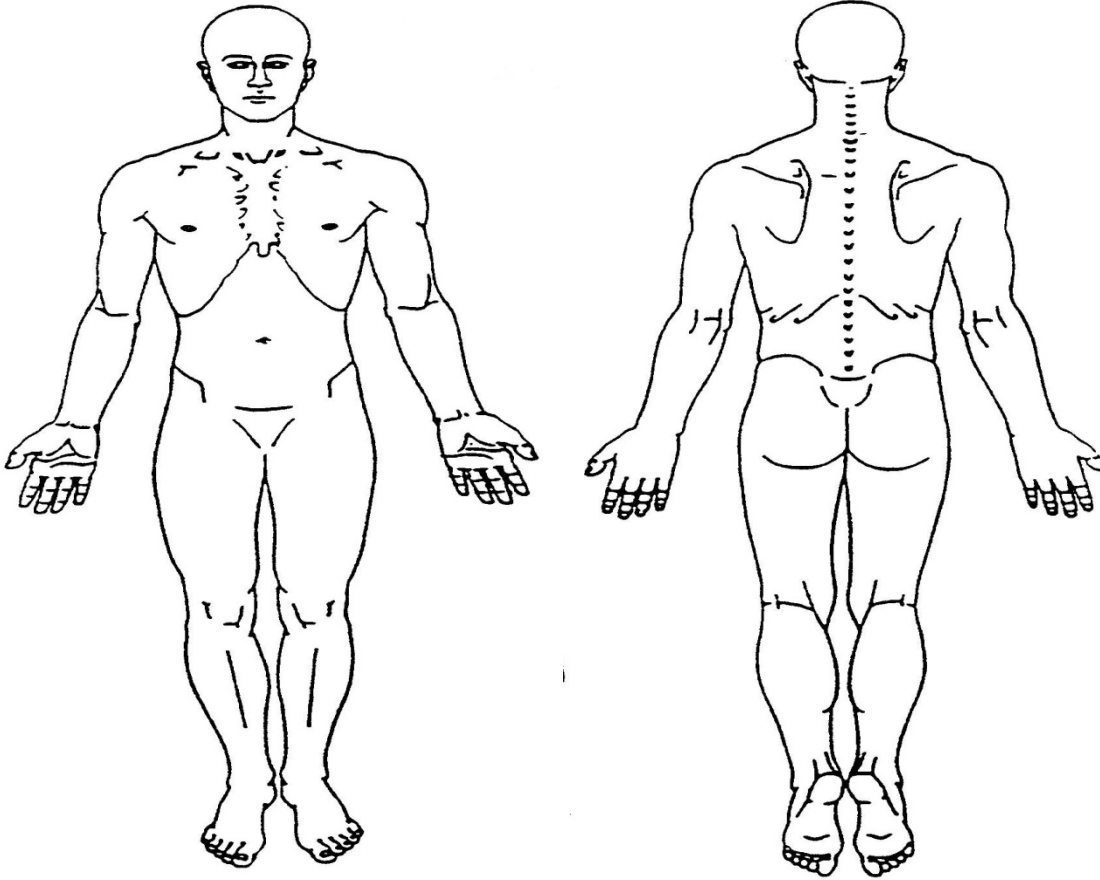
PAIN DIAGRAM

Instructions: Mark the area of your pain with the corresponding pain symbol on the lines

SHARP PAIN = X

DULL PAIN = 0

NUMB/TINGLING = +



VISUAL ANALOG SCALE

Circle level of pain by circling the number on the scale

0 **1** **2** **3** **4** **5** **6** **7** **8** **9** **10**
No Pain Severe Pain

Print Name: _____ Date: _____



Date: _____ Cell: _____
 Name: _____ Home: _____
 DOB: _____ SS# _____ Work: _____
 Address: _____ Other: _____
 City: _____ State: _____ Zip Code: _____
 Email: _____

Sex: Male Female Other

Marital Status: _____ Occupation: _____

Employer/School: _____ Employer/School Phone: _____

Employer/School Address: _____

Spouse's Name: _____ Spouse's DOB: _____

Whom may we thank for referral? _____

Reason for visit: _____

Self Insurance Company: _____ Member ID: _____

Attorney: Name: _____ Phone #: _____

Worker Compensation Insurance Company: _____ Claim #: _____

Adjuster: _____ Phone #: _____

Third-Party Responsible Insurance Company: _____ Claim #: _____

Adjuster: _____ Phone #: _____

What treatment have you already received for your condition?

Medications Surgery Physical therapy Chiropractic None Other

Name and address of other doctor(s) who have treated you for your condition:

Date of Last: Physical Exam _____ Spinal X-Ray _____ Blood Test _____

Spinal Exam _____ Chest X-Ray _____ Urine Test _____

Dental X-Ray _____ MRI _____ CT Scan _____ Bone Scan _____

List any known allergies: _____



DUTIES UNDER DURESS

The injured party has difficulty with Work Duties, Domestic Duties (inside the home), Household Duties (outside the home) and Educational/studies in School, and actually does one of the following activities while in pain. The pain interferes in these activities causing duties to be performed under duress.

Work Difficulties:

- Pain that interferes w/duties
- Difficulty performing duties
- Balance, strength, and moving
- Different body positions
- Tiredness/Fatigue
- Reduced work quality
- Loss of job security

Domestic Duties:

(vacuuming, taking care of children, dusting, laundry, cooking)

- Pain that interferes w/duties
- Balance, strength, and moving
- Different body positions
- Tiredness/Fatigue

Household Duties:

(yard work, family, shopping, take out trash)

- Pain that interferes w/duties
- Balance, strength, and moving
- Different body positions
- Tiredness/Fatigue

These Duties Under Duress:

(choose all that apply)

- are experienced daily
- have been experienced since the accident

Patient: _____



LOSS OF ENJOYMENT

The patient attests to experiencing a loss of enjoyment with the following activities due to pain:

Movements/activities that cause pain:

- Sitting long periods
- Standing long periods
- Walking
- Lifting
- Pulling
- Twisting
- Climbing
- Lying on R / L side
- Lying on stomach
- Lying on back

Domestic Activities:

- Interior cleaning
- Interior maintaining
- Preparing meals
- Attending to children
- Interior decorating
- Vacuuming

Household Activities:

- Exterior cleaning
- Mowing or yard work
- Transporting family
- Shopping
- Taking out the trash

Study/School:

- Attending class
- Gym class
- Studying

After Difficulty Sleeping:

- Irritability
- Feeling "foggy and dazed"
- Drowsiness
- Tiredness/worn out feeling
- Muscle Tension

Sexual Activity

- Loss of libido or sexual drive
- Cannot perform or limited performance due to pain

Hobbies

- Shopping
- Hunting
- Fishing
- Exercising
- Jogging
- Socializing
- Vacations
- Entertaining
- Watching TV
- Using the cell phone
- Using the computer
- Playing computer/video games
- _____
- _____

Anxiety:

- with normal everyday activities
- while driving

These Loss of Life enjoyment factors:

(choose all that apply)

- Are experienced daily
- Have been experienced since the accident

Please describe any other activities you enjoy less because of pain:

Patient Name: _____

Date: _____



HIPPA

I hereby state that by signing this consent, I acknowledge and agree as follows:

1. The Privacy Notice includes a complete description of the uses and/or disclosures of my protected health information ("PHI") necessary for the Practice to provide treatment to me, and also necessary for the Practice to obtain payment for that treatment and to carry out its healthcare operations. The Practice has explained to me that the Privacy Notice would be available to me in the future at my request. The Practice has further explained my rights to obtain a copy of the privacy notice carefully prior to signing this consent.
2. The Practice reserves the right to change its privacy practice that is described in its Privacy Notice, in accordance with applicable law.
3. I understand that, and consent to, the following appointment reminders that will be used by the Practice:
 - a. A postcard mailed to me at the address provided by me.
 - b. Telephoning my home and/or cell phone and leaving a message on my answering machine/voicemail or with the person answering the telephone.
4. The Practice may use/and or disclose my PHI (which includes information about my health or condition and the treatment provided to me) in order for the Practice to treat me and obtain payment for that treatment, and as necessary for the Practice to conduct its specific healthcare operations.
5. I understand that I have the right to request that the Practice restrict how my PHI is used and/or disclosed to carry out treatment, payment, and/or healthcare operations. However, the Practice is not required to agree to any restrictions that I have requested. If the Practice agrees to a requested restriction, then the restriction is binding on the Practice.
6. I understand that this consent is valid for seven years. I further understand that I have the understating that any such revocation shall not apply to the extent that the Practice has already taken action in reliance on this consent.
7. I understand that if I revoke this consent at any time, the Practice has the right to refuse to treat me.
8. I understand that if I do not sign this consent evidencing my consent to the uses and disclosures described and contained in the Privacy Notice, then the Practice may not treat me.

I have read and understand the foregoing notice, and all of my questions have been answered to my full satisfaction in a way that I can understand.

Print Patient Name: _____

Signature of Patient: _____ Date: _____

SIGN HERE

PLEASE DATE HERE



INFORMED CONSENT TO CHIROPRACTIC ADJUSTMENTS AND CARE

I hereby request and consent to the performance of chiropractic adjustments and other chiropractic procedures, including various modes of physical therapy and diagnostic x-rays on me (or on the patient named below, for whom I am legally responsible) by the doctor of chiropractic named below and/or other licensed doctors of chiropractic who now or in the future treat me which employ by, working or associated with or serving as backup for the doctor of chiropractic named below, including those working at the clinic or office listed below or any other office or clinic.

I have had an opportunity to discuss with the doctor of chiropractic named below/or with other office or clinic personnel the nature and purpose of chiropractic adjustment and other procedures.

I understand and am informed that as in the practice of medicine, in practice of chiropractic there are some risks to treatment, including, but not limited to, fractures, disc injuries, strokes, dislocations, and sprains. I do not expect the doctor to be able to anticipate and explain all risks and complications, and wish to rely on the doctor to exercise judgment during the course of the procedure which the doctor feels at the time, based upon the facts then known, is in my best interest.

I have read, or have had read to me, the above consent. I have also had the opportunity to ask questions about its content, and by signing below I agree to the above-named procedure. I intend this consent form to cover the entire course of treatment for my present condition and for any future conditions for which I seek treatment.

Print Patient Name: _____ Date: _____

Signature of Patient: _____

Signature of Legal Guardian (if patient is minor): _____

Print Legal Guardian Name: _____



1108 West Airline Highway
LaPlace, LA 70068

1959 Highway 3125 Suite 3
Lutcher, LA 70071

Robert R. Dale, D.C.
Dwayne Burch, D.C.
Nicholas Laird D.C.
Carol Boyce D.C.
Tradina Pichon MD

Physician Signature: _____ Date: _____