NEW ENGLAND CHIROPRACTIC

KELLY LARSON-BRUNNER D.C. WARREN LAIN D.C.
YOUR FAMILY WELLNESS TEAM

89 LARRABEE ROAD • WESTBROOK, ME • 04092 • TEL 207.854.2001 • FAX 207.854.2004
www.newenglandchiropractic.net

Motor Vehicle Accident Report

Name _____ Date of Birth _____ Phone _____
Address _____ City _____ State _____ Zip _____
Employer's Name _____ Employer's Address _____
Your Ins. Co. _____ Policy # _____ Agent's Name _____
Driver/Other Vehicle _____ Ins. Co. _____ Policy # _____
Have you retained an attorney? ( ) Yes ( ) No Name _____
Were there any witnesses? ( ) Yes ( ) No Name(s) _____

Nature of Accident:

1. Date of Accident: _____ Time of Day _____
2. Were you: ( ) Driver ( ) Passenger ( ) Front Seat ( ) Back Seat
3. Number of people in your vehicle? _____ Other Vehicle? _____
4. What direction were you headed? ( ) North ( ) East ( ) South ( ) West
   on (name of street) _____
5. What direction was the other vehicle headed? ( ) North ( ) East ( ) South
   ( ) West on (name of street) _____
6. Did your vehicle strike the other vehicle? ( ) Yes ( ) No
7. Did the other vehicle strike yours? ( ) Yes ( ) No
8. Were you struck from: ( ) Behind ( ) Front ( ) Left side ( ) Right side
9. At the time of impact were you looking ( ) Straight ahead ( ) Left ( ) Right
10. Type of vehicle you were in _____ Other vehicle type _____
11. Were you wearing a seatbelt? ( ) Yes ( ) No
12. Did the airbags deploy? ( ) Yes ( ) No
13. Did the airbag strike you? ( ) Yes ( ) No
14. Headrest level: ( ) Shoulder high ( ) Neck level ( ) Over the head
15. Did your head strike: ( ) Headrest ( ) Steering wheel ( ) Window
    ( ) Other _____
16. Were you knocked unconscious? ( ) Yes ( ) No
    If yes, for how long? _____
17. Were police notified? ( ) Yes ( ) No
18. In your own words, please describe accident: _____
    _____
    _____
19. Did you have any physical complaints BEFORE THE ACCIDENT?( )Yes ( ) No
    If yes, please describe in detail: _____
    _____
    _____

20. Please describe how you felt:
    a. DURING the accident: _____
    b. IMMEDIATELY AFTER the accident: _____
    c. LATER THAT DAY: _____
    d. THE NEXT DAY: _____
21. Since the accident your pain has:( ) Improved ( ) Stayed the same ( ) Worsened
22. What are your PRESENT complaints and symptoms? _____
_____
_____
23. Do you have any congenital (from birth) factors which relate to this problem?
( ) Yes ( ) No. If yes, please describe: _____
_____
24. Do you have any previous illnesses which relate to this case? ( ) Yes ( ) No
If yes, please describe: _____
_____
25. Have you ever been involved in an accident before? ( ) Yes ( ) No. If yes, please describe, including date(s) and type(s) of accidents, as well as injuries received. _____
_____
_____
26. Where were you taken after the accident? _____
27. Have you ever been treated by another doctor since the accident? ( ) Yes ( ) No.
If yes, please list doctor's name and address: _____
What type of treatment did you receive? _____
_____
28. Since this injury occurred, are your symptoms:
( ) Improving ( ) Getting Worse ( ) Same

29.CHECK SYMPTOMS YOU HAVE NOTICED SINCE ACCIDENT:

☐ Headache ☐ Irritability ☐ Numbness in Toes ☐ Face Flushed
☐ Feet Cold ☐ Neck Pain ☐ Chest Pain ☐ Shortness of Breath
☐ Buzzing in Ears ☐ Hands Cold ☐ Neck Stiff ☐ Dizziness ☐ Fatigue
☐ Loss of Balance ☐ Stomach Upset ☐ Sleeping Problems
☐ Head seems Too Heavy ☐ Depression ☐ Fainting ☐ Constipation
☐ Back Pain ☐ Pins & Needles in Arms ☐ Lights Bother Eyes
☐ Loss of Smell ☐ Cold Sweats ☐ Nervousness
☐ Pins & Needles in Legs ☐ Loss of Memory ☐ Loss of Taste
☐ Fever ☐ Tension ☐ Numbness in Fingers ☐ Ears Ring
☐ Diarrhea

Symptoms Other Than Above _____

New England Chiropractic

30. Have you lost time from work as a result of this accident? ( ) Yes ( ) No.
    If yes, please complete this question.
    a. Last Day Worked: _____
    b. Type of Employment: _____
    c. Are you being compensated for time lost from work? ( ) Yes ( ) No.
    If yes, please state type of compensation you are receiving? _____
31. Do you notice any activity restrictions as a result of this injury?( ) Yes ( ) No.
    If yes, please describe, in detail: _____

32. Other pertinent information: _____

_____ _____
Signature Date

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www.newenglandchiropractic.net

Date:

_____

_____

_____

Re: Payment for Chiropractic Treatment

Dear: _____

I hereby instruct you, as my attorney, to pay **New England Chiropractic** the balance of any charges I have incurred or may hereafter incur for my care and treatment. This payment is to be made from any proceeds you may receive on my behalf by the way of judgment, settlement, and insurance payment to include "PIP" and "med-pay" or otherwise.

In reliance upon my assurances that this arrangement would be made and honored, **New England Chiropractic** has agreed to treat me without payment at the time of service. In consideration of that agreement which has enabled me to obtain treatment without financial hardship, I hereby make and declare the instructions herein contained to be irrevocable. Your cooperation in the prompt disbursement of proceeds to **New England Chiropractic** prior to making any payment to me will be most sincerely appreciated.

Please make payment directly to: New England Chiropractic, 89 Larrabee Rd, Westbrook, ME 04092

_____ _____

Date: Signature

Witness: _____

Print name

_____ _____

Signature Address

_____ _____

Print Name City, State and Zip Code

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Letter of Intent

Patient Name: _____ Today's Date:_____

Address: _____ Date of Birth: _____

City, State, Zip _____ Date of Injury: _____

Assignment of Insurance Benefits

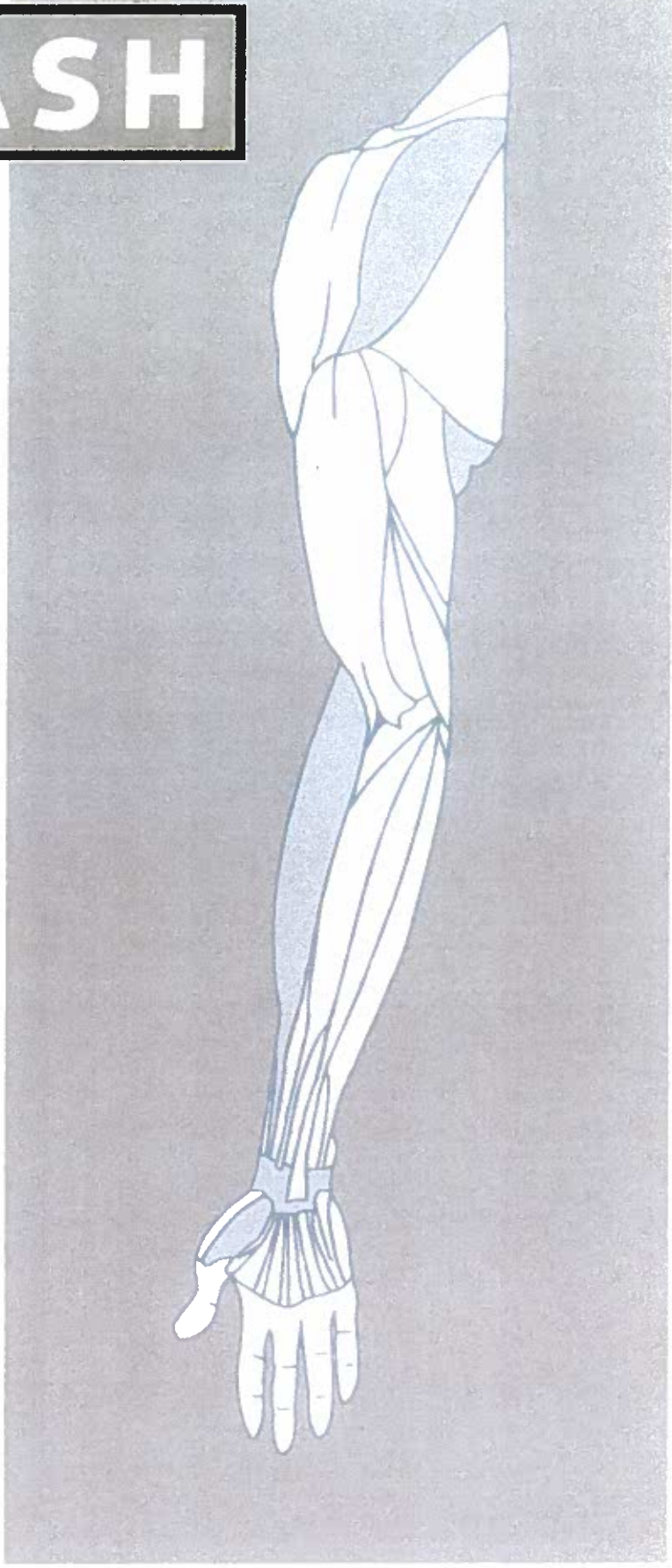
I authorize and direct that payment be made directly to New England Chiropractic, 89 Larrabee Road, Westbrook, Maine 04092, for any and all insurance benefits or reimbursement for services rendered by them which amounts would otherwise be payable to us under any insurance or pre-paid health care plan.

I understand that there is no guarantee that my insurance companies or prepaid health plan will cover or pay for all of my charges. Notwithstanding denial, reduction of benefits or failure to pay for any reason, I understand that I am responsible for all remaining charges.

_____ _____

Date Patient Signature

THE DASH



INSTRUCTIONS

This questionnaire asks about your symptoms as well as your ability to perform certain activities.

Please answer *every question*, based on your condition in the last week, by circling the appropriate number.

If you did not have the opportunity to perform an activity in the past week, please make your *best estimate* on which response would be the most accurate.

It doesn't matter which hand or arm you use to perform the activity; please answer based on your ability regardless of how you perform the task.

DISABILITIES OF THE ARM, SHOULDER AND HAND

WORK MODULE (OPTIONAL)

The following questions ask about the impact of your arm, shoulder or hand problem on your ability to work (including homemaking if that is your main work role).

Please indicate what your job/work is:_____

❒ I do not work. (You may skip this section.)

Please circle the number that best describes your physical ability in the past week. Did you have any difficulty:

	NO DIFFICULTY	MILD DIFFICULTY	MODERATE DIFFICULTY	SEVERE DIFFICULTY	UNABLE
1. using your usual technique for your work?	1	2	3	4	5
2. doing your usual work because of arm, shoulder or hand pain?	1	2	3	4	5
3. doing your work as well as you would like?	1	2	3	4	5
4. spending your usual amount of time doing your work?	1	2	3	4	5

SPORTS/PERFORMING ARTS MODULE (OPTIONAL)

The following questions relate to the impact of your arm, shoulder or hand problem on playing *your musical instrument or sport or both*.
If you play more than one sport or instrument (or play both), please answer with respect to that activity which is most important to you.

Please indicate the sport or instrument which is most important to you:_____

❑ I do not play a sport or an instrument. (You may skip this section.)

Please circle the number that best describes your physical ability in the past week. Did you have any difficulty:

	NO DIFFICULTY	MILD DIFFICULTY	MODERATE DIFFICULTY	SEVERE DIFFICULTY	UNABLE
1. using your usual technique for playing your instrument or sport?	1	2	3	4	5
2. playing your musical instrument or sport because of arm, shoulder or hand pain?	1	2	3	4	5
3. playing your musical instrument or sport as well as you would like?	1	2	3	4	5
4. spending your usual amount of time practising or playing your instrument or sport?	1	2	3	4	5

SCORING THE OPTIONAL MODULES: Add up assigned values for each response; divide by 4 (number of items); subtract 1; multiply by 25.
An optional module score may <u>not</u> be calculated if there are any missing items.

DISABILITIES OF THE ARM, SHOULDER AND HAND

Please rate your ability to do the following activities in the last week by circling the number below the appropriate response.

	NO DIFFICULTY	MILD DIFFICULTY	MODERATE DIFFICULTY	SEVERE DIFFICULTY	UNABLE
1. Open a tight or new jar.	1	2	3	4	5
2. Write.	1	2	3	4	5
3. Turn a key.	1	2	3	4	5
4. Prepare a meal.	1	2	3	4	5
5. Push open a heavy door.	1	2	3	4	5
6. Place an object on a shelf above your head.	1	2	3	4	5
7. Do heavy household chores (e.g., wash walls, wash floors).	1	2	3	4	5
8. Garden or do yard work.	1	2	3	4	5
9. Make a bed.	1	2	3	4	5
10. Carry a shopping bag or briefcase.	1	2	3	4	5
11. Carry a heavy object (over 10 lbs).	1	2	3	4	5
12. Change a lightbulb overhead.	1	2	3	4	5
13. Wash or blow dry your hair.	1	2	3	4	5
14. Wash your back.	1	2	3	4	5
15. Put on a pullover sweater.	1	2	3	4	5
16. Use a knife to cut food.	1	2	3	4	5
17. Recreational activities which require little effort (e.g., cardplaying, knitting, etc.).	1	2	3	4	5
18. Recreational activities in which you take some force or impact through your arm, shoulder or hand (e.g., golf, hammering, tennis, etc.).	1	2	3	4	5
19. Recreational activities in which you move your arm freely (e.g., playing frisbee, badminton, etc.).	1	2	3	4	5
20. Manage transportation needs (getting from one place to another).	1	2	3	4	5
21. Sexual activities.	1	2	3	4	5

DISABILITIES OF THE ARM, SHOULDER AND HAND

	NOT AT ALL	SLIGHTLY	MODERATELY	QUITE A BIT	EXTREMELY
22. During the past week, *to what extent* has your arm, shoulder or hand problem interfered with your normal social activities with family, friends, neighbours or groups? *(circle number)*	1	2	3	4	5

	NOT LIMITED AT ALL	SLIGHTLY LIMITED	MODERATELY LIMITED	VERY LIMITED	UNABLE
23. During the past week, were you limited in your work or other regular daily activities as a result of your arm, shoulder or hand problem? *(circle number)*	1	2	3	4	5

Please rate the severity of the following symptoms in the last week. *(circle number)*

	NONE	MILD	MODERATE	SEVERE	EXTREME
24. Arm, shoulder or hand pain.	1	2	3	4	5
25. Arm, shoulder or hand pain when you performed any specific activity.	1	2	3	4	5
26. Tingling (pins and needles) in your arm, shoulder or hand.	1	2	3	4	5
27. Weakness in your arm, shoulder or hand.	1	2	3	4	5
28. Stiffness in your arm, shoulder or hand.	1	2	3	4	5

	NO DIFFICULTY	MILD DIFFICULTY	MODERATE DIFFICULTY	SEVERE DIFFICULTY	SO MUCH DIFFICULTY THAT I CAN'T SLEEP
29. During the past week, how much difficulty have you had sleeping because of the pain in your arm, shoulder or hand? *(circle number)*	1	2	3	4	5

	STRONGLY DISAGREE	DISAGREE	NEITHER AGREE NOR DISAGREE	AGREE	STRONGLY AGREE
30. I feel less capable, less confident or less useful because of my arm, shoulder or hand problem. *(circle number)*	1	2	3	4	5

DASH DISABILITY/SYMPTOM SCORE = ____ ([(sum of n responses / n) - 1] x 25, where n is the number of completed responses.)

A DASH score may <u>not</u> be calculated if there are greater than 3 missing items.

HEADACHE DISABILITY INDEX

Patient Name _____ Date _____

INSTRUCTIONS: Please CIRCLE the correct response:

1. I have headache: (1) 1 per month (2) more than 1 but less than 4 per month (3) more than one per week
2. My headache is: (1) mild (2) moderate (3) severe

Please read carefully: The purpose of the scale is to identify difficulties that you may be experiencing because of your headache. Please check off "YES", "SOMETIMES", or "NO" to each item. Answer each question as it pertains to your headache only.

YES	SOMETIMES	NO		
____	____	____	E1.	Because of my headaches I feel handicapped.
____	____	____	F2.	Because of my headaches I feel restricted in performing my routine daily activities.
____	____	____	E3.	No one understands the effect my headaches have on my life.
____	____	____	F4.	I restrict my recreational activities (eg, sports, hobbies) because of my headaches.
____	____	____	E5.	My headaches make me angry.
____	____	____	E6.	Sometimes I feel that I am going to lose control because of my headaches.
____	____	____	F7.	Because of my headaches I am less likely to socialize.
____	____	____	E8.	My spouse (significant other), or family and friends have no idea what I am going through because of my headaches.
____	____	____	E9.	My headaches are so bad that I feel that I am going to go insane.
____	____	____	E10.	My outlook on the world is affected by my headaches.
____	____	____	E11.	I am afraid to go outside when I feel that a headaches is starting.
____	____	____	E12.	I feel desperate because of my headaches.
____	____	____	F13.	I am concerned that I am paying penalties at work or at home because of my headaches.
____	____	____	E14.	My headaches place stress on my relationships with family or friends.
____	____	____	F15.	I avoid being around people when I have a headache.
____	____	____	F16.	I believe my headaches are making it difficult for me to achieve my goals in life.
____	____	____	F17.	I am unable to think clearly because of my headaches.
____	____	____	F18.	I get tense (eg, muscle tension) because of my headaches.
____	____	____	F19.	I do not enjoy social gatherings because of my headaches.
____	____	____	E20.	I feel irritable because of my headaches.
____	____	____	F21.	I avoid traveling because of my headaches.
____	____	____	E22.	My headaches make me feel confused.
____	____	____	E23.	My headaches make me feel frustrated.
____	____	____	F24.	I find it difficult to read because of my headaches.
____	____	____	F25.	I find it difficult to focus my attention away from my headaches and on other things.

OTHER COMMENTS: _____

_____
Examiner

With permission from: Jacobson GP, Ramadan NM, et al. *The Henry Ford Hospital headache disability inventory (HDI).* Neurology 1994;44:837-842.

Back Index

Form BI100

rev 3/27/2003

Patient Name _____ **Date**

This questionnaire will give your provider information about how your back condition affects your everyday life. Please answer every section by marking the one statement that applies to you. If two or more statements in one section apply, please mark 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 and dressing without help.

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.

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.

Sitting

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

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.

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.

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.

Walking

⓪ I have no 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.

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.

Index Score = [Sum of all statements selected / (# of sections with a statement selected x 5)] x 100

Back Index Score

THE LOWER EXTREMITY FUNCTIONAL SCALE

We are interested in knowing whether you are having any difficulty at all with the activities listed below because of your lower limb Problem for which you are currently seeking attention. Please provide an answer for **each** activity.

Today, do you or would you have any difficulty at all with:

	Activities	Extreme Difficulty or Unable to Perform Activity	Quite a Bit of Difficulty	Moderate Difficulty	A Little Bit of Difficulty	No Difficulty
1	Any of your usual work, housework, or school activities.	0	1	2	3	4
2	Your usual hobbies, re creational or sporting activities.	0	1	2	3	4
3	Getting into or out of the bath.	0	1	2	3	4
4	Walking between rooms.	0	1	2	3	4
5	Putting on your shoes or socks.	0	1	2	3	4
6	Squatting.	0	1	2	3	4
7	Lifting an object, like a bag of groceries from the floor.	0	1	2	3	4
8	Performing light activities around your home.	0	1	2	3	4
9	Performing heavy activities around your home.	0	1	2	3	4
10	Getting into or out of a car.	0	1	2	3	4
11	Walking 2 blocks.	0	1	2	3	4
12	Walking a mile.	0	1	2	3	4
13	Going up or down 10 stairs (about 1 flight of stairs).	0	1	2	3	4
14	Standing for 1 hour.	0	1	2	3	4
15	Sitting for 1 hour.	0	1	2	3	4
16	Running on even ground.	0	1	2	3	4
17	Running on uneven ground.	0	1	2	3	4
18	Making sharp turns while running fast.	0	1	2	3	4
19	Hopping.	0	1	2	3	4
20	Rolling over in bed.	0	1	2	3	4
	Column Totals:					

Minimum Level of Detectable Change (90% Confidence): 9 points

SCORE: _____/ 80

Please submit the sum of responses.

Reprinted from Binkley, J., Stratford, P., Lott, S., Riddle, D., & The North American Orthopaedic Rehabilitation Research Network, The Lower Extremity Functional Scale: Scale development, measurement properties, and clinical application, Physical Therapy, 1999, 79, 4371-383, with permission of the American Physical Therapy Association.

Form N1-100

Neck

rev 3/27/2003

Patient Name **Date**

This questionnaire will give your provider information about how your neck condition affects your everyday life. Please answer every section by marking the one statement that applies to you. If two or more statements in one section apply, please mark 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.

Sleeping

⓪ I have no trouble sleeping.
① My sleep is slightly 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).

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.

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.

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.

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 moderate 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.

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

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.

Index Score = [Sum of all statements selected / (# of sections with a statement selected x 5)] x 100

Neck Index Score ____