WOMACK CHIROPRACTIC CENTER, P.A.
1430 Palm Bay Rd. NE, Suite C
Palm Bay, FL 32905
(321)723-2113 Fax (321)952-0848

PERSONAL INJURY QUESTIONNAIRE

Name ________________________________ Home Phone ____________________ Cell Phone __________________

Address ______________________________ City ______________________ State _________ Zip ________________

Birth date ________________ Age ______ Male____ Female ____ SS# ________________________________

Marital Status M S D W (circle one) Spouse's Name ____

Work Phone ________________ Employer Name ____

Person to contact in an emergency ____________________________________ Phone ________________________

EMAIL Address: _____________________________ Full Time Student? _____________

Race: ◻ American Indian or Alaska Native ◻ Asian ◻ Black or African American ◻ White
◻ Native Hawaiian or Other Pacific Islander ◻ Declined ◻ Unknown/Unavailable

Ethnicity: ◻ Hispanic or Latino ◻ Not Hispanic or Latino ◻ Declined ◻ Unknown/Unavailable

Primary Language: ◻ Arabic ◻ Chinese ◻ English ◻ French ◻ German ◻ Greek ◻ Hebrew ◻ Italian
◻ Japanese ◻ Korean ◻ Spanish ◻ Vietnamese ◻ Declined ◻ Unknown/Unavailable

Date of most recent: Annual Physical ________ Spinal X-rays ________ Spinal MRI/CT SCAN __________

Current Medications: ____

Medications you are allergic to: ____

Have you ever smoked cigars or cigarettes? ____ Do you currently smoke? ____ If so, packs per: Day___ Week___

Do you drink alcohol? _____ If so, how many drinks per: Day ______ Week _____

Height ______ Weight _____ For Women Only : Most Recent Menstrual Cycle ______ Are you pregnant: ( ) Yes ( ) N

AUTO INSURANCE
Auto Insurance ____ Claim# _____________ _____________________

Policyholder's Name ____________________________________ Policy # __________________________________

Relationship to policyholder ______________________________

HEALTH INSURANCE
Health Insurance ______________________________________ Policy # _________________________________

Policyholder's Name __________________________________ Policyholder's Date of Birth ________________

Policyholder's Employer ______________________________ Policyholder's SS# ________________________

Relationship to Policyholder ____________________________

For office use only
Blood Pressure ______/______ Pulse _______ Respirations ______

ATTORNEY
Name ____ Phone ___________________________________

NATURE OF ACCIDENT

Date of Accident____________ Time of Day _____________AM/PM Were police notified? ( ) Yes ( ) No

Were you: ( ) Driver ( ) Passenger ( ) Front Seat ( ) Back Seat

Did you sense or see the accident coming? ( ) Yes ( ) No

Number of people in your vehicle? __________ Were you wearing seatbelts? ______Yes ______No

What direction were you headed? ( ) North ( ) East ( ) South ( ) West

On (name of street) ___________________________________City _______________________State_________

Were you struck from: ( ) Behind ( ) Front ( ) Left side ( ) Right side

Approximate speed of your car: _______mph Other car: ________mph

Were you knocked unconscious? ( ) Yes ( ) No If yes, for how long?________________________

Where were you taken after the accident?______________________________ Did you receive treatment for your injuries? Describe ____

Are you still receiving treatment at that facility or any other? ____

Did you have any XRAYS/MRI/CT Scans following the accident?____

In your own words, please describe the accident: ____

____

____

Did you have any physical complaints BEFORE THE ACCIDENT: ( ) Yes ( ) No If yes, please describe in detail:____

____

Please describe how you felt:

DURING the accident: ______________________________ LATER THAT DAY: ______________________________
THE NEXT DAY: ______________________________________

IMMEDIATELY FOLLOWING the accident how did you feel? (select one or more)
□ Disoriented or Dizzy □ Nausea □ Tightness in your chest □ Unconscious □ Other - Please describe:

____

What are your PRESENT complaints and symptoms? ____

____

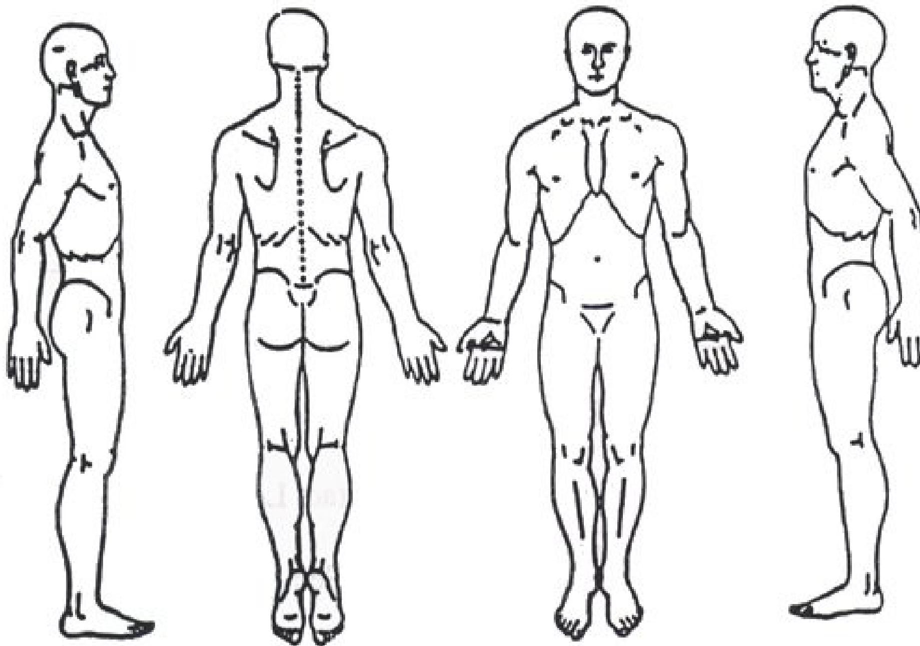
Frequency of symptoms: ___Constant ___75% of the time ___ 50% of the time ___25% of the time ___ Rare

Nature of your symptoms? ___ Sharp ___ Dull ache ___ Numb ___ Shooting ___ Burning ___ Tingling Other ______

Which phrase best describes ***changes*** in your symptoms throughout the day: ____Worse in morning
_____ Worse in afternoon ____ Worse at night ___ Changes with weather ___ Does not change

Do you have increased symptoms after any of the following activities, if so after how long?
Sitting ____ minutes Standing ____ minutes Walking ____ minutes Other ____________________________

Indicate where your symptoms are located, and rate from 0 - 10:



0 1 2 3 4 5 6 7 8 9 10
None Unbearable

Does anything help relieve your symptoms? Ice Heat Stretches Rest Medications __________ Other _________

Please briefly list any general health issues you have ____

Do you have a family history of neck or back problems, if so please describe:____________________________________
Father __________ Mother _____________ Brother _______________ Sister ___________________

Do you have any congenital (from birth) factors which relate to this problem? ( ) Yes ( ) No If yes, please describe:
____

Do you have any previous illnesses which relate to this case? ( ) Yes ( ) No If yes, please describe:
____

Have you been treated by another doctor since the accident? ( ) Yes ( ) No If yes, please list doctor's name:

______________________________________ What type of treatment did you receive?____________________________

Family Physician Name____

Since this injury occurred, are your symptoms: ( ) Improving ( ) Getting worse ( ) Same

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	□ Loss of Balance	□ Stomach Upset	□ Fainting
□ Fatigue	□ Tension	□ Head Seems to Heavy	□ Constipation	□ Depression
□ Back Pain	□ Ears Ringing	□ Pins & Needles in Arms	□ Lights Bother Eyes	□ Loss of Taste
□ Fever	□ Sleeping Problem	□ Numbness in Fingers	□ Loss of Smell	□ Diarrhea
□ Nervousness	□ Cold Sweats	□ Pins & Needles in Legs	□ Loss of Memory	□ _____________

What activities are limited by your discomfort: (select one or more)

□ Bending	□ Bowel Movements	□ Coughing	□ Daily Routine	□ Driving	□ Getting Up
□ Lifting	□ Lying Down	□ Pulling	□ Pushing	□ Reading	□ Sitting
□ Sleeping	□ Sneezing	□ Standing	□ Urination	□ Turning my head	
□ Walking	□ Working	□ Other ___________________________________			

Have you lost time from work as a result of this accident? ( ) Yes ( ) No If yes, please complete this question:

Last date worked: _____________ Type of Employment: ____________________Present Salary: ____________

Are you being compensated for time lost from work? ( ) Yes ( ) No

Are you covered by _____Medicare or _____Medicaid?

I understand and agree that health and accident policies are an arrangement between an insurance carrier and myself. Furthermore, I understand that Womack Chiropractic Center, P.A. will prepare any necessary reports and forms to assist me in making collection from the insurance co. and that any amount authorized to be paid directly to Womack Chiropractic Center, P.A. will be credited to my account on receipt. However, I clearly understand and agree that all services rendered me are charged directly to me and that I am personally responsible for payment. I also understand that if I terminate my care and treatment, any fees for professional services rendered me will be immediately due and payable.

___________________________________ ___________________

Patient Signature Date

ACKNOWLEDGMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

I acknowledge that I was provided a copy of the Notice of Privacy Practices and that I have read them or declined the opportunity to read them and understand the Notice of Privacy Practices. I understand that this form will be placed in my patient chart and maintained for six years.

_____________________________________ ___________________________

Patient Name (please print) Date

____

Parent, Guardian or Patient's legal representative

____

Signature

THIS FORM WILL BE PLACED IN THE PATIENT'S CHART AND MAINTAINED FOR SIX YEARS.

List below the names and relationship of people of whom you authorize the Practice to release PHI.

____________________________________ _________________________________

____________________________________ _________________________________

LOW BACK DISABILITY INDEX

Name ___________________________________ Today's Date: _________________________

Please read carefully. This questionnaire is designed to enable us to understand how much your **low back pain** has affected your ability to manage your everyday activities. **Please circle the LETTER that most closely describes your situation.**

1 Pain Intensity

A. The pain **comes and goes** and is **very mild**
B. The pain is **mild** and does **not vary** much.
C. The pain **comes and goes** and is **moderate**.
D. The pain is **moderate** and does **not vary** much.
E. The pain **comes and goes** and is **severe**.
F. The pain is **severe** and does **not vary** much.

2 Personal Care

A. I do not have to change my way of washing or dressing in order to **avoid pain**.
B. I do not normally change my way of washing or dressing even though it causes **some pain**.
C. Washing and dressing **increases the pain**, but I manage **not to change** my way of doing it.
D. Washing and dressing **increases the pain** and I find it **necessary to change** my way of doing it.
E. Because of the pain, I am **unable** to do **some** washing and dressing **without help**.
F. Because of the pain, I am **unable** to do **any** washing or dressing **without help**.

3 Lifting

A. I can lift heavy weights **without extra pain**.
B. I can lift heavy weights but it gives me **extra pain**.
C. Pain prevents me from **lifting heavy weights off the floor**.
D. Pain prevents me from lifting **heavy** weights, but I **can manage if they are conveniently positioned**, e.g., on a table.
E. Pain prevents me from lifting heavy weights, but I **can manage light to medium weights** if they are conveniently positioned.
F. I can **only lift very light weights**, at the most.

4 Walking

A. Pain does **not prevent** me from walking any distance.
B. Pain **prevents** me from walking more than **1 mile**.
C. Pain **prevents** me from walking more than **½ mile**.
D. Pain **prevents** me from walking more than **¼ mile**.
E. I can only walk using a **cane or crutches**.
F. I am in bed most of the time and have to **crawl** to the toilet.

5 Sitting

A. I can sit in any chair **as long as I like without pain**.
B. I can **only sit in my favorite chair** as long as I like.
C. Pain **prevents** me sitting more than **1 hour**.
D. Pain **prevents** me sitting more than **½ hour**.
E. Pain **prevents** me sitting more than **10 minutes**.
F. Pain **prevents me from sitting at all**.

6 Standing

A. I can stand as long as I want **without pain**.
B. I have **some pain** while standing, but it **does not increase** with time.
C. I **cannot stand** for longer than **1 hour without increasing** pain.
D. I cannot stand for longer than ½ **hour without increasing** pain.
E. I cannot stand for longer than **10 minutes without increasing** pain.
F. I **avoid** standing because it **increases pain right away**.

7 Sleeping

A. I get **no pain** in bed.
B. I get pain in bed, but it **does not prevent** me from sleeping well.
C. Because of pain, my normal night's sleep is **reduced by less than one-quarter**.
D. Because of pain, my normal night's sleep is **reduced by less than one-half**.
E. Because of pain, my normal night's sleep is **reduced by less than three-quarters**.
F. Pain **prevents** me from sleeping **at all**.

8 Social Life

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

9 Traveling

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

10 Changing Degree of Pain

A. My pain is **rapidly getting better**.
B. My pain **fluctuates**, but overall **is definitely getting better**.
C. My pain seems to be **getting better**, but **improvement is slow** at present.
D. My pain is **neither getting better nor worse**.
E. My pain is **gradually worsening**.
F. My pain is **rapidly worsening**.

Circle the number which best describes your pain RIGHT NOW:

0 1 2 3 4 5 6 7 8 9 10

No Pain **Unbearable Pain**

NECK DISABILITY INDEX

Name____ Today's Date: _________________________

Please read carefully: This questionnaire is designed to enable us to understand how much your **neck pain** has affected your ability to manage your everyday activities. **Please circle the LETTER that most closely describes your situation**.

1 Pain Intensity

A. I have **no pain** at the moment.
B. The pain is **very mild** at the moment.
C. The pain is **moderate** at the moment.
D. The pain is **fairly severe** at the moment.
E. The pain is **very severe** at the moment.
F. The pain is the **worst imaginable** at the moment.

2 Personal Care (washing,dressing,etc)

A. I can look after myself normally **without causing extra pain**.
B. I can look after myself normally but it **causes extra pain.**
C. It is **painful** to look after myself and I am slow and careful.
D. I **need some help** but manage most of my personal care.
E. I **need help every day** in most aspects of self-care.
F. I do not get dressed, wash with difficulty and stay in bed.

3 Lifting

A. I can lift heavy weights **without extra pain**.
B. I can lift heavy weights but it **gives me extra pain**.
C. Pain prevents me from **lifting heavy weights off the floor**, but I can manage if they are conveniently positioned (e.g. on a table).
D. Pain prevents me from lifting heavy weights, but I **can manage light to medium weights** if they are conveniently positioned.
E. I can lift **only very light weights**.
F. I **cannot lift** or carry **anything** at all.

4 Reading

A. I **can read** as much as I want with **no pain** in my neck.
B. I **can read** as much as I want with **slight pain** in my neck.
C. I **can read** as much as I want with **moderate pain** in my neck.
D. I **cannot read** as much as I want because of **moderate pain** in my neck.
E. I **can hardly read** at all because of **severe pain** in my neck
F. I **cannot read** at all.

5 Headaches

A. I have **no** headaches at all.
B. I have **slight** headaches which come infrequently.
C. I have **moderate** headaches which come **infrequently.**
D. I have **moderate** headaches which come **frequently.**
E. I have **severe headaches** which come **frequently**.
F. I have headaches **almost all the time**.

6 Concentration

A. I can concentrate fully when I want to with **no difficulty**.
B. I can concentrate fully when I want to with **slight difficulty**.
C. I have a **fair degree of difficulty** in concentrating when I want to.
D. I have **a lot of difficulty** in concentrating when I want to.
E. I have a **great deal of difficulty** concentrating when I want to.
F. I **cannot** concentrate **at all**.

7 Work

A. I can do **as much** work **as I want** to.
B. I can **only do my usual work**, but no more.
C. I can do **most of my usual work**, but no more.
D. I **cannot do** my usual work.
E. I can **hardly do** any work at all.
F. I **cannot do any** work at all.

8 Driving

A. I can drive **without** any neck pain.
B. I can drive as long as I want with **slight** pain in my my neck.
C. I can drive as long as I want with **moderate** pain in my neck.
D. I **cannot drive** as long as I want because of **moderate** pain in my neck.
E. I can **hardly drive** at all because of **severe** pain in my neck.
F. I **cannot drive my car at all**.

9 Sleeping

A. I have **no trouble** sleeping.
B. My sleep is **slightly disturbed** (less than 1 hr. sleepless).
C. My sleep is **mildly disturbed** (1-2 hrs. sleepless).
D. My sleep is **moderately disturbed** (2-3 hrs. sleepless).
E. My sleep is **greatly disturbed** (3-5 hrs. sleepless).
F. My sleep is **completely disturbed** (5-7 hrs. sleepless).

10 Recreation

A. I am able to engage in all my recreation activities with **no neck pain** at all.
B. I am able to engage in **all** my recreation activities with **some pain** in my neck.
C. I am able to engage in **most**, **but not all** of my usual recreation activities because of pain in my neck.
D. I am able to engage in a **few** of my usual recreation activities because of pain in my neck.
E. I **can hardly do any** recreation activities because of pain in my neck.
F. I **cannot do** any recreation activities at all.

Circle the number which best describes your pain

RIGHT NOW: 0 1 2 3 4 5 6 7 8 9 10

No Pain **Unbearable Pain**

PATIENT NAME: ______________________________

Treatment Consent Form
Womack Chiropractic Center

To the patient: Please read this entire document prior to signing it. It is important that you understand the information contained in this document. Please ask questions before you sign if there is anything that is unclear.

The nature of the chiropractic adjustment:

The primary treatment I use as a Doctor of Chiropractic is spinal manipulative therapy. I will use that procedure to treat you. I may use my hands or a mechanical instrument upon your body in such a way as to move your joints. That may cause an audible "pop" or "click", much as you have experienced when you "crack" your knuckles. You may feel a sense of movement.

Analysis / Examination / Treatment:

As a part of the analysis, examination and treatment, you are consenting to the following procedures:

- spinal manipulative therapy, palpation, range of motion testing
- orthopedic testing, basic neurological testing, radiographic studies
- muscle strength testing, electric muscle stimulation, hot/cold therapy

The material risks inherent in chiropractic adjustment:

As with any healthcare procedure, there are certain complications which may arise during chiropractic manipulation and therapy. These complications include but are not limited to: fractures, disc injuries, dislocations, muscle strain, cervical myelopathy, costovertebral strains and separations, and burns. Some types of manipulation of the neck have been associated with injuries to the arteries in the neck leading to or contributing to serious complications including stroke. Some patients will feel some stiffness and soreness following the first few days of treatment. I will make every reasonable effort during the examination to screen for contraindications to care; however, if you have a condition that would otherwise not come to my attention, it is your responsibility to inform me.

The probability of those risks occurring:

Fractures are rare occurrences and generally result from some underlying weakness of the bone which I check for during the taking of your history, during examination and upon examination/review of available diagnostic tests. Stroke has been the subject of tremendous disagreement. The incidences of stroke are exceedingly rare and are estimated to occur between one in one million and one in five million cervical adjustments. The other complications are also generally described as rare.

The availability and nature of other treatment options:

Other treatment options for your condition may include:

- Self-administered, over-the-counter analgesics and rest
- Medical care and prescription drugs such as anti-inflammatory, muscle relaxants and pain killers
- Hospitalization
- Surgery

If you choose to use one of the above noted "other treatment" options, you should be aware that there are risks and benefits of such options and you may wish to discuss these with your primary medical physician.

The risks and dangers attendant to remaining untreated:

Remaining untreated may allow the formation of adhesions and reduce mobility which may set up a pain reaction further reducing mobility. Over time this process may complicate treatment making it more difficult and less effective the longer it is postponed.

DO NOT SIGN UNTIL YOU HAVE READ AND UNDERSTAND THE ABOVE. PLEASE CHECK THE APPROPRIATE BLOCK AND SIGN BELOW.

I have read [ ] or have had read to me [ ] the above explanation of chiropractic adjustment and related treatment. By signing below I state that I have weighed the risks involved in undergoing treatment and have decided that it is in my best interest to undergo the treatment recommended. Having been informed of the risks, I hereby give my consent to that treatment.

Dated: ______________________________

____
Patient's name

____
Signature

Dated: ______________________________

Michael W.Womack, D.C. or Mitchell A. Womack, D.C.
Doctor's Name

____
Doctor Signature

____
Signature of parent or Guardian (if a minor)

REV 01/18