Rita Goldman, DC
Arnold Goldman, DC
Jerry Jason Lyles, DC

REPORT OF HISTORY FOR PERSONAL INJURY

VITAL HISTORY

Name: _____ Phone: _____
Email address: _____ Cell Phone: _____
Address: _____ City: _____ State: _____ Zip: _____
Your Social Security #:_____ Birthdate: _____
Spouse Social Security #: _____ Birthdate: _____
Ht: _____Wt:_____Age:_____ Number of Children: _____ Marital Status: _____
Occupation: _____ Employed by: _____ Phone: _____
Spouse Name: _____ Employed by: _____ Phone: _____
Primary Health Insurance: _____ Secondary: _____
Last Physician: _____ Address: _____
Referred By: _____

AUTO INSURANCE

Your Auto Insurance Co.:_____ Policy #:_____ Agent's Name: _____
Secondary Policyholder (if other than self):_____ Policy #:_____
Responsible Party Name: _____
Address: _____ City: _____ State: _____ Zip: _____
Policyholder Company Name: _____ Policy #:_____

ATTORNEY Yes No (please circle one)

Name: _____ Phone: _____
Address: _____ City: _____ State: _____ Zip: _____

Witnesses? ☐ Yes ☐ No Name(s):_____

INSURANCE PATIENTS

Our office does not guarantee that your insurance will pay. We will make every effort, at the beginning of your health care, to receive verification of your policy and its benefits. However, if for some reason, your insurance claim is denied, you are responsible for the full amount of your bill.

I authorize the release of any medical information necessary to process the claim.

If my current policy prohibits direct payment to doctor, then I hereby also instruct and direct you to make out the check to me and mail it as follows:

☐	☐
MAYSVILLE FAMILY CHIROPRACTIC 1335 US Highway 68 Maysville, KY 41056 606-564-4213 ● 800-571.1117 Fax: 606-564-4406	**GEORGETOWN FAMILY CHIROPRACTIC** 100 Eastside Drive Georgetown, KY 40324 502-868-0097 ● 800-869-0714 Fax: 502-868-7499

I AUTHORIZE PAYMENT OF MEDICAL BENEFITS TO

MAYSVILLE / GEORGETOWN FAMILY CHIROPRACTIC WELLNESS CENTER

FOR SERVICES RENDERED

SIGNED (Insured or Authorized Person)_____Date:_____

CONSENT TO TREATMENT OF MINOR CHILD	PREGNANCY RELEASE
I hereby authorize Dr._____ and whomever he/she may designate as his/her assistants to administer chiropractic care as they deem necessary to my _____ _____ (indicate relationship of child). Name: _____ Signed and Dated in _____/_____ (city/state) this _____ day of _____, 20_____. Signed: _____ (Parent/Guardian Signature) Witness: _____	DATE: _____ I, _____, in signing this form, state that to the best of my knowledge there is NO pregnancy (confirmed nor suspected) at the time this service was rendered. _____ (Patient Signature) Witness: _____

I hereby certify that the enclosed information is true and answered correctly. I give my consent for examination, x-rays and treatment at the office of ***Maysville / Georgetown Family Chiropractic****. I agree that if* ***Maysville / Georgetown Family Chiropractic*** *deem it necessary to have my X-rays read by an outside radiologist and my insurer fails to pay, I will accept full responsibility for payment.*

I understand that I am responsible for payment to ***Maysville / Georgetown Family Chiropractic****, and that I will be responsible for any and all collection costs in addition to my bill that may arise including collection fees, court costs, and reasonable attorney fees should collection action be taken on this bill. Accounts 90 days past due are subject to an interest rate of 1 ½% per month on the unpaid balance.*

Signature_____ _____
Date

Witness_____ _____
Date

Neck Pain and Disability Index (Vernon-Mior)

Patient Name: _____ File # _____ Date: _____

This questionnaire has been designed to give the doctor information as to how your neck pain has affected your ability to manage in everyday life. Please answer every section and mark in each section only the ONE box which applies to you. We realize you may consider that two of the statements in any one section relate to you, but please just mark the box which most closely describes your problem.

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 conveniently 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 can't 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.

Pain Severity Scale: Rate the Severity of your pain by checking one box of the following scale.

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

Patient Signature _____

Low Back Pain and Disability Questionnaire (Revised Oswestry)

Patient Name: _____ File # _____ Date: _____

This questionnaire has been designed to give the doctor information as to how your back pain has affected your ability to manage everyday life. Please answer every section and mark in each section only the ONE box which applies to you. We realize you may consider that two of the statements in any one section relate to you, but please just mark the box which most closely describes your problem.

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 very severe.
☐ The pain is severe and does not vary much.

SECTION 2 – PERSONAL CARE

☐ 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 causes extra pain.
☐ Pain prevents me from lifting heavy weights off the floor.
☐ Pain prevents me from lifting heavy weights off the floor, but I 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 ½ mile without increasing pain.
☐ I cannot walk more than ¼ 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.
☐ I can only sit in my favorite chair as long as I like.
☐ Pain prevents me from sitting more than one hour.
☐ Pain prevents me from sitting more than half hour.
☐ Pain prevents me from sitting more than 10 minutes.
☐ I avoid sitting because it increases pain straight away.

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 ½ hour without increasing pain.
☐ I cannot stand for longer than 10 minutes without increasing pain.
☐ I avoid standing because it increases the pain straight away.

SECTION 7 – SLEEPING

☐ I get not 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 ¼.
☐ Because of pain my normal night's sleep is reduced by less than ½.
☐ Because of pain my normal night's sleep is reduced by less than ¾.
☐ 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 – TRAVELLING

☐ I get no pain whilst travelling.
☐ I get some pain whilst travelling but none of my usual forms of travel make it any worse.
☐ I get extra pain whilst travelling but it does not compel me to seek alternative forms of travel.
☐ I get extra pain whilst travelling 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 at present.
☐ My pain is neither getting better nor worse.
☐ My pain is gradually worsening.
☐ My pain is rapidly worsening.

Pain Severity Scale: Rate the Severity of your pain by checking one box of the following scale.

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

Patient Signature _____

ASSIGNMENT OF MEDICAL BENEFITS & INFORMED CONSENT

I understand that **my doctor is submitting my x-rays to Midwest Radiology Consultants for radiological evaluation**. I also understand that the fee for such services will be submitted to my insurance company, workers' compensation carrier, or my attorney.

I authorize my insurance company to **pay directly to Midwest Radiology Consultants for services rendered.**

In the event my insurance company, attorney, or workman's compensation carrier does not reimburse for the fee in full, or if I do not have insurance coverage, **I agree that I am directly responsible for the charges or any unpaid portion.** Returned checks for insufficient funds will be assessed a $20.00 service charge. ***Accounts delinquent by 90 days from the time of my 1st billing statement may be placed with a legal collection agency. I am fully responsible for all collection costs unless prior payment arrangements have been made with Midwest Radiology Consultants.***

I understand that Dr. Doran L. Nicholson is not a participating provider in my insurance plan and that his services may not be covered by my insurance. ***I also understand that this service is not covered by Medicare or Medicaid.***

In the event that my insurance company sends payment directly to me, I agree to promptly remit such payments to Midwest Radiology Consultants.

Patient Signature:

_____

(Patient, Parent or Guardian)

Date: _____

MIDWEST RADIOLOGY CONSULTANTS
706 NE Langsford Rd.
Lee's Summit, MO 64063
Phone: 816 525-2822
800-454-2822
Doran L. Nicholson, D.C., D.A.C.B.R.

MIDWEST
RADIOLOGY
CONSULTANTS

706 N.E. LANGSFORD RD. (P.O. BOX 1122)
LEE'S SUMMIT, MO 64063
PHONE: 816 525-2822 FAX: 816 525-4540

Doctor Information:

Maysville Family Chiropractic

Dr. Rita Goldman

1335 Southgate Plaza

Maysville, KY 41056

Trauma? Y ☐ N ☐ Explain:

Malignancy? Y ☐ N ☐ Explain:

Areas of Concern:

Results Requested: ☐ Phone: 606-564-4213

☐ Fax: 606-564-4406

☐ E-Mail _____

Payment: ☐ Payment Enclosed ☐ Bill Patient ☐ Insurance ☐ Work Comp ☐ PI ☐ Auto Accident
(Date of Accident: ____/____/____)

CONFIDENTIAL

PATIENT INFORMATION		INSURED PARTY
Name:		Name:
Street:		Street:
City/State/Zip:		City/State/Zip:
Phone:	M ☐ F ☐	Phone:
Soc. Sec. #	Date of Birth:	Relation to insured: ☐Self ☐Spouse ☐Child ☐Other

INSURANCE INFORMATION		SECONDARY INSURANCE	
Company & Adjustor Name:		Company & Adjustor: Name:	
Street:		Street:	
City/State/Zip:		City/State/Zip:	
Phone #	Claim #	Phone #	
Group #	Policy / ID #	Claim #	Group#

ATTORNEY INFORMATION		WORKER'S COMPENSATION CARRIER	
Name		Company Name:	
Street:		Street:	
City/State/Zip:		City/State/Zip:	
Phone:		Phone	Claim#