PERSONAL INJURY QUESTIONNAIRE

ABOUT YOU:

Name:_____
Address:_____
_____
Phone: H:_____ W:_____
Age:_____ Birthdate:_____
Sex: M F SS#_____
Employer's name:_____
Employer's address:_____
_____

ATTORNEY

Do you have any attorney? ( )Y ( )N
Name:_____
Address:_____
_____
Phone number:_____

AUTO/PERSONAL INJURY INSURANCE

Your Ins. Co:_____
Ins. Co. Address:_____
_____
Policy #:_____
Name on policy *(if other than self)* _____
Agent's name:_____
Agent's phone #:_____
Phone # of Ins. Co._____
Claim #:_____
Adjuster's name:_____
Adjuster's phone #:_____
Were you responsible for the accident? ( )Y ( )N
If no, what is the responsible party's name?:
_____
Address:_____
_____
Policy holder's name:_____
Policy #:_____

NATURE OF THE ACCIDENT

Date of the accident:_____ Time of day:_____( )a.m. ( )p.m.
City and State in which the accident occurred:_____
Were you: ( )Driver ( )Passenger ( )Front Seat ( )Back Seat
Were you wearing your seat belt? ( )Y ( )N
In what direction were you headed? ( )North ( )East ( )South ( )West
on (name of street)_____
What direction was the other vehicle headed? ( )North ( )East ( )South ( )West
on (name of street)_____
Were you struck from: ( )Behind ( )Front ( )Left side ( )Right side
Approximate speed of your car:_____mph. Other car:_____mph.
Were you knocked unconscious? ( )Y ( )N If yes, for how long?_____
Were the police notified? ( )Y ( )N
Were there any witnesses? ( )Y ( )N Names:_____
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:
a. DURING the accident:_____
b. IMMEDIATELY AFTER the accident:_____
c. LATER THAT DAY:_____
d. THE NEXT DAY:_____
_____
What are your present complaints and symptoms?_____
_____
_____
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, including date(s) and type(s) of accidents, as well as injury(ies) received:_____
_____
_____
Where were you taken after the accident? _____
Have you 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?_____
Since the injury occurred, are your symptoms: ( )Improving ( )Getting worse ( )Same

CHECK THE SYMPTOMS YOU HAVE NOTICED SINCE THE ACCIDENT:

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

Symptoms other than above:_____
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. Present salary:_____
d. Are you being compensated for time lost from work? ( )Yes ( )No If yes, please describe, in detail:
_____
Other pertinent information:_____

PERSONAL HEALTH INSURANCE INFORMATION

Ins. Company Name:_____Address:_____
Ins. Co. Phone #:_____Insured's name:_____SS#_____
Insured's employer:_____Insured's Date of Birth___/___/___ Policy #:_____

OTHER PASSENGERS IN THE CAR

Were there any other passengers in the car? ( )Yes ( )No If yes, please list:

Name	Age	Relationship to you	Phone number
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

Patient's Signature_____ Today's Date_____

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Chiropractic Physician
6015 E. Grant Road
Tucson, AZ 85712
520-818-8857

New Practice Member Intake Form

First Name: _____
Last Name: _____
Nickname: _____
Address: _____
City: _____
State: _____ Zip Code: _____
Age: _____ Date of Birth: _____
Sex: ( ) Male ( ) Female
( ) Single ( ) Married ( ) Divorced ( ) Separated
( ) Widowed
Social Security #: _____- _____- _____
Home Phone: _____
Work Phone: _____
Cell Phone: _____
Email Address: _____
Do you prefer a TEXT MESSAGE or EMAIL for appointment reminders? (Please circle preference)

Type of work: _____
Insurance: ( ) Work Comp ( ) Auto ( ) MA
( ) Medicare ( ) Private: _____
Whom may we thank for referring you to our office? _____
How were you referred to our office?
( ) Yellow pages ( ) Lecture ( ) Drive by
( ) Coupon ( ) Screening Where? _____
_____
( ) Mailing - which one? _____
( ) Other: _____

In case of an emergency, please contact:
Name: _____
Phone: _____
Relationship: _____

Your Health Profile

At Synergy Wellness, we realize that we can only help a person as much as they want to help themselves. We cannot force upon someone the desire to get healthy and stay there, but, we can provide the necessary tools when that person arrives at that point. While filling this out, please be honest with yourself, but more importantly, start to envision your ideal health so we know how far we can take you!

Please rate your perceived overall health status:

Poor 1 2 3 4 5 6 7 8 9 10 Excellent

What are your health objectives? _____
_____

Name/Address/Phone of the last doctor who put you on a health development program? _____
_____

Were you able to stay on the program? Y N How long? _____

What were your results? _____

Are you healthier today than you were 5 years ago? Y N Not Sure

If so, what did you do to improve your health? _____
_____

If not, why do you think your health declined? _____
_____

Doctor Initials:_____

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Patient Name _____ Date _____

Will you be healthier 5 years from now than you are today? Y N Not Sure

If so, what are you planning to do to improve your health and if not, what could you do to improve your health rather than have it continue to decline? _____
_____

After making these changes in your life, how do you expect your health to be 5 years from now?
_____

Have you had previous chiropractic care? Y N

If yes, what was the doctor's name? _____

What was the approximate date of your last visit? _____

What was the duration of your care? _____

Were you aware that:

--Doctors of Chiropractic work with the nervous system? ___Yes ___No
--The nervous system controls all bodily functions and systems? ___Yes ___No
--Chiropractic is the largest natural healing profession in this world? ___Yes ___No
--If Chiropractic care starts at birth, you can achieve a higher level of health throughout life? ___Yes ___No

What other wellness professionals are currently parts of your health care team?
( ) Massage Therapist ( ) Acupuncturist ( ) Naturopath ( ) Homeopath
( ) Other: _____

How many Medical Doctor's office visits did you and your family have last year?
( ) None ( ) Less that 5 ( ) More than 5 ( ) More than 10

Is your current condition the result of a **recent**: ( ) auto accident? ( ) work related injury

What was the date of injury? _____

If so, please inform the front desk staff immediately to obtain additional necessary paperwork.

Doctor Initials:_____

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6015 E. Grant Road
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520-818-8857

Patient Name _____ Date _____

Please describe below, in the following 2 sections, your primary, secondary and additional reasons, if any, for seeking care in our office:

Primary Complaint (*List one only*): _____

When did you first experience this problem? _____

How did this problem first begin? _____
_____

What seems to aggravate this problem? _____

What have you **tried to relieve this problem** (i.e. interventions, treatments, aspirin, medications, surgery)? _____
_____

What have you tried that has **improved this problem**? _____
_____

How would you describe the symptoms (i.e. burning, stabbing, aching, sharp, etc.)?
_____ Burning _____ Stabbing _____ Aching _____ Sharp
_____ Tingling _____ Numb _____ Other: _____

Please describe the location of the pain. _____
_____

Does this problem cause pain that travels to any other areas of the body? Y N If yes, where?
_____

Please grade the severity of this problem (with 10 being worst):

Now 1 2 3 4 5 6 7 8 9 10

On Average 1 2 3 4 5 6 7 8 9 10

Is this problem: In the AM: ( ) worse? ( ) better?
In the PM: ( ) worse? ( ) better?

How often do you experience this problem? (Please Circle One)

<25% (Intermittent) 26-50% (Occasional) 51-75% (Frequent) >76% (Constant)

Have you seen any other doctors for this problem? Y N If yes, who? _____
_____

Doctor Initials:_____

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Patient Name _____ Date _____

Secondary Complaint (*List one only*): _____

When did you first experience this problem? _____

How did this problem first begin? _____
_____

What seems to aggravate this problem? _____

What have you tried to relieve this problem (i.e. interventions, treatments, aspirin, medications, surgery)? _____
_____

What have you tried that has improved this problem? _____
_____

How would you describe the symptoms (i.e. burning, stabbing, aching, sharp, etc.)?

_____ Burning _____ Stabbing _____ Aching _____ Sharp
_____ Tingling _____ Numb _____ Other: _____

Please describe the location of the pain. _____
_____

Does this problem cause pain that travels to any other areas of the body? Y N If yes, where?
_____

Please grade the severity of this problem (with 10 being worst):

Now 1 2 3 4 5 6 7 8 9 10

On Average 1 2 3 4 5 6 7 8 9 10

Is this problem: In the AM: ( ) worse? ( ) better?
In the PM: ( ) worse? ( ) better?

How often do you experience this problem? (Please Circle One)

<25% (Intermittent) 26-50% (Occasional) 51-75% (Frequent) >76% (Constant)

Have you seen any other doctors for this problem? Y N If yes, who? _____
_____

Doctor Initials:_____

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Patient Name _____ Date _____

Lifestyle/Social History

Job Description: _____

Work Schedule: _____

Recreational Activities: _____

Do you smoke? Y N If yes, how much? _____
Do you drink alcohol? Y N If yes, how much? _____
Do you drink coffee? Y N If yes, how much? _____
Do you drink tea? Y N If yes, how much? _____

Daily water intake: ( ) None ( ) 1-2 ( ) 3-4 ( ) 5+

Daily servings of vegetables: ( ) None ( ) 1-2 ( ) 3-4 ( ) 5+

Daily servings of fruits: ( ) None ( ) 1-2 ( ) 3-4 ( ) 5+

How regularly do you exercise? ( ) never ( ) occasionally ( ) ___x/week ( ) daily

What kind of exercise do you do? _____

How many hours of sleep do you get on average? _____

What position do you regularly sleep in? Back Side Stomach

On a scale of 1-10 please rate your stress level (1=none and 10=extreme):

Occupational	1	2	3	4	5	6	7	8	9	10
Personal	1	2	3	4	5	6	7	8	9	10

Women Only

Pregnancies and outcomes:

Date of pregnancy	Outcome
_____	_____
_____	_____
_____	_____
_____	_____

When was your last period? _____

Are you pregnant? ( ) Yes ( ) No ( ) Not sure

Doctor Initials:_____

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Patient Name _____ Date _____

Medical History

Please list the cause of death (including cancer, heart disease, stroke or diabetes) and age of any immediate family members (parents or siblings):

Relationship	Cause of Death	Age of death

Surgeries:

Date	Type	Reason for surgery

Previous injuries, trauma or fractures (please give type and date): _____
_____

Medications (including over the counter drugs):

Medication & Dosage	Reason for taking

Nutritional Supplements you are currently taking:

Supplement & Dosage	Reason for taking

Allergies: _____
_____

Doctor Initials:_____

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Patient Name _____ Date _____

Stress History

Please indicate whether you have **ever** experienced stress in any of the following areas. Your answers will enable us to determine which factors have contributed to your present health condition/concerns.

Childhood

Repeated/Prolonged Antibiotic Use	Y	N	Inhaler Use	Y	N
Car Accident	Y	N	Prescription Medications	Y	N
Childhood Illness	Y	N	Surgery	Y	N
Fall/Jump from a Height < 3 feet	Y	N	Vaccinations	Y	N
Fall/Jump from a Height > 3 feet	Y	N	Youth Sports	Y	N
Head Trauma	Y	N	Other Traumas (physical or emotional) _____		

_____

Adulthood

Alcohol Consumption	Y	N	Inhaler Use	Y	N
Repeated/Prolonged Antibiotic Use	Y	N	Prescription Medications	Y	N
Car Accident	Y	N	Smoker	Y	N
Coffee Drinker	Y	N	Surgery	Y	N
Drug Use/Abuse	Y	N	Contact Sports	Y	N
Fall/Jump from a Height	Y	N	Extreme Sports	Y	N
Head Trauma	Y	N	Workplace Stress	Y	N
Home Environment Stress	Y	N	Other Traumas (physical or emotional) _____		

_____

Please CHECK AND EXPLAIN any of the following you have had in the last 12 MONTHS AND/OR EVER RECEIVED TREATMENT FOR:

MUSCULO-SKELETAL: Check and Explain

____Low Back Pain ____Pain Between Shoulders ____Neck Pain ____Arm Pain
____Joint Pain/Stiffness ____Walking Problems ____Difficult Chewing/Clicking Jaw ____General Stiffness

Symptom	Date Last Experienced	Treatment Received
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

GENITO-URINARY: Check and Explain

____Painful/Excessive Urination ____Discolored Urine ____Bladder Trouble

Symptom	Date Last Experienced	Treatment Received
_____	_____	_____
_____	_____	_____

Doctor Initials:_____

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Patient Name _____ Date _____

CARDIO-VASCULAR- RESPIRATORY: Check and Explain

____Chest Pain ____Short Breath ____Irregular Heartbeat ____Blood Pressure Problems
____Heart Problems ____Varicose Veins ____Ankle Swelling ____Stroke ____ Lung Problems/Congestion

Symptom	Date Last Experienced	Treatment Received
_____	_____	_____
_____	_____	_____
_____	_____	_____

NERVOUS SYSTEM: Check and Explain

____Nervous ____Numbness ____Hearing Difficulty ____Forgetfulness ____Confusion/Depression
____Fainting ____Stress ____Dizziness ____Paralysis ____Cold/Tingling Extremities
____Convulsions

Symptom	Date Last Experienced	Treatment Received
_____	_____	_____
_____	_____	_____
_____	_____	_____

EYES, EARS, NOSE, THROAT: Check and Explain

____Vision Problems ____Dental Problems ____Sore Throat ____Ear Aches ____Stuffed Nose

Symptom	Date Last Experienced	Treatment Received
_____	_____	_____
_____	_____	_____

GENERAL: Check and Explain

____Fatigue ____Allergies ____Headaches ____Fever

Symptom	Date Last Experienced	Treatment Received
_____	_____	_____
_____	_____	_____

MALE / FEMALE: Check and Explain

____Menstrual Irregularity ____Menstrual Cramps ____Vaginal Pain/Infection ____Breast Pain/Lumps
____Prostate/Sexual Dysfunction ____Other: _____

Symptom	Date Last Experienced	Treatment Received
_____	_____	_____
_____	_____	_____

Doctor Initials:_____

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Patient Name _____ Date _____

GASTRO-INTESTINAL: Check and Explain

____Excessive Thirst	____Frequent Nausea	____Vomiting	____Black/Bloody Stools	____Poor/Excessive Appetite
____Constipation	____Hemorrhoids	____Colitis	____Liver Problems	____Gall Bladder Problems
____Weight Trouble	____Abdominal Cramps	____Diarrhea	____Heartburn	____Gas/Bloating after Meals

Symptom	Date Last Experienced	Treatment Received
_____	_____	_____
_____	_____	_____
_____	_____	_____

Please <u>check and explain</u> any of the following illnesses you have ever had:

____Cancer	____Diabetes	____Mental Disorders	____Pneumonia	____Heart Disease
____Rheumatic Fever	____Small Pox	____Pleurisy	____Polio	____Chicken Pox
____Arthritis	____Tuberculosis	____Epilepsy	____Anemia	____Measles
____Whooping Cough	____Mumps	____Thyroid Disorder		

Symptom	Date Last Experienced	Treatment Received
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

Which best describes your reason for consulting our office?

_____ I have a specific concern and require help with this concern.

_____ I want to ensure that my health concerns do not become an ongoing problem that will impact my future health.

_____ I want to be healthier five years from now than I am today.

Patient's Signature _____ Date _____

Doctor Initials:_____

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Consent for Purposes of Treatment, Payment & Healthcare Operations (3/03)

In this document, "I" and "my" refer to the patient, and the "Chiropractor" refers to Dr. Tim Harrigan, D.C..

I consent to the use or disclosure of my protected health information by Chiropractor for the purpose of analyzing, diagnosing, or providing treatment for me, obtaining payment for my healthcare bills or to conduct healthcare operations of Chiropractor. I understand that analysis, diagnosis, or treatment of me by Chiropractor may be conditional upon my consent as evidenced by my signature below.

I understand I have the right to request a restriction as to how my protected health information is used or disclosed to carry out treatment, payment, or healthcare operations of the practice. Chiropractor is not required to agree to the restrictions that I may request. However, if Chiropractor agrees to a restriction that I request, the restriction is binding on Chiropractor. I have the right to revoke this consent, in writing, at any time, except to the extent that Chiropractor has taken action in reliance on this Consent.

My "protected health information" means health information, including my demographic information, collected from me and created or received by my physician, another healthcare provider, my employer, or a healthcare clearinghouse. This protected health information relates to my past, present, or future physical or mental health or condition and identifies me; of there is a reasonable basis to believe the information may identify me.

I have been provided with a copy of the Notice of Privacy Practices of Chiropractor and understand that I have a right that Notice's Notice of Practices prior signing this document. The Notice of Privacy Practices describes the types of uses and disclosures of my protected health information that will occur in my treatment, payment of my bills, or in the performance of healthcare operations of Chiropractor. The Notice of Privacy Practices for Chiropractor is available at the front desk of Synergy Wellness. This Notice of Privacy Practices also describes my rights and duties of the Chiropractor with respect to my protected health information.

Chiropractor reserves the right to change the privacy practices that are described in the Notice of Privacy Practices. I may obtain a revised Notice of Privacy Practices by calling the office of Chiropractor and requesting a revised copy be sent in the mail or asking for one at the time of my next appointment.

Printed Name of Patient _____

Signature of Patient or Personal Representative _____

Date of Signing _____

Doctor Initials:_____

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TERMS OF ACCEPTANCE

When a patient seeks chiropractic healthcare and we accept a patient for such care, it is essential for both to be working towards the same objective.

Chiropractic has only one goal. It is important that each patient understand both the objective and the method that will be used to attain it. This will prevent any confusion or disappointment.

Adjustment
An adjustment is the specific application of forces to facilitate the body's correction of vertebral subluxation. Our chiropractic method of correction is by specific adjustments of the spine.

Health
A state of optimal physical, mental, and social well-being, not merely the absence of disease or infirmity.

Vertebral Subluxation
A misalignment of one or more of the 24 vertebra in the spinal column which causes alteration of nerve function and interference to the transmission of mental impulses, resulting in a lessening of the body's innate ability to express its maximum health potential.

We only offer to diagnose either vertebral subluxations or neuro-musculoskeletal conditions. However, if during the course of a chiropractic spinal examination, we encounter non-chiropractic or unusual findings, we will advise you. If you desire advice, diagnosis, or treatment for those findings, we will recommend you seek the services of another healthcare provider.

We do not offer advice regarding treatment prescribed by others. OUR ONLY PRACTICE OBJECTIVE is to eliminate major interference to the expression of the body's innate wisdom. Our only method is specific adjusting to correct vertebral subluxations. However, we may use other procedures to help your body hold the adjustments.

I, _____ have read and fully understand the above statements. *(Print Name)*

Consent to evaluate and adjust a minor child
I, _____ being the parent of legal guardian of _____ have read and fully understand the above terms of acceptance and hereby grant permission for my child to receive chiropractic care. All questions regarding the doctor's objectives pertaining to my/ my child's care in this office have been answered to my complete satisfaction. I therefore accept chiropractic care on this basis.

Patient/Guardian Signature _____ Date _____

Doctor Initials:_____

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Authorization to Release Medical Information

I authorize the release of medical information necessary to process my insurance claim(s) and also certify that all insurance information given to this clinic is correct and complete.

Patient Signature _____ Date _____

Agreement for Payment of Services

I understand and agree that health and accident insurance policies are an arrangement between an insurance carrier and myself. Furthermore, I understand that this office will prepare any necessary reports and forms to assist me in making collection from the insurance company and that if any amount is authorized to be paid directly to this office, it will be credited to my account. **HOWEVER, I CLEARLY UNDERSTAND AND AGREE THAT ALL SERVICES RENDERED TO ME ARE CHARGED DIRECTLY TO ME AND THAT I AM PERSONALLY REPSONSIBLE FOR THE PAYMENT OF MY ACCOUNT.** It is the policy of this clinic to collect for services as they are rendered, unless other financial arrangements are made.

Patient Signature _____ Date _____

E-Practice Form

In our never-ending quest to serve our practice members better, we are constantly updating our database and requesting current information. By providing this information it will allow you to take advantage of and have access to our on-line scheduling, online class/lecture registration and receive up to the minute information about all the events occurring with Dr. Tim Harrigan (including schedule changes, current events, and newsletters). This data will never be released to anyone! Our efforts are to provide you with unparalleled service. We look forward to continuing our tradition of exceeding all your expectations.

Name: _____

E-Mail Address: _____

Doctor Initials:_____

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NUTRITIONAL INFORMED CONSENT

Please be advised that any suggested nutritional or dietary advice that we may give you is not intended as primary treatment for any disease or particular bodily symptom.

Although Arizona law does not allow chiropractors to prescribe or administer medicine or drugs, chiropractors are allowed to provide nutritional counseling and advise and prescribe and sell nutritional products including, but not limited to, vitamins, minerals, water, enzymes, botanicals, homeopathic preparations, phytonutrients, glandular extracts, and natural hormones.

Nutritional counseling, vitamin recommendations, and the adjunctive schedule of nutrition is provided solely to upgrade the quality of foods in your diet in order to supply good nutrition supporting the physiological and bio-mechanical processes of the human body.

Following our nutritional advice and suggested nutritional intake may also enhance the stabilization of the chemical components of the Subluxation Complex.

I, _____have read and understand the above:
Print Name

Signature :_____ Date:_____

Supplement/Nutritional Product Refunds and Returns

In our efforts to provide the most fresh and effective nutritional supplements available, we do not allow returns/refunds after 30 days of actual purchase date. If it is within 30 days, bottles must be unopened, with complete boxes/packaging, and in immaculate condition. There are many factors that contribute to preserving the quality and therapeutic properties of whole food nutritional products. To ensure that we are providing the freshest products to our patients, we must enforce this policy as we cannot reuse the products. Any returns will also forfeit any discounts, and will be prorated at full retail price, as well as an additional 20% administration fee of any returned items. Thank you for understanding. Quality and efficacy is the foundation to our nutritional programs success.

Signature:_____ Date:_____

Doctor Initials:_____

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Medicare Notice of Non-Payable Services

Patient Name: _____ Patient Acct #: _____

Medicare does not pay for all services and items provided in this office even though we have a good reason to think you need them. Medicare only pays for covered services and items (e.g., spinal manipulation by a chiropractor). The below services and items are **non-payable** under Medicare when delivered and/or ordered by a Doctor of Chiropractic and you are responsible to pay for them:

- Chiropractic Examinations
- Chiropractic X-rays
- Chiropractic Extra-spinal adjustments
- Chiropractic Modalities/Therapeutic Procedures
- Orthotics
- Spinal Traction Therapy
- Muscle Work/Myofascial Release/Trigger Point Therapy
- Computerized ROM
- Surface EMG
- Thermography
- Heart Rate Variability Stress Testing
- Vitamins/Supplements
- Lumbar Braces
- Lumbar Supports
- Seat Cushion/Supports
- TENS
- Home Use Cervical Traction
- Etc….(Only spinal manipulation is covered by Medicare)

Patient Acknowledgement:
I acknowledge that I have been told in advance that the services and items listed above are non-payable by Medicare and I agree to pay for these services and items at the time the service or item is provided.

Patient Signature: _____

Date: _____

Doctor Initials:_____

NOTICE OF LIEN FOR CHIROPRACTIC SERVICES

I, _____, hereby agree to pay out of an settlement, claim, judgment or verdict obtained as a result of an accident occurring on _____ such sums as may be due and owing to Synergy Wellness (hereinafter referred to as "Provider"), who has provided or will provide chiropractic services to me for injuries sustained as a result of that accident. I agree to withhold such sums from my portion of such settlement, claim, judgment or verdict as is necessary to pay the amount owed and to pay such amount directly to the Provider.

I completely understand that I am directly and fully responsible to Provider for all bills for services rendered to me, that payment of such bills is not contingent on my obtaining any settlement, claim, judgment or verdict, and that Provider is entitled to be paid my me for services rendered to me even if no settlement, claim, judgment or verdict is recovered. I further understand that this *Agreement* is made solely for Provider's protection and in consideration of Provider's willingness to await payment or to render or continue rendering services to me without immediate payment.

I fully understand this *Agreement* and am agreeing to the terms of it willingly.

_____ _____
Print Client's name Date

_____
Client's signature

_____ _____
Witness Date

_____ _____
Print Attorney's name Date

_____ _____
Attorney's signature

Synergy Wellness
Dr. Tim Harrigan
Chiropractic
Physician 6015 E.
Grant Rd. Tucson, AZ
85712

Neck Index

Form N1-100

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

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.

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.

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.

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.

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.

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.

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.

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.

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.

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

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

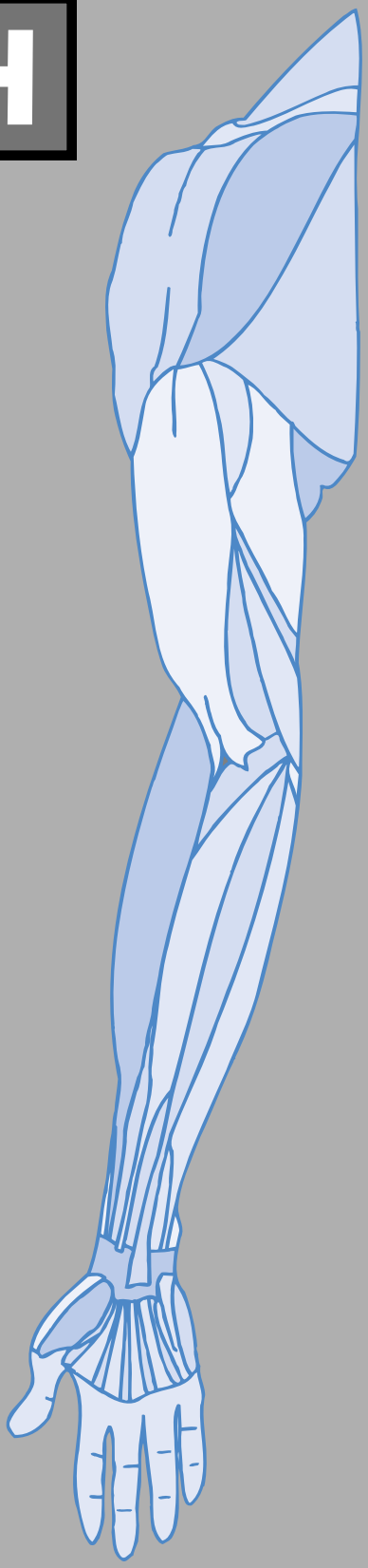
	NO DIFFICULTY	MILD DIFFICULTY	MODERATE DIFFICULTY	SEVERE DIFFICULTY	SO MUCH DIFFICULTY THAT I CAN'T SLEEP
29. During the past week, how much difficulty have you had sleeping because of the pain in your arm, shoulder or hand? *(circle number)*	1	2	3	4	5

	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.

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.

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.

AUTHORIZATION FOR USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION

We are very concerned with protecting your privacy. While the law requires that you give us this disclosure, please understand that we have, and always will, respect the privacy of your health information.

There are several circumstances in which we may have to use or disclose your health information.

- We may have to disclose your health information to another health care provider or a hospital if it is necessary to refer you to them for the diagnosis, assessment, or treatment of your health condition.
- We may have to disclose your health information and billing records to another party if they are potentially responsible for the payment of your services.
- We may need to use your health information within our practice for quality control or other operational purposes.

We have a more complete notice that provides a detailed description of how your health information may be used or disclosed. You have the right to review that notice before you sign this consent form (§ 164.520). We reserve the right to change our privacy practices as described in that notice. If we make a change to our privacy practices, we will notify you in writing when you come in for treatment or by mail. Please feel free to call us at any time for a copy for our privacy notices.

I authorized Synergy Wellness doctors and staff to contact me with information related to my personal health needs and interests. The physician's office may use any phone number or email in my personal records to contact me. If contact is made by phone and I am unable to respond, a message may be left with my home answering machine or voice mail service. I may be contacted about the following:

- Appointment reminders or schedule changes.
- Information about alternative treatments, presentations or events
- Other health related information that may be of interest to me

To contact me, I authorize Synergy Wellness to use and disclose the following information:

- My Name, Address, Email and Phone Numbers
- The Name of my Physician and the Clinic where I was treated

NOTE: NO DIAGNOSIS OR TREATMENT INFORMATION WILL BE USED OR DISCLOSED.

Patient Name: Date of Birth:
(PLEASE PRINT)

Address of Patient: Phone:
(STREET)

Email:

(CITY, STATE, ZIP CODE)

Synergy Wellness fully supports the protection of health information. Only the physician and office staff will use this information to contact you. While we retain the standard rights of disclosure as provided under HIPAA, this authorization allows us to access only the above authorized information for contact purposes.

This authorization will remain valid for ten (10) years from the date of signature. You may revoke this authorization at any time or request to receive a copy of the protected health information to be used by writing to Synergy Wellness, Chiropractic, Nutrition, Weight Loss – 6015 E. Grant Rd., Tucson, AZ 85712. In this case, every effort will be made to discontinue future communications.

Signature (PATIENT OR PERSON AUTHORIZED) Date