Automobile Accident

Name: _____ **Chart #:** _____ **Today's Date:** _____ **Accident Date:** _____

DESCRIBE THE VEHICLE

Patient's Vehicle Type:	○ Sports car	○ Sedan	○ Station Wagon	○ Truck
○ Bus	○ Coupe	○ Sport-utility vehicle	○ Pick-up truck	○ Van
Vehicle Size:	○ Full-Size	○ Mid-Size	○ Sub-compact	○
○ Compact	○ Light	○ Mini	○ Semi	○
Position in vehicle:	○ Front mid passenger	○ Rear left passenger	○ Rear right passenger	○
○ Driver	○ Front right passenger	○ Rear mid passenger	○	○

DESCRIBE THE ACCIDENT

Action of patient vehicle:	○ Stopped for pedestrian	○ Traveling faster than	○ Traveling slower than	○
○ Crossing intersection	○ Stopped in traffic	speed limit	speed limit	○
○ Stopped at intersection	○ Traveling speed limit	○ Turning left	○ Turning right	○
Patient's Vehicle was hit:	○ On the left front	○ On the left rear	○ Was rear-ended	○ Sideswiped on right
○ Head-on	○ On the right front	○ On the right rear	○ Sideswiped on left	○
Patient's Vehicle hit:	○ Left rear of other veh.	○ Rear-ended other veh.	○ Sideswiped other veh	○
○ Other vehicle head-on	○ Rt rear of other veh.	○ Sideswiped other veh	on the right	○
○ Left front of other veh.	○ Rt front of other veh.	on the left	○	○
Damage:	○ Complete	○ Extensive	○ Minimal	○ Moderate
Patient's Vehicle was hit:	○ By a mid-sized car	○ By a light truck	○ By a full-sized van	○
○ By a compact car	○ By a subcompact car	○ By a pick-up truck	○ By a mini-van	○
○ By a full-sized car	○ By a semi-trailer	○ By a sport-utility veh.	○ None of the above	○
Patient's Vehicle hit:	○ A mid-sized car	○ A light truck	○ A full-sized van	○
○ A compact car	○ A subcompact car	○ A pick-up truck	○ A mini-van	○
○ A full-sized car	○ A semi-trailer	○ A sports utility vehicle	○ None of the above	○
Damage to other Vehicle:	○ Complete	○ Extensive	○ Minimal	○ Moderate
Weather Conditions:	○ Cloudy	○ Foggy	○ Snowing	○ Sunny
○ Clear	○ Drizzling	○ Rainy	○ Storming	○
Road Conditions:	○ Dry	○ Iced over	○ Wet	○
○ Damp	○ Dry with icy patches	○ Snowed over	○	○
Time of Day	○ Dawn	○ Daylight	○ Dusk	○ Night
Visibility:	○ Fair	○ Good	○ Poor	○

DESCRIBE MOMENT OF IMPACT

Body Position at impact:	○ Slouched in seat	○ Turned left	○	○
○ Leaning forward	○ Straight	○ Turned right	○	○
Direction body was thrown:	○ Forward then back	○ To the right	○ Outside the vehicle	○
○ Backward then forward	To the left	○ About the vehicle	○ Under the vehicle	○
Head Position at impact:	○ Straight	○ Tilted forward	○ Turned left	○ Turned right
Direction head was thrown:	○ Back then forward	○ Forward then back	○ Side to side	○
Type of Passive Restraint:	○ Airbag	○ Lap belt	○ Shoulder belt	○ Shoulder-lap belt
Did airbag deploy?	○ Deployed	○ Did not deploy		
Position of Headrests:	○ High position	○ Low position	○ Middle position	○ Not installed
Did you brace for impact?	○ Yes	○ No		

I understand that the information I have provided above is current and complete to the best of my knowledge.

Signature: _____

Revised Oswestry Low Back Pain and Disability

Name:_____ **Chart #:**_____ **Date:**_____

Please Read Instructions:

This questionnaire has been designed to give the doctor information as to how your low back pain has affected your ability to manage in everyday life. In each section, please fill in ONE circle which most closely describes your problem.

Section 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 very severe.
- ○ **F.** The pain is severe and doesn't vary much.

Section 2 - Personal Care

- ○ **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 can manage most of my personal care.
- ○ **E.** I need help every day in most aspects of self care.
- ○ **F.** I do not get dressed, I wash with difficulty and stay in bed.

Section 3 - Lifting

- ○ **A.** I can lift heavy weight without extra pain.
- ○ **B.** I can lift heavy weight but it gives 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.** Pain prevents me from lifting heavy weights, but I can manage light-medium weights if they are conveniently positioned.
- ○ **F.** I can only lift very light weights at the most.

Section 4 - Walking

- ○ **A.** I have no pain walking.
- ○ **B.** I cannot walk more than one mile without increasing pain.
- ○ **C.** I cannot walk more than 1/2 mile without increasing pain.
- ○ **D.** I cannot walk more than 1/4 mile without increasing pain.
- ○ **E.** I can walk with crutches.
- ○ **F.** I cannot walk at all without increasing pain.

Section 5 - Sitting

- ○ **A.** I can sit in any chair as long as I like.
- ○ **B.** I can only sit in my favorite chair as long as I like.
- ○ **C.** Pain prevents me from sitting more than one hour.
- ○ **D.** Pain prevents me from sitting more than a half hour.
- ○ **E.** Pain prevents me from sitting more than 10 minutes.
- ○ **F.** I avoid sitting because it increases pain straight away.

Section 6 - Standing

- ○ **A.** I can stand as long as I want without pain.
- ○ **B.** I have some pain on standing but it does not increase with time.
- ○ **C.** I cannot stand for longer than one hour without increasing pain.
- ○ **D.** I cannot stand for longer thanf 1/2 hour without increasing pain.
- ○ **E.** I can't stand for longer than 10 minutes without increasing pain.
- ○ **F.** I avoid standing because it increases the pain straight away.

Section 7 - Sleeping

- ○ **A.** I get no pain in bed.
- ○ **B.** I get pain in bed but it doesn't prevent me from sleeping well.
- ○ **C.** Because of pain my normal night's sleep is reduced by < 1/4.
- ○ **D.** Because of pain my normal night's sleep is reduced by < 1/2.
- ○ **E.** Because of pain my normal night's sleep is reduced by < 3/4.
- ○ **F.** Pain prevents me from sleeping at all.

Section 8 - 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.

Section 9 - Social Life

- ○ **A.** My social life is normal and gives me no pain.
- ○ **B.** My social life is normal but increases the degree of pain.
- ○ **C.** Pain limits 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.

Section 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.
- ○ **D.** My pain is neither getting better nor worse.
- ○ **E.** My pain is gradually worsening.
- ○ **F.** My pain is rapidly worsening.

I understand that the information I have provided above is current and complete to the best of my knowledge.

Signature:_____

Office Use Only

Score:_____

Neck Pain and Disability Index

Name:_____ **Chart #:**_____ **Date:**_____

Please Read Instructions:

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. In each section, please fill in ONE circle only which most closely describes your problem.

Section 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.

Section 2 - Personal Care

- ○ **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, I wash with difficulty and stay in bed.

Section 3 - Lifting

- ○ **A.** I can lift heavy weight without extra pain.
- ○ **B.** I can lift heavy weight but it gives extra pain.
- ○ **C.** Pain prevents me from lifting heavy weights off the floor, but I can manage if they are conveniently positioned.
- ○ **D.** Pain prevents me from lifting heavy weights, but I can manage light-medium weights if they are conveniently positioned.
- ○ **E.** I can lift very light weights.
- ○ **F.** I cannot lift or carry anything at all.

Section 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 can't 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.

Section 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.

Section 6 - Concentration

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

Section 7 - Work

- ○ **A.** I can do as much work as I want.
- ○ **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 can hardly do any work at all.
- ○ **E.** I cannot do my usual work.
- ○ **F.** I can't do any work at all.

Section 8 - Driving

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

Section 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).

Section 10 - Recreation

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

I understand that the information I have provided above is current and complete to the best of my knowledge.

Signature:_____

Office Use Only Score:_____

INTEGRATED WELLNESS

10684 S. River Front Pkwy
South Jordan, UT, 84020
Phone: (801) 816-0332
Fax: (801) 816-0331

CLAIM AGREEMENT & LIEN

This Agreement is entered into among the treating doctors at Integrated Wellness (hereinafter "Provider") and _____ (hereinafter "Patient"), and _____ (hereinafter "Attorney"), in consideration of the mutual obligations set forth herein and establishes their responsibilities to each other during the pendency of Patient's claim arising from Patient's accident, (hereinafter "Claim.")

1. The Patient hereby gives a lien and assigns to the Provider against all proceeds derived from this claim after attorneys' fees and costs (whether by settlement, judgement, or otherwise) to secure payment of all fees owed to Provider by patient for treatment arising out of injuries sustained, as of time such proceeds are received. Patient hereby directs Attorney to honor said lien and to pay such sums as are secured hereby directly to Provider, as soon as possible after any proceeds are received. Patient agrees to never rescind this document and that a rescission will not be honored by my attorney.
2. Patient hereby directs the insurance company to honor said lien, and to pay provider directly all sums due.
3. Patient hereby expressly recognizes that even though this lien has been given, Patient still remains personally responsible for Provider's fees and that payment of them must be made by Patient regardless of whether any money is received through this claim.
4. Patient hereby authorizes Provider to provide Attorney, at reasonable intervals upon Attorney's request, complete reports of Patient's medical condition, care and cost of treatment. Provider agrees to furnish these reports within a reasonable time, and at a reasonable cost.
5. Provider hereby agrees to await Patient's payment of Provider fees as long as the claim is still active until this claim is concluded, except to the extent that payment is available from insurance, which provides health care benefits for Patient. Provider agrees to be available to Attorney, upon reasonable notice and for reasonable compensation for consultations, depositions and court appearances.
6. In the event of any dispute between the Provider and the Patient concerning Provider's fees, the Attorney will make every effort to make sure that the Provider receives payment for the Provider's fees, barring some unforeseen or impossible situation.
7. Attorney and patient hereby agree to notify Provider, immediately, should Patient retain new legal counsel. Patient agrees to direct new legal counsel to execute another copy of this Claim Agreement and Lien when one is furnished by Provider and instructs the new attorney to honor this lien as inherent to the settlement and enforceable upon the case as if it were executed by him.
8. Attorney hereby agrees that Attorney is a party to this contract and further recognizes that Attorney is receiving a benefit from this Agreement, which constitutes valid consideration, and Attorney is bound by the terms of this contract.
9. Before Attorney distributes any monies received through this claim, Attorney agrees to request and Provider shall provide a response in regard to the patient's outstanding account balance.
10. Should any party seek judicial enforcement of this agreement, the prevailing party shall be entitled to reasonable attorney's fees.
11. This Claim Agreement and Lien cannot be modified, changed or revoked by any party without the express written consent of all parties.
12. Patient instructs Attorney to sign below, honor this agreement and return this form to the office of Integrated Wellness. Patient has been advised that if the attorney does not wish to cooperate in protecting the medical entity's interest, the medical entity will not await payment but will require Patient to make payments on a current basis.

Patient (Print): _____ Signature _____ Date: _____

Parent (Print if patient is minor) _____ Signature _____ Date: _____

Provider/Witness (Print): _____Signature_____ Date: _____

Attorney (Print): _____Signature_____ Date: _____