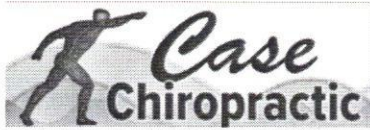


# A Fax From:



4010 NW Cache Road ~ Lawton, OK 73505  
Phone: 580-357-8688 ~ Fax: 580-357-7483

FAX NUMBER: \_\_\_\_\_

PAGES: (including cover page): \_\_\_\_\_

DATE: \_\_\_\_\_ ATTENTION: \_\_\_\_\_ FROM: \_\_\_\_\_

## Request for Medical Records

### By signature below I authorize:

\_\_\_\_\_ to release identifiable information from the medical record(s) of:  
(Patient's Name) \_\_\_\_\_ to Case Chiropractic, 4010 NW Cache Road,  
Lawton, OK 73505.

Or, By signature below I authorize:

Case Chiropractic to release identifiable information from the medical record(s) of: (Patient's Name)  
\_\_\_\_\_ to \_\_\_\_\_.

### Describe protected health information, date, type, or origin:

\_\_\_\_\_

This protected health information is being used or disclosed for the following purposes: The evaluation and diagnosis of my health.

This authorization shall be in force and effect until \_\_\_\_\_.

The information authorized for release may include information which may be considered a communicable or venereal disease, which may include but is not limited to diseases such as hepatitis, syphilis, gonorrhea, and the human immunodeficiency virus know as acquired immune deficiency syndrome (AIDS).

\_\_\_\_\_  
Signature of Patient or Personal Representative

\_\_\_\_\_  
Date

\_\_\_\_\_  
Print Name of Patient or Personal Representative

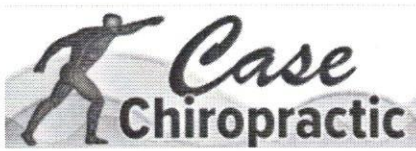
\_\_\_\_\_  
Social Security Number

\_\_\_\_\_  
Description of personal Representative's Authority

\_\_\_\_\_  
Patient's Date of Birth

CC: Patient

The information contained in the transmission accompanying this notice is confidential and protected by the physician and patient privilege. It is intended only for the use of the individual or entity identified below. If the render of this message is not the intended recipient, you are hereby notified that any dissemination or distribution of the accompanying communication is prohibited. The parties sending the accompanying documents do not waive the physician and patient privilege. If you have received this communication in error, please notify us immediately by telephone and return the original message to us at the address below via the United States Postal Service.



4010 NW Cache Road ~ Lawton, OK 73505  
Phone: 580-357-8688 ~ Fax: 580-357-7483

## AUTHORIZATION TO ENDORSE CHECKS

I, \_\_\_\_\_, have or will have incurred certain financial obligations for chiropractic services rendered by Case Chiropractic and/or Dr. Conran.

I understand that I may be entitled to receive compensation for said obligations or expenses from any insurance carriers. I specifically authorize Case Chiropractic and/or Dr. Conran to receive any insurance company checks as payment for the chiropractic services, and to endorse, deposit, and negotiate said checks in payment of my financial obligation to Case Chiropractic and/or Dr. Casey Conran.

I understand and acknowledge that all charges incurred by me are my responsibility regardless of any settlement made by a third party. I am instructing and agreeing to the above conditions as a safeguard to the physician's right to collect payment. I understand that the physician/clinic has the right to expect good faith payments on my account and that a full payment is being deferred only until such time as a third party settlement occurs. If a settlement does not occur within a reasonable amount of time, I agree to make other arrangements to pay my account in full. This authorization shall remain valid unless and until revoked in writing by me.

Signed: \_\_\_\_\_ Date: \_\_\_\_\_ Acct# \_\_\_\_\_

Print Patient's Name: \_\_\_\_\_ Witness: \_\_\_\_\_

Date of Accident: \_\_\_/\_\_\_/\_\_\_ Location of Accident: \_\_\_\_\_

### 3<sup>RD</sup> PARTY:

Company: \_\_\_\_\_

Attn:/Adj: \_\_\_\_\_

Address: \_\_\_\_\_

Phone: \_\_\_\_\_

Pol/Clm: \_\_\_\_\_

Insured: \_\_\_\_\_

### ATTORNEY:

Name: \_\_\_\_\_

Attn: \_\_\_\_\_

Address: \_\_\_\_\_

Phone: \_\_\_\_\_

### MEDICAL PAY/PIP/and/or UM:

Company: \_\_\_\_\_

Attn:/Adj: \_\_\_\_\_

Address: \_\_\_\_\_

Phone: \_\_\_\_\_

Pol/Clm: \_\_\_\_\_

Insured: \_\_\_\_\_

### MAJOR MEDICAL:

Company: \_\_\_\_\_

Address: \_\_\_\_\_

Phone: \_\_\_\_\_

Pol/Clm: \_\_\_\_\_

Insured: \_\_\_\_\_

## Chiropractic Patient Information

Name: \_\_\_\_\_ Address (mailing): \_\_\_\_\_ City: \_\_\_\_\_

State: \_\_\_\_\_ Zip: \_\_\_\_\_ +(4) Home Phone: \_\_\_\_\_ Cell \_\_\_\_\_

E-mail address: \_\_\_\_\_

Race (circle only 1): American Indian Alaskan Native Asian White Black or African American  
 Native Hawaiian Other Pacific Islander Declined to State

Ethnicity (circle only 1) Hispanic or Latino Not Hispanic or Latino Declined to State Preferred Language: \_\_\_\_\_

Marital: M S W D Age: \_\_\_\_\_ Birth Date: \_\_\_\_\_ Social Security # \_\_\_\_\_

How were you referred to our office? \_\_\_\_\_

Occupation: \_\_\_\_\_ Employer: \_\_\_\_\_ Employer's Address: \_\_\_\_\_

Work Phone: \_\_\_\_\_

Spouse: \_\_\_\_\_ Occupation: \_\_\_\_\_ Employer: \_\_\_\_\_

**HISTORY OF PRESENT ILLNESS:** List in order of severity if more than one:

Chief Complaint: (Purpose of this appointment): \_\_\_\_\_

Date symptoms appeared or accident happened: \_\_\_\_\_

Is this due to: Auto Work Other: \_\_\_\_\_ Days lost from work: \_\_\_\_\_

Have you ever had the same or a similar condition?  Yes  No If yes, when: \_\_\_\_\_

Treatment already received:  Medication  Physical Therapy  Surgery  Chiropractic  None  Other

Rate your pain on a scale of 1 to 10. \_\_\_\_\_

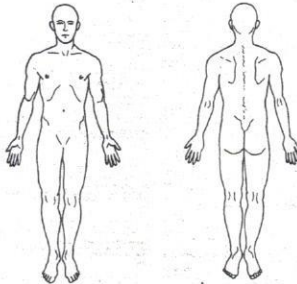
Does this pain affect you : constantly \_\_\_\_\_ intermittently \_\_\_\_\_

Name and address of Doctor(s) who have treated you: \_\_\_\_\_

Date of last: Physical examination: \_\_\_\_\_ Spinal Exam: \_\_\_\_\_ Spinal X Rays: \_\_\_\_\_ Chest X Rays: \_\_\_\_\_  
 MRI \_\_\_\_\_ CT \_\_\_\_\_ Bone Density \_\_\_\_\_ Bone Scan \_\_\_\_\_ Blood Test: \_\_\_\_\_ Urine Test: \_\_\_\_\_

Please Indicate Region of Complaint

- HEADACHE PAIN
- LOW BACK PAIN
- ELBOW PAIN
- HAND PAIN
- KNEE PAIN
- FOOT PAIN
- UPPER/MID BACK PAIN
- OTHER \_\_\_\_\_
- NECK PAIN
- SHOULDER PAIN
- WRIST PAIN
- HIP PAIN
- ANKLE PAIN
- TMJ



Use the letters listed below to indicate the *type and location* of your pain and sensations...

**KEY**

- A = ACHE
- B = B BURNING
- S = STABBING
- N = NUMBNESS
- P = PINS & NEEDLES
- O = OTHER

**PAST MEDICAL HISTORY**

Have you ever been diagnosed as having or have suffered from? (Place a check all conditions that apply to you)

- Broken or Fractured Bones
- Circulatory Problems
- Rheumatoid Arthritis
- Seizures/Convulsions
- A Congenital Disease
- Excessive Bleeding
- High  Low Blood Pressure
- Osteoarthritis
- Osteoporosis
- Pace Maker
- Diabetes
- Cancer
- Ruptures
- Coughing Blood
- Eating Disorder
- Alcoholism
- Drug Addiction
- HIV Positive
- Gall Bladder
- Depression
- Epilepsy
- Heart Disease
- COPD
- Migraines
- Vaginal Infections
- Ulcer
- Prostate
- Liver Disease
- Prosthesis
- Psychiatric Care
- Thyroid
- STD
- Kidney disease
- Reflux
- Other \_\_\_\_\_

Do you have a history of stroke or hypertension? \_\_\_\_\_

Smoking Status: Start Date: \_\_\_\_\_ End Date: \_\_\_\_\_ Currently (circle): Every Day / Some Days / Quit / Never

In an effort to quit smoking, I am currently taking; \_\_\_\_\_

Patient's Initials \_\_\_\_\_

Date: \_\_\_\_\_ Patient Name: \_\_\_\_\_ Patient # \_\_\_\_\_

Are you currently taking any medications, including over the counter? Yes No If Yes, please indicate the following:

Medication: \_\_\_\_\_ mg Medication: \_\_\_\_\_ mg Medication: \_\_\_\_\_ mg
Route: (circle 1) Oral Tab/Capsule Route: (circle 1) Oral Tab / Capsule Route: (circle 1) Oral Tab / Capsule
Intravenous Intravenous Intravenous
Other: \_\_\_\_\_ Other: \_\_\_\_\_ Other: \_\_\_\_\_
Frequency: \_\_\_\_\_ Frequency: \_\_\_\_\_ Frequency: \_\_\_\_\_
Began Use: \_\_\_\_\_ Began Use: \_\_\_\_\_ Began Use: \_\_\_\_\_
Discontinued Use: \_\_\_\_\_ Discontinued Use: \_\_\_\_\_ Discontinued Use: \_\_\_\_\_

If there are more than three medications we can call your pharmacy for your list or bring all bottles on next visit.

Do you have any allergies to medication? Yes No If Yes, please indicate the following:

Table with 3 columns: MEDICATION ALLERGIES, SEASONAL ALLERGIES, VITAMINS/HERBS/MINERALS. Below are sections for EXERCISE, WORK/HOME ACTIVITY, HABITS, and HOBBIES with checkboxes.

SURGERIES/INJURIES

Description:

Date

Falls \_\_\_\_\_
Head Injuries \_\_\_\_\_
Broken Bones \_\_\_\_\_
Dislocations \_\_\_\_\_
Surgeries \_\_\_\_\_

Please list any other health problems you have, no matter how insignificant they may be:

What percentage of time during the day (at home / your job / away from home) do you spend:

Lifting: \_\_\_\_\_ Pulling \_\_\_\_\_ Pushing \_\_\_\_\_ Sitting: \_\_\_\_\_ Bending: \_\_\_\_\_ Working at a computer: \_\_\_\_\_

FAMILY HISTORY: Parents: (check one)

Father:  living  deceased  Current age if still living: \_\_\_\_\_ Cause of death and age at death if deceased: \_\_\_\_\_

Mother:  living  deceased  Current age if still living: \_\_\_\_\_ Cause of death and age at death if deceased: \_\_\_\_\_

Do you have any family members who suffer from the same condition you do?  Yes  No If so, please list:

FAMILY DISEASES (check if applicable and indicate whether family member is Father, Mother, Sister, Brother):

\_\_\_\_\_ Tuberculosis \_\_\_\_\_ Cancer \_\_\_\_\_ Mental Illness \_\_\_\_\_ Kidney Disease
\_\_\_\_\_ Diabetes \_\_\_\_\_ Asthma \_\_\_\_\_ Heart Disease \_\_\_\_\_ Liver Disease
\_\_\_\_\_ Stroke \_\_\_\_\_ Arthritis \_\_\_\_\_ Lung Disease \_\_\_\_\_ Other

Please check any and all insurance coverage applicable in this case:  Major Medical  Medicare  Medigap/supplemental
 Medicare secondary insurance  Auto Accident  Worker's Comp  Medical Savings Acct & Flex Plans  Other

Name of Primary Insurance Company \_\_\_\_\_

Name of Secondary Insurance Company (if any): \_\_\_\_\_

AUTHORIZATION AND RELEASE: I authorize payment of insurance benefits directly to Case Chiropractic. I understand and agree to allow this chiropractic office to use their Patient Health Information (PHI) for the purpose of treatment, payment, healthcare operations and coordination of care.

We want you to know how your Patient Health Information is going to be used in this office and your rights concerning those records. If you would like to have a more detailed account of our policies and procedures concerning the privacy of your Patient Health Information we encourage you to read the HIPAA NOTICE that is available to you at the front desk before signing this consent.

Check this box of you would like to have access to your Electronic Health Records

Patient's Signature \_\_\_\_\_ Date \_\_\_\_\_

Guardian's Signature Authorizing Care \_\_\_\_\_ Date \_\_\_\_\_

Date: \_\_\_\_\_ Patient Name: \_\_\_\_\_ Patient # \_\_\_\_\_

## SUMMARY

1. What is your major symptom? \_\_\_\_\_

2. What does this prevent you from doing or enjoying? \_\_\_\_\_

3. If this is a recurrence, when was the first time you noticed this problem? \_\_\_\_\_  
How did it originally occur? \_\_\_\_\_

Has it become worse recently?  Yes  No  Same  Better  Gradually Worse  
If yes, when and how? \_\_\_\_\_

4. How frequent is the condition?  Daily  Constant  Intermittent  Night Only  
How long does it last?  All Day  Few Hours  Minutes

5. Are there any other conditions or symptoms that may be related to your major symptom?

Yes  No If yes, describe: \_\_\_\_\_

Are there other unrelated health problems?

Yes  No If yes, describe: \_\_\_\_\_

6. Describe the pain:  Sharp  Dull  Numbness  Tingling  Aching

Burning  Stabbing  Other: \_\_\_\_\_

7. Is there anything you can do to relieve the problem?  Yes  No If yes, describe \_\_\_\_\_  
\_\_\_\_\_. If no, what have you tried to do that has not helped? \_\_\_\_\_

8. What makes the problem worse?  Standing  Sitting  Lying  Bending

Lifting  Twisting  Other: \_\_\_\_\_

9. List any major accidents you have had other than those that might be mentioned above: \_\_\_\_\_

10. WOMEN ONLY: Are you pregnant or is there any possibility you may be pregnant?

Yes  No  Uncertain

1 No Pain or Dis-comfort.	2 Slight Dis- comfort	3 Pain that does not affect my activity	4 Pain that affects my daily activities	5 Pain that prevents performing my daily activities	6 Pain that limits my work schedule	7 Pain that prevents working at all	8 Pain that prevents work and all personal activity	9 Pain that keeps me bed ridden	10 Pain that makes you cry out.
---------------------------------	-----------------------------	---	---	--	---	---	--	--	--

Patients Signature \_\_\_\_\_

Date \_\_\_\_\_

Guardian's Signature Authorizing Care \_\_\_\_\_

Date \_\_\_\_\_

OFFICE NOTES:

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Doctor's Signature \_\_\_\_\_

Date \_\_\_\_\_

# ACCIDENTAL INJURY FORM

NAME \_\_\_\_\_ TODAYS DATE \_\_\_\_\_  
Date of Accident \_\_\_\_\_ Time: \_\_\_\_ am \_\_\_\_ pm Location of Accident \_\_\_\_\_

## AUTO INJURY

Were You: ( ) Driver ( ) Passenger ( ) Pedestrian  
Were you struck from: ( ) Behind ( ) Right Side ( ) Left Side ( ) Front ( ) Parked  
Did your car strike the others involved: ( ) Yes ( ) No ( ) Undetermined  
Did the other car strike yours: ( ) Yes ( ) No ( ) Undetermined  
As a result of the Accident, were traffic citations issued to you? ( ) Yes ( ) No  
Did you strike any of the following? (Check all that apply) ( ) Steering Wheel ( ) Air Bag  
( ) Dashboard ( ) Rear-view mirror ( ) Windshield ( ) Car interior ( ) other: \_\_\_\_\_  
Did you receive any of the following: \_\_\_ Cuts \_\_\_ Bruises \_\_\_ Other? \_\_\_\_\_ Seatbelt in use? ( ) Yes ( ) No  
Was your head above or below the headrest? \_\_\_\_\_ Did Air Bag Deploy? \_\_\_\_\_  
What was the damage to your car? \$ \_\_\_\_\_

## ON-THE-JOB INJURY

How did the injury occur? \_\_\_\_\_  
Did you report the injury to your foreman or employer: ( ) Yes ( ) No  
Employer: \_\_\_\_\_ Address: \_\_\_\_\_

## OTHER

Describe the circumstances of the accident (Be Specific) \_\_\_\_\_

\*\*\*\*\*

## CHECK SYMPTOMS YOU HAVE NOTICED SINCE THE ACCIDENT

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

Did you require post-accident hospitalization? ( ) Yes ( ) No X-Rays? ( ) Yes ( ) No  
Name of Hospital or Emergency \_\_\_\_\_ Date \_\_\_\_\_  
Have you lost any days of work? ( ) Yes ( ) No If Yes, \_\_\_\_\_ through \_\_\_\_\_

## INSURANCE INFORMATION

Your Insurance Company \_\_\_\_\_ Address \_\_\_\_\_  
Other Party's Name \_\_\_\_\_ Address \_\_\_\_\_  
Other Party's Ins. Co. \_\_\_\_\_ Address \_\_\_\_\_  
Have you been contacted by an insurance adjustor regarding this claim ( ) Yes ( ) No  
If yes, name of adjuster \_\_\_\_\_ Company \_\_\_\_\_  
Do you have an attorney that has advised you in this case: ( ) Yes ( ) No  
If yes, attorney's name \_\_\_\_\_ Address \_\_\_\_\_

Signature: \_\_\_\_\_



4010 NW Cache Road ~ Lawton, OK 73505  
Phone: 580-357-8688 ~ Fax: 580-357-7483

# Neck Disability Index

Date: \_\_\_\_\_

Patient Name: \_\_\_\_\_

Patient # \_\_\_\_\_

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 everyday life. Please answer every section and mark in each section only the ONE box that applies to you. We realize that you may consider that two of the statements in any one section relate to you, but please just mark the box that 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 (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; I wash with difficulty and stay in bed.

## SECTION 3-LIFTING

- A. I can lift heavy weights without extra pain.
- B. I can lift heavy weights, 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, for example, on a table.
- D. Pain prevents me from lifting heavy weights off the floor, but I can manage light to 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 to, with no pain in my neck.
- B. I can read as much as I want to, with slight pain in my neck.
- C. I can read as much as I want to, 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 that come infrequently.
- C. I have moderate headaches that come infrequently.
- D. I have moderate headaches that come frequently.
- E. I have severe headaches that come frequently.
- F. I have headaches almost all the time.

## SECTION 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 in concentrating when I want to.
- F. I cannot concentrate at all.

## SECTION 7-WORK

- A. I can as much work as I want to.
- B. I can 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.

## 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 in my neck.
- D. I can't drive my car 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 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 my recreation activities, with no neck pain at all.
- B. I am able to engage in all my recreation activities, with some neck pain.
- 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 recreation activities, because of pain in my neck.
- E. I can hardly do any recreation activities, because of pain in my neck.
- F. I can't do any recreation activities at all.

Patients Signature \_\_\_\_\_ Date \_\_\_\_\_

### Instructions:

1. The NDI is scored in the same way as the Oswestry Disability Index.
2. Using this system, a score of 10-25% (i.e., 5-14 points) is considered by the authors to constitute mild disability; 30-40% is moderate; 50-68% is severe; 72% or more is complex.

Name: \_\_\_\_\_



Date: \_\_\_\_\_  
Patient #: \_\_\_\_\_

4010 NW Cache Road, Lawton, OK 73505

Please Read: This questionnaire is designed to enable us to understand how much your low back has affected your ability to manage everyday activities. Please answer each section by circling the **ONE CHOICE** that most applies to you. We realize that you may feel that more than one statement may relate to you, but **Please, just, circle the one choice which best describes your problem right now.**

**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 severe.
- F. The pain is severe and does not vary much.

**Section 2—Personal Care**

- A. I would 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 and dressing without help.

**Section 3—Lifting**

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

**Section 4—Walking**

- A. Pain does not prevent me from walking any distance.
- B. Pain prevents me from walking more than one mile.
- C. Pain prevents me from walking more than 1/2 mile.
- D. Pain prevents me from walking more than 1/4 mile.
- E. I can only walk while using a cane or on crutches.
- F. I am in bed most of the time and have to crawl to the toilet.

**Section 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 from sitting more than one hour.
- D. Pain prevents me from sitting more than 1/2 hour.
- E. Pain prevents me from sitting more than ten minutes.
- F. Pain prevents me from sitting at all.

Patient signature \_\_\_\_\_  
**DISABILITY INDEX SCORE: %** \_\_\_\_\_

**Section 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 one hour without increasing pain.
- D. I cannot stand for longer than 1/2 hour without increasing pain.
- E. I can't stand for more than 10 minutes without increasing pain.
- F. I avoid standing because it immediately increases the pain.

**Section 7—Sleeping**

- A. I get no pain in bed.
- B. I get some 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.

**Section 8—Social Life**

- A. My social life is normal and gives me no pain.
- B. My social life is normal, but increases my degree of pain.
- C. Pain has no significant effect on my social life apart from limiting my more energetic interactions, 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 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.

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

## BACK BOURNEMOUTH QUESTIONNAIRE

Patient Name \_\_\_\_\_ Date \_\_\_\_\_ Age \_\_\_\_\_

**Instructions:** The following scales have been designed to find out about your back pain and how it is affecting you. Please answer ALL the scales, and mark the ONE number on EACH scale that best describes how you feel.

1. Over the past week, on average, how would you rate your back pain?

No pain Worst pain possible  
0 1 2 3 4 5 6 7 8 9 10

2. Over the past week, how much has your back pain interfered with your daily activities (housework, washing, dressing, walking, climbing stairs, getting in/out of bed/chair)?

No interference Unable to carry out activity  
0 1 2 3 4 5 6 7 8 9 10

3. Over the past week, how much has your back pain interfered with your ability to take part in recreational, social, and family activities?

No interference Unable to carry out activity  
0 1 2 3 4 5 6 7 8 9 10

4. Over the past week, how anxious (tense, uptight, irritable, difficulty in concentrating/relaxing) have you been feeling?

Not at all anxious Extremely anxious  
0 1 2 3 4 5 6 7 8 9 10

5. Over the past week, how depressed (down-in-the-dumps, sad, in low spirits, pessimistic, unhappy) have you been feeling?

Not at all depressed Extremely depressed  
0 1 2 3 4 5 6 7 8 9 10

6. Over the past week, how have you felt your work (both inside and outside the home) has affected (or would affect) your back pain?

Have made it no worse Have made it much worse  
0 1 2 3 4 5 6 7 8 9 10

7. Over the past week, how much have you been able to control (reduce/help) your back pain on your own?

Completely control it No control whatsoever  
0 1 2 3 4 5 6 7 8 9 10

\_\_\_\_\_  
Examiner

**OTHER COMMENTS:** \_\_\_\_\_



4010 NW Cache Road ~ Lawton, OK 73505  
Phone: 580-357-8688 ~ Fax: 580-357-7483

### INFORMED CONSENT FOR TREATMENT

PATIENT NAME \_\_\_\_\_

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 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:

- |  |   |   |
|--|---|---|
| <input type="checkbox"/> spinal manipulation therapy | <input type="checkbox"/> palpation          | <input type="checkbox"/> vital signs                |
| <input type="checkbox"/> range of motion testing     | <input type="checkbox"/> orthopedic testing | <input type="checkbox"/> basic neurological testing |
| <input type="checkbox"/> muscle strength testing     | <input type="checkbox"/> postural analysis  | <input type="checkbox"/> EMS                        |
| <input type="checkbox"/> radiographic studies        | <input type="checkbox"/> hot-cold therapy   | <input type="checkbox"/> other (please explain)     |

#### 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 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 and during examination and X-ray. 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 chose 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 information of adhesions and reduce mobility when 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 the chiropractic adjustment and related treatment. I have discussed it with Dr. Casey A. Conran and have had my questions answered to my satisfaction. 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.

Date: \_\_\_\_\_ Patient's Name \_\_\_\_\_ Patient's signature \_\_\_\_\_

Date: \_\_\_\_\_ Signature of Parent or Guardian (if a minor) \_\_\_\_\_

Date: \_\_\_\_\_ Doctor's Name: Casey A. Conran, D.C. Doctor's Signature: \_\_\_\_\_



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## X-RAY STATEMENT

Date: \_\_\_\_\_

Please complete and sign this statement regarding your x-ray examination.  
**IT IS VERY IMPORTANT YOU ARE NOT PREGNANT**

Date of last period: \_\_\_\_\_

Type of birth control method being used if any: \_\_\_\_\_

List any surgical procedure performed that prevent you from becoming pregnant:

\_\_\_\_\_

Print Patients Name: \_\_\_\_\_

Patients Signature: \_\_\_\_\_

Signature of Guardian for the Minor Patient: \_\_\_\_\_

Patient's Birth date: \_\_\_\_\_

Patient's Social Security #: \_\_\_\_\_

Witness: \_\_\_\_\_

# *Financial Policy*

The following information is provided to avoid any misunderstanding or disagreement concerning Case Chiropractic's patient financial policy.

Prompt payment, allows us to control costs. Outstanding accounts cost both of us time and money: therefore, all patients will be required to establish financial arrangements for payment of their accounts.

Worker's compensation patients: As long as your care is determined to be W/C there is no financial responsibility due from you. However, if your claim is controverted or denied the balance will be your responsibility and the financial policy will apply to your account.

It should be mentioned that your insurance coverage is an agreement between you and your insurer. As a courtesy our practice will bill your insurance carrier. After 90 days it will then be your responsibility to remit payment for any unpaid claims by your carrier as well as any and all charges not covered by your carrier.

All copays, deductibles, and patient co-insurances are due at the time of service.

Our office does accept third party liability, however, if the third party insurance does not pay it is the patient's responsibility.

If your carrier requires Authorization our office will be happy to assist you in this process however, ultimately this is your responsibility.

Each month you will receive a monthly statement for services which are due and payable within 10 days.

All patients refusing to remit payment after the 10 days have passed; will force us to limit their future credit until the previous balance is paid in full. All patients will be required to sign a written legal agreement with our practice. All accounts are subject to be forwarded to a collection agency and credit bureau as well as all additional costs occurred in collecting the debt.

All returned check for non-sufficient funds will be subjected to a \$40.00 fee.

Our practice firmly believes that a good doctor/patient relationship is based upon understanding and open communication. Our staff has been instructed to make every effort available to you to clarify any misunderstandings you have concerning your balance. We hope to possibly avoid any disagreement over payment for professional services.

If you have any questions concerning our policy or need assistance, please contact us immediately.

\_\_\_\_\_  
Patient's Name

\_\_\_\_\_  
Date

\_\_\_\_\_  
Guardian Signature

\_\_\_\_\_  
Date



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Dear Accident Patient,

You are about to begin chiropractic care for injuries relating to a motor vehicle collision or other personal injury accident. At Case Chiropractic, we do everything possible to see that you receive the highest quality of care, as well as assist you in processing insurance claims most efficiently. Unlike many physicians' offices, we do not demand payment at the time of service; we accept assignment, not consignment, until settlement of your claim. Only you, the patient, have a contractual agreement with the insurance company; we do not. This is why your cooperation is so important. Your case, including settlement with insurance companies, is your responsibility. We will gladly help however we are able.

### Office Policy

In order for our office to accept your case on assignment (meaning payments from insurance or a legal settlement are transferred to pay for treatment so you do not have to pay out of your own pocket, at the time of service), we must ask that you sign any and/or all of the following forms that apply:

1. Automobile Insurance Health Coverage or Med Pay – This often offers 100% coverage (no deductible) in the event that the claim is related to the accident. Claims on this portion DO NOT increase your premium. Your insurance agent can tell you if you have this type of coverage.
2. Any Major Medical Coverage (Group or Private) – This will provide payment as you are treated and will be subrogated upon settlement with the third party.
3. A Physician's Lien – Liens will be filed with the courthouse for each vehicle or accident policy. Copies of the liens will be mailed to all insurance companies involved, to the patient, and to the attorney, if applicable.

As you can see, we are requesting payment from all potential sources. We can only collect once for our services, so any excess funds that might result from your case are immediately refunded directly to you, the patient, in compliance with state laws.

I, \_\_\_\_\_, have read and understand the requirements to become a Motor Vehicle Collision or Personal Injury Patient. I fully understand that it is my responsibility to disclose any insurance coverage of the above mentioned variety. I agree to assist in the filing of claims, for my health care charges. I realize that failure to disclose and/or assist with the filing of these claims will result in my entire balance being due immediately. I understand Dr. Conran is accepting my case on assignment as long as I follow the prescribed treatment.

I understand that I am responsible for any and all charges for services rendered.

\_\_\_\_\_  
Patient's Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
CA's Signature

\_\_\_\_\_  
Date



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Name of Patient \_\_\_\_\_ Date \_\_\_\_\_

## WHAT TO EXPECT AFTER YOUR FIRST ADJUSTMENT

**Please read the following information carefully. Sign the bottom of the sheet to indicate that you understand the instructions and information given.**

1. If you have never been adjusted, or if it has been awhile since your last adjustment, you may experience soreness or discomfort for a few hours to a few days. This is a normal reaction to chiropractic adjustments.
2. If you are sore, use ice packs on the affected area. Ice therapy consists of the use of ice packs at 20-minute intervals followed by 40 minutes of rest. This can be repeated as often as needed. Do not apply ice directly to bare skin. Always protect skin with a thin covering such as a shirt or light towel. Cover the ice pack with a thick towel to retain the cold.
3. Do not use heat except under the doctor's instruction. Heat may aggravate your injury.
4. Stay away from heavy lifting or repetitive movements until the doctor indicates you are ready for normal activities. Strenuous athletic activities such as running, lifting weights, impact aerobics, racquetball, tennis, skiing, bowling, etc. should be avoided. Other things to avoid are yard work such as raking, digging, lifting heavy objects such as groceries, pets and children, and any other activities that could aggravate or re-injure your condition.
5. Unless indicated by the doctor, you may return to work/school after your appointment.
6. If you experience pain between scheduled visits, contact the clinic at 357-8688 during office hours.

I have read and understand the instructions given for my follow-up care.

\_\_\_\_\_  
Patient's Signature

\_\_\_\_\_  
Date