

## **NEW PI PATIENT**

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

Date of first visit: \_\_\_\_\_



## **Personal Injury Information**

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

Date of Accident: \_\_\_\_\_

## **Personal Auto Insurance Information (Patient)**

Agency: \_\_\_\_\_

Adjuster's Name: \_\_\_\_\_

Adjuster's Phone Number: \_\_\_\_\_

Claim #: \_\_\_\_\_

## **3<sup>rd</sup> Party Auto Insurance Information**

Agency: \_\_\_\_\_

Adjuster's Name: \_\_\_\_\_

Adjuster's Phone Number: \_\_\_\_\_

Claim #: \_\_\_\_\_

## **Attorney Information**

Name of Firm: \_\_\_\_\_

Attorney: \_\_\_\_\_

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

Holten Wellness Center  
7626 Paragon Rd.  
Centerville, OH 45459  
937-435-8480  
Fax 937-435-8486

RE: Personal Injury Patient

Let me start by saying on behalf of myself, and Holten Wellness Center, we are dedicated to making sure you receive the best care possible during this frustrating time. I will be personally handling your claim, and making sure all corners are covered. This is a task I will need your help on. Make sure that you have turned in all information surrounding your claim to our front desk. Information should include: your personal auto insurance information, your auto declaration page, 3<sup>rd</sup> party insurance information (insurance of the person at fault), your medical carrier information, and if you have an attorney I will need that information also. Our office is willing to not charge you at the time of service, as long as we have received all the information above.

I will be consulting with you personally within your 4<sup>th</sup> or 5<sup>th</sup> visit to discuss how your claim will process.

If you have any questions feel free to contact me directly.

Take care and live well.

Sincerely,  
Jodee K.  
Billing Manager  
[jodee@drholten.com](mailto:jodee@drholten.com) (email)

## ATTENTION

The following paperwork requests information and details directly related to your auto accident.

In order for you to be treated in our office without payment at time of service, *you must provide all of the requested information.*

If you do not have the requested information today- it is essential that it is submitted at your **next** appointment.

Thank you in advance for your cooperation and assistance in this matter!



# WELCOME

## PATIENT INFORMATION

Date \_\_\_\_\_

SS/HIC/Patient ID # \_\_\_\_\_

Patient Name \_\_\_\_\_  
Last Name \_\_\_\_\_  
First Name \_\_\_\_\_ Middle Initial \_\_\_\_\_

Address \_\_\_\_\_

City \_\_\_\_\_

State \_\_\_\_\_ Zip \_\_\_\_\_

E-mail \_\_\_\_\_

Sex ☐ M ☐ F Age \_\_\_\_\_

Birthdate \_\_\_\_\_

☐ Married ☐ Widowed ☐ Single ☐ Minor

☐ Separated ☐ Divorced ☐ Partnered for \_\_\_\_\_ years

Occupation \_\_\_\_\_

Patient Employer/School \_\_\_\_\_

Employer/School Address \_\_\_\_\_

Employer/School Phone (\_\_\_\_) \_\_\_\_\_

Spouse's Name \_\_\_\_\_

Birthdate \_\_\_\_\_

SS# \_\_\_\_\_

Spouse's Employer \_\_\_\_\_

Whom may we thank for referring you? \_\_\_\_\_

## INSURANCE

Who is responsible for this account? \_\_\_\_\_

Relationship to Patient \_\_\_\_\_

Insurance Co. \_\_\_\_\_

Group # \_\_\_\_\_

Is patient covered by additional insurance? ☐ Yes ☐ No

Subscriber's Name \_\_\_\_\_

Birthdate \_\_\_\_\_ SS# \_\_\_\_\_

Relationship to Patient \_\_\_\_\_

Insurance Co. \_\_\_\_\_

Group # \_\_\_\_\_

### ASSIGNMENT AND RELEASE

I certify that I, and/or my dependent(s), have insurance coverage with \_\_\_\_\_ and assign directly to \_\_\_\_\_  
Name of Insurance Company(ies)

Dr. \_\_\_\_\_ all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I authorize the use of my signature on all insurance submissions.

The above-named doctor may use my health care information and may disclose such information to the above-named Insurance Company(ies) and their agents for the purpose of obtaining payment for services and determining insurance benefits or the benefits payable for related services. This consent will end when my current treatment plan is completed or one year from the date signed below.

Signature of Patient, Parent, Guardian or Personal Representative \_\_\_\_\_

Please print name of Patient, Parent, Guardian or Personal Representative \_\_\_\_\_

Date \_\_\_\_\_

Relationship to Patient \_\_\_\_\_

## PHONE NUMBERS

Home Phone (\_\_\_\_) \_\_\_\_\_

Cell Phone (\_\_\_\_) \_\_\_\_\_

Best time and place to reach you \_\_\_\_\_

### IN CASE OF EMERGENCY, CONTACT

Name \_\_\_\_\_

Relationship \_\_\_\_\_

Home Phone (\_\_\_\_) \_\_\_\_\_

Work Phone (\_\_\_\_) \_\_\_\_\_

## ACCIDENT INFORMATION

Is condition due to an accident? ☐ Yes ☐ No

Date \_\_\_\_\_

Type of accident ☐ Auto ☐ Work ☐ Home ☐ Other

To whom have you made a report of your accident?

☐ Auto Insurance ☐ Employer ☐ Worker Comp. ☐ Other

Attorney Name (if applicable) \_\_\_\_\_

## PATIENT CONDITION

Reason for Visit \_\_\_\_\_

When did your symptoms appear? \_\_\_\_\_

Is this condition getting progressively worse? ☐ Yes ☐ No ☐ Unknown

Mark an X on the picture where you continue to have pain, numbness, or tingling.

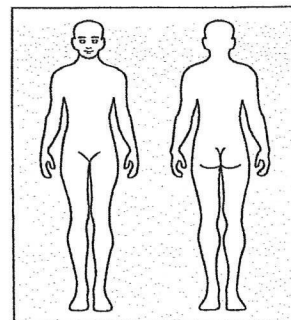
Rate the severity of your pain on a scale from 1 (least pain) to 10 (severe pain) \_\_\_\_\_

Type of pain: ☐ Sharp ☐ Dull ☐ Throbbing ☐ Numbness ☐ Aching ☐ Shooting  
☐ Burning ☐ Tingling ☐ Cramps ☐ Stiffness ☐ Swelling ☐ Other

How often do you have this pain? \_\_\_\_\_

Is it constant or does it come and go? \_\_\_\_\_

Does it interfere with your ☐ Work ☐ Sleep ☐ Daily Routine ☐ Recreation



## HEALTH HISTORY

What treatment have you already received for your condition? ☐ Medications ☐ Surgery ☐ Physical Therapy

☐ Chiropractic Services ☐ None ☐ Other \_\_\_\_\_

Name and address of other doctor(s) who have treated you for your condition \_\_\_\_\_

Date of Last: Physical Exam \_\_\_\_\_ Spinal X-Ray \_\_\_\_\_ Blood Test \_\_\_\_\_

Spinal Exam \_\_\_\_\_ Chest X-Ray \_\_\_\_\_ Urine Test \_\_\_\_\_

Dental X-Ray \_\_\_\_\_ MRI, CT-Scan, Bone Scan \_\_\_\_\_

Place a mark on "Yes" or "No" to indicate if you have had any of the following:

AIDS/HIV <input type="checkbox"/> Yes <input type="checkbox"/> No	Diabetes <input type="checkbox"/> Yes <input type="checkbox"/> No	Liver Disease <input type="checkbox"/> Yes <input type="checkbox"/> No	Rheumatic Fever <input type="checkbox"/> Yes <input type="checkbox"/> No
Alcoholism <input type="checkbox"/> Yes <input type="checkbox"/> No	Emphysema <input type="checkbox"/> Yes <input type="checkbox"/> No	Measles <input type="checkbox"/> Yes <input type="checkbox"/> No	Scarlet Fever <input type="checkbox"/> Yes <input type="checkbox"/> No
Allergy Shots <input type="checkbox"/> Yes <input type="checkbox"/> No	Epilepsy <input type="checkbox"/> Yes <input type="checkbox"/> No	Migraine Headaches <input type="checkbox"/> Yes <input type="checkbox"/> No	Sexually Transmitted Disease <input type="checkbox"/> Yes <input type="checkbox"/> No
Anemia <input type="checkbox"/> Yes <input type="checkbox"/> No	Fractures <input type="checkbox"/> Yes <input type="checkbox"/> No	Miscarriage <input type="checkbox"/> Yes <input type="checkbox"/> No	Stroke <input type="checkbox"/> Yes <input type="checkbox"/> No
Anorexia <input type="checkbox"/> Yes <input type="checkbox"/> No	Glaucoma <input type="checkbox"/> Yes <input type="checkbox"/> No	Mononucleosis <input type="checkbox"/> Yes <input type="checkbox"/> No	Suicide Attempt <input type="checkbox"/> Yes <input type="checkbox"/> No
Appendicitis <input type="checkbox"/> Yes <input type="checkbox"/> No	Goiter <input type="checkbox"/> Yes <input type="checkbox"/> No	Multiple Sclerosis <input type="checkbox"/> Yes <input type="checkbox"/> No	Thyroid Problems <input type="checkbox"/> Yes <input type="checkbox"/> No
Arthritis <input type="checkbox"/> Yes <input type="checkbox"/> No	Gonorrhea <input type="checkbox"/> Yes <input type="checkbox"/> No	Mumps <input type="checkbox"/> Yes <input type="checkbox"/> No	Tonsillitis <input type="checkbox"/> Yes <input type="checkbox"/> No
Asthma <input type="checkbox"/> Yes <input type="checkbox"/> No	Gout <input type="checkbox"/> Yes <input type="checkbox"/> No	Osteoporosis <input type="checkbox"/> Yes <input type="checkbox"/> No	Tuberculosis <input type="checkbox"/> Yes <input type="checkbox"/> No
Bleeding Disorders <input type="checkbox"/> Yes <input type="checkbox"/> No	Heart Disease <input type="checkbox"/> Yes <input type="checkbox"/> No	Pacemaker <input type="checkbox"/> Yes <input type="checkbox"/> No	Tumors, Growths <input type="checkbox"/> Yes <input type="checkbox"/> No
Breast Lump <input type="checkbox"/> Yes <input type="checkbox"/> No	Hepatitis <input type="checkbox"/> Yes <input type="checkbox"/> No	Parkinson's Disease <input type="checkbox"/> Yes <input type="checkbox"/> No	Typhoid Fever <input type="checkbox"/> Yes <input type="checkbox"/> No
Bronchitis <input type="checkbox"/> Yes <input type="checkbox"/> No	Hernia <input type="checkbox"/> Yes <input type="checkbox"/> No	Pinched Nerve <input type="checkbox"/> Yes <input type="checkbox"/> No	Ulcers <input type="checkbox"/> Yes <input type="checkbox"/> No
Bulimia <input type="checkbox"/> Yes <input type="checkbox"/> No	Herniated Disk <input type="checkbox"/> Yes <input type="checkbox"/> No	Pneumonia <input type="checkbox"/> Yes <input type="checkbox"/> No	Vaginal Infections <input type="checkbox"/> Yes <input type="checkbox"/> No
Cancer <input type="checkbox"/> Yes <input type="checkbox"/> No	Herpes <input type="checkbox"/> Yes <input type="checkbox"/> No	Polio <input type="checkbox"/> Yes <input type="checkbox"/> No	Whooping Cough <input type="checkbox"/> Yes <input type="checkbox"/> No
Cataracts <input type="checkbox"/> Yes <input type="checkbox"/> No	High Blood Pressure <input type="checkbox"/> Yes <input type="checkbox"/> No	Prostate Problem <input type="checkbox"/> Yes <input type="checkbox"/> No	Other _____
Chemical Dependency <input type="checkbox"/> Yes <input type="checkbox"/> No	High Cholesterol <input type="checkbox"/> Yes <input type="checkbox"/> No	Prosthesis <input type="checkbox"/> Yes <input type="checkbox"/> No	
Chicken Pox <input type="checkbox"/> Yes <input type="checkbox"/> No	Kidney Disease <input type="checkbox"/> Yes <input type="checkbox"/> No	Psychiatric Care <input type="checkbox"/> Yes <input type="checkbox"/> No	
		Rheumatoid Arthritis <input type="checkbox"/> Yes <input type="checkbox"/> No	

### EXERCISE

☐ None  
☐ Moderate  
☐ Daily  
☐ Heavy

### WORK ACTIVITY

☐ Sitting  
☐ Standing  
☐ Light Labor  
☐ Heavy Labor

### HABITS

☐ Smoking Packs/Day \_\_\_\_\_  
☐ Alcohol Drinks/Week \_\_\_\_\_  
☐ Coffee/Caffeine Drinks Cups/Day \_\_\_\_\_  
☐ High Stress Level Reason \_\_\_\_\_

Are you pregnant? ☐ Yes ☐ No Due Date \_\_\_\_\_

Injuries/Surgeries you have had	Description	Date
Falls	_____	_____
Head Injuries	_____	_____
Broken Bones	_____	_____
Dislocations	_____	_____
Surgeries	_____	_____

### MEDICATIONS

### ALLERGIES

### VITAMINS/HERBS/MINERALS

\_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_  
 Pharmacy Name \_\_\_\_\_  
 Pharmacy Phone (\_\_\_\_\_) \_\_\_\_\_

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

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

# VEHICLE ACCIDENT INFORMATION

## PATIENT INFORMATION

Date \_\_\_\_\_

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

Date of Accident \_\_\_\_\_ Time of Accident \_\_\_\_\_ ☐ a.m.

☐ p.m.

Please describe the accident in your own words: \_\_\_\_\_

Were you the:

☐ Driver

☐ Front Passenger

How many people were

☐ Rear Passenger

☐ Pedestrian

in the accident vehicle? \_\_\_\_\_

## ACCIDENT SITE

Road/Street Name \_\_\_\_\_

City/State \_\_\_\_\_

Nearest intersection with road/street \_\_\_\_\_

Driving conditions ☐ Dry ☐ Wet ☐ Icy ☐ Other \_\_\_\_\_

Which direction were you headed? \_\_\_\_\_

Speed you were traveling? \_\_\_\_\_

## IMPACT

Did your car impact another vehicle? ☐ Yes ☐ No

Did your car impact a structure? ☐ Yes ☐ No

If yes, explain \_\_\_\_\_

Did any part of your body strike anything in the vehicle?

☐ Yes ☐ No If yes, explain \_\_\_\_\_

Was impact from :

☐ Front ☐ Rear ☐ Left ☐ Right ☐ Other \_\_\_\_\_

At the time of impact were you:

☐ Looking straight ahead

☐ Looking to the right

☐ Looking to the left

☐ Looking down

☐ Looking up

Were both hands on the steering wheel? ☐ Yes ☐ No

If no, which hand was on the wheel? ☐ Right ☐ Left

Was your foot on the brake? ☐ Yes ☐ No

If yes, which foot was on the brake? ☐ Right ☐ Left

Were you: ☐ Surprised by impact ☐ Braced for impact

## VEHICLE

Make and model of vehicle you were in: \_\_\_\_\_

Were you wearing a seatbelt? ☐ Yes ☐ No

If yes, what type? ☐ Lap ☐ Shoulder

Was vehicle equipped with airbags? ☐ Yes ☐ No

If yes, did it/they inflate properly? ☐ Yes ☐ No

Did your seat have a headrest? ☐ Yes ☐ No

If yes, what was the position of the headrest?

☐ Low

☐ Midposition

☐ High

## OTHER VEHICLE

(if applicable)

Make and model of other vehicle \_\_\_\_\_

Which direction was other vehicle headed? \_\_\_\_\_

Speed other vehicle was traveling \_\_\_\_\_

## POLICE

Did the police come to the accident site? ☐ Yes ☐ No

Were there any witnesses? ☐ Yes ☐ No

Was a police report filed? ☐ Yes ☐ No

Was a traffic violation issued? ☐ Yes ☐ No

If yes, to whom? \_\_\_\_\_

## PATIENT CONDITION

Were you unconscious immediately after the accident? ☐ Yes ☐ No If yes, for how long? \_\_\_\_\_

Please describe how you felt immediately after the accident:

## TREATMENT

Did you go to the hospital? ☐ Yes ☐ No

When did you go? ☐ Immediately after accident ☐ Next day ☐ 2 days or more after the accident

How did you get to the hospital? ☐ Ambulance ☐ Private transportation

Name of hospital \_\_\_\_\_ Name of doctor \_\_\_\_\_

Diagnosis \_\_\_\_\_

Treatment received \_\_\_\_\_

X-rays taken \_\_\_\_\_

## SYMPTOMS/INJURIES

Have you been able to work since this injury? ☐ Yes ☐ No How many work days have you missed? \_\_\_\_\_

Prior to the injury were you able to work on an equal basis with others your age? ☐ Yes ☐ No

If you have had any of the following symptoms since your injury, please ☒ check:

- |  |   |  |
|--|---|--|
| <input type="checkbox"/> Arm/shoulder pain | <input type="checkbox"/> Feet/toe numbness    | <input type="checkbox"/> Neck pain           |
| <input type="checkbox"/> Back pain         | <input type="checkbox"/> Hand/finger numbness | <input type="checkbox"/> Neck stiff          |
| <input type="checkbox"/> Back stiffness    | <input type="checkbox"/> Headaches            | <input type="checkbox"/> Shortness of breath |
| <input type="checkbox"/> Chest pain        | <input type="checkbox"/> Irritability         | <input type="checkbox"/> Sleep difficulty    |
| <input type="checkbox"/> Dizziness         | <input type="checkbox"/> Jaw problems         | <input type="checkbox"/> Stomach upset       |
| <input type="checkbox"/> Ear buzzing       | <input type="checkbox"/> Leg pain             | <input type="checkbox"/> Tension             |
| <input type="checkbox"/> Ear ringing       | <input type="checkbox"/> Memory loss          | <input type="checkbox"/> Vision blurred      |
| <input type="checkbox"/> Fatigue           | <input type="checkbox"/> Nausea               |  |

Is this condition getting progressively worse? ☐ Yes ☐ No ☐ Unknown

Mark an X on the picture where you continue to have pain, numbness, or tingling.

Rate the severity of your pain on a scale from 1 (least pain) to 10 (severe pain) \_\_\_\_\_

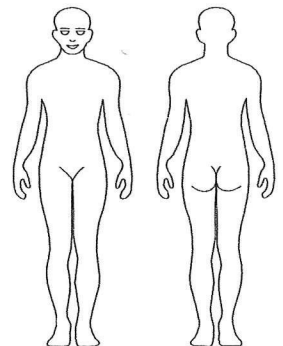
Type of pain: ☐ Sharp ☐ Dull ☐ Throbbing ☐ Numbness  
☐ Aching ☐ Shooting ☐ Burning ☐ Tingling  
☐ Cramps ☐ Stiffness ☐ Swelling ☐ Other \_\_\_\_\_

How often do you have this pain? \_\_\_\_\_

Is it constant or does it come and go? \_\_\_\_\_

Does it interfere with your: ☐ Work ☐ Sleep ☐ Daily Routine ☐ Recreation

Movements that are painful to perform: ☐ Sitting ☐ Standing ☐ Walking  
☐ Bending ☐ Lying Down



To the best of my knowledge, the above information is complete and correct. I understand that it is my responsibility to inform my doctor if I, or my minor child, ever have a change in health.

\_\_\_\_\_  
Signature of Patient, Parent, Guardian or Personal Representative

\_\_\_\_\_  
Date



# HOLTEN WELLNESS CENTER



The goal of our office is to enable patients to assume control of their health. To assist in attaining control we believe communication is a key factor. There are often topics in health care that may hard to understand and we hope this document will clarify some of these issues. Please read the information below and if you have any questions feel free to ask one of our staff members.

## INFORMED CONSENT

A patient, in coming to the chiropractic doctor, gives the doctor permission and authority to care for the patient in accordance with chiropractic tests, diagnoses and analysis. The chiropractic adjustment or other clinical procedures are usually beneficial and seldom cause any problems. In rare cases, underlying physical defects, deformities or pathologies may render the patient susceptible to injury. The doctor, or course, will not give any treatment or care if he/she is aware that such care may be contra-indicated. It is the responsibility of the patient to make it known, or to learn through healthcare procedures what he/she is suffering from; latent pathological defects, illnesses, or deformities which would otherwise not come to the attention of the chiropractic physician. The chiropractic doctor provides a specialized, non-duplicating health care service. Your doctor of chiropractic is licensed in a special practice and is available to work with other types of providers in your health care regimen.

I understand that if I am accepted as a patient by a physician at Holten Wellness Center, I am authorizing them to proceed with any treatment that they deem necessary. Furthermore, any risk involved regarding chiropractic treatment will be explained to me upon my request.

**WOMEN ONLY:** Please check one: To the best of my knowledge - ☐ I am ☐ I am NOT - pregnant and:  
☐ Give my permission ☐ Do NOT give permission - to x ray me for diagnostic interpretation.

## CONSENT TO EVALUATE AND TREAT A MINOR

I, \_\_\_\_\_ being the parent or legal guardian of \_\_\_\_\_, have read and fully understand the above terms of acceptance and hereby grant permission for my child to receive chiropractic care.

## COMMUNICATIONS

In the event we would need to communicate your healthcare information, to whom do we have your permission to do so?

☐ Spouse (\_\_\_\_\_) ☐ Child (\_\_\_\_\_) ☐ Other (\_\_\_\_\_) ☐ No One

May we leave messages regarding your personal healthcare information or appointment details on any answering device, such as a home answering machine, mobile voicemail, or work voice mail or with any individual who may answer our call?

☐ YES ☐ NO

*I have read and fully understand the above statements. I have been provided an opportunity to discuss my right to privacy and acknowledge that upon request I will be provided a copy of privacy practices.*

\_\_\_\_\_  
PRINTED NAME

\_\_\_\_\_  
SIGNATURE

\_\_\_\_\_  
DATE

## **HOLTEN WELLNESS CENTER**

### **Endorsement Agreement**

With recent changes in the health insurance industry, it has come to our attention that your insurance company may send checks directly to you. The checks you receive for services rendered in our office are actual payments from the insurance carrier to your doctor to be applied to your account.

***By signing this agreement, you agree to endorse the insurance checks and forward the check(s) along with the attached Explanation of Benefits, to Holten Wellness Center.***

**Our office will monitor, via your insurance company, whether or not payments have been submitted directly to you.**

In the event that you receive insurance payments for services rendered in our office and fail to forward those payments to us, the balance due on your account will be charged 18% interest per month until payment is received.

In addition, should your account at anytime fall into default, and be deemed necessary to be sent to collections, there will be a service charge of up to 50% on the balance owed at the time of default.

\_\_\_\_\_  
Patient Signature

\_\_\_\_\_  
Date

---

### **WAIVER OF LIABILITY**

To the best of my knowledge, I am in good physical condition and am not aware of any physical infirmity which would place me at risk to receive treatment/care at Holten Wellness Center. I am fully aware of risks and hazards connected with receiving treatment, including the risk of injury to my neck, back, spine, knees or other parts of my body, and I hereby elect to receive the requested/recommended care.

I hereby release, waive, discharge and hold harmless from any and all liability, claims, costs and expenses whatsoever arising out of or related to any loss, damage, or injury, that may be sustained while receiving any treatment at Holten Wellness Center.

\_\_\_\_\_  
Patient Signature

\_\_\_\_\_  
Date

---

### **MISSED APPOINTMENTS**

If for any reason, you would not be able to keep a scheduled appointment with our office, we ask that you call and notify our office, preferably 24 hours in advance of the appointment but certainly as soon as you become aware of your inability to keep the appointment ***Fees may be assessed for late or no notice of cancellation.*** Emergency situations will be evaluated on a case by case basis. Your consideration in this matter is greatly appreciated! Should you need to change an existing appointment, we will do our best to accommodate your needs.

# 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

- ① I have no pain at the moment.
- ② The pain is very mild at the moment.
- ③ The pain comes and goes and is moderate.
- ④ The pain is fairly severe at the moment.
- ⑤ The pain is very severe at the moment.
- ⑥ The pain is the worst imaginable at the moment.

## Sleeping

- ① I have no trouble sleeping.
- ② My sleep is slightly disturbed (less than 1 hour sleepless).
- ③ My sleep is mildly disturbed (1-2 hours sleepless).
- ④ My sleep is moderately disturbed (2-3 hours sleepless).
- ⑤ My sleep is greatly disturbed (3-5 hours sleepless).
- ⑥ My sleep is completely disturbed (5-7 hours sleepless).

## Reading

- ① I can read as much as I want with no neck pain.
- ② I can read as much as I want with slight neck pain.
- ③ I can read as much as I want with moderate neck pain.
- ④ I cannot read as much as I want because of moderate neck pain.
- ⑤ I can hardly read at all because of severe neck pain.
- ⑥ I cannot read at all because of neck pain.

## Concentration

- ① I can concentrate fully when I want with no difficulty.
- ② I can concentrate fully when I want with slight difficulty.
- ③ I have a fair degree of difficulty concentrating when I want.
- ④ I have a lot of difficulty concentrating when I want.
- ⑤ I have a great deal of difficulty concentrating when I want.
- ⑥ I cannot concentrate at all.

## Work

- ① I can do as much work as I want.
- ② I can only do my usual work but no more.
- ③ I can only do most of my usual work but no more.
- ④ I cannot do my usual work.
- ⑤ I can hardly do any work at all.
- ⑥ I cannot do any work at all.

## Personal Care

- ① I can look after myself normally without causing extra pain.
- ② I can look after myself normally but it causes extra pain.
- ③ It is painful to look after myself and I am slow and careful.
- ④ I need some help but I manage most of my personal care.
- ⑤ I need help every day in most aspects of self care.
- ⑥ I do not get dressed, I wash with difficulty and stay in bed.

## Lifting

- ① I can lift heavy weights without extra pain.
- ② I can lift heavy weights but it causes extra pain.
- 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.
- ⑥ I cannot lift or carry anything at all.

## Driving

- ① I can drive my car without any neck pain.
- ② I can drive my car as long as I want with slight neck pain.
- ③ I can drive my car as long as I want with moderate neck pain.
- ④ I cannot drive my car as long as I want because of moderate neck pain.
- ⑤ I can hardly drive at all because of severe neck pain.
- ⑥ I cannot drive my car at all because of neck pain.

## Recreation

- ① I am able to engage in all my recreation activities without neck pain.
- ② I am able to engage in all my usual recreation activities with some neck pain.
- ③ I am able to engage in most but not all my usual recreation activities because of neck pain.
- ④ I am only able to engage in a few of my usual recreation activities because of neck pain.
- ⑤ I can hardly do any recreation activities because of neck pain.
- ⑥ I cannot do any recreation activities at all.

## Headaches

- ① I have no headaches at all.
- ② I have slight headaches which come infrequently.
- ③ I have moderate headaches which come infrequently.
- ④ I have moderate headaches which come frequently.
- ⑤ I have severe headaches which come frequently.
- ⑥ I have headaches almost all the time.

Neck  
Index  
Score

Index Score = [Sum of all statements selected / (# of sections with a statement selected x 5)] x 100

# 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

- ① The pain comes and goes and is very mild.
- ② The pain is mild and does not vary much.
- ③ The pain comes and goes and is moderate.
- ④ The pain is moderate and does not vary much.
- ⑤ The pain comes and goes and is very severe.
- ⑥ The pain is very severe and does not vary much.

## Sleeping

- ① I get no pain in bed.
- ② I get pain in bed but it does not prevent me from sleeping well.
- ③ Because of pain my normal sleep is reduced by less than 25%.
- ④ Because of pain my normal sleep is reduced by less than 50%.
- ⑤ Because of pain my normal sleep is reduced by less than 75%.
- ⑥ Pain prevents me from sleeping at all.

## Sitting

- ① I can sit in any chair as long as I like.
- ② I can only sit in my favorite chair as long as I like.
- ③ Pain prevents me from sitting more than 1 hour.
- ④ Pain prevents me from sitting more than 1/2 hour.
- ⑤ Pain prevents me from sitting more than 10 minutes.
- ⑥ I avoid sitting because it increases pain immediately.

## Standing

- ① I can stand as long as I want without pain.
- ② I have some pain while standing but it does not increase with time.
- ③ I cannot stand for longer than 1 hour without increasing pain.
- ④ I cannot stand for longer than 1/2 hour without increasing pain.
- ⑤ I cannot stand for longer than 10 minutes without increasing pain.
- ⑥ I avoid standing because it increases pain immediately.

## Walking

- ① I have no pain while walking.
- ② I have some pain while walking but it doesn't increase with distance.
- ③ I cannot walk more than 1 mile without increasing pain.
- ④ I cannot walk more than 1/2 mile without increasing pain.
- ⑤ I cannot walk more than 1/4 mile without increasing pain.
- ⑥ I cannot walk at all without increasing pain.

## Personal Care

- ① I do not have to change my way of washing or dressing in order to avoid pain.
- ② I do not normally change my way of washing or dressing even though it causes some pain.
- ③ Washing and dressing increases the pain but I manage not to change my way of doing it.
- ④ Washing and dressing increases the pain and I find it necessary to change my way of doing it.
- ⑤ Because of the pain I am unable to do some washing and dressing without help.
- ⑥ Because of the pain I am unable to do any washing and dressing without help.

## Lifting

- ① I can lift heavy weights without extra pain.
- ② I can lift heavy weights but it causes extra pain.
- ③ Pain prevents me from lifting heavy weights off the floor.
- ④ Pain prevents me from lifting heavy weights off the floor, but I can manage if they are conveniently positioned (e.g., on a table).
- ⑤ Pain prevents me from lifting heavy weights off the floor, but I can manage light to medium weights if they are conveniently positioned.
- ⑥ I can only lift very light weights.

## Traveling

- ① I get no pain while traveling.
- ② I get some pain while traveling but none of my usual forms of travel make it worse.
- ③ I get extra pain while traveling but it does not cause me to seek alternate forms of travel.
- ④ I get extra pain while traveling which causes me to seek alternate forms of travel.
- ⑤ Pain restricts all forms of travel except that done while lying down.
- ⑥ Pain restricts all forms of travel.

## Social Life

- ① My social life is normal and gives me no extra pain.
- ② My social life is normal but increases the degree of pain.
- ③ Pain has no significant affect on my social life apart from limiting my more energetic interests (e.g., dancing, etc).
- ④ Pain has restricted my social life and I do not go out very often.
- ⑤ Pain has restricted my social life to my home.
- ⑥ I have hardly any social life because of the pain.

## Changing degree of pain

- ① My pain is rapidly getting better.
- ② My pain fluctuates but overall is definitely getting better.
- ③ My pain seems to be getting better but improvement is slow.
- ④ My pain is neither getting better or worse.
- ⑤ My pain is gradually worsening.
- ⑥ 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

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**Holten Wellness Center**

**7626 Paragon Rd.**

**Centerville, OH 45459**

**937-435-8480**

**937-435-8486 (fax) 1 of 2**

To: \_\_\_\_\_, Attorney at Law Printed Name

\_\_\_\_\_

**MEDICAL LIEN**

I authorize Holten Wellness Center to receive payment directly from others for any examination, diagnosis, treatment and prognosis of me in reference to the accident on

(date) which necessitated those services.

I authorize and direct you, my attorney, to pay directly to Molten Wellness Center on an ongoing basis any sums that may be due and owed for treatment provided to me by reason of the accident, from any and all proceeds of any settlement, judgment or verdict which may be paid to you or to me as a result of the injuries for which I have received treatment, within ten (10) days after you or I receive them, and from any other source, including payments from my personal auto insurance, whether for uninsured/underinsured coverage, medical payments coverage or otherwise, within ten (10) days after you or I receive them.

I understand that this document is only a guarantee of payment from the funds described above; that I am directly responsible to Molten Wellness Center for all bills submitted by them for treatment provided to me; and, that this agreement is made solely for 1-Iolten Wellness Center's additional protection and in consideration for any delay in my making payments to them on a current basis.

I also understand that payment is not contingent on my receiving any settlement, judgment or verdict and that I am still responsible for payment should no recovery be made.

Please acknowledge this document by signing below and returning to Molten Wellness Center.

PATIENT'S SIGNATURE \_\_\_\_\_

DATE \_\_\_\_\_

Printed Name \_\_\_\_\_

**Holten Wellness Center**

**7626 Paragon Rd.**

**Centerville, OH 45459**

**937-435-8480**

**937-435-8486 (fax) 2 of 2**

The undersigned attorney for the above patient agrees to comply with all of the terms of this document in accordance with Rule I 15(d) of the Ohio Rules of Professional Conduct:

And otherwise as necessary to adequately protect Holten Wellness Center" s financial interests.

ATTORNEY'S SIGNATURE \_\_\_\_\_ DATE \_\_\_\_\_

Printed Name \_\_\_\_\_

Note: The requested agreement and signature by the patient's attorney is only additional consideration to Holten Wellness Center for possibly having to wait for payment. Whether or not a patient's attorney signs, Rule I 15(d) applies and requires an attorney having "actual knowledge" of "a written agreement by the client.. Guaranteeing payment from the specific funds..." to "promptly deliver to the...Third person any funds or other property that the... third person is entitled to receive."



Holten Back and Neck Center  
7626 Paragon Rd.  
Centerville, OH 45459  
937-435-8480  
Fax 937-435-8486

**Credit Card Usage Agreement**

I \_\_\_\_\_ am accumulating an account balance with Holten Back and Neck Center due to an automobile accident. Holten Back and Neck Center has agreed not to charge me at the time of service, but will wait until settlement with the third party carrier has been reached. In the event I lose my claim against the third party, or if the third party settles with me directly, and I do not make payment to Holten Back and Neck Center within 10 business days of settlement, I have put my credit card on file. I give Holten Back and Neck Center permission to charge my credit card on the 11<sup>th</sup> business day after settlement to cover all services rendered due to my accident.

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

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