Health In Balance Integrative Medicine

Auto Accident – Information, Financial and Office Policies: The following information must be provided to our office on your first visit.

NAME OF PATIENT: _____

1) **Date of Accident**: _____/_____/_____
   Police report ☐ yes report made ☐ no report made ☐ copy in file
   Accident Case # : _____
   Responsible Party: _____
   Estimated amount of damage to vehicle: $_____

2) **Medical Records (Auto Related):** (If Applicable – Patient has seen another doctor before coming to Health in Balance)
   Name of Doctor/Clinic**:** _____Phone: (_____)_____
   Type of records: _____
   Total medical to date: $_____
   Name of Doctor/Clinic: _____Phone: (_____)_____
   Type of records: _____
   Total medical to date: $_____

3) **Your Auto/1st Party Insurance Carrier**: _____
   Address: _____ City _____ ST _____ ZIP _____
   Name Policy is under if different than patients name: _____
   Driver's License #: _____
   Auto Policy #: _____ Effective date: ____/____/____
   Injury Claim #: _____

   (An injury claim is different than an auto claim so make sure you have both open before coming in)

   Insurance Adjusters Name: _____

   (You must call your Insurance Agent before coming in to ask if you have MEDPAY and how much? Typically, it's between $2,000 - $10,000)

   Do you have Med-pay: (Circle) Yes / No How much Medpay*:_____
   Other: _____
   *MEDPAY coverage has a limit based on your insurance policy. Once this is reached, you will be responsible for any charges over this amount. Therefore, please ask for regular statements to track your coverage.

4) **Name of 3rd Party** (other driver involved): _____
   Address: _____
   City, State, ZIP: _____
   Phone: H (_____)_____ W (_____)_____
   Drivers License #: _____
   License Plate #: _____

3rd Party Auto Insurance Carrier: _____
   Address: _____ City:_____ ST_____ ZIP _____
   Name Policy is under: _____
   Insured's Phone # (if not driver) H (_____)_____ W (_____)_____
   Policy #: _____ Effective date: _____/_____/_____
   Claim # (for accident): _____
   Ins. Adjuster's Name: _____ Adj. Phone #:(_____)_____
   Other: _____

If you have retained an attorney, we will have you sign a Provider/Patient/Attorney Lien.

4) **Attorney Information (if applicable):**
Attorney Name: _____ Phone #: (_____)_____
Address: _____ City:_____ ST_____ ZIP _____

5) **Group Health Insurance**: (PPO only) _____
(We will also make a copy of the insurance card for our records)
Name Policy is under: _____Policy Holders DOB: _____
ID #: _____ Group #: _____
Phone #: (_____)_____

If there is no medical coverage (MEDPAY) on your auto insurance a 3rd Party is responsible for the accident; payment from the 3rd Party's insurance will not be made until you are released from care and a settlement has been reached. This payment will be made directly to you, but by signing this document you agree that the money is owed to APCC/HIB and must be paid within 1 week of receiving the check. In addition, we will provide receipts at the end of treatment for your records as well as to the 3rd Party's insurance carrier so that both parties can agree upon a settlement. ***It is imperative that you share the initial settlement offer with APCC/HIB if the medical portion of your settlement is less than your costs. If this amount is not approved, you will be responsible to pay your amount in full.***

In the event, that you are a 3rd Party lien case **you will need to pay a co-pay of $200 for the initial examination** until a lien agreement has been made between yourself and APCC/HIB. Typically, this is done during your report of findings on the second visit.

Below is our current Fee Schedule. The below fees highlight the most commonly used CPT codes, however if other codes are used you will still be liable for those fees.

New Patient Intensive Exam 99205	$320.00
New Patient Intermediate Exam– 99204	$280.00
New Patient Comprehensive Exam– 99203	$197.00
Office Visit Intermediate - 99212	$57.00
Office Visit Comprehensive - 99213	$111.00
Office Visit Intensive - 99215	$300.00
Chiropractic Manipulative Treatment (Spinal 1-2 seg) 98940	$56.00
Chiropractic Manipulative Treatment (Spinal 3-4 seg) 98941	$76.00
Extraspinal (1 or more regions) - 98943	$52.00
Massage – 1 Hour - 97140-22 (4 units)	$116.00
Massage – ½ Hour – 97140-22 (2 units)	$58.00
Massage, Regional – 15 Minutes - 97140	$29.00
Kinetic Activity – 97530 – (1 TE)	$79.00
Therapeutic Exercise – 97110 – (1 TE)	$58.00
Hot/Cold Packs - 97010	$20.00
Ultra Sound – 97035	$40.00
PEMF	$37.00
Neuromuscular Re-Education – 97112-52	$58.00
Percussion Therapy - 97016	$58.00
Re-Exam- 99214	$160.00
Back Brace L0648	$1000.00
Tens Unit - E0730	$600.00
Tens Garment – E0731	$200.00

Denneroll Gravity Assisted Traction Device – E0941	$80.00
Soft Cervical Collar – L0120	$60.00
Cervical Traction Collar – E0855	$60.00
X-Rays (3 View Cervical) - 72040	$50.00
X-Rays (5 View Cervical) - 72050	$100.00
X-Rays (2 View Lumbar) - 72100	$100.00
X-Rays (2 View Thoracic) - 72070	$100.00
Narrative Report (Per Page) – 99080	$50.00

I have read and agree to the fee schedule presented to me for services rendered.

Patient's Signature _____ **Date** _____

It is important that you understand that health and accident insurance policies are an arrangement between you and your insurance company. As a courtesy to you, our patient, upon receiving official verification concerning your policy, we will bill your insurance company. ***You are responsible for all service charges incurred in our office that your insurance or any 3rd party insurance does not cover****. If at any point during your case, you experience financial hardship, please notify the front desk. I have also been informed and agree to the fact that there is a service charge of half the appointment fee for not showing up for or canceling a scheduled massage appointment without a minimum of a 24-hour notice to the clinic. This charge is not a covered benefit under my insurance policy, and I understand that it will be solely my financial responsibility. Thank You.*

I have read the above statement and understand all fees must be paid in full. I also understand that Health In Balance does not accept reductions in payment for services rendered. A 10% annual interest fee will be added to any balances not paid within 1 week of settlement. By signing below, I acknowledge that I remain personally responsible for all charges incurred for my treatment regardless of whether any money is paid from any other 3rd party payor.

Patient's Signature _____ **Date** _____

Witness _____ **Date** _____

Revised 1/1/2020

Accident History Questionnaire & New Patient Paperwork

PATIENT INFORMATION

Name: _____ SSN: _____ - _____ - _____
(Title) (First) (Last) (Middle Initial)

Address _____City_____State_____ Zip_____

Birthdate _____ /_____ / _____ Age _____ Sex _____ Height _____ Weight _____

Cell/Work Phone _____ Home Phone _____

Email _____ Best way to contact you _____

Occupation Description _____ Employer_____

Employment Status: ☐ Full ☐ Part ☐ Unemployed ☐ Retired ☐ Student: Full ____ Part ____ ☐ Other _____

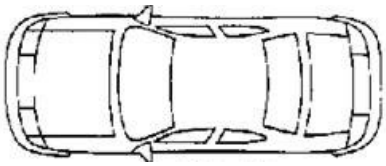
Marital Status: ☐ Single ☐ Married ☐ Divorced ☐ Separated ☐ Widowed ☐ Other:_____

Emergency Contact _____ Relationship _____ Phone _____

How did you hear about Health in Balance?_____

Who can we thank for this referral? _____Contact Info: _____

1. Driver of Car: _____ # of Passengers _____
2. Where were you seated? _____
3. Who owns the car? _____
4. Year & Model of your car._____
   Year & Model of the other car._____
5. Visibility at time of accident: ☐ poor ☐ fair ☐good ☐ other: _____
6. Road conditions at time of accident: ☐ icy ☐ rainy ☐ wet ☐ clear ☐ dark
   ☐ Other (describe): _____
7. Where was your car struck?



FRONT REAR

8. Type of Accident: ☐ Head-on collision ☐ Broad-side collision ☐ Front Impact
   ☐ Rear-end car in front ☐ Non-collision
9. At the time of the accident, recall what parts of your head or body hit what parts on the inside of your car: _____
10. Did you see the accident coming? ☐ Yes ☐ No
11. Did you brace for impact? ☐ Yes ☐ No
12. Were seatbelts worn? ☐ Yes ☐ No
13. Were shoulder harnesses worn? ☐ Yes ☐ No
14. Does your car have headrests? ☐ Yes ☐ No
15. If yes, what was the position of those headrests compared to your head before the accident?
    ☐ Top of headrest even with bottom of head
    ☐ Top of headrest even with top of head
    ☐ Top of headrest even with the middle of neck
16. Was your car braking? ☐ Yes ☐ No
17. Was your car moving at the time of the accident? ☐ Yes ☐ No
18. If yes, how fast would you estimate you were going? _____mph
19. How fast would you estimate the other car was going? _____mph

20. Head/Body position at the time of the impact:
☐ Head turned left/ right ☐ Body straight in sitting position
☐ Head looking back ☐ Body rotated right/left
☐ Head straight forward ☐ Other: _____
21. As a result of the accident you were: ☐ Rendered unconscious ☐ In shock
☐ Dazed, circumstances vague ☐ Other: _____
22. How was the shoulder harness adjusted? ☐ Loose ☐ Snug
23. Were you wearing a hat or glasses? ☐ Yes ☐ No
24. Could you move all parts of your body? ☐ Yes ☐ No
25. If no, what parts couldn't you move and why? _____
_____
26. Were you able to get out of the car and walk unaided? ☐ Yes ☐ No
27. If no, why not? _____

Illustrate below how the accident happened

INJURY AND SYMPTOM REPORTS

1. Did you get any bleeding cuts? ☐ Yes ☐ No If yes, where? _____
2. Did you get any bruises? ☐ Yes ☐ No If yes, where? _____
3. Please describe how you felt:
Immediately after the accident: _____
Later that day: _____
The next day: _____

In these next few sections (4-6), your answers may be similar to those filled out previously in other paperwork, but these sections are provided for you to describe the symptoms specifically dealing with the accident.

4. Check Symptoms apparent since the accident:

☐ Headache	☐ Neck pain/Stiffness	☐ Mid back pain
☐ Low Back Pain	☐ Arm wrist or hand pain	☐ Leg, knee, ankle or foot pain
☐ Eyes light sensitive	☐ Pain behind Eyes	☐ Dizziness
☐ Fainting	☐ Sleeping Problems	☐ Numbness in fingers
☐ Numbness in toes	☐ Loss of Smell	☐ Loss of taste
☐ Loss of memory	☐ Fatigue	☐ Breath shortness
☐ Irritability	☐ Depression	☐ Ringing/ Buzzing
☐ Loss of balance	☐ Tension	☐ Cold Hands
☐ Cold feet	☐ Diarrhea	☐ Constipation
☐ Chest Pain	☐ Nervousness	☐ Cold Sweats
☐ Anxious	☐ Facial Pain	☐ Clicking or Popping Jaw

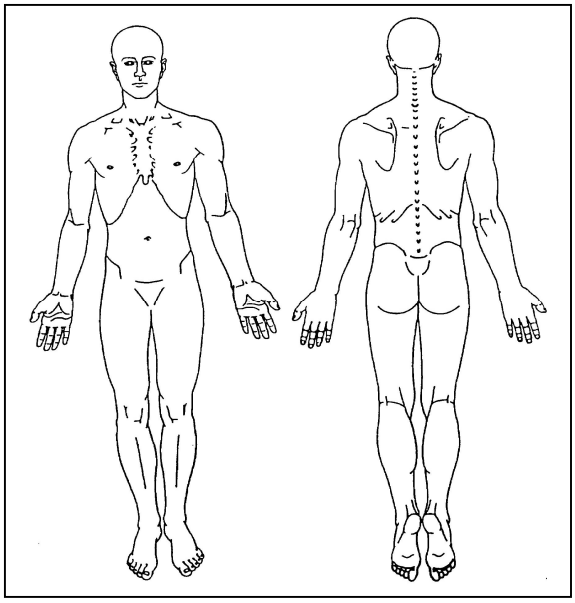
☐ Other _____

5. (*Circle the pain severity level*)

Pain Severity Level	None 0 No Pain	Mild 1 2 3 Annoying Pain	Moderate 4 5 6 7 Pain causes you to slow down.	Severe 8 9 10 Pain levels must limit your ability to perform some activities.
Effect		Aware of discomfort Able to do activities.	Takes longer to complete work. May be unable to Do demanding work.	Inability to do certain activities. Must have some difficulty sleeping.
Feeling		Dull soreness ache, stiffness.	Hurting pain, very sore, limited motion.	Sharp pain, stabbing or jabbing pain.

Draw a line from each type of pain/ symptom that you are experiencing, to the corresponding area of the body. Rate the pain/symptom level by writing the level # on each line.

Achy
Burning
Cramping
Dull
Electrical Shock
Numbness
Radiating
Sharp
Shooting
Stabbing
Stiffness
Swelling
Throbbing
Tingling
Other_____



Please mark your average level of pain intensity on the scale below:

0 **10**

Please mark the daily frequency of your pain on the scale below:

0 **10**

Never Intermittent Constant

6. **The Pain**...

☐ Wakes me up at night	☐ Is worse in the morning	☐ Is worse at the end of the day
☐ Is getting worse	☐ Worsens with sexual activity	☐ Worsens with changes in the weather
☐ Is staying the same	☐ Is getting better on its own	☐ Is constant
☐ Comes and goes	☐ Is better in the morning	☐ Other_____

The pain is worse if I _____

_____

The pain is better when I _____

_____

The pain lasts for (minutes, hours, days, weeks, longer _____

_____

7. Have you missed time from work: ☐ Yes ☐ No
8. If yes, full time off work: _____to _____
9. If yes, part time off work: _____
10. Have you lost any time from work as a result of this accident?
    a. Last day worked: _____
    b. Type of employment: _____
    c. Present Salary: _____
    d. Are you being compensated for time lost work? ☐ Yes ☐ No
       If yes, type of compensation you are receiving: _____
11. Do you notice any activity restrictions as a result of this injury?
    If yes, please describe: _____
    _____
12. Other pertinent information: _____
    _____
    _____
13. Did you seek medical help immediately after the accident? ☐ Yes ☐ No
14. If yes, how did you get there? ☐ Ambulance ☐ Police ☐ Someone else drove me
    ☐ Drove own car ☐ Other: _____
15. Doctor #1: Name: _____
16. First Visit Date: _____
17. Were you examined? ☐ Yes ☐ No
18. Were X-Rays taken? ☐ Yes ☐ No
19. Did you receive treatment? ☐ Yes ☐ No ☐ Medications ☐ Braces ☐ Collars
20. If yes, what kind of treatment did you receive? _____
21. What benefits did you receive from the treatment? _____
22. Date of last treatment: _____
23. Doctor #2: Name: _____
24. First visit Date: _____
25. Were you examined? ☐ Yes ☐ No
26. Were X-rays taken? ☐ Yes ☐ No
27. Did you receive treatment? ☐ Yes ☐ No
28. If yes, what kind of treatment did you receive? _____
29. What benefits did you receive from the treatment? _____
30. Date of last treatment: _____

PAST MEDICAL INJURIES

Did you have any physical complaints before the accident? ☐ Yes ☐ No
If yes, please describe: _____

_____

_____

PERSONAL / FAMILY HISTORY

Check Y if you have had. **Check F** if a family member has had.

Y	F		Y	F		Y	F		Y	F		Y	F	
☐	☐	Allergy	☐	☐	Diabetes	☐	☐	Kidney Disease	☐	☐	Polio	☐	☐	Thyroid
☐	☐	Anemia	☐	☐	Eczema	☐	☐	Lung Disease	☐	☐	Pleurisy	☐	☐	Tonsillitis
☐	☐	Arthritis	☐	☐	Epilepsy	☐	☐	Mental Illness	☐	☐	Pneumonia	☐	☐	Tuberculosis
☐	☐	Asthma	☐	☐	Gout	☐	☐	Measles	☐	☐	Rheumatic Fever	☐	☐	Whooping Cough
☐	☐	Cancer	☐	☐	Heart Disease/Attack	☐	☐	Migraines	☐	☐	Small Pox	☐	☐	Other:_____
☐	☐	Chicken Pox	☐	☐	Influenza	☐	☐	Mumps	☐	☐	Spinal Disorders	☐	☐	_____

I agree, that to the best of my knowledge, the above information is accurate. And should I need to add anything to the above documentation that I will notify the doctor and have him add it to the notes of his examination.

Patient's Signature: _____ Date: _____

AUTHORIZATION CARE

OPEN ROOM TREATMENT

I give permission to Health In Balance to treat me in an open room where other patients are also being treated. I am aware that other persons in the office may overhear some of my protective health care information during the course of my treatment. Should I need to speak with a doctor or therapist in private, the doctor or therapist will provide a private room for these conversations. _____ (Initial)

A patient coming to our facility gives our Healthcare Providers permission and authority to provide medical and alternative health care for them after examination, assessment and any diagnostic testing deemed necessary. The clinical procedures and/or therapies performed are designed to benefit and aid in the healing of your body. Seldom do these therapies or care cause any adverse or unwanted effects. On rare occasion, underlying physical abnormalities or other pathologies may render the patient susceptible for complications or injury. The Healthcare Provider will not perform specific procedures or therapies if he/she feels that the therapy or procedure may be contraindicated with said abnormalities or pathologies. It is the responsibility of the patient to inform the Healthcare Provider of any latent pathological abnormalities, illnesses, or deformities which they may have. This office does not perform breast, pelvic, prostate, rectal, or full skin evaluations. These examinations should be performed by your primary care provider, gynecologist and/or dermatologist to assess for cancers, or other illnesses and conditions. The patient assumes all responsibility/liability for adverse events related to or resulting from non-disclosure of past medical history, illnesses, medications, allergies or other conditions.

Furthermore, I authorize and agree to allow the doctors and/or therapists to work with my spine through the use spinal adjustments and rehabilitative exercises for the sole purpose of postural and structural restoration of normal biomechanical and neurological function.

The Doctor and/or therapist will not be held responsible for any health conditions or diagnoses which are pre-existing, given by another health care practitioner, or are not related to the spinal structural conditions diagnosed at this clinic.

I also clearly understand that if I do not follow the doctors and/or therapist specific recommendations at this clinic that I will not receive the full benefit from these programs, and that if I terminate my care prematurely that all fees incurred will be due and payable at that time. I authorize the assignment of all insurance benefits be directed to the doctor and/or therapist for all services rendered.

I have read, understand and agree to the above consent form.

Patient's Signature _____ Date _____

Patient's Parent/Guardian (minors)_____ Date_____

authorizing care for minor authorizing care for minor

APPOINTMENT POLICIES

In an effort to efficiently provide the best care for you, we have established the following policies for our appointments, and payment requirements. Please read them carefully and feel free to present any questions you may have regarding these policies to our Clinic Director.

- When scheduling your appointments, we will make every effort to accommodate you to the best of our ability.
- Keep in mind that appointment times vary according to the type of treatment you will be seen for that day, so please arrive on time as our goal is to be able to stay on schedule. If you find that you will be more than 10 minutes late to your appointment, please contact our office as soon as possible. Often, we are still able to accommodate you, but may also need to reschedule your appointment, depending on the procedure(s) being done.
- The patient agrees to pay for all services received from Health in Balance. Any unpaid balance owed to HIB at the end of 90 days will be subject to a rate of 1% a month (12% per year) until paid.
- At HIB, we value our patients and their health. We know that you want to find relief and healing, and we want to ensure your best possible outcomes. Missing your scheduled appointments loses continuity in your treatment and may slow your improvement and positive outcomes; consistency is key in order to receive the highest benefit from your care plan.
- You will receive a text (possibly a call on occasion) the day before your appointment reminding you of your scheduled time.
- All Durable Medical Equipment (DME) has a 30-day return policy from the date given with a restock fee of $10 per item. After that date there will be no returns of the product.

Patient's Signature_____ Date_____

DISCLOSURE & CONSENT FOR CHIROPRACTIC ADJUSTMENTS AND CARE

Congratulations for choosing chiropractic and natural healthcare, the safest and most natural health care program in the world. This painless, natural and effective approach to healthcare has been providing healing for people all over the world for over 100 years.

In accordance with California law this disclosure is to inform you, the patient, of the potential but highly unlikely risks associated with chiropractic care. These risks include, but are not limited to fractures, disc injuries, dislocations, strains, sprains, cervical myelopathy, costovertebral strains and separations and burns.

Some types of manipulation have been associated with injuries to the arteries of the neck leading or contributing to serious complications including stroke related with Vertebral Artery Defect (AVD). This occurrence is exceptionally rare and remote. However, you are being informed of the possibility regardless of the extreme remote chance.

It should be noted that in the history of chiropractic care there has been an extremely low rate of occurrence for muscle spasms, tightness, rib fractures, disc injuries and AVD. Most literature written against the use of chiropractic care and adjustments is vague and sometimes biased and there is no absolute proof that there are any actual risks from chiropractic care in general.

The largest study done in 2001 by the Canadian Medical Association Journal reported that there is a 1 in 5.85 million risk that cervical manipulation performed by a Doctor of Chiropractic would be followed by stroke due to AVD. David Cassidy a professor of epidemiology at the University of Toronto and the author of the study found that patients already had a damaged artery before ever seeking help from either a medical doctor or a chiropractor.

Out doctors will make every effort to screen for any contraindication to care; however, if you have a condition that would otherwise not come to my attention, it is your responsibility to inform me. The probabilities of these complications are rare and generally result from some underlying weakness of the bone or tissue which I check for during the history, examination and x-rays (when warranted).

You may experience some mild symptoms like stiffness and soreness during your treatment, but these are normal and indicate healing as your health returns to its optimal state.

By signing this document, I acknowledge that I have discussed or have had the opportunity to discuss all of the possible risks associated with chiropractic treatment. I understand that the Doctor of Chiropractic listed below will not give an adjustment if they are aware that such care may be contra-indicated. I do not expect the Doctor of Chiropractic named below and / or any other office or clinic staff to be able to anticipate all risks and complications and I wish to allow them to exercise their best judgment during the course of my chiropractic adjustments and treatments. I understand that the at all times the Doctor of Chiropractic named below and / or any other office or clinic staff assigned to provide care will be acting in my best interest based on the known facts and information I provide. As such I request and consent to the performance of chiropractic adjustments and other chiropractic treatments as recommended by the doctor(s) named below.

Patient Name (Please Print): _____

Patient/Parent Signature_____ Date _____

Doctor Signature: _____ Date_____

Name /Address of Clinic:
Arthur Professional Chiropractic /Health in Balance Int. Medicine
330 Park Avenue, Suite 3 Laguna Beach, CA 92651

Names of doctor(s) treating this patient:
Gary Arthur, D.C., Lisa Arthur, D.C
Jordan Martin, D.C.

MARKETING AND PRIVACY CONSENT

ACKNOWLEDGEMENT OF RECIEPT & NOTICE OF PRIVACY PRACTICES

I _____ understand and have been provided with a notice of information practices that provides me a more complete description of information uses and disclosures, I understand that I have the following rights and privileges:

* The right to review the notice prior to signing this consent
* The right to object to the use of my health care information for directory purpose
* The right to request restrictions as to how my health care information may be used or disclosed in this office to carry out treatment, payment, or health care operations

Patient's Signature _____ Date _____

USE OF CONTACT INFORMATION

I give permission to Health In Balance to use my name, address, phone numbers and clinical records to contact me with birthday cards, holiday related cards, health related e-mails messages and information about treatment alternatives or other health related information as well as any advertisements, newsletters or patient of the week/month postings.

Patient Signature_____ Date_____

If you would not like to be involved in this type of contact explained above, check here: Opt Out ☐

RADIOGRAPH CONSENT

I hereby give my consent to allow Health In Balance and its representatives, as deemed necessary by the examining Healthcare Provider to take radiographs of my spine and/or extremities. In addition, I recognize that these X-rays are meant for postural purposes only and I should go to my PCP or the ER to determine if I have a fracture.

I also hereby declare that to my knowledge that I am not pregnant _____ (Initial)

Patient's Signature _____ Date _____

Patient's Parent/Guardian (minors)_____ Date_____

CANCELLATION & NO SHOW POLICY

Please understand that when an appointment is scheduled for you, a time is set aside and reserved for you on the master schedule. Failure to cancel without appropriate notice prevents us from filling the vacancies in our schedule and often prevents people in need from receiving desire services in a timely manner. Therefore,

I understand and agree to the following:

1. It is my responsibility to notify:

HEALTH IN BALANCE
AT 949.497.2553
OR Office@HealthinBalance.com

24 Hours prior to the scheduled appointment if I am unable to keep the scheduled appointment.

2. I agree that I will be billed 50% of the scheduled services in the event that I miss an appointment and fail to cancel 24 hours prior to the scheduled appointment.

_____ _____ _____

Patient's Name Printed Patient's Signature Date

PHYSICIAN-PATIENT ARBITRATION AGREEMENT

Article 1 – Agreement to Arbitrate: It is understood that any dispute as to medical malpractice, that is as to whether any medical services rendered under this contract were unnecessary or unauthorized or were improperly, negligently or incompetently rendered, will be determined by submission to arbitration as provided by California law, and not by a lawsuit or resort to court process expect as California law provides for judicial review of arbitration proceedings. Both parties to this contract, by entering into it are giving up their constitutional right to have any such dispute decided in a court of law before a jury, and instead are accepting the use of arbitration.

Article 2 – All claims must be arbitrated: It is the intention of the parties that this agreement bind all parties whose claims may arise out of or relate to treatment or services provided by the physician including any spouse or heirs of the patient and any children, whether born or unborn, at the time of the occurrence giving rise to any claim. IN the case of any pregnant mother, the term "patient" herein shall mean bot the mother and the mother's expected child or children.

All claims for monetary damages exceeding the jurisdictional limit of the small claims court against the physician, and the physician's partners, associated, association, corporation or partnership, and the employees, agents and estates of any of them, must be arbitrated including, without limitation, claims for loss of consortium, any fee from the patient shall not waive the right to compel arbitration or any malpractice claim. However, following the assertion of any claim against the physician, any fee dispute, whether or not the subject of any existing court action, shall also be resolved by arbitration.

Article 3 – Procedures and Applicable Law: A demand for arbitration must be communicated in writing to all parties. Each party shall select an arbitrator (party arbitrator) within thirty days and a third arbitrator (neutral arbitrator) shall be selected by the arbitrators appointed by the parties within thirty days thereafter. Each party to the arbitration shall pay such party's pro rata share of the expenses and fees of the neutral arbitrator, together with other expenses of the arbitration incurred or approved by the neutral arbitrator, not including counsel fees or witness fees, or other expenses of the arbitration incurred or approved by the neutral arbitrator, not including counsel fees or witness fees, or other expenses incurred by a party for such party's own benefit.

Either party shall have the absolute right to arbitrate separately the issues of liability and damages upon written request to the neutral arbitrator.

The parties' consent to the intervention and joinder in this arbitration of any person or entity which would otherwise be a proper additional person or entity shall be stayed pending arbitration.

The parties agree that provisions of California law applicable to health care providers shall apply to disputes within this arbitration agreement, including but not limited to Code of Civil Procedure Section 340.5 and 667.7 and Civil Code Section 3333.1 and 3333.2. Any party may bring before the arbitrators a motion for summary judgement or summary adjudication in accordance with the Code of Civil Procedure.

Article 4 – General Provisions: All claims based upon the same incident, transaction or related circumstances shall be arbitrated in one proceeding. A claim shall be waived and forever barred if (1) on the date notice thereof is received, the claim, if asserted in a civil action, would be barred by the applicable California statute of limitations, or (2) the claimant fails to pursue the arbitration claim in accordance with the procedure prescribed herein with reasonable diligence. With respect to any matter not herein expressly provided for, the arbitration shall be governed by the California Code of Civil Procedure provisions relating to arbitration.

Article 5 - Revocation: This agreement may be revoked by written notice delivered to the physician within 30 days of signature and if not revoked will govern all medical services received by the patient.

Article 6 – Retroactive Effect: If patient intends this agreement to cover services rendered before the date it is signed (including, but not limited to, emergency treatment)

Effective as of the date of first services.

If any provision of this arbitration agreement is held invalid or unenforceable, the remaining provisions shall remain in full force and shall not be affected by the invalidity of any other provision.

I understand that I have the right to receive a copy of this arbitration agreement. By my signature below, I acknowledge that I have received a copy.

NOTICE: BY SIGNING THIS CONTRACT YOU ARE AGREEING TO HAVE ANY ISSUE OF MEDICAL MALPRACTICE DECIDED BY NEUTRAL ARBITRATION AND YOU ARE GIVING UP YOUR RIGHT TO A JURY OR COURT TRIAL SEE ARTICLE 1 OF THIS CONTRACT.

BY:_____ BY: ARTHUR PROFESSIONAL CHIROPRACTIC & HIB

Patient's Signature or Representative (DATE)

_____

Print Patient's Name or Representative

A signed copy of this document is available if the patient requests one

HIPPA COMPLAINT MEDICAL AUTHORIZATION FOR DISCLOSURE OF HEALTH INFORMATION

If there is a provider that you want APCC or HIB to obtain medical records or labs from please sign the below form:

Name of Patient: _____ Date of Birth:_____

Maiden Name: _____

Patient's Phone Number:_____

The undersigned hereby authorize the release of all medical documentation and other information, including protected health information that I could personally obtain upon request, which may be in the possession of any health care provider, medical care facility, insurer, physician, hospital, ambulance service or nurse or any other covered entity under the Health Insurance Portability and Accountability Act of 1996 ("HIPPA") to :

Health In Balance Integrative Medicine
330 Park Ave Ste 3
Laguna Beach, Ca, 92651
Phone 949.497.2553
Fax: 949.497.5273
Email: Office@HealthinBalance.com

I intend the person(s) listed above to have authority to gain immediate access to my medical records.

Upon presentation of this authorization (or a photocopy), you are authorized to release a copy of these records to any person who is my personal representative. I understand that information disclosed pursuant to this authorization may be subject to re-disclosure by the personal representative and may no longer be protected by federal law.

The purpose of the disclosure is to enable the person(s) named above to fully act as my personal representative under HIPAA, including the ability to access and re-release my medical records. This authorization shall be deemed to comply with all requirements of HIPAA (45 CFR Section 164).

This authorization shall become effective on the date it is signed and expire two years after my death. I understand that I may revoke this authorization at any time, without regard to my mental or physical condition, by sending written notice to my medical providers or by using any method capable of revoking a health care agency under California law.

_____ _____ _____

Signature Date Signature of Witness

If Individual is unable to sign this Authorization, please complete the information below:

_____ _____ _____ _____

Name of Guardian/ Representative | Legal Relationship | Date | Witness

In furtherance of this authorization, we do hereby waive all provisions of law and privileges relating to the disclosure hereby authorized.

Patient Privacy

It is the policy of the Clinic to maintain the privacy and security of all individually identifiable health information for all patients. The Clinic provides notice to all Clinic patients who arrive for appointments, informing them of their right to privacy of their protected health information (PHI). This policy describes procedures implemented by the Clinic to ensure the privacy of PHI. The Clinic obtains acknowledgment of receipt of such notice.

Procedures

1. A designated privacy officer is appointed from within the Clinic to oversee the policies and procedures to ensure that patient's rights to privacy are fulfilled.
2. All patients arriving for care receive a Notice of Patient's Privacy Rights and the Clinic's Receipt of Notice of Privacy Practices Written Acknowledgment Form. All patients are asked to sign the acknowledgment of receipt form.
3. The Clinic website contains the privacy notice, privacy practices, and the acknowledgment response.
4. The Clinic obtains written acknowledgment from the patient or legal guardian prior to engaging in treatment, payment, or health care operations.
5. Patients may request an accounting of certain non-routine disclosures of their PHI. The request may be a time period not longer than six (6) years and may not include dates prior to April 14, 2011, as stated in the request for an accounting of certain disclosures for non-treatment, payment, or health care operations (TPO) purposes.
6. The Clinic obtains written authorization for use or disclosure of PHI in connection with research and marketing.
    a. When appropriate, the Clinic uses a combined informed consent authorization form, especially as it relates to patients participating in research studies
7. The Clinic discloses only the minimum PHI to requesting entities and insurance companies in order to accomplish the intended purpose
8. As a covered entity, the Clinic fully complies with the Privacy Rule of the Health Insurance Portability and Accountability Act (HIPAA).
9. The Clinic provides the patient, in the Notice of Privacy Practices, a clear, written explanation of how the covered entity may use PHI.
10. Patients are provided access to their medical records and receive copies upon completing a Request to Inspect and Copy PHI. If the Clinic is unable to provide copies based upon the HIPAA guidelines, written notice, in the form of the Patient Denial Letter, is provided to the patient.
11. Patients are given the opportunity to request a correction or amendment to their PHI by completing the Request for Correction/Amendment of Protected Health Information. Any allowed amendments must be in a written amendment; no changes are made directly to the medical record. The Clinic must inform patients that a written request for a correction or amendment is required, and that the patient is required to provide a reason to support the requested change. The amendment is accepted or denied in a provider's written response, on a Disposition of Amendment Request.
12. Anyone who feels the confidentiality of a patient's PHI has been violated may must submit a Patient Complaint Form to the privacy officer. Complaints are kept confidential and no repercussion may occur due to the report. Complaints are logged by the privacy officer.
13. Sanctions are imposed upon employees who violate the privacy of a patient's PHI; sanctions could be disciplinary action, up to and including termination of employment.

ll employees of the Clinic receive initial and ongoing training on how to prevent misuse of PHI and how to obtain authorization for its use.

14. The Clinic secures a signed release form whenever a patient requests files be sent to another provider or vice versa.
15. The Clinic releases no PHI to employers or financial institutions without explicit authorization from the patient or legal guardian.
16. Electronic, physical, and logistical safeguards are implemented to secure the confidentiality of PHI of all patients.
17. The patient may submit a written Request for Limitations and Restrictions of Protected Health Information.
18. The clinic does not sell or distribute the patient's information for any reason.

NECK PAIN AND DISABILITY INDEX – BEFORE THE ACCIDENT

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 mark only the answer 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.

Office Use Only: **Score:** _____

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 Iwant.
___**D.** I have a lot of difficulty in concentrating when I want.
___**E.** I have a great degree of difficulty in concentrating.
___**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 if I want with slight pain in my neck.
___**C.** I can drive my car if I want with moderate pain.
___**D.** I can't drive my car if 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 can engage in all recreational activities with no neck pain.
___**B.** I can engage in all my recreational activities, with some pain in my neck.
___**C.** I can engage in most, but not all of my usual recreational activities because of pain in my neck.
___**D.** I can 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: _____

OCCUPATIONAL HISTORY – BEFORE THE ACCIDENT

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

Current Employer:
Current Occupation:

What limitations have you experienced as a result of your injury? (choose all that apply)

___Cannot use left arm
___Cannot use right arm
___Cannot use left leg
___Cannot use right leg
___Cannot drive due to condition
___Increased fatigability
___Lifting exacerbates condition
___Pain limits amount of movement
___Cannot sit due to condition
___Unable to lift more than 10 pounds
___Unable to lift more than 15 pounds
___Unable to lift more than 20 pounds
___Unable to lift more than 25 lbs
___Unable to lift more than 50 lbs
___Cannot walk due to condition

Your present job involves:

___Standing for:	___30 minutes	___2 hours	___4 hours	___8 hours
	___1 hour	___3 hours	___6 hours	___More than 8 hours
___Driving for:	___30 minutes	___2 hours	___4 hours	___8 hours
	___1 hour	___3 hours	___6 hours	___More than 8 hours
___Walking for:	___30 minutes	___2 hours	___4 hours	___8 hours
	___1 hour	___3 hours	___6 hours	___More than 8 hours
___Sitting for:	___30 minutes	___2 hours	___4 hours	___8 hours
	___1 hour	___3 hours	___6 hours	___More than 8 hours
___Lifting	___Less than 5 lbs.	___10 - 15 lbs.	___20 - 25 lbs.	___40 - 50 lbs.
	___05 - 10 lbs.	___15 - 20 lbs.	___25 - 40 lbs.	___More than 50 lbs.

___Repetitive Motion

Have you missed any work as a result of your condition? ___Yes ___No

If yes, how many days did you miss?_____ ***Your last full day of work was:_____***

Are you currently receiving worker's compensation? ___Yes ___No

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

Signature: _____

REVISED OWESTRY LOW BACK PAIN AND DISABILITY – BEFORE THE ACCIDENT

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 mark only the answer 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 than 30 min 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.

Office Use Only: **Score:** _____

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

Signature: _____

ROLAND – MORRIS LOW BACK PAIN AND DISABILITY – BEFORE THE ACCIDENT

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

Please Read Instructions:

This list contains some sentences that people have used to describe themselves when they have back pain. When you read them, you may find that some stand out because they describe you today. As you read the list, think of yourself today. Mark next to any sentence that describes you today. If the sentence does not describe you, then leave the space blank and go on to the next one. Remember, only check the sentences that describe you today.

___**1)** I stay at home most of the time because of my back.

___**2)** I change position frequently to try and get my back comfortable.

___**3)** I walk more slowly than usual because of my back.

___**4)** Because of my back, I am not doing any of the jobs that I usually do around the house.

___**5)** Because of my back, I use a handrail to get upstairs.

___**6)** Because of my back, I lie down to rest more often.

___**7)** Because of my back, I have to hold on to something to get out of an easy chair.

___**8)** Because of my back, I try to get other people to do things for me.

___**9)** I get dressed more slowly than usual because of my back.

___**10)** I only stand up for short periods of time because of my back.

___**11)** Because of my back, I try not to bend or kneel down.

___**12)** I find it difficult to get out of a chair because of my back.

___**13)** My back is painful almost all the time.

___**14)** I find it difficult to turn over in bed because of my back.

___**15)** My appetite is not very good because of my back pain.

___**16)** I have trouble putting on my socks (stockings) because of the pain in my back.

___**17)** I only walk short distances because of my back pain.

___**18)** I sleep less well because of my back.

___**19)** Because of my back pain, I get dressed with help from someone else.

___**20)** I sit down for most of the day because of my back.

___**21)** I avoid heavy jobs around the house because of my back.

___**22)** Because of my back pain, I am more irritable and bad tempered with people than usual.

___**23)** Because of my back, I go upstairs more slowly than usual.

___**24)** I stay in bed most of the time because of my back.

Office Use Only: Score: _____

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

Signature: _____

NECK PAIN AND DISABILITY INDEX – AFTER THE ACCIDENT

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 mark only the answer 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 Iwant.
___**D.** I have a lot of difficulty in concentrating when I want.
___**E.** I have a great degree of difficulty in concentrating.
___**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 if I want with slight pain in my neck.
___**C.** I can drive my car if I want with moderate pain.
___**D.** I can't drive my car if 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 can engage in all recreational activities with no neck pain.
___**B.** I can engage in all my recreational activities, with some pain in my neck.
___**C.** I can engage in most, but not all of my usual recreational activities because of pain in my neck.
___**D.** I can 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.

Office Use Only: **Score:** _____

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

Signature: _____

OCCUPATIONAL HISTORY – AFTER THE ACCIDENT

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

Current Employer:
Current Occupation:

What limitations have you experienced as a result of your injury? (choose all that apply)

___Cannot use left arm
___Cannot use right arm
___Cannot use left leg
___Cannot use right leg
___Cannot drive due to condition
___Increased fatigability
___Lifting exacerbates condition
___Pain limits amount of movement
___Cannot sit due to condition
___Unable to lift more than 10 pounds
___Unable to lift more than 15 pounds
___Unable to lift more than 20 pounds
___Unable to lift more than 25 lbs
___Unable to lift more than 50 lbs
___Cannot walk due to condition

Your present job involves:

___Standing for:	___30 minutes ___1 hour	___2 hours ___3 hours	___4 hours ___6 hours	___8 hours ___More than 8 hours
___Driving for:	___30 minutes ___1 hour	___2 hours ___3 hours	___4 hours ___6 hours	___8 hours ___More than 8 hours
___Walking for:	___30 minutes ___1 hour	___2 hours ___3 hours	___4 hours ___6 hours	___8 hours ___More than 8 hours
___Sitting for:	___30 minutes ___1 hour	___2 hours ___3 hours	___4 hours ___6 hours	___8 hours ___More than 8 hours
___Lifting	___Less than 5 lbs. ___05 - 10 lbs.	___10 - 15 lbs. ___15 - 20 lbs.	___20 - 25 lbs. ___25 - 40 lbs.	___40 - 50 lbs. ___More than 50 lbs.

___Repetitive Motion

Have you missed any work as a result of your condition? ___Yes ___No

If yes, how many days did you miss?_____ ***Your last full day of work was:_____***

Are you currently receiving worker's compensation? ___Yes ___No

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

Signature: _____

REVISED OWESTRY LOW BACK PAIN AND DISABILITY – AFTER THE ACCIDENT

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 mark only the answer 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 than 30 min 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.

Office Use Only: **Score:** _____

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

Signature: _____

ROLAND – MORRIS LOW BACK PAIN AND DISABILITY – AFTER THE ACCIDENT

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

Please Read Instructions:

This list contains some sentences that people have used to describe themselves when they have back pain. When you read them, you may find that some stand out because they describe you today. As you read the list, think of yourself today. Mark next to any sentence that describes you today. If the sentence does not describe you, then leave the space blank and go on to the next one. Remember, only check the sentences that describe you today.

___**1)** I stay at home most of the time because of my back.

___**2)** I change position frequently to try and get my back comfortable.

___**3)** I walk more slowly than usual because of my back.

___**4)** Because of my back, I am not doing any of the jobs that I usually do around the house.

___**5)** Because of my back, I use a handrail to get upstairs.

___**6)** Because of my back, I lie down to rest more often.

___**7)** Because of my back, I have to hold on to something to get out of an easy chair.

___**8)** Because of my back, I try to get other people to do things for me.

___**9)** I get dressed more slowly than usual because of my back.

___**10)** I only stand up for short periods of time because of my back.

___**11)** Because of my back, I try not to bend or kneel down.

___**12)** I find it difficult to get out of a chair because of my back.

___**13)** My back is painful almost all the time.

___**14)** I find it difficult to turn over in bed because of my back.

___**15)** My appetite is not very good because of my back pain.

___**16)** I have trouble putting on my socks (stockings) because of the pain in my back.

___**17)** I only walk short distances because of my back pain.

___**18)** I sleep less well because of my back.

___**19)** Because of my back pain, I get dressed with help from someone else.

___**20)** I sit down for most of the day because of my back.

___**21)** I avoid heavy jobs around the house because of my back.

___**22)** Because of my back pain, I am more irritable and bad tempered with people than usual.

___**23)** Because of my back, I go upstairs more slowly than usual.

___**24)** I stay in bed most of the time because of my back.

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DIRECTIONS TO HEALTH IN BALANCE

- Welcome to Health In Balance! We are located at 330 Park Ave #3, Laguna Beach, CA 92651.
- **Please arrive on time to your exam with the paperwork filled out so that this will not interfere with your scheduled appointment**
- In addition, please allow additional time to find our office for your first visit, as well as an additional 15 minutes during summertime commute as traffic can cause unnecessary delays.
- There is parking just past our office on the left-hand side. You can use the first (covered) or second (open) driveway. Please note that the second driveway, you must park facing the ocean. If both lots are full there are parking lots and parking spaces on the street that take quarters.
- Our office #3 is located just off the sidewalk level with a small staircase up with bamboo planter boxes. Please let our office know if you require handicap access and we will walk you through how to enter our office.

We look forward to working with you and your healthcare needs!

Please do not hesitate to call or email if you have any additional questions.

Office #: 949.497.2553 Email: Office@HealthinBalance.com