WELCOME TO OUR OFFICE

__/__/__
TODAY'S DATE

1. PATIENT INFORMATION

(PLEASE PRINT)

NAME_____
FIRST LAST MI

ADDRESS_____

_____
CITY STATE ZIP

SEX ☐M ☐F DATE OF BIRTH__/__/__ AGE__
☐SINGLE ☐MARRIED ☐WIDOW
☐SEPARATED ☐DIVORCED

OCCUPATION_____☐FT ☐PT
EMPLOYER_____
EMPLOYER ADDRESS_____
_____

SPOUSE'S NAME_____
DATE OF BIRTH __/__/__
ARE YOU THE PARENT OR LEGAL GUARDIAN OF THE PATIENT?
☐YES YOUR NAME_____
☐NO RELATIONSHIP TO PATIENT_____
_____

2. ACCIDENT INFORMATION

IS YOUR CONDITION DUE TO AN ACCIDENT? ☐YES ☐NO
TYPE OF ACCIDENT:
☐AUTO ☐WORK ☐HOME ☐OTHER

TO WHOM HAVE YOU MADE A REPORT OF THIS ACCIDENT ?
☐AUTO INSURANCE ☐EMPLOYER
☐WORK COMP ☐OTHER

ATTORNEY_____
PHONE _____

AUTOMOBILE INSURANCE

YOUR INSURANCE COMPANY
_____
I.D. NUMBER_____
CLAIM NUMBER_____
PHONE NUMBER_____
SUBSCRIBER'S NAME_____
DATE OF BIRTH___/___/___
PHONE_____

3. PHONE NUMBERS

HOME _____WORK _____ CELL _____
☐CHECK BOX IF OK TO LEAVE MESSAGES ON YOUR CELL OR TEXT WITH HIPAA PROTECTED INFORMATION

E-MAIL _____
☐CHECK BOX IF OK TO CONTACT YOU VIA E-MAIL WITH HIPAA PROTECTED INFORMATION

WHOM SHOULD WE CONTACT IN CASE OF EMERGENCY?
NAME _____RELATIONSHIP _____
CELL _____ WORK _____

4. PATIENT CONDITION – YOUR MAIN COMPLAINT...

REASON FOR TODAY'S VISIT_____ DATE STARTED__/__/__
DO YOU KNOW WHAT MAY HAVE CAUSED THIS? _____
IS YOUR PAIN/DISCOMFORT: ☐DULL ☐SHARP ☐BURNING ☐TINGLING
☐THROBBING ☐NUMBNESS ☐STABBING

AND IS IT? ☐MILD ☐MODERATE ☐SEVERE PAIN SCALE: MILD 1 2 3 4 5 6 7 8 9 10 SEVERE

HOW OFTEN DO YOU SUFFER FROM THIS? ☐DAILY ☐__X PER WEEK ☐__X PER MONTH ☐__X PER YEAR

HOW LONG DOES IT LAST? _____IS IT ☐INTERMITTENT ☐FREQUENT ☐CONSTANT
WHAT MAKES IT BETTER? _____WHAT MAKES IT WORSE? _____
DOES IT INTERFERE WITH: ☐WORK ☐SLEEP ☐DAILY ROUTINE ☐RECREATION
☐WALKING ☐BENDING ☐STANDING ☐SITTING
WHAT HAVE YOU TRIED TO RELIEVE YOUR SYMPTOMS? _____

6. PAST HEALTH HISTORY

PATIENT NAME:

Do you have any of the following?

Please check YES or NO for each condition.

Relative Contraindications:

Articular Hypermobility Disease	☐Yes	☐No
Severe Demineralization of Bone	☐Yes	☐No
Benign Bone Tumor (Spine)	☐Yes	☐No
Bleeding Disorder	☐Yes	☐No
Are you taking Anticoagulants Therapy	☐Yes	☐No
Radiculopathy with Progressive Neurological Signs, Radiating Pain, Numbness or Weakness into:		
Upper Extremities	☐Yes	☐No
Lower Extremities	☐Yes	☐No
Do you have a Pacemaker or any other Electrical Implant	☐Yes	☐No

Absolute Contraindications:

Rheumatoid Arthritis	☐Yes	☐No
Ankylosing Spondylitis	☐Yes	☐No
Fracture(s)_____	☐Yes	☐No
Dislocation(s)_____	☐Yes	☐No
Unstable OS Odontoedum	☐Yes	☐No
Malignancies	☐Yes	☐No
Infection of bones or joints of the vertebral column	☐Yes	☐No
Myelopathy	☐Yes	☐No
Cauda Equina Syndrome	☐Yes	☐No
Major Artery Aneurysm	☐Yes	☐No

Previous Major Illnesses and Injuries_____

Operations, Hospitalizations, Surgeries_____

Check off Conditions that You are Currently Taking Medications for: ☐None

High Blood Pressure_____ **Cholesterol**_____ **Pain**_____ **Arthritis**_____

Depression_____ **Anxiety**_____ **ADD/ADHD**_____ **Insulin**_____

Other_____

Allergies

FAMILY HISTORY -**Immediate Family Members (Father, Mother, Brother, Sister)**

Health Status of family Members:_____

Are there any family members that suffer from:

☐Stroke ☐ Heart Disease ☐Cancer ☐Tumor ☐Degenerative Disc Disease ☐Arthritis ☐Osteoporosis

☐Other_____

If any of the above items are checked, then whom in your family suffers?_____

_____

Are there any diseases that are "hereditary" or seem to run in your family?

SOCIAL HISTORY - **Please answer the following:**

Please tell the Doctor about your activities:

Exercise:	Work/School:	Habits: ☐None		Education:
☐None	☐Sitting	☐Smoking – Packs Per Day____	☐None Drugs _____☐None	☐High School
☐Occasional	☐Standing	☐Alcohol –Times Per Week_____	☐None	☐Some College
☐Daily	☐Light Labor	☐Caffeine: Coffee, Tea, Sodas…Cups Per Day_____	☐None	☐College Grad
☐Weekly	☐Heavy Labor	Hobbies_____	☐None	☐Post Grad
☐Other	☐Computer			

I certify the information on these forms are true to the best of my knowledge, and hereby authorize this office of chiropractic to provide me with chiropractic and therapeutic care for my condition if I am accepted as a patient

Patient Signature_____ **Date** ___/___/___

Doctors Signature_____ **Date** ___/___/___

SYMPTOM(S) QUESTIONNAIRE

Patient Name _____ ☐ Initial Visit ☐ Subsequent Visit

Please tell us about your symptoms: _____

_____

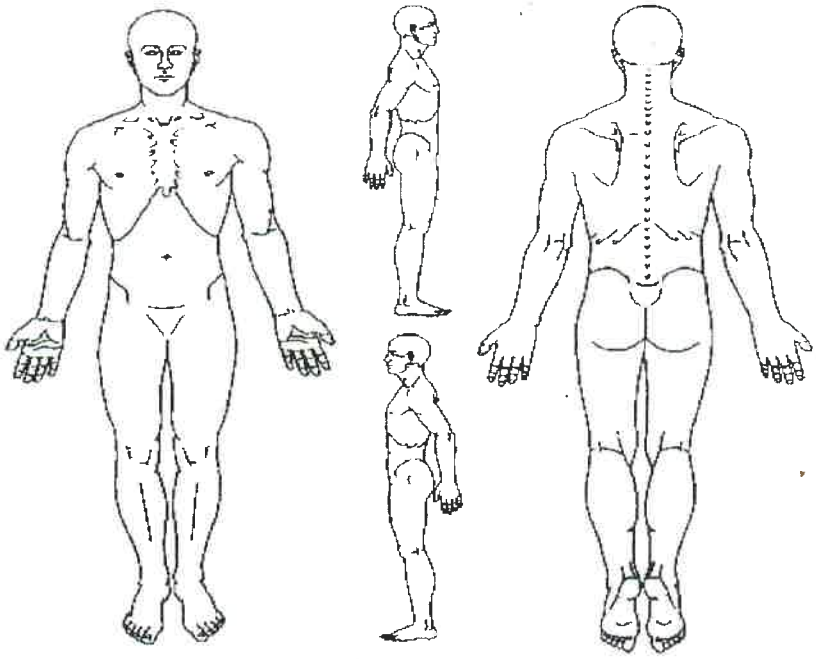
My pain / symptom(s) are getting: Better Worse About the same Other

Please use the key to mark the diagram

Pain / Discomfort Scale: (please Circle) Least 0 1 2 3 4 5 6 7 8 9 10+ Worst

A = Ache B = Burning N = Numbness S = Stiff SR = Sore

T = Tingle P = Pain W = Weak P&N = Pins & Needles



Please tell us how your symptoms are affecting your activities

HOME	No Effect	Mild Effect	Moderate Effect	Severe Effect
Sleeping	☐	☐	☐	☐
Self Care	☐	☐	☐	☐
Household Chores	☐	☐	☐	☐
Yard Work	☐	☐	☐	☐
Enjoyment	☐	☐	☐	☐
Productivity	☐	☐	☐	☐

WORK	No Effect	Mild Effect	Moderate Effect	Severe Effect
Concentration	☐	☐	☐	☐
Duties, Activities	☐	☐	☐	☐
Mood	☐	☐	☐	☐
Travel	☐	☐	☐	☐
Enjoyment	☐	☐	☐	☐
Productivity	☐	☐	☐	☐

OTHER ACTIVITIES	No Effect	Mild Effect	Moderate Effect	Severe Effect
Sit, Stand, Walk	☐	☐	☐	☐
Raising from Chair	☐	☐	☐	☐
Bend, Lift, Twist	☐	☐	☐	☐
Turn Head	☐	☐	☐	☐
Hobbies, Exercise, Sports	☐	☐	☐	☐
Enjoyment	☐	☐	☐	☐

Patient Signature _____ Date ____/____/____

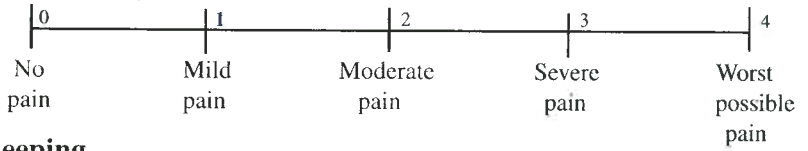
Doctor Signature _____ Date ____/____/____

Functional Rating Index

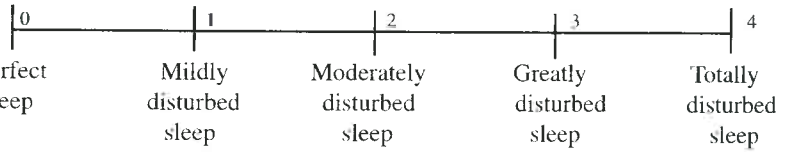
For use with **Neck and/or Back Problems** only.

In order to properly assess your condition, we must understand how much your **neck and/or back problems** have affected your ability to manage everyday activities.
For each item below, **please circle the number which most closely describes your condition right now.**

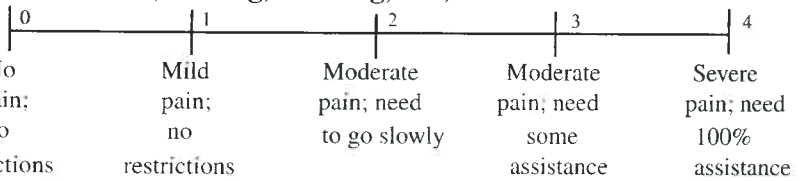
1. Pain Intensity



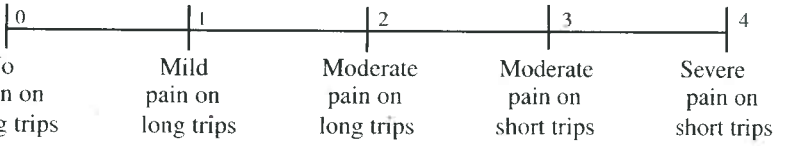
2. Sleeping



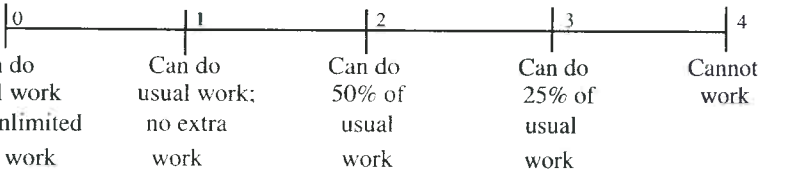
3. Personal Care (washing, dressing, etc.)



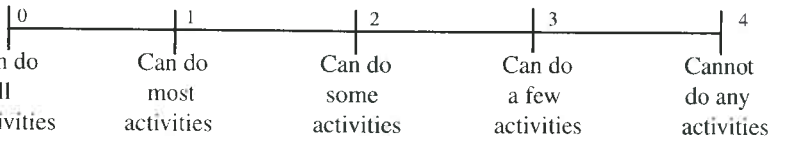
4. Travel (driving, etc.)



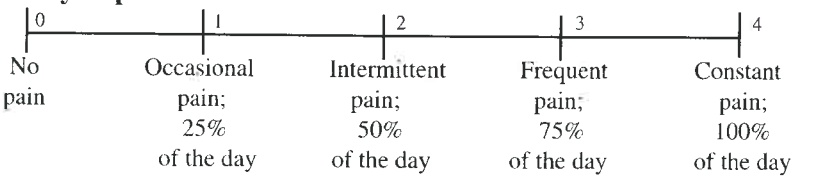
5. Work



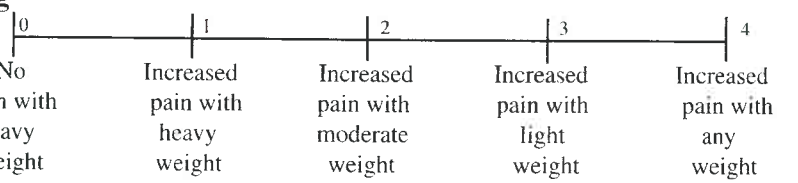
6. Recreation



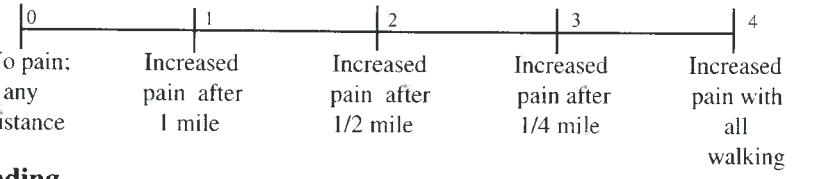
7. Frequency of pain



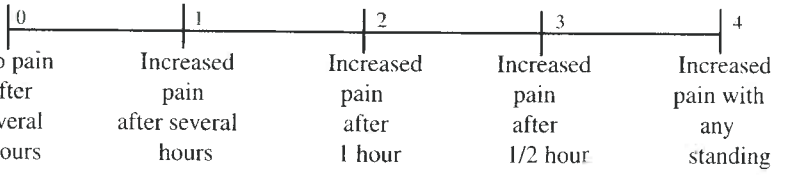
8. Lifting



9. Walking



10. Standing



Name _____
PRINTED

_____
Signature

_____
Date

Total Score _____

Informed Consent for Chiropractic Treatment

TO THE PATIENT: *You have a right to be informed about your condition, the recommended chiropractic treatment, and the potential risks involved with the recommended treatment. This information will assist you in making an informed decision whether or not to have the treatment. This information is not meant to scare or alarm you; it is simply an effort to make you better informed so you may give or refuse to give your consent to treatment.*

I request and consent to chiropractic adjustments and other chiropractic procedures, including various modes of physical therapy and diagnostic X-rays. The chiropractic treatment may be performed by the Doctor of Chiropractic named below and/or other licensed Doctors of Chiropractic working at this clinic or office. Chiropractic treatment may also be performed by a Doctor of Chiropractic who is serving as a backup for the Doctor of Chiropractic named below.

I have had the opportunity to discuss with the Doctor of Chiropractic named below, my diagnosis, the nature and purpose of my chiropractic treatment, the risks and benefits of my chiropractic treatment, alternatives to my chiropractic treatment, and the risks and benefits of alternative treatment, including no treatment at all.

I understand that, there are some risks to chiropractic treatment including, but not limited to:

- ☐ Broken bones
- ☐ Dislocations
- ☐ Sprains/strains
- ☐ Burns or frostbite (physical therapy)
- ☐ Worsening/aggravation of spinal conditions
- ☐ increased symptoms and pain
- ☐ No improvement of symptoms or pain
- ☐ Infection (acupuncture)
- ☐ Punctured lung (acupuncture)
- ☐ Other _____

In rare cases there have been reported complications of vertebral artery dissection (stroke) when a patient receives a cervical adjustment. The complications reported can include temporary minor dizziness, nausea, paralysis, vision loss, locked in syndrome (complete paralysis of voluntary muscles in all parts of the body except for those that control eye movement), and death.

I do not expect the doctor to be able to anticipate and explain all risks and complications. I also understand that no guarantees or promises have been made to me concerning the results expected from the treatment.

I have read, or have had read to me, the above consent. I have also had an opportunity to ask questions. All of my questions have been answered to my satisfaction. By signing below, I consent to the treatment plan. I intend this consent form to cover the entire course of treatment for my current condition.

To be completed by the patient:

_____
print name

_____
signature of patient

_____
date signed

To be completed by the patient's representative:

_____
print name of patient

_____
print name of patient's representative

_____
signature of patient's representative

as:_____
relationship/authority of patient's representative

_____
date signed

To be completed by doctor or staff:

_____
witness to patient's signature

_____
date

_____
translated by

_____
date

1500

HEALTH INSURANCE CLAIM FORM

APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE 08/05

PICA

PICA

CARRIER

1. MEDICARE (Medicare #) | MEDICAID (Medicaid #) | TRICARE CHAMPUS (Sponsor's SSN) | CHAMPVA (Member ID#) | GROUP HEALTH PLAN (SSN or ID) | FECA BLK LUNG (SSN) | OTHER (ID)

1a. INSURED'S I.D. NUMBER (For Program in Item 1)

2. PATIENT'S NAME (Last Name, First Name, Middle Initial)

3. PATIENT'S BIRTH DATE MM DD YY SEX M F

4. INSURED'S NAME (Last Name, First Name, Middle Initial)

5. PATIENT'S ADDRESS (No., Street)

6. PATIENT RELATIONSHIP TO INSURED Self | Spouse | Child | Other

7. INSURED'S ADDRESS (No., Street)

CITY | STATE

8. PATIENT STATUS Single | Married | Other; Employed | Full-Time Student | Part-Time Student

CITY | STATE

ZIP CODE | TELEPHONE (Include Area Code)

ZIP CODE | TELEPHONE (Include Area Code)

9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)

10. IS PATIENT'S CONDITION RELATED TO:

11. INSURED'S POLICY GROUP OR FECA NUMBER

a. OTHER INSURED'S POLICY OR GROUP NUMBER

a. EMPLOYMENT? (Current or Previous) YES NO

a. INSURED'S DATE OF BIRTH MM DD YY SEX M F

b. OTHER INSURED'S DATE OF BIRTH MM DD YY SEX M F

b. AUTO ACCIDENT? YES NO PLACE (State)

b. EMPLOYER'S NAME OR SCHOOL NAME

c. EMPLOYER'S NAME OR SCHOOL NAME

c. OTHER ACCIDENT? YES NO

c. INSURANCE PLAN NAME OR PROGRAM NAME

d. INSURANCE PLAN NAME OR PROGRAM NAME

10d. RESERVED FOR LOCAL USE

d. IS THERE ANOTHER HEALTH BENEFIT PLAN? YES NO *If yes*, return to and complete item 9 a-d.

READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM.

12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below.

SIGNED _____ DATE _____

13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for services described below.

SIGNED _____

PATIENT AND INSURED INFORMATION

14. DATE OF CURRENT: MM DD YY ILLNESS (First symptom) OR INJURY (Accident) OR PREGNANCY(LMP)

15. IF PATIENT HAS HAD SAME OR SIMILAR ILLNESS, GIVE FIRST DATE MM DD YY

16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION MM DD YY FROM MM DD YY TO

17. NAME OF REFERRING PROVIDER OR OTHER SOURCE

17a.

17b. NPI

18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES MM DD YY FROM MM DD YY TO

19. RESERVED FOR LOCAL USE

20. OUTSIDE LAB? YES NO $ CHARGES

21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY (Relate Items 1, 2, 3 or 4 to Item 24E by Line)

1. _____ 3. _____

2. _____ 4. _____

22. MEDICAID RESUBMISSION CODE ORIGINAL REF. NO.

23. PRIOR AUTHORIZATION NUMBER

Fold

24. A. DATE(S) OF SERVICE From MM DD YY To MM DD YY	B. PLACE OF SERVICE	C. EMG	D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS MODIFIER	E. DIAGNOSIS POINTER	F. $ CHARGES	G. DAYS OR UNITS	H. EPSDT Family Plan	I. ID. QUAL	J. RENDERING PROVIDER ID. #
1								NPI	
2								NPI	
3								NPI	
4								NPI	
5								NPI	
6								NPI	

PHYSICIAN OR SUPPLIER INFORMATION

25. FEDERAL TAX I.D. NUMBER SSN EIN

26. PATIENT'S ACCOUNT NO.

27. ACCEPT ASSIGNMENT? (For govt. claims, see back) YES NO

28. TOTAL CHARGE $

29. AMOUNT PAID $

30. BALANCE DUE $

31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part thereof.)

SIGNED DATE

32. SERVICE FACILITY LOCATION INFORMATION

a. b.

33. BILLING PROVIDER INFO & PH # ( )

a. b.

Cove Freedom Chiropractic

Dr. John B. Stockton

ASSIGNMENT OF BENEFITS: ASSIGNMENT OF CAUSE OF ACTION: CONTRACTUAL LIEN

The undersigned patient and/or responsible party, in addition to continuing personal responsibility, and in consideration of treatment rendered or to be rendered assigns to Dr. John B. Stockton, the following rights, power and authority:

RELEASE OF INFORMATION: You are authorized to release information concerning my condition and treatment to my insurance company, attorney, or insurance adjustor for purposes of processing my claim for benefits of payment of services rendered to me.

IRREVOCABLE ASSIGNMENT OF RIGHTS: You are assigned the exclusive, irrevocable right to any cause of action that exists in my favor against any insurance company for the terms of the policy, including the exclusive, irrevocable right to receive payment for such services, make demand in my name for payment, and prosecute and receive penalties, interest, court loss, or other legally compensable amounts owed by an insurance company in accordance with Article 21.55 of the Texas Insurance Code to cooperate, provide information as needed, and appear as needed, wherever to assist in the prosecution of such claims for benefits upon request.

DEMAND FOR PAYMENT(S): To any insurance company providing benefits of any kind to me/us for treatment rendered by the physician facility named above, you are hereby tendered demand to pay in full the bill for services to the extent such bills are payable under the terms of the policy. This demand specifically conforms to Article 21.55 of the Texas Insurance Code (15 day limitation), providing for attorney fees, 18% penalty, court cost, and interest from judgment, upon violation. I further instruct the provider to make all checks payable to **COVE FREEDOM CHIROPRACTIC** to send all checks to ***211 LIBERTY BELL LANE SUITE 111 COPPERAS COVE TEXAS 76522.***

THIRD PARTY LIABILITY: If my injuries are the result of negligence from a third party, then I instruct the Liability carrier to cut a separate draft to pay in full all services rendered, payable directly to **COVE FREEDOM CHIROPRACTIC** and to send any and all checks to ***211 LIBERTY BELL LANE SUITE 111 COPPERAS COVE TEXAS 76522.***

STATUE OF LIMITATIONS: I waive my rights to claim any statue of limitations regarding claims for services rendered by the physician/facility named above, in addition to reasonable cost of collection, including attorney fees and court cost incurred.

LIMITED POWER OF ATTORNEY: I hereby grant to the physician/facility named above the power to endorse my name upon any checks, drafts, or other negotiable instrument representing payment from any insurance company representing payment for treatment and healthcare rendered by the physician/facility named above. I agree that any insurance payment representing an amount in excess of the charges for treatment rendered will be credited to my/our account or forwarded to my/our address upon request in writing to the physician/facility named above.

REJECTION IN WRITING: I hereby authorize the physician/clinic named above to establish a PIP or UM claim on my behalf. I also instruct my insurance carrier to provide upon request to the provider/clinic named above, any rejections in writing as they apply to my lack of PIP or UM/UIM coverage. If my carrier is unable to provide said rejections per section 1952.152 of the Texas Insurance Code, and further instruct my carrier to pay up to available limits directly to physician/clinic named above, and to send any and all checks or financial instruments to **COVE FREEDOM CHIROPRACTIC at 211 LIBERTY BELL LANE SUITE 111 COPPERAS COVE TEXAS 76522.**

TERMINATION OF CARE: I hereby acknowledge and understand that if I do not keep appointments as recommended to me by my caring doctor at this clinic, he/she has full and complete right to terminate responsibility for my care and relinquish any disability granted to me within a reasonable period of time. If during the course of my care, my insurance company requires me to take an examination from any other doctor, I will notify this physician/facility immediately. I understand that failure to do so may jeopardize my case.

PRINT NAME OF PATIENT _____ DATE _____

SIGNATURE OR PATIENT AND OR RESPONSIBLE PARTIES _____

254-547-6654 • 254-383-3931 (text) • askdr.john@yahoo.com
211 Liberty Bell Lane • Copperas Cove, TX 76522

Cove Freedom
Chiropractic
211 Liberty Bell Lane,
Suite 111
Copperas Cove, TX 76522

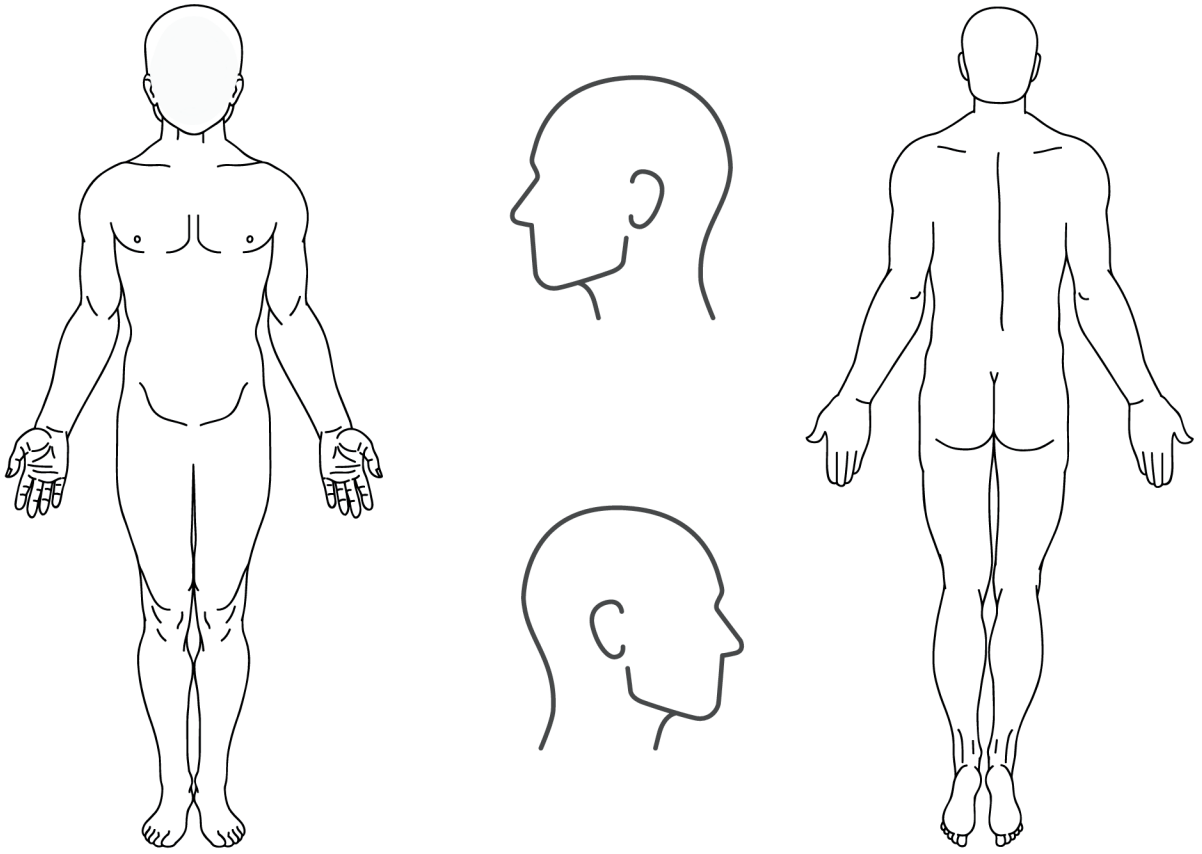
Name:_____ **Date:**_____

Borg Pain Scale

On a scale of 1 - 10, please rate your pain level

Normal	Low Pain	Moderate Pain	Intense Pain	Emergency
_0	_1	_4	_7	_10
	_2	_5	_8	
	_3	_6	_9	

Please place an "X" where you feel your pain.



Cove Freedom Chiropractic
211 Liberty Bell Ln., Suite111
Copperas Cove, TX 76522

Name:_____ Date:_____

Neck Disability Index

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. **Please answer every section and mark in each section only ONE box** which applies to you. We realize you may consider that two of the statements in any one section relate to you, but **please just mark the box which MOST CLOSELY describes your problem**

Section 1- Pain Intensity

- ☐ I have no pain at the moment
- ☐ The pain is very mild at the moment
- ☐ The pain is moderate at the moment
- ☐ The pain is fairly severe at the moment
- ☐ The pain is very severe at the moment
- ☐ The pain is the worst imaginable at the moment

Section 2- Personal Care(washing, dressing, etc.)

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

Section 3- Lifting

- ☐ I can lift heavy weights without extra pain.
- ☐ I can lift heavy weights but it gives extra pain.
- ☐ Pain prevents me from lifting heavy weights off the floor, but I can manage if they are conveniently positioned, for example on a table.
- ☐ Pain prevents me from lifting heavy weights, but I can manage light to medium weights if they are conveniently positioned.
- ☐ I can lift very light weights.
- ☐ I cannot lift or carry anything at all.

Section 4- Reading

- ☐ I can read as much as I want to with no pain in my neck.
- ☐ I can read as much as I want with slight pain in my neck.
- ☐ I can read as much as I want with moderate pain.
- ☐ I can't read as much as I want because of moderate pain in my neck.
- ☐ I can hardly read at all because of severe pain in my neck.
- ☐ I cannot read at all.

Section 5- Headaches

- ☐ I have no headaches at all.
- ☐ I have slight headaches which come infrequently.
- ☐ I have slight headaches which come frequently.
- ☐ I have moderate headaches which come infrequently.
- ☐ I have severe headaches which come frequently.
- ☐ I have headaches almost all the time.

Section 6- Concentration

- ☐ I can concentrate fully when I want to with no difficulty
- ☐ I can concentrate fully when I want to with slight difficulty.
- ☐ I have a fair degree of difficulty in concentrating when I want to.
- ☐ I have a lot of difficulty in concentrating when I want to.
- ☐ I have a great deal of difficulty in concentrating when I want to.
- ☐ I cannot concentrate at all.

Section 7- Work

- ☐ I can do as much work as I want to.
- ☐ I can only do my usual work, but no more.
- ☐ I can do most of my usual work, but no more
- ☐ I cannot do my usual work.
- ☐ I can hardly do any work.
- ☐ I can't do any work at all.

Section 8- Driving

- ☐ I drive my car without any neck pain.
- ☐ I can drive my car as long as I want with slight pain in my neck
- ☐ I can drive my car as long as I want with moderate pain in my neck.
- ☐ I can't drive my car as long as I want because of moderate pain in my neck.
- ☐ I can hardly drive my car at all because of severe pain in my neck. I can't drive my car at all.

Section 9- Sleeping

- ☐ I have no trouble sleeping.
- ☐ My sleep is slightly disturbed (less than 1 hr. sleepless).
- ☐ My sleep is moderately disturbed (1 - 2 hrs. sleepless).
- ☐ My sleep is moderately disturbed (2 - 3 hrs. sleepless).
- ☐ My sleep is greatly disturbed (3 - 4 hrs. sleepless).
- ☐ My sleep is completely disturbed (5 - 7 hrs. sleepless).

Section 10- Recreation

- ☐ I am able to engage in all my recreation activities with no neck pain at all.
- ☐ I am able to engage in all my recreation activities, with some pain in my neck.
- ☐ I am able to engage in most, but not all of my usual recreation activities because of pain in my neck.
- ☐ I am able to engage in a few of my usual recreation activities because of pain in my neck.
- ☐ I can hardly do any recreation activities because of pain in my neck.
- ☐ I can't do any recreation activities at all.

Scoring: Questions are scored on a vertical scale of 0-5. Total scores and multiply by 2. Divide by number of sections answered multiplied by 10. A score of 22% or more is considered a significant activities of daily living disability.
(Score:_____x2) / (____Sections x 10) =_____% ADL_____

Comments_____

Reference: Vernon, Mllor. JMPT 1991: 14(7): 409-15

Cove Freedom Chiropractic
211 Liberty Bell Ln., Suite111
Copperas Cove, TX 76522

Name:_____ Date:_____

Low Back Disability Questionaire (Revised OSWESTRY)

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. **Please answer every section and mark in each section only ONE box** which applies to you. We realize you may consider that two of the statements in any one section relate to you, but please just mark the box which **MOST CLOSELY describes your problem**

Section 1- Pain Intensity

- ☐ I can tolerate the pain without having to use painkillers.
- ☐ The pain is bad but I can manage without taking painkillers.
- ☐ Painkillers give complete relief from pain.
- ☐ Painkillers give moderate relief from pain.
- ☐ Painkillers give very little relief from pain.
- ☐ Painkillers have no effect on the pain and I do not use them.

Section 2- Personal Care(washing, dressing, etc.)

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

Section 3- Lifting

- ☐ I can lift heavy weights without extra pain.
- ☐ I can lift heavy weights but it gives extra pain.
- ☐ Pain prevents me from lifting heavy weights off the floor, but I can manage if they are conveniently positioned, for example on a table.
- ☐ Pain prevents me from lifting heavy weights, but I can manage light to medium weights if they are conveniently positioned.
- ☐ I can lift very light weights.
- ☐ I cannot lift or carry anything at all.

Section 4- Walking

- ☐ Pain does not prevent me from walking any distance.
- ☐ Pain prevents me from walking more than one mile.
- ☐ Pain prevents me from walking more than one-half mile.
- ☐ Pain prevents me from walking more than on-quarter mile.
- ☐ I can only walk using a stick or crutches.
- ☐ I am in bed most of the time and have to crawl to the toilet.

Section 5- Sitting

- ☐ I can sit in any chair as long as I like.
- ☐ I can only sit in my favorite chair as long as I like.
- ☐ Pain prevents me from sitting more than one hour.
- ☐ Pain prevents me from sitting more than 30 minutes.
- ☐ Pain prevents me from sitting more than 10 minutes.
- ☐ Pain prevents me from sitting almost all the time.

Section 6- Standing

- ☐ I can stand as long as I want without extra pain.
- ☐ I can stand as long as I want but it gives me extra pain.
- ☐ Pain prevents me from standing more than 1 hour.
- ☐ Pain prevents me from standing more than 30 minutes.
- ☐ Pain prevents me from standing more than 10 minutes.
- ☐ Pain prevents me from standing at all.

Section 7- Sleeping

- ☐ Pain does not prevent me from sleeping well.
- ☐ I can sleep well only by using tablets.
- ☐ Even when I take tablets I have less than 6 hours sleep.
- ☐ Even when I take tablets I have less than 4 hours sleep.
- ☐ Even when I take tablets I have less than 2 hours sleep.
- ☐ Pain prevents me from sleeping at all.

Section 8- Social Life

- ☐ My social life is normal and gives me no extra pain.
- ☐ My social life is normal but increases the degree of pain.
- ☐ Pain has no significant effect on my social life apart from limiting my more energetic interests, e.g. dancing.
- ☐ Pain has restricted my social life and I do not go out as often.
  Pain has restricted my social life to my home.
- ☐ I have no social life because of pain.

Section 9- Traveling

- ☐ I can travel anywhere without extra pain.
- ☐ I can travel anywhere but it gives me extra pain.
- ☐ Pain is bad but I manage journeys over 2 hours.
- ☐ Pain is bad but I manage journeys less than 1 hour.
- ☐ Pain restricts me to short necessary journeys under 30 minutes.
- ☐ Pain prevents me from traveling except to the doctor or hospital.

Section 10- Changing Degree of Pain

- ☐ My pain is rapidly getting better.
- ☐ My pain fluctuates but overall is definitely getting better.
- ☐ My pain seems to be getting better but improvement is slow at the present.
- ☐ My pain is neither getting better nor worse.
- ☐ My pain is gradually worsening.
- ☐ My pain is rapidly worsening.

Comments_____

Scoring: Questions are scored on a vertical scale of 0-5. Total scores and multiply by 2. Divide by number of sections answered multiplied by 10. A score of 22% or more is considered a significant activities of daily living disability.
(Score:_____x2) / (____Sections x 10) =_____% ADL_____

Reference: Fairbank, Physiotherapy 1981;66(8): 271-3, Hudson-Cook. In Rland, Jenner (eds.), Back Pain New Approoaches To Rehabilitation & Education. manchester Univ Pres, manchester 1989: 187-204

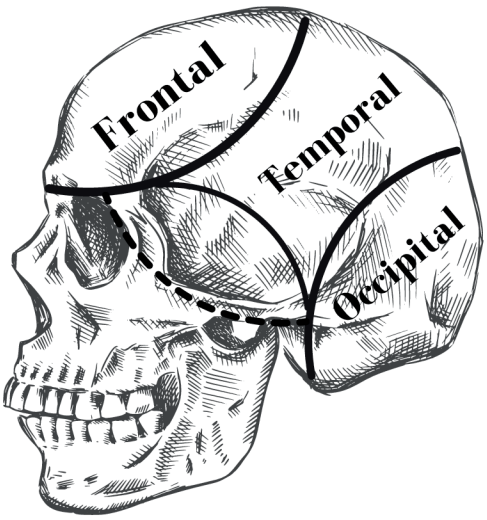
Cove Freedom Chiropractic
211 Liberty Bell Ln., Suite 111
Copperas Cove, TX 76522

Name:_____ Date:_____

Headache Pain and Its Effect on Daily Living

Using the grading scale below, locate and describe your headache pain completely. Place your grades in the boxes on the bottom of the page.(If your headaches are in more than one area grade each separately.)

Site
Indicate where the pain is: If your pain is in the front, is it on the right side, left side or both sides? If your pain is on the side, is it on the right, left or both sides. Grade each headache separately. If it occurs in more than one area (i.e. Front and Back)



Grade your headaches effect due to pain and discomfort.

1. Minimal - The pain is annoying, but it is forgotten during activities of daily living
2. Slight - The pain is tollerated, but it does interfere with some daily activities
3. Moderate - The pain extensively interferes with activities, including sleep. Recreation and socialization are also severely limited.
4. Marked - The pain prevents most activities, including sleep. Recreation and socialization are impossible

Frequency

1. Have Intermittent symptoms occurring up to 25% of my awake time.
2. I experience occasional symptoms between 25% and 50% of the time.
3. Pain is frequent and occurs between 50% and 75% of the time.
4. I have constant pain occurring between 75% and 100% of my awake time.

☐ **Site:** Front of head(Frontal) _____Right _____Left _____Both
Grade: ____1 ____2 ____3 ____4
Frequency: ____1 _____2 ____3 ____4

☐ **Site:** Side of Head(Temporal) _____Right _____Left _____Both
Grade: ____1 ____2 ____3 ____4
Frequency: ____1 _____2 ____3 ____4

☐ **Site:** Back of Head(Occipital) _____Right _____Left _____Both
Grade: ____1 ____2 ____3 ____4
Frequency: ____1 _____2 ____3 ____4

Cove Freedom Chiropractic

211 Liberty Bell Lane, Ste 111 Copperas Cove, TX 76522
Phone: 254-547-6654 Fax: 254-547-6652
John B. Stockton, D.C.

Agreement and Instruction for Direct Payment by Private and Group or Accident and Health Insurance

RE: Patient:_____ Insured:_____
Employer:_____
Group / Claim #:_____
S.S. or ID #:_____

I hereby instruct and direct the _____
Insurance Company to pay by check made out and mailed directly to:

Cove Freedom Chiropractic
211 Liberty Bell Lane Ste 111
Copperas Cove, TX 76522

Or, if my current policy prohibits direct payment to the provider, then I hereby also instruct and direct you to make out the check to me and mail it as follows:

Cove Freedom Chiropractic
211 Liberty Bell Lane Ste 111
Copperas Cove, TX 76522

The medical expenses benefits allowable under my health or PIP policy, and otherwise payable to me under my current insurance policy as payment toward the charges for chiropractic services rendered.

THIS IS A DIRECT ASSIGNMENT OF MY RIGHTS AND BENEFITS UNDER THE POLICY.

This payment will not exceed my indebtedness to the above-mentioned assignee, and I have agreed to pay, in a current manner any balance for chiropractic services charges over and above this insurance payment.

A PHOTOCOPY OF THIS ASSIGNMENT SHALL BE CONSIDERED AS EFFECTIVE AND VALID AS THE ORIGINAL

I authorize the release of any information pertinent to my case to you as the insurance company

Dated this _____ day of _____, 20___
Policyholder_____
Patient Signature_____
Witness_____

ATHORIZATION, ASSIGNMENT AND RELEASE FORM
AUTHORIZATION AND ASSIGNMENT

COVE FREEDOM CHIROPRACTIC 211 Liberty Bell Ln. Suite 111 Copperas Cove, TX. 76522
Ph#(254)547-6654

In consideration of your undertaking to care for me, I agree to the following:

1. You are authorized to release any information you deem appropriate concerning my physical condition to any insurance company, attorney or adjuster in order to process any claim for reimbursement of charges incurred.

2. I authorize the direct payment to you of any sum I now or hereafter owe you by my attorney, out of the proceeds of any settlement of my case, and/or by any insurance company obligated to make payment to me or you based in whole or in part upon the charges made for your services.

3. In the event any insurance company obligated by contractual agreement to make payment to me or to you for the charges made for your services refuses to make such payment upon demand by you, I hereby assign and transfer to you the cause of action that exists in my favor against any such company (the name(s) of which is believed to be correctly set forth under pertinent data) and authorize you to prosecute said action in my name as you see fit and further authorize you to compromise, settle or otherwise resolve said claim as you see fit. However, it is understood that until a reasonable effort has been made to collect the sums due from the insurance company or companies contractually obligated, you will refrain from collection the amounts owed, directly from me. I understand that what ever amounts you do not collect from insurance companies proceeds, whether it be all or part of what is due, I personally owe and agree to pay to you.

4. In addition to the above, I hereby waive the statute of limitations on collection and/or recovery in this state of Texas.

5. I further agree that this Authorization and Assignment is irrevocable and ongoing until all monies owed are paid in full.

6. This Authorization for Assignment will be in continual effect until revoked by both parties.

_____ _____
Date Patient/Insured Signature

RECORDS RELEASE

To Cove Freedom Chiropractic, I hereby authorize you to release to _____ any Information including the diagnosis and records of treatment or examination rendered to me for all care during the period from _____ to _____

_____ _____
Date Patient/insured

_____ _____
Date Staff Signature

RELEASE FROM CARE

I _____ here by understand that Dr. John B. Stockton is releasing me from care, for my accident dated _____, and that I have reached a pre accident status or maximum medical improvement. I further understand that all expenses incurred from this accident are my responsibility or the insurance company's and that all expenses incurred after the date below will be my personal responsibility. I will make financial arrangements for payment directly.

_____ _____ _____
Date Patient Signature Staff Signature

APPLICATION FOR BENEFITS — AUTOMOBILE PERSONAL INJURY PROTECTION

NAME AND ADDRESS OF IMPAIRED INSURER				
DATE	NAME OF POLICY HOLDER	POLICY NUMBER	DATE OF ACCIDENT	FILE NUMBER

TO ENABLE US TO DETERMINE IF YOU ARE ENTITLED TO BENEFITS UNDER A TEXAS AUTOMOBILE PERSONAL INJURY PROTECTION POLICY, PLEASE COMPLETE THIS FORM AND RETURN IT PROMPTLY

TO:

YOUR NAME	LENGTH OF TIME IN STATE	PHONE NO.	HOME	BUSINESS
YOUR ADDRESS (NO., STREET, CITY OR TOWN, STATE AND ZIP CODE)			DATE OF BIRTH	SOCIAL SECURITY NO.
DATE AND TIME OF ACCIDENT	A.M. P.M.	PLACE OF ACCIDENT (STREET, CITY OR TOWN AND STATE)		
BRIEF DESCRIPTION OF ACCIDENT AND AUTOMOBILE YOU OCCUPIED, OR WERE STRUCK BY				
OTHER AUTOMOBILES IN YOUR FAMILY	AUTO: 1 2 3	OWNER: 1 2 3	INSURER: 1 2 3	
ARE YOU A MEMBER OF THE POLICY HOLDER'S HOUSEHOLD? ☐ YES ☐ NO				
AS A RESULT OF THIS ACCIDENT WERE YOU INJURED? ☐ YES ☐ NO IF YOUR ANSWER IS YES, COMPLETE THE REST OF THIS FORM. IF NO, SIGN HERE AND RETURN THIS FORM TO US.				
SIGNATURE	DATE			
DESCRIBE YOUR INJURY				
WERE UPI TREATED BY A DOCTOR? ☐ YES ☐ NO	DATE OF 1ST TREATMENT	DOCTOR'S NAME AND ADDRESS		
IF YOU WERE TREATED IN A HOSPITAL, WERE YOU ☐ AN IN-PATIENT ☐ AN OUT-PATIENT		HOSPITAL'S NAME AND ADDRESS		
AMOUNT OF MEDICAL BILLS TO DATE $	WILL YOU HAVE MORE MED. EXPENSES? ☐ YES ☐ NO	AT THE TIME OF THIS ACCIDENT WERE YOU WORKING FOR YOUR EMPLOYER? ☐ YES ☐ NO		
DID YOU LOSE TIME FROM WORK AS A RESULT OF YOUR INJURY$ ☐ YES ☐ NO	IF YES, AMOUNT LOST TO DATE $	WHAT IS YOU AVERAGE WEEKLY WAGE OR SALARY $		
HAVE YOU RECEIVED OR ARE YOU ELIGIBLE FOR WAGE LOSS AND/OR MEDICAL BENEFITS UNDER (1) WORKER'S COMPENSATION LAW? ☐ YES ☐ NO (2) ANY OTHER SOURCE? ☐ YES ☐ NO (name)		IF YES, AMOUNT OF MEDICAL & WAGE ☐ PER WEEK ☐ PER MO. $		

LIST NAMES AND ADDRESSES OF YOUR EMPLOYERS AT THE DATE OF THE ACCIDENT OR LAST PREVIOUS EMPLOYER AND GIVE OCCUPATION AND DATES OF EMPLOYMENT.

EMPLOYER AND ADDRESS	OCCUPATION	FROM	TO

AS A RESULT OF YOUR INJURY HAVE YOU HAD ANY OTHER EXPENSES? ☐ YES ☐ NO IF YES, EXPLAIN ON REVERSE SIDE.

SIGNATURE DATE

IMPORTANT:
1. TO PRESENT YOUR CLAIM FOR BENEFITS YOU MUST COMPLETE AND SIGN THIS APPLICATION.
2. YOU MUST ALSO SIGN ANY ATTACHED AUTHORIZATION(S).
3. RETURN PROMPTLY WITH ANY MEDICAL BILLS YOU HAVE RECEIVED TO DATE.

Cove Freedom Chiropractic
211 Liberty Bell Ln. · Suite 111 · Copperas Cove, TX 76522 · (254) 547-6654

Waiting for Settlement

As a service to you, the Cove Freedom Chiropractic Clinic will wait a reasonable amount of time for payment. Up to three months after you are released or having reached maximum improvement.
Note: Your attorney can start working on resolution once we report either of the above.

If no resolution is in sight after three months, you will be expected to take care of your balance. We suggest staying in contact with your attorney regularly at that point to insure prompt resolution.

We are one of the few clinics that offer a grace period for payment. It will only be allowed with the following provisions:

1. You do not miss any of the scheduled appointments – the party being asked to pay the bill will question your injuries because of non-compliance.
2. You jeopardize your health as well as your case if you do not keep your scheduled appointments. Because you are responsible for your bill a non-compliant schedule makes your account due and payable immediately.
3. Discontinuance of your care with our office results in your account balance being due and payable immediately in full. We will not wait for settlement.

I have read the above and agree to comply with my treatment schedule and the provisions stated. I understand that the Cove Freedom Chiropractic Clinic has agreed to allow me to charge my account as long as I follow the above provisions.

X_____ X_____
PATIENT SIGNATURE DATE

X_____ X_____
CLINIC REPRESENTATIVES SIGNATURE DATE

Cove Freedom Chiropractic

211 Liberty Bell Lane, Suite 111
Copperas Cove, Tx 76522

Clinic Policies

The following is an explanation of our clinic policies. We believe that a clear definition will allow us all to concentrate on the most important issue. Regaining and maintaining your health.

No Charge Consultation
Cove Freedom Chiropractic Clinic will do a special "no charge" consultation, or brief conference, with anyone interested in finding out if chiropractic can help them with their individual health problems. There is no charge or obligation in connection with this appointment.

New Patient Care Services
We require the payment in full on the first visit unless prior arrangements are made. Then the balance of these charges may be made in payments over the course of your treatment schedule. Properly documented auto accident claims are not required to pay at this time if appropriate forms and liens are signed.

Established Patient Care
Patients under care are required to make regular payments on all unpaid balances except for properly documented auto injury claims. Payments need to be made according to prior arrangements. We reserve the right to charge finance charges and late fees to any account that is not paid in a timely manner.

Appointments
In order to better serve our patients, we ask that you call if you need to reschedule your appointment or if you will be late. Your appointment time is reserved for you. If you fail to notify our office, it leaves a time slot open that could have been used to help someone else. Please help us help others.

Questions and Answers
Your questions about any aspect of your care and account are invited. Please feel free to ask your doctors or staff members. We will make every effort to answer your inquiries.

Payments
Payments for office visits are due the same day as your office visits unless other documented arrangements have been made, such as our Cove Freedom Finance plan, Special Consideration payment Plan, or our Cove Freedom Membership plan.

I have read the Cove Freedom Chiropractic Clinic Policies and will honor them.

Patient's Signature_____ **Date**_____/_____/_____