



PLEASE READ BEFORE FILLING OUT YOUR PATIENT PAPERWORK:

It is very important that all your forms are dated ***the day of your original examination*** with us. This is for insurance and documentation purposes. Please ***do not date any of your forms*** until actually coming into the office, and then the receptionist will stamp all of your forms with a date stamp. Thank you in advance for your help with this matter.

- The Staff at LifeSource Health & Wellness



Welcome.....

On behalf of the doctors and staff at LifeSource Health & Wellness (LSHW), we would like to say thank you for choosing us to evaluate and/or care for your health concerns. We wish to make your experience here as pleasant as possible. We certainly understand how frustrating pain and other symptoms may be, as well as dealing with the struggles of paperwork, insurance companies and attorneys, so we will do our best to guide you through what can often be a difficult and stressful time. We have treated thousands of patients over the years and have become very proficient in handling injuries, paperwork, insurance companies, and any other challenges that may arise. Our staff updates their training weekly on how to best deal with any situation that may manifest, and if you ever have a concern, please do not hesitate to inform us.

We ask that at this time you turn off all cell phones and electronic devices in order to not interfere with other patients. In the event that you must take a call, we regret that we may have to reschedule your appointment in order to not effect other patient's appointment times. Thank you for your kindness and consideration.

The forms that will follow in your packet must be filled out completely. Some questions may be repeated, we apologize, but this is for your benefit as it is requested by the insurance companies and/or state laws. We do need all information filled out completely before we can begin the consultation, so we have allotted additional time during your appointment for you to answer all questions thoroughly and we will start your evaluation as soon as possible after you complete this paperwork.

If you have any questions about your insurance policy or about medical or legal referrals, please direct them to one of the doctors on staff. If they are not present, a staff member can write down your question and he/she should be able to get back to you within 48 hours. If you need a referral to another physician, or require additional testing or MRI's, and/or are already planning to participate in any of these, please notify Dr. Berns or the examining doctor before proceeding.

Additionally, we are not able to offer legal advice, but if you are in need of help in that area, please let your doctor know and they will direct you accordingly.

Again, thank you for choosing LifeSource Health & Wellness. We feel confident we can help you to achieve your health goals in a timely manner and we look forward to serving you.

Sincerely,

The Doctors &
Staff of LifeSource



1722 Bruce B. Downs. Blvd
 Wesley Chapel, FL 33544
 PH: (813) 929-3700
 FAX: (813) 929-3711

AUTO/WORK RELATED INJURY NEW PATIENT QUESTIONNAIRE

Date of Birth _____ Age: _____ S.S. # _____
 Last Name _____ First Name _____
 Address _____ Apt # _____
 City _____ State _____ Zip Code _____
 Phone (H) _____ (W) _____ (C) _____ E-mail _____
 Contact in case of an emergency _____ Phone # _____ Relationship _____
 Your Occupation _____ Employer _____
 FEMALES: Are you pregnant? ___ No ___ Yes If yes, How many weeks? ___ Date of last menstrual cycle? _____

If patient is a minor (under 18 y/o), please fill out this section. If not, skip this box.
 Parent/Guardian's Name _____ Relationship _____ DOB: _____ Age _____
 Address _____ Apt # _____
 City _____ State _____ Zip Code _____
 Phone (H) _____ (W) _____ (C) _____ E-mail _____
 Occupation _____ Employer _____

WHAT BRINGS YOU TO THIS OFFICE?

FIRST COMPLAINT

- ▶ Date when symptoms first appeared: _____ ▶ Have you had this condition before? Y N
- ▶ Is this condition related to : Work Auto Date of accident: _____ Have you lost days from work? Y N
- ▶ Did it begin Gradual Y N Sudden Y N How many days? _____
- ▶ What makes the symptom increase ? _____
- ▶ What relieves the symptoms? _____
- ▶ Type of pain ___ Sharp ___ Dull ___ Aching ___ Burning ___ Throbbing
- ▶ Does the pain radiate into your L R Shoulder-Arm-Hand L R Buttox-Leg-Foot ___ Does not radiate
- ▶ Do you experience numbness and tingling? Y N How often do you get pain? 100% 75% 50% 10%

Place an "X" on the drawing on areas causing you pain and a letter describing it

S = STABBING
N = NUMBNESS
B = BURNING
A = ACHING
P = PINS & NEEDLES

PAIN INTENSITY
 Please circle the number that best describes your pain
0 1 2 3 4 5 6 7 8 9 10
 NONE LITTLE MEDIUM SEVERE

Patient Signature _____

OTHER COMPLAINT

- ▶ Date when symptoms first appeared: _____ ▶ Have you had this condition before? Y N
- ▶ Did it begin Gradual Y N Sudden Y N How many days? _____
- ▶ What makes the symptom increase? _____
- ▶ What relieves the symptoms? _____
- ▶ Type of pain ___ Sharp ___ Dull ___ Aching ___ Burning ___ Throbbing
- ▶ Does the pain radiate into your L R Shoulder-Arm-Hand L R Buttox-Leg-Foot ___ Does not radiate
- ▶ Do you experience numbness and tingling? Y N How often do you get pain? 100% 75% 50% 10%

PAIN INTENSITY

Please describe the number that best describes your pain.

0 1 2 3 4 5 6 7 8 9 10
 NONE LITTLE MEDIUM SEVERE

If you have additional complaints to address with the doctor, please let the front desk know. They will give you an additional form.

PREVIOUS ACCIDENT HISTORY

Have you ever been involved in another motor vehicle accident?

Yes No Please describe briefly with dates: _____

PRESENT ACCIDENT HISTORY

Date of accident: _____

Street and Address: _____

Were any tickets issued and to whom? _____

Please indicate if you were the/at: Driver Front seat Back seat L or R Other _____

Did the impact to your vehicle come from the: Front Rear

Right Side Left side Did the air bag deploy? Yes No

Did you hit anything inside the vehicle? No Yes

If yes, describe: _____

Did you experience immediate pain? No Yes

Did the ambulance/paramedics arrive at the scene? Yes No

Were you taken to the hospital? No Yes Did you drive to the hospital? No Yes

If yes, which hospital? _____

Were x-rays taken? No Yes Did they prescribe any medication? No Yes Are you currently taking other medication? No Yes

If yes, please name: _____

Please briefly describe the accident in your own words:

SOCIAL HISTORY▶ Do you drink alcohol? No Yes

If yes how much? _____

▶ Do you use tobacco (smoke or chew)?

No Yes How much? _____

▶ Do you use any other drugs?

No Yes If yes, how much

and which ones? _____

Please if you have experienced any of the following since this accidentNausea Neck Pain Vomiting Mid-Back Pain Ringing in ears Low-Back Pain Headaches Dizziness Changes in vision Brain Fog Difficulty swallowing Numbness Difficulty talking Tingling Difficulty with balance Other Hand/Arm/Shoulder Pain Buttox/Leg/Foot Pain Bowel/Bladder difficulty **Doctor's Name:** _____**Signature:** _____**Date:** _____



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PATIENT HISTORY

Please list all previous treatments for this condition:

Name of treating physician _____ Dates of treatment _____
 Type of treatment or drugs prescribed _____

Name of treating physician _____ Dates of treatment _____
 Type of treatment or drugs prescribed _____

Please list all past surgeries:

Type _____	When _____
Type _____	When _____
Type _____	When _____
Type _____	When _____

- | | |
|---|---|
| ▶ Have you ever suffered a stroke? Y N | ▶ Anyone in your family had a stroke? Who/Age _____ |
| ▶ Have you ever had a heart attack? Y N | ▶ Anyone in your family had a heart attack? Who/Age _____ |
| ▶ Do you have vascular disease? Y N | ▶ Anyone in your family have vascular disease Who/Age _____ |
| ▶ Do you have high blood pressure? Y N | ▶ Anyone in your family have high blood pressure? Who/Age _____ |
| ▶ Do you smoke? Y N How much? _____ | ▶ Have you ever smoked in the past? Y N How much? _____ |
| ▶ Do you take birth control pills? Y N | ▶ Have you ever taken birth control pills? Y N |

Barre Leiou + -

George's Test + -

Please list any medications or vitamins you are currently taking:

- | | |
|--|---------------------------------------|
| ▶ When was your last Visit to the chiropractor? _____ | ▶ Were you helped? Y N |
| ▶ What spinal correction program were you given? _____ | |
| ▶ Did you follow it? _____ | ▶ How did the post x-rays look? _____ |

Please mark X for present conditions, O for past conditions

- | | | | |
|-------------------------------|---------------------------------|--|-----------------------------|
| _____ Fractured bones | _____ Sinus Problems | _____ Fainting | _____ Varicose Veins |
| _____ Auto Accidents | _____ Eating Disorders | _____ Loss of Balance | _____ Liver Trouble |
| _____ 0-1 year ago | _____ Trouble Sleeping | _____ Blurred vision R L | _____ Gall Bladder Trouble |
| _____ 1-5 years ago | _____ Trouble Concentrating | _____ Double Vision R L | _____ Digestive Problems |
| _____ more that 5 years ago | _____ Learning Disability | _____ Upper Back Pain/Stiffness | _____ Heartburn |
| _____ Other accidents/ Falls | _____ Mood changes | _____ Mid back Pain/Stiffness | _____ Ulcers |
| _____ Back curvature | _____ Headache | _____ Low BackPain/Stiffness | _____ Diarrhea/Constipation |
| _____ Arthritis | _____ Pain/Stiff Neck R L | _____ Numbness, Tingling or Pain | _____ Colon Trouble |
| _____ Diabetes | _____ Numbness/Tingling/Pain | _____ in buttocks, thighs, legs, feet, toes. | _____ Hemorrhoids |
| _____ Swollen/Painfull joints | _____ Arms/Hands/Fingers | _____ Pain with cough/sneeze | _____ Prostate Problems |
| _____ Convulsions/Epilepsy | _____ R L | _____ Hip Pain R L | _____ Impotence |
| _____ Skin Problems | _____ Jaw Pain/ TMJ R L | _____ Foot Trouble R L | _____ Kidney Trouble |
| _____ Cancer | _____ Head/Shoulders Feel Tired | _____ Chest Pain | _____ Menstrual Problems |
| _____ Frequent Colds/Flu | _____ Difficulty in Excessive | _____ Asthma | _____ Menopausal Problems |
| _____ Depressed | _____ Standing Lifting | _____ Lung Problems | _____ Pregnant (Now) |
| _____ Irritable | _____ Walking Household duties | _____ Difficulty breathing | _____ Bed Wetting |
| _____ Anemia | _____ Bending Twisting | _____ Heart Problem | _____ Ear Infection |
| _____ Tremors | _____ Riding | _____ Stroke | _____ AIDS/HIV |
| _____ Allergies | _____ Shoulder Pain R L | _____ High/Low Blood Pressure | _____ Last Menstrual Period |



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REVIEW OF SYSTEMS

This information may be addressed on other forms in addition to this one. This is for insurance purposes. Please fill it out completely.

PATIENT'S NAME: _____

DATE: _____

PLEASE CHECK ANY OF THE FOLLOWING THAT APPLY TO YOU:

GENERAL INFORMATION:		
Any recent weight gain/loss	Y	N
Weakness	Y	N
Fatigue	Y	N
Fever	Y	N
Fainting spells	Y	N
Nausea	Y	N
Vomiting	Y	N
Balance problems	Y	N
Jaw pain	Y	N
Neck Pain	Y	N
Neck Stiffness	Y	N
Shoulder Pain	Y	N
Arm Pain	Y	N
Wrist /Hand Pain	Y	N
Numbness arms or hand	Y	N
Upper back pain	Y	N
Lower back pain	Y	N
Hip pain	Y	N
Leg Pain	Y	N
Ankle /Foot Pain	Y	N
Numbness Legs or Feet	Y	N
Joint swelling	Y	N
Tension	Y	N
Nervousness	Y	N
Anxiety	Y	N
Irritability	Y	N
Sleeping Problems/Insomnia	Y	N
Depression	Y	N
Liver problems	Y	N
Cancer (if yes indicate what type)		
Metal implants	Y	N
If yes Indicate where: _____		

HEAD	
Headaches	Y N
Loss of consciousness	Y N
Dizziness	Y N
Memory problems	Y N
Seizures/Convulsions	Y N

EYES	
Wear Glasses/Contact Lenses	Y N
Double vision	Y N
Blurred Vision	Y N
Eyes sensitive to light	Y N

EARS	
Loss of hearing	Y N
Ringing/Buzzing in ears	Y N
Ear infections	Y N
Vertigo (Dizziness)	Y N
Any discharge from ears	Y N

NOSE	
Sinus Problems	Y N
Epitaxis (Nosebleeds)	Y N
Loss of smell	Y N
Any discharge form nose	Y N

MOUTH/THROAT	
Tooth Pain	Y N
Any Lesion/Sores in mouth or lips or gums	Y N
Frequent sore throats	Y N
Difficulty swallowing	Y N
Thyroid problems	Y N

RESPIRATORY (LUNG)	
Difficulty Breathing	Y N
Chronic Cough	Y N
Asthma	Y N
Bronchitis	Y N
Emphysema	Y N
Tuberculosis	Y N
Pneumonia	Y N

Date of last chest x-ray	

CARDIOVASCULAR(HEART)	
Chest Pain	Y N
Difficulty Breathing	Y N
(Shortness of Breath)	Y N
Palpitations	Y N
Night sweats	Y N
Cold extremities	Y N
High blood Pressure	Y N
Low Blood Pressure	Y N
Heart Murmur	Y N
Ever had an EKG/ECG	Y N

GI (Gastrointestinal)	
Upset stomach	Y N
Loss of appetite	Y N
Indigestion	Y N
Constipation	Y N
Diarrhea	Y N
Blood Stool	Y N
Abdominal Pain	Y N
Excessive Gas	Y N
Loss of bowel control	Y N

ENDOCRINE	
Cold or Heat intolerance	Y N
Excessive sweating	Y N
Excessive thirst or hunger	Y N
Diabetes (If yes indicate	Y N
If Insulin dependent)	

Thyroid problems	Y N
Kidney Problems	Y N

GU(GENITOURINARY)	
FEMALES	
History of Pelvic Inflammatory Disease	Y N
Urinary Tract Infections	Y N
Breast Cancer &/or Benign Tumors	Y N
Blood in Urine	Y N
Painful urination	Y N
Vaginal discharge	Y N
PMS	Y N
Loss of Bladder Control	Y N
Currently pregnant	Y N
Use Birth Control Pills	Y N
Date of last menstrual period	_____
If indicated age of menopause	_____
Last Pelvic Exam (Date and Results)	_____
Last Pap Smear (Date and Results)	_____
Last Breast Exam (Date and Results)	_____
Any Sexual transmitted disease (STDs)	Y N
MALES	
Prostate Problems	Y N
Hernias	Y N
Penile Discharge	Y N
Blood in urine	Y N
Frequent urination	Y N
Testicular pain	Y N
Loss of bladder control	Y N
Last Prostate Exam (Date and Results)	_____
Last PSA Date and Results	_____
Any Sexual transmitted disease (STDs)	Y N

PATIENT SIGNATURE :
 X _____

DATE:
 X _____



LIFESOURCE
HEALTH & WELLNESS

OFFICE POLICIES

1. It is our office policy that any patient and /or insurance company that pays up-front or in advance is entitled to an administrative discount.
2. The fee paid for treatment x-rays is for analysis only. The film itself is the property of this office. Once films are taken, they cannot be released, but may be copied. There may be a fee for copying of the x-rays.
3. If you have any out of pocket responsibility what will be your method of payment?

Cash Check Credit Card/Debit Card Attorney /Letter of Protection.

I understand and agree that health and accident insurance policies are an agreement between the insurance carrier and my self. Furthermore, I understand LifeSource Health & Wellness will prepare any necessary reports, and forms to assist in making collections from my insurance company and that any amount authorized to be paid directly to LifeSource Health & Wellness will be credited to my account upon receipt. *However*, I clearly understand and agree that all services rendered to me, are charged directly to me and that I am personally responsible for payment.

I also understand that if I suspend or terminate my care at this office, any outstanding charges for professional services rendered to me will be immediately due and payable. I agree that I will be responsible for all attorney and legal fees if legal action becomes necessary to collect this amount.

Print Patient Name: _____ Date: _____

Patient Signature (or Guardian authorizing care): _____ Date: _____

In case of emergency notify: _____ Relationship: _____

Address: _____ City: _____

State: _____ Phone Number: _____



Jonathan Berns, D.C.
Justin Scott, D.C.

LIFESOURCE
HEALTH & WELLNESS

Erica Berns, D.C.
Melissa Kolenda, D.C.

“New Tampa’s Source for Maximizing Living”

TERMS OF ACCEPTANCE AND CONSENT FOR CARE
THIS DOCUMENT CONSTITUTES INFORMED CONSENT FOR
CHIROPRACTIC CARE

Our office has one goal, to aid the patient in achieving optimal health as quickly and safely as possible, through the removal of interference in their body. We do this through safe and gentle chiropractic care.

We will attempt to identify and diagnose any ailments you may have that may be corrected through chiropractic care, massage therapy and/or active/passive rehabilitation. If any condition or disease appears to be present out of our scope of practice, we will refer you to an appropriate physician to diagnose and/or treat that condition.

Our primary focus is the detection and correction of vertebral subluxation. This is the misalignment of one spinal bone or multiple bones with interference to the nervous system. Any interference to the nervous system may or may not cause various different symptoms. Again, our focus is to correct the cause, not the symptom.

Vertebral subluxations come on from physical, chemical, and/or emotional stress or trauma. Through specific chiropractic adjustments, we reduce and/or correct these subluxations. It is also important to note that the sooner we are able to treat your subluxations and the degenerative processes that are involved the faster and more completely your body will heal. It may be necessary to examine an individual each time a new injury occurs and often x-rays are necessary to maintain the utmost safety when dealing with your body. The risks of chiropractic care or massage therapy are minimal when dealing with a licensed professional; however, if you have concerns about these risks, please discuss them with the doctor prior to the examination.

I have read and I accept the terms above and understand them fully. I hereby give consent to the LIFESOURCE HEALTH & WELLNESS to evaluate me to determine my condition and treat me for such conditions. I also understand that I may at anytime discontinue with the exam and/or x-rays or any treatment if I so choose.

I, _____ have read and fully understand the above statements.
(PRINT NAME)

(SIGNATURE)

(DATE)

Complete if patient is a minor child. _____
(PRINT CHILD’S NAME)

I, _____ being the parent or legal guardian of the aforementioned child, have read and fully understand the above terms of acceptance and hereby grant permission for my child to receive treatment.

(SIGNATURE)

(DATE)

Dr. Jonathan Berns
Dr. Justin Scott



Dr. Erica Berns
Dr. Melissa Kolenda

**PATIENT CONSENT FOR USE AND DISCLOSURE OF PROTECTED
HEALTH INFORMATION**

I hereby give my consent for LifeSource Health & Wellness (hereinafter referred to as the “Practice”) to use and disclose protected health information (PHI) about me to carry out treatment, payment and healthcare operations (TPO). The Practice’s Notice of Privacy Practices provides a more complete description of such uses and disclosures.

I have the right to review the Notice of Privacy prior to signing this consent. The practice reserves the right to revise its Notice of Privacy Practice any time. A revised Notice of Privacy Practices may be obtained by forwarding a written request to:

**Dr. Jonathan Berns, our Privacy Officer, at the following address:
1722 Bruce B. Downs Blvd., Wesley Chapel, FL 33544**

With this consent, the practice may call my home or other alternative location and leave a message on voice mail or in person in reference to any items that assist the practice in carrying out TPO, such as appointment reminders, insurance items and calls pertaining to my clinical care.

With this consent, the Practice may mail to my home or other alternative location any items that assists the practice in carrying out TPO, such as appointment reminder cards and patient statements as long as they are marked “Personal and Confidential”.

With this consent, The Practice may e-mail to my home or other alternative location any items that assist the practice in carrying out TPO, such as appointment reminder cards and patient statements. I have the right to request that the Practice restrict how it uses or discloses my PHI to carryout TPO, however; the practice is not required to agree to my requested restrictions. If The Practice does agree to my requested restrictions, it is bound by this agreement.

By signing this form, I am consenting to The Practice’s use and disclosure of my PHI to carry out TPO. In addition, I allow LifeSource Health & Wellness to contact me by any of my phone numbers, postal mail or email and leave me a message if necessary.

I may revoke my consent in writing except to the extent that the Practice has already made disclosures in reliance upon my prior consent.

If I do not sign this consent, or later revoke it, The Practice may decline to provide treatment to me.

Patient’s Name

Signature of Patient or Legal Guardian

Print Name of Legal Guardian (if patient is a minor)

Date

The Neck Disability Index

Patient name: _____ File# _____ 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 everyday life. Please answer every section and mark in each section only the ONE box that applies to you. We realize that you may consider that two of the statements in any one section relate to you, but please just mark the box that most closely describes your problem.

SECTION 1-PAIN INTENSITY

- 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 off the floor, 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 to, with slight pain in my neck.
- I can read as much as I want to, with moderate pain in my neck.
- 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 that come infrequently.
- I have moderate headaches that come infrequently.
- I have moderate headaches that come frequently.
- I have severe headaches that come frequently.
- I have headaches almost all the time.

Instructions:

1. The NDI is scored in the same way as the Oswestry Disability Index.

2. Using this system, a score of 10-28% (i.e., 5-14 points) is considered by the authors to constitute mild disability; 30-48% is moderate; 50-68% is severe; 72% or more is complete.

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 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 at all.
- I can't do any work at all.

SECTION 8-DRIVING

- I can 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 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 mildly disturbed (1-2 hrs sleepless).
- My sleep is moderately disturbed (2-3 hrs sleepless).
- My sleep is greatly disturbed (3-5 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 neck pain at all.
- 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 few of my 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.

Oswestry Disability Questionnaire

This questionnaire has been designed to give us information as to how your back or leg pain is affecting your ability to manage in everyday life. Please answer by checking **one box in each section** for the statement which best applies to you. We realise you may consider that two or more statements in any one section apply but please just shade out the spot that indicates the statement **which most clearly 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 (eg. washing, dressing)

- 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 can manage most of my personal care
- I need help every day in most aspects of self-care
- I do not get dressed, 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 me extra pain
- Pain prevents me lifting heavy weights off the floor but I can manage if they are conveniently placed eg. on a table
- Pain prevents me lifting heavy weights but I can manage light to medium weights if they are conveniently positioned
- I can only lift very light weights
- I cannot lift or carry anything

Section 4: Walking*

- Pain does not prevent me walking any distance
- Pain prevents me from walking more than 2 kilometres
- Pain prevents me from walking more than 1 kilometre
- Pain prevents me from walking more than 500 metres
- I can only walk using a stick or crutches
- I am in bed most of the time

Section 5: Sitting

- I can sit in any chair as long as I like
- I can only sit in my favourite chair as long as I like
- Pain prevents me 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 at all

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 for more than 1 hour
- Pain prevents me from standing for more than 30 minutes
- Pain prevents me from standing for more than 10 minutes
- Pain prevents me from standing at all

Section 7: Sleeping

- My sleep is never disturbed by pain
- My sleep is occasionally disturbed by pain
- Because of pain I have less than 6 hours sleep
- Because of pain I have less than 4 hours sleep
- Because of pain I have less than 2 hours sleep
- Pain prevents me from sleeping at all

Section 8: Sex Life (if applicable)

- My sex life is normal and causes no extra pain
- My sex life is normal but causes some extra pain
- My sex life is nearly normal but is very painful
- My sex life is severely restricted by pain
- My sex life is nearly absent because of pain
- Pain prevents any sex life at all

Section 9: 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. sport
- 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 10: Travelling

- I can travel anywhere without pain
- I can travel anywhere but it gives me extra pain
- Pain is bad but I manage journeys over two hours
- Pain restricts me to journeys of less than one hour
- Pain restricts me to short necessary journeys under 30 minutes
- Pain prevents me from travelling except to receive treatment



Pain Disability Index

Name: _____ Date: _____

Pain disability index: The rating scales below are designed to measure the degree to which aspects of your life are disrupted by chronic pain. In other words, we would like to know how much your pain is preventing you from doing what you would normally do or from doing it as well as you normally would. Respond to each category by indicating the overall impact of pain in your life, not just when the pain is at its worst.

For each of the 7 categories of life activity listed, please circle the number on the scale that describes the level of disability you typically experience. A score of 0 means no disability at all, and a score of 10 signifies that all of the activities in which you would normally be involved have been totally disrupted or prevented by your pain.

Family/Home responsibilities: This category refers to activities of the home or family. It includes chores/duties performed around the house (eg, yard work) and errands or favors for other family member (eg, driving the children to school).

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

Recreation: This category includes hobbies, sports, and other similar leisure time activities.

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

Social activity: This category refers to activities that involve participation with friends and acquaintances other than family members. It includes parties, theatre, concerts, dining out, and other social functions.

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

Occupation: This category refers to activities that are a part of or directly related to one's job. This includes nonpaying jobs as well, such as that of a housewife or volunteer worker.

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

Sexual behavior: This category refers to the frequency and quality of one's sex life.

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

Self Care: This category includes activities, which involve personal maintenance and independent daily living (eg, taking a shower, driving, getting dressed, etc.)

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

Life-support activity: This category refers to basic life-supporting behaviors such as eating, sleeping, and breathing.

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



LIFESOURCE
HEALTH & WELLNESS

SIGNATURE ON FILE

Please initial by each:

_____ **I authorize use of this form on all my insurance submissions**

_____ **I authorize release of information to all my Insurance Companies**

_____ **I understand that I am responsible for my bill**

_____ **I authorize my doctor to act as my agent in helping me obtain payment from my insurance companies**

_____ **I authorize payment directly to my doctor**

_____ **I permit a copy of this authorization to be used in place of the original**

(NAME)

(S.S.#)

(SIGNATURE)

(DATE)



LIFESOURCE
HEALTH & WELLNESS

To: _____

Phone: _____
Fax: _____

Patient: _____

RE: HEALTH RECORDS AND PROVIDER'S LIEN

I do hereby authorize the above provider, LifeSource Family Chiropractic, to furnish you, my attorney, with a full report of this examination, diagnosis, treatment, prognosis, etc., of myself in regard to the injury in which I was involved.

I hereby authorize and direct you, my attorney, to pay directly to LifeSource Family Chiropractic such sums as may be due and owing them for medical service rendered me both by reason of this injury and by reason of any other bills that are due their office and withhold sums from any settlement, judgment or verdict as may necessary to adequately protect said provider. And I hereby further give a lien on my case to said company against any and all proceeds of any settlement, judgment or verdict which may be paid to me as a result of the injuries for which I have been treated or injuries in connection herewith.

I full understand that I am directly and fully responsible to said provider for all medical bills submitted by them for services rendered me and that this agreement is made solely for said provider's additional protection and in consideration of their awaiting payment. And I further understand that such payment is not contingent on any settlement, judgment or verdict by which I may eventually recover said fee.

I forbid you, my attorney, from paying my provider any sums less that the full amounts owed to said provider, without its written consent.

Date: _____ Patient Signature: _____

The undersigned being attorney of record for this above patient does hereby agree to observe all of the terms of the above and agrees to withhold such sums from any settlement, judgment or verdict as may necessary to adequately protect said providers above named.

Date: _____ Attorney Signature: _____

Please date, sign and return one copy to Provider's office. Keep a copy for your records. A photocopy of this form shall be considered as valid as the original.