Lemire Chiropractic
Spine & Sport Inc

2354 Maritime drive, Suite 100 Elk Grove, CA 95758
ph: 916.683.3900 fx: 916.683.3339

ACCIDENT QUESTIONNAIRE FORM

Date: _____

Name: _____ Birth date ___/___/___ Age ____ ☐ Male ☐ Female

Address: _____ City: _____ Zip: _____

Social Security # _____ Phone: _____ Cell: _____ Email_____

Employer: _____ Work # _____

Details of Accident

Please explain in detail how the accident occurred: _____

_____

_____

_____

List extent of injuries as you know them _____

_____

Did you require post- accident hospitalization? ☐ Yes ☐ No

Did you lose consciousness? ☐ Yes ☐ No If yes for how long? _____

Were the police on the scene? ☐ Yes ☐ No Report Filed ☐ Yes ☐ No Police Report # _____

Ambulance on the scene? ☐ Yes ☐ No

Did your body strike a object? ☐ Yes ☐ No if Yes, (What/Where _____)

Were you wearing a hat or glasses? ☐ Yes ☐ No Were they still on after the accident? ☐ Yes ☐ No

Symptoms after the accident?

☐ Headache
☐ Dizziness
☐ Nausea
☐ Confusion/disorientation
☐ Neck Pain
☐ Upper back pain
☐ Lower back pain
☐ Arm pain/numbness
☐ Wrist pain/numbness
☐ Leg pain/numbness
☐ Knee pain/contusion
☐ Other: _____

When did the symptoms first appear?

☐ Immediately, ☐ ___ hours later, ☐ next day, ☐ ___ days later

Where did you go after the accident? ☐ ER (How? ☐ Ambulance, ☐ Drove self, ☐ Driven by another)

☐ Home ☐ Work ☐ Doctor

Emergency room: ☐N/A ☐ X-rays _____ ☐ Medication ☐ Other _____

Other doctors you have seen since this accident:

1. Name _____ Specialty _____
2. Name _____ Specialty _____
3. Name _____ Specialty _____

Treatment received: _____

Have you had similar physical complaints? ☐ Yes ☐ No (if yes, when _____

_____

Prior treatment history: Have you been in any other accidents? ☐ Yes ☐ No (if yes, please list all dates, areas injured, type of treatment received and the name of the treating health care professional.

_____

_____

I certify that the above information is true to the best of my knowledge. I authorize the release of any information necessary to process my claim for this accident. A copy of this authorization shall be as valid as the original.

Patient's Signature _____ Date: _____

Lemire Chiropractic
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2354 Maritime Drive, Suite 100Elk Grove, CA 95758
Phone: (916)683-3900 • Fax: (916) 683-3339

Brett J. Lemire, D.C.,CSCS
Nancy Lee Gambelli-Lemire, D.C.
Nelson S. Ong, D.C.

INFORMED CONSENT FOR CHIROPRACTIC CARE

I hereby request and consent to chiropractic care including examination, chiropractic adjustments and therapeutic exercise and modalities, such as ultrasound and electric stimulation, etc, the use of diagnostic x-rays on me, or the patient whom I am legally responsible, by Dr. Brett Lemire, Dr. Nancy Lemire, Dr. Nelson Ong, or any other licensed doctor of chiropractic that may be employed in their absence.

I understand that chiropractic care involves the use of the hands to provide a chiropractic adjustment in such a way to restore proper motion to the joints. I understand that there are risks involved in chiropractic care just as there is in any health care. Some of the risks involved, but not limited to, are fractures, disc injury, sprains or strains, dislocation, and strokes.

These complications are generally regarded as rare. The subject of stroke and chiropractic adjustments has been subject to debate in and out of the profession, with one prominent authority saying that the chance of stroke is approximately one in a million adjustments (S.Haldeman, DC, MD) We employ tests in our exams that are designed to identify if you may be susceptible to such an injury as stroke.

I have had an opportunity to discuss the possible risks and benefits with the doctor and I am aware that results are not guaranteed.

I have read or have had read to me the above consent form and intend that this form will cover the entire course of treatment for my present condition and for any future care that I may receive from Dr. Brett Lemire, Dr. Nancy Lemire, Dr. Nelson Ong, or any other licensed doctor of chiropractic working in their stead.

Print Patient's Name	Print Representative's Name
Signature of Patient	Signature of Representative
Date Signed	Relationship of Representative
Witness	Date Signed
Date Signed	

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Brett J. Lemire, D.C., CSCS
Nancy L. Lemire, D.C.
Nelson S. Ong, D.C.

Notice of Doctor's Lien For:
Lemire Chiropractic Spine & Sport Inc

To Attorney: _____

_____

Re: _____
DOI: _____

I hereby authorize the above doctor(s) to furnish, you, my attorney, with full report of his/her examination, diagnosis, treatment, prognosis, etc., of myself in regards to the accident in which I was involved.

I hereby authorize and direct you, my attorney, to pay directly to the said doctor such sums as may be due and owed to him/her for medical service rendered by me by reason of the accident, which occurred on the above date, in the event of any settlement or judgment in my favor, as may be necessary to adequately protect said doctor. And, I hereby further give a lien on my case to said doctor against any and all proceeds of any settlement, judgment, or verdict which may be paid to you, my attorney, or myself as a result of injuries from this accident for which I have been treated or injuries in connection therewith.

I fully understand that I am directly and fully responsible to said doctor for all medical and/or surgical benefits, including major medical, submitted by him/her for service rendered by me and that this agreement is made solely for said doctor's additional protection and in consideration of his/her 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 understand that this account is assigned for collection and/or suit, collection costs and/or attorney fees, and/or court costs to the amount due.

Patient's Signature: _____ **Dated:** _____
Address: _____ **Witness:** _____

_____

Acknowledgement of Attorney:

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

Dated: _____ **Attorney's Signature:** _____

Attorney, Please date, sign, and return one copy to the above doctor's office at once. Please keep a copy for your records.

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Patient's Signature: _____ **Dated:** _____
Address: _____ **Witness:** _____

_____

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Dated: _____ **Attorney's Signature:** _____

Attorney, Please date, sign, and return one copy to the above doctor's office at once. Please keep a copy for your records.

Lemire Chiropractic Spine & Sport Inc
Health Survey

Name: Age: Today's Date

Please mark all conditions you have now, or have had in the past:

General
- ☐ Allergies
- ☐ Dizziness
- ☐ Fevers
- ☐ Fainting
- ☐ Fatigue
- ☐ Depression
- ☐ Weight loss
- ☐ Loss of sleep
- ☐ Night Sweats
- ☐ Bruise Easily
- ☐ Hernia
- ☐ Surgeries

_____

_____

Muscle/Joint
- ☐ Arthritis
- ☐ Bursitis
- ☐ Swollen Joints
- ☐ Whiplash
- ☐ Foot/Ankle trouble
- ☐ Hip trouble
- ☐ Shoulder trouble
- ☐ Elbow trouble
- ☐ Wrist trouble
- ☐ Jaw trouble

Cardiovascular
- ☐ Heart Attack
- ☐ Stroke
- ☐ Open Heart Surgery
- ☐ High Blood Pressure
- ☐ Low Blood Pressure
- ☐ Chest Pain
- ☐ Poor Circulation
- ☐ Fast Heart Rate

Genitourinary
- ☐ Painful Urination
- ☐ Frequent Urination
- ☐ Kidney Problems
- ☐ Bladder Problems
- ☐ Prostate Problems

Women
- ☐ Never Pregnant
- ☐ Now Pregnant # of Months ____
- ☐ Previously Pregnant # of Births ___

Systemic
- ☐ Aids
- ☐ Alcoholism
- ☐ Anorexia/ Bulimia
- ☐ Asthma
- ☐ Cancer
- ☐ Chicken Pox
- ☐ Cold Sores
- ☐ Diabetes
- ☐ Eczema
- ☐ Emphysema
- ☐ Gout
- ☐ Herpes
- ☐ Measles
- ☐ Mumps
- ☐ Multiple Sclerosis
- ☐ Pneumonia
- ☐ Polio
- ☐ Rheumatic fever
- ☐ Rheumatoid Arthritis
- ☐ Seizures
- ☐ Tuberculosis
- ☐ Ulcers
- ☐ Other

_____

Family History – Please Mark Conditions present in your Family
- ☐ Auto Immune Disorder
  Who? /_____
- ☐ Arthritis
  Who? _____
- ☐ Back Trouble
  Who? _____
- ☐ Cancer
  Who? _____
  What Type: _____
- ☐ Diabetes
  Who? _____
- ☐ Heart Disease
  Who? _____
- ☐ Kidney Disease
  Who? _____
- ☐ Seizure Disorder
  Who? _____

Patient's Signature _____ **Date** _____

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VISUAL ANALOG SCALE, PAIN DRAWING & ADL

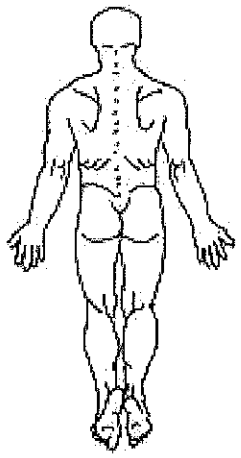
Name: _____ Date: _____ ☐ PI ☐ WC ☐ GI ☐ PP

Section 1 – Pain intensity: *Please circle the appropriate # that describes your present pain levels, with 0 being no pain and 10 being the worst pain you can imagine, and indicate how frequent the pain is.*

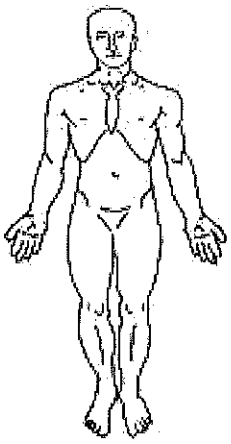
Area of pain	Normal	Mild	Moderate	Severe	Frequency of Pain
Neck	0 1	2 3 4	5 6 7	8 9 10	0----------50%----------100%
Headaches	0 1	2 3 4	5 6 7	8 9 10	0----------50%----------100%
Mid back Pain	0 1	2 3 4	5 6 7	8 9 10	0----------50%----------100%
Low back pain	0 1	2 3 4	5 6 7	8 9 10	0----------50%----------100%
Hip(s) Lt Rt	0 1	2 3 4	5 6 7	8 9 10	0----------50%----------100%
Shoulder(s) Lt Rt	0 1	2 3 4	5 6 7	8 9 10	0----------50%----------100%
Arm(s) Lt Rt	0 1	2 3 4	5 6 7	8 9 10	0----------50%----------100%
Leg(s) Lt Rt	0 1	2 3 4	5 6 7	8 9 10	0----------50%----------100%
Other: Lt Rt	0 1	2 3 4	5 6 7	8 9 10	0----------50%----------100%

Section 2 – Pain Drawing & Description

Please indicate the appropriate location of your pain and use the symbol to that best describes the discomfort that you are presently experiencing



vvv = dull & achy
+++ = sharp & stabbing
000 = pins and needles
\\\\\ = numbness



Section 3 Activities of Daily Living or Job Demands that increase your pain levels:

☐ Sitting ☐ Standing ☐ Stooping ☐ Bending ☐Climbing ☐ Reaching ☐ Lifting (max) _____
☐ Driving ☐ Housework? _____ ☐ Sports/Recreation? _____

Section 4 Mechanism of Injury

Please describe what initially caused your problem: _____
How long have you had this problem? _____ Is the pain getting ☐ Better ☐Worse ☐ Same
Pain affects your, ☐ work ☐ sleep ☐ activities of daily living ☐ is the pain worst at night?
Have you lost any time from work, due to your injuries? ☐ No ☐ Yes, When? _____
Are you currently under medical care for this condition? ☐ No ☐ Yes, Where and what type? _____
Taking any prescription medication? ☐ No ☐ Yes What? _____
Taking non prescription medication? ☐ No ☐ Yes What? _____
Have you seen another chiropractor? ☐ No ☐ Yes Why? _____

Lemire Chiropractic Spine & Sport Inc

Low Back Pain and Disability Questionnaire
(Modified Roland-Morris)

Name _____ Date _____

When your back hurts, you may find it difficult to do some of the things you normally do. Mark only the sentences that describe you today.

- ☐ I stay at home most of the time because of my back
- ☐ I walk more slowly then usual because of my back
- ☐ Because of my back, I am not doing any jobs that I usually do around the house
- ☐ I avoid heavy jobs around the house because of my back
- ☐ Because of my back, I use a handrail to get upstairs
- ☐ Because of my back, I go upstairs more slowly then usual
- ☐ Because of my back, I lie down to rest more often
- ☐ Because of my back, I have to hold onto something to get out of an easy chair
- ☐ Because of my back, I try to get other people to do things for me
- ☐ I stand up only for short periods of time because of my back
- ☐ Because of my back, I try not to bend or kneel down
- ☐ My back or leg is painful almost all of the time
- ☐ I find it difficult to turn over in bed because of my back
- ☐ I get dressed more slowly than usual because of my back
- ☐ I have trouble putting on my socks (or stockings) because of my back
- ☐ I sleep less well because of my back
- ☐ Because of my back pain, I am more irritable and bad tempered with people then usual

Score _____

Thank you for your cooperation.

Lemire Chiropractic Spine & Sport, Inc
(NDI/ Neck Disability Index)

Patient Name: _____ **Date:** _____

Please read: This questionnaire is designed to give the doctor information as how your neck pain has affected your ability to manage everyday life. Please answer each section and mark only the ONE box that applies to you.

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
- ☐ 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.

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