2012 LIST OF NORDHOFF CHIROPRACTIC OFFICE FORMS

FORM #	DESCRIPTION	FORM #	DESCRIPTION
	MISCELLANEOUS FILES		**"FORM 2000C"**
900	Informed Consent (English and Spanish)	3100	Patient Instruction for Insurance Payment
901	ICD Codes 2012	3110	Factors that have Complicated Recovery
902	Headache Calendar	3120	Patient Update Form
903	Sign-In Form for Patient	3200	Physician Request for Testing
904	Color Pain NAS Scale (print on color printer)	3210	Physician Request for Supplies
905	Check Ledger for office	3230	Physician Referral (work comp)
906	Spanish Forms (28 pages)	3240	Consultation-Referral Form
907	Radiology Forms	3242	Sports-Recreational-Home Injury
908	Pain and Disability Graph	3310	Bill for Reports/Copying
910	Activities of Daily Living Forms	3320	Pre-Payment Request for Reports/Copying
920	Exercise-Rehab Forms	3600	History Forms
930	Examination forms		
940	Fax form		
950	Record Request Form		
955	Proof of Service by Mail Form		**"FORM 2000D"**
		3700	Sample IME worksheet
		3705	Sample PI Report
	"FORM 2000A"	3710	Appointment Calendar (10 and 15 Min)
1000	Patient Introduction Form (Cash-Ins cases)		
1010	General Health History (2 pages)		
1020	Headache-Migraine Questionnaire		**MEDICARE FORMS**
1030	Symptom Questionnaire (Spine,Extremity)	3800	Sign-in Form
1050	Post-traumatic Symptom Questionnaire	3801	ADL-Functional Capacity Form
1060	Head Injury Questionnaire	3805	Medicare subluxation documentation form
1080	Symptom Intensity & Frequency Form	3810	Medicare progress notes
1090	Before & After Injury Comparison Form	3815	Treatment Plan and Discharge Summary
1100	Pain Intensity NAS Scale (0-10) Not colored		
1105	History Forms		
1410	Discharge summary		
			PERSONAL INJURY FORMS
		4000	Personal Injury Introduction Form
		4010	Motor Vehicle Crash Form (3 pages)
	PROGRESS AND SOAP NOTES	4100	Motorcycle Injury Form (2 pages)
1500	Front of Travel Card	4110	Bicycle Injury Form (2 pages)
1501	Back of Travel Card-Report of findings	4120	Pedestrian Injury Form (2 pages)
1510	SOAP Notes (complex case)	4130	Slip-and-Fall Injury Form
1530	Progress Notes	4200	Doctor's Lien DC/MD (1 & 2 pages)
		4210	Lien Reduction Letter to Attorney
		4300	Notice of PI Case Closure to Insurance Co
		4310	Notice of PI Case Closure to Attorney
	"FORM 2000B"	4400	PI Physician Progress Report (2 pages)
2000	Emergency Room and Disability dates	4450	Motor Vehicle Collision Injury Report
2100	List of All Providers Seen (3 pages)	4500	Notice of New Injury to Insurance Co
2200	Patient Home Instructions	4600	Fee Structure for Deposition/Trial Testimony
2210	Post Injury Instructions	4610	Case Worksheet for Deposition/Trial
2220	Headache Instruction Form	4620	DC-Attorney Agreement for Deposition
2230	Head Injury Home Instruction Form		
2240	Disc Protrusion and Spinal Stenosis		
2250	Collar Bone Instruction Form		
2300	Risk Factors for Nontraumatic Back Pain		**HIPAA FORMS**
2400	Prescription for Gym Exercise Trainer	4700	Release of Medical Records,
2410	Prescription for Massage Therapy	4745	Employment and Staff forms
2420	Prescription for Physical Therapy	4750	Business Associates
2500	Disability Form (General)		
2510	Return to Work Form		**WORKERS' COMPENSATION FORMS**
2520	Return to Work After Head Injury	5000	Workers' Compensation Introduction Form
2800	School Activity Exemption-Sports	5100	Employment Information-general
2801	Return to School Activity	5150	Job Description Information

GENERAL HEALTH HISTORY (Page 1)

DESCRIBE ALL OF THE REASON(S) WHY YOU HAVE COME TO OUR OFFICE (Symptoms/Injury). Print Clearly

Check no or yes to the questions below. If yes, check if you have it presently or had the condition in the past.

NO	YES	GENERAL QUESTIONS	PAST	PRESENT
☐	☐	History of poor healing or told that you have a healing disorder?	☐	☐
☐	☐	Smoke cigarettes or use tobacco products?	☐	☐
☐	☐	History of thyroid, kidney, liver/gallbladder, pancreas, or other endocrine-metabolic disorder?	☐	☐
☐	☐	Have you been told you are pre-diabetic (hypoglycemia), diabetic or have high cholesterol?	☐	☐
☐	☐	Heart attack, heart disease or do you have a heart pacemaker or neck or chest shunt?	☐	☐
☐	☐	History of infectious diseases such as AIDS, Tuberculosis, Meningitis, Hepatitis, etc.?	☐	☐
☐	☐	Do you have difficulties or intolerance to heat packs or ice packs on your skin?	☐	☐
☐	☐	Do you have problems with dizziness, blacking out, balance problems, fainting, or tripping?	☐	☐
☐	☐	Epilepsy-Seizure-Convulsion history or any other neurological disease?	☐	☐
☐	☐	History of multiple sclerosis, lupus, psoriasis, paralysis, or disease affecting nerves?	☐	☐
☐	☐	Cancer history or cancer treatment or surgery of any type?	☐	☐
☐	☐	Stroke history (Indicate any suspected mild strokes or transient ischemic attacks-TIA)?	☐	☐
☐	☐	Blood clots, bleeding or vascular disorder, or told you have an abdominal or brain aneurysm?	☐	☐
☐	☐	Hypertension or high blood pressure? If yes, name of MD seeing:	☐	☐
☐	☐	Autoimmune disease, digestive or intestinal disease, or respiratory diseases, etc?	☐	☐
☐	☐	History of fatigue, weight loss/gain, fever, kidney/ovarian pain, or bowel/bladder disorders	☐	☐
☐	☐	**Women only**: Check box to left if there any chance that you are currently pregnant		

If you checked yes, please describe:

HAVE YOU HAD PRIOR INJURY OR PREVIOUS MUSCULOSKELETAL PAIN?

☐ **NO,** ☐ **YES. (Check NO box if you have never had a history in the past)** If yes, please describe below:

HAVE YOU HAD FRACTURES/BROKEN BONES IN THE PAST?

☐ **NO,** ☐ **YES. (Check NO box if you have never had any broken bones in the past).** If yes, please describe below:

HAVE YOU EVER BEEN HOSPITALIZED?

☐ **NO,** ☐ **YES. (Check NO box if you have never been hospitalized in the past)** If yes, please describe below:

HAVE YOU HAD ANY PREVIOUS SURGERIES?

☐ **NO,** ☐ **YES. (Check NO box if you never had any surgical procedure in the past).** If yes (including silicone implants, cancer, spine, herniated discs, genetic conditions, ports in the chest/abdomen). Please describe the type and dates:

GENERAL HEALTH HISTORY (Page 2)

PRIOR INTERVENTION BY OTHER HEALTH CARE PROVIDERS

☐ No, ☐ Yes. **Have you seen any other doctors for the same condition(s) that you are seeking chiropractic today?**

If yes, list doctor names, tests, and results:

☐ No, ☐ Yes**. Have you taken any pain or anti-inflammatory medications today?** If yes, describe the name(s) of the medication(s) and when you took it last:_____

☐ No, ☐ Yes**. Have you recently had or do you currently have a fever, cold, virus, or infection?** If yes, describe:_____

☐ No, ☐ Yes. **Do you have a family history** of high blood pressure, stroke, heart attacks, scoliosis, spina bifida, genetic conditions of the spine, rheumatoid arthritis, collagen disorders, hypermobility, other forms of joint or spine arthritis, herniated discs in the spine, spinal cord disease, brain disease, nerve disease, blood vessel aneurysms, blood disease, or other diseases?

If yes, please describe:

☐ No, ☐ Yes. **Have you been treated by a Chiropractor for any condition and/or injury in the past?**
List Chiropractor's Name: _____ City: _____ Year:_____
List Problem(s) for which the Chiropractor treated you :_____

Please list the name of your primary medical doctor and when you had your last appointment?	

☐ No, ☐ Yes. **Do you have any problems lying face down on an examination table?** (tender breasts, chest or breast surgical implants, ports, etc)? If yes, why: _____

SLEEPING PATTERNS AND/OR DISORDERS

☐ No, ☐ Yes. **Do you sleep normally at night?** If no, please describe your sleeping problems below:

MEDICATION USE CURRENTLY (PRESCRIBED AND OVER-THE-COUNTER)

☐ No, ☐ Yes. **Currently, are you taking any medications?** In yes, list all medications that you are taking:

FOOD OR MEDICATION ALLERGY HISTORY

☐ No, ☐ Yes**. Do you have allergies to any medications, foods, shellfish, seafood, etc**? If yes, List:

NUTRITION-DIET

☐ No, ☐ Yes**. Recently, do you consider that your usual diet is good and well balanced**?

If you are anemic, bruise easily, or have a poor diet please describe :

EXERCISE ROUTINE

☐ No, ☐ Yes**. Do you exercise every week?** If yes, describe your typical routine over the past month.

NECK, BACK, SACRUM, PELVIS PAIN AND/OR INJURY HISTORY (Page 3)

Please print clearly. Check all boxes that apply to you and describe your "YES" responses. Your doctor will be going over this questionnaire with you during your consultation, and you can clarify your answers at that time.

YES	NO	GENERAL SPINE HISTORY (HEAD, NECK, BACK, SACRUM, AND PELVIS)
☐	☐	Have you been told that you have scoliosis, spondylolisthesis, spina bifida, or fused vertebrae?
☐	☐	Have you been told that you have a bulging/herniated disc or disc degeneration in the spine?
☐	☐	Have you been told you have weak bones, osteoporosis, osteopenia, or ankylosing spondylitis in your spine or joints?
☐	☐	Have you been told you have arthritis, degeneration, or rheumatoid arthritis in your spine or joints?
☐	☐	Have you had a previous head injury or brain/spinal cord disease in the past?
☐	☐	Have you injured your neck, back, sacrum or pelvis in the past?
☐	☐	Have you ever had an injection into your discs or spine (facet joints) in your back, sacrum or neck?
☐	☐	Do you have a stomach, intestinal, digestive, malabsorption disorder (wheat allergy, etc.), muscle disease, prostate, ovarian, or uterine problem, condition or disease that could be affecting your back?

If yes, describe and provide dates:

SYMPTOM OR COMPLAINT ONSET

☐ **Suddenly,** ☐ **Gradually. Check box indicating if your current neck/back symptoms developed gradually or suddenly.**

NECK PAIN AND/OR INJURY HISTORY

Describe your neck pain location (left side, right side, middle of your neck, both sides, front, or back).	
When did your neck pain begin and/or injury occur?	Date required:
Describe how or why your pain began (mechanism). Describe any neck injury (what happened)?	
Describe all aggravating physical activities/motions. What makes your neck or referring arm pain worse?	
Describe any relieving physical activities. What activities lessen your neck/arm symptoms?	
Describe how your symptoms feel (examples: dull, sharp, ache, sore, pain, numbness, tingling, stiff, etc).	
Describe any symptoms that originate from your neck that radiate to your head/shoulders/arms/hands.	
How frequent/severe are your pain/symptoms?	Percent of time _____%. Pain Severity (0-10) _____
List all doctors you have seen for your neck before.	

YES	NO	NECK REGION RECENT HISTORY (Check following)
☐	☐	Recently, have you had blurry or double vision, trouble speaking/swallowing, dizziness, fainting spells, nausea, trouble walking or balance problems, or hand/feet numbness or weakness?
☐	☐	Do you black out, lose your balance or get a headache when you look up or twist your head?
☐	☐	Do you feel your neck pain sends pain downward between your shoulders or to the front of your chest?
☐	☐	Have you recently had a new type of headache or an unusually severe headache?
☐	☐	Have you recently noticed your head leaning or tilting to one side?

UPPER BACK, LOW BACK, SACRUM, PELVIS REGION HISTORY (Page 4)

Describe your pain location (middle back, lower back, sacrum and if located in the front/side/back of body).	
When did your pain begin and/or injury occur?	Date required:
Describe how or why your pain began (mechanism). Describe any injury (what happened)?	
Describe all aggravating physical activities/motions. What makes your back or referring leg pain worse?	
Describe any relieving physical activities. What activities lessen your back or leg symptoms?	
Describe any symptoms that originate from your back that radiate to your chest, hips, legs, or feet.	
Describe how your symptoms feel (examples: dull, sharp, ache, sore, pain, numbness, tingling, stiff, etc).	
How frequent are your pain/symptoms (Percent)?	
How severe are your pain/symptoms (Zero-to-10)?	
List all doctors you have seen in the past for your back.	

YES	NO	UPPER BACK AND LOW BACK REGION HISTORY CONTINUED
☐	☐	Do you have pain that shoots or radiates outward along your rib cage?
☐	☐	Does your middle or upper back or chest wall pain intensify when you take in a deep breath or cough?
☐	☐	Do you sometimes have a tight band-like feeling around your chest?
☐	☐	Have you recently have any associated unusual indigestion, chest pressure, or pain down your left arm?
☐	☐	When you move your neck around, does your middle back pain or chest pain increase?
☐	☐	When you cough, sneeze, or bear down to have a bowel movement, does your back/leg pain get worse?
☐	☐	Do you have a consistent pattern of getting severe leg pain or cramping after walking for similar distances that is relieved by resting or sitting down?
☐	☐	Do you get leg pain or hip pain while walking that is consistently relieved by sitting down or lying down?
☐	☐	Does either leg or foot drag on the floor when you walk?
☐	☐	Have you recently had a lot of leg cramps at night?
☐	☐	Are you taking a calcium or other dietary supplements to help your leg cramps?
☐	☐	Have you recently had any urinary or bowel incontinence or had difficulty urinating?
☐	☐	Have your feet felt cold recently? If yes, indicate which foot or if both feet:
☐	☐	Have you recently noticed that either of your legs occasionally gives out on you when you walk?
☐	☐	Have you recently felt weakness in one or both of your legs?
☐	☐	Has your anal-rectal region been completely numb recently?

Please print clearly

If yes, describe and indicate dates:

EXTREMITY PAIN OR INJURY QUESTIONNAIRE

Please answer the following sections that apply to you. If some of the questions are unclear to you, skip ahead to the next question. Your doctor will be going over this questionnaire with you. Please print clearly.

SHOULDER, ARM, ELBOW, WRIST AND HAND REGION

Describe pain location (left, right, middle, front, back, top). Example: top of shoulder joint/inside left elbow)	
When did your pain begin and/or injury occur?	Date required:
Describe how or why your pain began (mechanism). Describe any injury (what happened)?	
Describe all aggravating physical activities/motions. What makes your shoulder-arm symptoms worse?	
Describe any relieving physical activities/motions. What lessens your shoulder-arm pain-symptoms?	
If present, describe which fingers or part of your hand have any pain, numbness, or tingling.	
Describe how your symptoms feel (examples: dull, sharp, ache, sore, pain, numbness, tingling, stiff, etc).	
How frequent are your pain/symptoms (Percent)?	
How severe are your pain/symptoms (Zero-to-10)?	
List all doctors you have seen in the past for your shoulder, arm, and/or hands.	

HIP, LEG, KNEE, ANKLE AND FOOT REGION

Describe your pain location (left, right, middle, front, back). Example: front of hip/outer calf area.	
When did your pain begin and/or injury occur?	Date required:
Describe how or why your pain began (mechanism). Describe any injury (what happened?).	
Describe all aggravating physical activities/motions: What makes your hip-leg pain-symptoms worse?	
Describe any relieving physical activities: What lessens your hip-leg symptoms-pain?	
If present, describe which toes or part of leg/foot have pain, numbness, or tingling.	
Describe how your symptoms feel (examples: dull, sharp, ache, numbness/tingling, stiff, etc).	
How frequent are your pain/symptoms (Percent)?	
How severe are your pain/symptoms (Zero-to-10)?	
List all doctors you have seen in the past for your hip, leg, knee, ankle, and/or foot.	

☐ No, ☐ Yes. **HAVE YOU HAD ANY PRIOR INJURIES OR FRACTURES TO YOUR ARMS AND LEGS?**

Describe body part, date, and residual pain:

INFORMED CONSENT-CHIROPRACTIC

PATIENT NAME: _____ DATE: _____

Chiropractors have been providing great health care services to patients for more than 100 years. Many patients with acute and chronic spine-related and extremity disorders and joint stiffness, arm and leg complaints, and other musculoskeletal conditions or injuries have benefited by having chiropractic care. In order for said chiropractor (see below) to determine what types of treatment may be beneficial to you, it is necessary to perform a physical examination of your spine and other joints. Identifying subluxations or abnormal joint function is achieved by looking at x-rays and/or during the examination which involves moving various joint(s) or areas of your body in specific directions to determine how well each of the painful or restricted joints or bony structures of your body moves or is positioned when compared to the normal population. Spinal manipulation, a procedure that involves the application of controlled mechanical forces to specific joint structures, has the goal of improving and restoring normal joint motion of the spine and other joints. Better bone and joint alignment and motion improves the function and health of the joint, associated muscles and nerves and thus reduces inflammation and related symptoms. After treatment, most of our patients experience increased flexibility, feel less pain and other symptoms, and are able to return to their normal physical activities at work and home. The goal of chiropractic care is to improve and normalize the quality of joint motion in the affected areas of your body, to encourage you to adopt good lifestyle habits such as exercise and good nutrition, and assist you during the recovery process.

Rejecting chiropractic care may lead to progression of joint restrictions, stiffness, pain and other symptoms and may compromise your ability to perform activities at home and work. There are various types of non-chiropractic treatment available for patients who have your type of condition(s), including; acupuncture, physical therapy, or from a medical doctor or other health care provider. While uncommon, some patients may experience short-term increase of pain and other symptoms or muscle and ligaments strains or sprains as a result of manipulation and manual therapy techniques such as joint mobilization or deep massage. There are some rare potential serious bodily harm risks to chiropractic manipulations and procedures to various regions of the body, including, but not limited to, strains, sprains, fractures, disc injuries, dislocations, strokes, and nerve injuries.

Strokes are a very rare event in the general population and have been reported after patients visit chiropractors or primary care providers (medical doctors). Scientific evidence shows that the increased stroke risks are likely due to patients seeking care from chiropractors or medical doctors because of an unusual type or severity of headache and neck pain. These symptoms are from an early stroke that is already occurring and progressing from prior damage to an artery in the neck. Once seen by a doctor, the risk of the stroke progressing has been found in the literature to be similar (no excessive risk) for patients who are seen by chiropractors and primary care providers. There is scientific evidence that shows that patients who have these developing strokes may have weakened or diseased artery vessel walls that are particularly vulnerable to a variety of motions or movements of the neck and head or they may occur spontaneously without any known reason. Research has shown that there are many stroke risk factors, including: disease of blood vessels, high blood pressure, birth control pills, environmental and genetic factors, infections, occurring during falls, violent car accidents, coughing/sneezing, sport activities, or even during such trivial movements as turning ones head to back up a car or to paint a ceiling. The literature shows that there are rare risks of strokes specifically from rotating and extending the head and neck during cervical spine manipulation or other maneuvers that rotate or extend the head and neck, particularly the upper cervical spine. You are being informed of this reported association because a stroke may cause serious injury or even death.

I voluntarily consent to the performance of chiropractic examination, manipulation and other chiropractic procedures, on myself, (or on the patient named below, for whom I am legally responsible) by said chiropractor (see below), his/her preceptor(s), and/or other licensed doctors of chiropractic who now or in the future provide chiropractic treatment for me. This consent includes other doctors of chiropractic that are employed by, associated with, or serve as back-up for said chiropractor, whether or not their names are listed on this form. I understand that the results from the chiropractic treatment are not guaranteed for my condition. The doctor has verbally discussed the goals and potential benefits of the proposed treatment, other alternative types of treatment for my condition and the associated risks by having chiropractic examination, manipulation, and other procedures. I have had the opportunity to read this form and understand the above statements, accept the risks mentioned, and hereby consent and agree to the recommended chiropractic treatment over the entire course of treatment for my present condition and any future conditions for which I seek treatment.

X_____ X _____

DR SIGNATURE: CONSENT WAS DISCUSSED VERBALLY. DR SIGNATURE: PATIENT WAS ASKED "DO YOU UNDERSTAND?"

X_____

SIGNATURE OF PATIENT OR RESPONSIBLE PARTY

NAME: _____ RELATIONSHIP _____

Indicate your name and relationship (parent/guardian/personal representative) if signing for patient (minor):

Lawrence Nordhoff, DC, 4133 Mohr Ave, Ste F, Pleasanton CA 94566 Phone 925-484-2928

		PATIENT PROGRESS NOTES
DATE	**S**	See Pain Drawing. ☐ H/A, ☐ Nk pn, ☐ MB pn, ☐ LBP, ☐ SI pn, ☐
	O	Pain-Tenderness with palpation: Asymmetry ROM Tissue Tone Abnormalities
	A	☐ Responding (Normally/Slowly/No improvement). ADLs/Function
Dr. Signature	**P**	☐ See ____ times a week/mo. ☐ See PRN. ☐ Cerv tract ___ min ___ lbs, ☐ Muscle Stim ____ min, ☐ Ice, ☐ ☐CMT: ☐ Nk _____, ☐ MB_____, ☐ LB_____, ☐SI, Other:_____ ☐ Mobilization ☐ Nk, ☐ MB, ☐ LB, ☐SI, Other: ☐ Myotherapy ____ min (gentle/deep) to areas noted in objectives ☐ Therapeutic Exercises ____ min/Neuromuscular reeducation ____ min: Frequency of future treatment: ☐ will continue as set in initial plan, ☐ frequency changed (explain):

These have 2 dates per page.

		CMS-MEDICARE PATIENT PROGRESS NOTES
DATE	**S**	Pain Intensity (0-10). _____ Pain levels: (better/same/worse than last visit) List ADL functional activities that are better/same/worse.
Manipulation ☐ Acute Treatment 98940-AT 98941-AT	**O**	Pain-Tenderness with palpation: Asymmetry ROM Tissue Tone Abnormalities
☐ Maintenance Care 98940-GA Non-Manipulation ☐ -GY –GZ	**A**	Asses change in pts condition (function, posture, etc) Patient response to manipulation: (better/same/worse)
Signature: Lawrence Nordhoff, DC	**P**	CMT to_____ subluxations. ☐ Mobilization ☐ Nk, ☐ MB, ☐ LB, ☐SI, Other: ☐ Myotherapy (gentle/deep) to areas noted in objectives ☐ Therapeutic Exercises ____ min/Neuromuscular reeducation ____ min: Frequency of future treatment: ☐ will continue as set in initial plan, ☐ frequency changed (explain):

MOTOR VEHICLE COLLISION FORM

Patient Name:_____ Date: _____
Date of crash:_____ Time of collision: _____ ☐ AM ☐ PM
City where crash occurred: _____ Was the street wet or dry? ☐ Wet ☐ Dry
Street (location) where crash occurred: _____
Who owns the vehicle in which you were hit? _____
What is the estimated repair damage to your vehicle? $_____ ☐ Unknown, ☐ Estimate not done yet
How many people were in your vehicle at the time of the crash? _____
☐ Yes, ☐ No Did the police come to the crash scene?
☐ Yes, ☐ No Did the police make a written report?
☐ Yes, ☐ No Were any photographs taken of the vehicles? If yes, who took them?

DESCRIBE HOW THE CRASH HAPPENED

COLLISION DESCRIPTION-TYPE

Check all that apply to you. Indicate which type of automobile crash you were involved in:

☐	Single-vehicle crash	☐	Two-vehicle crash	☐	Three-or-more vehicles
☐	Rear-end crash	☐	Side crash	☐	Rollover
☐	Head-on or frontal crash	☐	Hit guard rail, tree, or object	☐	Ran off the road
☐	Other (Describe):				

CIRCLE YOUR SEATING POSITION **(The number's 1-9 indicate where you were seated at the time of the crash. The #1 spot is the driver. Seating numbers 7-9 are for a third row seat.**

Front of Vehicle

1 2 3

4 5 6

7 8 9

Rear of Vehicle

DURING AND AFTER THE CRASH, YOUR VEHICLE:

☐	Kept going straight, not hitting anything	☐	Spun around, not hitting anything
☐	Kept going straight, hitting car in front	☐	Spun around, hitting another car
☐	Was hit by another vehicle	☐	Spun around, hitting object/curb other than car

INDICATE IF YOUR BODY HIT SOMETHING OR WAS HIT BY ANY OF THE FOLLOWING:
Please draw lines from the body regions on the left side and match to the right side.

BODY REGION	OBJECT YOU HAD CONTACT WITH
Head	Windshield or side window
Face	Steering wheel
Shoulder	Side of door
Arm/hand	Dashboard
Front chest wall	Knee bolster/glove compartment
Side chest wall	Direct contact with other vehicle (hood)
Hip/abdomen	Frame/Pillar within vehicle near window
Knee	Roof or top part of vehicle
Leg	Another person sitting in your vehicle
Foot	Other

CHECK IF ANY OF THE FOLLOWING PARTS OF YOUR VEHICLE WERE DAMAGED IN THE COLLISION:

☐ Windshield	☐ Seat bent or damaged	☐ Dash or area around knee/foot
☐ Steering wheel	☐ Side or rear window broken	☐ Other
Describe Damage:		

ALL TYPES OF COLLISIONS Indicate those relevant to your case.

YES	NO	
☐	☐	Did any of the interior front or side structures within your vehicle, such as the side door, dashboard, steering wheel, or floorboard of your car dent inward during the crash?
☐	☐	Did the side door, dash, or interior of your vehicle touch or hit your body during the crash?
☐	☐	Did you strike or did any objects or animals within your vehicle hit you during the crash?
☐	☐	Was the door(s) of your vehicle damaged to a point where you could not open the door?
☐	☐	Did an airbag deploy in your vehicle during the crash? If yes, circle (side airbag/front airbag)
☐	☐	Did you have any cuts, bruises, or abrasions from the airbag deploying?
☐	☐	Did your seatbelt system require repairs after the crash?
☐	☐	Was the back of your seat that your were sitting in damaged or bent during the crash?
☐	☐	If a side impact, did the front of the other vehicle strike the door next to where you were sitting?

SEATBELT USAGE AND STEERING WHEEL HAND PLACEMENT:

YES	NO	
☐	☐	Were you wearing a seatbelt? If yes, does your seatbelt have a: ☐ Lap and Shoulder Strap, ☐ Automatic shoulder strap with driver needing to manually attach lap belt, ☐ Lap belt only
☐	☐	Did you have any portion of your seatbelt positioned behind your chest, back or shoulder.
☐	☐	Did you have any cuts, bruises, or abrasions from the seatbelts?
☐	☐	Were you holding onto the steering wheel (driver only) at the time of impact? If yes, Indicate where each hand was positioned ***(Use time clock face as your reference point)*** Left hand: ☐ Not on wheel, ☐ Yes, hand at ____ o'clock, ☐ Hand elsewhere Right hand: ☐ Not on wheel, ☐ Yes, hand at ____ o'clock, ☐ Hand elsewhere

REAR-END COLLISIONS ONLY Answer this section only if you were hit from the rear.

Describe your vehicle's head restraint system:

☐ Movable/adjustable head restraint ☐ Fixed, non-moveable head restraint
☐ No headrests in my vehicle ☐ Bench seat in your vehicle without head restraint

Please indicate how your <u>head restraint</u> was positioned at the time of crash (if present):

☐ At the top of the back of your head ☐ Midway height of the back of your head
☐ Lower height of the back of your head ☐ Located at the level of your neck
☐ Level of your shoulder blades

BRUISING AFTER THE CRASH?

YES	NO	
☐	☐	Did your body have any bruising (areas that were visibly black, red, and/or blue) after the crash? If yes, indicate where bruising was located on your body and what caused the bruising (if known):

AWARENESS AND BODY POSITION DESCRIPTIONS: *Check all areas that apply to you.*

☐	You were unaware of the impending collision. You did not see or hear brakes prior to the impact.
☐	You were aware of the impending crash and relaxed before the collision.
☐	You were aware of the impending crash and braced yourself.
☐	Your body, torso, and head were facing straight ahead.
☐	You had your head and/or torso turned at the time of collision: ☐ Turned to left, ☐ Turned to right Describe how far you were turned/twisted and why you were turned/what were you doing?
☐	You were leaning forward at the time of impact resulting in a gap between your body and the seatback. If yes, indicate how far you were leaning and why you were leaning forward?
☐	Your torso/body were positioned normally against the seatback with no gaps due to leaning/twisting.

HOW SOON DID YOU *FIRST* NOTICE ANY PAIN/SORENESS AFTER THE CRASH?

_____

Doctor's Name: Lawrence Nordhoff, DC	Patient's Name: Sally Jones

POST-TRAUMATIC SYMPTOM QUESTIONNAIRE

PATIENT INSTRUCTIONS: *It is important for this section to be filled out in detail. Look at each symptom listed in the left column and make a single check mark or several check marks in the appropriate columns for the specific symptom which applies to you. Be certain to indicate when you had the beginning of any of the following symptoms. Leave the row blank if the symptom listed below does not apply to you.*

SYMPTOM LIST (Check all that apply to you)	BEGAN IN LESS THAN 24 HOURS AFTER INJURY	BEGAN 1 TO 7 DAYS AFTER INJURY	YOU HAVE SYMPTOMS RECENTLY	HAD SIMILAR SYMPTOMS ONE YEAR BEFORE THIS INJURY
Headache/migraine				
Dizziness				
Tinnitus (ear ringing)				
Blurry vision				
Memory problems				
Poor concentration				
Nausea or vomiting				
Balance problems				
Loss of coordination				
Sensitivity to sound				
Sensitivity to light				
Fatigue				
Loss of smell				
Pain/difficulty swallowing				
Jaw pain/soreness				
Neck pain/soreness/aching/stiff				
Shoulder pain/stiffness				
Arm pain/tingling/numbness				
Wrist/hand/finger pain/numbness				
Weakness in arms/legs				
Upper/middle back pain/soreness				
Chest pain or bruising				
Rib cage pain or bruising				
Abdominal-Pelvic pain or bruising				
Low back pain/soreness/aching				
Hip pain or bruising				
Upper leg or thigh pain				
Leg numbness/tingling				
Pain radiating down leg(s)				
Lower leg or calf pain				
Knee pain				
Ankle/foot/toe pain				
Other				

Doctor's Name: Lawrence Nordhoff, DC	Patient Name: Sally Jones

(Report of Findings)

PROBLEM LIST	ETIOLOGY	TREATMENT RENDERED
☐ Headaches/Migraines ☐ Neck pain/soreness/stiffness ☐ Middle back pain/soreness ☐ Chest wall pain ☐ Low back pain/soreness ☐ Hip/Sacroiliac joint pain ☐ Knee pain ☐ Calf/ankle/foot pain ☐ Rotator Cuff Syndrome ☐ Shoulder pain ☐ Elbow/forearm/wrist pain ☐ Upper extremity pain/paresthesia ☐ Lower extremity pain/paresthesia ☐ Radiculopathy ☐ Biomechanically weak area ☐ Thoracic Outlet Syndrome ☐ Carpal Tunnel Syndrome ☐ Strain _____ ☐ Sprain _____ ☐ Strain/Sprain _____ ☐	☐ Recent trauma _____ ☐ Old trauma _____ ☐ Joint dysfunction ☐ Post-traumatic inflammation/swelling ☐ Zygapophyseal joint/capsule irritation ☐ Facet Joint/Capsule Inflammation ☐ Spinal stenosis ☐ Myofascial scar tissue-post traumatic ☐ Myofascial adhesions, nontraumatic ☐ Shortening-contracture of muscle ☐ Active trigger points ☐ Postural-Ergonomic muscle tension ☐ Meniscoid entrapment (synovial fold) ☐ Disc Annular fiber injury ☐ Bulging/herniated cervical disc ☐ Bulging/herniated lumbar disc ☐ Peripheral nerve root compression ☐ Degeneration of discs ☐ Degeneration of joints (osteoarthritis) ☐ Scapular winging, dorsal weakness ☐ Weak low back/abdominal muscles ☐	☐ Spinal adjustments ☐ Extremity adjustments ☐ Joint mobilization ☐ Myotherapy (gentle/deep) _____ min Areas: ☐ Therapeutic exercises ☐ Cervical/Lumbar traction ___ lbs, ___ min ☐ Muscle Stim ___ setting for ___ min ☐ Ice packs/ Moist heat packs (home/office) ☐ Exercises (home/gym/office) ___ x week ☐ Stretching (home/gym/office) ___ x week ☐ Dietary/Nutritional advice _____ ☐ Posture modifications _____ ☐ Ergonomic modifications _____ ☐ Cervical collar ☐ Cervical pillow ☐ Brace (wrist etc) _____ ☐ Lumbar brace ☐ Orthotics _____ ☐

TREATMENT OBJECTIVES

☐ Decrease pain/paresthesias ☐ Enhance and improve repair ☐ Decrease swelling/inflammation ☐ Improve and normalize joint motion ☐ Improve circulation to joint	☐ Break up myofascial adhesions ☐ Neutralize active trigger points ☐ Lessen impingement ☐ Strengthen weak areas ☐ Get pt reliant on self-management ☐	☐ Stabilize condition ☐ Improve body-joint function ☐ Improve posture/ergonomics ☐ Prevent or lessen risk of chronicity ☐ Avoid surgery

NOTES: _____

_____

X-ray necessity:	☐ Yes, indicated, ☐ Not indicated. Will wait and observe response first before ordering x-rays.
Complicating factors:	☐ None noted, ☐ Yes:
Referral for testing or to a MD:	☐ None noted, ☐ Yes, indicated:

INITIAL OFFICE VISIT FREQUENCY (ESTIMATE)	☐ Daily, ☐ 4-5x wk, ☐ 3x wk, ☐ 2x wk, ☐ 1x wk for ____ week(s), then patient will be re-evaluated. Based on exam findings and response to treatment, the visit frequency will then be determined. Will re-evaluate pt in _____ weeks.

☐ Condition outlined to patient	☐ Treatment objectives explained	☐ Pt willing to do home recommendations.

Travel Card-Progress Notes Abbreviations: adj = adjustment, MH = moist heat, Elect Stim = Electrical Stimulation, US = Ultrasound, mm = muscle, H/A = headache, Nk pn = neck pain, MB pn = middle back pain, UB pn = upper back pain, SI = Sacroiliac, Sh = shoulder, cerv tract = cervical traction, TP = trigger point, Tx = treatment, ThEx = Therapeutic exercises, MT = manual therapy, Flex-Dist = Flexion-Distraction, Int traction = intersegmental traction, mm = muscle, wk = week.

Patient Name:	Doctor's Name/Address:

PROVIDERS SEEN SINCE INJURY OR WHEN CONDITION BEGAN

Start with the first doctor that you went to after your injury or your condition began and list all providers (all types of doctors or therapists), up to your last provider seen, and check all that apply for each. Be certain to list these in sequence from first to last.

① Name Emergency Room, hospital/doctor/therapist/center: _____

Address:_____ Date _____

Indicate what was done:

☐ Exam-consultation	☐ Rehabilitation	☐ Exercises
☐ Exam or consult only (no treatment)	☐ Ultrasound	☐ Acupuncture
☐ X-ray of neck or head	☐ Spinal adjustments	☐ Injection(s)
☐ X-ray of chest/ribs/middle back	☐ Muscle massage/myotherapy	☐ Wrist brace-splint
☐ X-ray of low back/ pelvis/hips	☐ Muscle stimulation	☐ Neck collar (brace)
☐ X-ray of shoulder/arms/legs	☐ Physical therapy	☐ Low back brace
☐ MRI/CT scan	☐ Anti-inflammatory medications	☐ Heat packs
☐ EMG/Nerve conduction study	☐ Pain medications	☐ Ice packs
☐ Other tests	☐ Muscle relaxants	☐ Other: _____

Indicate if treatment with this provider: ☐ Helped, ☐ Did not help, ☐ Made condition worse

DISABILITY FORM

EMPLOYEE NAME: _____ DATE: _____

This letter/form certifies that this patient is under my care for the following:

☐	Neck or back pain	☐	Automobile crash injury Date:
☐	Knee, leg, or foot pain	☐	Work related injury Date:
☐	Arm pain	☐	Sports/Home related injury and/or pain
☐	Disc pain	☐	Other:

HE/SHE IS PRESCRIBED:

☐	**Temporary Partial Disability (See Modifications)**	☐	**Temporary Total Disability**	☐	**Permanent Partial Disability (See Modifications)**	☐	**Permanent Total Disability**

Modifications/Restrictions include the following:

☐	Single lifting limited to pounds	☐	(No/Limited) fingering/handling/grasping
☐	No repeated lifting over pounds	☐	(No/Limited) bending head-neck
☐	Lifting restricted to times per hour	☐	Keyboarding limited to (minutes/hours) per day
☐	No lifting above (waist/shoulder/head) level	☐	Sitting limited to (minutes/hours) per day
☐	No raising/lowering objects to other levels	☐	(No/Limited) carrying activity
☐	(No/Limited) bending/stooping waist	☐	To take a _____ minute break every _____ hours
☐	(No/Limited) crouching/squatting	☐	Allow worker to move about when needed for pain
☐	(No/Limited) twisting/pushing/pulling	☐	Limited to _____ hours of work per day
☐	(No/Limited) climbing/crawling	☐	To wear a (support/brace) at work
☐	No (walking/standing)	☐	
☐	No prolonged walking/standing	☐	

ACTIVITIES OF DAILY LIVING RESTRICTIONS-MEDICARE

PATIENT NAME: _____ DATE: _____

INSTRUCTIONS FOR PATIENTS: Please write in all physical activities for each of the following sections that you are having difficulty performing or that you cannot perform at the time of your initial consultation. The chiropractor needs to identify specific restrictions or disabilities that only relate to your neck, middle back, low back, and pelvic regions. It is important to not include any restrictions or disabilities that you have that relate to other body regions, such as your arms and legs. If not employed please indicate "N/A." If able to perform all activities in a specific section please indicate "None." For example: if you do not participate in any sport activities you would indicate "None."

WORK ACTIVITIES (Please write in all work activities that you have difficulty or inability performing recently):

_____
_____
_____

Which work activity is most difficult to perform: _____

HOME ACTIVITIES (Please write in all home activities that you have difficulty or inability performing recently):

_____
_____
_____

Which home activity is most difficult to perform: _____

RECREATIONAL ACTIVITIES (Please write in all hobby-recreational activities that you have difficulty or inability performing recently):

_____
_____
_____

Which hobby-recreational activity is most difficult to perform: _____

SPORT ACTIVITIES (Please write in all sport activities that you have difficulty or inability performing recently):

_____
_____
_____

Which sport activity is most difficult to perform: _____

Patient Name:	Doctor: Lawrence Nordhoff, DC 4133 Mohr Ave, Ste F, Pleasanton,CA 94566

PATIENT NAME: _____ DATE: _____

SUBLUXATION EXAMINATION FINDINGS

LEFT SIDE OF BODY						RIGHT SIDE OF BODY				
Muscle Spasm	Tissue Tone	Range-of-Motion	Asymmetry	Pain Tenderness	LEVEL	Pain Tenderness	Asymmetry	Range-of-Motion	Tissue Tone	Muscle Spasm
					Occ					
					C1					
					C2					
					C3					
					C4					
					C5					
					C6					
					C7					
					T1					
					T2					
					T3					
					T4					
					T5					
					T6					
					T7					
					T8					
					T9					
					T10					
					T11					
					T12					
					L1					
					L2					
					L3					
					L4					
					L5					
					Sacral					
					Pelvis SI Jt					

+ Mild, ++ Moderate, +++ Severe (Findings from Palpation-ROM testing-X-ray). Circled vertebra: indicates subluxation level

FORMULARIO DE INTRODUCCION DEL PACIENTE

Nombre del Paciente:	Fecha de Hoy:
Direccion:	Teléfono de la Casa:
Ciudad/Codigo Postal:	Teléfono del Trabajo:
Fecha de Nacimiento:	Edad:
Estatura:	Ocupacion:
Peso:	Empleo:
Licencia de Manejar Num.:	Seguro Social Num.:

LA VISITA ESTA RELACIONADA CON:

- ☐ Lesion Relacionada con el Trabajo
- ☐ Lesion Relacionada con la Casa
- ☐ Síntomas Sin Lesiones
- ☐ Lesion por Caída o por Resbalar
- ☐ Lesion de Accidente Automovilístico
- ☐ Lesion por un Deporte
- ☐ Revision General Solamente
- ☐ Exámen Físico requerido por la Escuela

MUJERES SOLAMENTE

☐ Sí, ☐ No ¿Hay posibilidad que esté embarazada ahora o sospeche estar embarazada?

INFORMACION DEL SEGURO MEDICO

☐ Sí, ☐ No ¿Tiene usted seguro que cubra un tratamiento Quiropráctico?

Nombre y Direccion de la Compañía de Seguro:_____

¿Es usted el ☐ asegurado, o ☐ dependiente?

¿Cuál es el porcentaje que pagan? _____

¿Cuál es la cantidad del deducible? _____

¿Limitan la cantidad de pago por cada visita? _____

¿Limitan el numero de visitas? _____

Nuestra oficina mandará como cortesía la factura a su compañía aseguradora. Si usted tiene una poliza de seguro secundaria, es su responsabilidad mandarles la factura. Tendrá que pagar por todo lo que su compañía de seguros principal no pague. Su segunda compañía aseguradora le pagará después, basado en los beneficios de su poliza.

Si usted lo desea, nuestra oficina le proveerá los servicios para mandar las facturas. *Recuerde que usted es responsable por cualquier cargo incurrido en esta oficina. Es su responsabilidad pagar cualquier deducible, y cualquier otro balance que no sea pagado por su compañía de seguros.*

PARA DE MANTENER BAJOS LOS GASTOS EN NUESTRA OFICINA Y LAS CUOTAS RAZONABLES, SE REQUIERE EL PAGO AL FINAL DE CADA TRATAMIENTO PARA NUESTROS PACIENTES QUE PAGUEN EN EFECTIVO Y LA PARTE DE PAGO CORRESPONDIENTE PARA LOS PACIENTES REGULARES CON SEGURO MEDICO.

Firma de la parte responsable (Paciente o Padres):_____ Fecha_____

(Doctor's Name/Address/Telephone)

COPYING THE OFFICE FORM FILES ON THE CD INTO AN EXISTING MICROSOFT WORD SOFTWARE IN AN IBM COMPATIBLE COMPUTER.

INSTRUCTIONS: Trying to copy these files by any other means may create margin/tab, page format and font problems. **Do not attempt to install these files under the "Run" option or the "Control Panel" option for "Add/Remove" programs.** See "HelpForm" file on the CD or on this page in how to copy the files on the CD onto a computers [C] drive. You must already have Microsoft Word (Office 2003 or newer version) program installed and a Windows XP or newer operating system on your IBM compatible computer for these medical forms to copy properly. The tables in these files may not work in Mac-Apple based computers even with IBM compatible software. Once your computer boots up fully, insert the CD into your "Compact Disk" [D:] Drive. If your computer is set up to automatically detect this CD in your computer follow option 'A' instructions. If your computer does not automatically detect the CD, then use option 'B' copying instructions.

OPTION A. AUTOMATIC CD DETECTION FOR FILE COPYING. If your computer is set on Auto Run when you put a CD in your 'D' drive, your computer will automatically detect that you have inserted a CD into the [D:] drive of your computer. After the computer reads this CD, you will see the office forms files that are on the CD listed on your computer screen. Simply click on the "Edit" menu with the left mouse button. Next click on "**Select All."** All of the office form files on the CD will become highlighted on your screen. Then click on "Edit" again and then click on "**Copy**." The computer will ask you where you want the office form files on the CD copied on your computer's [C:] drive. Click on "**My Documents**" and follow the computer prompts to indicate that it is "ok" to copy or paste these office form files to My Documents. Only copy files onto "My Documents." You also have to option to put all of these files into a separate folder.

OPTION B. MANUAL CD FILE COPYING INSTRUCTIONS. If your computer does not have the automatic run-detection feature turned on in your computer to detect when you insert a CD into the 'D' drive, you will have to tell the computer how and where to copy these form files into your existing Microsoft Word program. First, click the left button on your mouse on the **"Start"** on the bottom left of your computer screen. Next click on **"Programs."** *Don't click on "Run."* Next locate and double click on **"Windows Explorer."** Your "Windows Explorer" may not be seen at first on your screen and may be listed under "Accessories" and if so you need to click on **"Accessories"** and then click on **"Windows Explorer."** If you have the "Windows Explorer" ICON on your desktop simply double click it with left mouse button. Once your "Windows Explorer" is open look at the top of your screen you will see a directory. Look for and click on **"My Computer."** Then look for the heading of "**Devices with Removable Storage.**" Double click (left button) on your "**Disk Drive i.e. [D:]" (Look how your computer is configured for your CD drive location as some computers have 'E' drives).** You should now see a list of **"Files Currently on your 'D' Drive** on the right side of your screen. If Dr Nordhoff provided you additional files such as MVCI Seminar notes or on facet and disc you can copy these files onto your computer as well by pressing and holding the "Ctrl" button on your keyboard and clicking the left side of your mouse on each file which should become highlighted. Then release the "Ctrl" button. To copy the selected files you need to go the pull down menu at the top of your screen and click on **"Edit"** and then click **"Copy"** next. Before proceeding, look at the top of the screen for the **"Address"** line and you will see your "D" drive listed. You need to tell your computer that you want copy these files to your hard disc in your computer. You do this by looking to the right of the "Address" for a down arrow and click on the down arrow. You will then need to Click on **"My Documents."** Your screen will now indicate that you are copying these files to your "My Documents" location in your computer which is your 'C' drive. You then need to go to the top of your screen and click on **"Edit"** and then click on **"Paste."** You should then see your screen change showing the various files being copied onto your computer. You can exit the Windows Explorer feature by clicking on **"x"** at the top right of the computer monitor screen or by clicking on "File" then "Close." To verify that all of the files have copied, get into your "Microsoft Word" program and open each of the files. If you see "READ ONLY" at the top of the screen, you need to read section 4 instructions to fix the setting on your computer to change these files so you can make changes to the files.

QUIRKS WITH MS WORD WHEN COPYING FILES AND USING THE "SAVE AS" FEATURE TO RENAME FILES. Dr Nordhoff only uses the Arial or Times New Roman fonts in the files. Sometimes Microsoft Word will preset defaults to the Calibri font when you cut and paste or copy a file. Get rid of any Calibri fonts. If you notice an abnormal gap in the rows or sentences after copying/pasting material in these files, put cursor where problem exists and block it, then click on "Page Layout" Look for "Spacing" they should all read "0 pt" and if not make the change.

When desiring to use a portion or to make new versions of a file, it is best open the desired file, then click on the "File" or "Office Button" then click on the "Save As" feature, then rename file making certain to keep the file in "My Documents," then delete everything you do not want in the file, leaving just the material that is desired. This process is less problematic overall and will save the margins, font sizes and the file format.

THE DOCTOR'S AND PATIENT NAME AS WELL AS DATE SHOULD BE ON EVERY PAGE ON INTAKE FORMS. USE « REPLACE » FEATURE TO MAKE CHANGES EASILY BEFORE PRINTING.