OFFICE OF INSURANCE REGULATION
Bureau of Property & Casualty Forms and Rates

Standard Disclosure and Acknowledgement Form
Personal Injury Protection - Initial Treatment or Service Provided

The undersigned insured person (or guardian of such person) affirms:

1. The services or treatment set forth below were **actually rendered.** This means that those services have **already been provided.**

_____

_____

2. I have the right and the **duty to confirm** that the services have already been provided.

3. I was **not solicited** by any person to seek any services from the medical provider of the services described above.

4. The medical provider has **explained** the services to me for which payment is being claimed.

5. If I notify the insurer in writing of a billing error, I may be entitled to a portion of any reduction in the amounts paid by my motor vehicle insurer. If entitled, my share would be at least 20% of the amount of the reduction, up to $500.

Insured Person (patient receiving treatment or services) or Guardian of Insured Person:

Name *(PRINT or TYPE)*	Signature	Date

The undersigned licensed medical professional or medical director, if applicable, affirms the statement numbered 1 above and also:

A. I have **not solicited** or caused the insured person, who was involved in a motor vehicle accident, to be solicited to make a claim for Personal Injury Protection benefits.

B. The treatment or services rendered were explained to the insured person, or his or her guardian, **sufficiently** for that person to sign this form with informed consent.

C. The accompanying statement or bill is **properly completed** in all material provisions and all relevant information has been provided therein. This means that each request for information has been responded to **truthfully, accurately**, and in a **substantially complete** manner.

D. The coding of procedures on the accompanying statement or bill is proper. This means that **no service has been upcoded, unbundled**, or constitutes an invalid **or not medically necessary diagnostic test** as defined by Section 627.732(14) and (15), Florida Statutes or Section 627.736(5)(b)6, Florida Statutes.

Licensed Medical Professional Rendering Treatment/Services or Medical Director, if applicable ***(Signature by his/ her own hand)****:*

ALEXANDER C. FRANK , DC, DACNB		
Name *(PRINT or TYPE)*	Signature	Date

Any person who knowingly and with intent to injure, defraud, or deceive any insurer files a statement of Claim or an application containing any false, incomplete, or misleading information is guilty of a felony of the third degree per Section 817.234(1)(b), Florida Statutes.

Note: The **original** of this form must be furnished to the insurer pursuant to Section 627.736(4)(b), Florida Statutes and may **not** be electronically furnished. Failure to furnish this form may result in non-payment of the claim.

1317 SE 25th Loop #102, Ocala, FL. 34471 4076 E. FL-44 #4, Wildwood, FL. 34785
P: 352.571.5155 Fax: 352.877.9637

Patient Information and Method of Payment

PLEASE PRINT

Other

Patient's Name _____ Male Female
(First) (Middle Initial) (Last)

Address _____
(Street) (Apt #) (City) (State) (Zip)

1st Contact # ( )_____ 2nd Contact # ( )_____ Marital Status _____ Language _____

3rd Contact # ( )_____ Email Address _____

Date of Birth _____ Race _____ Ethnicity _____ Social Security # _____

Employer_____ Occupation_____

In Case of Emergency Contact _____
(Please provide the name, phone number and relationship of someone not at your address)

Auto Insurance _____

Primary Card Holder Name_____ Date of Birth_____
(Last) (First)

Relationship to Patient _____ Policy # _____ Claim # _____

Adjustor Name: _____ Phone Number: _____

Additional _____ ( ) Health Insurance ( ) Automobile ( ) Worker's Compensation Primary

Card Holder Name_____ Date of Birth _____
(Last) (First)

Relationship to Patient _____ Policy # _____ Group # _____

Attorney's Name: _____ Phone Number: _____

I authorize payment from my insurance company directly to Alexander C. Frank, DC, DACNB and/or Florida Functional Neurology Group, for treating my medical needs. I understand the fee will not exceed the allowed amount by the insurance company. I authorize any provider examining and or treating me to release my medical and psychiatric information to any third party payor (such as an insurance company or governmental agency) should they request it with no charge to the patient. I also authorize any provider examining and or treating me to release my financial information should my account be turned over to a professional collection agency for non-payment. I understand that all fees and charges are payable at the time the services are rendered and that I am responsible for payment or charges. I agree to pay for charges not covered by insurance at the time of my visit or when they are billed to me.

_____ _____
(Signature) Date

Office Financial Policy

You are considered a cash patient until your bring in your completed insurance forms, and we qualify and accept your insurance coverage.

All payments are expected at the time of service.

If you have insurance: We will provide you with a superbill for your records (i.e. submission to your insurance provider, etc.).

If you are being treated due to an auto accident: The state of Florida is considered a No-Fault State, which means that regardless of who was at fault in the accident the patient's Personal Injury Protection (PIP) policy **will be filed first** for any treatment rendered. Any portion of the treatment not covered by the PIP insurance, will be patient's responsibility.

If you have obtained the representation of an attorney due to an auto accident, worker's compensation or slip and fall: We will send your attorney a letter of protection signed by you to ensure that any treatment not covered by either your PIP or health insurance will be paid out of any settlements received. We will wait for settlement of your claim for up to 6 months after your care is completed. Once the claim is settled, any fees for services are due , in full, immediately.

Charges may apply for missed appointments without a 24 hrs notice.

Our fees are considered usual, customary and reasonable by most companies, and therefore are covered up to the maximum allowance determined by each carrier. This statement does not apply to companies who reimburse based on arbitrary schedules of fees bearing no relationship to the current standard of care in this area.

If your carrier has not paid a claim within forty-five (45) days of submission, you agree to take an active part in the recovery of your claim. If your insurance carrier has not paid within sixty (60) days of submission, you accept responsibility for payment in full. If you discontinue care for any reason other than discharge by a doctor, all balances will become immediately due and payable in full by you, regardless of any claims submitted.

Our policy is to extend to you the courtesy of allowing you to assign your insurance benefits directly to us. This policy reduces your out-of-pocket expense.

_____ (please initial) I acknowledge that I have received and understand FSRC **Notice of Privacy Practices (HIPAA)** containing a description of the uses and disclosures of my health information. I further understand that FSRC may update its Notice of Privacy Practices at any time and that I may receive an updated copy by submitting a request in writing.

_____ _____

Patient or Legal Guardian Name (printed) Date

_____ _____

Patient or legal Guardian Signature Relationship to Patient

_____ _____

Witness Signature (office staff) Date

1317 SE 25th Loop #102, Ocala, FL. 34471 4076 E. FL-44 #4, Wildwood, FL. 34785
Phone: (352) 571-5155 - Fax: (352) 877-9637 info@ffng.org

NOTICE OF INITIATION OF MEDICAL TREATMENT
PURSUANT TO FLORIDA STATUTE 627.736

PATIENT_____ DATE OF LOSS _____/_____/_____

INSURANCE CO_____ CLAIM NUMBER_____

Dear Sir/Madam:

Please be advised that the above medical provider is hereby giving notice pursuant to F.S. 627.736 of initiation of medical treatment within 21 days after first examination or treatment of the claimant. By giving the aforementioned notice, the medical provider may bill for charges for treatment or services rendered up to, but not more than, 75 days before the postmark date of the billing statement.

Billing Address
FUCNTIONL HEALTH PLANNING, LLC.
(D/B/A FLORIDA FUNCTIONAL NEUROLOGY GROUP)
4076 E. FL.-44 #4, Wildwood, FL. 34785

OFFICIAL CERTIFICATION OF PATIENT AS TO INSURANCE COVERAGE

PATIENT_____ DATE OF LOSS _____/_____/_____

INSURANCE CO_____ CLAIM NUMBER_____

I, as the above captioned patient hereby attest that to the best of my knowledge, that the insurance claims information I have provided above is in fact the correct insurance information under which I am entitled to medical and/or PIP coverage.

I understand that the medical provider is relying on this correct information in order to receive the appropriate coverage and qualify for payment for medical services provided to me.

SIGNATURE_____ DATE_____/_____/_____

Florida Functional Neurology Group

GENERAL RELEASE AND RELEASE OF X-RAYS

KNOW ALL MEN BY THESE PRESENTS: That I have requested the release of the X-rays and any Doctors notes of _____ which are part of the records of _____, DOB:_____

(Patient)

I hereby acknowledge receipt of these records and x-ray Films/ CDs. In consideration of the foregoing, I hereby release and forever discharge the aforesaid doctor from any and all responsibility or liability of any kind, nature, or character whatsoever arising from said treatment.

PLEASE FAX OR MAIL ALL RECORDS AND X-RAYS TO:
FLORIDA FUNCTIONAL NEUROLOGY GROUP
FAX (352) 877-9637
4706 E. FL-44 #4, Wildwood, FL. 34785
Ph (352) 352-5155

_____ _____
Patient or Legal Representative Dated

Florida Functional Neurology Group

Medical Reports and Doctor's Lien

YOUR CLIENT/OUR PATIENT: _____

I hereby authorize Alexander C. Frank, DC, DACNB, and/or Florida Functional Neurology Group (FFNG), to furnish you, my attorney, with a full report of my examination, diagnosis, treatment, prognosis, etc.

I hereby authorize and direct you, my attorney, to pay directly to said doctor and FFNG such sums as may be due and owing for services rendered both by reason of this accident and by reason of any other bills that are due, and to withhold and forward immediately to FFNG such sums from any insurance reimbursement, settlement, judgment, or verdict which may be paid to you, my attorney, or myself as a result of the injuries in connection herewith.

I fully understand that I am directly and fully responsible to said doctor and FFNG for all medical bills submitted by both parties for any and all services rendered and that I will pay bills no later than three months from the time such services have been provided, and forward immediately to said doctor and FFNG reimbursement received from my insurance carriers. This agreement is made solely for said doctors and FFNG's additional protection and in consideration of their awaiting payment. I further understand that my obligations to make in full payment to said doctor and FFNG are unconditional and are not contingent on my receiving any insurance reimbursement, settlement, judgment or verdict.

In the event my insurance carrier fails to pay FFNG for services rendered within thirty day as prescribed by Florida Statutes, I HEREBY AUTHORIZE FFNG TO RETAIN THEIR OWN CORPORATE ATTORNEY(S) TO REPRESENT ME ON MY OWN BEHALF IN ORDER TO COLLECT FROM SAID INSURANCE CARRIER THE REASONABLE MONEYS OWED TO FFNG. I hereby acknowledge and understand that I shall incur no attorneys fees or costs as a result of FFNG retaining their own corporate attorney(s) on my behalf. Representation by FFNG to institute corporate attorney(s) shall solely be for collections of overdue and/or unpaid medical bills owed to FFNG for services previously rendered on my, that patient's behalf.

Furthermore, if it becomes necessary for FFNG to institute a lawsuit against patient/client to recover any moneys due to a result of services rendered to patient/client, the prevailing party in any such cause of action shall be entitled to recover from the other, its reasonable costs, including any and all attorney's fees at all levels.

It is the intent of the undersigned that this agreement is irrevocable and shall apply to the previously described cause of action whether or not the undersigned should engage co-counsel or substitute attorneys at any future time. In the event this should occur, the undersigned further agrees to immediately advise the doctor's office in writing of said substitution or engagement at the time said substitution or engagement of co-counsel should occur.

Patient's attorney agrees to forward immediately to FFNG payments received as reimbursement for services rendered to the above patient by FFNG. The attorney agrees to provide the doctor's office with a brief report on the status of said patient's case.

Patient_____ Date_____

Witness_____ _____ Date_____

The undersigned being attorney of record for the above patient hereby agrees to comply with all of the terms of the above and consents to and shall withhold sufficient sums from any insurance reimbursement, settlement, or judgment.

Furthermore, attorney agrees to immediately notify the doctor's office in writing should there occur a substitution of counsel, referral to another attorney, retention of co-counsel or termination or modification in any manner of attorney/client relationship. The attorney further agrees to immediately notify the doctor's office in writing, should there occur any insurance reimbursement, settlement, judgment or verdict in said patient's case.

Attorney's Signature_____Date_____

4076 E. FL-44 #4, Wildwood, FL. 34785

Phone: (352) 571-5155 - Fax: (352) 877-9637 info@ffng.org

PIP Payout RELEASE

This document gives authorization to obtain the insurance company PAYOUT sheet.

A photocopy of this document shall be as binding as an original signature page.

_____

PATIENT'S NAME (PLEASE PRINT)

_____

PATIENT'S SIGNATURE or Guardian's signature if patient is a minor

_____

Date

4076 E. FL-44 #4, Wildwood, FL. 34785

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Florida Functional Neurology Group
(P) 352-571-5155
(F) 352-877-9637

FLORIDA FUNCTIONAL NEUROLOGY GROUP
ALEXANDER C. FRANK, DC, DACNB
4076 E. FL.-44 #4
Wildwood, FL. 34785

ASSIGNMENT OF INSURANCE BENEFITS, RELEASE, & DEMAND

Insurer and Patient Please Read the Following in its Entirety Carefully!

I, the undersigned patient/insured knowingly, voluntarily and intentionally assign the rights and benefits of my automobile Insurance, a/k/a Personal Injury Protection (hereinafter PIP), Uninsured Motorist, and Medical Payments policy of insurance to the above health care provider. I understand it is the intention of the provider to accept this assignment of benefits in lieu of demanding payment at the time services are rendered. I understand this document will allow the provider to file suit against an insurer for payment of the insurance benefits or an explanation of benefits and to seek §627.428 damages from the insurer. If the provider's bills are applied to a deductible, I agree this will serve as a benefit to me. This assignment of benefits includes the cost of transportation, medications, supplies, overdue interest and any potential claim for common law or statutory bad faith/unfair claims handling. If the insurer disputes the validity of this assignment of benefits then the insurer is instructed to notify the provider in writing within five days of receipt of this document. Failure to inform the provider shall result in a waiver by the insurer to contest the validity of this document. The undersigned directs the insurer to pay the health care provider the maximum amount directly without any reductions & without including the patient's name on the check. To the extent the PIP insurer contends there is a material misrepresentation on the application for insurance resulting in the policy of insurance is declared voided, rescinded, or canceled, I, as the named insured under said policy of insurance, hereby assign the right to receive the premiums paid for my PIP insurance to this provider and to file suit for recovery of the premiums. The insurer is directed to issue such a refund check payable to this provider only. Should the medical bills not exceed the premium refunded, then the provider is directed to mail the patient/named insured a check which represents the difference between the medical bills and the premiums paid.

Disputes: The insurer is directed by the provider and the undersigned to not issue any checks or drafts in partial settlement of a claim that contain or are accompanied by language releasing the insurer or its insured/patient from liability unless there has been a prior written settlement agreed to by the health provider (specifically the office manager) and the insurer as to the amount payable under the insurance policy. The insured and the provider hereby contests and objects to any reductions or partial payments. Any partial or reduced payment, regardless of the accompanying language, issued by the insurer and deposited by the provider shall be done so under protest, at the risk of the insurer, and the deposit shall not be deemed a waiver, accord, satisfaction, discharge, settlement or agreement by the provider to accept a reduced amount as payment in full. The insurer is hereby placed on notice that this provider reserves the right to seek the full amount of the bills submitted. If the PIP insurer states it can pay claims at 200% of Medicare then the insurer is instructed & directed to provide this provider with a copy of the policy of insurance within 10 days**. Any effort by the insurer to pay a disputed debt as full satisfaction must be mailed to the address above, after speaking with the office manager, and mailed to the specific attention of the Office Manager. See Fla. Stat. §673.3111.**

EUOs and IMEs: If the insurer schedules a defense examination or examination under oath (hereinafter "EUO") the insurer is hereby INSTRUCTED to send a copy of said notification to this provider. The provider or the provider's attorney is expressly authorized to appear at any EUO or IME set by the insurer. The health care provider is not the agent of the insurer or the patient for any purpose. This assignment applies to both past and future medical expenses and is valid even if undated. A photocopy of this assignment is to be considered as valid as the original. I agree to pay any applicable deductible, co-payments, for services rendered after the policy of insurance exhausts and for any other services unrelated to the automobile accident. The health care provider is given the power of attorney to: endorse my name on any check for services rendered by the above provider; and to request and obtain a copy of any statements or examinations under oath given by patient.

Release of information: I authorize this provider to: furnish an insurer, an insurer's intermediary, the patient's other medical providers, and the patient's attorney via mail, fax, or email, with any and all information that may be contained in the medical records; to obtain insurance coverage information (declaration sheet & policy of insurance) in writing and telephonically from the insurer; request from any insurer all explanation of benefits (EOBs) for all providers and non-redacted PIP payout sheets; obtain any written and verbal statements the patient or anyone else provided to the insurer; obtain copies of the entire claim file, the property damage file, and all medical records, including but not limited to, documents, reports, scans, notes, bills, opinions, X-rays, IMEs, and MRIs, from any other medical provider or any insurer. The provider is permitted to produce my medical records to its attorney in connection with any pending lawsuits. The insurer is directed to keep the patient's medical records from this provider private and confidential. The insurer is not authorized to provide these medical records to anyone without the patient's and the provider's prior express written permission.

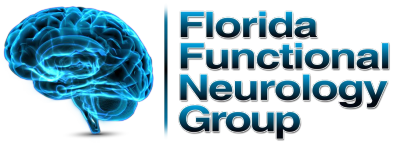
Demand: Demand is hereby made for the insurer to pay all bills within 30 days without reductions and to mail the latest non-redacted PIP payout sheet and the insurance coverage declaration sheet to the above provider within 15 days. The insurer is directed to pay the bills in the order they are received. However, if a bill from this provider and a claim from anyone else is received by the insurer on the same day the insurer is directed to not apply this provider's bill to the deductible. If a bill from this provider and claim from anyone else is received by the insurer on the same day then the insurer is directed to pay this provider first before the policy is exhausted. In the event the provider's medical bills are disputed or reduced by the insurer for any reason, or amount, the insurer is to: set aside the entire amount disputed or reduced; escrow the full amount at issue; and not pay the disputed amount to anyone or any entity, including myself, until the dispute is resolved by a Court. Do not exhaust the policy. The insurer is instructed to inform, in writing, the provider of any dispute.

Certification: I certify that: I have read and agree to the above; I have not been solicited or promised anything in exchange for receiving health care; I have not received any promises or guarantees from anyone as to the results that may be obtained by any treatment or service; and I agree the provider's prices for medical services, treatment and supplies are reasonable, usual and customary.

Caution: Please read before signing. **If you do not completely understand this document please ask us to explain it to you. If you sign below we will assume you understand and agree to the above.**

Patient's Name _____ Patient's Signature _____
(Please Print) (If patient is a minor, signature of parent/guardian)

Date _____



Terms of Acceptance

Informed Consent:

A patient, in coming to the chiropractic physician, gives the doctor permission and authority to care for the patient in accordance with the chiropractic tests, diagnosis, and analysis. The chiropractic adjustment or other clinical procedures are usually beneficial and seldom cause any problems. In rare cases, underlying physical defects, deformities or pathologies may render the patient susceptible to injury. The doctor, of course, will not give any treatment or care if he is aware that such care may be contra-indicated. Again, it is the responsibility of the patient to make it known, or to learn through healthcare procedures whatever he/she is suffering from: latent pathological defects, illnesses or deformities which would otherwise not come to the attention of the chiropractic physician. The chiropractic physician provides a specialized, non-duplicating health care service. Your doctor of chiropractic is licensed in a special practice and is available to work with other types of providers in your health care regimen. I understand that if I am accepted as a patient FFNG and Alexander C. Frank, DC, DACNB, I am authorizing them to proceed with any treatment that may be necessary. Furthermore, any risk involved, regarding chiropractic treatment, will be explained to me upon my request.

Missed Appointments:

There is a possible $25 fee charged for all appointments that are not canceled prior to scheduled visit.

Consent to Evaluate and Treat a Minor:

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

Communications:

In the event that we would need to communicate your healthcare information, to whom may we do so?

Spouse: _____

Children: _____

Others: _____

_____ None

May we mail postcards or leave messages on any answering device, i.e. home answering machines or voicemails? Yes [ ] No [ ]

Acknowledgement:

I have reviewed the notice of privacy practices (HIPAA) and have been provided an opportunity to discuss my right to privacy. Upon request I will be given a copy.

I, _____, have read and fully understand the above statements.

Signature: _____ Date_____

4076 E. FL-44 #4, Wildwood, FL. 34785
Phone: (352) 571-5155 - Fax: (352) 877-9637 info@ffng.org

Florida Functional Neurology Group

Alexander C. Frank, D.C., D.A.C.N.B., F.A.B.E.S.
Board Certified Chiropractic Neurologist
1317 SE 25th Loop #102, Ocala, FL. 34471 4076 E. FL.-44 #4, Wildwood, FL. 34785
P: 352.571.5155 F: 352.877.9637

Name: _____ Today's Date____/____/____

HISTORY OF INJURY

Date of Accident / Fall ____/____/____ Time of Accident / Fall: _____am / pm (write **time** on blank & circle am/pm)
Please give a brief explanation of the accident, fall or description of how you received your injuries. If it was from a fall please provide the type of surface you were on i.e.: asphalt, concrete, dirt, grass, tile, carpet, level, uneven ect.

_____

_____

_____

_____

_____

_____

_____

Were you ___ Driver ___ Passenger ___ Pedestrian ___ Other _____
Front seat passenger: ___Middle ___Right; Rear seat passenger ___Left ___Middle ___Right ___ Other
Car you were in: Year____ Make_____ Model _____ Other Car: _____
Damage Estimate: (circle one) mild / moderate / severe / total loss Select Damage Estimate
Where did the first impact (damage) to your vehicle occur? Circle all that appl ☐ Left (driver side) ☐ Right (passenger side) ☐ front / ☐ rear / other _____
Was there a second impact? Please describe the areas of damage to you car _____
What road were you traveling on? _____ Direction? North / South / East / West
Were you wearing your seat belt? ___ Yes ___ No If yes, was your seat belt : ___ a lap belt only;
___ a shoulder harness and lap belt; ___ a shoulder harness only ___ other _____
What direction was your head facing at the time of the accident? ☐ Forward ☐ Left ☐ Right ☐ Down ☐ Up
____other: _____
Were you wearing glasses? ___ Yes ___ No If yes, were your glasses still in place after the accident ___ Yes ___ No If not in place, to where were they displaced? _____
How did you know the accident was about to happen? _____
Did you strike anything in the vehicle? ___ Yes ___ No
If yes, which object(s) did you strike: With what part of the body?

☐ Steering Wheel ……_____
☐ Dashboard ……_____
☐ Windshield ……_____
☐ Rear View Mirror……_____
☐ Door Frame/Window ……_____
☐ Headrest ……_____
☐ Other _____ …… _____

Were you rendered **unconscious? ___ Yes ___ No If yes for how long?** _____
If you were unconscious, how do you know? _____
If you were ☐ Cut ☐ Bleeding or ☐ Bruised please explain here _____
Was the police called to the accident scene? ___ Yes ___ No

Name: _____

_____

Florida Functional Neurology Group

MEDICAL TREATMENT

Did you go to the emergency room or urgent care? ___Yes ___No. Which hospital/facility Select Hospital/ED/UC

How did you get there? ___Ambulance ___Drove myself ___Other_____

Did you seek medical treatment elsewhere after the accident? If yes when? ___ / ___ / ___ and where? _____

Name of the facility _____ Doctor's name _____ Address _____

What was done the day of your visit?

- ___Examination
- ___Xrays / CT scan / MRI
- ___Cervical Collar / Cast / Crutches
- ___Given Home Instructions
- ___Prescriptions _____
- ___Stitches / Cast_____
- ___Injection / Medications _____
- ___Other: _____

Name address and phone of your family doctor: _____

REVIEW OF SYSTEMS / MEDICAL HISTORY

Please number: 1. Issue PRIOR to accident 2. Prior issues that has WORSENED since the accdient

3. New Complaints since the accident

GENERAL

___Allergy
___Tremors
___Convulsions
___Dizziness
___Fainting
___Fatigue
___Fever
___Headache
___Sleep loss
___Weight loss
___Nervousness/depression
___Nerve Pain / Neuralgia
___Numbness
___Sweats
___Chills and or sweats
___Anemia
___Shingles
___Cancer
___HIV+ / Aids
___Seizures
___Epilepsy

EYES, EARS, NOSE, THROAT

___Cough
___Colds
___Deafness
___Dental decay
___Earache / Ringing
___Ear discharge
___Sinus infection
___Enlarged glands
___Enlarged thyroid
___Nose bleeds
___Failing vision
___Far sighted
___Gum trouble
___Hay fever
___Hoarseness
___Nasal obstruction

PSYCH

___ Bipolar
___Nervousness / Anxiety
___Depression
___ADHD
___Dementia
___Confusion
___Difficulty concentrating
___Mood changes

MUSCULOSKELETAL

___Arthritis
___Bursitis
___Foot trouble
___Hernia
___Low back pain
___Neck pain/stiffness
___Artificial joints / Implants
___Pain or numbness in:
___ Shoulders / Shoulder Blade
___ Arms
___ Elbows
___ Hands
___ Hips
___ Legs
___ Knees
___ Feet
___Painful tailbone
___Sciatic Pain
___Spinal curvature

GENITO-URINARY / ENDOCRINE

___Bedwetting
___Blood in urine
___Frequent urination
___Inability to control bladder
___Kidney infection or stones
___Painful urination
___Prostate trouble
___Pus in urine
___Painful menstruation
___Hot flashes
___Irregular cycle
___Gout
___Diabetes

CARDIOVASCULAR

___Hardening of arteries
___High blood pressure
___Low blood pressure
___Pain over heart
___Poor circulation
___Rapid heart beat
___Slow heart beat
___Swelling of ankles

RESPIRATORY

___Chest pain
___Chronic cough
___Wheezing
___Spitting up blood
___Spitting up phlegm
___Difficult breathing
___Asthma
___Emphysema
___Tuberculosis

GASTROINTESTINAL

___Belching or gas
___Colitis / IBS
___Constipation
___Diarrhea
___Difficult digestion
___Distention of abdomen
___Excessive hunger
___Gall bladder trouble
___Hemorrhoids
___Intestinal worms
___Jaundice
___Liver trouble
___Nausea
___Pain over stomach
___Poor appetite
___Vomiting
___ Hepatitis
___Ulcers

OTHER:_____

Female: Are you **pregnant**? ____Yes ____No If no, your last menstrual period was: ____/____/____

SEE ADDITONAL FORM FOR REVIEW OF SYSTEMS

Florida Functional Neurology Group

WWW.FFNG.ORG

Name: _____

Date: _____ Age: _____

Concussion/Mild Traumatic Brain Injury Intake Form

Please provide us with some information about your injury, if you do not understand a question, your therapist will assist you during the evaluation.

Date/Time of Injury: _____ **Injury description**: _____

_____

1b. Location of Impact: On the head- ☐ Front ☐ Left Front ☐ Right Front ☐ Left Back ☐ Right Back ☐ Back
Other location- ☐ Neck ☐ Body

2. Cause: ☐ Car accident ☐ Hit by a car ☐ Fall ☐ Assault ☐ Sports (specify)_____ ☐ Other _____

3. Are there any events just BEFORE the injury that you have no memory of (even brief)? ◯ Yes ◯ No Duration_____

4. Are there any events just AFTER the injury that you have no memory of (even brief)? ◯ Yes ◯ No Duration_____

5. Did you lose consciousness? ◯ Yes ◯ No Duration_____

6. Early Signs: ☐ Dazed or stunned ☐ Confused about events ☐ Slow to respond ☐ Dizzy ☐ Forgetful ☐ Repeating things

7. Were seizures observed? ◯ Yes ◯ No If **yes**, please provide details_____

8. **Did you receive medical attention at the time of the injury?** ◯ Yes ◯ No If **yes**, please explain, including any tests & results:

_____

Since the injury, have you experienced any of these symptoms more than usual **today** or **in the past day**?

☐ Headache	☐ Fatigue	☐ Difficulty Concentrating	☐ Drowsiness	☐ Sleeping more than usual
☐ Nausea	☐ Sensitivity to light	☐ Difficulty remembering	☐ Trouble falling asleep	☐ Sleeping less than usual
☐ Vomiting	☐ Sensitivity to noise	☐ Irritability		
☐ Balance Problems	☐ Numbness/tingling	☐ Sadness		
☐ Dizziness	☐ Feeling mentally foggy	☐ More emotional		
☐ Visual Problems	☐ Feeling slowed down	☐ Nervousness		

Exertion: Do these symptoms worsen with:
Physical Activity SELECT ONE
Concentration/thinking SELECT ONE

Has anything like this ever happened in the past? SELECT ONE
If yes, how many times? SELECT ONE
What's the longest you experienced symptoms? ◯ Days ◯ Weeks ◯ Months ◯ Years

Vision	Headache (HA)	Developmental	✓	Psychiatric	✓
History of vision change or disturbance? ◯ Y ◯ N	Prior treatment for HA? ◯ Y ◯ N	Learning disabilities		Anxiety	
If yes, please explain: _____	History of migraine headache	ADD/ADHD		Depression	
_____	☐ Personal ☐ Family	Other Developmental Disorder_____		Sleep Disorder	
	_____			Other psychiatric disorder	

How do you learn best? By:
☐ Hearing it ☐ Reading it ☐ Seeing it demonstrated ☐ Performing it yourself ☐ Observing someone else

Rate your **average pain** or symptom on a scale of 0-10 with **"0" equals to no pain** and **"10" equals the worst imaginable**.
→ Mark the line at the point that represents your pain or symptom.

0 | 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | 10 SELECT ONE

Rate how near you are to your **normal function** on a scale of 0-10 by with **"0" equals not able** to perform ***any*** of your normal activities and "**10" equals able** to do ***all*** normal activities without difficulty. → Mark the line at the point that represents your level of function.

0 | 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | 10 SELECT ONE

Which skills or abilities do you hope to regain by coming to therapy? _____

Your last office visit from your medical physician SHOULD contain all your current medications. Make sure to sign the Records Requestso that we can request these documents

Medication Name	Dosage	Physician
1.		
2.		
3.		
4.		
5.		
6.		
7.		
8.		
9.		
10.		
Medical Physicians	Conditions	Contact Info
1.		
2.		
3.		
4.		
5.		
6.		
7.		

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Alexander C. Frank, D.C., D.A.C.N.B., F.A.B.E.S.
Board Certified Chiropractic Neurologist
Diplomate, American Chiropractic Neurology Board
Fellow, Electrodiagnostic Specialties

Please describe in your own words the condition(s) you are seeking evaluation for. When did it start? What makes it better? What makes it worse? Information such as "pain is worse in the morning", or "the pain reduces when I lay on my left side". What has/has not helped?

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Patient:_____

Date:____/____/2021

Review of Systems

Please check all that apply

General-
□ Weight loss or gain
□ Fatigue
□ Fever or chills
□ Weakness
□ Trouble sleeping

Skin-
□ Rashes
□ Lumps
□ Itching
□ Dryness
□ Color changes
□ Hair and nail changes

Head-
□ Headache
□ Head injury
□ Neck Pain

Ears-
□ Decreased hearing
□ Ringing in ears
□ Earache
□ Drainage

Eyes-
□ Vision Loss/Changes
□ Glasses or contacts
□ Pain
□ Redness
□ Blurry or double vision
□ Flashing lights
□ Specks
□ Glaucoma
□ Cataracts
□ Last eye exam

Nose-
□ Stuffiness
□ Discharge
□ Itching
□ Hay fever
□ Nosebleeds
□ Sinus pain

Throat-
□ Bleeding
□ Dentures
□ Sore tongue
□ Dry mouth
□ Sore throat
□ Hoarseness
□ Thrush
□ Non-healing sores

Neck-
□ Lumps
□ Swollen glands
□ Pain
□ Stiffness

Breasts-
□ Lumps
□ Pain
□ Discharge
□ Self-exams
□ Breast-feeding

Respiratory-
□ Cough
□ Sputum
□ Coughing up blood
□ Shortness of breath
□ Wheezing
□ Painful breathing

Cardiovascular-
□ Chest pain or discomfort
□ Tightness
□ Palpitations
□ Shortness of breath with activity
□ Difficulty breathing lying down
□ Swelling
□ Sudden awakening from sleep with shortness of breath

Gastrointestinal-
□ Swallowing difficulties
□ Heartburn
□ Change in appetite
□ Nausea
□ Change in bowel habits
□ Rectal bleeding
□ Constipation
□ Diarrhea
□Yellow eyes or skin

Urinary-
□ Frequency
□ Urgency
□ Burning or pain
□ Blood in urine
□ Incontinence
□ Change in urinary strength

Vascular-
□ Calf pain with walking
□ Leg cramping

Musculoskeletal-
□ Muscle or joint pain
□ Stiffness
□ Back pain
□ Redness of joints
□ Swelling of joints
□ Trauma

Neurologic-
□ Dizziness
□ Fainting
□ Seizures
□ Weakness
□ Numbness
□ Tingling
□ Tremor

Hematologic-
□ Ease of bruising
□ Ease of bleeding

Endocrine-
□ Head or cold intolerance
□ Sweating
□ Frequent urination
□ Thirst
□ Change in appetite

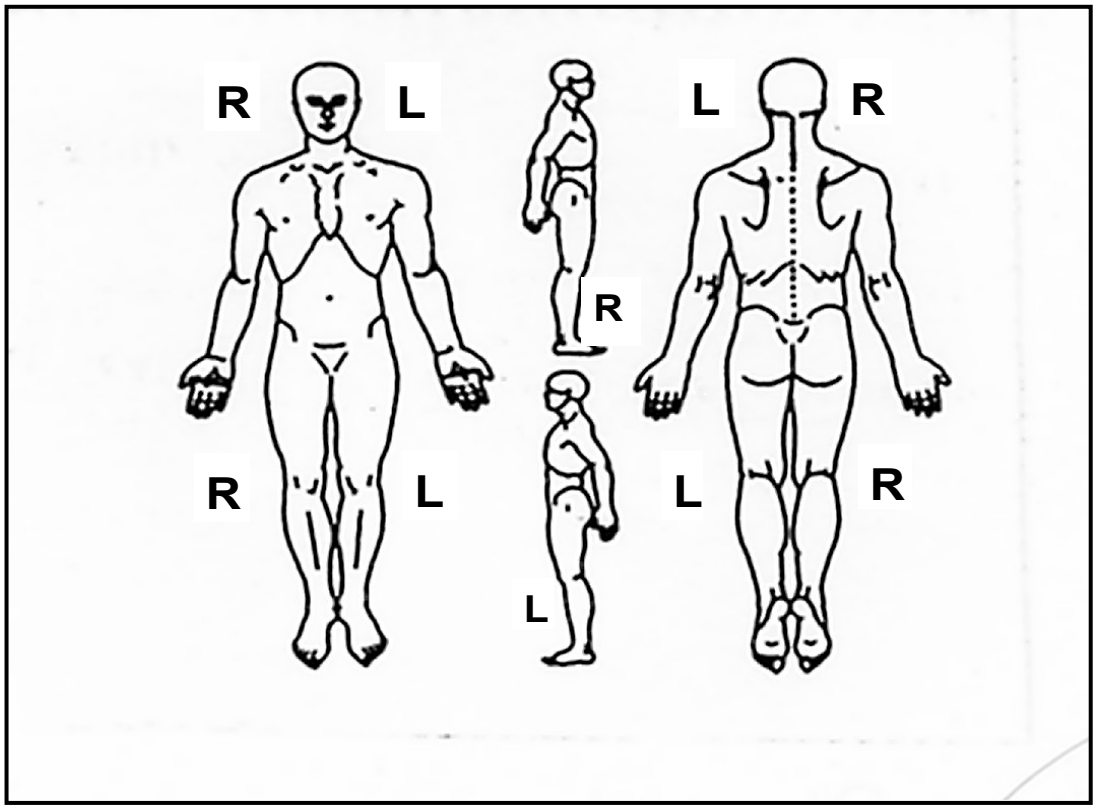
Psychiatric-
□ Nervousness
□ Stress
□ Depression
□ Memory loss

Signature _____

P: (352) 571-5155 F: (352) 877-9637 info@ffng.org

Name: _____

SYMPTOM CHART: *[If you are currently experiencing symptoms, on the chart below place an **X** on **all** the area(s) where symptom(s) are present.]*



If you can use a tablet to indicate where you pain hurts. Not available on desktop computers

Rate your pain levels on a scale of 0-10

0 = There are times, when I am awake, that I do not notice pain.
9 = I almost pass out because of pain and I cannot get out of bed.
10 = I pass out because of pain.

10 worst pain; 0 no pain

Neck Pain:

My **neck** pain is:
- ○ Constant (100-75 % of the time)
- ○ Frequent (75-50% of the time)
- ○ Intermittent (50-25% of the time)
- ○ Occasional (Less than 25%)

This pain when at its ***worst*** = 0
This pain when at its ***best*** = 0

Check all that apply for the quality of your **neck** symptoms:

☐ Stiff ☐ Pressure ☐ Dull ☐ Numbness ☐ Pulling ☐ Sharp
☐ Pins/Needles ☐ Burning ☐ Tingling ☐ Ache ☐ Other_____

Where does the pain radiate to? _____

How long after the accident did you begin to feel **neck** related symptoms? _____

10 worst pain; 0 no pain

Upper / Mid Back:

My **upper/mid back** pain is:
- ○ Constant (100-75 % of the time)
- ○ Frequent (75-50% of the time)
- ○ Intermittent (50-25% of the time)
- ○ Occasional (Less than 25% of time)

This pain when at its ***worst*** = 0
This pain when at its ***best*** = 0

Check all that apply ☐ Upper Back ☐ Goes into my neck ☐ Mid Back ☐ Shoulder Blades
☐ Goes in to lower back ☐ Other _____ ☐ Other _____

Check all that apply for the quality of your **upper / mid back** symptoms:

☐ Stiff ☐ Pressure ☐ Dull ☐ Numbness ☐ Pulling ☐ Sharp
☐ Pins/Needles ☐ Burning ☐ Tingling ☐ Ache ☐ Other_____ ☐ Other_____

Where does the pain radiate to? _____

How long after the accident did you begin to feel **upper / mid back** related symptoms? _____

Cont.

Name: _____

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Rate your pain levels on a scale of 0-10

0 = There are times when I am awake that I do not notice pain.
9 = I almost pass out because of pain and I cannot get out of bed.
10 = I pass out because of pain.

Low Back Pain:

pain when at its ***worst*** select one
pain when at its ***best*** = select one

My Low Back pain is:
- Constant (100-75% of the time)
- Frequent(75-50% of the time)
- Intermittent(50-25% of the time)
- Occasional (25% of the time or less)

Check all that apply for the quality

- ☐ Stiff
- ☐ Pressure
- ☐ Tingling
- ☐ Numbness
- ☐ Pulling
- ☐ Sharp
- ☐ Pins/Needles
- ☐ Burning
- ☐ Dull
- ☐ Ache
- ☐ Other_____
- ☐ Other_____

Where does your pain radiate to?

How long after the accident did you begin to feel **low back pain**

Headaches:

10 worst pain; 0 no pain

My **headaches** when at its ***worst***= select one
My **headaches** when at its ***best*** = select one

My **headaches are**
- Constant (100-75% of the time)
- Frequent (75-50% of the time)
- Intermittent (50-25% of the time)
- Occasional (25% or lessof the time)

How many days a week do you have **headaches**? select one **7** How many headaches do you have a day? 0

Check all that apply for the quality of your **headache** symptoms:

- ☐ Throbbing
- ☐ Pulsating
- ☐ Pounding
- ☐ Constant
- ☐ Tight
- ☐ Squeezing
- ☐ Pressure
- ☐ Sharp
- ☐ Grinding
- ☐ Tender

Please mark symptoms that are associated with your **headaches:**

- ☐ Loss of consciousness
- ☐ Light sensitivity
- ☐ Nausea or vomiting
- ☐ Noise sensitivity
- ☐ Dizziness
- ☐ Neck stiffness
- ☐ Numbness in face/arm/hand
- ☐ Visual disturbances
- ☐ Other _____

How long after the accident did you begin to feel your **headaches**? _____

Extremity:

Left / Right **(circle one)**

(circle one) Arm / Shoulder / Elbow / Wrist / Hand / Fingers / Leg / Hip SIDE select one Other _____

This pain when at its ***worst***= select one
This pain when at its ***best*** = select one

I notice this/these pain(s):
Constantly (100-75% of day)

Check all that apply for the quality of these symptoms:

- ☐ Stiff
- ☐ Pressure
- ☐ Dull
- ☐ Numbness
- ☐ Pulling
- ☐ Sharp
- ☐ Pins/Needles
- ☐ Burning
- ☐ Tingling
- ☐ Ache
- ☐ Pinching
- ☐ Throbbing
- ☐ Nagging
- ☐ Other_____

How long after the accident did you begin to feel **these** symptoms? _____

Extremity:

Left / Right **(circle one)**

(circle one) Arm / Shoulder / Elbow / Wrist / Hand / Fingers / Leg / Hip/Thig SIDE select one Other _____

This pain when at its ***worst***= select one
This pain when at its ***best*** = select one

I notice this pain
Constantly (100-75% of day)

Check all that apply for the quality of these symptoms:

- ☐ Stiff
- ☐ Pressure
- ☐ Dull
- ☐ Numbness
- ☐ Pulling
- ☐ Sharp
- ☐ Pins/Needles
- ☐ Burning
- ☐ Tingling
- ☐ Ache
- ☐ Pinching
- ☐ Throbbing
- ☐ Nagging
- ☐ Other_____

How long after the accident did you begin to feel **these** symptoms? _____

Please provide any additional symptoms / information here: _____

_____

_____

_____

Which of the following over the counter medications are you taking or have taken in the last week?

☐ Ibuprofen (Advil) ☐ Antihistamines ☐ Decongestants ☐ Naturopathic ☐ Vitamins ☐ Antacids
☐ Aspirin ☐ Laxatives ☐ Tylenol ☐ Naproxen Sodium (Aleve) ☐ Other: _____

Which of the following prescription medications are you taking?

☐ Allergy ☐ Hormones ☐ Pain ☐ Tone/Spasticity Reduction ☐ Other:_____
☐ Antibiotic ☐ Diabetes ☐ Reflux ☐ Cholesterol_____
☐ Anti-inflammatory ☐ Depression ☐ Seizure ☐ Thyroid
☐ Blood Pressure ☐ Respiratory ☐ Anti-nausea ☐ Bladder
☐ Heart ☐ Muscle Relaxant ☐ Blood Thinners ☐ MS Med/Fatigue

Medical History: For new patients only

☐ ADD/AHD
☐ Amputation
☐ Autism
☐ Auto Immune Disease: _____
☐ Balance Problems
☐ Bowel/Bladder Problems
☐ Cancer: _____
☐ Cardiac Condition: _____
☐ Chemical Dependency
☐ Chronic Otitis Media
☐ Cleft Palate
☐ Dementia
☐ Depression
☐ Diabetes
☐ Dizziness
☐ DVT's
☐ Failure to Thrive
☐ Falls
☐ Feeding/Swallowing Problems
☐ Fibromyalgia
☐ Fractures: _____
☐ Gastrointestinal: _____
☐ Hepatitis
☐ Hearing Loss
☐ Headaches/Migraines
☐ High Blood Pressure (Hypertension)
☐ Labor/Delivery Complication
☐ Neurological Condition: _____
☐ Noise Exposure
☐ Osteoarthritis
☐ Osteoporosis
☐ Psychological Condition: _____
☐ Respiratory Condition: _____
☐ Rheumatoid Arthritis
☐ Seizures
☐ Sleep disturbances
☐ Thyroid
☐ TMJ
☐ Vision
☐ Voice
☐ Other: _____

Do you have any known allergies: Drug_____ Food _____ Other _____

Social History:

1. Support system:
   ☐ Married ☐ Single ☐ Widowed ☐ Significant other: _____
2. Living arrangement:
   ☐ Home/alone ☐ Home w/family ☐ Assisted living center ☐ Adult Foster home
   ☐ Children at home #: _____ Ages of Children_____
3. Amount of help currently needed at home:
   ☐ None ☐ Part of the day ☐ During the day ☐ During the night ☐ 24 hours a day
4. Home Accessibility:
   ☐ # of Stairs/Steps ☐ Walk-in Shower ☐ Rail ☐ Tub/shower combination
5. Assistive Devices/Equipment:
   ☐ Cane ☐ Bath bench ☐ Resting splints ☐ Walker ☐ Brace
   ☐ Raised toilet seat ☐ Commode ☐ Prosthesis ☐ Wheelchair/scooter ☐ Grab bars
   ☐ Hospital bed ☐ Dressing equipment ☐ Hearing aids ☐ Glasses ☐ Lifeline

Work History: **Student** ☐ Occupation: _____

Current Status? ☐ Full duty ☐ Temporary disability ☐ Permanent disability ☐ Applied for disability

☐ Retired ☐ Volunteer ☐ Light duty ☐ Modified duty/job restrictions are: _____

Anticipated return to work date or work status change? _____

Physician follow-up: ☐ Physician recheck is scheduled for this date: _____

SIGNATURE:_____

Name: _____

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PAST HISTORY

Have you ever been involved in a previous motor vehicle accident(s)? ____Yes ____No
If yes what date(s) _____. If yes were you injured? ____Yes ____No

Have you had any **sports** / **work** injuries? ____Yes ____No If yes, to what body part(s) and when? _____
_____
_____
_____

Are you now or have you ever been **disabled** (unable to work) for any reason? ____Yes ____No
If yes, please explain why:_____
_____
_____

Have you ever had any **fractures** (broken bones)? ____Yes ____No If yes, where and when? _____
_____

~~Have you ever had **ANY** surgeries? ____Yes ____No If yes, please explain when and to what? _____~~
_____
_____
_____

Do you take **over-the-counter** or **prescription medications** now? ____Yes ____No If yes, please list the medications:
_____
_____
_____

Have you taken any **medication today**? ____Yes ____No
If yes list the medications:_____

SOCIAL HISTORY

I am ____Married ____Single ____Other _____ Were you employed when your accident occurred? ____Yes ____No
I work for_____ Job title _____ Have you missed time from work because of this accident? ___Yes ___No How many days? _____ Why? _____
At work I stand for ____ hour(s), sit for ____ hour(s), and walk for ____ hour(s) per day.

____ I currently / ____ I previously ____ I have never smok(ed) cigarettes, cigars or a pipe? For how many years? _____
How many packs per day?_____ How long ago did you quit? _____
Do you drink alcohol? ____never ____rare ____social ____occasional ____frequent ____it is a problem
Do you take illegal drugs? ____Yes ____No If yes, what and how often? _____
Do you have any history of alcohol / drug abuse treatment? Y / N

SLEEP HISTORY

Has the quality or quantity of your **sleep** changed since your accident? ____Yes ____No
How many **hours** did you sleep before your injury? ____ How many hours do you sleep now? ____
How many times do you **wake up** per night? ____

Patient's Signature: _____ Date: _____

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Functional Loss
Permanent Losses and Duties Under Duress

Permanent loss indicates what can no longer performed after a reasonable course of care has concluded and duties under duress indicates what you can still do, but causes pain and/or limitations

Name:_____ Date:_____

Employment

Activity	Reason for Difficulty	Please choose one: unable to perform **or** a date range
Lifting: ☐	Increased Pain ☐ Restricted Movement ☐ Weakness	☐ Unable to Perform since Accident From: To:
Bending: ☐	Increased Pain ☐ Restricted Movement ☐ Weakness	☐ Unable to Perform since Accident From: To:
Sitting: ☐	Increased Pain ☐ Restricted Movement ☐ Weakness	☐ Unable to Perform since Accident From: To:
Walking: ☐	Increased Pain ☐ Restricted Movement ☐ Weakness	☐ Unable to Perform since Accident From: To:
Carrying: ☐	Increased Pain ☐ Restricted Movement ☐ Weakness	☐ Unable to Perform since Accident From: To:
Computer: ☐	Increased Pain ☐ Restricted Movement ☐ Weakness	☐ Unable to Perform since Accident From: To:

Specific Activities/Duties are asked on a seperate page

Loss of: **Job** ☐ **Chance of raise** ☐ **Job status** ☐ **Promotion** ☐

On a separate piece of paper, please explain in detail your job description and what changed, or what you can no longer do that you could do before your accident.

Restrictions within your home

Activity	Reason for Difficulty	Please choose one: unable to perform **or** a date range
Lifting: ☐	Increased Pain ☐ Restricted Movement ☐ Weakness	☐ Unable to Perform since Accident From: To:
Bending: ☐	Increased Pain ☐ Restricted Movement ☐ Weakness	☐ Unable to Perform since Accident From: To:
Sitting: ☐	Increased Pain ☐ Restricted Movement ☐ Weakness	☐ Unable to Perform since Accident From: To:
Walking: ☐	Increased Pain ☐ Restricted Movement ☐ Weakness	☐ Unable to Perform since Accident From: To:
Carrying: ☐	Increased Pain ☐ Restricted Movement ☐ Weakness	☐ Unable to Perform since Accident From: To:
Computer: ☐	Increased Pain ☐ Restricted Movement ☐ Weakness	☐ Unable to Perform since Accident From: To:

Specific Activities/Duties are asked on a seperate page

On page 3 and 4, please explain in detail your job description and what changed, or what you can no longer do that you could do before your accident.

Restrictions outside your home

Activity	Reason for Difficulty	Please choose one: unable to perform **or** a date range
Lifting: ☐	Increased Pain ☐ Restricted Movement ☐ Weakness	☐ Unable to Perform since Accident From: To:
Bending: ☐	Increased Pain ☐ Restricted Movement ☐ Weakness	☐ Unable to Perform since Accident From: To:
Sitting: ☐	Increased Pain ☐ Restricted Movement ☐ Weakness	☐ Unable to Perform since Accident From: To:
Walking: ☐	Increased Pain ☐ Restricted Movement ☐ Weakness	☐ Unable to Perform since Accident From: To:
Carrying: ☐	Increased Pain ☐ Restricted Movement ☐ Weakness	☐ Unable to Perform since Accident From: To:
Yard work: ☐	Increased Pain ☐ Restricted Movement ☐ Weakness	☐ Unable to Perform since Accident From: To:

Specific Activities/Duties are asked on a seperate page

On page 3 and 4, please explain in detail your job description and what changed, or what you can no longer do that you could do before your accident.

Recreational sports and activites

Activity	Reason for Difficulty	Please choose one: unable to perform **or** a date range
Lifting: ☐	Increased Pain ☐ Restricted Movement ☐ Weakness	☐ Unable to Perform since Accident From: To:
Bending: ☐	Increased Pain ☐ Restricted Movement ☐ Weakness	☐ Unable to Perform since Accident From: To:
Sitting: ☐	Increased Pain ☐ Restricted Movement ☐ Weakness	☐ Unable to Perform since Accident From: To:
Walking: ☐	Increased Pain ☐ Restricted Movement ☐ Weakness	☐ Unable to Perform since Accident From: To:
Carrying: ☐	Increased Pain ☐ Restricted Movement ☐ Weakness	☐ Unable to Perform since Accident From: To:
Physical Activity: ☐	Increased Pain ☐ Restricted Movement ☐ Weakness	☐ Unable to Perform since Accident From: To:

Specific Activities/Duties are asked on a seperate page

On page 3 and 4, please explain in detail your job description and what changed, or what you can no longer do that you could do before your accident.

School | Educational

Activity	Reason for Difficulty	Please choose one: unable to perform **or** a date range
Lifting: ☐	Increased Pain ☐ Restricted Movement ☐ Weakness	☐ Unable to Perform since Accident From: To:
Bending: ☐	Increased Pain ☐ Restricted Movement ☐ Weakness	☐ Unable to Perform since Accident From: To:
Sitting: ☐	Increased Pain ☐ Restricted Movement ☐ Weakness	☐ Unable to Perform since Accident From: To:
Walking: ☐	Increased Pain ☐ Restricted Movement ☐ Weakness	☐ Unable to Perform since Accident From: To:
Carrying: ☐	Increased Pain ☐ Restricted Movement ☐ Weakness	☐ Unable to Perform since Accident From: To:
Computer: ☐	Increased Pain ☐ Restricted Movement ☐ Weakness	☐ Unable to Perform since Accident From: To:

Specific Activities/Duties are asked on a seperate page

On page 3 and 4, please explain in detail your job description and what changed, or what you can no longer do that you could do before your accident.

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On the next page, please write 10 separate statements about what both can no longer do and what you can, but is done with pain, or under duress.

The following are samples to help guide you:

Name:_____Date:_____

Work Limitations: "I am an automobile mechanic. I can't lean over the car for a long period of time. When I use my right hand to hold tools for a long period of time I get pain that shoots up to my neck and down to my lower back. I have to stop from time to time and rest so it's hard to finish repairs in a timely manner Therefore I had to change my job from a full time mechanic to a part time mechanic and a part time service writer reducing my pay by 30%."

Work Limitations Due to Pain: I was a full time employee at Mr. Fixit and my duties are being a mechanic. Since the accident I have resumed my job with lighter duties and less hours. Since the accident I have lost my status, job security, promotional prospects and my quality of work has lessened due to the pain.

Inside Domestic Permanent Losses: "I have become very agitated. I can no longer pick up my infant daughter. When I wake up in the morning I have neck and back pain. I can't reach over my head or stretch my legs. There are times when I feel like I'm being stabbed in the back. I can no longer carry groceries fro the car to my kitchen and I am unable to vacuum. I am also having difficulty during sexual relations due to the pain in my neck and back."

Inside Domestic Limitations Due to Pain: "I have lost enjoyment when performing my domestic activities due to the pain in my neck as a result of the injury. I have experienced a loss of enjoyment with the following activities inside my home: laundry, dishwashing, washing windows, cleaning and preparing meals, which I do with pain and to a much lesser extent. As a result I no longer enjoy these duties as I did before my accident."

Outside Household Permanent Losses: I can no longer paint the house, weed the garden, mow the lawn, wash the car, repair broken shingles, shovel snow or maintain the lawn as I did before the accident due to the pain in my neck and back.

Outside Household Limitations Due to Pain: "I have experienced a loss of enjoyment with the following activities outside my home: landscaping, trimming bushes, washing windows, gardening and taking out the trash since the accident due to the pain in my neck and back."

Social Permanent Limitations: "When I go to the movies or concerts I can't enjoy them because I can't sit for long periods of time without pain so I do not go. I tried to play touch football and shoot basketballs as I did prior to the accident, but I have difficulty due to my neck and back pain and limitations with my arm and can no longer play."

Social Limitations Due to Pain: "I can only walk for 30 minutes, where before the accident I could walk for 2-3 hours. I have a fear when driving in the car. Whenever I hear a horn or screeching brakes I am afraid I'm going to get hit again so I drive in the right lane very slow."

Education/School Permanent Losses: I was enrolled part time in college and due to the pain as a result of the accident I can no longer sit in class, therefore I had to drop out of school and enroll in an online program.

Education/School Limitations Due to Pain: I have experienced a loss of enjoyment when performing the following educational activities as a result of the injury. I am attending an Online college degree program and I have dropped to part time and have been getting lower grades. This is problematic as I am on a degree tract that will now take much longer and my prospect for advancement has significantly diminished with lower grades.

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Name:_____Date:_____

Using the guide above, please complete the following about what YOU can either no longer do, or can do under duress (with pain:)

1. Work Limitations:

2. Work Limitations Due to Pain:

3. Inside Domestic Permanent Losses:

4. Inside Domestic Limitations Due to Pain:

5. Outside Household Permanent Losses:

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Name:_____Date:_____

6. Outside Household Limitations Due to Pain:

7. Social Permanent Limitations:

8. Social Limitations Due to Pain:

9. Education/School Permanent Losses:

10. Education/School Limitations Due to Pain:

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