

# ORANGE PARK & ARGYLE CHIROPRACTIC CENTERS

## AUTO INJURY QUESTIONNAIRE

Date: \_\_\_\_\_

Email Address: \_\_\_\_\_

Last Name: \_\_\_\_\_ First: \_\_\_\_\_ Middle: \_\_\_\_\_

Mailing Address: \_\_\_\_\_ Apt #: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_ Home Phone: \_\_\_\_\_

Sex: M F DOB: \_\_\_/\_\_\_/\_\_\_ Marital Status: S M D W

Weight: \_\_\_\_\_ Height: \_\_\_\_\_

Employed By: \_\_\_\_\_ Phone: \_\_\_\_\_

Emergency Contact Name: \_\_\_\_\_ Phone: \_\_\_\_\_

HEARD ABOUT OUR OFFICE BY: \_\_\_\_\_

**Is patient here as the result of an accident? Y N Date of Accident: \_\_\_/\_\_\_/\_\_\_**

Accident type: AUTO WORK HOME RECREATION SPORTS

Primary Insurance Company: \_\_\_\_\_

Insured: SELF SPOUSE PARENT/GUARDIAN

Insured's DOB: \_\_\_/\_\_\_/\_\_\_ Insured's SS#: \_\_\_\_\_

Insured Employer: \_\_\_\_\_

Who is your Primary Care Physician? \_\_\_\_\_

WHAT IS YOUR CURRENT AREA(S) OF COMPLAINT? \_\_\_\_\_

What surgeries have you had (type and when): \_\_\_\_\_

List any previous accidents and falls: (Auto, Work, Sports, Home, Other): \_\_\_\_\_

List any broken bones you may have had: \_\_\_\_\_

List any medications and/or supplements you may be taking:

Do you have any drug allergies?

Do you smoke: Y N Alcohol: Y N \_\_\_\_\_

### ASSIGNMENT OF BENEFITS

I, \_\_\_\_\_, hereby irrevocably assign to Argyle Chiropractic Center, P.A. / Orange Park Chiropractic Center, P.A. any and all benefits and rights I have under any policy of insurance, indemnity agreement, or any other collateral source as defined by the Florida Statutes for any service and/or charges provided by Argyle Chiropractic Center, P.A. / Orange Park Chiropractic Center, P.A.

In witness whereof, the undersigned have hereunto set their hands, this \_\_\_\_\_ day of \_\_\_\_\_ of 20\_\_\_\_.

\_\_\_\_\_  
Patient Name

X \_\_\_\_\_  
Patient Signature

PLEASE CIRCLE ALL CURRENT CONDITIONS

**SKIN**

Skin Disorder  
Shingles  
Bruises Easily  
Boils  
Hives or Allergies

**RESPIRATORY**

Difficulty Breathing  
Chronic Cough  
Coughing Phlegm/Blood  
Asthma

**NERVOUS SYSTEM**

Hot/Cold Spots  
Numbness/Tingling  
Dizziness  
Paralysis  
Fainting  
Convulsions  
Irritability  
Tremors  
Insomnia  
Depression  
Confusion  
Forgetfulness

**GENERAL**

Fever  
Thyroid Disorder  
Chills  
Diabetes  
Sweats  
Rheumatic Fever  
Chronic Fatigue  
Cancer  
Loss of Weight  
Weight Trouble

**GENIO-URINARY**

Urine Disorder Frequent  
Excessive/Scanty/Painful  
Discolored/Blood/Pus  
Kidney Infections/Stones  
Cancer  
Prostatitis  
Bladder Trouble

**FEMALE**

Periods-Painful  
Irregular/Cramps  
Hot Flashes  
Breast-Lumps/Congested  
Menopause Symptoms

**GASTRO-INTESTINAL**

Chronic Nausea  
Vomiting  
Vomiting Blood  
Difficulty Chewing  
Swallowing  
Excessive Thirst  
Gastritis/Heartburn  
Pain over Stomach  
Ulcers/Stomach Disorders  
Distention of Abdomen  
Constipation  
Diarrhea  
Liver Trouble  
Gallbladder Trouble

**PRIMARY SYMPTOMS**

Recurring Headaches  
Facial/Jaw Pain  
Restricted Movement  
Head/Neck  
Neck Pain  
Neck Spasms  
Poor Posture  
Upper Back Pain  
Sore Aching  
"Shawl Muscles"  
Pain Shoulder/Arm/Hand  
Restricted Movement  
Shoulder/Arm/Hand  
Swollen Arm/Hand  
Arthritis  
Pain Beneath/Under  
Shoulder Blade  
Pain around Collar Bone  
Mid Back Pain  
Scoliosis  
Low Back Pain  
Neuritis  
Buttock Pain  
Hip Pain  
Sciatica  
Restricted Movement  
Leg/Foot  
Leg Cramps  
Leg Pain/Lower/Upper  
Sore Weak Muscles  
Walking Problems

**CARDIO VASCULAR**

Heart Attack  
High Blood Pressure  
Low Blood Pressure  
Rapid Beating Heart  
Slow Beating Heart  
Pain Over Heart  
Hardening Arteries  
Swelling of Ankles  
Poor Circulation  
Stroke  
Varicose Veins

**EYES/EARS/NOSE  
AND THROAT**

Zig Zag Flashes  
Chronic Earache  
Hearing Loss  
Ear Discharge  
Nose Pain  
Nose Bleeding  
Sore Throat  
Hoarseness

I, \_\_\_\_\_ agree that if I do not give a 24 hour notice I will be responsible to pay the no show fee of \$20.00.

Sign \_\_\_\_\_ Date: \_\_\_\_\_

Witness \_\_\_\_\_ Date: \_\_\_\_\_

PLEASE USE THE FOLLOWING COLORS TO SHOW THE PRESENT AREAS OF COMPLAINTS AND THE TYPES OF PAIN:

- BLUE = PAIN / ACHE / TENDERNESS
- PINK = BURNING
- GREEN = SPASMS / CRAMPING
- YELLOW = PINS / NEEDLES / NUMBNESS / TINGLING
- ORANGE = TIGHTNESS / STIFFNESS

Comments: \_\_\_\_\_

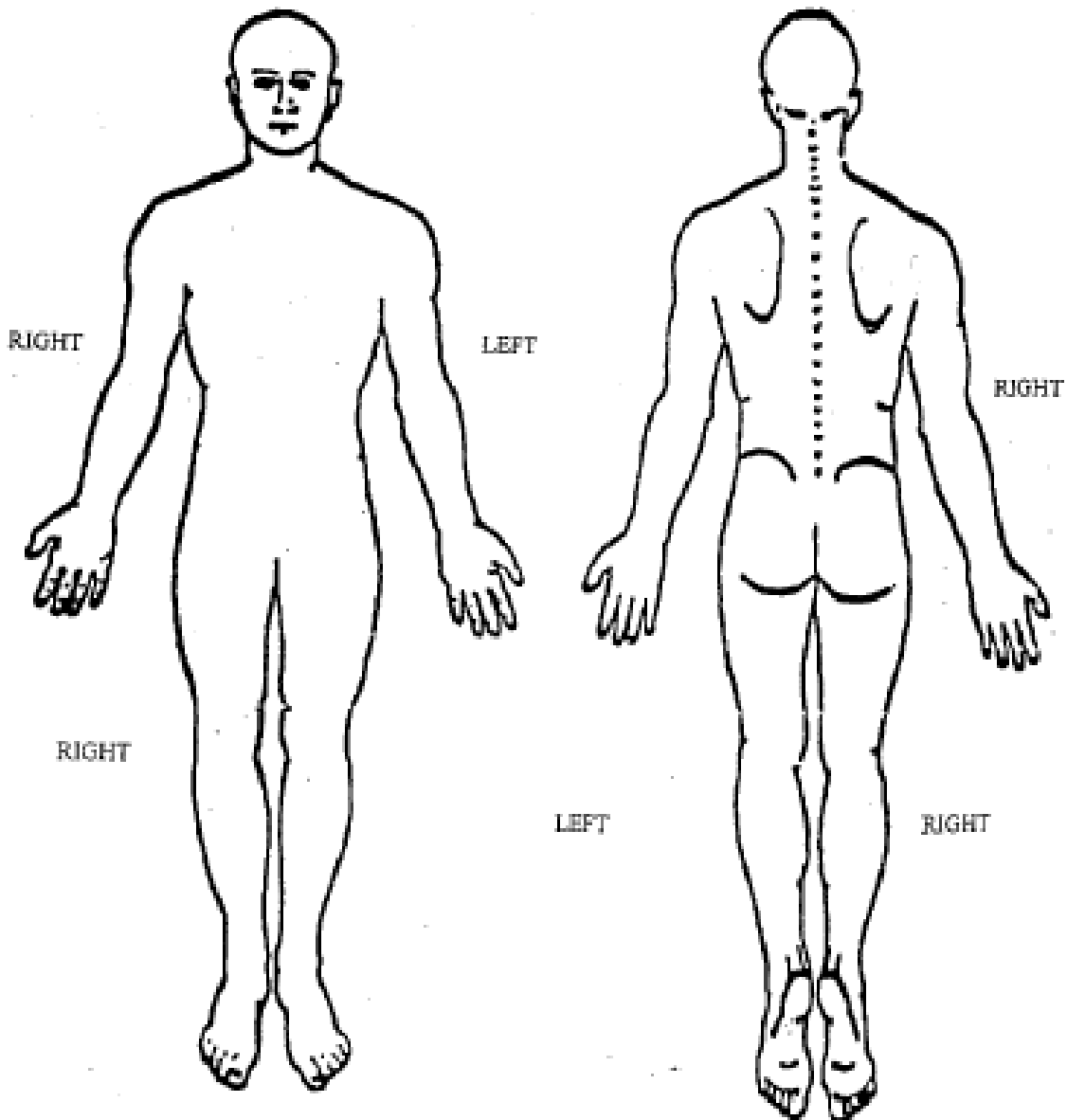
Patient's Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Name Printed: \_\_\_\_\_

Using a scale of 1 – 10, Rate the Intensity of each complaint area:

1 = Least Intensity

10 = Greatest Intensity



STRESS-RELAXATION PROFILE:

Circle all stressors: Coworker Boss Financial Home Personal Health Issues  
Friend Parent Child Spouse Ex-Spouse Mental Health Issue Emotional  
Circle all relaxation methods: Sleep TV Read Music Alcohol Smoking Drugs Eating Quietness  
Walk Jog Run Swim Prayer Meditate Centering Solitude Deep Breathing

FAMILY HISTORY: Review the disease categories and use the appropriate letter (s):

GP (grandparent) F (father) M (mother) H (husband) W (wife) B (brother) S (sister) C (child)

Arthritis _____	Kidney/Liver _____
Asthma _____	Low Back Pain _____
Cancer _____	Mental Illness _____
Depression _____	Migraine _____
Diabetes _____	Multiple Sclerosis _____
Disc Degeneration _____	Polio _____
Emphysema/Lung _____	Scoliosis _____
Epilepsy _____	Sinus Infections _____
Headaches _____	Stomach _____
Heart Attack _____	Thyroid _____
High Blood Pressure _____	Tuberculosis _____

FOR WOMEN ONLY: Are you pregnant? N Y Any Chance? N Y

Use Birth Control? N Y Pills Condoms Shots Diaphragm Tubal Hysterectomy Vasectomy

Date last menstrual period began: \_\_\_\_/\_\_\_\_/\_\_\_\_ Do you have painful periods? N Y

Patient Signature \_\_\_\_\_ Date \_\_\_\_\_

**AUTHORIZATION TO RELEASE OR  
RECEIVE MEDICAL INFORMATION  
and  
AUTHORIZATION OF  
ASSIGNMENT OF BENEFITS**

We strongly feel that all patients deserve from us the very best medical care that we can provide. Further, we feel that everyone benefits when definitive financial arrangements are agreed upon. Accordingly, we have prepared this material to acquaint you with our policy.

Our professional services are rendered to you, not the insurance company. Therefore, payment for treatment is your responsibility.

**PLEASE READ AND SIGN THE FOLLOWING:**

- 1) I authorize this office to release or receive any information necessary for my medical file and to expedite insurance claims.
- 2) I hereby authorize this office to bill my insurance company directly for their services.
- 3) I authorize payment directly to this physician of any insurance benefits otherwise payment to me.
- 4) In the event I receive payment from my insurance carrier, I agree to endorse any payment I receive over to my physician for which these fees are payable.

I understand that I am directly and fully financially responsible to this physician for charges not paid by my insurance. I further understand that such payment is not contingent on any settlement, judgment or insurance payment by which I eventually recover that fee. I realize that if my insurance company fails to pay my balance in full, or there is no payment made within 60 days, it is my responsibility to pay my doctor's bill directly. Further, I agree to pay Orange Park Chiropractic Center, P.A. / Argyle Chiropractic Center, P.A. the difference, if any, between the total amount of charges and the amount paid to me by the attorney and/or insurance carrier.

I further understand and agree that if I had to make timely payments on my account, I will be responsible for any and all reasonable costs of collection, including filing fees as well as reasonable attorney's fee.

A photo static copy of these authorizations and agreement shall be as valid as the original.

I understand that if I am accepted as a patient at Orange Park Chiropractic Center, P.A. / Argyle Chiropractic Center, P.A., I am authorizing them to proceed with any treatment that may be necessary. Furthermore, any risks associated with chiropractic will be explained upon my request.

**Signature** \_\_\_\_\_

**Date** \_\_\_\_\_

**Witness** \_\_\_\_\_



ACKNOWLEDGEMENT OF RECEIPT  
OF  
NOTICE OF PRIVACY PRACTICES

I acknowledge that I was provided a copy of the Notice of Privacy Practices and that I have read them or declined the opportunity to read them and understand the Notice of Privacy Practices. I understand that this form will be placed in my patient chart and maintained for six years.

\_\_\_\_\_  
Patient Name (please print)

\_\_\_\_\_  
Date

\_\_\_\_\_  
Parent, Guardian or Patient's Legal Representative

\_\_\_\_\_  
Signature

THIS FORM WILL BE PLACED IN THE PATIENT'S CHART AND MAINTAINED FOR SIX YEARS.

**ORANGE PARK CHIROPRACTIC CENTER**  
**ARGYLE CHIROPRACTIC CENTER**  
**Dr. Keith Schertell Dr. James Dautel Dr. Tina Warren**

784 Blanding Blvd., Suite 106 Orange Park, FL 32065 (904) 272-4555  
8540 Argyle Forest Blvd., Suite 4, Jacksonville, FL 32244 (904) 778-0968

**DOCTOR'S LIEN**

I hereby authorize Orange Park Chiropractic Center, P.A. / Argyle Chiropractic Center, P.A. hereafter referred to as doctor to furnish you, my attorney, with a full report of the examination, diagnosis, treatment, prognosis, etc., of myself in regard to the accident in which I was recently involved.

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

I agree never to rescind this document and that a rescission will not be honored by my attorney. I hereby instruct that in the event another attorney is substituted in this matter, the new attorney honor this lien as inherent to the settlement and enforceable upon the case as if it were executed by the new attorney.

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

Please acknowledge this letter by signing below and returning to the doctor's office. I have been advised that if my attorney does not wish to cooperate in protecting the doctor's interest, the doctor will not await payment but will require me to pay on my account and keep it on a current basis.

Date \_\_\_\_\_ Patient's Signature \_\_\_\_\_

The undersigned being attorney of record for the above patient does hereby agree to observe all terms of the above and agrees to withhold such sums from any settlement, judgment, or verdict as may be necessary to adequately protect said doctor. Attorney further agrees that in the event this lien is litigated that the prevailing party will be awarded attorney fees and costs.

Date \_\_\_\_\_ Attorney's Signature \_\_\_\_\_

(A photocopy of this form shall be considered as valid as the original.)

PERSONAL INJURY QUESTIONNAIRE

Name: \_\_\_\_\_ Phone: \_\_\_\_\_  
Address: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Employer: \_\_\_\_\_ Address: \_\_\_\_\_  
Employee Number: \_\_\_\_\_ Supervisor: \_\_\_\_\_

Auto Insurance Company: \_\_\_\_\_  
Policy: \_\_\_\_\_ Adjustor: \_\_\_\_\_  
Claim #: \_\_\_\_\_

Secondary Insurance Company: \_\_\_\_\_  
Policy: \_\_\_\_\_ Agent: \_\_\_\_\_

Attorney Name: \_\_\_\_\_ Phone: \_\_\_\_\_  
Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Were there any witnesses? ( ) Yes ( ) No  
If yes, please list: \_\_\_\_\_

**ACCIDENT INFORMATION**

Date of accident: \_\_\_\_\_ Time of day: \_\_\_\_\_

Were you: ( ) Driver ( ) Passenger ( ) Front Seat ( ) Rear Seat

Number of people in your vehicle: \_\_\_\_\_ Other vehicle: \_\_\_\_\_

What direction were you headed? ( ) North ( ) South ( ) East ( ) West

On what street? \_\_\_\_\_

What direction was the other vehicle headed? ( ) North ( ) South ( ) East ( ) West

On what street? \_\_\_\_\_

Were you struck from: ( ) Behind ( ) Front ( ) Left Side ( ) Right Side

Were you knocked unconscious? ( ) Yes ( ) No If yes, for how long? \_\_\_\_\_

Were the police notified? ( ) Yes ( ) No

What was your position in the car?

( ) Driver: if driver were your hands on the steering wheel? ( ) Left ( ) Right ( ) Both

( ) Passenger: if passenger, were you sitting in ( ) Front Seat ( ) Right Rear ( ) Left Rear

Did your vehicle strike another vehicle? ( ) Yes ( ) No

Angles of impact...First collision: ( ) Front ( ) Back ( ) Left ( ) Right

If second collision: ( ) Front ( ) Back ( ) Left ( ) Right

Were you wearing a seat belt? ( ) Yes ( ) No

Did you brace for impact? ( ) Yes ( ) No ( ) I braced with my hands ( ) I braced with my feet

Which way were you facing at the time of impact? ( ) Straight ahead ( ) Left ( ) Right

Did you strike anything in the vehicle during the impact? ( ) Yes ( ) No

If yes, specify what part of your body struck what: (i.e....head, chest, shoulder, right/left knee)

( ) Steering wheel \_\_\_\_\_ ( ) Dashboard \_\_\_\_\_

( ) Windshield \_\_\_\_\_ ( ) Roof \_\_\_\_\_

( ) Left Side Door \_\_\_\_\_ ( ) Right Side Door \_\_\_\_\_

( ) Left Side Window \_\_\_\_\_ ( ) Right Window \_\_\_\_\_

( ) Other \_\_\_\_\_

Did the seat back bend/break? ( ) Yes ( ) No

In your own words, please describe the accident:

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Did you have physical complaints before the accident? ( ) Yes ( ) No

If yes, please describe:

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Describe how you felt:

During the accident: \_\_\_\_\_

Immediately after the accident: \_\_\_\_\_

Later that day: \_\_\_\_\_

The next day: \_\_\_\_\_

What are your present complaints and symptoms?

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Do you have any congenital (from birth) factors that relate to this problem? ( ) Yes ( ) No

If yes, please describe: \_\_\_\_\_

Do you have any previous illnesses that relate to this situation? ( ) Yes ( ) No If yes, please describe:

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Have you ever been involved in an accident before? ( ) Yes ( ) No If yes, please describe in detail (including injuries):

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Where were you taken after the accident? \_\_\_\_\_

What physicians treated you after the accident?

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What type of treatment did you receive?

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Since this is the most recent accident, are your symptoms: ( ) Improving ( ) Getting worse ( ) Same

Check the symptoms that you have noticed:

- |                                      |  |  |
|--------------------------------------|--|--|
| <input type="checkbox"/> Headache    | <input type="checkbox"/> Irritability        | <input type="checkbox"/> Loss of Balance     |
| <input type="checkbox"/> Neck Pain   | <input type="checkbox"/> Numbness            | <input type="checkbox"/> Fainting            |
| <input type="checkbox"/> Chest Pain  | <input type="checkbox"/> Shortness of Breath | <input type="checkbox"/> Loss of Senses      |
| <input type="checkbox"/> Back Pain   | <input type="checkbox"/> Fatigue             | <input type="checkbox"/> Diarrhea            |
| <input type="checkbox"/> Dizziness   | <input type="checkbox"/> Depression          | <input type="checkbox"/> Cold in Extremities |
| <input type="checkbox"/> Tension     | <input type="checkbox"/> Ears Ring or Buzz   | <input type="checkbox"/> Stomach Upset       |
| <input type="checkbox"/> Cold Sweats | <input type="checkbox"/> Sharp Pains         | <input type="checkbox"/> Constipation        |

Have you lost time at work as a result of this accident? ( ) Yes ( ) No

Last Day Worked: \_\_\_\_\_

Type of Employment: \_\_\_\_\_

Do you notice any activity limitations as a result of this injury? ( ) Yes ( ) No

If yes, describe:

\_\_\_\_\_

\_\_\_\_\_

Other pertinent information:

\_\_\_\_\_

\_\_\_\_\_

PATIENT SIGNATURE: \_\_\_\_\_ DATE: \_\_\_\_\_

## Activities of Daily Living Assessment

Patient Name: \_\_\_\_\_ Date: \_\_\_\_/\_\_\_\_/\_\_\_\_

Directions: This questionnaire has been designed to give the doctor information as to how your pain continues to affect your ability to manage in every day life. Please circle one number in each section which most closely applies to you.

### Section I – Pain Intensity

1. The patient can tolerate the pain they have.
2. The pain is bad but the patient can manage without taking pain medication.
3. Pain medication gives complete relief from pain.
4. Pain medication gives moderate relief from pain.
5. Pain medication gives very little relief from pain.
6. Pain medication has no effect on the pain and the patient does not use them.

### Section II – Personal Care (Washing, Dressing, Etc.)

1. The patient's personal care does not cause additional pain.
2. The patient can perform personal care normally but it causes additional pain.
3. The patient finds it painful to perform personal care and is slow and careful.
4. The patient needs some help but manages most of the personal care.
5. The patient needs help everyday in most aspects of self care.
6. The patient does not get dressed, washes with difficulty and stays in bed.

### Section III – Lifting

1. The patient can lift heavy weights without extra pain.
2. The patient can lift heavy weights but it gives extra pain.
3. Pain prevents the patient from lifting heavy weights off of the floor, but can manage if they are conveniently positioned.
4. Pain prevents the patient from lifting heavy weights but can manage light to medium weights if they are convenient.
5. The patient can lift only very light weight.
6. The patient cannot lift or carry anything at all.

### Section IV – Walking

1. Pain does not prevent the patient from walking any distance.
2. Pain prevents the patient from walking more than one (1) mile.
3. Pain prevents the patient from walking more than ½ mile.
4. Pain prevents the patient from walking more than ¼ mile.
5. The patient can only walk using a cane or crutches.
6. The patient is in bed most of the time and has to crawl to the toilet.

## Section V – Sitting

1. The patient can sit in any chair for any given length of time.
2. The patient can only sit in their favorite chair for any given length of time.
3. Pain prevents the patient from sitting more than 1 hour.
4. Pain prevents the patient from sitting more than ½ hour.
5. Pain prevents the patient from sitting more than 10 minutes.
6. Pain prevents the patient from sitting at all.

## Section VI – Standing

1. The patient can stand for any given length of time without additional pain.
2. The patient can stand for any given length of time but it causes additional pain.
3. Pain prevents the patient from standing more than 2 hours.
4. Pain prevents the patient from standing more than 30 minutes.
5. Pain prevents the patient from standing more than 10 minutes.
6. Pain prevents the patient from standing at all.

## Section VII – Sleeping

1. Pain does not prevent the patient from sleeping well.
2. The patient can sleep well but only by using tablets.
3. The patient has less than 6 hours sleep before the pain wakes them.
4. The patient has less than 4 hours sleep before the pain wakes them.
5. The patient has less than 2 hours sleep before the pain wakes them.
6. Pain prevents the patient from sleeping at all.

## Section VIII – Sex Life

1. The patient's sex life is normal.
2. The patient's sex life is normal but causes some extra pain.
3. The patient's sex life is nearly normal but is very painful.
4. The patient's sex life is severely restricted by pain.
5. The patient's sex life is nearly absent because of pain.
6. Pain prevents any sexual activity at all.

## Section IX – Social Life

1. The patient's social life is normal and causes no extra pain.
2. The patient's social life is normal but increases the degree of pain.
3. Pain has no significant effect on the patient's social life apart from limiting the more energetic interests such as dancing, etc.
4. Pain restricts the patient's social life; therefore the patient can not go out as often.
5. Pain has restricted the patient's social life to home.
6. The patient has no social life because of pain.

Section X – Traveling

1. The patient can travel anywhere without extra pain.
2. The patient can travel anywhere but it causes extra pain.
3. Pain is bad but the patient can manage journeys over 2 hours.
4. Pain restricts the patient to journeys of less than 1 hour.
5. Pain restricts the patient to short necessary journeys less than 30 minutes.
6. Pain prevents the patient from traveling except to the doctor.

Section XI – Menstrual Cycle (WOMEN ONLY)

1. Since the accident my menstrual cycle is normal.
2. Since the accident my menstrual cycle is normal but causes some extra pain.
3. Since the accident my menstrual cycle is nearly normal but is very painful.
4. Since the accident my menstrual cycle is not normal and causes severe pain.
5. Since the accident my menstrual cycle restricts me from performing daily tasks because the pain is so severe.
6. Since the accident I am totally bedridden with my menstrual cycle.

Are there any other activities not listed that you have had to stop doing since the accident?

A) \_\_\_\_\_ D) \_\_\_\_\_

B) \_\_\_\_\_ E) \_\_\_\_\_

C) \_\_\_\_\_ F) \_\_\_\_\_

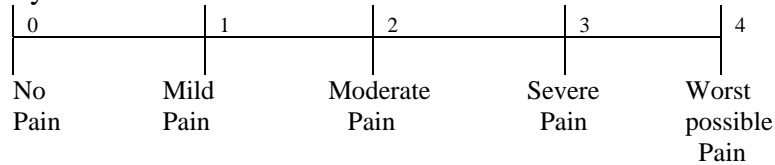
Patient Signature \_\_\_\_\_ Date: \_\_\_\_\_

# Functional Rating Index

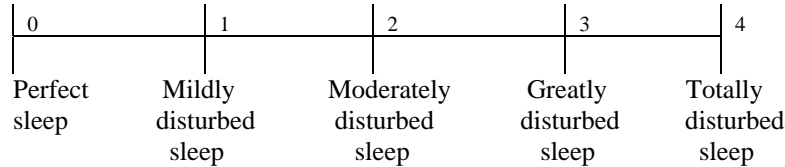
For use with Neck and/or Back Problems only

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

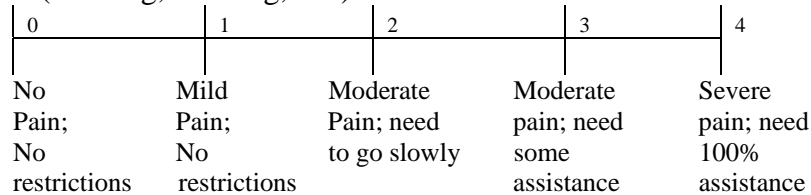
## 1. Pain Intensity



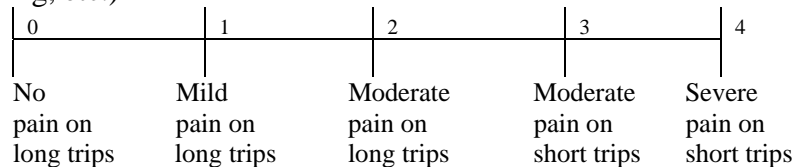
## 2. Sleeping



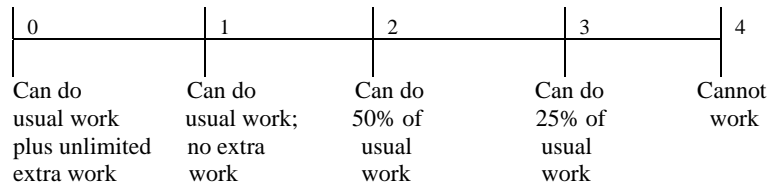
## 3. Personal Care (washing, dressing, etc.)



## 4. Travel (driving, etc.)

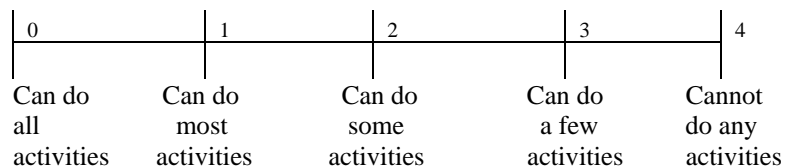


## 5. Work

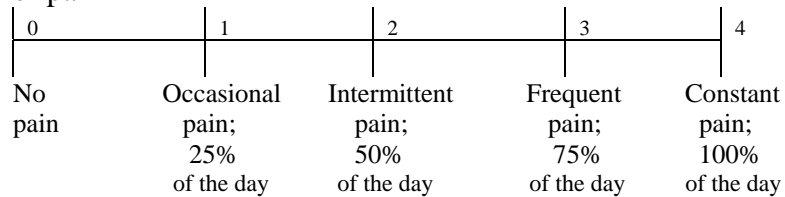


**Please Turn Over**

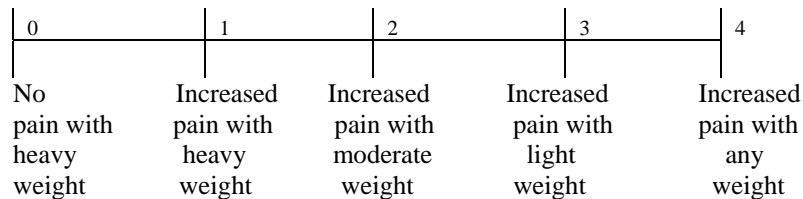
6. Recreation



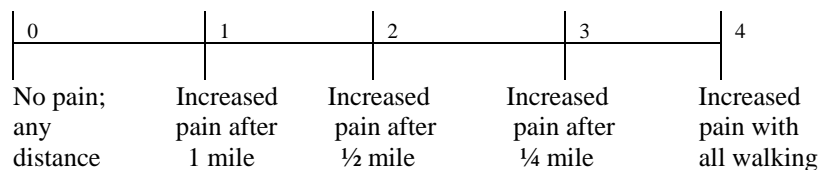
7. Frequency of pain



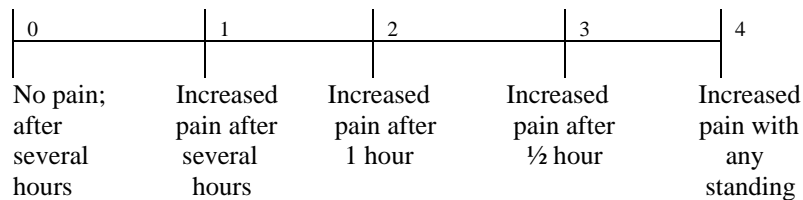
8. Lifting



9. Walking



10. Standing



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Patient's Signature

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Date

~ LOW BACK PAIN AND DISABILITY QUESTIONNAIRE (ROWLAND-MORRIS) ~

When your low back hurts, you may find it difficult to do things that you normally do each day.

CIRCLE ONLY THE SENTENCES THAT DESCRIBE YOU RIGHT NOW!

1. I stay at home most of the time because of my back.
2. I walk more slowly than usual because of my back.
3. Because of my back, I am not doing any jobs that I usually do around the house.
4. Because of my back, I have to use a handrail to go upstairs.
5. Because of my back, I lie down to rest more often.
6. Because of my back, I have to hold onto something to get out of an easy chair.
7. Because of my back, I try to get other people to do things for me.
8. I get dressed more slowly than usual because of my back.
9. I stand up only for short periods of time because of my back.
10. Because of my back, I try not to bend or kneel down.
11. I find it difficult to get out of a chair because of my back.
12. My back or leg is painful almost all of the time.
13. I find it difficult to turn over in bed because of pain in my back.
14. I have trouble putting on my socks or stockings because of my pain.
15. I do not sleep well because of my back.
16. I avoid heavy jobs around the house because of my back.
17. Because of my back pain, I am more irritable and bad tempered with people than usual.
18. Because of my back, I go up stairs more slowly than usual.
19. I change position frequently to try and get my back comfortable.
20. I sit down most of the day because of my back.

Circle your pain level **right now**; place a “B” by the best # you felt today & a “W” by the worst.

0	1	2	3	4	5	6	7	8	9	10
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0 = No Pain 10 = Unbearable Pain

Patient Signature \_\_\_\_\_ Date \_\_\_\_\_





**ASSIGNMENT OF BENEFITS**

I, \_\_\_\_\_, authorize \_\_\_\_\_  
(Patient's name) (Insurance Company name)

to make medical benefits payments otherwise payable to me for services rendered by **ORANGE PARK CHIROPRACTIC CENTER, P.A. / ARGYLE CHIROPRACTIC CENTER, P.A.**, but not to exceed the charges of those services, payable to and mailed directly to:

**ORANGE PARK CHIROPRACTIC CENTER, P.A.  
784 BLANDING BOULEVARD, SUITE 106  
ORANGE PARK, FL 32065**

**ARGYLE CHIROPRACTIC CENTER, P.A.  
8540 ARGYLE FOREST BOULEVARD, SUITE 4  
JACKSONVILLE, FL 32244**

I hereby instruct the insurance carrier that in the event that the subject medical benefits are disputed and/or reduced for any reason, including medical reasonableness and/or necessity, that the amount of the unpaid benefits claimed by **ORANGE PARK CHIROPRACTIC CENTER, P.A. / ARGYLE CHIROPRACTIC CENTER, P.A.**, is to be set aside and not disbursed until the dispute is resolved.

Furthermore, I hereby **IRREVOCABLY ASSIGN TO ORANGE PARK CHIROPRACTIC CENTER, P.A. / ARGYLE CHIROPRACTIC CENTER, P.A.**, the rights and benefits and any and all causes of action resulting from any reduction and/or nonpayment under any policy of insurance, indemnity agreement or any other collateral source as defined by Florida Statutes for any service and/or charges provided by **ORANGE PARK CHIROPRACTIC CENTER, P.A. / ARGYLE CHIROPRACTIC CENTER, P.A.**

IN WITNESS WHEREOF, the undersigned have hereunto set their hands, this \_\_\_\_\_ day of \_\_\_\_\_, 20\_\_\_\_\_.

\_\_\_\_\_  
Patient Name Printed

\_\_\_\_\_  
Patient Signature

\_\_\_\_\_  
Provider Signature



**ORANGE PARK CHIROPRACTIC CENTER**  
**ARGYLE CHIROPRACTIC CENTER**

DR. KEITH A. SCHERTELL  
DR. JAMES W. DAUTEL  
DR. TINA WARREN

## MESSAGE NOTICE

I agree that a No-show fee of \$15.00 will be assessed for any missed Neuro Muscular Therapy appointments without a 24 hrs cancellation notice.

X\_\_\_\_\_