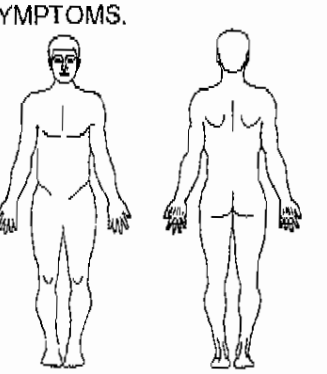
American Specialty Health (ASH)
P.O. Box 509001, San Diego, CA 92150-9001
California Only Fax: 877.427.4777 All Other States Fax: 877.304.2746

# INITIAL HEALTH STATUS
Chiropractic

Patient Name_____ Birthdate_____ Sex: M / F
Address_____ City_____
State_____ Zip_____ Phone (____)_____ Patient Primary Language_____
Occupation_____ Employer_____ Work Phone_____
Address_____ City_____ State_____ Zip_____
Subscriber Name_____ Health Plan_____
Subscriber ID #_____ Group #_____ Spouse Name_____
Spouse Employer_____ City_____ State_____ Zip_____
Primary Care Physician Name_____ PCP Phone_____

MARK AN **X** ON THE PICTURE WHERE YOU HAVE PAIN OR OTHER SYMPTOMS.



**DESCRIBE YOUR CURRENT PROBLEM AND HOW IT BEGAN:**

☐ Headache ☐ Neck Pain ☐ Mid-Back Pain ☐ Low Back Pain
☐ Other_____

**Is this?** ☐ Work Related ☐ Auto Related ☐ N/A

**Date Problem Began**_____

**How Problem Began**

Current complaint (how you feel today):

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

How often are your symptoms present?
(Occasional) ☐ 0 – 25% ☐ 26 – 50% ☐ 51 – 75% ☐ 76 – 100% (Constant)

In the past week, how much has your pain interfered with your daily activities (e.g., work, social activities, or household chores?

No interference 0 1 2 3 4 5 6 7 8 9 10 Unable to carry on any activities

**In general would you say your overall health right now is:**
☐ Excellent ☐ Very Good ☐ Good ☐ Fair ☐ Poor

**HAVE YOU HAD SPINAL X-RAYS, MRI, CT SCAN FOR YOUR AREA(S) OF COMPLAINT?** ☐ No ☐ Yes

**Date(s) taken**_____ **What areas were taken?**_____

**Please check all of the following that apply to you:**

☐ Alcohol/Drug Dependence
☐ Recent Fever
☐ Diabetes
☐ High Blood Pressure
☐ Stroke (Date)_____
☐ Corticosteroid Use (Cortisone, Prednisone, etc.)
☐ Taking Birth Control Pills
☐ Dizziness/Fainting
☐ Numbness in Groin/Buttocks
☐ Cancer/Tumor (Explain)_____
☐ Osteoporosis
☐ Epilepsy/Seizures
☐ Other Health Problems (Explain)_____

☐ Prostate Problems
☐ Menstrual Problems
☐ Urinary Problems
☐ Currently Pregnant, # Weeks_____
☐ Abnormal Weight ☐ Gain ☐ Loss
☐ Marked Morning Pain/Stiffness
☐ Pain Unrelieved by Position or Rest
☐ Pain at Night
☐ Visual Disturbances
☐ Surgeries_____
☐ Tobacco Use - Type_____
Frequency_____/Day
☐ Medications_____

**Family History**: ☐ Cancer ☐ Diabetes ☐ High Blood Pressure
☐ Heart Problems/Stroke ☐ Rheumatoid Arthritis

I certify to the best of my knowledge, the above information is complete and accurate. If the health plan information is not accurate, or if I am not eligible to receive a health care benefit through this practitioner, I understand that I am liable for all charges for services rendered and I agree to notify this practitioner immediately whenever I have changes in my health condition or health plan coverage in the future. I understand that my chiropractor may need to contact my physician if my condition needs to be co-managed. Therefore I give authorization to my chiropractor to contact my physician, if necessary.

**Patient Signature**_____ **Date**_____

# NECK DISABILITY INDEX QUESTIONNAIRE

**NAME**_____ **AGE**_____ **DATE**_____ **SCORE**_____

***PLEASE READ:*** This questionnaire is designed to enable us to understand how much your neck pain has affected your ability to manage your everyday activities. Please answer each section by circling the ONE CHOICE that most applies to you. We realize that you may feel that more than one statement may relate to you, but ***PLEASE JUST CIRCLE THE ONE CHOICE THAT MOST CLOSELY DESCRIBES YOUR PROBLEM RIGHT NOW.***

*SECTION 1 - Pain Intensity*

A. I have no pain at the moment.
B. The pain is very mild at the moment.
C. The pain is moderate at the moment.
D. The pain is fairly severe at the moment.
E. The pain is very severe at the moment.
F. The pain is the worst imaginable at the moment.

*SECTION 2 -Personal Care (Washing, Dressing, etc.)*

A. I can look after myself normally without causing extra pain.
B. I can look after myself normally, but it causes extra pain.
C. It is painful to look after myself and I am slow and careful.
D. I need some help, but manage most of my personal care.
E. I need help every day in most aspects of self care.
F. I do not get dressed, I wash with difficulty and stay in bed.

*SECTION 3 - Lifting*

A. I can lift heavy weights without extra pain.
B. I can lift heavy weights, but it gives extra pain.
C. Pain prevents me from lifting heavy weights off the floor, but I can manage if they are conveniently positioned, for example, on a table.
D. Pain prevents me from lifting heavy weights, but I can manage light to medium weights if they are conveniently positioned.
E. I can lift very light weights.
F. I cannot lift or carry anything at all.

*SECTION 4 - Reading*

A. I can read as much as I want to with no pain in my neck.
B. I can read as much as I want to with slight pain in my neck.
C. I can read as much as I want to with moderate pain in my neck.
D. I cannot read as much as I want because of moderate pain in my neck.
E. I cannot read as much as I want because of severe pain in my neck.
F. I cannot read at all.

*SECTION 5 – Headaches*

A. I have no headaches at all.
B. I have slight headaches which come infrequently.
C. I have moderate headaches which come infrequently.
D. I have moderate headaches which come frequently.
E. I have severe headaches which come frequently.
F. I have headaches almost all the time.

*SECTION 6 - Concentration/*

A. I can concentrate fully when I want to with no difficulty.
B. I can concentrate fully when I want to with slight difficulty.
C. I have a fair degree of difficulty in concentrating when I want to.
D. I have a lot of difficulty in concentrating when I want to.
E. I have a great deal of difficulty in concentrating when I want to.
F. I cannot concentrate at all.

*SECTION 7 - Work*

A. I can do as much work as I want to.
B. I can only do my usual work, but no more.
C. I can do most of my usual work, but no more.
D. I cannot do my usual work.
E. I can hardly do any work at all.
F. I cannot do any work at all.

*SECTION 8 – Driving*

A. I can drive my car without any neck pain.
B. I can drive my car as long as I want with slight pain in my neck.
C. I can drive my car as long as I want with moderate pain in my neck.
D. I cannot drive my car as long as I want because of moderate pain in my neck.
E. I can hardly drive at all because of severe pain in my neck.
F. I cannot drive my car at all.

*SECTION 9 – Sleeping*

A. I have no trouble sleeping.
B. My sleep is slightly disturbed (less than 1 hour sleepless).
C .My sleep is mildly disturbed (1-2 hours sleepless).
D. My sleep is moderately disturbed (2-3 hours sleepless).
E. My sleep is greatly disturbed (3-5 hours sleepless).
F. My sleep is completely disturbed (5-7 hours)

*SECTION 10 – Recreation*

A. I am able to engage in all of my recreational activities with no neck pain at all.
B. I am able to engage in all of my recreational activities with some pain in my neck.
C. I am able to engage in most, but not all of my recreational activities because of pain in my neck.
D. I am able to engage in a few of my recreational activities because of pain in my neck.
E. I can hardly do any recreational activities because of pain in my neck.
F. I cannot do any recreational activities at all.

**COMMENTS:** _____

*Vernon H, Mior S. The Neck Disability Index: A study of reliability and validity. J Manipulative Physiol Ther 1991;14:409-415.*

# OSWESTRY DISABILITY INDEX 2.0

**NAME**_____ **DATE**_____ **SCORE**_____

***PLEASE READ:*** Could you please complete this questionnaire. It is designed to give us information as to how your back (or leg) trouble has affected your ability to manage in everyday life.

Please answer ***every section***. Mark ***one box only*** in each section that most closely describes you ***today***.

*SECTION 1 - Pain Intensity*
- A ☐ I have no pain at the moment.
- B ☐ The pain is very mild at the moment.
- C ☐ The pain is moderate at the moment.
- D ☐ The pain is fairly severe at the moment.
- E ☐ The pain is very severe at the moment.
- F ☐ The pain is the worst imaginable at the moment.

*SECTION 2 - Personal Care (washing, dressing, etc.)*
- A ☐ I can look after myself normally without causing extra pain.
- B ☐ I can look after myself normally but it is very painful.
- C ☐ It is painful to look after myself and I am slow and careful.
- D ☐ I need some help but manage most of my personal care.
- E ☐ I need help every day in most aspects of self care.
- F ☐ I do not get dressed, wash with difficulty and stay in bed.

*SECTION 3 - Lifting*
- A ☐ I can lift heavy weights without extra pain.
- B ☐ I can lift heavy weights, but it causes extra pain.
- C ☐ Pain prevents me from lifting heavy weights off the floor, but I can manage if they are conveniently positioned, e.g. on a table.
- D ☐ Pain prevents me from lifting heavy weights, but I can manage light to medium weights if they are conveniently positioned.
- E ☐ I can only lift very light weights, at the most.
- F ☐ I cannot lift or carry anything at all.

*SECTION 4 - Walking*
- A ☐ Pain does not prevent me from walking any distance.
- B ☐ Pain prevents me from walking more than one mile.
- C ☐ Pain prevents me from walking more than 1/4 mile.
- D ☐ Pain prevents me from walking more than 100 yards.
- E ☐ I can only walk while using a stick or crutches.
- F ☐ I am in bed most of the time and have to crawl to the toilet.

*SECTION 5 - Sitting*
- A ☐ I can sit in any chair as long as I like.
- B ☐ I can only sit in my favorite chair as long as I like.
- C ☐ Pain prevents me from sitting more than 1 hour.
- D ☐ Pain prevents me from sitting more than 1/2 hour.
- E ☐ Pain prevents me from sitting more than ten minutes.
- F ☐ Pain prevents me from sitting at all.

*SECTION 6 - Standing*
- A ☐ I can stand as long as I want without extra pain.
- B ☐ I can stand as long as I want but it gives me extra pain.
- C ☐ Pain prevents me from standing for more than 1 hour.
- D ☐ Pain prevents me from standing for more than 1/2 hour.
- E ☐ Pain prevents me from standing for more than 10 minutes.
- F ☐ Pain prevents me from standing at all.

*SECTION 7 - Sleeping*
- A ☐ My sleep is never disturbed by pain.
- B ☐ My sleep is occasionally disturbed by pain.
- C ☐ Because of pain I have less than 6 hours' sleep.
- D ☐ Because of pain I have less than 4 hours' sleep.
- E ☐ Because of pain I have less than 2 hours' sleep.
- F ☐ Pain prevents me from sleeping at all.

*SECTION 8 - Sex Life (if applicable)*
- A ☐ My sex life is normal and causes me no extra pain.
- B ☐ My sex life is normal, but causes some extra pain.
- C ☐ My sex life is nearly normal but is very painful.
- D ☐ My sex life is severely restricted by pain.
- E ☐ My sex life is nearly absent because of pain.
- F ☐ Pain prevents any sex life at all.

*SECTION 9 - Social Life*
- A ☐ My social life is normal and causes me no extra pain.
- B ☐ My social life is normal, but increases the degree of pain.
- C ☐ Pain has no significant effect on my social life apart from limiting my more energetic interests, e.g., sport, etc.
- D ☐ Pain has restricted my social life and I do not go out as often.
- E ☐ Pain has restricted my social life to my home.
- F ☐ I have no social life because of the pain.

*SECTION 10 - Traveling*
- A ☐ I can travel anywhere without pain.
- B ☐ I can travel anywhere but I gives extra pain.
- C ☐ Pain is bad but I manage journeys over 2 hours.
- D ☐ Pain restricts me to journeys of less than 1 hour.
- E ☐ Pain restricts me to short necessary journeys under 30 minutes.
- F ☐ Pain prevents me from traveling except to receive treatment.

**COMMENTS:** _____

*Roland, M. and J. Fairbank (2000). "The Roland-Morris Disability Questionnaire and the Oswestry Disability Questionnaire." Spine 25(24): 3115-24.*

# ASSIGNMENT OF BENEFITS

PATIENT: _____

INSURED: _____

GROUP #: _____ CLAIM #: _____

SS #: _____ ID #: _____

I hereby instruct and direct the _____ Insurance Company to pay by check made out and mailed directly to:

SETH D. GOLDSTEIN, D.C.
19350 Business Center Drive, Suite 103
Northridge, California 91324

If my current policy prohibits direct payment to the doctor, then I hereby also instruct and direct you to make out the check to me and mail it to the following address:

SETH D. GOLDSTEIN, D.C.
19350 Business Center Drive, Suite 103
Northridge, California 91324

The professional or medical expense benefits allowable, and otherwise payable to me under my current insurance policy as payment toward the total charges for professional services rendered. This is a direct assignment of my rights and benefits under this policy. This payment will not exceed my indebtedness to the above-mentioned assignee, and I have agreed to pay in a current manner, any balance of said professional service charges over and above this insurance payment. A photocopy of this Assignment shall be considered as effective and valid as the original.

I also authorize the release of any information pertinent to my case to any insurance adjuster or attorney in this case.

Dated at Northridge, California this _____ day of _____,

_____ _____

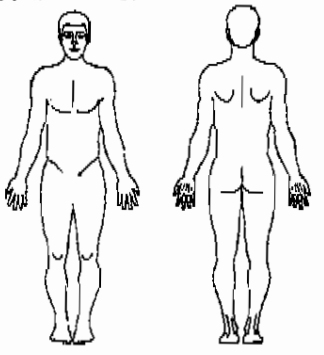
Signature of Patient Witness

American Specialty Health (ASH)
P.O. Box 509001, San Diego, CA 92150-9001
California Only Fax: 877.427.4777 All Other States Fax: 877.304.2746

# INITIAL HEALTH STATUS
Chiropractic

Patient Name_____ Birthdate_____ Sex: M / F
Address_____ City_____
State_____ Zip_____ Phone (____)_____ Patient Primary Language_____
Occupation_____ Employer_____ Work Phone_____
Address_____ City_____ State_____ Zip_____
Subscriber Name_____ Health Plan_____
Subscriber ID #_____ Group #_____ Spouse Name_____
Spouse Employer_____ City_____ State_____ Zip_____
Primary Care Physician Name_____ PCP Phone_____

MARK AN **X** ON THE PICTURE WHERE YOU HAVE PAIN OR OTHER SYMPTOMS.



**DESCRIBE YOUR CURRENT PROBLEM AND HOW IT BEGAN:**

☐ Headache ☐ Neck Pain ☐ Mid-Back Pain ☐ Low Back Pain
☐ Other_____

**Is this?** ☐ Work Related ☐ Auto Related ☐ N/A

**Date Problem Began**_____

**How Problem Began**

Current complaint (how you feel today):

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

How often are your symptoms present?
(Occasional) ☐ 0 – 25% ☐ 26 – 50% ☐ 51 – 75% ☐ 76 – 100% (Constant)

In the past week, how much has your pain interfered with your daily activities (e.g., work, social activities, or household chores?

No interference 0 1 2 3 4 5 6 7 8 9 10 Unable to carry on any activities

**In general would you say your overall health right now is:**
☐ Excellent ☐ Very Good ☐ Good ☐ Fair ☐ Poor

**HAVE YOU HAD SPINAL X-RAYS, MRI, CT SCAN FOR YOUR AREA(S) OF COMPLAINT?** ☐ No ☐ Yes

**Date(s) taken**_____ **What areas were taken?**_____

**Please check all of the following that apply to you:**

☐ Alcohol/Drug Dependence
☐ Recent Fever
☐ Diabetes
☐ High Blood Pressure
☐ Stroke (Date)_____
☐ Corticosteroid Use (Cortisone, Prednisone, etc.)
☐ Taking Birth Control Pills
☐ Dizziness/Fainting
☐ Numbness in Groin/Buttocks
☐ Cancer/Tumor (Explain)_____
☐ Osteoporosis
☐ Epilepsy/Seizures
☐ Other Health Problems (Explain)_____

☐ Prostate Problems
☐ Menstrual Problems
☐ Urinary Problems
☐ Currently Pregnant, # Weeks_____
☐ Abnormal Weight ☐ Gain ☐ Loss
☐ Marked Morning Pain/Stiffness
☐ Pain Unrelieved by Position or Rest
☐ Pain at Night
☐ Visual Disturbances
☐ Surgeries_____
☐ Tobacco Use - Type_____
Frequency_____/Day
☐ Medications_____

**Family History:** ☐ Cancer ☐ Diabetes ☐ High Blood Pressure
☐ Heart Problems/Stroke ☐ Rheumatoid Arthritis

I certify to the best of my knowledge, the above information is complete and accurate. If the health plan information is not accurate, or if I am not eligible to receive a health care benefit through this practitioner, I understand that I am liable for all charges for services rendered and I agree to notify this practitioner immediately whenever I have changes in my health condition or health plan coverage in the future. I understand that my chiropractor may need to contact my physician if my condition needs to be co-managed. Therefore I give authorization to my chiropractor to contact my physician, if necessary.

**Patient Signature**_____ **Date**_____

# WORK / COMP HISTORY

Patient _____ Phone (  ) _____

Address _____ City _____ State _____ Zip _____

Age _____ Birthdate _____ Sex _____ S/S # _____

Name of Compensation Carrier: _____ Phone (  ) _____

Address of Carrier: _____ City _____ State _____ Zip _____

Employer's Name: _____ Phone (  ) _____

Employer's Address: _____ City _____ State _____ Zip _____

1. Type of Business _____ Your Occupation _____
2. Date Injured _____ Hour _____ AM / PM Last Date Worked _____ Are you off work? (  ) Yes (  ) No
3. Previous Workers' Compensation Injury? (  ) Yes (  ) No
4. Accident reported to employer? (  ) Yes (  ) No Name of person reported accident to _____
5. Injured at: _____ City _____ State _____ Zip _____
6. Length of time worked there prior to accident: _____
7. Type of work being done at time of injury: _____

   _____
8. In your own words, please describe accident: _____

   _____

   _____

   _____
9. Have you been treated by another doctor for this accident? (  ) Yes (  ) No

   If yes, please list doctor's name and address: _____

   _____

   What type of treatment did you receive? _____

   How long were you treated by this doctor? _____
10. Are you: (  ) improved (  ) unchanged (  ) getting worse
11. What types of medicines are you taking? _____

    _____

    Do these medicines help? (  ) Yes (  ) No (  ) Don't know
12. Have you had physical therapy? (  ) Yes (  ) No If yes, how often?

    (  ) Daily (  ) Every other day (  ) Several times a week (  ) Weekly (  ) Every other week

    (  ) Monthly (  ) Other _____

    Does the physical therapy help? (  ) Yes (  ) No (  ) Don't know
13. Prior to this accident, have you ever had any of the physical complaints similar to what you have now?

    (  ) Yes (  ) No (  ) Don't know

    If yes, describe: _____

    _____

    _____

    Were these similar complaints the results of a previous accident(s)? (  ) Yes (  ) No

    Please provide details of accident(s): _____

    _____

14. Have you had any other serious accidents which required medical care? ( ) Yes ( ) No

    Describe: _____

15. Have you had any serious illnesses that required hospitalization? ( ) Yes ( ) No

    Describe: _____

16. Have you had any surgeries? ( ) Yes ( ) No

    If yes, list type of surgery and date: _____

17. Have you had any nervous or mental illnesses? ( ) Yes ( ) No

    Have you had psychiatric care? ( ) Yes ( ) No

18. Have you received a medical discharge from the Armed Forces? ( ) Yes ( ) No

19. Have you returned to work since this accident? ( ) Yes ( ) No

    If you have returned to work since your accident, please fill out the information below:

| DATE | EMPLOYER | OCCUPATION | LIGHT DUTY REG. DUTY | FULL-TIME PART-TIME |
|---|---|---|---|---|
| | | | | |
| | | | | |
| | | | | |
| | | | | |

## CURRENT MEDICAL COMPLAINTS

**BACK PAIN:**

1. Currently, I have pain in my: ( ) low back ( ) mid back ( ) upper back
2. My pain began: ( ) gradually ( ) suddenly
3. I have pain: ( ) sometimes ( ) all of the time
4. My pain goes into my: ( ) right leg ( ) left leg ( ) both
5. I have tingling and/or numbness in my: ( ) right leg ( ) left leg ( ) both
6. My pain is worse when I:
   - cough or sneeze ( ) Yes ( ) No
   - sit ( ) Yes ( ) No
   - bend ( ) Yes ( ) No
   - walk ( ) Yes ( ) No
   - lift ( ) Yes ( ) No
   - push ( ) Yes ( ) No
   - pull ( ) Yes ( ) No
7. My back is worse with sexual activity ( ) Yes ( ) No
8. My pain wakes me up during the night ( ) Yes ( ) No
9. Changes in the weather affect my pain ( ) Yes ( ) No

## NECK PAIN:

1. My neck pain began: ( ) gradually ( ) suddenly
2. I have pain: ( ) sometimes ( ) all of the time
3. My pain goes into my: ( ) right arm ( ) left arm ( ) both
4. I have tingling and/or numbness in my: ( ) right arm ( ) left arm ( ) both
5. My pain is worse when I:
   - cough or sneeze ( ) Yes ( ) No
   - bend forward ( ) Yes ( ) No
   - lift ( ) Yes ( ) No
   - push ( ) Yes ( ) No
   - pull ( ) Yes ( ) No
   - turn my head ( ) Yes ( ) No
6. My pain wakes me up during the night ( ) Yes ( ) No
7. Changes in the weather affect my pain ( ) Yes ( ) No
8. I have neck stiffness ( ) Yes ( ) No
9. I have headaches ( ) Yes ( ) No
10. If I do get headaches, they occur: ( ) sometimes ( ) all of the time

## OTHER PAIN:

Please describe any current medical complaints which you are experiencing and were not previously covered on this questionnaire, or list any additional comments you wish to make regarding your condition:

_____

_____

_____

_____

## JOB DESCRIPTION:

(In terms of an 8-hour workday, "occasionally" means 33%, "frequently" means 34% to 66%, and "continuously" means 67% to 100% of the day).

1. In a typical 8-hour workday, I: (Circle # of hours / activity)

| | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|
| Sit: | 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | hours |
| Stand: | 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | hours |
| Walk: | 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | hours |

2. On the job, I perform the following activities:

| | NOT AT ALL | OCCASIONALLY | FREQUENTLY | CONTINUOUSLY |
|---|---|---|---|---|
| Bend / stoop | ( ) | ( ) | ( ) | ( ) |
| Squat | ( ) | ( ) | ( ) | ( ) |
| Crawl | ( ) | ( ) | ( ) | ( ) |
| Climb | ( ) | ( ) | ( ) | ( ) |
| Reach above shoulder level | ( ) | ( ) | ( ) | ( ) |
| Crouch | ( ) | ( ) | ( ) | ( ) |
| Kneel | ( ) | ( ) | ( ) | ( ) |
| Balancing | ( ) | ( ) | ( ) | ( ) |
| Pushing / Pulling | ( ) | ( ) | ( ) | ( ) |

3. On the job, I lift:

| | NOT AT ALL | OCCASIONALLY | FREQUENTLY | CONTINUOUSLY |
|---|---|---|---|---|
| Up to 10 pounds | ( ) | ( ) | ( ) | ( ) |
| 11 to 24 pounds | ( ) | ( ) | ( ) | ( ) |
| 25 to 34 pounds | ( ) | ( ) | ( ) | ( ) |
| 35 to 50 pounds | ( ) | ( ) | ( ) | ( ) |
| 51 to 74 pounds | ( ) | ( ) | ( ) | ( ) |
| 75 to 100 pounds | ( ) | ( ) | ( ) | ( ) |

4. Do you have to bend over while doing any lifting? ( ) Yes ( ) No

5. Are your feet used for repetitive movements, such as in operating foot controls? ( ) Yes ( ) No

6. Do you use your hands for repetitive actions, such as:

| | SIMPLE GRASPING | | FIRM GRASPING | | FINE MANIPULATING | |
|---|---|---|---|---|---|---|
| Right hand | ( ) Yes | ( ) No | ( ) Yes | ( ) No | ( ) Yes | ( ) No |
| Left hand | ( ) Yes | ( ) No | ( ) Yes | ( ) No | ( ) Yes | ( ) No |

7. Are you required to work on unprotected heights? ( ) Yes ( ) No

Describe: _____

_____

_____

8. Are you required to be around moving machinery? ( ) Yes ( ) No

Describe: _____

_____

_____

9. Are you exposed to marked changes in temperature and humidity? ( ) Yes ( ) No

Describe: _____

_____

_____

10. Are you required to drive automotive equipment? ( ) Yes ( ) No

Describe: _____

_____

_____

11. Are you exposed to dust, fumes and/or gases? ( ) Yes ( ) No

Describe: _____

_____

_____

12. Please list any additional comments: _____

_____

_____

Signature: _____ Date: _____

STATE OF CALIFORNIA
DEPARTMENT OF INDUSTRIAL RELATIONS

# WORKERS' COMPENSATION APPEALS BOARD

## NOTICE AND REQUEST FOR ALLOWANCE OF LIEN

*(Print or type names and addresses; include ZIP Codes)*

I.D. OR CASE NO._____

Injured Worker _____ Address _____

Date of Claimed Injury _____ Social Security Number _____ Date of Birth _____

Attorney for Injured Worker _____ Address _____

Employer _____ Address _____

Insurance Carrier or, if Self-Insured, Certificate Name _____

Address Where Claim Administered _____

Adjusting Agency, if Agency Administered _____

Attorney for Employer/Carrier _____ Address _____

Lien Claimant _____ Address and Telephone No. _____

Attorney for Lien Claimant _____ Address and Telephone No. _____

The lien claimant hereby requests the Workers' Compensation Appeals Board to determine and allow as a lien the sum of _____ Dollars ($_____) against any amount now due or which may hereafter become payable as compensation to the above named worker on account of the above claimed injury.

This request and claim for lien is for (Mark appropriate box):

☐ The reasonable expense incurred by or on behalf of said worker for medical treatment to cure or relieve from the effects of said injury; or

☐ The reasonable medical expense incurred to prove a contested claim; or

☐ The reasonable value of living expenses of said worker or of his or her dependents, subsequent to the injury, or

☐ The reasonable living expenses of the spouse or minor children, or both, of said worker, subsequent to the date of injury, where such worker has deserted or is neglecting his or her family; or

☐ The reasonable fee for interpreter's services performed on _____, 19____.

☐

*NOTE: ITEMIZED STATEMENT JUSTIFYING THE LIEN MUST BE ATTACHED*

FOR INJURIES OCCURRING ON OR AFTER JANUARY 1, 1990, FOR WHICH THE LIEN CLAIMANT DOES NOT HAVE A WCAB IDENTIFICATION NUMBER, the lien claimant declares under penalty of perjury that:

☐ a copy of the original completed Employee's Claim for Workers' Compensation Benefits (DWC Form 1) is attached, or

☐ the lien claimant does not have a copy of the claim form, but made the following efforts to secure one:

☐ A copy of the lien claim and supporting documents was served by mail or delivered to each of the above-named parties.

Signature of Attorney for Lien Claimant _____ Signature of Lien Claimant _____ Date _____

## EMPLOYEE'S CONSENT TO ALLOWANCE OF LIEN

*I consent to the requested allowance of a lien against my compensation.*

Signature of Attorney for Injured Worker _____ X _____ Signature of Injured Worker

# NOTICE OF PERSONAL CHIROPRACTOR OR PERSONAL ACUPUNCTURIST

If your employer or your employer's insurer does not have a Medical Provider Network, you may be able to change your treating physician to your personal chiropractor or acupuncturist following a work-related injury or illness. In order to be eligible to make this change, you must give your employer the name and business address of a personal chiropractor or acupuncturist in writing prior to the injury or illness. Your claims administrator generally has the right to select your treating physician within the first 30 days after your employer knows of your injury or illness. After your claims administrator has initiated your treatment with another doctor during this period, you may then, upon request, have your treatment transferred to your personal chiropractor or acupuncturist.

You may use this form to notify your employer of your personal chiropractor or acupuncturist.

**Your Chiropractor or Acupuncturist's Information:**

SETH D. GOLDSTEIN, D.C.

**(name of chiropractor or acupuncturist)**

19350 BUSINESS CENTER DR., SUITE 103, NORTHRIDGE, CA 91324

**(street address, city, state, zip code)**

818-993-3668

**(telephone number)**

Employee Name (please print):

Employee's address:

Employee's Signature_____ Date:_____

# General Pain Index Questionnaire

We would like to know how much your pain ***presently*** prevents you from doing what you would normally do. Regarding each category, please indicate the ***overall*** impact your present pain has on your life, not just when the pain is at its worst.

Please ***circle the number*** which best describes how your typical level of pain affects these six categories of activities.

1. **FAMILY / AT-HOME RESPONSIBILITIES** SUCH AS YARD WORK, CHORES AROUND THE HOUSE OR DRIVING THE KIDS TO SCHOOL –

0 1 2 3 4 5 6 7 8 9 10

COMPLETELY ABLE TO FUNCTION — TOTALLY UNABLE TO FUNCTION

2. **RECREATION** INCLUDING HOBBIES, SPORTS OR OTHER LEISURE ACTIVITIES –

0 1 2 3 4 5 6 7 8 9 10

COMPLETELY ABLE TO FUNCTION — TOTALLY UNABLE TO FUNCTION

3. **SOCIAL ACTIVITES** INCLUDING PARTIES, THEATER, CONCERTS, DINING –OUT AND ATTENDING OTHER SOCIAL FUNCTIONS –

0 1 2 3 4 5 6 7 8 9 10

COMPLETELY ABLE TO FUNCTION — TOTALLY UNABLE TO FUNCTION

4. **EMPLOYMENT** INCLUDING VOLUNTEER WORK AND HOMEMAKING TASKS –

0 1 2 3 4 5 6 7 8 9 10

COMPLETELY ABLE TO FUNCTION — TOTALLY UNABLE TO FUNCTION

5. **SELF -CARE** SUCH AS TAKING A SHOWER, DRIVING OR GETTING DRESSES –

0 1 2 3 4 5 6 7 8 9 10

COMPLETELY ABLE TO FUNCTION — TOTALLY UNABLE TO FUNCTION

6. LIFE –**SUPPORT ACTIVITES** SUCH AS EATING AND SLEEPING –

0 1 2 3 4 5 6 7 8 9 10

COMPLETELY ABLE TO FUNCTION — TOTALLY UNABLE TO FUNCTION

PATIENT NAME _____ DATE _____

SCORE _____ [60] BENCHMARK - = 5 _____

# OSWESTRY DISABILITY INDEX 2.0

**NAME**_____ **DATE**_____ **SCORE**_____

***PLEASE READ:*** Could you please complete this questionnaire. It is designed to give us information as to how your back (or leg) trouble has affected your ability to manage in everyday life.

Please answer ***every section.*** Mark ***one box only*** in each section that most closely describes you ***today.***

*SECTION 1 - Pain Intensity*
- A ☐ I have no pain at the moment.
- B ☐ The pain is very mild at the moment.
- C ☐ The pain is moderate at the moment.
- D ☐ The pain is fairly severe at the moment.
- E ☐ The pain is very severe at the moment.
- F ☐ The pain is the worst imaginable at the moment.

*SECTION 2 - Personal Care (washing, dressing, etc.)*
- A ☐ I can look after myself normally without causing extra pain.
- B ☐ I can look after myself normally but it is very painful.
- C ☐ It is painful to look after myself and I am slow and careful.
- D ☐ I need some help but manage most of my personal care.
- E ☐ I need help every day in most aspects of self care.
- F ☐ I do not get dressed, wash with difficulty☐ and stay in bed.

*SECTION 3 - Lifting*
- A ☐ I can lift heavy weights without extra pain.
- B ☐ I can lift heavy weights, but it causes extra pain.
- C ☐ Pain prevents me from lifting heavy weights off the floor, but I can manage if they are conveniently positioned, e.g. on a table.
- D ☐ Pain prevents me from lifting heavy weights, but I can manage light to medium weights if they are conveniently positioned.
- E ☐ I can only lift very light weights, at the most.
- F ☐ I cannot lift or carry anything at all.

*SECTION 4 - Walking*
- A ☐ Pain does not prevent me from walking any distance.
- B ☐ Pain prevents me from walking more than one mile.
- C ☐ Pain prevents me from walking more than 1/4 mile.
- D ☐ Pain prevents me from walking more than 100 yards.
- E ☐ I can only walk while using a stick or crutches.
- F ☐ I am in bed most of the time and have to crawl to the toilet.

*SECTION 5 - Sitting*
- A ☐ I can sit in any chair as long as I like.
- B ☐ I can only sit in my favorite chair as long as I like.
- C ☐ Pain prevents me from sitting more than 1 hour.
- D ☐ Pain prevents me from sitting more than 1/2 hour.
- E ☐ Pain prevents me from sitting more than ten minutes.
- F ☐ Pain prevents me from sitting at all.

*SECTION 6 - Standing*
- A ☐ I can stand as long as I want without extra pain.
- B ☐ I can stand as long as I want but it gives me extra pain.
- C ☐ Pain prevents me from standing for more than 1 hour.
- D ☐ Pain prevents me from standing for more than 1/2 hour.
- E ☐ Pain prevents me from standing for more than 10 minutes.
- F ☐ Pain prevents me from standing at all.

*SECTION 7 - Sleeping*
- A ☐ My sleep is never disturbed by pain.
- B ☐ My sleep is occasionally disturbed by pain.
- C ☐ Because of pain I have less than 6 hours' sleep.
- D ☐ Because of pain I have less than 4 hours' sleep.
- E ☐ Because of pain I have less than 2 hours' sleep.
- F ☐ Pain prevents me from sleeping at all.

*SECTION 8 - Sex Life (if applicable)*
- A ☐ My sex life is normal and causes me no extra pain.
- B ☐ My sex life is normal, but causes some extra pain.
- C ☐ My sex life is nearly normal but is very painful.
- D ☐ My sex life is severely restricted by pain.
- E ☐ My sex life is nearly absent because of pain.
- F ☐ Pain prevents any sex life at all.

*SECTION 9 - Social Life*
- A ☐ My social life is normal and causes me no extra pain.
- B ☐ My social life is normal, but increases the degree of pain.
- C ☐ Pain has no significant effect on my social life apart from limiting my more energetic interests, e.g., sport, etc.
- D ☐ Pain has restricted my social life and I do not go out as often.
- E ☐ Pain has restricted my social life to my home.
- F ☐ I have no social life because of the pain.

*SECTION 10 - Traveling*
- A ☐ I can travel anywhere without pain.
- B ☐ I can travel anywhere but I gives extra pain.
- C ☐ Pain is bad but I manage journeys over 2 hours.
- D ☐ Pain restricts me to journeys of less than 1 hour.
- E ☐ Pain restricts me to short necessary journeys under 30 minutes.
- F ☐ Pain prevents me from traveling except to receive treatment.

**COMMENTS:** _____

*Roland, M. and J. Fairbank (2000). "The Roland-Morris Disability Questionnaire and the Oswestry Disability Questionnaire." Spine 25(24): 3115-24.*

# NECK DISABILITY INDEX QUESTIONNAIRE

**NAME**_____ **AGE**_____ **DATE**_____ **SCORE**_____

***PLEASE READ***: This questionnaire is designed to enable us to understand how much your neck pain has affected your ability to manage your everyday activities. Please answer each section by circling the ONE CHOICE that most applies to you. We realize that you may feel that more than one statement may relate to you, but ***PLEASE JUST CIRCLE THE ONE CHOICE THAT MOST CLOSELY DESCRIBES YOUR PROBLEM RIGHT NOW.***

*SECTION 1 - Pain Intensity*

A. I have no pain at the moment.
B. The pain is very mild at the moment.
C. The pain is moderate at the moment.
D. The pain is fairly severe at the moment.
E. The pain is very severe at the moment.
F. The pain is the worst imaginable at the moment.

*SECTION 2 -Personal Care (Washing, Dressing, etc.)*

A. I can look after myself normally without causing extra pain.
B. I can look after myself normally, but it causes extra pain.
C. It is painful to look after myself and I am slow and careful.
D. I need some help, but manage most of my personal care.
E. I need help every day in most aspects of self care.
F. I do not get dressed, I wash with difficulty and stay in bed.

*SECTION 3 - Lifting*

A. I can lift heavy weights without extra pain.
B. I can lift heavy weights, but it gives extra pain.
C. Pain prevents me from lifting heavy weights off the floor, but I can manage if they are conveniently positioned, for example, on a table.
D. Pain prevents me from lifting heavy weights, but I can manage light to medium weights if they are conveniently positioned.
E. I can lift very light weights.
F. I cannot lift or carry anything at all.

*SECTION 4 - Reading*

A. I can read as much as I want to with no pain in my neck.
B. I can read as much as I want to with slight pain in my neck.
C. I can read as much as I want to with moderate pain in my neck.
D. I cannot read as much as I want because of moderate pain in my neck.
E. I cannot read as much as I want because of severe pain in my neck.
F. I cannot read at all.

*SECTION 5 – Headaches*

A. I have no headaches at all.
B. I have slight headaches which come infrequently.
C. I have moderate headaches which come infrequently.
D. I have moderate headaches which come frequently.
E. I have severe headaches which come frequently.
F. I have headaches almost all the time.

*SECTION 6 - Concentration/*

A. I can concentrate fully when I want to with no difficulty.
B. I can concentrate fully when I want to with slight difficulty.
C. I have a fair degree of difficulty in concentrating when I want to.
D. I have a lot of difficulty in concentrating when I want to.
E. I have a great deal of difficulty in concentrating when I want to.
F. I cannot concentrate at all.

*SECTION 7 - Work*

A. I can do as much work as I want to.
B. I can only do my usual work, but no more.
C. I can do most of my usual work, but no more.
D. I cannot do my usual work.
E. I can hardly do any work at all.
F. I cannot do any work at all.

*SECTION 8 – Driving*

A. I can drive my car without any neck pain.
B. I can drive my car as long as I want with slight pain in my neck.
C. I can drive my car as long as I want with moderate pain in my neck.
D. I cannot drive my car as long as I want because of moderate pain in my neck.
E. I can hardly drive at all because of severe pain in my neck.
F. I cannot drive my car at all.

*SECTION 9 – Sleeping*

A. I have no trouble sleeping.
B. My sleep is slightly disturbed (less than 1 hour sleepless).
C .My sleep is mildly disturbed (1-2 hours sleepless).
D. My sleep is moderately disturbed (2-3 hours sleepless).
E. My sleep is greatly disturbed (3-5 hours sleepless).
F. My sleep is completely disturbed (5-7 hours)

*SECTION 10 – Recreation*

A. I am able to engage in all of my recreational activities with no neck pain at all.
B. I am able to engage in all of my recreational activities with some pain in my neck.
C. I am able to engage in most, but not all of my recreational activities because of pain in my neck.
D. I am able to engage in a few of my recreational activities because of pain in my neck.
E. I can hardly do any recreational activities because of pain in my neck.
F. I cannot do any recreational activities at all.

**COMMENTS:** _____

*Vernon H, Mior S. The Neck Disability Index: A study of reliability and validity. J Manipulative Physiol Ther 1991;14:409-415.*

# ASSIGNMENT OF BENEFITS

PATIENT: _____

INSURED: _____

GROUP #: _____ CLAIM #: _____

SS #: _____ ID #: _____

I hereby instruct and direct the _____ Insurance Company to pay by check made out and mailed directly to:

SETH D. GOLDSTEIN, D.C.
19350 Business Center Drive, Suite 103
Northridge, California 91324

If my current policy prohibits direct payment to the doctor, then I hereby also instruct and direct you to make out the check to me and mail it to the following address:

SETH D. GOLDSTEIN, D.C.
19350 Business Center Drive, Suite 103
Northridge, California 91324

The professional or medical expense benefits allowable, and otherwise payable to me under my current insurance policy as payment toward the total charges for professional services rendered. This is a direct assignment of my rights and benefits under this policy. This payment will not exceed my indebtedness to the above-mentioned assignee, and I have agreed to pay in a current manner, any balance of said professional service charges over and above this insurance payment. A photocopy of this Assignment shall be considered as effective and valid as the original.

I also authorize the release of any information pertinent to my case to any insurance adjuster or attorney in this case.

Dated at Northridge, California this _____ day of _____,

_____ Signature of Patient

_____ Witness

# Informed Consent for Chiropractic Treatment of your Pain

**The nature of chiropractic treatment:** The doctor will use her/his hands or a mechanical device to manipulate the area treated. You may feel or hear a "click" or "pop," and you may feel movement. Chiropractic treatment also includes activity advice, exercise, hot or cold packs, or electric stimulation. Your chiropractor will recommend treatment she/he determines is most appropriate for your condition.

**Possible risks:** Chiropractic treatment for pain is safe and the majority of patients experience decreased pain and improved mobility. Approximately 30% of patients experience slight increased pain in the treated area, possibly due to minor strain of muscle, tendon, or ligament. When this occurs within the first few days of treatment, the increased pain is brief and returns to baseline or improves over the next few days. Increased pain may also occur with exercise, heat, cold, and electrical stimulation. Possible skin irritation or burns may occur with thermal or electrical therapy.

Serious bodily harm is extremely rare and not an inherent risk of chiropractic treatment. Many variables can adversely affect one's health, including previous injury, medications, osteoporosis, cancer and other illness or disease or condition. When these conditions are present, chiropractic treatment may be associated with serious adverse events, such as fracture, dislocation, or aggravation of previous injury to ligaments, intervertebral discs, nerves, or spinal cord. Symptoms of stroke or cerebrovascular injury alert patients to seek medical and/or chiropractic care. Your chiropractor is aware of this association and when appropriate may assess for symptoms and signs of stroke. *Please inform your chiropractor of all medications you are taking, including blood thinners, any surgeries you have had, and any other medical condition you have, including osteoporosis, heart disease, cancer, stroke, fracture, or previous severe injury.*

**Other options for the treatment of pain include:** *do nothing – live with it, over-the-counter medications, physical therapy, medical care, injections, or surgery*. There are hundreds of other treatments for pain. Most treatments that have potential benefit also have potential risk. You are encouraged to ask questions regarding possible risks of chiropractic treatment, and may use the space below for this purpose.

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**My signature below confirms that I have read the paragraphs above and that I understand what my chiropractor has told me about possible risks of chiropractic treatment and that I have had the opportunity to ask questions and have my questions answered. Also, I have fully disclosed to my chiropractor my medical history regarding the above specified complicating factors and all other conditions that have caused me pain in the past.**

| | | |
|---|---|---|
| **Patient Name** | **Signature** | **Date** |
| **Witness Name** | **Signature** | **Date** |

# Informed Consent for Chiropractic Treatment of your Pain

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| | | |
|---|---|---|
| **Patient Name** | **Signature** | **Date** |
| **Witness Name** | **Signature** | **Date** |