NECK PAIN AND DISABILITY INDEX

Patient Name: _____ **Date of Birth:** _____ **Date:** _____

Please read instructions carefully: This questionnaire has been designed to give the doctor information as to how your neck pain has affected your ability to manage everyday life. Please read all statements in each section then mark the box that most closely describes your problem.

SECTION 1 – PAIN INTENSITY
- ☐ I have no pain at the moment.
- ☐ The pain is very mild at the moment.
- ☐ The pain is moderate at the moment.
- ☐ The pain is fairly severe at the moment.
- ☐ The pain is very severe at the moment.
- ☐ The pain is worse than imaginable at the moment.

SECTION 2 – PERSONAL CARE
- ☐ I can look after myself normally, without causing extra pain.
- ☐ I can look after myself normally but it causes extra pain.
- ☐ It is painful to look after myself and I am slow and careful.
- ☐ I need some help but manage most of my personal care.
- ☐ I need help everyday in most aspects of self care.
- ☐ I do not get dressed. I wash with difficulty and stay in bed.

SECTION 3 – LIFTING
- ☐ I can lift heavy objects without any extra pain.
- ☐ I can lift heavy objects, but it gives extra pain.
- ☐ Pain prevents me from lifting heavy objects off the floor but I can manage if they are conveniently positioned on a table.
- ☐ Pain prevents me from lifting heavy objects but I can manage light to medium objects.
- ☐ I can only lift very light objects.
- ☐ I cannot lift or carry anything at all.

SECTION 4 – READING
- ☐ I can read as much as I want to with no pain in my neck.
- ☐ I can read as much as I want to with light pain in my neck.
- ☐ I can read as much as I want to with moderate pain in my neck.
- ☐ I can't read as much as I want to because of moderate pain in my neck.
- ☐ I can hardly read at all because of severe pain in my neck.
- ☐ I cannot read at all.

SECTION 5 – HEADACHES
- ☐ I have no headache at all.
- ☐ I have slight headaches which come infrequently.
- ☐ I have moderate headaches which come infrequently.
- ☐ I have moderate headaches which come frequently.
- ☐ I have severe headaches which come frequently.
- ☐ I have headaches almost all the time.

SECTION 6 – CONCENTRATION
- ☐ I can concentrate fully when I want to with no difficulty.
- ☐ I can concentrate fully when I want to with slight difficulty.
- ☐ I have a fair degree of difficulty in concentrating when I want to.
- ☐ I have a lot of difficulty in concentrating when I want to.
- ☐ I have a great deal of difficulty in concentrating when I want to.
- ☐ I cannot concentrate at all.

SECTION 7 – WORK
- ☐ I can do as much work as I want.
- ☐ I can do only my usual work, but no more.
- ☐ I can do most of my usual work, but no more.
- ☐ I cannot do my usual work.
- ☐ I can hardly work at all.
- ☐ I cannot do any work at all.

SECTION 8 – DRIVING
- ☐ I can drive without any neck pain.
- ☐ I can drive as long as I want with slight neck pain.
- ☐ I can drive as long as I want with moderate neck pain.
- ☐ I can hardly drive at all because of severe neck pain.
- ☐ I cannot drive at all.

SECTION 9 - SLEEPING
- ☐ I have no trouble sleeping.
- ☐ My sleep is slightly disturbed (less than 1 hr sleepless).
- ☐ My sleep is mildly disturbed (1-2 hrs sleepless).
- ☐ My sleep is moderately disturbed (3-5 hrs sleepless).
- ☐ My sleep is completely disturbed (5-7 hrs sleepless).

SECTION 10 – RECREATION
- ☐ I am able to engage in all my recreational activities with no neck pain.
- ☐ I am able to engage in all my recreational activities with some neck pain.
- ☐ I am able to engage in most, but not all of my usual recreational activities because of neck pain.
- ☐ I am able to engage in a few of my usual recreational activities because of neck pain.
- ☐ I can hardly do any recreational activities because of neck pain.
- ☐ I cannot do any recreational activities at all.

NECK PAIN SCALE

Rate the severity of your **Neck Pain** by indicating on the following scale.

Absent I----------I Extreme

LOW BACK PAIN AND DISABILITY INDEX (REVISED OSWESTRY)

Patient Name: _____ **Date of Birth:** _____ **Date:** _____

Please read instructions carefully: This questionnaire has been designed to give the doctor information as to how your low back pain has affected your ability to manage everyday life. Please read all statements in each section then mark the box that most closely describes your problem.

SECTION 1 – PAIN INTENSITY
- ☐ The pain comes and goes and is very mild.
- ☐ The pain is mild and does not vary much.
- ☐ The pain comes and goes and is moderate.
- ☐ The pain is moderate and does not vary much.
- ☐ The pain comes and goes and is very severe.
- ☐ The pain is severe and does not vary much.

SECTION 2 – PERSONAL CARE
- ☐ I do not have to change my way of washing or dressing to avoid pain.
- ☐ I do not normally change my way of washing or dressing even though it causes some pain.
- ☐ Washing and dressing increases the pain but I manage not to change my way of doing it.
- ☐ Washing and dressing increases the pain and I find it necessary to change my way of doing it.
- ☐ Because of the pain, I am unable to do some washing and dressing without help.
- ☐ Because of the pain, I am unable to do any washing or dressing without help.

SECTION 3 – LIFTING
- ☐ I can lift heavy objects without any extra pain.
- ☐ I can lift heavy objects, but it gives extra pain.
- ☐ Pain prevents me from lifting heavy objects off the floor.
- ☐ Pain prevents me from lifting heavy objects off the floor but I can manage if they are conveniently positioned on a table.
- ☐ Pain prevents me from lifting heavy objects but I can manage light to medium objects.
- ☐ I can only lift very light objects at the most.

SECTION 4 – WALKING
- ☐ I have no pain on walking.
- ☐ I have some pain but it does not increase with distance.
- ☐ I cannot walk more than one mile without increasing pain.
- ☐ I cannot walk more than 1 / 2 mile without increasing pain
- ☐ I cannot walk more than 1 / 4 mile without increasing pain.
- ☐ I cannot walk at all without increasing pain.

SECTION 5 – SITTING
- ☐ I can sit in any chair as long as I like.
- ☐ I can only sit in my favorite chair as long as I like.
- ☐ Pain prevents me from sitting more than one hour.
- ☐ Pain prevents me from sitting more than half an hour.
- ☐ Pain prevents me from sitting more than ten minutes.
- ☐ I avoid sitting because it increases pain.

SECTION 6 - STANDING
- ☐ I can stand as long as I want without pain.
- ☐ I have some pain on standing but it does not increase with time.
- ☐ I cannot stand for longer than one hour without increasing pain.
- ☐ I cannot stand for longer than ½ hour without increasing pain.
- ☐ I cannot stand longer than ten minutes without increasing pain.
- ☐ I avoid standing because it increases the pain.

SECTION 7 – SLEEPING
- ☐ I have no pain in bed.
- ☐ I have pain in bed but it does not prevent me from sleeping well.
- ☐ Pain reduces my normal sleep by 1 / 4 each night.
- ☐ Pain reduces my normal sleep by 1 / 2 each night.
- ☐ Pain reduces my normal sleep by 3 / 4 each night.
- ☐ Pain prevents me from sleeping at all.

SECTION 8 – SOCIAL LIFE
- ☐ My social life is normal and gives me no pain.
- ☐ My social life is normal but increases the degree of pain.
- ☐ My social life is unaffected by pain apart from limiting more energetic interests.
- ☐ Pain has restricted my social life and I do not go out very often.
- ☐ Pain has restricted my social life to my home.
- ☐ I have hardly any social life because of the pain.

SECTION 9 – DRIVING / RIDING IN CAR
- ☐ I have no pain while traveling.
- ☐ I have some pain while traveling but none of my usual forms of travel make it any worse.
- ☐ I have extra pain while traveling but it does not compel me to seek alternate forms of travel.
- ☐ I have extra pain while traveling which compels me to seek alternate forms of travel.
- ☐ Pain restricts all forms of travel.
- ☐ Pain restricts all forms of travel except those done lying down.

SECTION 10 – CHANGING DEGREE OF PAIN
- ☐ My pain is rapidly getting better.
- ☐ My pain fluctuates but overall is definitely getting better.
- ☐ My pain seems to be getting better but improvement is slow at present.
- ☐ My pain is neither getting better or worse.
- ☐ My pain is gradually worsening.
- ☐ My pain is rapidly worsening.

LOW BACK PAIN SCALE

Rate the severity of your **Low Back Pain** by indicating on the following scale.

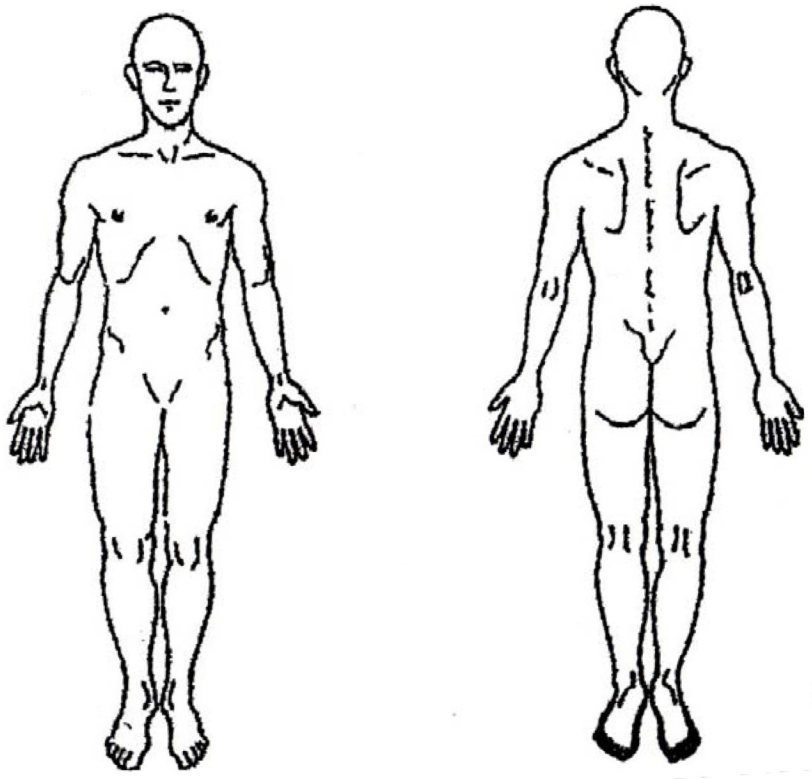
Absent I----------I Extreme

Patient Name: _____ **Date of Birth:** _____ **Date:** _____

PAIN DRAWING

Ache	Numbness	Pins & Needles
<<<<<	.....	ooooo
<<<<<	.....	ooooo

Burning	Stabbing	Throbbing
xxxxx	//////	~~~~~
xxxxx	//////	~~~~~



SYMPTOM RATING SCALE

Symptoms often vary in intensity. Please answer these questions about your CURRENT symptoms.

1. What is your symptom intensity **RIGHT NOW**?

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

2. What is your **TYPICAL or AVERAGE** symptom intensity?

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

3. What is your symptom intensity at its **WORST**?

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

4. How often are your symptoms present? _____ %

5. What are you concerned about today? _____

_____

_____

Additional comments or questions: _____

_____

_____

Patient Name: _____ **Date of Birth:** _____ **Date:** _____

INJURY CLAIM INFORMATION

Your Auto Insurance Information

Date of Injury: _____

Name of Policy Holder: _____

Insurance Company: _____

Insurance Company's Phone: _____

Policy Number: _____

Claim Number: _____

Your PIP Adjuster

You will have a PIP adjuster once the medical portion of your claim has been opened.
Please verify with your insurance company that this has been done BEFORE your first visit.

PIP Adjuster Name: _____

PIP Adjuster Phone: _____

Your Attorney Information

Please leave blank if you do not currently have an attorney.

Attorney's Name: _____

Attorney's Address: _____

Attorney's Phone: _____

Attorney's Fax: _____

Legal Assistant / Paralegal's Name: _____

Release of Information & Assignment of Benefits

I authorize Gretchen Blyss, DC to release my records in order to obtain payment on my account for services provided to me. I authorize payment for such services to be paid directly to Gretchen Blyss, DC. I understand that I am financially responsible for any charges not paid by my insurance carrier or attorney.

Signature: _____ **Date:** _____

Patient Name: _____ **Date of Birth:** _____ **Date:** _____

MOTOR VEHICLE INJURY CASES

If you are hurt in a motor vehicle collision and it is deemed the other driver's fault, the other driver's auto insurance company is responsible; however, will not pay out on a claim until the case is settled. If you choose not to file a PIP claim and want to wait on the third party settlement; it is required you be a self-pay patient, pay at the time of service, and submit the bill yourself to the third party so you can be reimbursed when your claim settles. If you decide to open a PIP claim with your own motor vehicle company, then our billing company will submit claims on your behalf, but only after a signed lien is on file.

All auto liability policies in Oregon are required to provide "no-fault" Personal Injury Protection (PIP) coverage for prompt payment of reasonable and necessary medical expenses resulting from an auto collision. There is no penalty to you for making a PIP claim under your own policy. However, your insurance company is entitled to be reimbursed by the responsible person's insurance company. First general rule: "PIP follows the car." If the car is insured, PIP covers all occupants no matter who was at fault. By law, PIP must cover at least $15,000 worth of medical expenses occurring within 365 days of the collision as long as it is deemed reasonable and necessary. Any amounts over your PIP should be covered by your healthcare insurance. If you do not have healthcare insurance or your healthcare insurance policy does not cover the services provided in our clinic, you will be personally liable for any amounts in excess of your PIP coverage.

Even though you file a PIP claim, there may come a time during the course of your treatment where your PIP stops making payments on your medical expenses. For this reason, we have all motor vehicle crash patients sign an assignment and lien with our clinic. If your PIP exhausts, denies, and/or expires and we are unable to secure payment from your healthcare insurance, the lien gives our clinic added protection so that we can be assured reimbursement for services rendered from any settlement awarded to you resulting from the injury case. Your insurance company will not advise us on how much money is available in your PIP or warn us when it is about to exhaust. Only you are authorized to obtain that information. If you feel your injuries have not resolved and require further treatment beyond your PIP policy limits, you may want to seek legal counsel so that you can continue care towards resolution, while the attorney works with your insurance for a fair settlement.

Periodically throughout your treatment plan, our office will be contacted to provide your medical records to various parties. These parties could include, and not to be limited to, your health insurance and/or motor vehicle insurance companies, the other party's motor vehicle insurance companies, attorneys, etc. To protect your privacy, HIPPA regulations require that our office will not release your information without a signature from you. Our office will never release any patient information without a current, signed Authorization to Release Records form.

PATIENT ACKNOWLEDGMENT
By signing this document, I acknowledge that the above information has been provided to me and applies to any treatment that is provided to me within this medical office. I further acknowledge that based on the above information I am fully responsible for the payment of the services provided. I understand and agree to all of the above applicable responsibilities, policies, and risks.

Patient Signature: _____ **Date:** _____

ASSIGNMENT, LIEN AND AUTHORIZATION FOR DIRECT PAYMENT

Date of Injury or Onset: _____

Purpose: The purpose of this Assignment & Lien is to assist the Office in obtaining Proceeds from various Payers for the payment of my Charges. Accordingly, I agree to the following and direct all Payers as follows:

Definitions: In this Assignment & Lien, the following terms shall have the following meaning:

"**Office**" and "**Clinic**" shall refer to Dr. Gretchen Blyss, DBA Blyss Chiropractic located at 111 SW Columbia Suite #100, Portland OR, 97201.

"**Payer**" shall refer to without limit any insurance carrier, health benefit plan, administrator and fiduciary, health maintenance organization, preferred and independent provider organization, attorney, adjuster, claims handler, medical examiner, individual reviewer or review entity, at-fault party, individual and any other entity, which may elect or be obligated to pay or disburse Proceeds, either now or in the future, or which may be involved directly or indirectly in determining the obligation to pay or disburse Proceeds, either now or in the future;

"**Proceeds**" shall include without limit, the Proceeds from any settlement, judgment or verdict, the Proceeds from any promise to pay or reimburse, the Proceeds relating "health-care-insurance receivables" as such are defined by the applicable Uniform Commercial Code and the Proceeds relation to the following benefits, plans or coverages: Individual and group health benefits, Medicare and Medicaid, workers' compensation, disability, liability, uninsured and underinsured motorists, no-fault medical payments, Personal Injury Protection (PIP), medical payments benefits, lost wages, lost services, property damage, errors & omissions and malpractice.

"**Charges**" shall include without limit the full fees for the Clinic's goods and services (including without limit: treatment, diagnostic services, medical equipment, supplies, supplements, narrative reports, photocopies, pre-authorization requests, no-shows, depositions and testimony, whether rendered before or after the date of this Assignment & Lien), any collection costs incurred by the Office, delinquency penalties to the maximum extent permitted under law and any other Charges incurred by me at the Office. "Collection Costs" shall include without limit any pre- and post-judgment court costs, filing fees, service of process Charges, attorney's fees, fees or costs associated with requests for reconsideration, independent reviews, appeals, mediation, arbitration and any other costs of collection incurred by the Clinic in any effort or action to collect my Charges either from me or from any Payer.

Assignment and Lien Terms: I hereby assign to the Clinic to the extent permitted by law, but only to the extent of my Charges, all of my claims to, rights to, and interests in, Proceeds, whether resolved or unresolved, including without limit ownership rights, which I may have now or in the future relating directly or indirectly to my Charges, condition, or causes of my condition ("Claims to Proceeds"), including without limit any and all causes of action, receivables, payment intangibles and remedies that I might have against or with respect to any Payer now or in the future and the right to prosecute, seek, settle or otherwise resolve such Claims to Proceeds either in my name or in the Clinic's name and as the Clinic otherwise sees fit.

I agree that this assignment shall be effective as of the date and time the initial cause of my condition occurred. I further intend for this Assignment & Lien to create a security interest under the applicable Uniform Commercial Code. Accordingly, I hereby grant to the Clinic a primary, non-contingent security interest in all of my Claims to Proceeds to the extent permitted by law for the purpose of securing payment of my Charges, the attachment and perfection of which shall relate back to and be effective as of, the date and time the initial cause of my condition occurred. I further authorize the Clinic to file the form(s) normally filed with the secretary of state or other governmental agency relating to such security interests and to make such filings in all relevant jurisdictions as the Clinic sees fit in its sole discretion.

I agree that once payment in-full has been made towards all outstanding Charges to the full extent permitted by law or contract and also as defined by my financial agreement with the Office, such security interest shall be removed or terminated solely upon my written request sent through the United States Postal Service Certified Mail. Consistent with these terms, I hereby direct any and all Payers, to pay the Proceeds directly to, immediately to and exclusively in the name of the Clinic to the full extent of my Charges.

I understand and agree that even though this Assignment and Lien has been executed, I remain directly and fully responsible to Clinic for all Charges submitted by Clinic for services rendered as stated in the clinic's Financial Agreement and that this Assignment and Lien is made solely for provider's additional protection.

I further understand that payment of such Charges are not contingent on any settlement, judgment or verdict by which may eventually recover said Charges. In the event Charges are not partially or fully recovered by said Proceeds, I am personally and solely responsible to execute immediate and appropriate arrangements for payment of such Charges.

Specific Direction to Any Attorney I retain, Such as in Accident Cases: In the event that I retain one or more attorneys who receive(s) Proceeds from one or more Payers, I hereby direct (and the Clinic hereby requests) each attorney to provide immediate notice to the Clinic regarding such Proceeds, to promptly pay the Clinic in-full out of such Proceeds and to provide full accounting of such Proceeds to the Office. I agree that the purpose of such Proceeds shall be primarily to pay my Charges. If I have a dispute regarding the Charges, any remedies I may have shall not include instructing my attorney to withhold or delay payment of Proceeds to the office. I further agree to and hereby irrevocably waive any present or future right I may have, whether arising under a "Common Fund Doctrine" or other legal basis, to require the Clinic to absorb the costs associated with, or otherwise assume responsibility for, any portion of my attorney's fees and costs, or other expenses of obtaining Proceeds.

Disclosure Directives: I agree to promptly notify Clinic billing or office manager of any addition of attorney(s) used in connection with this condition onset, and instruct attorney to do the same. I further agree to keep Clinic advised of the progress of my case at reasonable intervals and instruct attorney to do the same.

I hereby direct each and every Payer to immediately release the Clinic any pertinent information relating to (a) any coverage I may have and (b) any Proceeds determination by the Payer relating to the Clinic's Charges. "Pertinent Information" shall include without limit the amount of total coverage available and remaining, as well as the amount of any outstanding claims which the Payer has received from any claimant relating to my condition. "Pertinent Information" shall also include without limit copies of all documents, records and other information (a) relied upon by the Payer in making a Proceeds Determination or (b) was submitted, considered or generated in the course of making a Proceeds determination without regard to whether such document, record or other information was relied upon in making the Proceeds determination. "Proceeds Determination" shall include without limit any determination by the Payer to pay, deny or delay payment of any Proceeds relating to the Clinic's Charges, as well as a decision to refer the Charges to an independent review or audit, utilization review or independent medical exam. I further authorize and direct the Clinic to release any information relating any services rendered to or for me by the Clinic to all Payers, including without limit a copy of my Charges and a copy of this Assignment & Lien, unless otherwise agreed upon in writing.

Miscellaneous: Except as provided in this paragraph, this Assignment & Lien shall not be modified or revoked without the expressed written consent of the Office. I hereby revoke, with the Clinic's consent the terms of any previously signed documents, but only to the extent those terms conflict with the terms of this Assignment & Lien. I agree that each and every provision of this Assignment & Lien is reasonably necessary. However, should any provision of this Assignment & Lien be found to be invalid, illegal and unenforceable or for any reason cease to be binding on any party hereto, all other portions and provisions of this Assignment & Lien shall, nevertheless, remain in full force and effect. This Assignment & Lien shall be governed under the laws of the state where the Clinic is located and is performable in the country where the Clinic is located. In any action based upon this Assignment & Lien, I hereby consent to personal jurisdiction and venue of any court in said country and waive all objections based on improper jurisdiction, venue or forum inconvenience. I further waive any statute of limitations which may apply in any action based upon this Assignment & Lien.

I have read, understood and agree to the terms of this Assignment, Lien and Authorization.

Patient Name (print): _____ Date of Birth: _____

Patient Signature: _____ Date: _____

Attorney Name: _____ Attorney Office: _____

Attorney Signature: _____ Date: _____

Provider Name (print): _____

Provider Signature: _____ Date: _____

Name of Custodial Parent/Legal Guardian, on Behalf of the Patient (print): _____

Parent/Guardian Signature: _____ Date: _____