

# CULVER CHIROPRACTIC, P.C.

**Dr. Thomas E. Culver – Palmer Graduate**

1490 Springfield Ave., Ste 2 New Providence, NJ 07974  
Telephone: (908)508-1212 Facsimile: (908)508-9211

**Dear Patient:** This information is considered confidential. We need this information because we care enough to want to know, and your answers will help us determine if chiropractic can help you. If we do not sincerely believe your condition will respond satisfactorily, we will not accept your case in order for us to understand your condition properly, please be as neat and accurate as possible while completing this form. Thank you.

Name: \_\_\_\_\_ Sex: \_\_\_\_ Marital Status: \_\_\_\_ Birth date: \_\_\_\_\_

Home phone: \_\_\_\_\_ Cell phone: \_\_\_\_\_ E-mail: \_\_\_\_\_

Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_ Zip code: \_\_\_\_\_

Occupation: \_\_\_\_\_ Referred by: \_\_\_\_\_

SSN# \_\_\_\_\_ Company: \_\_\_\_\_ Work phone: \_\_\_\_\_

Spouse's Name: \_\_\_\_\_ SSN# \_\_\_\_\_ Spouse's Employer \_\_\_\_\_

Please explain in detail how your accident happened: \_\_\_\_\_

What were the time and date of present injury? \_\_\_\_\_

Where did you feel pain immediately after the accident? \_\_\_\_\_

List the extent of injuries as you know them: \_\_\_\_\_

Did you require post accident hospitalization? Y / N

Check symptoms you have noticed since the accident:

<input type="checkbox"/> Headache	<input type="checkbox"/> Dizziness	<input type="checkbox"/> Depression	<input type="checkbox"/> Cold feet
<input type="checkbox"/> Stomach upset	<input type="checkbox"/> Light Bothers Eyes	<input type="checkbox"/> Buzzing in ears	<input type="checkbox"/> Cold hands
<input type="checkbox"/> Neck pain	<input type="checkbox"/> Head seems too heavy	<input type="checkbox"/> Loss of memory	<input type="checkbox"/> Back pain
<input type="checkbox"/> Stiff neck	<input type="checkbox"/> Pins and needles in arms	<input type="checkbox"/> Ears ring	<input type="checkbox"/> Tension
<input type="checkbox"/> Fainting	<input type="checkbox"/> Sleeping problems	<input type="checkbox"/> Loss of balance	<input type="checkbox"/> Fever
<input type="checkbox"/> Face flushed	<input type="checkbox"/> Pins and needles in legs	<input type="checkbox"/> Constipation	<input type="checkbox"/> Chest pain
<input type="checkbox"/> Nervousness	<input type="checkbox"/> Numbness in fingers	<input type="checkbox"/> Loss of smell	<input type="checkbox"/> Diarrhea
<input type="checkbox"/> Irritability	<input type="checkbox"/> Numbness in toes	<input type="checkbox"/> Loss of taste	<input type="checkbox"/> Shortness of breath
<input type="checkbox"/> Cold sweats		<input type="checkbox"/> Fatigue	

Symptoms other than above: \_\_\_\_\_

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

Hospitalized? Y / N If yes, admitted? \_\_\_\_\_ How long? \_\_\_\_\_

Name of Hospital: \_\_\_\_\_

Name of Doctors: \_\_\_\_\_

What treatment was given? \_\_\_\_\_

Was any other doctor consulted? \_\_\_\_\_ If yes, what was the doctor's name? \_\_\_\_\_

What was the diagnosis? \_\_\_\_\_

What treatment was given? \_\_\_\_\_

How often did you see the doctor & how long? \_\_\_\_\_

Have you ever had any complaints in the involved area before? Y / N

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If so, what were the complaints? \_\_\_\_\_

Before the injury were you capable of working on an equal basis with others your age? Y / N

Are your work activities restricted as a result of this accident? Y / N

Since this injury are your symptoms? Improving / Getting Worse / Same

## Information Regarding Driver of the Vehicle (if any)

Name: \_\_\_\_\_ Insurance Company: \_\_\_\_\_ Policy# \_\_\_\_\_

## Information Regarding Yourself

Name: \_\_\_\_\_ Insurance Company: \_\_\_\_\_ Policy# \_\_\_\_\_

Name of your insurance adjustor: \_\_\_\_\_ Phone number: \_\_\_\_\_

Have you retained an attorney? Y / N

If so, his name and address? \_\_\_\_\_

You were heading: North / East / South / West on \_\_\_\_\_ (street or highway)

Other vehicle was heading: North / East / South / West on \_\_\_\_\_ (street or highway)

Were the police notified? Y / N

Were you knocked unconscious? Y / N If so, for how long? \_\_\_\_\_

You were struck from: Behind / Front / Left side / Right side

You were: Driver / Passenger / Front seat / Back seat / Using seat belts / Other protective devices

*I understand and agree that health and accident policies are an arrangement between an insurance carrier and myself. Furthermore, I understand that this Chiropractic Office will prepare any necessary reports and forms to assist me in making collection from the insurance company and that any amount authorized to be paid directly to this Chiropractic Office will be credited to my account on receipt. However, I clearly understand and agree that all services rendered me are charged directly to me and that I am personally responsible for payment. I also understand that if I suspend or terminate my care and treatment, any fees for professional services rendered me will be immediately due and payable.*

\_\_\_\_\_  
Name (printed) Signature Date

\_\_\_\_\_  
Guardian or Spouse's Name Signature Date

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## ROLAND MORRIS DISABILITY INDEX

Name \_\_\_\_\_ Date \_\_\_\_/\_\_\_\_/\_\_\_\_ File# \_\_\_\_\_  
(Please Print)

**When your back hurts, you may find it difficult to do some of the things you normally do. Check the box before each sentence that describes you today. Leave the box blank if the sentence does not describe you.**

- I stay home most of the time because of my back.
- I change positions frequently to try and get my back comfortable.
- I walk more slowly than usual because of my back.
- Because of my back, I am not doing any of the jobs that I usually do around the house.
- Because of my back, I use a handrail to get upstairs.
- Because of my back, I lie down to rest more.
- Because of my back, I have to hold on to something to get out of an easy chair.
- Because of my back, I try to get other people to do things for me.
- I get dressed more slowly because of my back.
- I only stand up for short periods of time because of my back.
- Because of my back, I try not to bend or kneel.
- I find it difficult to get out of a chair because of my back.
- My back is painful almost all of the time.
- I find it difficult to turn over in bed because of my back.
- My appetite is not very good because of my back.
- I have trouble putting on my socks (stockings) because of my back.
- I only walk short distances because of my back pain.
- I sleep less well because of my back pain.
- Because of my back pain, I get dressed with help from someone else.
- I sit down for most of the day because of my back.
- I avoid heavy jobs around the house because of my back.
- Because of my back pain, I am more irritable and bad tempered with people than usual.
- Because of my back, I go upstairs more slowly than usual.
- I stay in bed most of the time because of my back.

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## REVISED OSWESTRY DISABILITY

**Name:** \_\_\_\_\_ **Date:** \_\_\_\_\_ **File#** \_\_\_\_\_

This questionnaire helps us to understand how much your low back pain has affected your ability to perform everyday activities. Please check the one box in each section that most clearly describes your problem right now.

<p><b>Section 1: Pain Intensity</b></p> <ul style="list-style-type: none"> <li><input type="checkbox"/> The pain comes and goes and is very mild.</li> <li><input type="checkbox"/> The pain is mild and does not vary much.</li> <li><input type="checkbox"/> The pain comes and goes and is moderate.</li> <li><input type="checkbox"/> The pain is moderate and does not vary much.</li> <li><input type="checkbox"/> The pain comes and goes and is severe</li> <li><input type="checkbox"/> The pain is severe and does not vary much</li> </ul>	<p><b>Section 6: Standing</b></p> <ul style="list-style-type: none"> <li><input type="checkbox"/> I can stand as long as I want without pain</li> <li><input type="checkbox"/> I have some pain on standing, but it does not, increase with time.</li> <li><input type="checkbox"/> I cannot stand for longer than on hour without increasing pain.</li> <li><input type="checkbox"/> I cannot stand for longer than ½ hour without increasing pain.</li> <li><input type="checkbox"/> I cannot stand for longer than 10 minutes without increasing pain.</li> <li><input type="checkbox"/> I avoid standing, because it increases the pain immediately</li> </ul>
<p><b>Section 2: Personal Care (Washing, Dressing, etc.)</b></p> <ul style="list-style-type: none"> <li><input type="checkbox"/> I would not have to change my way of washing or dressing in order to avoid pain.</li> <li><input type="checkbox"/> I do not normally change my way of washing or dressing even though it causes some pain.</li> <li><input type="checkbox"/> Washing and dressing increases the pain, but I manage not to change my way of doing it.</li> <li><input type="checkbox"/> Washing and dressing increases the pain and I find it necessary to change my way of doing it.</li> <li><input type="checkbox"/> Because of the pain, I am unable to do some washing and dressing without help.</li> <li><input type="checkbox"/> Because of the pain, I am unable to do any washing and dressing without help</li> </ul>	<p><b>Section 7 – Sleeping</b></p> <ul style="list-style-type: none"> <li><input type="checkbox"/> I get no pain in bed.</li> <li><input type="checkbox"/> I get pain in bed but it does not prevent me from sleeping well.</li> <li><input type="checkbox"/> Because of pain, my normal night’s sleep is reduced by less than ¼.</li> <li><input type="checkbox"/> Because of pain, my normal night’s sleep is reduced by less than ½.</li> <li><input type="checkbox"/> Because of pain, my normal nights sleep is reduced by less than ¾.</li> <li><input type="checkbox"/> Pain prevents me from sleeping at all</li> </ul>
<p><b>Section 3 – Lifting</b></p> <ul style="list-style-type: none"> <li><input type="checkbox"/> I can lift heavy weights without extra pain.</li> <li><input type="checkbox"/> I can lift heavy weights but it gives extra pain.</li> <li><input type="checkbox"/> Pain prevents me from lifting heavy weights of the floor.</li> <li><input type="checkbox"/> Pain prevents me from lifting heavy weights off the floor, but I can manage if they are conveniently positions, e.g., on a table.</li> <li><input type="checkbox"/> Pain prevents me from lifting heavy weights, but I can manage light to medium weights if they are conveniently positioned.</li> <li><input type="checkbox"/> I can only lift very light weights at the most.</li> </ul>	<p><b>Section 8 – Social Life</b></p> <ul style="list-style-type: none"> <li><input type="checkbox"/> My social life is normal and gives me no pain.</li> <li><input type="checkbox"/> My social life is normal, but increases the degree of pain.</li> <li><input type="checkbox"/> Pain has no significant effect on my social life apart from limiting my more energetic interests, e.g. dancing, etc.</li> <li><input type="checkbox"/> Pain has restricted my social life and I do not go out very often.</li> <li><input type="checkbox"/> Pain has restricted my social life to my home.</li> <li><input type="checkbox"/> I have hardly any social life because of the pain.</li> </ul>
<p><b>Section 4 – Walking</b></p> <ul style="list-style-type: none"> <li><input type="checkbox"/> I have no pain on walking.</li> <li><input type="checkbox"/> I have some pain on walking but it does not increase with distance.</li> <li><input type="checkbox"/> I cannot walk more than one mile without increasing pain.</li> <li><input type="checkbox"/> I cannot walk more than ½ mile without increasing pain.</li> <li><input type="checkbox"/> I cannot walk more than ¼ mile without increasing pain.</li> <li><input type="checkbox"/> I cannot walk at all without increasing pain.</li> </ul>	<p><b>Section 9 – Traveling</b></p> <ul style="list-style-type: none"> <li><input type="checkbox"/> I get no pain while traveling.</li> <li><input type="checkbox"/> I get some pain while traveling but none of my usual forms of travel make it any worse.</li> <li><input type="checkbox"/> I get extra pain while traveling, but it does not compel me to seek alternative forms of travel.</li> <li><input type="checkbox"/> I get extra pain while traveling which compels me to seek alternative forms of travel.</li> <li><input type="checkbox"/> Pain restricts all forms of travel.</li> <li><input type="checkbox"/> Pain prevents all forms of travel except that done lying down.</li> </ul>
<p><b>Section 5 – Sitting</b></p> <ul style="list-style-type: none"> <li><input type="checkbox"/> I can sit in any chair as long as I like without pain.</li> <li><input type="checkbox"/> I can sit only in my favorite chair as long as I like.</li> <li><input type="checkbox"/> Pain prevents me from sitting more than 1 hour.</li> <li><input type="checkbox"/> Pain prevents me from sitting more than ½ hour.</li> <li><input type="checkbox"/> Pain prevents me from sitting for more than 10 minutes.</li> <li><input type="checkbox"/> I avoid sitting because it increases pain immediately.</li> </ul>	<p><b>Section 10 – Changing Degree of Pain</b></p> <ul style="list-style-type: none"> <li><input type="checkbox"/> My pain is rapidly getting better.</li> <li><input type="checkbox"/> My pain fluctuates, but overall is definitely getting better.</li> <li><input type="checkbox"/> My pain seems to be getting better, but improvement is slow.</li> <li><input type="checkbox"/> My pain is neither getting better nor getting worse.</li> <li><input type="checkbox"/> My pain is gradually worsening.</li> <li><input type="checkbox"/> My pain is rapidly worsening.</li> </ul>

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## LIEN AGREEMENT AND RELEASE OF MEDICAL REPORTS

I authorize (herein doctor) to furnish my attorney, as identified below, with a full report of his examination, diagnosis, treatment, prognosis, and opinion of myself in regard to my accident of

I authorize and direct my attorney, to pay directly to the doctor such sums as may be due and owing for medical service rendered to me by reason of this accident and for any other bills that are due and owing to the doctor, and to withhold such sums from any settlement, arbitration award, Order, Judgment or verdict as may be necessary to satisfy the doctor's bill in full. I hereby give a Lien on my case to the doctor against any and all proceeds of my settlement arbitration award, Order, Judgment or verdict which may be paid to my attorney, or myself, as the result of the injuries for which I have sought and received treatment.

I agree never to rescind this Lien Agreement and that a rescission shall not be honored by my attorney. I hereby instruct my attorney that in the event another attorney is substituted as my legal representative in this case, the new attorney shall also honor this Lien as condition to my continued treatment and it shall remain fully enforceable.

It has been explained to me and I understand that I remain fully responsible to the doctor for all medical bills submitted for services rendered to me and that this agreement is made solely for the doctor's protection and in consideration of the doctor foregoing payment for services when rendered. It has been explained to me and I understand that such payment is not contingent on any settlement, arbitration award, Order, Judgment or verdict by which I may eventually recover medical expenses.

It has been explained to me and I understand that by signing this Lien Agreement I am bound by all of its terms and conditions. It has been explained to me and I understand that if my attorney does not wish to cooperate in protecting the doctor's bill and complying with this Lien Agreement, the doctor shall require me to make payment immediately upon the receipt of medical services.

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Patient Name (printed) Signature Date

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Witness Name (printed) Signature Date

The undersigned being attorney of record for the above patient does hereby agree to observe all the terms of this Lien Agreement and to withhold such sums from any settlement, arbitration award, Order, Judgment or verdict, as may be necessary to fully satisfy the doctor's bill.

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Attorney Name (printed) Signature Date

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Attorney Address Phone Number

Please date, sign and return the original to the doctor's office as soon as possible.

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## Acknowledgement of Financial Responsibility

If your insurance denies payment for any reason you will be responsible for that amount. We will be happy to help you, but knowledge of your benefits is your responsibility. If we submit your treatment plan late, you will not be responsible for those charges. I acknowledge I have read and understand this form.

---

Name (printed)

Signature

Date

## Chiropractic Informed Consent for Diagnosis and Treatment

I hereby give my consent to the performance of diagnosis tests and procedures and chiropractic treatment or management of my condition(s).

Chiropractic treatment or management of conditions almost always includes the chiropractic adjustment, a specific type of manipulation. Like most healthcare procedures, the chiropractic adjustment carries with it some risks. Unlike many procedures, the serious risks associated with the chiropractic adjustment are extremely rare.

I have read or had read to me this informed consent document. *I have discussed or been given the opportunity to discuss any questions or concerns with my doctor and have had these answered to my satisfaction **prior to my signing this informed consent document.*** I have made my decision voluntarily and freely.

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Signature of Patient or Guardian

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Signature of Witness

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## Signature on File

- I authorize the doctor named above to use my name on any and all claims or documents that relate to health insurance benefits due to me and my dependents.
- I authorize release of any information related to any claims to all my insurance companies or other relevant parties.
- I understand that I am responsible for my bill and agree to pay all charges for services and items provided to me.
- I authorize my doctor to act as my agent in helping me obtain payment from my insurance companies.
- I authorize payment of health benefits otherwise payable to me, directly to my doctor.
- I permit a copy of this authorization to be used in place of the original.
- This "Signature on File" is valid for one year from the date indicated below.

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Signature of Beneficiary, Guardian,  
or Personal Representative

Medicare # (if applicable)

Date

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Print name of Beneficiary, Guardian,  
or Personal Representative

Relationship to Beneficiary

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## 21 Day Notice Letter

Please print and bring this to your first office visit. Fill out patient information and have Dr. Culver fill out the diagnosis codes and findings. Thank you.

Patient's Name: \_\_\_\_\_ Birthdate: \_\_\_\_\_

Patient's Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Patient Home Phone: \_\_\_\_\_ Patient Cell Phone: \_\_\_\_\_

Date of Accident: \_\_\_\_\_

Claim Number: \_\_\_\_\_

First Day of Treatment: \_\_\_\_\_

Diagnosis Codes: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Findings: \_\_\_\_\_

\_\_\_\_\_

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Physician Signature

Date

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Tax ID

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## **Patient Authorization for Referral Board and Patient Information Board**

The purpose of a referral board in our waiting room is to express our thanks to those that have referred a patient to our office and to also encourage people to make referrals.

The purpose of a patient information board is to keep you informed on current health issues and to inform you of any of our patient involvement in the surrounding towns.

This authorizes your first and last name to be used on these boards in our office.

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Name (printed)

Signature

Date