INTRODUCTION PATIENT CASE HISTORY

Today's Date: _____

PATIENT INFORMATION

Name: *(First MI Last)* _____ **Preferred Name**: _____

Address: _____ **City:** _____ **State:** _____ **Zip:** _____

Home: _____ **Mobile:** _____ **Mobile Carrier:** _____ **Work:** _____

Email: _____ **Gender:** M / F **Marital Status:** Single / Married / Other

Social Security #:_____ **Date of Birth:** _____

Student Status: Full Student / Part Student / Non-Student **Employed:** Y / N

Ethnicity: Hispanic or Latino / Not Hispanic or Latino / Decline **Preferred Language:** English / Decline / Other: _____

Race: Asian / African American / American Indian or Alaskan Native / Other / Native Hawaii or Pacific Islander / White / Decline

***Referred By:** (*Name):* _____ Family / Friend / Co-Worker / Doctor / Other Source

EMERGENCY CONTACT INFORMATION

Name: *(First MI Last)* _____ **Primary Care Physician: _____**

Home: _____ **Mobile:** _____ **Doctor's Phone: _____**

Relationship: Child / Parent / Spouse / Other: _____

FINANCIAL INFORMATION

☐ Insurance ☐ Worker's Comp ☐ Self-Pay *(Cash)* ☐ Personal Injury/Auto ☐ Other *(please explain)*:_____

PRIMARY INSURANCE

Insurance Name: ______

Relation to Insured: Self / Spouse / Parent / Child / Other

Other than Self:

Insured's Name: _____ **Gender:** M / F

Address: _____

City: _____ **State:** _____ **Zip:** _____

Phone: _____ **Date of Birth:** _____

SECONDARY INSURANCE

Insurance Name: _____

Relation to Insured: Self / Spouse / Parent / Child / Other

Other than Self:

Insured's Name: _____ **Gender:** M / F

Address: _____

City: _____ **State:** _____ **Zip:** _____

Phone: _____ **Date of Birth:** _____

RESPONSIBLE PARTY

Who is responsible for payment? Self / Other - *(Relationship)* _____

Other than Self:

Name: *(First MI Last)*_____

Address: _____ **City:** _____ **State:** _____ **Zip:** _____

Phone: _____ **Email:** _____

It is Usual and Customary to Pay for Services as Rendered Unless Otherwise Arranged

Patient No: _____

Name:_____ Date:_____

PATIENT CASE HISTORY

HISTORY OF CURRENT CONDITION

Describe PRIMARY Complaint:_____

Describe WHEN and HOW this began:_____

_____

Grade Intensity/Severity of Complaint: None (0) / Mild (1-2) / Mild-Mod (2-4) / Moderate (4-6) / Mod-Severe (6-8) / Severe (8-10)

Quality of the complaint/pain: Sharp / Stabbing / Burning / Achy / Dull / Stiff & Sore / Other: _____

How frequent is the complaint present? Occasional (0-25%) / Intermittent (26-50%) / Frequent (51-75%) / Constant (76-100%)

When is it worse? Morning / Afternoon / Evening / Night / All Times

Does this complaint radiate/shoot to any areas of your body? No/Yes (*Describe*)_____

Head – Base of Skull / Forehead / Sides-Temples R / L / Both *Leg* – Hip / Thigh-Knee / Calf / Foot-Toes R / L/ Both

Arm – Across Shoulder / Elbow / Hands-Fingers R / L / Both *Other Area*: _____

Does anything make the complaint better? Ice / Heat / Rest / Movement / Stretching / OTC / Other: _____

Does anything make the complaint worse? Sit / Stand / Walk / Lying / Sleep / Overuse / Other: _____

Which daily activities are being affected by this condition? *(Describe)* _____

For this CURRENT condition, have you:

- **Received any other treatment?** None / DC / MD / PT / Massage / ER / Other: _____ Where?_____
- **Had any diagnostic testing?** X-rays / MRI / CT / Other: _____ When and Where? _____

Describe SECOND Complaint:_____

Describe WHEN and HOW this began:_____

_____

Grade Intensity/Severity of Complaint: None (0) / Mild (1-2) / Mild-Mod (2-4) / Moderate (4-6) / Mod-Severe (6-8) / Severe (8-10)

Quality of the complaint/pain: Sharp / Stabbing / Burning / Achy / Dull / Stiff & Sore / Other:_____

How frequent is the complaint present? Occasional (0-25%) / Intermittent (26-50%) / Frequent (51-75%) / Constant (76-100%)

When is it worse? Morning / Afternoon / Evening / Night / All Times

Does this complaint radiate/shoot to any areas of your body? No/Yes (*Describe*)_____

Head – Base of Skull / Forehead / Sides-Temples R / L / Both *Leg* – Hip / Thigh-Knee / Calf / Foot-Toes R / L/ Both

Arm – Across Shoulder / Elbow / Hands-Fingers R / L / Both *Other Area*: _____

Does anything make the complaint better? Ice / Heat / Rest / Movement / Stretching / OTC / Other: _____

Does anything make the complaint worse? Sit / Stand / Walk / Lying / Sleep / Overuse / Other: _____

Describe OTHER Complaints:_____

_____

_____

Patient No: _____

Name:_____ Date:_____

PATIENT CASE HISTORY

Health History – (*PLEASE USE THE REVERSE SIDE OF THIS PAGE IF ADDITIONAL SPACE IS NEEDED)*

Medications and Supplements:

Allergies to Medications: *NONE*

Name	Reaction

Current Medications and Supplements: *NONE*

Name	Dosage	Frequency	Method

Past Health History: (*Please list any past…*)

Number of Falls in the last 24 months: _____
Injuries? Y or N
Surgeries: ***NONE***

Date	Area of the Body	Reason

Major Injuries / Traumas / Hospitalizations: ***NONE***

Date	Describe

Family Health Histoy: *N/A*

List *relevant* major health problems of First degree relatives:

Problem	Parent (M of F)	Sibling (B or S)	Child (S or D)

Social and Occupational History:

Smoking/Tobacco Use: Every Day / Some Days / Former / Never

Habit	Type	Amount	Year Started
Smoking			
Tobacco			
Alcohol			
Caffine			
Rec. Drugs			

Education: High School / College Grad. / Post Grad. / Other:

Lifestyle	Describe
Hobbies	
Recreation	
Exercise	
Diet	
Work	
Other	

Patient No: _____

Are you *currently* experiencing any of these symptoms? *(Check all the apply)*
Many of the following conditions respond to Chiropractic and Acupuncture treatment.

General: *(constitutional)*
- ☐ Recent Weight Change
- ☐ Fever
- ☐ Fatigue
- ☐ *None in this Category*

Musculoskeletal:
- ☐ Low Back Pain
- ☐ Mid Back Pain
- ☐ Neck Pain
- ☐ Arm Problems _____
- ☐ Leg Problems _____
- ☐ Painful Joints
- ☐ Stiff/Swollen Joints
- ☐ Sore/Weak Muscles or Joints
- ☐ Muscle Spasms/Cramps
- ☐ Broken Bones_____
- ☐ Other: _____
- ☐ *None in this Category*

Neurological:
- ☐ Numbness or tingling sensations
- ☐ Loss of Feeling
- ☐ Dizziness or light headed
- ☐ Frequent or Recurrent Headaches
- ☐ Convulsions or seizures
- ☐ Tremors
- ☐ Stroke
- ☐ Other: _____
- ☐ *None in this Category*

Mind/Stress:
- ☐ Nervousness
- ☐ Depression
- ☐ Sleep Problems
- ☐ Memory Loss or Confusion
- ☐ Other: _____
- ☐ *None in this Category*

Genitourinary:
- ☐ Sexual Difficulty
- ☐ Kidney Stones
- ☐ Burning/Painful Urination
- ☐ Change in force/strain w Urination
- ☐ Frequent Urination
- ☐ Blood in Urine
- ☐ Incontinence or Bed Wetting
- ☐ Other: _____
- ☐ *None in this Category*

Gastrointestinal:
- ☐ Loss of Appetite
- ☐ Blood in Stool
- ☐ Change in Bowel Movements
- ☐ Painful Bowel Movements
- ☐ Nausea or Vomiting
- ☐ Abdominal Pain
- ☐ Frequent Diarrhea
- ☐ Constipation
- ☐ Other: _____
- ☐ *None in this Category*

Cardiovascular & Heart:
- ☐ Chest Pains
- ☐ Rapid or Heartbeat changes
- ☐ Blood Pressure Problems
- ☐ Swelling of Hands, Ankles, or Feet
- ☐ Heart Problems
- ☐ Other: _____
- ☐ *None in this Category*

Respiratory:
- ☐ Difficulty Breathing
- ☐ Persistent Cough
- ☐ Coughing Blood
- ☐ Asthma or Wheezing
- ☐ Lung Problems
- ☐ Other: _____
- ☐ *None in this Category*

Eyes and Vision:
- ☐ Wear contacts/glasses
- ☐ Blurred or double vision
- ☐ Glaucoma
- ☐ Eye disease or injury
- ☐ Other: _____
- ☐ *None in this Category*

Ears, Nose and Throat:
- ☐ Bleeding gums / mouth sores
- ☐ Bad Breath or bad taste
- ☐ Dental Problems
- ☐ Swollen throat or voice change
- ☐ Swollen glands in neck
- ☐ Ringing in the ears
- ☐ Ear - Ache/Ringing/Drainage
- ☐ Sinus / Allergy problems
- ☐ Nose Bleeds
- ☐ Hearing Loss
- ☐ Other: _____
- ☐ *None in this Category*

Endocrine, Hematologic, and Lymphatic:
- ☐ Thyroid problems
- ☐ Diabetes
- ☐ Excessive Thirst or urination
- ☐ Cold Extremities
- ☐ Heat or Cold intolerance
- ☐ Change in hat or glove size
- ☐ Dry skin
- ☐ Glandular or hormone problem
- ☐ Swollen Glands
- ☐ Anemia
- ☐ Easily Bruise or Bleed
- ☐ Phlebitis
- ☐ Transfusion
- ☐ Immune system disorder
- ☐ Other: _____
- ☐ *None in this Category*

Skin and Breasts:
- ☐ Rash or Itching
- ☐ Change in Skin Color
- ☐ Change in hair or nails
- ☐ Non-healing sores
- ☐ Change of appearance of a mole
- ☐ Breast Pain
- ☐ Breast Lump
- ☐ Breast Discharge
- ☐ Other: _____
- ☐ *None in this Category*

Women Only:

Are you pregnant?
- ☐ **Yes -** ***Due Date*** __/__/____
- ☐ **No -** ***Last Menstrual Period*** __/__/____
- ☐ Infertility
- ☐ Painful or Irregular periods
- ☐ Vaginal Discharge
- ☐ Other: _____
- ☐ *None in this Category*

Pregnancies:

Date	Outcome

Comments: _____

_____

I have read the above information and certify it to be true and correct to the best of my knowledge, and hereby authorize this office to provide me with chiropractic care, diagnostic testing, and/or therapeutic services, in accordance with this state's statutes.

Patient or Guardian Signature _____ Date_____

Treating Doctor Signature _____ Date_____

Patient No: _____

CHOICE OF HEALTH P.A.
DR. RICHARD SNOW
9163 W 133RD STREET OVERLAND PARK, KANSAS 66213

Notices of Privacy Practices
HIPAA

I understand that, under the Health Insurance Portability & Accountability Act of 1996 (HIPAA) and updated laws on 9/23/2013, I have certain rights to privacy regarding my protected health information. I understand that this information can and will be used to: *Conduct, plan and direct my treatment and follow-up among the multiple healthcare providers who may be involved in that treatment directly and indirectly. *Obtain payment from third-party payers. *Conduct normal healthcare operations such as quality assessments and physician certifications. I have been informed by you and your Notice of Privacy Practices containing a more complete description of the uses and disclosures of my health information. I have been given the right to review such Notice of Privacy Practices prior to signing this consent I understand that this organization has the right to change its Notice of Privacy Practices from time to time and that I may contact this organization at any time to obtain a current copy of the Notice of Privacy Practices. I understand that I may request in writing that you restrict how my private information is used or disclosed to carry out treatment, payment or health care operations. I also understand you are not required to agree to my requested restriction, but if you do agree then you are bound to abide by such restrictions. I further authorize disclosure of all or any part of my patients record to any person or corporation which is or may be liable under a contract to the clinic or to the patient or to a family member or employer of the patient for all or part of the clinics charge including, and not limited to, hospital or medical services companies, insurance companies, workers compensation carriers, welfare funds or the patient's employer. I understand that I may revoke this consent in writing at any time, except to the extent that you have taken action relying on this account.

Consent of Professional Services and Release of Information

I hereby authorize and release the doctor and whomever he may designate as his assistants to administer treatment, physical examination, orthopedic and neurological evaluation, visual inspection, palpation, X-ray studies, laboratory procedures, chiropractic care, or any clinic services that he deems necessary in my case. The undersigned also consents to observation of therapeutic or diagnostic procedures by staff personnel or medical personnel in training as permitted by the attending practitioner and allowed by clinic policy. Treatment procedures that may be used in your treatment include, but are not limited to, manipulative therapy, activator, joint mobilization, myofascial release, trigger-point therapy, electrical therapy, intersegmental traction, muscle stretching, and any directional handouts. Cases will be managed with all due concern and with the evaluation of response to previous care provided. Home care instructions will be given as appropriate to enhance your treatment program. Compliance with the recommendations for home care and follow-up care is necessary for the resolution of your complaint. Because of modern techniques and equipment, examination and therapeutic procedures involve a very low risk of complication. Even though serious problems rarely occur with these procedures, risks must be recognized and considered. Any procedure that is intended to help may also do harm. While examination and therapeutic procedures used in this clinic are considered remarkably safe and effective, understand that occasionally there may be adverse reactions that occur. Although the chances of experiencing any of these complications are extremely small, it is the practice of this office to fully inform and educate our patients. These complications include but are not limited to pain, swelling, bruising, discoloration, inflammation, disc injury, sensory changes, bleeding, fracture, fainting, irregular heartbeat, heart attack, spinal cord damage, nausea, burns, soft tissue injury, stroke, dizziness or weakness. A patient, in coming to Choice of Health, P.A., gives Dr. Richard Snow *(the doctor)* permission and authority to care for the patient in accordance with the chiropractic tests, diagnosis, and analysis. The chiropractic adjustment or other clinical procedures are usually beneficial and seldom cause any problems. In rare cases, underlying physical defects, deformities or pathologies may render the patient susceptible to injury. The doctor, of course, will not give any treatment or care if he/she is aware that such care may be contra-indicated. Again, it is the responsibility of the patient to make it known, or to learn through healthcare procedures what he/she is suffering from: latent pathological defects, illnesses or deformities which would otherwise not come to the attention of Dr. Richard Snow. The doctor provides a specialized, non-duplicating health care service. Dr. Richard Snow is licensed in a special practice and is available to work with other types of providers in your health care regimen. I understand that if I am accepted as a patient by a physician at Choice of Health, P.A., I am authorizing them to proceed with any treatment that they deem necessary. Furthermore, any risk involved, regarding chiropractic treatment, will be explained to me upon my request. No guarantee or warranty for a specific cure or result is implied by the acceptance of your case. All patients respond differently to the treatment procedures. Each case must be evaluated separately. If you do not fully understand the above or have questions about anything mentioned in this document, please do not sign it until these matters have been resolved with further discussion. I have read the above explanation of treatment and diagnostic procedures used in this clinic and have myself decided that it is in my best interest to submit to these procedures.

I declare that, to the best of my knowledge, (I am not pregnant, my child is not pregnant), nor are there any known complicating limitations which would forbid taking x-rays. I understand that in the event x-rays are taken, that they will be referred to RADIOLOGY DIAGNOSTICS for a second opinion for further interpretation and give consent for their release. I understand that there will be a fee for this service of $70.00.

Appointment Reminders and Health Care Information Authorization

At times our office may need to contact you with appointment reminders, information about treatment or other health related information. By signing below, you are giving us authorization to contact you with these reminders/information and understand that I may be contacted by: phone at home or work, mobile phone, e-mail, text, or postcard. Messages may be left: on answering machine/voicemail at home, work, a mobile phone and/or with individuals answering my phone at home, or work.

Clinical Summary Report (CCR) regarding EHR

I understand that a clinical summary report is created after each visit for the purpose of EHR and is available for my review. At this time, I am asking Choice of Health, P.A. to save these electronically for me and not print them out after each visit. I understand that, upon request, these reports are available to be printed or emailed to me for review.

Assignment of Benefits

I understand and agree that health and accident insurance policies are an agreement between an insurance carrier and myself. Furthermore, I understand that Choice of Health P.A. will prepare any necessary reports and forms to assist me in making collections from the insurance company and that any amount authorized to be paid directly to Choice of Health P.A. will be credited to my account upon receipt. However, I clearly understand and agree that all services rendered to 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 to me will be immediately due and payable.

Print Patient Name: _____ **Authorized Signature**: _____

Relationship to patient (if not self) _____ Date: _____

ACCIDENT/INJURY QUESTIONNAIRE

Name: (Last, First MI)_____ **Today's Date:** _____

AUTOMOBILE ACCIDENT – ADDITIONAL INFORMATION

- **Was anyone else in the vehicle with you? · No · Yes -** *(Number of people)* _____
- **You were? · Front seat –** *Driver / Passenger* **· Rear Seat**– Behind Driver / Middle / Behind Passenger / 2nd Row / 3rd Row
- **Name of Driver**, *if not self*: _____ **Name of Driver of other vehicle:** _____
- **Did airbags deploy? · No · Yes Did Police arrive? · No · Yes Using Seatbelt? · No · Yes**
- **Did you strike the windshield or object in car? · No · Yes -** *(Describe)* _____
- **What direction were you looking? · Right · Left · Straight**
- **Were you knocked unconscious? · No · Yes** *(How long?)* _____
- **Where was your vehicle impacted?** Front / Rear / Passenger Side / Driver's Side / Other: _____
- **Was your vehicle totaled? · No · Yes**
- **Where was the other vehicle impacted?** Front / Rear / Passenger Side / Driver's Side / Other: _____
- **Your vehicle Year**:_____ **Make**:_____ **Model**:_____ **Speed During Collision**:_____
- **Your Auto Ins:** _____ **Policy #:** _____ **Claim #:** _____ **Phone #:**_____
  - **Address:** _____**City:** _____ **State:** _____ **Zip:** _____
- **Other's vehicle Year**:_____ **Make**:_____ **Model**:_____ **Speed During Collision**:_____
- **Other's Auto Ins:** _____ **Policy #:** _____ **Claim #:** _____ **Phone #:**_____
  - **Address:** _____ **City:** _____ **State:** _____ **Zip:** _____

WORKER'S COMPENSATION INJURY – ADDITIONAL INFORMATION

Employer: _____ **Occupation:** _____ **Claim #:** _____
Address: _____ **City:** _____ **State:** _____ **Zip:** _____
Contact Person: _____ **Phone:** _____ **Email:** _____

GENERAL ACCIDENT/INJURY INFORMATION – (*PLEASE USE THE REVERSE SIDE OF THIS PAGE IF ADDITIONAL SPACE IS NEEDED*)

Date of Accident: ____/____/_____ **Time**: ___:_____ AM / PM **State Accident Occurred In**:_____
Please describe the accident in as much detail as possible? _____
_____
_____
_____

Before the accident/injury:

- **Have you ever had any complaints in the involved area before? · No · Yes**
  - *If yes* - **Were they present at the time of the accident/injury? · No · Yes**
    - *If yes* - **Summarize these complaints prior to the accident:** _____
- **Were you capable of performing all of your work activities without restriction? · No · Yes**

At the time of the accident/injury:

- **Did you feel pain immediately after the accident? · No · Yes · Later that day · Next day · When?** _____
- **Were you taken anywhere after the accident? · No · Yes · Later that day · Next day · When?** _____
  - *If yes,* **How?**_____ **Where?**_____
  - *If yes,* **Did you receive treatment? · No · Yes -** *(Describe)*_____

Since the accident/injury:

- **Are your symptoms: · Improving? · Getting Worse? · The Same?**
- **Are your work activities restricted as a result of this accident/injury? · No · Yes -** *(How?)* _____
- **Have you missed any work since this accident? · No · Yes -** *(Dates?)* _____
- **Have you retained an Attorney? · No · Yes - Name:**_____ **Phone:** _____
  - **Address:** _____ **City:** _____ **State:** _____ **Zip:** _____

Patient No: _____

Name:

Duties Under Duress Index

Have you continued to do any of the following activities despite the pain caused by your collision?

Work:

1. Why have you continued to work?

- ☐ I would lose my job if I took time off.
- ☐ I couldn't support my family otherwise.
- ☐ I don't believe in taking time off, even when I am injured or in pain.
- ☐ My business would fail if I didn't work.
- ☐ I cannot take time off, because I care for my own children.
- ☐ Other: _____.

2. I have experienced the following changes in my ability to perform work:
   - ☐ Mobility/Stability Problems:
     - ☐ Climbing
     - ☐ Kneeling
     - ☐ Lifting
     - ☐ Walking for long periods
   - ☐ Dexterity Problems:
     - ☐ Finger Movements
     - ☐ Wrist Movements
   - ☐ Problems with Fatigue:
     - ☐ Yes
     - ☐ No
   - ☐ Postural Difficulties:
     - ☐ Bending
     - ☐ Sitting for long periods
     - ☐ Standing for long periods
     - ☐ Stooping
   - ☐ Problems with Anxiety/Depression:
     - ☐ Yes
     - ☐ No
   - ☐ Problems with Vertigo or Spinning Sensations:
     - ☐ Dizziness
     - ☐ Giddiness
     - ☐ Sensation of Irregular Motion

- ☐ Sensation of Whirling Motion
- ☐ Problems with Tinnitus or Ringing in the Ears:
  - ☐ Yes
  - ☐ No
- ☐ Problems with Reduced Concentration:
  - ☐ Can't Concentrate
  - ☐ Can't Think Properly
  - ☐ Making Mistakes you otherwise wouldn't
- ☐ Pain:
  - ☐ Yes
    - Where: _____
  - ☐ No
- ☐ Duration of Symptoms:
  - ☐ I experienced problems doing normal work activities for ____ weeks.
  - ☐ Other doctors have instructed me that my inability to perform my normal pre-accident work activities without pain is a permanent condition.
  - ☐ My problems in performing my normal work activities is ongoing.

Domestic Duties:

1. I have experienced pain while performing the following activities *inside* my home, but have done them anyway:
   - ☐ Laundry
   - ☐ Dishwashing
   - ☐ Vacuuming
   - ☐ Washing Windows
   - ☐ Cleaning
   - ☐ Preparing Meals
   - ☐ Personal hygiene

2. Due to my injuries, I have brought in the following assistance:
   - ☐ Paid Housekeeper
   - ☐ Unpaid Assistance
   - ☐ None

3. My family status would be best described as:
   - ☐ Single
   - ☐ Single Parent at Home
   - ☐ Spouse Only
   - ☐ Spouse and Children at Home

4. I have the following numbers of children:
    - ☐ 0
    - ☐ 1
    - ☐ 2
    - ☐ 3
    - ☐ 4
    - ☐ 5
    - ☐ Other: ___

5. The number of my children in the following age category is:
    - ☐ 0-5 years
    - ☐ 5-11 years
    - ☐ 11+

6. Domestic Assistance:
    - ☐ I do receive domestic assistance
    - ☐ I do not receive domestic assistance

7. I have not been able to engage in sexual activity without pain/discomfort.
    - ☐ Yes
    - ☐ No

8. Duration of Symptoms:
    - ☐ I experienced problems doing my normal domestic activities for ___ weeks.
    - ☐ Other doctors have instructed me that my inability to perform my normal pre-accident domestic activities without pain is a permanent condition.
    - ☐ My problem is performing my normal domestic activities is ongoing.

Household:

1. I have experienced problems with the following activities outside my home:
    - ☐ Painting the Outside of the House
    - ☐ Landscaping
    - ☐ Mowing the Grass
    - ☐ Trimming the Bushes/Trees
    - ☐ Washing Windows
    - ☐ Gardening
    - ☐ Taking Out the Trash
    - ☐ Washing the Cars

- ☐ Maintaining the Cars
- ☐ Maintaining Yard Equipment
- ☐ Doing Other External House Work; Specify: _____.

2. Duration of symptoms
   - ☐ I experienced problems being doing my normal household activities for ____ weeks.
   - ☐ Other doctors have instructed me that my inability to perform normal pre-accident household activities without pain is a permanent condition.
   - ☐ My problem in performing normal household activities is ongoing.

Studies/Educational Duties:

1. As a student, I have experienced problems with one of the following activities since the collision:
   - ☐ Carrying Books
   - ☐ Sitting in Classes
   - ☐ Looking Down to Read Textbooks
   - ☐ Other: _____

2. I have also experienced the following changes in my ability to perform at school as a result of injuries sustained from this collision:
   - ☐ Mobility/Stability Problems:
     - ☐ Climbing
     - ☐ Kneeling
     - ☐ Lifting
     - ☐ Walking for long periods
   - ☐ Dexterity Problems:
     - ☐ Finger Movements
     - ☐ Wrist Movement
   - ☐ Problems with Fatigue
   - ☐ Postural Difficulties:
     - ☐ Bending
     - ☐ Sitting for Long Periods
     - ☐ Standing for Long Periods
     - ☐ Stooping
   - ☐ Problems with Anxiety/Depression
   - ☐ Problems with Vertigo or Spinning Sensations:
     - ☐ Dizziness
     - ☐ Giddiness

- ☐ Sensation of Irregular Motion
- ☐ Sensation of Whirling Motion

☐ Problems with Tinnitus or Ringing in the Ears

☐ Problems with Reduced Concentration:

- ☐ Can't Concentrate
- ☐ Can't Think Properly
- ☐ Making Mistakes

☐ Pain:

- ☐ If so, where:_____.

3. At the time of the collision, my education would best be described as:
   - ☐ High School
   - ☐ Apprenticeship Studies
   - ☐ Technical College
   - ☐ University
   - ☐ Correspondence Course

4. My attendance before the collision is best described as:
   - ☐ Full Time
   - ☐ Part Time

Print Name: _____

Signature: _____ Date: _____

Patient No:_____

Name:

Loss of Enjoyment of Life Index

This form is to determine whether you have lost the enjoyment of certain activities in you life, or lost status or skills in these activities as a result of your injuries from the collision.

Work activities:

- ☐ I have lost enjoyment in performing my job as a result of the injuries caused in this collision.
- ☐ My employment status at the time of the collision is best described as:
    - ☐ Full Time Employee
    - ☐ Part Time Employee
    - ☐ Casual Employee
    - ☐ Seasonal Employee
    - ☐ Not Employed

If your answer is Full Time, Part Time, or Casual Employee, which of the following categories best describes your work capacity since the collision:

- ☐ I Resumed My Same Job and Duties
- ☐ I Resumed My Same Job with Lighter Duties
- ☐ I Resumed Alternate Duties Within the Same Industry
- ☐ I Changed Industry
- ☐ I Have Not Resumed Work

The injuries from this collision have had the following effects on my work:

- ☐ I have lost status within the company
- ☐ I have lost job security
- ☐ I have lost promotional prospects
- ☐ I have difficulty in performing my normal job duties
- ☐ My quality of work is reduced since the collision
- ☐ I am unable to perform my pre-accident job

Domestic Activities:

- ☐ I have lost enjoyment in performing domestic activities as a result of the injuries caused in this collision.
- ☐ I have experienced a loss of enjoyment with the following activities *inside* my home, since the collision:
    - ☐ Laundry
    - ☐ Dishwashing

- ☐ Vacuuming
- ☐ Washing Windows
- ☐ Cleaning
- ☐ Preparing Meals
- ☐ Others:_____

Household Activities:

- ☐ I have lost enjoyment in performing my household activities, outside the home, as a result of the injuries caused in this collision.
- ☐ I have experienced problems with the following activities, *outside* the home:
  - ☐ Painting the outside of house
  - ☐ Landscaping
  - ☐ Mowing the grass
  - ☐ Trimming the bushes/Trees
  - ☐ Washing windows
  - ☐ Gardening
  - ☐ Taking out the trash
  - ☐ Washing the car(s)
  - ☐ Maintaining the car(s)
  - ☐ Maintaining yard equipment
  - ☐ Doing other external house work; specify:_____

Studies/Educational Activities:

- ☐ I have lost enjoyment in performing my educational activities as a result of the injuries caused in this collision.
  - ☐ I am no longer able to attend school
  - ☐ I have dropped to part time
  - ☐ My grades have dropped
  - ☐ I have been forced to change schools due to injuries:
    - Before the collision, I am attending:
      - ☐ High School
      - ☐ Apprenticeship Studies
      - ☐ Technical College
      - ☐ University; specify_____
      - ☐ Correspondence Course
      - ☐ Graduate College/University
    - I am now attending:
      - ☐ High School
      - ☐ Apprenticeship Studies
      - ☐ Technical College

- ☐ A Different University; Specify_____
- ☐ Correspondence Course

Hobby Activities:

- ☐ I have lost enjoyment in performing hobby activities as a result of the injuries caused in this collision.

- ☐ Activity #1: _____
  - ☐ Prior to the collision, I performed this activity at the following level:
    - ☐ Informal and amateur
    - ☐ Competitive
    - ☐ Semi-Professional
    - ☐ Professional
  - ☐ Prior to the collision:
    - ☐ I did not make money with this hobby
    - ☐ I made money with this hobby
      - I made $____/month on average with this hobby, as reported to the IRS.
  - ☐ After this collision, I performed this hobby/activity at the following level:
    - ☐ I can't perform the activity at all
    - ☐ Informal and amateur
    - ☐ Competitive
    - ☐ Semi-Professional
    - ☐ Professional
  - ☐ After this collision:
    - ☐ I do not make money with this hobby
    - ☐ I make money with this hobby
    - ☐ I made $____/month on average with this hobby, as reported to the IRS.
  - ☐ Duration of Symptoms:
    - ☐ I did not enjoy this activity for ____ weeks
    - ☐ My doctors have instructed me that my inability to enjoy this activity without pain is a permanent condition.
    - ☐ My problems in enjoying this activity is ongoing, but my doctors have not instructed me that the conditions is permanent.

- ☐ Activity #2: _____
  - ☐ Prior to the collision, I performed this activity at the following level:
    - ☐ Informal and amateur
    - ☐ Competitive
    - ☐ Semi-Professional

- ☐ Professional
- ☐ Prior to the collision:
  - ☐ I did not make money with this hobby
  - ☐ I made money with this hobby
  - ☐ I made $____/month on average with this hobby, as reported to the IRS.
- ☐ After this collision, I performed this hobby/activity at the following level:
  - ☐ I can't perform the activity at all
  - ☐ Informal and amateur
  - ☐ Competitive
  - ☐ Semi-Professional
  - ☐ Professional
- ☐ After this collision:
  - ☐ I do not make money with this hobby
  - ☐ I make money with this hobby
    - I made $____/month on average with this hobby, as reported to the IRS.
- ☐ Duration of Symptoms:
  - ☐ I did not enjoy this activity for ____ weeks
  - ☐ My doctors have instructed me that my inability to enjoy this activity without pain is a permanent condition.
  - ☐ My problems in enjoying this activity is ongoing, but my doctors have not instructed me that the conditions is permanent.

☐ Activity #3: _____

- ☐ Prior to the collision, I performed this activity at the following level:
  - ☐ Informal and amateur
  - ☐ Competitive
  - ☐ Semi-Professional
  - ☐ Professional
- ☐ Prior to the collision:
  - ☐ I did not make money with this hobby
  - ☐ I made money with this hobby
  - ☐ I made $____/month on average with this hobby, as reported to the IRS.
- ☐ After this collision, I performed this hobby/activity at the following level:
  - ☐ I can't perform the activity at all
  - ☐ Informal and amateur
  - ☐ Competitive
  - ☐ Semi-Professional
  - ☐ Professional

- ☐ After this collision:
  - ☐ I do not make money with this hobby
  - ☐ I make money with this hobby
  - ☐ I made $____/month on average with this hobby, as reported to the IRS.
- ☐ Duration of Symptoms:
  - ☐ I did not enjoy this activity for ____ weeks
  - ☐ My doctors have instructed me that my inability to enjoy this activity without pain is a permanent condition.
  - ☐ My problems in enjoying this activity is ongoing, but my doctors have not instructed me that the conditions is permanent

☐ Activity #4 _____

- ☐ Prior to the collision, I performed this activity at the following level:
  - ☐ Informal and amateur
  - ☐ Competitive
  - ☐ Semi-Professional
  - ☐ Professional
- ☐ Prior to the collision:
  - ☐ I did not make money with this hobby
  - ☐ I made money with this hobby
  - ☐ I made $____/month on average with this hobby, as reported to the IRS.
- ☐ After this collision, I performed this hobby/activity at the following level:
  - ☐ I can't perform the activity at all
  - ☐ Informal and amateur
  - ☐ Competitive
  - ☐ Semi-Professional
  - ☐ Professional
  - ☐
- ☐ After this collision:
  - ☐ I do not make money with this hobby
  - ☐ I make money with this hobby
  - ☐ I made $____/month on average with this hobby, as reported to the IRS.
- ☐ Duration of Symptoms:
  - ☐ I did not enjoy this activity for ____ weeks
  - ☐ My doctors have instructed me that my inability to enjoy this activity without pain is a permanent condition.
  - ☐ My problems in enjoying this activity is ongoing, but my doctors have not instructed me that the conditions is permanent.

Sports Activities:

- ☐ I have lost enjoyment in performing sports activities as a result of the injuries caused in this collision.

- ☐ Sports Activity #1_____
  - ☐ Prior to the Collision, I performed this sports at the following level:
    - ☐ Informal/Social/Amateur
    - ☐ Competitive
    - ☐ Regionally Recognized
    - ☐ Semi-Professional
    - ☐ Professional
  - ☐ Prior to the Collision:
    - ☐ I did not make money with this sports activity
    - ☐ I made money with this sports activity
      - I made $_____/ month on average with this sports activity, as reported to the IRS.
  - ☐ After this Collision, I performed this activity at the following level:
    - ☐ Informal/Social/Amateur
    - ☐ Competitive
    - ☐ Regionally Recognized
    - ☐ Cannot Play the Original Sport
    - ☐ Cannot Play Any Sports
  - ☐ After the Collision:
    - ☐ I do not make money with this sports activity
    - ☐ I make money with this sports activity
      - I make $_____/ month on average with this sports activity, as reported to the IRS.
  - ☐ Duration of Symptoms
    - ☐ I did not enjoy this activity for _____ weeks.
    - ☐ Other Doctors have instructed me that my inability to enjoy this activity without pain is a permanent condition.
    - ☐ My problems in enjoying this activity is ongoing, but other Doctors have not instructed me that the condition is permanent.

- ☐ Sports Activity #2_____
  - ☐ Prior to the Collision, I performed this sport at the following level:
    - ☐ Informal/Social/Amateur

- ☐ Competitive
- ☐ Regionally Recognized
- ☐ Semi-Professional
- ☐ Professional

☐ Prior to the Collision:
- ☐ I did not make money with this sports activity
- ☐ I made money with this sports activity
  - I made $_____/ month on average with this sports activity, as reported to the IRS.

☐ After this Collision, I performed this activity at the following level:
- ☐ Informal/Social/Amateur
- ☐ Competitive
- ☐ Regionally Recognized
- ☐ Cannot Play the Original Sport
- ☐ Cannot Play Any Sports

☐ After the Collision:
- ☐ I do not make money with this sports activity
- ☐ I make money with this sports activity
  - I make $_____/ month on average with this sports activity, as reported to the IRS.

☐ Duration of Symptoms
- ☐ I did not enjoy this activity for _____ weeks.
- ☐ Other Doctors have instructed me that my inability to enjoy this activity without pain is a permanent condition.
- ☐ My problems in enjoying this activity is ongoing, but other Doctors have not instructed me that the condition is permanent.

Vacationing/ Travel Activities

☐ I have lost enjoyment in traveling activities as a result of the injuries caused in this collision.

☐ Traveling Activity #1_____

☐ Prior to the Collision, I performed this activity at the following level:
- ☐ Pleasure Travel
- ☐ Business Travel
- ☐ Yearly

- ☐ Seasonal
- ☐ After this Collision, I altered this travel in the following way:
  - ☐ I cancelled the travel plans
  - ☐ I didn't make the normal travel plans
  - ☐ I altered the travel plans due to the injury
  - ☐ I went, but with an increased level of pain
  - ☐ I went, but was impaired in my activities
  - ☐ I went and had minimal trouble
  - ☐ I went and had no trouble

☐ Traveling Activity #2_____

- ☐ Prior to the Collision, I performed this activity at the following level:
  - ☐ Pleasure Travel
  - ☐ Business Travel
  - ☐ Yearly
  - ☐ Seasonal
- ☐ After this Collision, I altered this travel in the following way:
  - ☐ I cancelled the travel plans
  - ☐ I didn't make the normal travel plans
  - ☐ I altered the travel plans due to the injury

☐ Traveling Activity #3_____

- ☐ Prior to the Collision, I performed this activity at the following level:
  - ☐ Pleasure Travel
  - ☐ Business Travel
  - ☐ Yearly
  - ☐ Seasonal
- ☐ After this Collision, I altered this travel in the following way:
  - ☐ I cancelled the travel plans
  - ☐ I didn't make the normal travel plans
  - ☐ I altered the travel plans due to the injury

Print Name:_____

Signature:_____ Date:_____