3960 Ivywood Lane
Pueblo, CO 81005
(719) 565-1276
Fax: (719) 565-2313

## Welcome to Avila Integrative Medicine

- If you will be paying **CASH**, payment is expected at the time services are rendered unless prior arrangements have been made. ***We accept Cash/Check/Credit Card/Debit Card.***

- If we will be billing your **INSURANCE** we will need the following information:

  1. Copy of your Current Insurance Card
  2. Copy of your Current Driver License

**Prior to your appointment with our facility, we will be happy to verify your coverage and discuss any deductible/co-pay information.**

- If your insurance is **MEDICARE** we will need the following information:

  1. Copy of your Current Medicare Card
  2. Copy of your Current Driver License
  3. Copy of your Supplement Insurance

- If you were injured in an **AUTO ACCIDENT** we will need the following information:

  1. Claim number assigned by **the responsible** insurance company.
  2. A copy of the accident report.
  3. A copy of your proof of insurance card.
  4. A copy of your auto policy.
  5. A copy of your Current Driver License.

**Once your claim is processed, the insurance company will send you some paperwork. We can assist you with these forms and we would like a copy of the assignment of benefits form.**

**Thank You!**

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# PATIENT ADMITTANCE FORM

Full Name ______________________________ Date __________
Address ______________________ City __________ State ____ Zip ______
Phone (Home) ____________ (Work) ____________ Cellular: __________
Date of Birth __________ Sex ____ Marital Status ______ Email: __________
Occupation ______________ Children (Ages) ______________
Employer ______________ Employer Address ______________
Social Security # __________ Drivers License # __________ State ______
How did you hear about our office __________ Name of Personal Physician __________
Nearest relative not living with you (Emergency Contact) Name ______________
Relationship __________ Phone __________ Address ______________

## ACCIDENT WORK RELATED INJURY INFORMATION

Can you relate your symptoms to any specific event/activity? □ Yes □ No Date of event/activity: ___/___/___
If yes, please describe: ______________________________
Are your present problems due to an accident-injury? ______________________
Type of accident-injury (circle): Auto On-the-Job Sports Military Household Slip & Fall Personal Other
Name of attorney handling your case __________ Address __________ Phone __________

## INSURANCE INFORMATION

Type of insurance you plan to use (circle): Auto On-the Job Company Group Personal Group Medicare Other
Insurance Co. ______________ Address ______________ Phone __________
Agent __________ Policy # __________ Claim # __________ Group Plan ______
Insured's Name ______________ Insured's Date of Birth ______________
Spouse's Name ______________ Spouse's Employer ______________
Spouse's Occupation ______________ Spouse's Social Security # __________
Spouse's Insurance or other insurance you may use:
Insurance Co. ______________ Address ______________
Policy # __________ Claim # ______________ Group Plan __________

## TREATMENT AUTHORIZATION

I hereby authorize this office, its staff, and doctors to examine and treat my condition as the doctors deem appropriate and I give authority for these procedures to be performed. I clearly understand and agree that all services rendered me are charged directly to me and that I am responsible for payment of services by this office and all outside laboratory or radiology services performed on my behalf. Should collection of past due amount be necessary, I will become responsible for all charges, fees, and attorney fees.

Patient's Signature (X) ______________________________ Date __________

## CONSENT TO TREAT A MINOR

I (we) being the parents, guardian or custodian of the minor being ______________, Age ______, do hereby authorize, request, and direct this office, its doctors and staff to perform examinations, diagnostic X-rays, laboratory tests, and any treatment that in their judgment is deemed advisable or is required while said minor child is under care of this office's doctors and staff until legal age. All charges for services and care given to said minor child will be charged directly to me (us) and I (we) will be personally responsible for payment of them.

Parent, Guardian, or Custodian Signature ______________________________ Date ______

Witness ______________________________ Date ______

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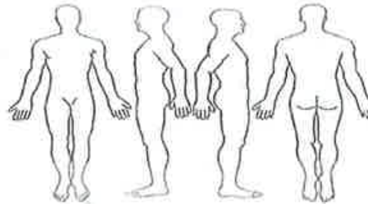
## MAJOR COMPLAINT

What is your major complaint (Exact Description) ____________________
________________________________________
________________________________________
________________________________________

Is it related to a fall or accident? (describe) ____________________
How long have you had this condition? ____________________
Have you had similar conditions in the past? ____________________
The condition is (circle): Worse Same Better Consistent Recurring
How does this condition interfere with your work or daily routine? ____________________
When is your condition worse? (circle): Morning Afternoon Evening Night
What aggravates your condition? ____________________
What relieves your condition? ____________________
Names of other doctors seen for this condition ____________________
Name of Hospital (if applicable) ____________________
Previous diagnosis for this condition ____________________
Type of previous treatment and/or surgery for this condition ____________________
Duration of previous treatment for this condition ____________________
Result of previous treatment (circle): Good Fair Poor Other ____________________

Please indicate on the diagram the areas where you are experiencing symptoms using the suggested marks below to describe your symptoms:

Pain ^^^^
Numbness = = =
Pins & Needles 0 0 0
Burning X X X
Stabbing / / / /



Using the scale, what is your pain TODAY (please circle):
0 1 2 3 4 5 6 7 8 9 10
No pain --------------------Worst Pain Imaginable

Please list your symptoms in order of their severity, most significant or painful symptoms first:

| Symptom(s) | Date |
|---|---|
| 1.______________________ | ___/___/___ |
| 2.______________________ | ___/___/___ |
| 3.______________________ | ___/___/___ |
| 4.______________________ | ___/___/___ |
| 5.______________________ | ___/___/___ |

□ Yes □ No Have you received treatment for these symptoms in the past? If yes, please answer the following, beginning with your most recent treatment:

1. Name and location of provider: ____________________
   Date(s) seen: ____________ How many times? ____________
   Treatment received: □ Physical therapy/exercise □ Massage □ Chiropractic □ Injections □ Surgery
   □ X-Rays, CT scans, MRI: Which body areas? ____________________
   □ Prescriptions or medications? (please list): ____________________

X____________________________ (Patient Signature)

____________________ (Date)

Avila Integrative Medicine

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Patient Name: ______________________________ Date: ______________

## Symptoms

### GENERAL
- ☐ Chills
- ☐ Depression
- ☐ Dizziness
- ☐ Fainting
- ☐ Fever
- ☐ Forgetfulness
- ☐ Headache
- ☐ Loss of sleep
- ☐ Loss of weight
- ☐ Nervousness
- ☐ Numbness
- ☐ Sweats

### MUSCLE/JOINT/BONE
Pain, weakness, numbness in:
- ☐ Arms
- ☐ Hips
- ☐ Back
- ☐ Legs
- ☐ Feet
- ☐ Neck
- ☐ Hands
- ☐ Shoulders

### GENITO-URINARY
- ☐ Blood in urine
- ☐ Frequent urination
- ☐ Lack of bladder control
- ☐ Painful urination

### GASTROINTESTINAL
- ☐ Appetite poor
- ☐ Bloating
- ☐ Bowel changes
- ☐ Constipation
- ☐ Diarrhea
- ☐ Excessive hunger
- ☐ Excessive thirst
- ☐ Gas
- ☐ Hemorrhoids
- ☐ Indigestion
- ☐ Nausea
- ☐ Rectal bleeding
- ☐ Stomach pain
- ☐ Vomiting
- ☐ Vomiting blood

### CARDIOVASCULAR
- ☐ Chest pain
- ☐ High blood pressure
- ☐ Irregular heart beat
- ☐ Low blood pressure
- ☐ Poor circulation
- ☐ Rapid heart beat
- ☐ Swelling of ankles
- ☐ Varicose veins

### EYE, EAR, NOSE, THROAT
- ☐ Bleeding gums
- ☐ Blurred vision
- ☐ Crossed eyes
- ☐ Difficulty swallowing
- ☐ Double vision
- ☐ Earache
- ☐ Ear discharge
- ☐ Hay fever
- ☐ Hoarseness
- ☐ Loss of hearing
- ☐ Nosebleeds
- ☐ Persistent cough
- ☐ Ringing in ears
- ☐ Sinus problems
- ☐ Vision – Flashes
- ☐ Vision - halos

### SKIN
- ☐ Bruises easily
- ☐ Hives
- ☐ Itching
- ☐ Change in moles
- ☐ Rash
- ☐ Scars
- ☐ Sore that won't heal

### MEN ONLY
- ☐ Breast lump
- ☐ Erection difficulties
- ☐ Lump in testicles
- ☐ Penis discharge
- ☐ Sore on penis
- ☐ Other

### WOMEN ONLY
- ☐ Abnormal Pap Smear
- ☐ Bleeding between periods
- ☐ Breast lump
- ☐ Extreme menstrual pain
- ☐ Hot flashes
- ☐ Nipple discharge
- ☐ Painful intercourse
- ☐ Vaginal discharge
- ☐ Other

Date of last menstrual period __________
Date of last Pap Smear __________
Have you had a mammogram? __________
Are you pregnant? __________
Number of children __________

## Previous/Current Health Conditions

- ☐ AIDS
- ☐ Alcoholism
- ☐ Anemia
- ☐ Aneurysm
- ☐ Anorexia
- ☐ Appendicitis
- ☐ Arthritis
- ☐ Asthma
- ☐ Auto-Immune Disease
- ☐ Bleeding Disorders
- ☐ Birth Defects
- ☐ Bronchitis
- ☐ Bulimia
- ☐ Cancer
- ☐ Cervical Whiplash
- ☐ Chemical Dependency
- ☐ Concussion
- ☐ Convulsions
- ☐ Cyst
- ☐ Diabetes
- ☐ Dislocation
- ☐ Ear Infections
- ☐ Electronic Implant
- ☐ Emphysema
- ☐ Epilepsy
- ☐ Fractured Bone
- ☐ Glaucoma/Cataracts
- ☐ Goiter
- ☐ Gout
- ☐ Heart Disease
- ☐ Hepatitis
- ☐ Hernia
- ☐ Herpes
- ☐ High Cholesterol
- ☐ HIV Positive
- ☐ Joint replacement
- ☐ Knocked Unconscious
- ☐ Kidney Disease
- ☐ Liver Disease
- ☐ Measles
- ☐ Metal Screws/Implants
- ☐ Migraine Headaches
- ☐ Miscarriage
- ☐ Mononucleosis
- ☐ Multiple Sclerosis
- ☐ Osteoporosis
- ☐ Pacemaker
- ☐ Pinched Nerve
- ☐ Pneumonia
- ☐ Polio
- ☐ Prostate Problem
- ☐ Psychiatric Care
- ☐ Rheumatic Fever
- ☐ Rheumatoid Arthritis/Osteoarthritis
- ☐ Ruptured Spinal Disc
- ☐ Scarlet Fever
- ☐ Scoliosis
- ☐ Seizures
- ☐ Slipped Spinal Disc
- ☐ Spinal Surgery
- ☐ Spinal Injections
- ☐ Spinal Taps
- ☐ Stroke
- ☐ Thyroid Problems
- ☐ Tonsillitis
- ☐ Tuberculosis
- ☐ Tumor
- ☐ Typhoid Fever
- ☐ Ulcers
- ☐ Other Diseases/Problems with the neck and/or back
- ☐ Other __________

## Medications

______________________________
______________________________
______________________________

## Allergies

______________________________
______________________________
______________________________

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## Health History

| Relation | Age | State of Health | Age at Death | Cause of Death | Check (√) if your blood relatives had any of the following: Disease | | Relationship to you |
|---|---|---|---|---|---|---|---|
| Father | | | | | | Arthritis, Gout | |
| Mother | | | | | | Asthma, Hay Fever | |
| Brothers | | | | | | Cancer | |
| | | | | | | Chemical Dependency | |
| | | | | | | Diabetes | |
| | | | | | | Heart Disease, Strokes | |
| Sisters | | | | | | High Blood Pressure | |
| | | | | | | Kidney Disease | |
| | | | | | | Tuberculosis | |
| | | | | | | Other | |

## Hospitalizations

| Year | Hospital | Reason for Hospitalization and Outcome |
|---|---|---|
| | | |
| | | |
| | | |
| | | |
| | | |
| | | |
| | | |
| | | |
| | | |

Have you ever had a blood transfusion? ☐ Yes ☐ No
If yes, please give approximate dates ______________________

| Serious Illness/Injuries | Date | Outcome |
|---|---|---|
| | | |
| | | |
| | | |
| | | |
| | | |
| | | |

## Pregnancies

| Year of Birth | Sex of Birth | Complications, if any |
|---|---|---|
| | | |
| | | |
| | | |
| | | |
| | | |

## Health Habits

Check which substances you use and describe how much you use.

| | | |
|---|---|---|
| | Caffeine | |
| | Tobacco | |
| | Drugs | |
| | Other | |

## Conditions

Check if your work exposes you to the following:

| | | | |
|---|---|---|---|
| | Stress | | Hazardous substances |
| | Heavy Lifting | | |

Occupation

I certify that the above information is correct to the best of my knowledge. I will not hold my doctor or any members of his/her staff responsible for any errors or omissions that I may have made in the completion of this form

Signature ______________________ Date ______________________

Reviewed By ______________________ Date ______________________

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## CONSENT TO CHIROPRACTIC TREATMENT
## AUTHORIZATION FOR RELEASE OF INFORMATION FOR MEDICAL RECORDS

All references herein to Doctor mean and include **Avila Integrative Medicine and Dr. Robert J. Avila D.C., CCST,CCCN**. All references herein to **"Patient"** mean and include the patient and any other person acting on behalf of the patient.

The patient is: ______________________________________________

**PATIENT ACKNOWLEDGES THE READING OF THIS AGREEMENT, THAT IT HAS BEEN FULLY EXPLAINED, AND THAT IT IS FULLY UNDERSTOOD REGARDING CONTENTS, HAS RECEIVED A COPY THEREOF, AND THE PATIENT, OR A PERSON DULY AUTHORIZED TO EXECUTE THIS AGREEMENT AND ACCEPT ITS TERMS.**

Insured/Patient Signature: ______________________________Date: ____________

Witness: ______________________________________________

If the patient is a minor or for any reason is unable to consent because of physical disability or incompetence, complete the following:

The patient is unable to consent because: ______________________________

Person with Authority to Consent for Patient: ______________________________

Relationship: ____________________ Witness: ____________________

- **Chiropractic, Therapeutic, Nutritional, and Rehabilitative Care Consent**: The patient who is suffering from a condition requiring Chiropractic care, diagnostic, or chiropractic treatment does hereby voluntarily consent to and authorize such chiropractic care and diagnostic services, including but not limited to x-ray, chiropractic diagnostic or non-invasive procedures, which may be preformed under order from: **Dr. Robert J. Avila, D.C.,CCST, CCCN** his assistants or designee as is necessary in their judgment.

- **No Guarantee**: I am aware that the practice of chiropractic is not an exact science and I acknowledge that no promises or guarantees have been made to me as to the result of treatment to be provided for me by the assistant or my physician.

- **Assignment of Benefits:** I authorize and direct the Insurance Company(s) to pay directly to **Avila Integrative Medicine** all chiropractic insurance benefits otherwise payable to me. I understand that I am financially responsible to **Avila Integrative Medicine** for charges not covered by or paid pursuant to this authorization.

- **Medicare:** Patient certified that the information provided in applying for payment of charges for health care and the services of certain physicians for whom the health care facility is authorized to bill in connection with its services under Title XVIII or Title XIX of the Social Security Act is correct. Patient requests payment of authorized benefits under the Social Security Act be made to **Avila Integrative Medicine** on behalf of the patient and authorizes release of all records of the patient required to act on this request and agree that for such purpose a copy of this agreement may be used in place of the original. Patient herby assigns to **Avila Integrative Medicine** payment for such unpaid charges to those physicians for whom **Avila Integrative Medicine** is authorized to bill in connection with its services.

- **Release of Information:** I hereby authorize **Avila Integrative Medicine** to disclose, as necessary to substantiate claims, any or all parts of my medical records to any person or corporation, which is or may be liable under a contract for all or part of the charges, including but not limited to, my insurance company, any third party payer, providers of services, medical service companies, employer, workmen's compensation carrier, welfare agency, social agency, or governmental agency. I further authorize the release of medical records and medical information to facility personnel for the purpose of treating my chiropractic condition and protecting facility personnel and other patients from any contagious or communicable disease or illness. Information released will done so in compliance with state and federal laws.

- **Financial Agreement:** In consideration of the services to be rendered to patient, and all other persons signing this agreement, jointly and severally, agree to pay (I) in full, all costs, charges and expense of **Avila Integrative Medicine** of every kind and description for service, supplies, vitamins, and other items supplied or furnished by **Avila Integrative Medicine** to or for the benefit of the patient, and (II) all costs of collections, including reasonable attorney fees, and agree that a copy of this Agreement shall be as effective and valid as the original.

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# Responsibility For Payment Of X-Ray

Dr. Avila utilizes a 2nd opinion for a radiology consultation with a written report. This further objective data will assist in documenting your injuries and underlying condition.

I fully understand and agree that I am directly and fully responsible to pay **$45.00** in full for x-ray reports.

I further understand and agree that payment is not contingent upon any settlement, claim, judgement or verdict by which I may eventually recover said fee.

____________________________________________

Patient/Guardian Signature Date

____________________________________________

Witness Date

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# DOCTOR'S LIEN

TO: ______________________________

______________________________

______________________________

## Patient Record and Doctor's Lien

I do hereby authorize the above doctor to furnish you, my attorney/insurance carrier, with a full report of my case history, examination, diagnosis, treatment and prognosis, as determined by my doctor, in regard to my accident/illness which occurred/began on ______________________.

I do hereby give permanent and irrevocable lien to the above mentioned doctor on any settlement, claim, judgment, or verdict as a result of said accident/illness, and authorize and direct you, my attorney/insurance carrier, to pay directly to said doctor, such sums as may be due and owing to him/her for service rendered to me, and to withhold such sums from such settlement, claim, judgment or verdict as may be necessary to protect said doctor adequately.

I fully understand and agree that I am directly and fully responsible to said doctor for any and all chiropractic bills submitted by him/her for service rendered to me, and that this agreement is made solely for said doctor's additional protection and in consideration of my doctor awaiting payment. I further understand and agree that such payment is not contingent on any settlement, claim, judgment or verdict by which I may eventually recover said fee. I fully understand and agree that I am directly and fully responsible to pay said doctor for all bills submitted by him/her for services/products rendered to me and that this assignment does not relieve me of primary responsibility for said bills.

Dated: ______________________ Patient Signature: ______________________

Print Name: ______________________

The undersigned, being attorney of record or authorized representative of insurance carrier for the above named patient, does hereby acknowledge receipt of the above lien, and does agree to honor the same to protect the above named doctor adequately.

Dated: ______________________ Authorized Signature: ______________________

Print Name: ______________________

NOTICE: Please date, sign and return one copy to the above doctor's office at once. Keep one copy for your own records. A return-address envelope is enclosed for your convenience. Thank you!

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**If your injuries could be due to an auto accident, please fill out this page.**

## ACCIDENT PATIENT HISTORY

Date of Accident ______________________________ Time ______________

Were you: ☐ Driver ☐ Passenger ☐ Front Seat ☐ Back Seat

Were You Wearing a Seat Belt Y ______ N ______ Shoulder Harness Y ______ N ______

**DESCRIPTION OF ACCIDENT:**

Were you struck: ☐ From Behind ☐ In Front ☐ Right Front ☐ Right Middle ☐ Right Rear

Were you: ☐ Moving ☐ Stopped ☐ Turning R ☐ Turning L

Approximate speed of automobiles at time of impact: ______________________________

Did you see the accident coming? Y ______ N ______

Which way were you looking at the time of impact? ______________________________

Upon impact which way was your body thrown? ☐ Forward ☐ Backward ☐ Right ☐ Left

Did you hit your head on anything? Y ______ N ______ What? ______________________

Lose consciousness? Y ______ N ______ How Long? ______________________

Amount of damage to vehicle? ______________________________

Type of vehicle? Make: ______________________ Model: ______________ Year: __________

Police report filed? Y ______ N ______ Do you have a copy? Y ______ N ______

Citation issued? Y ______ N ______ To whom? ______________________________

When did the pain begin? ______________________________

Since MVA – pain is: ☐ Less ☐ Same ☐ Worse

Transported to hospital? Y ______ N ______ X-rays taken? Y ______ N ______

Have you seen another Dr. since MVA? Y ______ N ______

Doctors Name? ______________________________

What treatment did you receive? ______________________________

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# ASSIGMENT, LIEN, RELEASE & POWER OF ATTORNEY

THIS AGREEMENT, entered into this date and between ____________________ called "Patient" and **AVILA INTEGRATIVE MEDICINE,**

WHEREAS Patient desires to receive chiropractic services from **AVILA INTEGRATIVE MEDICINE** and assign certain rights and benefits to **AVILA INTEGRATIVE MEDICINE** as consideration for **AVILA INTEGRATIVE MEDICINE** awaiting payment of such benefits.

Accordingly, it is hereby agreed:

A. Patient hereby authorizes **AVILA INTEGRATIVE MEDICINE** to furnish a full report and records regarding case history, examination, diagnosis, treatment and prognosis, x-rays, laboratory reports and the results of all tests of any type or character of patients such persons as **AVILA INTEGRATIVE MEDICINE** deems appropriate.
B. Patient's assigns to **AVILA INTEGRATIVE MEDICINE** any and all benefits payable by Patient's insurance or health care plan(s) as a result of charges incurred by Patients for services rendered by **AVILA INTEGRATIVE MEDICINE.** Patient also assigns to **AVILA INTEGRATIVE MEDICINE** any and all contractual rights Patient has against insurance company, health care benefit plan, or any other party possible liable to Patient for payment of health care costs incurred by Patient as a result of services rendered by **AVILA INTEGRATIVE MEDICINE.**
C. Patient fully understands that Patient is directly and fully responsible to **AVILA IMTEGRATIVE MEDICINE** for all bills submitted for services rendered and that this agreement is made solely for additional protection and consideration for awaiting payment. Patients further understand that such payment is not contingent on any settlement, claim judgment, or verdict, which Patients may eventually recover. In the event of non-payment by any insurance company, health care benefit plan, or any other party possible liable to Patient for payment of health care costs incurred by Patient as result of services rendered by **AVILA INTEGRATIVE MEDICINE**, Patient agrees to be responsible for any such outstanding balance, including interest at a rate 9%, reasonable attorney's fees and costs.
D. Patient fully understands that the lien and assignment given to **AVILA INTEGRATIVE MEDICINE** herein is irrevocable.
E. By executing this agreement, Patient hereby instructs and directs any attorney-representing Patient to honor the above lien and assignments and make payment under the lien and assignment directly to **AVILA INTEGRATIVE MEDICINE**. Patient directs that attorney be bound by this lien and treat it, irrevocably, as an assignment due to **AVILA INTEGRATIVE MEDICINE. AVILA INTEGRATIVE MEDICINE** is relying upon this lien, assignment and directive to any attorney, and as a result of such reliance, **AVILA INTEGRATIVE MEDICINE** is providing care and treatment for which this lien, assignment and directive provides security for payment. Moreover, Patient agrees that **AVILA INTEGRATIVE MEDICINE** is to be viewed as a third party beneficiary of this direction to Patient's attorney an obligation to comply with the terms of this directive.
F. Patient hereby directs all insurers and other persons possibly responsible for Patient's healthcare costs to make all payments for healthcare services rendered by **AVILA INTEGRATIVE MEDICINE** directly to **AVILA INTEGRATIVE MEDICINE.**
G. Patient agrees that in the event Patient receives any check, draft, or other payment subject to this agreement, Patient agrees to act as fiduciary agent for **AVILA INTEGRATIVE MEDICINE** and will immediately deliver said check, draft, or payment to **AVILA INTEGRATIVE MEDICINE** to be applied to Patient's debt for services rendered.
H. Patient hereby, appoints **AVILA INTEGRATIVE MEDICINE** as Patient's true and lawful attorney, irrevocable, and with full power of substitution, for Patient and in Patient's name, to ask, demand, sue for, collect, endorse, sign and receive proceeds from insurance, other health benefits, and third party claims relating to services rendered to Patient by **AVILA INTEGRATIVE MEDICINE. AVILA INTEGRATIVE MEDICINE** is not obligated or compelled to exercise such powers but may do so in **AVILA INTEGRATIVE MEDICINE** sole discretion. Patient agrees to fully cooperate with **AVILA INTEGRATIVE MEDICINE** in collecting said amounts.
I. **AVILA INTEGRATIVE MEDICINE** agrees to submit a copy of this agreement with the initial claim form(s) which **AVILA INTEGRATIVE MEDICINE** submits to third party payor(s) as notice to the third party payor(s) of the assignment and other agreements contained herein. At the time each claim is submitted, a copy of the claim will be stored for safekeeping in Patient's file and may be picked up by the Patient, upon reasonable request and during normal business hours, or upon written request by Patient, be mailed to designated address.
J. Patient hereby authorized **AVILA INTEGRATIVE MEDICINE** to receive a complete copy of Patient's insurance policy, including any endorsements, conditions, limitations or exclusions.
K. A copy of these documents shall be as binding as the document bearing the original signatures.

______________________________ ______________
Patient's Signature Date

______________________________ ______________
AVILA INTEGRATIVE MEDICINE AGENT Date

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# QUESTIONAIRE

## HOW ARE YOU FEELING NOW?

- Where is your present pain, if any? ______________________________

______________________________________________

- How often do you experience pain? ______________________________
- How severe is the pain? (1-10) ______________________________
- What makes your pain worse? ______________________________

______________________________________________

- What have you done in the past and doing now to cope with the pain? ______________

______________________________________________

- What are other symptoms that may be associated with the pain (e.g. irritability, nausea, headaches, stress, inability to move body parts, insomnia, etc)? ______________________

______________________________________________

- How does your pain limit your activities? (Past "Just after the accident" /Present) __________

______________________________________________

- What activities cause you extra pain? (Past "Just after the accident"/Present)__________

______________________________________________

## HOW HAVE YOUR INJURIES AFFECTED YOUR LIFESTYLE?

**Work:**

**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.

**If you have continued to work despite the pain caused by your collision, please mark the reason why.**

- ☐ 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 did not work.
- ☐ Other: ______________________________

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

- ☐ I have lost status with 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.

**I have experience the following changes in my ability to perform at work.**

- ☐ Mobility/ Stability problems.
- ☐ Dexterity problems.
- ☐ Problems with fatigue.
- ☐ Postural difficulties.
- ☐ Problems with anxiety/depression.
- ☐ Problems with Vertigo or spinning sensations.
- ☐ Problems with Tinnitus or ringing in the ears.
- ☐ Problems with reduced concentration.
- ☐ Pain – Where? ______________________________________________

**Lost Wages (List Employer Name and Address):**

_____________________________________________________________________

_____________________________________________________________________

**DOMESTIC:**

**I have experienced pain while performing the following activities inside my home but have done them anyway.**

- ☐ Laundry
- ☐ Dishwashing
- ☐ Vacuuming
- ☐ Cleaning
- ☐ Preparing meals

**Due to my injuries, I have brought in the following assistance.**

- ☐ Paid Housekeeper
- ☐ Unpaid assistance
- ☐ NONE

**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
- ☐ Gardening
- ☐ Taking out the trash
- ☐ Washing the cars
- ☐ Maintaining yard equipment
- ☐ Doing other external house work; Specify: ________________________________

**EDUCATION: (If Applicable)**

**My educational activities have been impacted 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 the injuries.

**As a student I have experienced problems with one of the following activities since the collision.**

- ☐ Carrying books
- ☐ Sitting in class
- ☐ Looking down to read textbooks
- ☐ Other:______________________________________________

## HOBBIES AND /OR SPORTS ACTIVITES:

**(Please use another separate sheet for each activity):**

**I have lost enjoyment in performing activities as a result on the injuries caused in this collision.**

Activity: ________________________________________

**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.

**After the 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 did not make money with this hobby
- ☐ I make money with this hobby.

**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 problem in enjoying this activity is ongoing, but my doctors have not instructed me that the condition is not permanent.