COLORADO CHIROPRACTIC AND REHABILITATION CENTER, LLC

2460 W. 26th Ave. Suite C-40
Denver, Colorado 80211 (no mail here)

New Patient/Injury Form

Thank you for choosing Colorado Chiropractic and Rehabilitation Center, LLC to serve your health care needs. Please complete this Consent Form and provide documentation of insurance in order to receive treatment services. Our team looks forward to working with you toward your full recovery.

Patient Name: _____ **Date:** _____

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

Auto and Work Comp Patients please give full Social Security #: _____

Phone Number: _____ (H) _____ (C) Email: _____

How did you hear about us? _____

❑ Male ❑ Female Date of Birth: ___/___/_____ Age: _____ Height: ____'____" Weight: _____#

Emergency Contact: _____ Phone: _____ Relation: _____

Marital Status: ❑ Single ❑ Married ❑ Divorced ❑ Widowed ❑ Separated ❑ Other

Your Household: ❑ Alone ❑ Roommate(s) #___ ❑ Spouse/Partner ❑ Children #_____

Education: ❑ F/T ❑ P/T ❑ Non-Student Years completed _____ highest level completed _____

Employer: _____ Job Title: _____

Job Description: _____ Years Employed: _____

Employer Address: _____ Phone: _____

Employment: ❑ Full-Time ❑ Part-Time Job Satisfaction: Unsatisfied Satisfied Very Satisfied

Status: ❑ F/T ❑ P/T ❑ Not Working since _____ Restrictions: ❑ Yes ❑ No

Current Restrictions: _____

What type of injury are we seeing you for? _____

❑ Work ❑ Sports ❑ Third-Party/Liability ❑ Auto Accident Date of Loss/Accident/Injury: ___/___/_____

What happened? _____

Insurance/ Payment Information:

❑ None, I will be paying for services myself. ❑ Workers Compensation Claim ❑ Auto Claim

Attorney Name: _____ Firm Name: _____

Phone: _____ Date Retained: ___/___/_____ ❑ I have not retained an attorney

I understand it is unlawful to knowingly provide false, incomplete, or misleading facts or information to an insurance company for the purpose of defrauding or attempting to defraud the company. Penalties may include imprisonment, fines, denial of insurance and civil damages.

Patient Signature _____ Date: _____

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Consent for Treatment:

I hereby give my informed consent to receive health care services, evaluation, and treatment rendered according to the applicable standards of care at Colorado Chiropractic and Rehabilitation Center, LLC (hereinafter "CCRC"). I understand that options exist for treatment and all treatments are choices with risks and benefits. If the risks and benefits of a proposed treatment are not clear to me, I understand that I am responsible to request further information from CCRC. The information within my Patient Chart is confidential. I understand that all requests for release of my records, or any portion of my records, must be made in writing to CCRC. Protected health information will only be released with a written authorization, signed by me, and only the minimum disclosure related to my care necessary to fulfill such written request will be provided. I have been provided a copy of CCRC's Privacy Policy Practices and agree to comply with all of CCRC's policies and practices. I understand that I have a responsibility to communicate honestly with my health professionals working at CCRC and to notify them at the earliest time possible of any changes to my condition, health status, re-injury, and/or new injuries and accidents.

I further authorize any health professional working at CCRC to provide tests, procedures, and treatments that are necessary or advisable for the evaluation and management of my health care at CCC and within the scope of CCRC's practice whether rendered by Dr. Walker personally or by another health care provider or staff member under the orders or direction of Dr. Walker.

Patient Signature: _____ **Date:** __/__/____

Financial Responsibility Agreement:

CCRC explained and I understand that CCRC offers a "Time of Service Discount" off the normal fees charged for services rendered if payment in full is made at the time services are rendered. By signing below, I choose not to take advantage of the discounted rates. Instead, I authorize CCRC to bill my insurance company (including workers compensation) the normal fees for service.

I also realize that there is a possibility that my insurance company may not pay some or part of fees for certain services rendered by CCRC. CCRC does not promise or guarantee that services rendered to me will be paid by my insurance company. I agree to pay for all charges for services rendered to me if my insurance company reduces or denies payment for any services provided to me by CCRC. Workers Compensation patients with an open claim are not responsible for charges and services rendered if they have an open and accepted Workers Compensation Claim. CCRC will not balance bill services provided to an accepted claim for a Workers Compensation patient who has been provided services by CCRC. Any services provided after a denial of my claim or closure of my claim (without authorized maintenance services) will be my responsibility to pay in full. I am required to notify CCRC if my claim is denied for any reason and contact them to cancel all services immediately. I am responsible to pay any services provided to me after denial of my Workers Compensation Claim.

I UNDERSTAND THAT I AM PERSONALLY FINANCIALLY RESPONSIBLE and obligated to pay, in full, THE ENTIRE BILLED AMOUNT, for any and all health care and/or professional services rendered to me WHETHER OR NOT MY INSURANCE PAYS any portion of the charges incurred by me. I understand that I am personally responsible for any charges, and unpaid portions of charges, not covered by insurance. I understand that amounts unpaid for over 90 days from the date services were rendered are past-due and subject to a monthly finance charge of 1.5% and an annual finance charge of 18%.

I understand and agree that if I fail to make any payments in a timely manner (including but not limited to the balances after insurance benefits and/or settlement proceeds have been received), after such default and upon referral to a collection agency, attorney, or small claims court by CCRC, I will be responsible for all costs of collection, including, but not limited to, collection agency fees up to 50% collection fees, court costs, and CCRC's attorney fees.

Patient Signature:_____ **Date:** ___/___/_____

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Assignment of Benefits and/or Proceeds of Claims/Cases/Suits:

I, _____ ("Assignor"), expressly agree that I am personally liable for the entire billed amount for professional services rendered to me at Colorado Chiropractic and Rehabilitation Center, LLC ("Assignee"). Assignor hereby assigns and authorizes payment of all of my major medical insurance benefits, including Medicare, Medicaid, Auto, private insurance, and any other health plan and/or injury settlement, award, or judgment proceeds or benefits due because of liability of a third-party, payable by any party or organization to CCRC ("Assignee") together with any and all rights, privileges, and remedies to payment for health care services provided by Assignee to which I am entitled under any and all insurance and/or settlement proceeds available to me relating to the Loss/Accident/Injury identified above.

This assignment may be revoked at any time by the Assignor in writing accompanied by payment in full of the entire billed amount for services rendered by Assignee, including all interest or finance charges accrued on my account.

This agreement may be revoked by the Assignee if/when benefits under any insurance agreement are not payable due to Assignor's lack of coverage, denial of coverage, and/or violation of policy conditions due to the actions or conduct of the Assignor. I understand that if Assignee revokes this assignment, the entire balance becomes due and payable immediately and pre-payment at the time of service is required for any additional services sought or rendered after such revocation by Assignee.

The Assignee hereby certifies that they have not received any payment from or on behalf of the Assignor and shall not pursue payment directly from Assignor for services provided to Assignee for injuries sustained and/or reported to arise from the Loss/Accident/Injury identified above, notwithstanding any agreement to the contrary.

You are directed to pay, directly to Colorado Chiropractic and Rehabilitation Center, LLC, for all professional services rendered to me at Colorado Chiropractic Center, LLC. This Direction to Pay is a complete assignment of my benefits and rights under my medical coverage.

Pay To: Colorado Chiropractic and Rehabilitation Center, LLC TIN: 84-1662392
1700 Bassett St. Unit 816
Denver, CO 80202
Phone: (720) 401-5728 Fax: (303) 567-6256 Email: doctorjen17@gmail.com

Any amounts paid by my insurance or settlement under this Assignment shall be credited to my account with CCRC. I expressly understand that I shall remain personally responsible and financially liable to CCRC for the entire unpaid balance for any services not covered or paid by insurance and/or injury settlement, settlement, judgment, verdict, award, collection proceeds, or benefits due because of liability of a third-party, payable by any party or organization.

Patient Signature: _____ **Date:** __/__/____

Authorization to Release Records, Doctor's Lien, and Assignment of Proceeds:

Patient's Name: _____ Date of Injury: ___/___/_____ Date: ___/___/_____

Attorney/Firm: _____ Phone: _____

COLORADO CHIROPRACTIC AND REHABILITATION CENTER, LLC

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I, _____, hereby authorize Colorado Chiropractic and Rehabilitation Center, LLC/ Jennifer G. Walker, D.C. (hereinafter "CCCR"), to furnish my Attorney/Firm, named above or any successor Attorney/Firm, with a full report of my examination(s), diagnosis(es), treatment, prognosis, etc. regarding the Accident/Claim/Injury I assert was the cause of the injury(ies) for which I am seeking treatment with CCRC.

I further authorize and direct my Attorney/Firm to pay directly to CCRC all sums that are due and owing as described in the Financial Responsibility Agreement above both by reason of the Accident/Claim/Injury and by reason of any other bills and interest or finance charges that are due and to withhold such sums from any settlement, judgment, verdict, or award as may be necessary to fully compensate CCRC.

I hereby give a Doctor's Lien on my claim/case/action to CCRC against any and all proceeds of my settlement, judgment, verdict, or award which may be recovered as a result of the Accident/Claim/Injury for which CCRC has treated me and any other bills and interest or finance charges described in the Financial Responsibility Agreement above.

I fully understand that I am directly and fully responsible to CCRC for the billed amounts of all bills submitted by CCRC for services rendered to me plus any accrued interest or finance charges and that this agreement is made solely for CCRC's benefit and additional protection and in consideration of CCRC awaiting payment and forbearing their rights to pursue legally available actions to collect payment. I expressly understand that such payment is NOT contingent on any recovery by me from any source and that I remain fully responsible under the Financial Responsibility Agreement above. I expressly waive the defense of Statute of Limitations as it pertains to any claim or suit filed against me by CCRC or its successors to collect this debt. I agree to promptly inform CCRC of any change or addition of attorney(s) retained by me in connection with this Accident/Claim/Injury, and I instruct my attorney to do the same and to promptly deliver this Lien to any such additional or substituted attorney(s).

I have been advised and understand that if my Attorney/Firm does not agree to cooperate in protecting CCRC's interests by signing this Lien Agreement, CCRC will not await payment but may declare the entire balance immediately due and payable as well as require pre-payment at the time of service for any treatment.

Patient Signature:_____ **Date:** ___/___/_____

The undersigned Attorney expressly agrees:

1. To expressly comply with the above agreement(s),
2. To withhold and pay to CCRC from the proceeds of any settlement, judgment, verdict, award, collection, and/or insurance payments the amount of CCRC's outstanding account balance, after contacting CCC, or their billing representative, for the most up to date balance including interest and finance charges,
3. Advise CCRC within ten (10) days of their request, the status on the above referenced claim/case,
4. Promptly notify CCRC of any changes in the status of the claim/case that may preclude, limit. Or otherwise impair full payment of CCRC's charges,
5. Notify any attorney, in writing, who may assume the representation of this patient of this assignment and provide CCRC a copy of that notice.

Attorney Signature: _____ **Date:** ___/___/_____

Attorney Name (Print): _____

Firm Name: _____ **Phone:** (____)_____-_____

COLORADO CHIROPRACTIC AND REHABILITATION CENTER, LLC

2460 W. 26th Ave, Suite 40-C
Denver, Colorado 80211 (no mail here)

Office Policy

- **Fees**
  - I understand that Colorado Chiropractic and Rehabilitation Center, LLC is an independent clinic and sets its own fees for all services to conform to reasonable and customary fees for the services provided through this facility (this includes services provided by Dr. Walker, or any other member of the clinic staff or coverage staff). I understand that fees are subject to change without notice. I understand that a complete list of services and fees are available for my review upon written request.

- **Cancelation, Missed Appointment and Rescheduling Policy.**
  - **I agree that I may be charged a fee for any no-show, late cancelation, or rescheduling made less than 24-hours before my scheduled appointment. If you are a Workers Compensation patient, please note that missed appointments, no show or late cancellations (less than 24 hours' notice) are not billed to you but may seriously affect your claim and your ability to continue to treat under your claim with our office.**

- **Late Fees and Monthly Finance Charges.**
  - I agree that I may be charged late fees and/or a monthly finance charge if there is any outstanding balance owning on my account for over 30 days.

- **Time of Service Discount Option.**
  - I agree that, at the sole option and discretion of Colorado Chiropractic and Rehabilitation Center, LLC, I may be offered a Time of Service Discount on services rendered and that this is a reduction from the customary fees for services at Colorado Chiropractic and Rehabilitation Center, LLC. This requires that I pay in full at the time of service (the same day of my service or before my service). If I do not pay in full at or before the time of service, I will be charged the full customary fee for services with no reduction, and I agree that I am personally and solely responsible for the full-billed amount of the services rendered.

- **Other Accidents, Injuries, and Claims.**
  - I understand that if I am involved in a Workers Compensation, Auto Accident, Personal Injury Claim, or Third-Party Claim of any kind after beginning treatment with Colorado Chiropractic and Rehabilitation Center, LLC, any existing financial agreement(s) or Time of Service Discount are suspended and terminate. I understand that I am required to notify Colorado Chiropractic and Rehabilitation Center, LLC. I further understand and agree that Colorado Chiropractic and Rehabilitation Center, LLC, may unilaterally terminate any financial agreement(s) or Time of Service Discount at any time for any reason with written notice.

My signature below confirms I read, understand, and expressly to adhere with and agree to be bound by Colorado Chiropractic and Rehabilitation Center, LLC's Office Policy and all terms and conditions herein.

Patient Name (Print) _____

Patient Signature: _____ **Date:** _____

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FACTS OF THE COLLISION:

Date of Accident: ____/____/_____ Anyone else in the vehicle with you? _____

Day of the week? _____ Weather conditions(sun, rain, snow, ice)?_____

What street or cross section was the accident? _____

Description of Accident?_____

_____

_____

_____

_____

_____

Your vehicle type? _____ License Plate#_____

Owner of the vehicle? _____Your vehicle approximate speed?_____

Your foot position (gas, brake, clutch)? _____ Were you wearing a seatbelt? Y/N

Where was the headrest located (mid neck, mid head, upper head, none)?_____

Did your head or body strike anything inside the car? What? _____

Did you lose consciousness? Y/N Did your airbags deploy? Y/N Did your seat break? Y/N

Did items in the car get displaced? Y/N What?_____

What part of your vehicle was damaged?_____

Vehicle Damage estimate?_____ Repair Shop Name?_____ Vehicle repaired? Y/N

Police arrive? Y/N Name of officer? _____ Anyone cited? Y/N Who?_____

Statements by your or other party at the scene? Y/N Please list:_____

_____

Statements made to insurance company or anyone else? Y/N Please list:_____)_____

_____

Do you have pictures of the scene, vehicles or injuries Y/N Explain? _____

Were any vehicles towed? Y/N List vehicles: _____

OTHER DRIVER INFORMATION:

Name of driver_____ Owner of that vehicle_____

Type of vehicle?_____ Company vehicle? Y/N Company Name_____

Approximate speed?_____ Driver's License #_____

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Driver's Address_____Phone#_____

Company's Address (If applies) _____

Driver's Insurance Company:_____ Phone#_____

Insurance Address:_____

Claim #:_____ Adjustor Name:_____

Damage to their vehicle:_____ Estimated cost of Repair:_____

YOUR INSURANCE INFORMATION:

Name:_____ Phone:_____ Claim#_____

PIP Policy Limits:_____ Medical Insurance Amount (Med-pay)?_____

UN/UIM_____ Other_____

PHYSICAL INJURIES, IMPAIRMENT AND DAMAGES:

Please list all injures since the accident: _____

_____

_____

_____

Were you or the other driver taken by Ambulance to the ER? Y/N Explain?_____

_____Name of ER?_____

What testing, diagnostics, procedures or imaging was performed at the E/R?_____

_____

_____ Were you kept overnight or released? _____

Were you given medications? If so, what? _____

Did you take the medication or not? Explain? _____

Please list the doctors or health care providers names and facilities (other than the ER) where you have been since your accident? _____

_____

What treatment, medication, diagnostic studies or imaging have you been provided?_____

_____

Please list what things you are **NOT able to do anymore** as a result of this accident (work or home related)?

_____

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Your doctor's Name (PCP) and clinic name? _____ Phone#: _____

YOUR EMPLOYMENT:

Who is your Employer? _____ Phone#: _____

Address: _____

Job Title: _____ Job Duties: _____

Did you miss any work? Y/N How much? _____

What job duties are you unable to perform at work due to your injuries: _____

Patient Name (Print) _____ **Date:** _____

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Family History:

Please list your relative's health issues, current age or age at time of death with cause of death.

- Maternal Grandmother/ father
- Paternal Grandmother/father
- Mother
- Father
- Brothers & Sisters
- Children

Hospitalizations, Operations, Serious Illnesses, Auto Accidents or Prior Work Injuries:

Please list dates and body areas involved, type of accident, dates of occurrence and any treatment received:

Hobbies, Habits and Interests:

Do you smoke? **Y/N** If so, how much?
Do you drink? **Y/N** If so, how much and how often?
Do you consume caffeine? **Y/N** If so, how much per day?
Do you exercise? **Y/N** If so, how often and what type of exercise?

Are you right handed, left handed or Ambidextrous?
Rate your health? **Excellent Average Poor** **Since your injury**, do you feel depressed, have trouble falling asleep, have a poor appetite, have relationship problems or a lack of interest in normally enjoyable activities?

Medications, Allergies, Prior Tests/Imaging and Prior Treatment:

Please list your current medications and drugs:

Please list any vitamins or herbs you currently take:

Please list any allergies:
Please list your most recent imaging and the date completed:

Please list any prior treatment and the dates treated for your current complaint?

Circle any of the following problems that you are currently experiencing:

Back pain or stiffness, Neck pain or stiffness, shoulder pain, hip pain, foot pain, swollen or painful joints, cold hands or feet, numbness or pain in the arms, hands or fingers, feet or toes.

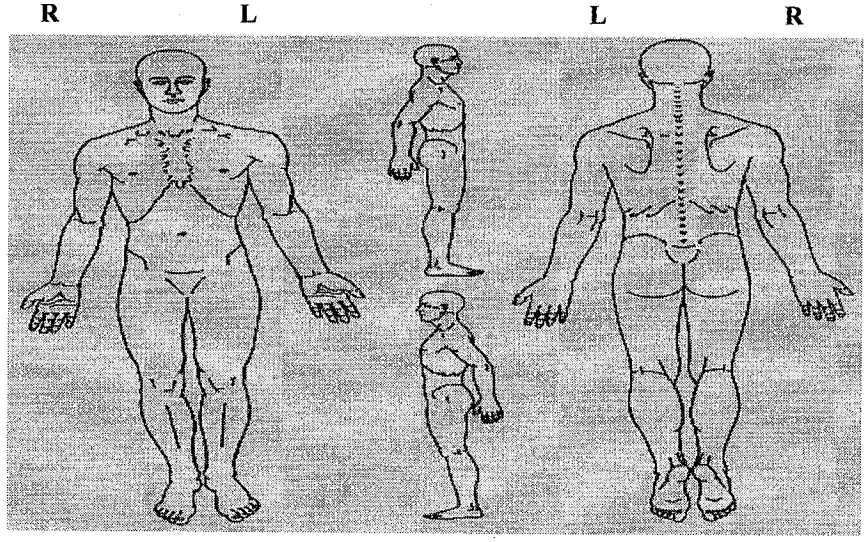
Men: Changes in urine stream, lumps in testicles, prostate trouble, sex concerns.
Women: menstrual problems, abnormal bleeding, breast lumps or pain, problems getting pregnant, vaginal discharge, tubal infections, sex concerns. Are you currently pregnant? **Y/N.**

Patient Name (Print) **Date:**

COLORADO CHIROPRACTIC CENTER PATIENT PAIN DIAGRAM

PLEASE USE THE LETTERS TO INDICATE TYPE AND LOCATION OF PAIN

A= Ache B= Burning C= Cramping S= Stabbing T= Tightness/Tension N= Numbness/Tingling



*Please **CIRLCLE** and **EXPLAIN** if you have pain or difficulty doing any of the following:

Bending Squatting Lifting Carrying Walking Reaching Sitting Standing Sleeping

PAIN Performing the following **duties at work** (please list) _____

_____

PAIN Performing the following **activities of daily living** (please list) _____

_____

List any **functional improvements** with your current treatment: _____

*** (CIRCLE) RATE YOUR PAIN: No pain (1-----x-----x-----x-----5-----x-----x-----x-----x-----10) Severe pain**

*Is your pain worse during the day or at night? **Please explain** _____

_____

*What **increases** your pain? _____

*What gives you the **greatest relief**/control of pain? _____

*Please list the **current medication** you are taking: _____

*Did your symptoms/pain improve since your last treatment? **YES / NO**

*Are you performing your stretches / exercises daily as prescribed? **YES / NO**

*Do you have a NEW injury, accident, or complaint? **YES / NO** If yes, explain_____

Patient Signature: _____ **Date:** _____

Print Name: _____

QUADRUPLE VISUAL ANALOGUE SCALE

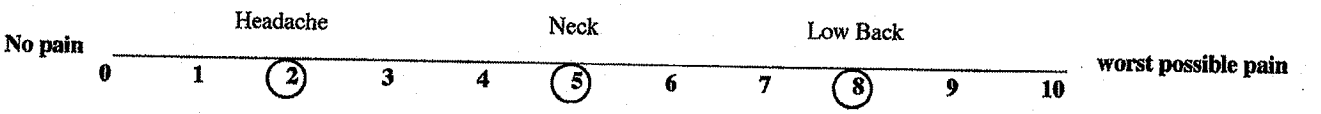
Patient Name _____ Date _____

Please read carefully:

Instructions: Please circle the number that best describes the question being asked.

Note: If you have more than one complaint, please answer each question for each individual complaint and indicate the score for each complaint. Please indicate your pain level right now, average pain, and pain at its best and worst.

Example:



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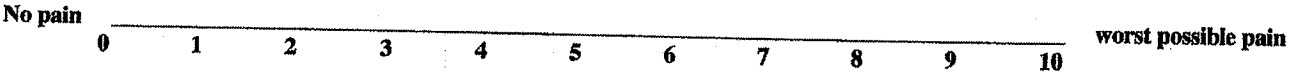
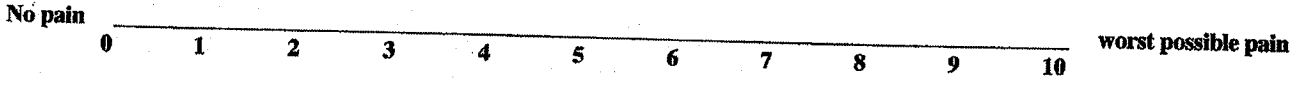
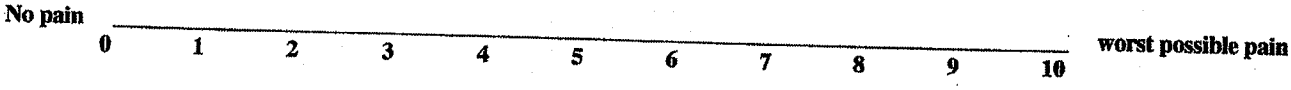
1 – What is your pain RIGHT NOW?



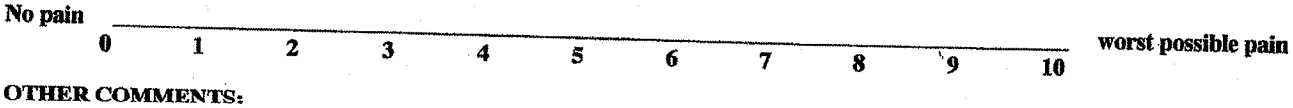
2 – What is your TYPICAL or AVERAGE pain?



3 – What is your pain level AT ITS BEST (How close to "0" does your pain get at its best)?



4 – What is your pain level AT ITS WORST (How close to "10" does your pain get at its worst)?



OTHER COMMENTS:

_____

_____

_____

Examiner

Reprinted from *Spine*, 18, Von Korff M, Deyo RA, Cherkin D, Barlow SF, Back pain in primary care: Outcomes at 1 year, 855-862, 1993, with permission from Elsevier Science.

Pain Disability Questionnaire (PDQ)

NAME: _____ **DATE:** _____

Please read:

This survey asks for your views about how your pain now affects how you function in everyday activities. This information will help you and your doctor know how you feel and how well you are able to do your daily tasks at this time.

Please answer every question by making an "X" along the line to show how much your pain problem has affected you (from having no problems at all to having the most severe problems you can imagine).

BE SURE TO ANSWER *ALL* QUESTIONS.

1. Does your pain interfere with your normal work inside and outside the home?
   Work normally — Unable to work at all
2. Does your pain interfere with personal care (such as washing, dressing, etc.)?
   Take care of myself completely — Need help with all my personal care
3. Does your pain interfere with your traveling?
   Travel anywhere I like — Only travel to see doctors
4. Does your pain affect your ability to sit or stand?
   No problems — Cannot sit/stand at all
5. Does your pain affect your ability to lift overhead, grasp objects, or reach for things?
   No problems — Cannot do at all
6. Does your pain affect your ability to lift objects off the floor, bend, stoop, or squat?
   No problems — Cannot do at all
7. Does your pain affect your ability to walk or run?
   No problems — Cannot walk/run at all
8. Has your income declined since your pain began?
   No decline — Lost all income
9. Do you have to take pain medication every day to control your pain?
   No medication needed — On pain medication throughout the day
10. Does your pain force you to see doctors much more often than before your pain began?
    Never see doctors — See doctors weekly
11. Does your pain interfere with your ability to see the people who are important to you as much as you would like
    No problem — Never see them
12. Does your pain interfere with recreational activities and hobbies that are important to you?
    Normal activity — No recreation/hobbies at all
13. Do you need the help of your family and friends to complete everyday tasks (including both work outside the home and housework) because of your pain?
    Never need help — Need help all the time
14. Do you now feel more depressed, tense, or anxious than before your pain began?
    No depression/tension — Severe depression/tension
15. Are there emotional problems caused by your pain that interfere with your family, social, or work activities?
    No problems — Severe problems

Reproduced with Permission from: Anagnostis C, Gatchel RJ Mayer TG, The Pain Disability Questionaire. Spine 2004, 29:2290-2302.

Which of the following do you suffer from now, which you did not prior to the accident:

☐Headaches	☐Dizziness	☐Difficulty Concentrating
☐Long Term Memory Loss	☐Short Term Memory Loss	☐Amnesia
☐Loss of Consciousness at Scene	☐"Blackouts" Since Collision	☐Forgetting ATM or PIN #s
☐Reading Problems	☐Writing Problems	☐Typing Problems
☐Apathy	☐Irritability	☐Sleep Disturbances
☐Personality Changes	☐Emotional Difficulties	☐Relationship Difficulties
☐Blurred Vision	☐Photophobia (Sensitivity to Light)	☐Vision Changes
☐Intolerance to Alcohol	☐Intolerance to Heat	☐Intolerance to Cold
☐Impaired Comprehension	☐Impaired Learning	☐Attention Impairment
☐Loss of Libido	☐Missing Periods of Time	☐Speech Difficulties
☐Concussion in Collision	☐Nausea	☐Vomiting
☐Extreme Thirst since Collision	☐Fatigue	☐Menstrual Irregularities
☐Tinnitus (Ringing in Ears)	☐Noise Intolerance	☐Loss of Coordination
☐Bumping into Objects in View	☐Loss of Balance	☐Fluid in Ears
☐Hearing Loss	☐Vertigo (Spinning Sensation)	☐Increased Symptoms in Crowds
☐Anxiety	☐Depression	☐Insomnia
☐Flashbacks to Accident Scene	☐Intrusive Thoughts of Accident	☐Nightmares since Collision
☐Unusual Behavior since Collision	☐Social Withdrawal	☐Panic Attacks
☐Thoughts of Death/Suicide	☐Weight Loss/Gain _____ lbs.	☐Loss of Taste/Smell
☐Blackouts with Neck Movements	☐Dizziness with Neck Movements	☐"Clunk" Sound w/Moving Neck
☐Jaw Pain	☐Clicking in Jaw	☐Pain with Chewing

Numbness / Tingling / Weakness in arms? Yes No R L Level(s) _____

Numbness / Tingling / Weakness in legs? Yes No R L Level(s) _____

Seatbelt: _____ Did the seatbelt bruise you? ☐Yes ☐No Where? _____

Head / Body position: ☐Straight ☐Right Rotated ☐Left Rotated ☐Up ☐Down

Was the type of impact of the vehicles: ☐Head On ☐Right Side ☐Left Side ☐Oblique Angle ☐Rear End

Impaired Activities

Circle all activities which have been impaired in any way by the accident in question:

Daily Activities

bathing/showering	bending	brushing teeth	dressing	driving car
vacationing	dining out	movie going	standing	sitting
sexual relations	lifting	church events	child care	religious activities (kneeling)
washing hair	eating	moving	reading	shaving
shopping	watching TV	sleeping	traveling	social events

Domestic Activities (Activities within the Home)

bending	cooking	ironing	housecleaning	laundry
washing dishes	vacuuming	dusting	interior painting	decorating

Household Activities (Activities outside the Home)

trimming bushes	gardening	tree trimming	mowing lawn	yard work
exterior painting	car washing	landscaping	house maintenance	farm activities

Work Activities

sitting	standing	lifting	using telephone	computer work
reading	bending	typing	writing	child care

Hobby Activities

aerobic exercises	archery	backpacking	bowling	badminton
baseball	basketball	basketry	bicycling	boxing
card playing	camping	dancing	fencing	fishing
flying	football	gardening	golf	handball
gymnastics	health clubs	hockey	hunting	judo
horseback riding	ice skating	karate	painting	yoga
jogging/running	photography	racquetball	rafting	sailing
mountain climbing	sewing	snow skiing	swimming	walking
musical instruments	volleyball	water skiing	water sports	weight lifting

Activities which you have performed despite pain, due to financial, family or personal needs (Duties Under Duress):

☐Work ☐Education ☐Domestic (Activities with the Home) ☐Household (Duties outside the Home)

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Past Motor Vehicle Accidents, Workers Compensation Claims, or other claims of any sort: _____

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