NEW PATIENT QUESTIONNAIRE

Today's Date: ____ / ____ / _____ ☐ **Dr. Wallace** ☐ **Dr. Beaman**

Your Name: _____ **[ ] Male [ ] Female**

Date of Birth: ____ / ____ / _____ **Age:** _____ **Social Security Number:** _____ - _____ - _____

Marital Status: [ ] Single [ ] Married [ ] Divorced [ ] Widowed [ ] Separated

Home Address: _____

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

Home Phone: (____) _____ **Email:** _____

Mobile Phone: (____) _____ **Mobile Carrier:** _____

Emergency Contact: _____ **Relationship to Patient:** _____

Home Phone: (____) _____ **Mobile Phone:** (____) _____

Employer: _____

Address: _____

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

Occupation: _____

How did you find our phone number? : _____

BILLING AUTHORIZATION

A. I hereby authorize the release of any health care information necessary to process this claim and request payment of insurance benefits either to myself or to the party who accepts assignment.

B. I authorize payment of any health care benefit from the third-parties for benefits submitted for my claim to be paid directly to this office. I authorize the direct payment to this office of any sum I now or hereafter owe this office by my attorney, out of proceeds of any settlement of my case and by any insurance company contractually obligated to make payment to me or you based upon the charges submitted for products/services rendered.

C. I understand and agree that the health and accident policies are an arrangement between an insurance carrier and me. Furthermore, I understand that this office will prepare any necessary reports and forms to assist me in making collection from the insurance company and that any amount authorized to be paid directly to this office 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/treatment, any fees for products or professional services rendered will be immediately due and payable.

Cancellation Policy: If you cannot make your appointment, your consideration to call and reschedule would be appreciated. The sooner the appointment is rescheduled or cancelled, the greater the possibility for that appointment time to be filled by another patient.

Anyone who fails to show up for an appointment and or does not provide 24 hour notice prior to the scheduled appointment may be subjected to a fee of $25. These charges will not and **cannot** be billed to your insurance provider.

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

Patient/Guardian Signature: _____ **Date:** _____

Notice of Privacy Practices

Dr. Wallace and Dr. Beaman, under the HIPPA Standards of Privacy of Individually Identifiable Health Information (The Privacy Rule), modified on August 14, 2002 will:

- Collect information that is relevant and necessary to carry out our role.
- Explain at the time the information is being collected, why it is needed, and how it will be used.
- Ensure that the records are used only for the reasons given or seek the person's permission when another purpose for their use is considered necessary or desirable.
- Provide adequate safeguards to protect the records from unauthorized access and disclosure.
- Allow people to see the records kept on them and provide them with the opportunity to correct inaccuracies in their records.
- Provide records to an entity, medical doctor or facility in order to coordinate your care.
- Obtain information needed to confirm your insurance benefits and obtain payment for services.
- Release information to your Health Plan at their request for billing of their administrative purpose.
- Release records when they are requested by you or your representative. Release records to certain government authorities as permitted or required by law to investigate or regulate health related issues such as child abuse, communicable diseases and prescription drugs.
- Certain lawyers and parties in a law suit if a patient's medical condition is an issue in a law suit.

The goal of Wallace Chiropractic/ Beaman Chiropractic is to protect our patients privacy (Private Health Care Information) at the same time providing them with the most efficient and effective care possible.

Please acknowledge you have read and understood the above description and understand that in order to give you the most efficient care any and all records regarding a healthcare issue will be forwarded to the facility or physician we may deem appropriate.

Printed Name: _____ Date: _____

Signature: _____ Date: _____

If you require more information regarding HIPAA regulation please contact this office at (702) 474-6996 or (702) 474-4400 and ask for the HIPPA representative.

INFORMED CONSENT TO CHIROPRACTIC CARE

As a patient in our office, you have the right to know about the type of treatment we will use, and complications / side-effects, as well as alternatives to chiropractic care and their complications. This form is intended to inform you of these prior to treatment and receive your written consent for you or your minor child.

The primary treatment used by Chiropractic Physicians is the adjustment or manipulation of the joints of the body to induce motion. The doctor will use the procedure most appropriate to treat your condition as well as ancillary treatments such as prescribing exercises, and using therapeutic modalities.

The nature of the Chiropractic Adjustment: I will use my hands and/ or a mechanical device upon your body in such a way as to move the joints to restore normal function. This procedure may cause an audible "click" or "pop" sound similar to what you feel when you pop your knuckles. You may feel or sense movement of the joint, which usually gives you a very pleasant sense of relief. If a traditional spinal adjustment is inappropriate for your condition, there is other less forceful and gentler type of adjustments that may be used.

The possible risk involved in the Chiropractic Adjustment: Serious complications to chiropractic treatment are rare. However, these may include fractures, disc injuries, dislocations, muscle strain, ligamentous sprain, and nerve injuries. Some patients may feel some stiffness or soreness following the first few days of treatment, which is considered normal.

The probability of serious complications occurring: Fractures, especially of the ribs, are rare occurrences and generally result from some underlying weakness of the bone such as osteoporosis. If you suffer from osteoporosis, please tell you doctor and care steps will be taken to adjust your spine. Stroke has been the subject of much study and debate within the health professions. Manipulation of the neck has been associated with other injuries to the arteries in the neck leading to a stroke in rare instances. Studies have estimated this occurrence rate to be between 1 in 1 million to 1 in 3 million adjustments. To put this in perspective, your chances of being hit by lighting are reported to be 1 in 3 million. We employ tests in our examination which are designed to identify possible risk factors for stroke and we combine this with your medical history and our clinical skills to determine if you are a candidate for cervical manipulation. Disc injuries are frequently successfully treated by chiropractic adjustments, yet occasionally chiropractic treatment may aggravate the problem and rarely surgery may become necessary to treat a disc injury. If necessary, we will refer you to a neurosurgeon or for an MRI exam. These problems are also rare with no reliable statistics to quantify their probability.

Ancillary treatments: In addition to chiropractic adjustments (manipulation of the joints), I intend to use the following treatments as needed to treat you condition:

- *Ice or Heath Packs: these may be used in the office or recommended for home use. Both may, in rare cases, irritate or burn the skin.
- *Myofascial release, Active Release Technique, and Trigger Point Therapy, which may, in rare cases, causes local bruising and soreness.
- *Electrical Stimulation: this therapy consists of a mild electrical current which helps relax tight muscles, blocks pain, reduces swelling, and facilitates healing. There are no known side-effects other than discomfort if the settings are too high. At any time, if any of these procedures are uncomfortable, you are to notify the doctor and/ or staff immediately and the procedure will be modified or discontinued.
- *Therapeutic and rehabilitative exercises, Active Release Technique, Neuromuscular Re-education, and Post Isometric Relaxation (PIR): these may be used to re-educate your muscles to restore normal functions and muscular balance. Every precaution is used to prevent injury. Injuries are rare and are usually from the patient "over doing it" or over stretching. Please follow your doctor's recommendations carefully.

Initial: _____ Date: _____

Alternative Medical Treatments Risks are:

- *Self-administered over the counter NSAIDS may cause gastro-intestinal problems and bleeding of liver and kidney disease. i.e.; Aspirin, Ibuprophen, Aleve, etc.

- *Prescription muscle relaxants and pain killers can produce undesirable side-effects and addictions. They can also make you drowsy and impair your motor skills.

- *Hospitalization and bed rest has the additional risk of exposure to communicable disease, loss of muscle tone and strength at the rate of 4% per day. It is very expensive, and research has shown bed rest has no benefit in helping back pain patients. In fact, it may make your condition worse.

- *Back or neck surgery poses many risk such as: infections, allergic reactions, disfiguring scars, severe loss of blood; loss of function of any limb, organ paralysis, paraplegia or quadriplegia; brain damage; cardiac arrest; death; loss of bladder, bowel or sexual function; increased or continued pain or numbness; injury to vessels in the abdomen; post-operative bleeding; unstable spine requiring fusion; and infection.

- *Injections of pain medications: The risks inherent in using injections or surgery included adverse reactions to anesthesia or the injected medication, iatrogenic (caused by a doctor) problems, hospitalization and possible convalescent time.

The Risks and Dangers of Remaining Untreated: Remaining untreated allows the formation of adhesions and reduced joint motion, which sets up a pain reaction further reducing mobility. Over time, this process may complicate treatment making it more difficult and less effective the longer it is postponed. Disc degeneration, joint arthritis, nerve damage and muscle weakness may progress if your spinal problem goes untreated.

DO NOT SIGN UNTIL YOU HAVE READ AND UNDERSTAND THE ABOVE INFORMATION

I have read, or have had read to me, the above information. I have had an opportunity to ask my questions, and all my questions have been answered fully and satisfactorily. By signing below, I consent to the treatment plan. I intend this consent form to cover the entire course of treatment for my present condition and for any further condition(s) for which I seek treatment in this office. Having considered the nature and risks of chiropractic care, I hereby give my consent to be treated.

Patient's Name (Printed)	Patient's Signature	Date

***If you are a minor, or if you are being represented by another party:**

Name of Parent or Guardian (printed)	Signature of Parent or Guardian	Date

Witness:

Name of Witness (Printed)	Signature of Witness	Date

DR. SCOTT M. WALLACE
Las Vegas Chiropractic Associates

ACKNOWLEDGEMENT- HEALTH INSURANCE

I, _____ hereby affirmatively instruct the provider not to bill my health insurance.

In addition, I understand that prior authorization may be required or the account may become stale dated and that provider will not be able to bill the health insurance, therefore, any future disclosure of health insurance coverage to provider or its assignee will not be considered.

Dated this _____ day of _____, 20_____

_____
Patient Signature

_____
Print Name

_____
Parent or Guardian Signature

_____
Print Name

_____
Witness Signature

8960 W. Cheyenne Ave., Ste. 110, Las Vegas, NV 89129 • Tel: (702) 474-6996 • Fax: (702) 655-4389

DR. SCOTT M. WALLACE

Chiropractic Physician

PHYSICIANS LIEN AND MEDICAL REPORTS AUTHORIZATION

I do hereby authorize this doctor's office to furnish my attorney with a full report of all medical records, including physician's notes, and other documents regarding the incident in which I was involved which required treatment by my doctor.

I do hereby authorize and direct my attorney to pay directly to said doctor such sums as may be due and owing him for medical service rendered me both by reason of this accident and by reason of any other bills that are due his office and to withhold such sums from any settlement, judgement or verdict as may be necessary to adequately protect said doctor. I hereby further give a lien on my case to said doctor against any and all proceeds of my settlement, judgement or verdict which may be paid to you, my attorney, or myself, as the result of the injuries for which I have been treated or injuries in connection therewith.

I agree that I will not rescind this document and that a rescission will not be honored by my attorney. I hereby instruct that in the event of another attorney is substituted in the matter, the new attorney must honor this lien as inherent to the settlement and enforceable upon the case as if it were executed by him. My agreement not to rescind this document is in consideration for my doctor rendering treatment to me while my case is being pursued through the process of negotiation, settlement and/or litigation.

I fully understand that I am directly and fully responsible to said doctor for all medical bills submitted by him for service rendered me and that his agreement is made solely for said doctor's additional protection and in consideration of his awaiting payment. I further understand that such payment is not contingent on any settlement, judgement or verdict by which I any eventually recover said fee.

I therefore acknowledge and fully accept the terms of this document by signing below. I have been advised that if my attorney does not wish to cooperate in protecting the doctor's interest, the doctor will not await payment but will require me to make payments on a current basis and that my doctor may also proceed against my attorney to recover such funds if my attorney receives such funds and refuses or fails to disperse such funds to my doctor.

It is further understood that the doctor shall be entitled to all reasonable cost of collection, including but not limited to, his attorney's fees and cost of suit, to recover his full cost of treatment as a result of myself or my attorney receiving any recovery, settlement, or compromise and failing and/or refusing to pay promptly the doctor for all medical service he and his office have rendered on my behalf.

I further agree that a service charge of two percent (2%) per month on any unpaid balance should be added to any outstanding balance remaining unpaid after ninety (90) days from the date of service, and the undersigned further agrees to pay all cost of collection of any such balance, including reasonable attorney's fees and cost of suit.

Dated_____ _____ _____

Patient's Signature (or Legal Guardian) *Print Patient Name*

Dated_____ _____ _____

Witness Signature *Print Witness Name*

The undersigned being attorney of record for the above patient does hereby agree to observe all the terms of the above and agrees to withhold such sums from any settlement, judgement, verdict, as may be necessary to adequately protect said doctor above-named.

Dated_____ _____ _____

Attorney's Signature *Name of Law Firm*

PLEASE DATE, SIGN AND RETURN ONE COPY TO DOCTOR'S OFFICE

8960 W. Cheyenne Ave., Ste. 110, Las Vegas, NV 89129 • Tel: (702) 474-6996 • Fax (702) 655-4389

Shield
Radiology Consultants Requisition

Toll Free 1-800-330-0772
Facsimile (435) 674-2588
info@shieldradiology.com

PATIENT INFORMATION & MEDICAL HISTORY

☐MVA ☐Acute Injury ☐Insidious Onset ☐Other

☐Malignancies ☐Surgeries ☐Congenital Anomalies

Patient Name (please print clearly) ☐ Female ☐ Male

Patient's Home Address

City, State, Zip Code

Social Security Number | Home Phone Number

Patient Date of Birth | Date of Injury

BILLING INFORMATION

☐Attorney ☐Insurance ☐Patient ☐Referring Physician

See Attached Paperwork ☐Past Medical History ☐Billing

Name of Attorney or Insurance Carrier

Address of Attorney or Insurance Carrier

City, State, Zip Code

Insurance Policy Number | Accident Claim Number

Name of Adjuster | Adjuster's Phone Number

INFORMED CONSENT: I understand and agree that the services of Strehlow Radiology Consulting, LLC, dba Shield Radiology Consulting ("SRC"), are being used to provide a secondary review and interpretation of my x-rays or other advanced imaging study for the purpose of determining the extent of any damage, diagnose and/or to determine the best course of treatment. I understand that there is a separate fee for this service and that all costs for services may be billed by SRC. In accordance with the Medicare Act, this is to advise you that this is a non-covered service.

RELEASE OF INFORMATION: I hereby authorize the SRC to obtain from, and to furnish to, my physician, attorney, and/or insurance carrier a full report of my case history, medical records, examination results, diagnosis, and prognosis as they relate to my accident, claim, treatment or illness.

DOCTORS LIEN: I hereby expressly grant to SRC a lien on any settlement, claims, judgments, verdicts or proceeds whatsoever arising from my accident or illness. I further expressly instruct, authorize and direct my attorney and insurance carrier to pay directly SRC at Shield Radiology Consulting, LLC, 144 W. Brigham Rd., Suite 8B-5 - St. George, UT 84790 all sums due and owing SRC for the services rendered to me or on my behalf, and to withhold such sums from any settlement, claim, judgment, verdict as are necessary to pay the same. I UNDERSTAND THAT I AM DIRECTLY RESPONSIBLE TO SRC FOR ALL CHIROPRACTIC OR RADIOLOGY BILLS SUBMITTED BY SRC FOR SERVICES RENDERED TO ME OR ON MY BEHALF, and that this agreement is made solely for SRC's protection and to insure payment. I expressly acknowledge and agree that payments for services to SRC are not contingent on any recovery, settlement, claim, judgment, or verdict being recovered by me. I understand and agree that this agreement shall be binding upon any substitute counsel retained by me and that I will promptly notify SRC of any change in counsel/attorney or changes in my home address.

SIGNATURES & COPIES: I hereby authorize SRC as my attorney-in-fact for the purposes of signing any two-party checks received by SRC any time payment is made in the form of a two-party check or when dual signatures are required for payment of services from an insurance company or third party payer. I do hereby warrant and agree that a photocopy or facsimile of this document will be as valid & binding on all parties involved as the original document.

Patient Signature or Guardian Signature Date

Referring Physician or Office

Being the Attorney of record or an authorized representative for the above named patient does hereby acknowledge this lien and does agree to honor the same to protect adequately Shield Radiology.

Attorney Signature or Authorized Representative

Disabilities of the Arm, Shoulder and Hand

Please rate your ability to do the following activities in the last week by circling the number below the appropriate response.

	NO DIFFICULTY	MILD DIFFICULTY	MODERATE DIFFICULTY	SEVERE DIFFICULTY	UNABLE
1. Open a tight or new jar.	1	2	3	4	5
2. Write.	1	2	3	4	5
3. Turn a key.	1	2	3	4	5
4. Prepare a meal.	1	2	3	4	5
5. Push open a heavy door.	1	2	3	4	5
6. Place an object on a shelf above your head.	1	2	3	4	5
7. Do heavy household chores (e.g., wash walls, wash floors).	1	2	3	4	5
8. Garden or do yard work.	1	2	3	4	5
9. Make a bed.	1	2	3	4	5
10. Carry a shopping bag or briefcase.	1	2	3	4	5
11. Carry a heavy object (over 10 lbs).	1	2	3	4	5
12. Change a lightbulb overhead.	1	2	3	4	5
13. Wash or blow dry your hair.	1	2	3	4	5
14. Wash your back.	1	2	3	4	5
15. Put on a pullover sweater.	1	2	3	4	5
16. Use a knife to cut food.	1	2	3	4	5
17. Recreational activities which require little effort (e.g., cardplaying, knitting, etc.).	1	2	3	4	5
18. Recreational activities in which you take some force or impact through your arm, shoulder or hand (e.g., golf, hammering, tennis, etc.).	1	2	3	4	5
19. Recreational activities in which you move your arm freely (e.g., playing frisbee, badminton, etc.).	1	2	3	4	5
20. Manage transportation needs (getting from one place to another).	1	2	3	4	5
21. Sexual activities.	1	2	3	4	5

DISABILITIES OF THE ARM, SHOULDER AND HAND

	NOT AT ALL	SLIGHTLY	MODERATELY	QUITE A BIT	EXTREMELY
22. During the past week, *to what extent* has your arm, shoulder or hand problem interfered with your normal social activities with family, friends, neighbours or groups? *(circle number)*	1	2	3	4	5

	NOT LIMITED AT ALL	SLIGHTLY LIMITED	MODERATELY LIMITED	VERY LIMITED	UNABLE
23. During the past week, were you limited in your work or other regular daily activities as a result of your arm, shoulder or hand problem? *(circle number)*	1	2	3	4	5

Please rate the severity of the following symptoms in the last week. *(circle number)*

	NONE	MILD	MODERATE	SEVERE	EXTREME
24. Arm, shoulder or hand pain.	1	2	3	4	5
25. Arm, shoulder or hand pain when you performed any specific activity.	1	2	3	4	5
26. Tingling (pins and needles) in your arm, shoulder or hand.	1	2	3	4	5
27. Weakness in your arm, shoulder or hand.	1	2	3	4	5
28. Stiffness in your arm, shoulder or hand.	1	2	3	4	5

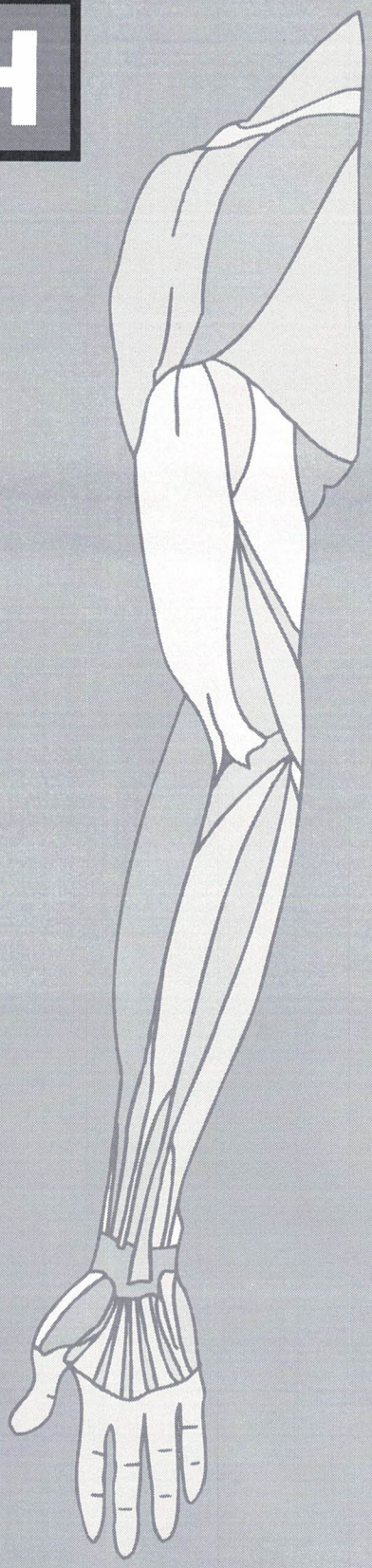
	NO DIFFICULTY	MILD DIFFICULTY	MODERATE DIFFICULTY	SEVERE DIFFICULTY	SO MUCH DIFFICULTY THAT I CAN'T SLEEP
29. During the past week, how much difficulty have you had sleeping because of the pain in your arm, shoulder or hand? *(circle number)*	1	2	3	4	5

	STRONGLY DISAGREE	DISAGREE	NEITHER AGREE NOR DISAGREE	AGREE	STRONGLY AGREE
30. I feel less capable, less confident or less useful because of my arm, shoulder or hand problem. *(circle number)*	1	2	3	4	5

DASH DISABILITY/SYMPTOM SCORE = _____ ([(sum of n responses / n) - 1] x 25, where n is the number of completed responses.)

A DASH score may <u>not</u> be calculated if there are greater than 3 missing items.

THE DASH



INSTRUCTIONS

This questionnaire asks about your symptoms as well as your ability to perform certain activities.

Please answer *every question*, based on your condition in the last week, by circling the appropriate number.

If you did not have the opportunity to perform an activity in the past week, please make your *best estimate* on which response would be the most accurate.

It doesn't matter which hand or arm you use to perform the activity; please answer based on your ability regardless of how you perform the task.

DISABILITIES OF THE ARM, SHOULDER AND HAND

WORK MODULE (OPTIONAL)

The following questions ask about the impact of your arm, shoulder or hand problem on your ability to work (including homemaking if that is your main work role).

Please indicate what your job/work is:_____

❒ I do not work. (You may skip this section.)

Please circle the number that best describes your physical ability in the past week. Did you have any difficulty:

	NO DIFFICULTY	MILD DIFFICULTY	MODERATE DIFFICULTY	SEVERE DIFFICULTY	UNABLE
1. using your usual technique for your work?	1	2	3	4	5
2. doing your usual work because of arm, shoulder or hand pain?	1	2	3	4	5
3. doing your work as well as you would like?	1	2	3	4	5
4. spending your usual amount of time doing your work?	1	2	3	4	5

SPORTS/PERFORMING ARTS MODULE (OPTIONAL)

The following questions relate to the impact of your arm, shoulder or hand problem on playing *your musical instrument or sport or both*.
If you play more than one sport or instrument (or play both), please answer with respect to that activity which is most important to you.

Please indicate the sport or instrument which is most important to you:_____

❒ I do not play a sport or an instrument. (You may skip this section.)

Please circle the number that best describes your physical ability in the past week. Did you have any difficulty:

	NO DIFFICULTY	MILD DIFFICULTY	MODERATE DIFFICULTY	SEVERE DIFFICULTY	UNABLE
1. using your usual technique for playing your instrument or sport?	1	2	3	4	5
2. playing your musical instrument or sport because of arm, shoulder or hand pain?	1	2	3	4	5
3. playing your musical instrument or sport as well as you would like?	1	2	3	4	5
4. spending your usual amount of time practising or playing your instrument or sport?	1	2	3	4	5

SCORING THE OPTIONAL MODULES: Add up assigned values for each response; divide by 4 (number of items); subtract 1; multiply by 25.
An optional module score may <u>not</u> be calculated if there are any missing items.

INSTITUTE FOR WORK & HEALTH
INSTITUT DE RECHERCHE SUR LE TRAVAIL ET LA SANTÉ

AAOS COMSS

THE LOWER EXTREMITY FUNCTIONAL SCALE

We are interested in knowing whether you are having any difficulty at all with the activities listed below because of your lower limb Problem for which you are currently seeking attention. Please provide an answer for **each** activity.

Today, do you or would you have any difficulty at all with:

	Activities	Extreme Difficulty or Unable to Perform Activity	Quite a Bit of Difficulty	Moderate Difficulty	A Little Bit of Difficulty	No Difficulty
1	Any of your usual work, housework, or school activities.	0	1	2	3	4
2	Your usual hobbies, re creational or sporting activities.	0	1	2	3	4
3	Getting into or out of the bath.	0	1	2	3	4
4	Walking between rooms.	0	1	2	3	4
5	Putting on your shoes or socks.	0	1	2	3	4
6	Squatting.	0	1	2	3	4
7	Lifting an object, like a bag of groceries from the floor.	0	1	2	3	4
8	Performing light activities around your home.	0	1	2	3	4
9	Performing heavy activities around your home.	0	1	2	3	4
10	Getting into or out of a car.	0	1	2	3	4
11	Walking 2 blocks.	0	1	2	3	4
12	Walking a mile.	0	1	2	3	4
13	Going up or down 10 stairs (about 1 flight of stairs).	0	1	2	3	4
14	Standing for 1 hour.	0	1	2	3	4
15	Sitting for 1 hour.	0	1	2	3	4
16	Running on even ground.	0	1	2	3	4
17	Running on uneven ground.	0	1	2	3	4
18	Making sharp turns while running fast.	0	1	2	3	4
19	Hopping.	0	1	2	3	4
20	Rolling over in bed.	0	1	2	3	4
	Column Totals:					

Minimum Level of Detectable Change (90% Confidence): 9 points

SCORE: _____/ 80

Please submit the sum of responses.

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