Pow-Her Chiropractic 600 Jefferson Plaza Suite 350 Rockville MD 20852 www.powherchiro.com

PATIENT REGISTRATION

Name_____ Social Security #_____ Date: _____
Last First MI

Address_____
Number Street City ST Zip

Sex: M / F Age: _____ Birth Date: _____ Height:_____ Weight: _____

Home # _____ Work # _____ Cell#_____ Single/Married/Divorced/Widow

Employer _____ Type of Work you do_____

In case of emergency contact_____ Relationship _____ Phone # _____

Email: _____ How did you hear about us?_____

Preferred way of communication: Home / Cell / Work / Email / Text

CAR INSURANCE INFORMATION

[ ] No car Insurance

YOUR CAR INSURANCE

Insured Person: [ ] Self [ ] Other

(Other) Social Security #_____
Ins. Provider:_____
Your Claim # _____
* *Contact person/adjuster:* _____
Phone # _____

[ ] No Health Insurance

YOUR HEALTH INSURANCE

Insured Person: [ ] Self [ ] Other
Social Security # _____
Plan Name:_____
Group # _____
Policy #_____

TREATMENT OF MINOR

[ ] Not applicable

Guardian's Name_____ Social Security #_____
Relationship to Patient _____ Home # _____ Work # _____
Address (if different) _____
Place of Employment _____

I hereby authorize Pow-Her Chiropractic and all it designates to treat this minor who is legally under my guardianship.

Signature_____ Date_____

RELEASE AND ASSIGNMENT

The information that I have given is correct to the best of my knowledge. I understand that it will be held in the strictest of confidence, and that it is my responsibility to notify this office of any changes. I further will not hold my doctor or any member of the staff responsible for any errors or omissions that I have made in the completion of this form.

I hereby authorize Pow-Her Chiropractic and or any of its subsidiaries to release all information necessary to secure the payment of benefits. I authorize the use of the signature on all insurance submissions. I hereby authorize and assign directly to Pow-Her Chiropractic all insurance benefits, if any, payable to services rendered. I understand that I am responsible for all charges whether or not paid by insurance.

Signature Date

Witness Date

Pow-Her Chiropractic 600 Jefferson Plaza Suite 350 Rockville MD 20852 www.powherchiro.com

CLINICAL HISTORY

Circle if you have a history of any of the following:

Skin
Rash
Eczema
Itching
Skin Changes
Redness
Bruise easily
Hair changes

Neurologic
Headache
Dizziness
Fainting
Convulsion
Nervousness
Confusion
Numbness
Paralysis
Cold/tingling extremities

Eyes/Ears
Hearing trouble
Ringing
Vision Trouble
Pain
Discharge

Musculoskeletal
Neck pain
Upper back pain
Low back pain
Upper extremity pain
Lower extremity pain
Jaw pain
General stiffness
Walking problems

Nose
Pain
Bleeding
Sinus Problems
Infections
No Smell

Mouth/Throat
Sores
Bleeding
Tonsilitis
Enlarged Glands
No Taste
Abnormal Taste
Bad breath

Heart Lungs
Cough
Wheezing
Asthma
Difficulty Breath
Swollen UE/LE
Blue UE/LE
Varicosities
Murmur
Chest Pain
Palpitations

Breasts
Lumps
Redness/Itching
Pain
Dimpling
Discharge

Stomach/Digestion
Decreased Appetite
Increased Appetite
Abdominal Pain
Hemorrhoids
Excess Gas
Vomit
Diarrhea
Constipation

Genitourinary
Inability hold urine
Painful Urination
Frequent Urination
Bedwetting
Irregular Menstruation
Painful Menstruation
Abnormal Vaginal Bleeding
Prostate Problems
Sterility

Endocrine
Thyroid
Heat/Cold intolerance
Sugar in urine
Goiter
Tremor

Psychological
Anxiety
Depression
Phobia
Mood Swings
ADD/ADHD
Mental Disorders

Arthritis / Anemia / Cancer / Diabetes / Epilepsy / Gout / Gallbladder / Hypertension / Influenza / Kidney disease / Lupus /Nausea / Vomiting / TB / Polio / Migraines / Mumps / Multiple Sclerosis / Psoriasis / Rheumatoid Arthritis / Scoliosis / Hernia / Lyme Disease

Broken Bones Y/N Explain:_____

Pregnant: Y/N _____ Last Mammogram:_____ Last prostate exam:_____

Doctor's you have seen in past 2 years:_____

Surgeries you have had: _____

Allergies: _____

List Drugs or Supplements: _____

Children: (# & ages) _____

Smoker packs per day_____ Caffeine (soda,coffee,tea) cups per day _____

Alcohol per day/week: _____ Commute:_____

Hobbies:_____

List health conditions family members have/had:

Mother:_____ Father:_____

Sister:_____ Brother:_____

Grandparents:_____ Children:_____

Have you ever been to a chiropractor? Y/N If yes explain:_____

Signature Date

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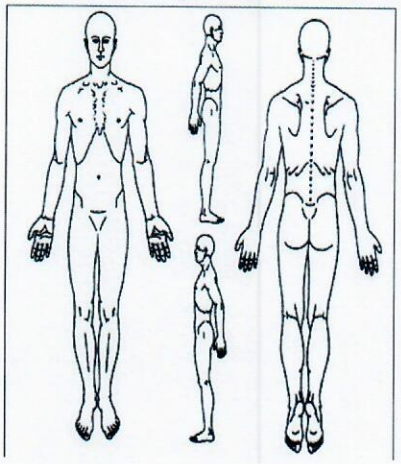
INJURY SURVEY



1. **Please outline the area(s) of your discomfort on the diagram.**
2. When did your symptoms begin: Month_____ Day_____ Year_____
3. Where did your symptoms begin? Home, Work, Accident_____
4. How did you hurt yourself:_____
5. What helps the pain feel better: Moving/Sit/Laying/Rest/Exercise/Nothing Other:_____Medications_____
6. What makes the pain worse: Sitting/Standing/Laying _____
7. Rate your overall pain on a scale 1-10 (0-well to 10-severe) morning____afternoon___evening ____overall_____

Please Circle Areas of Complaint:

Headaches	Mild Mod Severe	Occasional	Intermittent	Frequent	Constant	1-10
Neck Pain	Mild Mod Severe	Occasional	Intermittent	Frequent	Constant	
R/L Shoulder Pain	Mild Mod Severe	Occasional	Intermittent	Frequent	Constant	
R/L Arm	Mild Mod Severe	Occasional	Intermittent	Frequent	Constant	
R/L Elbow	Mild Mod Severe	Occasional	Intermittent	Frequent	Constant	
R/L Forearm	Mild Mod Severe	Occasional	Intermittent	Frequent	Constant	
R/L Wrist	Mild Mod Severe	Occasional	Intermittent	Frequent	Constant	
R/L Hand	Mild Mod Severe	Occasional	Intermittent	Frequent	Constant	
Upper Back Pain	Mild Mod Severe	Occasional	Intermittent	Frequent	Constant	
Midback Pain	Mild Mod Severe	Occasional	Intermittent	Frequent	Constant	
Lower Back Pain	Mild Mod Severe	Occasional	Intermittent	Frequent	Constant	
Buttock Pain	Mild Mod Severe	Occasional	Intermittent	Frequent	Constant	
R/L Hip Pain	Mild Mod Severe	Occasional	Intermittent	Frequent	Constant	
R/L Thigh Pain	Mild Mod Severe	Occasional	Intermittent	Frequent	Constant	
R/L Knee Pain	Mild Mod Severe	Occasional	Intermittent	Frequent	Constant	
R/L Ankle Pain	Mild Mod Severe	Occasional	Intermittent	Frequent	Constant	
R/L Foot Pain	Mild Mod Severe	Occasional	Intermittent	Frequent	Constant	
Other:	Mild Mod Severe	Occasional	Intermittent	Frequent	Constant	

Quality of pain:	Ache/ Dull	Sharp	Shooting	Stabbing	Throbbing
	Numb/Tingling	Sore	Deep	Electric	Fiery

8. Have you ever had this before: Y/N When? _____
9. Have you seen anyone else for the pain: Date/Provider/Treatment_____
_____
10. Have you missed work due to the pain? _____ Have you lost sleep due to the pain?_____
11. Have you been limited in any activities due to this pain? _____
12. Do you exercise? ( )Yes ( )No Has your exercise been hindered by this injury? ( )Yes ( )No

    Type of Exercise:_____

Motor Vehicle Accident Information

Last Name:	Social Security no.:
First Name:	Middle:

General Information

Date of Accident:			
Location (circle one)	**Driver**		
	Passenger	Location (circle one)	Front / Middle / Rear
		Position (circle one)	Left / Middle / Right

Work from Left to Right and Circle One

Patients Vehicle	**Type :**	Car / Van / Pickup / Truck / Bus / SUV / M. Cycle / Other:
	Size :	Mini / Sub Comp / compact / Mid Size / Full Size
	Action :	Stopped / Slowing / Acceleration / Cruising
	Speed : (MPH)	
	Time of Accident:	Day Light / Dawn / Dusk / Dark
	Road Condition :	Dry / Damp / Wet / Snow / Ice
	Visibility :	Good / Fair / Poor

Enter impact Information for up to three Vehicles or Objects

Impact Information: Vehicle or Object (I)

(Select one)	**Name Object :**	
☐ **Vehicle**	**Vehicle Type :**	Car / Van / Pickup / Truck / Bus / SUV / M. Cycle / Other:
	Size :	Mini / Sub Comp / compact / Mid Size / Full Size
☐ **Object**	**Damage to Veh.:**	Minimal / Moderate / Extensive / Totaled / Unsure
Impact Location		

Impact Information: Vehicle or Object (II)

(Select one)	**Name Object :**	
☐ **Vehicle**	**Vehicle Type :**	Car / Van / Pickup / Truck / Bus / SUV / M. Cycle / Other:
	Size :	Mini / Sub Comp / compact / Mid Size / Full Size
☐ **Object**	**Damage to Veh.:**	Minimal / Moderate / Extensive / Totaled / Unsure
Impact Location		

Impact Information: Vehicle or Object (III)

(Select one)	**Name Object :**	
☐ **Vehicle**	**Vehicle Type :**	Car / Van / Pickup / Truck / Bus / SUV / M. Cycle / Other:
	Size :	Mini / Sub Comp / compact / Mid Size / Full Size
☐ **Object**	**Damage to Veh.:**	Minimal / Moderate / Extensive / Totaled / Unsure
Impact Location		

During Impact Information:

Seat Belt?	☐ Yes	☐ No	Brakes Applied ?	☐ Yes	☐ No
Air Bag Deployed?	☐ Yes	☐ No	Seat Broken ?	☐ Yes	☐ No
Seat Back position Changed?	☐ Yes	☐ No			

Head Rest : (Circle one)	Low / Mid / High / None
Prepare for Accident: (Circle One)	Un-expected / Expected / Expected and Braced
Body Position : (Circle one)	Straight / Rotated Left / Rotated Right / Unsure / Other:
Body Thrown?	☐ Yes / ☐ No
Direction of Throw :(Circle One)	Backwards / Forward / Outside / Unsure / Other:

(Circle One)

Head Position :	Straight / Rotated Left / Rotated Right / Forward / Unsure / Other:
Head Motion :	Forward Backwards / Backwards Forward / Right Left / Left Right / Unsure / Other:

Body Impact (Indicate any parts of your body that were struck during the impact)

☐ Head	☐ Upper Back	☐ Right hand	☐ Lower Back
☐ Left Shoulder	☐ Left Leg	☐ Mid Torso	☐ Right Foot
☐ Left Arm	☐ Right Leg	☐ Mid Back	☐ Left Foot
☐ Left Elbow	☐ Right Shoulder	☐ Right Knee	☐ Other :
☐ Left hand	☐ Right Arm	☐ Left Knee	
☐ Upper Front Torso	☐ Right Elbow	☐ Lower Front Torso	

After Accident Information:

Immediately After Accident:	☐ Dizzy/dazed ☐ Upset ☐ Weak ☐ Nervous ☐ Headache ☐ Disoriented ☐ Unconscious ☐/Other:

Pain (Indicate if you experienced any pain immediately following the accident)

☐ Head	☐ Left foot	☐ Right foot	☐ Left Knee
☐ Left Hand	☐ Left Shoulder	☐ Right Shoulder	☐ Right knee
☐ Right Arm	☐ Left Elbow	☐ Left Arm	☐ Other :
☐ Upper Front Torso	☐ Mid Torso	☐ Right elbow	
☐ Upper Back	☐ Mid back	☐ Lower Front Torso	
☐ Left Leg	☐ Right Leg	☐ Lower Back	

Numbness:	☐Left Hand ☐ Right Hand ☐ Left Leg ☐ Right Leg ☐ Left Upper Arm ☐ Right Upper Arm ☐ Left Foot ☐ Right Foot ☐ Other:

Medical Information (Did you get medical care for this accident before coming to our office)

Medical Care?	☐ Yes	☐ No

Time of care	Next day / At time of Accident / Later that Day / Days Later: (Specify)
Transported	Drove Self / Ambulance / Other
Went To	Orthopedic / Chiropractor / Neurologist / Family Doc / ER / Other:(Specify)
Admitted to Hospital?	☐ Yes ☐ No Days Spent in Hospital:
Test:	☐ X-ray ☐ Lab Work ☐ MRI ☐ CT Scan ☐ Other:(Specify)
Treatment:	☐ Ice Pack ☐ Hot Pack ☐ None ☐ Cervical Collar ☐ Medication ☐ Other:(Specify)

Previous Injuries

Previous Injuries / Accidents	☐ No ☐ Yes, Specify:
Residual pain from Previous Injuries/Accidents	☐ No ☐ Yes, Specify:

Later Symptoms (Please note any symptoms that started after the accident occurred)

Head	☐ Headache ☐ Dizziness ☐ Blurred Vision ☐ Light Headedness ☐ Loss of Vision ☐ Fainting ☐ Loss of Memory ☐ Pain in ear ☐ Double Vision ☐ Other Specify:
Neck (with Movement)	☐ Pain in Neck ☐ Forward ☐ Backward ☐ Turn Left ☐ Popping in Neck ☐ Muscle Spasms ☐ Turn Right ☐ Bend Left ☐ bend Right ☐ Other Specify:
Shoulders	☐ Pain in Shoulder joint ☐ Tension in shoulders ☐ Muscle Spasms in Shoulder ☐ Pain across shoulder ☐ Cant raise arms above [ ] Above shoulder level [ ] Over head ☐ Other Specify:
Arms and Hands	☐ Pain in Fingers ☐ Numbness in Left Arm ☐ Hands Cold ☐ Pin & needles in hands ☐ Numbness in Right Arm ☐ Loss of Grip Strength ☐ Pin & needles in fingers ☐ Swollen joints in Fingers ☐ Other Specify:
Chest	☐ Chest pain ☐ Pain Around Ribs ☐ Shortness of Breadth ☐ Breast Pain ☐ Other Specify:
Abdomen	☐ Nervous Stomach ☐ Nausea ☐ Diarrhea ☐ Gas ☐ Constipation ☐ Other Specify:
Mid back	☐ Sharp Stabbing ☐ Mid pain back ☐ Pain From front to back ☐ Dull Ache ☐ Pain in Kidney Area ☐ Muscle Spasms ☐ Pain between shoulders ☐ Other Specify:
Lower Back	☐ Low Back Pain Low back pain is worse when ☐ Working ☐ Lifting ☐ Stooping ☐ Standing ☐ Sitting ☐ Bending ☐ Coughing ☐ Lying Down ☐ Muscle Spasms ☐ Other Specify:
Hips, Legs & Feet	☐ Pain in Buttocks ☐ Pain and needles in Legs ☐ Pain down leg ☐ Pain in hip joint ☐ Feet feel Cold ☐ Swollen Feet ☐ Numbness in Toes ☐ Numbness of Leg ☐ Knee pain ☐ Leg cramps ☐ Cramps in Feet ☐ Other Specify:
General	☐ Nervousness ☐ Fatigue ☐ Irritable ☐ Depressed ☐ Generally Feel Rundown ☐ Prostate Pain/Swelling ☐ Difficulty Urinating ☐ Night Urination ☐ Cramping ☐ Irregularity Loss of Sleep : [_____] hrs per night Loss of weight : [_____]lbs Gain weight : [_____] ibs Other:

Signature: _____ Date: _____

All questions contained in this questionnaire are strictly confidential and will become part of your medical record.

Pow-HER Chiropractic
Dr. Cheryl Lee-Pow

600 Jefferson Plaza Suite 350
Rockville MD 20852

www.powherchiro.com
301-279-9009

Authorization and assignment agreement

I, _____ hereby, authorize my chiropractor, Dr. Cheryl Lee Pow to furnish my attorney and/or insurance company named below, copies of medica1reports requested in reference to all illness and/or injuries sustained by me, or my child(ren), including, but not limited to, the injury(ries) which was (were) sustained on_____.

In exchange for furnishing such reports, I do hereby irrevocably assign to you, and do hereby authorize and direct said attorney(s) and/or insurance company to pay directly to you, therefore the proceeds of any recovery in claim or case to the extent of all your charges for services rendered (and, also including, for reports, conference preparation for testimony, deposition, and court testimony as an expert witness), whether said proceeds of monies received from PIP, med-pay, no fault, or any other insurance policy. Furthermore, I do hereby specifically agree payment of above said proceeds directly to Dr. Cheryl Lee Pow, D.C. and do hereby authorize and direct an additional, future, new or other succeeding attorney(s) or other representative(s) of mine, or of my child(-en), to the same.

I understand and agree that this Assignment & Authorization Agreement in NO way relieves me of my personal primary responsibility to pay for such service, and payment for such services is NOT contingent upon recovery of my claim or case. Furthermore, in the event my account is placed with an attorney for collection, I agree to pay costs incurred in the collection of these charges including but not limited to court costs, filing fees, and attorney fees. This Authorization & Assignment Agreement is in addition to and a reaffirmation of any and all terms accepted and the Fee Agreement and all terms of the Fee Agreement are incorporated herein by reference into this Authorization & Assignment.

I further direct and the undersigned agrees to withhold and pay from any proceeds from settlement collection judgment, PIP, med-pay or other insurance proceeds the amount of the provider's charges) after contacting the provider's office for a current balance. The undersigned also agrees to advise within ten (10) days of the provider's request, the status of the above-referenced claim and to notify the provider immediately of any change in the status of the above-referenced claim which may preclude payment of the provider's charges. Additionally, the undersigned agrees to require any attorney to whom the undersigned refers, within or outside the firm, to honor the assignment as a condition of referral and obtain their written confirmation of the same and cooperate fully furnishing home and work address information about the patient or family to aid in the collection of the bill, waive any pre-existing attorney-client privilege that might otherwise prevent my attorney's full cooperation.

It is further understood that the statute of limitations is three (3) years from the time said services were performed, I further understand that because of long delays in trail docket, many cases are not tried or settled until a date which is beyond three (3) years after the last service was performed. In view of this, I hereby agree that statute of limitations with respect to any claim for services mentioned above will not begin to run until there is denial in writing by me of the balance claimed to be due to you by me.

_____
Patient's Signature/Date

_____
Attorney's Signature/Date

_____
Spouse's Signature/Date

_____
Name of Attorney's Firm

Pow-HER Chiropractic
600 Jefferson Plaza, Suite 350
Rockville, Maryland, 20850
Phone: 301-279-9009 Fax: 301-279-9008

Patient: _____
Print

Lawyer: _____
Print

RE: PATIENT RECORDS AND DOCTOR'S LIEN

I do hereby authorize the above provider to furnish you, my attorney/insurance carrier, with a full report of his/her case history, examination, diagnosis, treatment, and prognosis of myself in regard to my, accident/illness which occurred/began on:_____

I hereby give a lien to said provider on any settlement, judgment, or verdict as a result of said accident/il1ness, and authorize and direct you, my attorney/insurance carrier to pay directly to said provider such sums as may be due and owing him/her for services rendered me, and to withhold such sums from such settlement, claim, judgment, or verdict as may be necessary to protect said provider adequately.

I fully understanding that I am directly and fully responsible to said provider for all bills submitted by he/she for service rendered me, and that this agreement is made solely for said provider's additional protection and in consideration of his /her awaiting payment. I further understand that such payment is not contingent on any settlement, claim, judgment, or verdict by which I may eventually recover said funds.

I further agree to be fully responsible for reasonable attorney's fees and cost that have accrued due to the pursuance of payment of my account. Also, that in the event of non- compliance to payment agreement I understand the amount of balance due will be subject to a 1% per month service charge.

Dated: _____ Patient's Signature: _____

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

Dated: _____ Attorney's Signature: _____

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Dr. Cheryl Lee-Pow

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Rockville MD 20852

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301-279-9009

Patient Name: _____ Date: ___/_____/20___

Duties Under Duress Summary

Complete the following questionnaire as it relates to how your injury(s) affect your performance of your living and work duties. Place a check in front of the day to day **living duties which are painful or difficult for you to perform as a result of the injuries** you sustained in the motor vehicle collision. Then check mark the appropriate box designating reason for difficulty. Include those duties/responsibilities which require that you reduce the time you are capable of performing them.

Job description: _____

N/A	Work	Reason for the difficulty
_____	Lifting	□ Increased Pain □ Restricted movement □ Weakness
_____	Bending	□ Increased Pain □ Restricted movement □ Weakness
_____	Sitting	□ Increased Pain □ Restricted movement □ Weakness
_____	Walking	□ Increased Pain □ Restricted movement □ Weakness
_____	Computer duties	□ Increased Pain □ Restricted movement □ Fatigue
Other: _____		□ Increased Pain □ Restricted movement □ Weakness

N/A	Studies/School	Reason for the difficulty
_____	Lifting	□ Increased Pain □ Restricted movement □ Weakness
_____	Bending	□ Increased Pain □ Restricted movement □ Weakness
_____	Sitting	□ Increased Pain □ Restricted movement □ Weakness
_____	Walking	□ Increased Pain □ Restricted movement □ Weakness
_____	Computer duties	□ Increased Pain □ Restricted movement □ Fatigue
_____	Studying	□ Increased Pain □ Restricted movement □ Fatigue
Other: _____		□ Increased Pain □ Restricted movement □ Weakness

N/A	Domestic Duties	Reason for the difficulty
_____	Vacuuming	□ Increased Pain □ Restricted movement □ Fatigue
_____	Taking care of kids	□ Increased Pain/Anxiety □ Restricted movement □ Fatigue
_____	Cleaning	□ Increased Pain □ Restricted movement □ Fatigue
_____	Preparing Meals	□ Increased Pain □ Restricted movement □ Fatigue
_____	Other: _____	□ Increased Pain/Anxiety □ Restricted movement □ Fatigue

N/A	Household Duties	Reason for the difficulty
_____	Yardwork	□ Increased Pain □ Restricted movement □ Fatigue
_____	Transportation	□ Increased Pain/Anxiety □ Restricted movement □ Fatigue
_____	Shopping	□ Increased Pain/Anxiety □ Restricted movement □ Fatigue
_____	Taking out trash	□ Increased Pain □ Restricted movement □ Weakness
_____	Other: _____	□ Increased Pain/Anxiety □ Restricted movement □ Fatigue

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Patient Name: _____ Date: _____/_____/20___

Opportunity for Enjoyment Summary

Complete the following questionnaire as it relates to the **activities** (work related or otherwise) **you normally would be enjoying** - but are **currently not enjoying** as a result of your injury(s). Include all activities which you:

- can no longer do or perform, and/or
- cannot do or perform as often as you did before your injury

Job description_____

N/A	**Work**	**Reason for the limitation**
_____	Lifting	□ Increased Pain □ Restricted movement □ Weakness
_____	Bending	□ Increased Pain □ Restricted movement □ Weakness
_____	Walking	□ Increased Pain □ Restricted movement □ Fatigue
_____	Computer duties	□ Increased Pain □ Restricted movement □ Fatigue
Other: _____		□ Increased Pain/Anxiety □ Restricted movement □ Fatigue

N/A	**Studies/School**	**Reason for the limitation**
_____	Lifting	□ Increased Pain □ Restricted movement □ Weakness
_____	Bending	□ Increased Pain □ Restricted movement □ Weakness
_____	Sitting	□ Increased Pain □ Restricted movement □ Fatigue
_____	Walking	□ Increased Pain □ Restricted movement □ Fatigue
_____	Computer duties	□ Increased Pain □ Restricted movement □ Fatigue
_____	Studying	□ Increased Pain □ Restricted movement □ Fatigue
Other: _____		□ Increased Pain □ Restricted movement □ Fatigue

N/A	**Domestic Duties**	**Reason for the limitation**
_____	Vacuuming	□ Increased Pain □ Restricted movement □ Fatigue
_____	Taking care of kids	□ Increased Pain/Anxiety □ Restricted movement □ Fatigue
_____	Cleaning	□ Increased Pain □ Restricted movement □ Fatigue
_____	Preparing Meals	□ Increased Pain □ Restricted movement □ Fatigue
_____	Other: _____	□ Increased Pain □ Restricted movement □ Fatigue

N/A	**Household Duties**	**Reason for the limitation**
_____	Yardwork	□ Increased Pain □ Restricted movement □ Fatigue
_____	Transportation	□ Increased Pain/Anxiety □ Restricted movement □ Fatigue
_____	Shopping	□ Increased Pain/Anxiety □ Restricted movement □ Fatigue
_____	Taking out trash	□ Increased Pain □ Restricted movement □ Weakness
_____	Other: _____	□ Increased Pain □ Restricted movement □ Weakness

N/A	**Sports**	**Reason for the limitation**
Name Sport: _____		□ Increased Pain □ Restricted movement □ Weakness

Pre-accident level of participation: □ Socially □ Competitively □ Professionally

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PATIENT CONSENT AND FINANCIAL POLICIES

CONSENT FOR EXAMINATION & TREATMENT: I voluntarily consent to receive chiropractic/medical treatment and diagnostic testing at Pow-HER Chiropractic. I know that I am responsible for all charges incurred at this facility. If I have no insurance benefits, payment is due at the time of service. My balance owed to this office will not exceed $50.00 unless I am placed on an authorized payment plan.

INSURANCE ASSIGNMENT OF BENEFITS: In order to receive the best care possible within your benefits, it is important that you comply with our financial policy: I assign payment by my insurance company directly to Pow-HER Chiropractic. If my current policy prohibits direct payment to this office, I instruct my insurance company to make the check out to me and mail it to Pow-HER Chiropractic.

Your insurance policy is a contract between you and the insurance company, and you are responsible for any unpaid or denied claim, and for any collection fees, court costs, and attorney' s fees if your account is turned over for collection. If your insurance company sends you checks, it is your responsibility to deliver them to our office. I hereby authorize you to furnish information to my insurance company concerning my care. I further hereby assign all insurance payments for services rendered to me or my dependents.

Payment is expected at the time of service in the form of a deductible, co-payment or co-insurance payment unless I am placed on an authorized payment plan. It is illegal to waive these fees. I understand that I am financially responsible for charges and co-payments not covered by my insurance carrier. In automobile cases, I will bring my Personal Injury Protection forms (from my automobile insurance carrier), no matter who caused the accident, to this office within four (4) weeks or I am personally responsible for my bill.

If my insurance carrier has not paid a claim within sixty (60) days of submission, I agree to take an active part in the recovery of my claim. If my insurance carrier has not paid a claim within ninety (90) days, I am responsible for the balance owed.

When my schedule of visits is one time per month or less, I am aware that this office will no longer accept insurance assignment. Pow-HER Chiropractic will provide me with an insurance form if I request it.

In the unfortunate event collection procedures are required to collect an outstanding account balance, the patient shall be responsible for all reasonable cost of a collection agency, attorney, and / or court costs.

RELEASE OF INFORMATI0N: I authorize the use and disclosure of health information that pertains to me for treatment, payment, or official operations. I understand that information disclosed pursuant to this authorization may be re-disclosed to additional parties and no longer protected. In addition I authorize Pow-HER Chiropractic to share findings/send reports to my family physician or other health care provider listed on my health history form.

I understand that I may revoke this authorization at any time by signing the revocation of my copy of this form and returning it to Pow-HER Chiropractic. I further understand that any such revocation does not apply to the extent that persons authorized to use or disclose my health information have already acted in reliance on this authorization.

I understand this authorization will automatically expire at the end of my treatment cycle. I understand that I have the right to inspect and to obtain a copy of any information disclosed pursuant to this authorization. I understand that Pow-HER Chiropractic will receive compensation for the uses and disclosures that I have authorized.

I authorize Pow-HER Chiropractic to leave any message necessary at my home/work in regards to any appointments, billing or insurance issues that may accrue.

I authorize Pow-HER Chiropractic to allow my spouse or anyone listed below to schedule or cancel an appointment on my behalf.

_____ _____ _____

Patient's or Patient's Guardian's Name (Signature) Patient's or Patient's Guardian's Name (Please Print)

Pow-HER Chiropractic
Dr. Cheryl Lee-Pow
600 Jefferson Plaza Suite 350
Rockville MD 20852
www.powherchiro.com
301-279-9009

CHIROPRACTIC

It is important to acknowledge the difference between the health care specialties of chiropractic, osteopathy and medicine. Chiropractic health care seeks to restore health through natural means without the use of medicine or surgery. This gives the body maximum opportunity to utilize its inherent recuperative powers. The success of the chiropractic doctor's procedures often depends on environment, underlying causes, physical and spinal conditions. It is important to understand what to expect from chiropractic health care services.

ANALYSIS

A doctor of chiropractic conducts a clinical analysis for the express purpose of determining whether there is evidence of Vertebral Subluxation Syndrome (VSS) or Vertebral Subluxation Complexes (VSC). When such VSS and VSC complexes are found, chiropractic adjustments and ancillary procedures may be given in an attempt to restore spinal integrity. It is the chiropractic premise that spinal alignment allows nerve transmission throughout the body and gives the body an opportunity to use its inherent recuperative powers. Due to the complexities of nature, no doctor can promise you specific results. This depends upon the inherent recuperative powers of the body. The incidence of complications associated with chiropractic services are extremely rare, anyone undergoing adjusting or manipulative procedures should know the rare possible hazards and complications that may be encountered or result during the course of care. These include but are not limited to fractures, disc injuries, strokes, dislocations, sprains and those which relate to physical aberrations unknown or undetectable by the doctor. Sometimes the response is phenomenal. _____

Initial Here

DIAGNOSIS

Although doctors of chiropractic are experts in chiropractic diagnosis, the VSS and VSC, they are not internal medical specialists. Every chiropractic patient should be mindful of his/her own symptoms and should secure other opinions if he/she has any concern as to the nature of his/her total condition. Your doctor of chiropractic may express an opinion as to whether or not you should take this step, but you are responsible for the final decision.

INFORMED CONSENT FOR CHIROPRACTIC CARE

I understand and give the doctor permission and authority to care for me in accordance with the chiropractic test, diagnosis and analysis. The practice of chiropractic or medicine is not an exact science and that the care may involve the making of judgments based on the facts known to the doctor. The chiropractic adjustment or other clinical procedures are usually beneficial and seldom cause any problem. In rare cases, underlying physical defects, deformities or pathologies may render the patient susceptible to injury. The doctor, of course, will not give a chiropractic adjustment, or health care, if he/she is aware that such care may be contraindicated. Again, it is the responsibility of the patient to make it known or to learn through health care procedures whatever he/she is suffering from: latent pathological defects, illnesses, or deformities which would otherwise not come to the attention of the doctor of chiropractic. The patient should look to the correct specialist for the proper diagnostic and clinical procedures. The doctor of chiropractic provides a specialized, non-duplicating health service. The doctor of chiropractic is licensed in a special practice and is available to work with other types of providers in your health care regime. It is not reasonable to expect the doctor to be able to anticipate or explain all risks and complications, or an undesirable result does not necessarily indicate an error in judgment or treatment. In addition there is no guarantee as to results with respect to any course of care or treatment.

RESULTS

The purpose of chiropractic services is to promote natural health. Since there are so many variables, it is difficult to predict the time schedule or efficacy of the chiropractic procedures. In most cases there is a more gradual, but quite satisfactory response. Occasionally, the results are less than expected. Two or more similar conditions may respond differently to the same chiropractic care. Many medical failures find quick relief through chiropractic. In turn, we must admit that conditions which do not respond to chiropractic care may come under the control or be helped through medical science. The fact is that the science of chiropractic and medicine may never be so exact as to provide definite answers to all problems. Both have made great strides in alleviating pain and controlling disease.

TO THE PATIENT

Please discuss any questions or problems with the doctor before signing this statement of policy. I have read and understand the Informed Consent Form.

Signature: _____ Date: _____

Witness: _____ Date: _____

Pow-HER Chiropractic
600 Jefferson Plaza, Suite 350
Rockville, Maryland, 20850
Phone: 301-279-9009 Fax: 301-279-9008

Notice of Privacy Practices

Effective Monday, September 23, 2013

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THAT INFORMATION. PLEASE REVIEW THIS NOTICE CAREFULLY.

The Practice (the "Practice"), in accordance with the Health Insurance Portability and Accountability Act (HIPAA) Privacy Rule, (the "Privacy Rule") and applicable state law, is committed to protecting the privacy of your protected health information ("PHI"). PHI includes information about your health condition and the care and treatment you receive from the Practice. The Practice understands that information about your health is personal. This Notice explains how your PHI may be used and disclosed to third parties. This Notice also details your rights regarding your PHI. The Practice is required by law to maintain the privacy of your PHI and to provide you with this Privacy Notice detailing the Practice's legal duties and practices with respect to your PHI. The Practice is also required by law to abide by the terms of this Notice.

HOW THE PRACTICE MAY USE AND DISCLOSE YOUR PROTECTED HEALTH INFORMATION

The Practice, in accordance with this Notice and without asking for your express consent or authorization, may use and disclose your PHI for the purposes of:

For Treatment – We may use your PHI to provide you with treatment. We may disclose your PHI to doctors, nurses, technicians, clinicians, medical students, hospitals and other health facilities involved in or consulting in your care. We may also disclose information about you to people outside the practice, such as other health care providers involved in providing treatment to you, and to people who may be involved in your care, such as family members, clergy, or others we use to provide services that are part of your care. If we refer you to another health care provider, we would, as part of the referral process share PHI information about you. For example, if you were referred to a specialist, we would contact the doctor's office and provide such information about you to them so that they could provide services to you.

For Payment – We may use and disclose your PHI so we can be paid for the services we provide to you. For example, we may need to give your insurance company information about the health care services we provided to you so your insurance company will pay us for those services or reimburse you for amounts you have paid. We also may need to provide your insurance company or a government program, such as Medicare or Medicaid, with information about your condition and the health care you need to receive prior approval or to determine whether your plan will cover the services.

For Health Care Operations – We may use and disclose your PHI for our own health care operations and the operations of other individuals or organizations involved in providing your care. This is necessary for us to operate and to make sure that our patients receive quality health care. For example, we may use information about you to review the services we provide and the performance of our employees in caring for you.

OTHER USE & DISCLOSURES THAT ARE REQUIRED OR PERMITTED BY LAW

The Practice may also use and disclose your PHI without your consent or authorization in the following instances:

Appointment Reminders -We may use and disclose your PHI to remind you by telephone or mail about appointments you have with us, annual exams, or to follow up on missed or cancelled appointments.

Individuals Involved in Your Care or Payment for Your Care – We may disclose to a family member, other relative, a close friend, or any other person identified by you. Certain limited PHI that is directly related to that person's involvement with your care or payment for your care. We may use or disclose your PHI to notify those persons of your location or general condition. This includes in the event of your death unless you have specifically instructed us otherwise. If you are unable to specifically agree or object, we may use our best judgment when communicating with your family and others.

Disaster Relief - We also may use or disclose your PHI to an authorized public or private entity to assist in disaster relief efforts. This will be done to coordinate information with those organizations in notifying a family member, other relative, close friend or other individual of your location and general condition.

De-identified Information – The Practice may use and disclose health information that may be related to your care but does not identify you and cannot be used to identify you.

Business Associate – The Practice may use and disclose PHI to one or more of its business associates if the Practice obtains satisfactory written assurance, in accordance with applicable law, that the business associate will appropriately safeguard your PHI. A business associate is an entity that assists the Practice in undertaking some essential function, such as a billing company that assists the office in submitting claims for payment to insurance companies.

Personal Representative – The Practice may use and disclose PHI to a person who, under applicable law, has the authority to represent you in making decisions related to your health care.

Emergency Situations – The Practice may use and disclose PHI for the purpose of obtaining or rendering emergency treatment to you provided that the Practice attempts to obtain your Consent as soon as possible: The Practice may also use and disclose PHI to a public or private entity authorized by law or by its charter to assist in disaster relief efforts, for the purpose of coordinating your care with such entities in an emergency situation.

Public Health and Safety Activities – The Practice may disclose your PHI about you for public health activities and purposes. This includes reporting information to a public health authority that is authorized by law to collect or receive the information. These activities generally include:

- To prevent or control disease, injury or disability
- To report births or deaths
- To report child, elder, or dependent adult abuse or neglect
- To report reactions to medications or problems with products
- To notify people of recalls of products they may be using
- To notify a person who may have been exposed to a disease or may be at risk for contracting or spreading a disease or condition.

Victims of Abuse, Neglect or Domestic Violence – We may disclose your PHI to a government authority authorized by law to receive reports of abuse, neglect, or domestic violence, if we believe an adult or child is a victim of abuse, neglect, or domestic violence. This will occur to the extent the disclosure is (a) required by law, (b) agreed to by you, (c) authorized by law and we believe the disclosure is necessary to prevent serious harm, or, (d) if you are incapacitated and certain other conditions are met, a law enforcement or other public official represents that immediate enforcement activity depends on the disclosure.

Health Oversight Activities – We may disclose your PHI to a health oversight agency for activities authorized by law, including audits, investigations, inspections, licensure or disciplinary actions. These and similar types of activities are necessary for appropriate oversight agencies to monitor the nation's health care system, government benefit programs, and for the enforcement of civil rights laws.

Judicial and Administrative Proceedings – We may disclose your PHI in response to a court or administrative order. We also may disclose information about you in response to a subpoena, discovery request, or other legal process but only if efforts have been made to tell you about the request or to obtain an order protecting the information to be disclosed.

Disclosures for Law Enforcement Purposes – We may disclose your PHI to law enforcement officials for these purposes:

- As required by law
- In response to a court, grand jury or administrative order, warrant or subpoena
- To identify or locate a suspect, fugitive, material witness or missing person
- About an actual or suspected victim of a crime if, under certain limited circumstances, we are unable to obtain that person's agreement
- To alert a potential victim or victims or intending harm ("duty to warn")
- To alert law enforcement officials to a death if we suspect the death may have resulted from criminal conduct
- About crimes that occur at our facilities
- To report a crime, a victim of a crime or a person who committed a crime in emergency circumstances

To Avert Serious Threat to Health or Safety – We will use and disclose your PHI when we have a "duty to report" under state or federal law because we believe that it is necessary to prevent a serious threat to your health and safety or the health and safety of the public or another person. Any disclosure would be to help prevent a threat.

Coroners, Medical Examiners and Funeral Directors – We may disclose your PHI to a coroner or medical examiner for purposes such as identifying a deceased person and determining cause of death. We also may disclose information to funeral directors so they can carry out their duties.

Organ, Eye or Tissue Donation – To facilitate organ, eye or tissue donation and transplantation, we may disclose your PHI to organizations that handle organ procurement, banking or transplantation.

Workers Compensation – We may disclose your PHI to the extent necessary to comply with worker's compensation and similar laws that provide benefits for work-related injuries or illness without regard to fault.

Special Government Functions – If you are a member of the armed forces, we may release your PHI as required by military command authorities. We may also release information about foreign military authority. We may disclose information about you to authorized federal officials for intelligence, counter-intelligence and other national security activities authorized by law.

Research – We may use and/or disclose your PHI for research projects that are subject to a special review process. If researchers are allowed access to information that information that identifies who you are, we will ask for your permission.

Fundraising – We may contact you with respect to fundraising campaigns. If you do not wish to be contacted for fundraising campaigns, please notify our Privacy Officer in writing.

AUTHORIZATION

The following uses and/or disclosures specifically require your express written permission:

Marketing Purposes – We will not use or disclose your PHI for marketing purposes for which we have accepted payment without your express written permission. However, we may contact you with information about products, services or treatment alternatives directly related to your treatment and care.

Sale of Health Information – We will not sell your PHI without your written authorization. If you do authorize such a sale, the authorization will disclose that we will receive compensation for the information that you have authorized us to sell. You have the right to revoke the authorization at any time, which will halt any future sale.

Uses and/or disclosures other than those described in this Notice will be made only with your written authorization. If you do authorize a use and/or disclosure, you have the right to revoke that authorization at any time by submitting a revocation in writing to our Privacy Officer. However, revocation cannot be retroactive and will only impact uses and/or disclosures after the date of revocation.

YOUR RIGHTS

Right to Revoke Authorization – You have the right to revoke any Authorization or consent you have given to the Practice, at any time. To request a revocation, you must submit a written request to the Practice's Privacy Officer.

Right to Request Restrictions – You have the right to request that we restrict the uses or disclosures of your information for treatment, payment or healthcare operations. You may also request that we limit the information we share about you with a relative or friend of yours. You also have the right to restrict disclosure of information to your commercial health insurance plan regarding services or products that you paid for in full, out-of-pocket and we will abide by that request unless we are legally obligated to do so.

We are not required to agree to any other requested restriction. If we agree, we will follow your request unless the information is needed to a) give you emergency treatment, b) report to the Department of Health and Human Services, or c) the disclosure is described in the "Uses and Disclosures That Are Required or Permitted by Law" section. To request a restriction, you must have your request in writing to the Practice's Privacy Officer. You must tell us: a) what information you want to limit, b) whether you want to limit use or disclosure or both and c) to whom you want the limits to apply. Either you or we can terminate restrictions at a later date.

Right to Receive Confidential Communications – You have the right to request that we communicate your PHI in a certain way or at a certain place. For example, you can ask that we only contact you by mail or at work.

If you want to request confidential communications you must do so in writing to our Practice's Privacy Officer and explain how or where you can be contacted. You do not need to give us a reason for your request. We will accommodate all reasonable requests.

Right to Inspect and Copy – You have the right to inspect and request copies of your information.

To inspect or copy your information, you may either complete an Authorization to Release/Obtain Information form or write a letter of request, stating the type of information to be released, the date(s) of service being requested, the purpose of the request, and whether you wish to review the record or receive copies of the requested information in your preferred format. We will abide by your request in the format you have requested, if we are able to do so. If we cannot provide your records to you in the requested format, we will attempt to provide them in an alternative format that you agree to. You may also request that your records be sent to another person that you have designated in writing. Direct this request to the Practice's Privacy Officer. You may be charged a fee for the cost of copying, mailing or other expenses related with your request.

We may deny your request to inspect and copy information in a few limited situations. If you request is denied, you may ask for our decision to be reviewed. The Practice will choose a licensed health care professional to review your request and the denial. The person conducting the review will not be the person who denied your request. We will comply with the outcome of that review.

Right to Amend – If you feel that your PHI is incorrect, you have the right to ask us to amend it, for as long as the information is maintained by us. To request an amendment, you must submit your request in writing to the Practice's Privacy Officer. You must provide a reason for the amendment.

We may deny your request for an amendment if it is not in writing or does not include a reason for wanting the amendment. We also may deny your request if the information: a) was not created by us, unless the person or entity that created the information is no longer available to amend the information, b) is not part of the information maintained by the Practice, c) is not information that you would be permitted to inspect and copy or d) is accurate and complete.

If your request is granted the Practice will make the appropriate changes and inform you and others, as needed or required. If we deny your request, we will explain the denial in writing to you and explain any further steps you may wish to take.

Right to an Accounting of Disclosures – You have the right to request an accounting of disclosures. This is a list of certain disclosures we have made regarding your PHI. To request an accounting of disclosures, you must write to the Practice's Privacy Officer. Your request must state a time period for the disclosures. The time period may be for up to six years prior to the date on which you request the list, but may not include disclosures made before April 14, 2003.

There is no charge for the first list we provide to you in any 12-month period. For additional lists, we may charge you for the cost of providing the list. If there will be a charge, we will notify you of the cost in advance. You may withdraw or change your request to avoid or reduce the fee.

Certain types of disclosures are not included in such an accounting. These include disclosures made for treatment, payment or healthcare operations; disclosures made to you or for our facility directory; disclosures made with your authorization; disclosures for national security or intelligence purposes or to correctional institutions or law enforcement officials in some circumstances.

Right to a Paper Copy of this Notice – You have the right to receive a paper copy of this Notice of Privacy Practices, even if you have agreed to receive this Notice electronically. You may request a paper copy of this Notice at any time.

Right to File a Complaint – You have the right to complain to the Practice or to the United States Secretary of Health and Human Services (as provided by the Privacy Rule) if you believe your privacy rights have been violated. To file a complaint with the Practice, you must contact the Practice's Privacy Officer. To file a complaint with the United States Secretary of Health and Human Services, you may write to: Office for Civil Rights, U.S. Department of Health and Human Services, 200 Independence Avenue, S.W., Washington, DC 20201. All complaints must be in writing.

To obtain more information about your privacy rights or if you have questions about your privacy rights you may contact the Practice's Privacy Officer as follows:

Name: **Cheryl Lee-Pow**

Address: **600 Jefferson Plaza Suite 350 Rockville MD 20852**

Telephone No.: **301-279-9009**

We encourage your feedback and we will not retaliate against you in any way for the filing of a complaint. The Practice reserves the right to change this Notice and make the revised Notice effective for all health information that we had at the time, and any information we create or receive in the future. We will distribute any revised Notice to you prior to implementation.

I acknowledge receipt of a copy of this Notice, and my understanding and my agreement to its terms.

Patient: _____ Date: _____

Pow-Her Chiropractic

Pain Disability Questionnaire

Self-Care/Hygiene

- I can provide for myself on most of my personal care
- I can provide for myself, but it creates extra pain
- I can provide for myself, I am slow, careful, & it is painful
- I manage most of my personal care, but it requires help
- In most accommodations of my daily care, I require extra help
- It is difficult to care for myself, I stay in bed & do not perform these tasks

Communication

- I can communicate in a normal fashion
- I can communicate, but it causes some pain
- My communication abilities are normal, but always painful
- My communication abilities are restricted by pain
- Pain seriously limits my communication except for emergencies
- Pain prevents communication abilities completely

Normal Living-Sitting

- I am able to assume a sitting position for an indefinite period of time without pain
- I can sit down for an indefinite period of time, but it causes pain
- I am restricted to one hour of sitting due to pain
- Due to pain, I am only able to sit for 30 minutes
- Pain restricts sitting for longer than 10 minutes
- I am unable to sit due to pain

Normal Living-Standing

- I am able to stand for as long as I like without pain
- I am able to stand for an indefinite period of time, but it causes pain
- I am restricted to one hour of standing due to pain
- Due to pain, I am only able to stand for 30 minutes
- Pain restricts standing for longer than 10 minute
- I am unable to stand due to pain

Normal Living-Lifting

- I am able to lift heavy objects without pain
- I am able to lift heavy objects, but it causes some pain
- I am unable to lift heavy objects off the floor. However, I can manage if they are at table height
- Due to pain, I am not able to lift heavy objects. However, light to medium weight objects are manageable
- Pain restricts lifting only very lightweight objects
- I am unable to lift any objects of any weight at all

Ambulation

- I am able to walk any distance without pain restrictions
- I am limited to walk one mile due to pain restrictions
- I am limited to ½ mile of walking due to pain
- Due to pain, I am restricted to walking less than ¼ mile
- I require the use of crutches or a cane to assist walking
- I remain in bed most of the time due to pain

Travel

- I am able to travel without pain restrictions
- I am able to travel almost anywhere, but it causes pain
- I can manage 2 hours of travel, but pain is present & severe
- Due to pain, I am limited to less than an hour of travel time
- Only short, urgent trips are possible due to pain limitations
- I am restricted in travel due to pain, other than emergencies of short distances (hospital, doctor visit)

Non-specialized Hand/Movement

- I can grasp in a normal fashion
- I can utilize grip & tactile discrimination, but there is some pain
- My grasp & grip capabilities are normal, but always painful
- Grasping, grip strength, & tactile sensations are restricted by pain
- Pain prevents grip strength, grasping, & tactile discrimination completely

Sexual Function

- I am able to engage in normal sexual activities without pain
- I am able to participate sexually, but it creates some pain
- I engage normally in sexual activities, but it is very painful
- I am restricted in sexual activities due to pain
- Pain has created a near absent sex life
- Due to pain, I abstain from any sexual activities

Sleep

- I sleep well in a normal fashion
- I sleep well at night, as long as I use sleeping pills
- I fail to accomplish more than 6 hours of sleep
- I fail to accomplish more than 4 hours of sleep
- I fail to accomplish more than 2 hours of sleep
- Pain prevents sleep

Social & recreational

- I am enjoying a normal active, social life without pain restrictions
- The presence of pain affects only the more energetic activities of my social life
- I participate in a normal social life, but pain is increasing during most activities
- Pain restricts all of my social activities, therefore, I do not go as often
- I am restricted to social activities at home due to pain
- Due to pain, I do not participate in any social activities

Effects of medication

- I am able to tolerate pain, therefore, I do not use any pain medication
- I use pain medication & experience complete relief from pain
- I use pain medication & experience moderate relief from pain
- Pain medication offers only very little relief from pain
- Pain medication fails to offer relief, therefore I no longer take them

Pain Intensity

- My pain is MINIMAL & tolerated, it is annoying, but does not limit my physical performance
- Pain is SLIGHT & tolerated, it causes some limitations on my physical performance
- I experience MODERATE pain, which causes a significant limitation on my physical performance of activities
- I experience SEVERE pain, which reduces my capability to perform any activity

Pain Frequency

- I have INTERMITTENT symptoms occurring less than 25% of my awake time
- I experience OCCASIONAL symptoms between 25% & 50% of my awake time
- Pain is FREQUENT, & occurs between 50% & 75% of my awake time
- I have CONSTANT pain occurring between 75% & 100% of my awake time

Pow-Her Chiropractic — Pain Disability Questionnaire

Patient name:_____ Signature:_____ Date: _____

Instructions: These questions ask your views about how your pain now affects how you function in everyday activities. Please answer every question and mark the ONE number on EACH scale that best describes how you feel.

1. Does your pain interfere with your normal work inside and outside the home?
Work normally — *Unable to work at all*
0 -------- 1 -------- 2 -------- 3 -------- 4 -------- 5 -------- 6 -------- 7 -------- 8 -------- 9 -------- 10

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*
0 -------- 1 -------- 2 -------- 3 -------- 4 -------- 5 -------- 6 -------- 7 -------- 8 -------- 9 -------- 10

3. Does your pain interfere with your traveling?
Travel anywhere I like — *Only travel to see doctors*
0 -------- 1 -------- 2 -------- 3 -------- 4 -------- 5 -------- 6 -------- 7 -------- 8 -------- 9 -------- 10

4. Does your pain affect your ability to sit or stand?
No problems — *Cannot sit /stand at all*
0 -------- 1 -------- 2 -------- 3 -------- 4 -------- 5 -------- 6 -------- 7 -------- 8 -------- 9 -------- 10

5. Does your pain affect your ability to lift overhead, grasp objects, or reach for things?
No problems — *Cannot do at all*
0 -------- 1 -------- 2 -------- 3 -------- 4 -------- 5 -------- 6 -------- 7 -------- 8 -------- 9 -------- 10

6. Does your pain affect your ability to lift objects off the floor, bend, stoop, or squat?
No problems — *Cannot do at all*
0 -------- 1 -------- 2 -------- 3 -------- 4 -------- 5 -------- 6 -------- 7 -------- 8 -------- 9 -------- 10

7. Does your pain affect your ability to walk or run?
No problems — *Cannot walk/run at all*
0 -------- 1 -------- 2 -------- 3 -------- 4 -------- 5 -------- 6 -------- 7 -------- 8 -------- 9 -------- 10

8. Has your income declined since your pain began?
No decline — *Lost all income*
0 -------- 1 -------- 2 -------- 3 -------- 4 -------- 5 -------- 6 -------- 7 -------- 8 -------- 9 -------- 10

9. Do you have to take pain medication every day to control your pain?
No medication needed — *On pain medication throughout the day*
0 -------- 1 -------- 2 -------- 3 -------- 4 -------- 5 -------- 6 -------- 7 -------- 8 -------- 9 -------- 10

10. Does your pain force your to see doctors much more often than before your pain began?
Never see doctors — *See doctors weekly*
0 -------- 1 -------- 2 -------- 3 -------- 4 -------- 5 -------- 6 -------- 7 -------- 8 -------- 9 -------- 10

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*
0 -------- 1 -------- 2 -------- 3 -------- 4 -------- 5 -------- 6 -------- 7 -------- 8 -------- 9 -------- 10

12. Does your pain interfere with recreational activities and hobbies that are important to you?
No interference — *Total interference*
0 -------- 1 -------- 2 -------- 3 -------- 4 -------- 5 -------- 6 -------- 7 -------- 8 -------- 9 -------- 10

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*
0 -------- 1 -------- 2 -------- 3 -------- 4 -------- 5 -------- 6 -------- 7 -------- 8 -------- 9 -------- 10

14. Do you now feel more depressed, tense, or anxious than before your pain began?
No depression/tension — *Severe depression / tension*
0 -------- 1 -------- 2 -------- 3 -------- 4 -------- 5 -------- 6 -------- 7 -------- 8 -------- 9 -------- 10

15. Are there emotional problems caused by your pain that interfere with your family, social and or work activities?
No problems — *Severe problems*
0 -------- 1 -------- 2 -------- 3 -------- 4 -------- 5 -------- 6 -------- 7 -------- 8 -------- 9 -------- 10

Pow-Her Chiropractic — Pain Disability Questionnaire

Roland-Morris Questionnaire

Patient name:_____ Signature:_____ Date: _____

Please read instructions: when your back hurts, you may find it difficult to do some of the things you normally do. Mark only the sentences that describe you today.

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

POWHER
Chiropractic & Wellness Center
HIGH ENERGY RECOVERY
Dr. Cheryl Lee-Pow
600 Jefferson Plaza Suite 350
Rockville MD 20852
301.279.9009 Office 301.279.9008 Fax
www.powherchiro.com

No Show/Late Cancellation "Fees" Policy

This policy, **effective 7/1/2015**, has been established to help Pow-Her Chiropractic provide better service to all its patients, by giving everyone the opportunity to be treated at the earliest possible time.

It is necessary for appointments to be made in order to see patients in an efficient manner. However, "No-shows" and "Late-cancellations" create problems, not only from a financial nature to Pow-Her, but deprives other patients from an earlier opportunity for medical treatment and improvement to their health. Some of these other patients may require critical treatment of an urgent nature.

A "No-show" is missing a scheduled appointment without calling the office, while a "Late-cancellation" is cancelling an appointment with less than 24 hours before the appointment.

Pow-Her recognizes that emergency situations do arise when an appointment cannot be kept or timely notice provided. These situations would be considered on a case by case basis as to whether fees should be waived.

Please understand that insurance companies view this charge to be the patient's responsibility.

In the interest of informing patients of this policy, we would waive the fees for the first missed appointment, but would take the opportunity then to ensure that the patient who missed the first appointment is provided with a written copy of the policy.

Fees to be Charged: $25.00 will be charged for 2nd and each subsequent "No-show" or "Late-cancellation," both of which are defined above.

Patient Signature: _____ Date: _____

Signature of Pow-Her: _____ Date: _____