Dr. Martin Schmaltz - Chiropractic Physician
7161 N Lindbergh Blvd - Hazelwood MO 63042 - (314) 731- 4383

Patient Name ________________________________ Date ____________________

Confidential Patient Health Record

Personal Information

Title: [ ] Mr. [ ] Mrs. [ ] Ms.

Last: ______________________________ First: __________________________ Middle: ____________

Suffix: [ ] Jr. [ ] Sr. [ ] II [ ] III Birth Date: ____/___/_____ Age:_______ Sex: Male / Female

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

Address: ____ Apt # _____

City: ________________________________ State: ____________________ Zip: ___________________

Cell Phone: (______) ______-__________ Work Phone: (______) ______-__________ Ext______________

Home Phone: (______) ______-__________ Fax #: (______) ______-__________ Ext __________________

Email Address:____ Social Security # _________________

Emergency Contact

Last: ______________________________ First: __________________________ Middle: ____________

Relationship: [ ] Spouse [ ] Relative [ ] Friend [ ] Other ____

Cell Phone: (______) ______-____________ Work Phone: (______) ______-__________ Ext______________

Home Phone: (______) ______-__________

Employment Information

Business Name:____

Phone: (______) ______-_____________ Fax #: (______) ______-__________ Ext __________________

Employer's Email Address:____

Occupation/Job Title:_____________________________ Job Description: ___________________________

Patient Name ___________________________________ Date _____________________

Current Health Condition

Unwanted Condition (Why are you here today?)______________

____

When did this condition BEGIN? ______/______/________

Has it occurred before? [ ] Yes [ ] No When?_______________

Is the condition: [ ] Auto Related [ ] Job Related [ ] Home Injury

[ ] Slip or Fall [ ] Lifting [ ] Slept Wrong [ ] Unknown [ ] Other

Explain:____

____

Date of Accident: ____/____/______ Time of Accident: _______

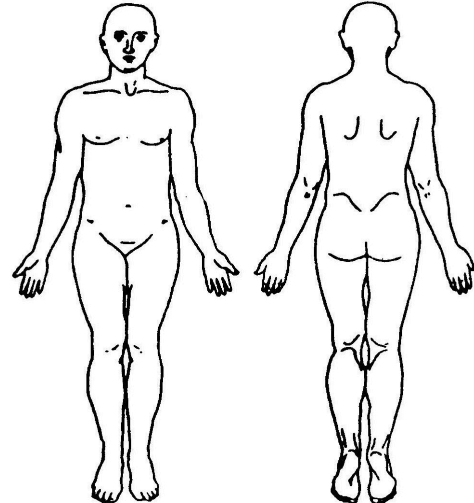
Condition/Pain STARTED on what date: ___________________

INDICATE YOUR PAIN LEVELS BELOW FOR EACH INJURED AREA

(No Pain) 1 2 3 4 5 6 7 8 9 10 (Worst Pain)

Use the letters below to indicate the TYPE and LOCATION of your sensations right now.

Key: A = Ache B = Burning N = Numbness P = Pins & Needles S = Stabbing



0 -1: NO PAIN- to just barely noticeable.
2 - 3: Pain is present, but you may have to stop and think about it to really tell it is there and not gone. You feel fairly comfortable.
4 - 5: You now notice your pain perhaps at rest or during activity. It may interfere with your activities.
6 - 7: Your pain is distracting you, you may be able to focus on something else rather than the pain for only short periods of time. You may be gritting your teeth or holding your breath to carry out activities.
8 -9: Your pain may be severe enough that it makes you stop in the middle of an activity, or not be able to complete it. It is difficult to think of anything else but your pain. You may be uncomfortable during rest or quiet times.
10: Your pain is now the worst you can imagine, though it is not necessary for you to be "crying" at this level

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REVIEW OF SYSTEMS - Below is a list of symptoms that may seem unrelated to the purpose of your appointment. However, these questions must be answered carefully as the problems can affect your overall course of care.

Constitutional: [ ] I DENY having or have had any of the symptoms or problems listed below.

[ ] chills [ ] fatigue [ ] night sweats [ ] weight loss
[ ] daytime drowsiness [ ] fever [ ] weight gain

Eye/Vision: [ ] I DENY having or have had any of the symptoms or problems listed below.

[ ] blindness [ ] change in vision [ ] field cuts [ ] photo phobia
[ ] blurred vision [ ] double vision [ ] glaucoma [ ] tearing
[ ] cataracts [ ] eye pain [ ] itching [ ] wear glasses/contacts

Ear, Nose & Throat: [ ] I DENY having or have had any of the symptoms or problems listed below.

[ ] bleeding [ ] ear drainage [ ] hearing loss [ ] nosebleeds [ ] sore throat
[ ] dentures [ ] ear pain [ ] history of head injury [ ] postnasal drip [ ] ringing in ears
[ ] difficulty swallow [ ] fainting [ ] hoarseness [ ] runny nose [ ] TMJ problems
[ ] discharge [ ] frequent sore throat [ ] loss of smell [ ] sinus infection [ ] headaches
[ ] dizziness [ ] snoring [ ] nasal congestion

Respiration: [ ] I DENY having or have had any of the symptoms or problems listed below.

[ ] asthma [ ] coughing up blood [ ] sputum production [ ] cough
[ ] shortness of breath [ ] wheezing

Patient Name ______________________________ Date ____________________

Cardiovascular: [ ] I DENY having or have had any of the symptoms or problems listed below.

[ ] angina (chest pain)
[ ] chest pain
[ ] claudications (leg pain/ache)
[ ] heart murmur
[ ] heart problems
[ ] varicose veins
[ ] low blood pressure
[ ] difficulty breathing lying down
[ ] palpitations
[ ] wake up at night w/shortness breath
[ ] shortness of breath w/exertion
[ ] swelling of legs
[ ] ulcers

Gastrointestinal: [ ] I DENY having or have had any of the symptoms or problems listed below.

[ ] abdominal pain
[ ] belching
[ ] black - tarry stool
[ ] constipation
[ ] dizziness
[ ] diarrhea
[ ] difficulty swallowing
[ ] heartburn
[ ] hemorrhoids
[ ] snoring
[ ] indigestion
[ ] jaundice
[ ] nausea
[ ] rectal bleeding
[ ] nasal congestion
[ ] abnormal stool caliber
[ ] abnormal stool color
[ ] abnormal stool consistency
[ ] vomiting blood
[ ] vomiting

Female: [ ] I DENY having or have had any of the symptoms or problems listed below.

[ ] birth control
[ ] hormone therapy
[ ] pregnancy
[ ] burning urination
[ ] frequent urination
[ ] urine retention
[ ] vaginal bleeding
[ ] irregular menstruation
[ ] cramps
[ ] vaginal discharge
[ ] breast lumps/pain

Male: [ ] I DENY having or have had any of the symptoms or problems listed below.

[ ] burning urination
[ ] erectile dysfunction
[ ] frequent urination
[ ] hesitancy/dribbling
[ ] prostate problems
[ ] urine retention

Endocrine: [ ] I DENY having or have had any of the symptoms or problems listed below.

[ ] cold intolerance
[ ] diabetes
[ ] excessive appetite
[ ] excessive hunger
[ ] excessive thirst
[ ] goiter
[ ] abnormal frequency of urination
[ ] hair loss
[ ] heat intolerance
[ ] unusual hair growth
[ ] voice changes

Skin: [ ] I DENY having or have had any of the symptoms or problems listed below.

[ ] changes in nail texture
[ ] changes in skin color
[ ] hair growth
[ ] hair loss
[ ] hives
[ ] history of skin disorder
[ ] itching
[ ] paresthesias
[ ] rash
[ ] skin lesion/ulcers
[ ] varicosities

Nervous System: [ ] I DENY having or have had any of the symptoms or problems listed below.

[ ] dizziness
[ ] facial weakness
[ ] headache
[ ] limb weakness
[ ] loss of consciousness
[ ] loss of memory
[ ] numbness
[ ] seizures
[ ] sleep disturbance
[ ] slurred speech
[ ] stress
[ ] strokes
[ ] tremor
[ ] unsteady gait
[ ] loss of balance

Psychologic: [ ] I DENY having or have had any of the symptoms or problems listed below.

[ ] anhedonia
[ ] anxiety
[ ] loss/change appetite
[ ] behavioral change
[ ] confusion
[ ] convulsion
[ ] depression
[ ] loss of consciousness
[ ] memory loss
[ ] insomnia
[ ] bi-polar disorder
[ ] mood changes

Allergy: [ ] I DENY having or have had any of the symptoms or problems listed below.

[ ] anaphylaxis
[ ] food intolerance
[ ] itching
[ ] acute nasal congestion
[ ] chronic nasal congestion
[ ] rash
[ ] sneezing

Hematologic: [ ] I DENY having or have had any of the symptoms or problems listed below.

[ ] anemia
[ ] bleeding
[ ] blood clotting
[ ] blood transfusion
[ ] bruising easily
[ ] fatigue
[ ] lymph node swelling

Patient Name ________________________________ Date ____________________

PAST HEALTH HISTORY - Fill out carefully as these problems can affect your overall course of care.

Previous care for this SAME CONDITION [ ] I have not previously seen a doctor for this condition. OR FILL in the information BELOW

Have you seen other doctors for THIS CONDITION? [ ] Yes [ ] No If yes, when? ______/______/_________

Dr.'s Name: ________________________________ Type of treatment: ______________________________

Was it beneficial in resolving condition? [ ] Yes [ ] No Explain: ____________________________________

____

Previous Chiropractic Care: [ ] I have not previously seen a chiropractor OR Fill in information BELOW

Dr.'s Name: ____________________ Location: ________________________ Date of last visit: ____________

Current Medications: List ANY/ALL medications you are CURRENTLY TAKING. Please be specific

Medication	Dosage	For What Condition?	How long have you been taking this?

Childhood Illnesses: LIST all health conditions. CIRCLE ALL CURRENT conditions

[ ] ADD
[ ] dermatitis
[ ] allergies/hay fever
[ ] anemia
[ ] asthma
[ ] bedwetting
[ ] cerebral palsy
[ ] chicken pox
[ ] crohn's/colitis
[ ] depression
[ ] diabetes
[ ] ear infections
[ ] fetal drug exposure
[ ] food allergies (list below)
[ ] headaches
[ ] hepatitis
[ ] HIV
[ ] measles
[ ] mumps
[ ] psoriasis
[ ] rash
[ ] scoliosis
[ ] seizure disorder
[ ] sickle cell anemia
[ ] spina bifida
[ ] other

Adult Illnesses: LIST all health conditions. CIRCLE ALL CURRENT conditions

[ ] ADD
[ ] Alzheimer's
[ ] anemia
[ ] arthritis
[ ] asthma
[ ] cancer
[ ] cerebral palsy
[ ] chicken pox
[ ] crohn's/colitis
[ ] CRPS (RSD)
[ ] CVA (stroke)
[ ] cystic kidney disease
[ ] depression
[ ] diabetes (insulin dep)
[ ] diabetes (non insulin)
[ ] eczema
[ ] emphysema
[ ] eye problems
[ ] fibromyalgia
[ ] heart disease
[ ] hepatitis
[ ] HIV
[ ] hypertension
[ ] influenza pneumonia
[ ] liver disease
[ ] lung disease
[ ] lupus erythema (discoid)
[ ] lupus erythema (systemic)
[ ] multiple sclerosis
[ ] Parkinson's disease
[ ] unspecified pleural effusion
[ ] pneumonia
[ ] psoriasis
[ ] psychiatric problem
[ ] scoliosis
[ ] seizures
[ ] shingles
[ ] past similar conditions
[ ] STD's
[ ] suicide attempt
[ ] thyroid problem
[ ] vertigo
[ ] other:

Doctor: Are Child/Adult Illnesses listed contributory to the CURRENT Condition? [ ] yes [ ] no

Patient Name ________________________________ Date ____________________

Surgery (ies): List all surgical procedures. Write the DATE of the procedure immediately afterward

[ ] angioplasty	[ ] cosmetic	[ ] hysterectomy	[ ] pacemaker insertion
[ ] appendectomy	[ ] D & C	[ ] joint reconstruction	[ ] rotator cuff
[ ] caesarian section	[ ] dental surgery	[ ] joint replacement	[ ] spinal fusion
[ ] cardiac catheterization	[ ] gall bladder	[ ] knee repair	[ ] tonsillectomy
[ ] carpal tunnel repair	[ ] hemorrhoidectomy	[ ] laminectomy	[ ] other
[ ] coronary artery bypass	[ ] hernia repair	[ ] mastectomy	

Injury (ies): List all injuries. Write the DATE of the procedure immediately afterward

[ ] back injury	[ ] head injury (loss consciousness)	[ ] motor vehicle accident
[ ] broken bones	[ ] head injury (no loss consciousness)	[ ] soft tissue injury (mild)
[ ] disability (ies)	[ ] industrial accident	[ ] soft tissue injury (moderate)
[ ] fall (severe)	[ ] joint injury	[ ] soft tissue injury (severe)
[ ] fracture	[ ] laceration (severe)	[ ] other

Family History: Mark all that apply below. List specific conditions past or present after has/had

general family	[ ] alive	[ ] deceased	[ ] normally developed	[ ] no significant disease	[ ] has/had:__________________
father	[ ] alive	[ ] deceased	[ ] normally developed	[ ] no significant disease	[ ] has/had:__________________
mother	[ ] alive	[ ] deceased	[ ] normally developed	[ ] no significant disease	[ ] has/had:__________________
paternal grandfather	[ ] alive	[ ] deceased	[ ] normally developed	[ ] no significant disease	[ ] has/had:__________________
paternal grandmother	[ ] alive	[ ] deceased	[ ] normally developed	[ ] no significant disease	[ ] has/had:__________________
maternal grandfather	[ ] alive	[ ] deceased	[ ] normally developed	[ ] no significant disease	[ ] has/had:__________________
maternal grandmother	[ ] alive	[ ] deceased	[ ] normally developed	[ ] no significant disease	[ ] has/had:__________________
son (s)	[ ] alive	[ ] deceased	[ ] normally developed	[ ] no significant disease	[ ] has/had:__________________
daughters (s)	[ ] alive	[ ] deceased	[ ] normally developed	[ ] no significant disease	[ ] has/had:__________________
brother (s)	[ ] alive	[ ] deceased	[ ] normally developed	[ ] no significant disease	[ ] has/had:__________________
sister (s)	[ ] alive	[ ] deceased	[ ] normally developed	[ ] no significant disease	[ ] has/had:__________________

Insurance Information:

Who is responsible for your bill? YOU and ..... (mark appropriate box (es)) [ ] Myself only [ ] Spouse

[ ] Worker's Comp [ ] Auto Insurance [ ] Medicare [ ] Medicate [ ] Other (be specific) __________________

Personal Health Insurance Carrier: ____________________ Health ID Card #: ________________________

Policy Holder’s Name: ______________________________ Group #: _________________________________

Policy Holders Date of Birth: _____/_____/_____ Primary Care Physician: ____________________

Workers Compensation Injury / Auto / Personal

Have you filed an injury report with your employer ? [ ] Yes [ ] No Date: ______/_____/_____ Time: _________

Carrier: ____ Policy # ____________________________

Carriers Phone #: (______) _________ - __________________ Adjuster: ____________________________

Claim #: ____ Attorney: ____________________________

Patient Print Name: ___________________________________ Date: _____________________________

Patient’s Signature: ___________________________________ Date: _____________________________

Dr. Martin Schmaltz, D.C.
7161 North Lindbergh Blvd., Hazelwood MO 63042
p 314.731.4383, f 314.731.4204

Patient: ____

Authorizations and Releases

Patient Health Information and Privacy Policy

This policy outlines the way Patient Health Information (PHI) will be used in this office and the patient's rights concerning those records. You must read and consent to this policy before receiving services. A complete copy of the Health Information Portability and Accountability Act (HIPPA) is available here: http;//ww.cms.hhs.gove/SecurityStandards/Downloads/securityproposedrule.pdf.

1. The patient understands and agrees to allow this office to use their PHI for purpose of treatment, payment, health care operations and coordination of care. The patient agrees to allow this office to submit requested PHI to the payor(s) name by the patient for the purpose of payment. This office will limit the release of all PHI to the minimum necessary to receive payment.
2. The patient has the right to examine and obtain a copy of their health records at any time and request corrections. The patient may request to know what disclosures have been made, and submit in writing any further restrictions on the use of their PHI. This office is not obligated to agree to those restrictions.
3. The patient's written consent shall remain in effect for as long as the patient receives care at this office, regardless of the passage of time, unless the patient provides written notice to revoke their consent. A revocation of consent will not apply to any prior care or services.
4. This office is committed to protecting your PHI and meeting its HIPAA obligations: Staff have been trained in the area of patient record privacy and a privacy official has been designated to enforce those procedures.
5. Patient have the right to file a formal complaint with our privacy official about any suspected violations.
6. This office has the right to refuse treatment if the patient does not accept the terms of this policy.

Initial ________

Consent to Professional Treatment & Informed Consent

The patient certifies that all information provided to this office is true and correct, to the best of their knowledge. The patient grants their consent to this office and its staff to render treatment as deemed necessary by the attending physician. If the patient is a minor child, under the age of eighteen (18) at the date of treatment, I hereby stipulate that I am the legal guardian of the child, and grant my consent for the treatment of the child as provided for herein.

I understand and am informed that, as in the practice of medicine, in the practice of chiropractic there are some risks to treatment, including but not limited to fractures, disc injuries, strokes, dislocation and sprains. Serious complications after manipulation of the cervical spine are estimated to be 1 in 4 million manipulations or fewer.

Initial ________

Consent to Perform and Interpret X-rays

The patient consents to the performance of x-rays as deemed necessary by the attending physician of this office. The patient acknowledges that certain risks are associated with x-rays. The patient hereby states that they have no known limitations that would forbid the taking of x-rays.

The patient further agrees that this office may seek outside interpretation of patient x-rays by a qualified professional not employed by this office. The patient agrees to any additional fees associated with this service and assigns benefits to be paid directly to that professional by your third party payor.

Initial ________

Assignment of Benefits and Release of Records

The patient hereby assigns benefits to be paid directly to this provider by all the third party payors. This assignment is irrevocable. Failure to fulfill this obligation will be considered a breach of contract between the patient and this office.

The patient authorizes this office to release any information required by a third party payor necessary for reimbursement of charges incurred.

Initial ________

Financial Obligation

The patient accepts full financial responsibility for services by this practice.

Initial ________

Patient's Signature: ____ **Date:** ___________________________________

AUTO ACCIDENT HISTORY

WELCOME

We will conduct a thorough history and physical examination to decide if we can assist you. If we do not believe that your condition will respond to chiropractic care, we will refer you to the appropriate healthcare provider. If you are a candidate for chiropractic care, a treatment plan will be recommended to fit your individual needs.

INSTRUCTIONS

Please complete the questions to the best of your ability. Be as descriptive as possible and check all the descriptors that apply. This form was designed to reduce the time involved in taking your initial history. In doing so, we are able to spend more time on determining the nature of your current problem through examination procedures. If you have questions, please ask a staff member for assistance or clarification. Please inform the doctor if there are circumstances surrounding your accident that are not covered here and that you feel would be helpful.

Name____ Today's Date ______/______/__________

HISTORY OF OCCURRENCE

1. I was the/a: [ ] Driver [ ] Passenger - right front [ ] Passenger - center front [ ] Passenger - right rear [ ] Passenger - center rear [ ] Passenger - left rear [ ] Pedestrian
   a. What was your point of impact? [ ] Head-on [ ] Rear-end [ ] Left Front [ ] Left Rear [ ] Right Front [ ] Right rear
   b. Did you feel pain immediately following the accident? [ ] Yes [ ] No If no, how long after the accident before the pain started? [ ] 30min - 1hr [ ] 1-4 hours [ ] 4-12 hours [ ] 12-24 hours [ ] ____ days
   c. Where did you go after the accident? [ ] Home [ ] Work [ ] Hospital ER [ ] Private Doctor
   d. Did you receive any of the following? [ ] x-ray [ ] CT scan [ ] MRI [ ] Lab work [ ] Treatment/medication
   e. How did you get there? [ ] Drove self [ ] Somebody else [ ] Ambulance [ ] Police [ ] Other:____________________
   f. List any doctors you've seen prior to this first visit to our office, their specialty and any treatment received:

   ____

2. Patient Vehicle Type (What type of car were you driving/in?)
[ ] Compact [ ] Mid-size [ ] Full-size [ ] SUV [ ] Pick-up [ ] Motorcycle [ ] Other:______________
3. Second Vehicle type (What was the opposing car type?)
[ ] Compact [ ] Mid-size [ ] Full-size [ ] SUV [ ] Pick-up [ ] Motorcycle [ ] Other:______________
4. Third Vehicle Type
[ ] Compact [ ] Mid-size [ ] Full-size [ ] SUV [ ] Pick-up [ ] Motorcycle [ ] Other:______________
5. Road Conditions
[ ] Dry [ ] Icy [ ] Wet [ ] Clear [ ] Foggy [ ] Dark [ ] Other:______________
6. Road Type
[ ] Concrete [ ] Asphalt [ ] Gravel [ ] Dirt [ ] Other:____
7. Where you aware that the accident was going to occur? [ ] Yes [ ] No Did you brace yourself? [ ] Yes [ ] No
8. Were you wearing a seatbelt? [ ] Yes [ ] No Were you wearing a shoulder belt? [ ] Yes [ ] No
9. Did the airbag deploy? [ ] Yes [ ] No
10. Does your car have a headrest? [ ] Yes [ ] No
11. What position was the head rest in? [ ] Up [ ] Middle [ ] Down
12. Head Position: (At the time of the accident were you looking...) [ ] Straight ahead [ ] Level left [ ] Left up [ ] Left down [ ] Right level [ ] Right up [ ] Right down [ ] Looking up [ ] Looking down
13. Where you pushing the brake (stopping) either during or before the impact? [ ] Yes [ ] No
14. Was your car moving before impact? [ ] Yes [ ] No
If yes, how fast? *(mph)* [ ] < 5 [ ] 6-10 [ ] 11-15 [ ] 16-20 [ ] 21-30 [ ] 31-40 [ ] 41-50 [ ] 51-60 [ ] 61-70 [ ] > 70
15. Was the driver of the second car braking (stopping)? [ ] Yes [ ] No
16. Was the second vehicle moving before impact? [ ] Yes [ ] No
If yes, how fast? *(mph)* [ ] < 5 [ ] 6-10 [ ] 11-15 [ ] 16-20 [ ] 21-30 [ ] 31-40 [ ] 41-50 [ ] 51-60 [ ] 61-70 [ ] > 70

17. Was the driver of the third car braking (stopping)? [ ] Yes [ ] No

18. Was the third vehicle moving before impact? [ ] Yes [ ] No
If yes, how fast? *(mph)* [ ] < 5 [ ] 6-10 [ ] 11-15 [ ] 16-20 [ ] 21-30 [ ] 31-40 [ ] 41-50 [ ] 51-60 [ ] 61-70 [ ] > 70

COLLISION DETAILS *(Describe how the cars collided. My vehicle was....)*

19. First Impact: [ ] Hit by another vehicle [ ] Hit another vehicle [ ] Hit by an object [ ] Hit an object
(My car was hit in the...) [ ] Front [ ] Front-right [ ] Front-left [ ] Left [ ] Right [ ] Right rear [ ] Left-rear [ ] Rear [ ] Top

20. Second impact:] Hit by another vehicle [ ] Hit another vehicle [ ] Hit by an object [ ] hit an object
(My car was hit in the...) [ ] Front [ ] Front-right [ ] Front-left [ ] Left [ ] Right [ ] Right rear [ ] Left-rear [ ] Rear [ ] Top

COLLISION RESULTS *(During the accident my...)*
21. Body was thrown: [ ] Backwards [ ] Forwards [ ] Left [ ] Right [ ] Can't remember

22. Head hit: [ ] Airbag [ ] Another person's body [ ] Back of front seat [ ] Dashboard
[ ] Windshield [ ] Rear-view mirror [ ] Side window/door [ ] Steering wheel

23. Chest hit: [ ] Another person's body [ ] Steering wheel [ ] Back of front seat [ ] Dashboard
[ ] Side window/door

24. Shoulders hit: [ ] Shoulder harness [ ] Another person's body [ ] Back of front seat [ ] Side window/door

25. Knees hit: [ ] Another person's body [ ] Steering wheel [ ] Back of front seat [ ] Dashboard
[ ] Door panel [ ] Center console

26. Hips hit: [ ] Another person's body [ ] Steering wheel [ ] Back of front seat [ ] Dashboard
[ ] Door panel [ ] Center console

If other area, then describe: ____

VEHICLE DAMAGE
27. First Vehicle [ ] Totaled [ ] Significant Damage [ ] Light Damage [ ] No Damage
28. Second Vehicle [ ] Totaled [ ] Significant Damage [ ] Light Damage [ ] No Damage
29. Third Vehicle [ ] Totaled [ ] Significant Damage [ ] Light Damage [ ] No Damage

PERSONAL INJURY
30. Were you hospitalized? [ ] Yes [ ] No *(If yes, please answer the questions below)*

When were you hospitalized? [ ] Date ______/_______/___________ [ ] Immediately [ ] Later the same day [ ] The next day

How were you transported to the hospital? [ ] Ambulance [ ] Life Flight [ ] Private transportation

What did the hospital recommend? [ ] No instructions [ ] See this clinic [ ] See DC [ ] See own doctor [ ] See neurologist
[ ] See orthopedist [ ] Over the counter medication [ ] Prescription medication
[ ] Other ____

Did you have x-rays, CT Scans or MRI's taken [ ] Yes [ ] No If yes, what areas?___________________________________

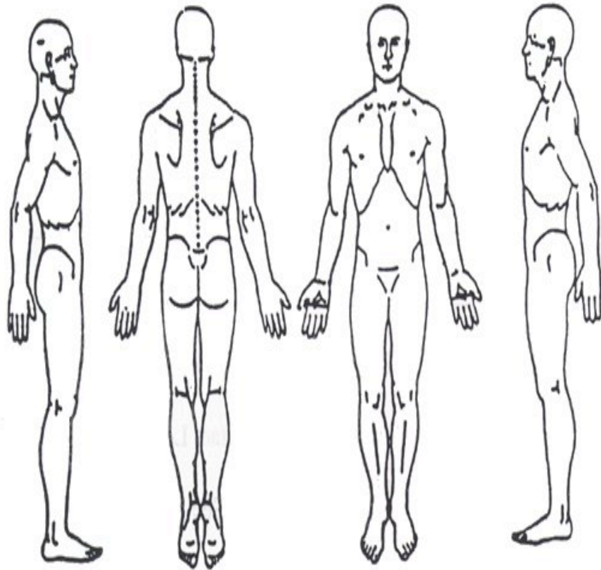
____

31. How would you describe your current symptoms: [ ] Pain [ ] Numbness [ ] Stiffness [ ] Weakness

32. Describe the quality of your symptoms:

[ ] Burning Pain [ ] Diffuse [ ] Dull/Aching [ ] Localized
[ ] Radiating [ ] Sharp [ ] Shooting [ ] Stabbing
[ ] Throbbing [ ] Tightness [ ] Tingling [ ] Other____________

33. Please mark the area of your symptoms



34. Using the scale below: How would you rate the effects of your condition or pain has on your daily functioning when you are at rest?

1 2 3 4 5 6 7 8 9 10

35. Using same scale: How would you rate the effects of your condition or pain has on your daily functioning when you are active?

1 2 3 4 5 6 7 8 9 10

0 -1: NO PAIN- to just barely noticeable.
2 - 3: Pain is present, but you may have to stop and think about it to really tell it is there and not gone. You feel fairly comfortable.
4 - 5: You now notice your pain perhaps at rest or during activity. It may interfere with your activities.
6 - 7: Your pain is distracting you, you may be able to focus on something else rather than the pain for only short periods of time. You may be gritting your teeth or holding your breath to carry out activities.
8 -9: Your pain may be severe enough that it makes you stop in the middle of an activity, or not be able to complete it. It is difficult to think of anything else but your pain. You may be uncomfortable during rest or quiet times.
10: Your pain is now the worst you can imagine, though it is not necessary for you to be "crying" at this level

36. When did this condition originally begin?____

37. Is your condition currently... [ ] worsening [ ] improving [ ] unchanged?

38. If your condition has worsened or is worsening, when did the increased symptoms start?__________________

39. When was the last time you experienced these symptoms?________________________________

40. Is your condition worse in the: [ ] Morning [ ] Afternoon [ ] Night [ ] With Activity

and it is mostly: [ ] Intermittent [ ] Constant throughout the day.

41. Is your condition better in: [ ] Warm Temp [ ] Cold Temp [ ] Neither

42. Is your condition worse in: [ ] Warm Temp [ ] Cold Temp [ ] Neither

43. Check any of the following signs or symptoms that are associated with your current condition:

[ ] Blurred Vision	[ ] Depression	[ ] Dizziness	[ ] Irritability/Mood Swings	[ ] Fainting	[ ] Confusion
[ ] Loss of smell	[ ] Nausea	[ ] Stiffness	[ ] Ringing in the ears	[ ] Aches	[ ] Cold limbs
[ ] Ecchymosis	[ ] Fatigue	[ ] Fever	[ ] Localized Tingling	[ ] Heartburn	[ ] Muscle spasm
[ ] Numbness	[ ] Panic	[ ] Pins & Needles	[ ] Pale/bluish skin	[ ] Runny nose	[ ] Short breath
[ ] Sweating	[ ] Swelling	[ ] Tingling	[ ] Vomiting	[ ] Loss of consciousness	

[ ] Headaches (Describe your headaches in detail) ______________________________________
____
[ ] Weakness (Describe the location)____
[ ] Radiating pain/sensation (Describe the location and type of sensation) ________________________
____
[ ] Other not listed (Describe) ____

44. Do your symptoms seem to be better with: [ ] Nothing [ ] Activity [ ] Bending [ ] Cold [ ] Heat [ ] Massage
[ ] Movement [ ] Over the counter medication [ ] Prescription medication
[ ] Rest [ ] Stretching [ ] Sitting [ ] Standing [ ] Twisting [ ] Walking

I certify that all the above information is true and to the best of my knowledge.

Patient Signature:________________________________ Date:_______________________

Neck Disability Index

This questionnaire has been designed to give the doctor information as to how your neck pain has affected your ability to manage in everyday life. Please answer every section and mark in each section only the ONE box which applies to you. We realize you may consider that two of the statements in any one section relate to you, but please just mark the box which most closely describes your problem.

Section 1 – Pain Intensity

- ❑ I have no pain at the moment. (0)
- ❑ The pain is very mild at the moment. (1)
- ❑ The pain is moderate at the moment. (2)
- ❑ The pain is fairly severe at the moment. (3)
- ❑ The pain is very severe at the moment. (4)
- ❑ The pain is the worst imaginable at the moment. (5)

Section 2 – Personal Care (Washing, Dressing, etc.)

- ❑ I can look after myself normally without causing extra pain. (0)
- ❑ I can look after myself normally but it causes extra pain. (1)
- ❑ It is painful to look after myself and I am slow and careful. (2)
- ❑ I need some help but manage most of my personal care. (3)
- ❑ I need help every day in most aspects of self care. (4)
- ❑ I do not get dressed, I wash with difficulty and stay in bed. (5)

Section 3 – Lifting

- ❑ I can lift heavy weights without extra pain. (0)
- ❑ I can lift heavy weights but it gives extra pain. (1)
- ❑ Pain prevents me from lifting heavy weights off the floor, but I can manage if they are conveniently positioned, for example on a table. (2)
- ❑ Pain prevents me from lifting heavy weights, but I can manage light to medium weights if they are conveniently positioned. (3)
- ❑ I can lift very light weights. (4)
- ❑ I cannot lift or carry anything at all. (5)

Section 4 – Reading

- ❑ I can read as much as I want to with no pain in my neck. (0)
- ❑ I can read as much as I want to with slight pain in my neck. (1)
- ❑ I can read as much as I want with moderate pain in my neck. (2)
- ❑ I cannot read as much as I want because of moderate pain in my neck. (3)
- ❑ I can hardly read at all because of severe pain in my neck. (4)
- ❑ I cannot read at all. (5)

Section 5 – Headaches

- ❑ I have no headaches at all. (0)
- ❑ I have slight headaches that come infrequently. (1)
- ❑ I have moderate headaches which come infrequently. (2)
- ❑ I have moderate headaches which come frequently. (3)
- ❑ I have severe headaches which come frequently. (4)
- ❑ I have headaches almost all the time. (5)

Section 6 – Concentration

- ❑ I can concentrate fully when I want to with no difficulty. (0)
- ❑ I can concentrate fully when I want to with slight difficulty. (1)
- ❑ I have a fair degree of difficulty in concentrating when I want to. (2)
- ❑ I have a lot of difficulty in concentrating when I want to. (3)
- ❑ I have a great deal of difficulty in concentrating when I want to. (4)
- ❑ I cannot concentrate at all. (5)

Section 7 – Work

- ❑ I can do as much work as I want to. (0)
- ❑ I can do my usual work, but no more. (1)
- ❑ I can do most of my usual work, but no more. (2)
- ❑ I cannot do my usual work. (3)
- ❑ I can hardly do any work at all. (4)
- ❑ I cannot do any work at all. (5)

Section 8 – Driving

- ❑ I can drive my car without any neck pain. (0)
- ❑ I can drive my car as long as I want with slight pain in my neck. (1)
- ❑ I can drive my car as long as I want with moderate pain in my neck. (2)
- ❑ I cannot drive my car as long as I want because of moderate pain in my neck. (3)
- ❑ I can hardly drive at all because of severe pain in my neck. (4)
- ❑ I cannot drive my car at all. (5)

Section 9 – Sleeping

- ❑ I have no trouble sleeping. (0)
- ❑ My sleep is slightly disturbed (less than 1 hour sleepless). (1)
- ❑ My sleep is mildly disturbed (1-2 hours sleepless). (2)
- ❑ My sleep is moderately disturbed (2-3 hours sleepless). (3)
- ❑ My sleep is greatly disturbed (3-5 hours sleepless). (4)
- ❑ My sleep is completely disturbed (5-7 hours sleepless). (5)

Section 10 – Recreation

- ❑ I am able to engage in all my recreation activities with no neck pain at all. (0)
- ❑ I am able to engage in all my recreation activities, with some pain in my neck. (1)
- ❑ I am able to engage in most, but not all, of my usual recreation activities because of pain in my neck. (2)
- ❑ I am able to engage in a few of my usual recreation activities because of pain in my neck. (3)
- ❑ I can hardly do any recreation activities because of pain in my neck. (4)
- ❑ I cannot do any recreation activities at all. (5)

Patient Name:______________________________ Signature:____________________________ Date:_______________

Oswestry Disability Index - Low Back

Section 1 - Pain Intensity

- ❑ I have no pain at the moment
- ❑ The pain is very mild at the moment
- ❑ The pain is moderate at the moment
- ❑ The pain is fairly severe at the moment
- ❑ The pain is very severe at the moment
- ❑ The pain is the worst imaginable at the moment

Section 2 - Personal Care (washing, dressing etc)

- ❑ I can look after myself normally without causing extra pain
- ❑ I can look after myself normally but it is very painful
- ❑ It is painful to look after myself and I am slow and careful
- ❑ I need some help but manage most of my personal care
- ❑ I need help every day in most aspects of self care
- ❑ I do not get dressed, wash with difficulty, and stay in bed

Section 3 - Lifting

- ❑ I can lift heavy weights without extra pain
- ❑ I can life heavy weights but it gives extra pain
- ❑ Pain prevents me from lifting heavy weights off the floor, but I can manage if they are conveniently positioned, e.g on a table
- ❑ Pain prevents me from lifting heavy weights but I can mange light to medium weights if they are conveniently positioned.
- ❑ I can lift only very light weights
- ❑ I cannot lift or carry anything at all

Section 4 - Walking

- ❑ Pain does not prevent me walking any distance
- ❑ Pain prevents me walking more than 1 mile
- ❑ pain prevents me walking more than a 1/2 of a mile
- ❑ Pain prevents me walking more than 100 yards
- ❑ I can only walk using a stick or crutches
- ❑ I am in bed most of the time and have to crawl to the toilet

Section 5 - Sitting

- ❑ I can sit in any chair as long as I like
- ❑ I can sit in my favorite chair as long as I like
- ❑ Pain prevents me from sitting for more than 1 hour
- ❑ Pain prevents me from sitting for more than 1/2 an hour
- ❑ Pain prevents me from sitting for more than 10 minutes
- ❑ Pain prevents me from sitting at all

Section 6 - Standing

- ❑ I can stand for as long as I want with out extra pain
- ❑ I can stand as long as I want but it gives me extra pain
- ❑ Pain prevents me from standing for more than 1 hour
- ❑ Pain prevents me from standing for more than 1/2 an hour
- ❑ Pain prevents me from standing for more than 10 minutes
- ❑ Pain prevents me from standing at all

Section 7 - Sleeping

- ❑ My sleep is never disturbed by pain
- ❑ My sleep is occasionally disturbed by pain
- ❑ Because of pain I have less than 6 hour's sleep
- ❑ Because of pain I have less than 4 hour's sleep
- ❑ Because of pain I have less than 2 hour's sleep
- ❑ Pain prevents me from sleeping at all

Section 8 - Sex Life (if applicable)

- ❑ My sex life is normal and causes no extra pain
- ❑ My sex life is normal but causes some extra pain
- ❑ My sex life is nearly normal but is very painful
- ❑ My sex life is severely restricted by pain
- ❑ My sex life is nearly absent because of pain
- ❑ Pain prevents any sex life at all

Section 9 - Social Life

- ❑ My social life is normal and cause me no extra pain
- ❑ My social life is normal but increases the degree of pain
- ❑ Pain has no significant effect on my social life apart from limiting my more energetic interests, e.g. sports etc.
- ❑ Pain has restricted my social life and I do not go out as often
- ❑ Pain has restricted social life to my home
- ❑ I have no social life because of pain

Section 10 - Traveling

- ❑ I can travel anywhere without pain
- ❑ I can travel anywhere but it give extra pain
- ❑ Pain is bad but I manage journeys over 2 hours
- ❑ Pain restricts me to journey of less than 1 hour
- ❑ Pain restricts me to short necessary journeys under 30 minutes
- ❑ Pain prevents me from traveling except to receive treatments.

Patient Name: _______________________________ Signature: __________________________ Date:__________________

The next form is a request for medical records. If you have sought medical care of any kind and went to the hospital or saw a doctor for your complaint, we need your permission to obtain a copy of those medical records.

Please sign the next form but leave the Doctor/Hospital information blank.

List below the hospital(s) and/or doctor(s) that you have seen.

Patient Name:____

Hospital: ____

Address:____

City:______________________________ State:__________ Zip:___________

Doctor: ____

Address:____

City:______________________________ State:__________ Zip:___________

Doctor: ____

Address:____

City:______________________________ State:__________ Zip:___________

Doctor: ____

Address:____

City:______________________________ State:__________ Zip:___________

Dr. Martin Schmaltz
7161 N Lindbergh Blvd, Hazelwood MO 63042
(314) 731-4383 Fax (314) 731-4204

REQUEST FOR MEDICAL RECORDS

Date:_________________

REQUESTING FROM:

____ FAX: ______________________
Doctor or Hospital Name

____
Address

____
City, State, Zip

PATIENT INFORMATION

Please send imaging films or disc and medical records from _______________ to the present.

____
Patient Name

____
SS#

____
Date Of Birth

I authorize the release of my imaging films or disc and medical records to be sent to the requestor:

Dr. Martin Schmaltz
7161 N Lindbergh Blvd, Hazelwood MO 63042
(314) 731-4383 Fax (314) 731-4204

____
Patient Signature Date

ASSIGNMENT OF BENEFITS PURSUANT TO RSMo SECTION 376.42

COMES NOW________________________________, (hereinafter referred to as "Insured") and does hereby knowingly, willingly and voluntarily assigns to North County Pain Relief Center (hereinafter referred to as "Provider") all benefits privileges and rights under Policy No._____________ issued by _______________________________ (hereinafter referred to as "Insurer") in consideration of "health care services" provided as a result of injuries sustained by insured on _________________.

"Insured" also authorizes and directs "Insurer" to voluntarily issue the instrument of payment in the singe name of the "provider", and directly to the "provider", for all "health care services" provided in accordance with V.A.M.S. & 376.427(2) and V.A.M.S. 376.427(3)(1991). Furthermore, "insurer" is authorized and directed to withhold such sums from all insurance benefits obligated to reimburse the "insured".

Insured:_______________________________________
(Patient Signature)

Provider:_______________________________________

This________day of____________, 20____.

STATE OF MISSOURI)
) SS
COUNTY OF ST. LOUIS)

On this __________ day of __________, 20____, before me, a Notary Public, personally appeared ______________________________, who being duly sworn by me did say that he/she is the person described in and who executed the foregoing document, and that he/she executed the same as his/her own free act and deed.

IN TESTIMONY WHEREOF, I have hereunto set my hand and official seal on the day and year above written.

My commission expires: _______________________________________

NOTARY PUBLIC

INCLUDE -or- ATTACH ALL PERSONAL INJURY INFO NEEDED FOR BILLING

PATIENT NAME		
STREET		
CITY		
STATE & ZIP		
TELEPHONE		
SOC. SEC #		
DATE OF BIRTH		
AGE AND SEX		

SEND BILL TO:

- ☐ ATTORNEY ONLY
- ☐ ATTORNEY + INSURANCE
- ☐ AUTO INSURANCE

CONDITION IS RELATED TO:

- ☐ AUTO ACCIDENT
- ☐ OTHER ACCIDENT
- ☐ EMPLOYMENT

PI - INSURANCE COMPANY INFO		SECONDARY INFO	ATTORNEY NAME
NAME			
STREET			
CITY			
STATE & ZIP			
PHONE			
POLICY #			
CLAIM #			
INSURED NAME			
ADJUSTOR NAME			
ADJUSTOR PHONE			
DATE OF ACCIDENT			

AUTHORIZATION TO RELEASE MEDICAL INFORMATION I HEREBY AUTHORIZE THE RELEASE OF ANY MEDICAL INFORMATION NECESSARY TO PROCESS THIS CLAIM.

AUTHORIZATION TO PAY BENEFITS I HEREBY AUTHORIZE PAYMENT OF THESE REASONABLE CHARGES TO Radiology Consultants Midwest FOR SERVICES RENDERED TO ME IN ACCORDANCE WITH §430.225, §430.230 RSMo, UPON ALL CLAIMS, COUNTER CLAIMS, DEMANDS, SUITS, OR RIGHTS OF ACTION BY ME AGAINST THE DEFENDANT/LIABLE PARTY IN WHICH ALLEGED LIABILITY IS INSURED. I AUTHORIZE PAYMENT DIRECTLY TO Radiology Consultants Midwest BENEFITS THAT WOULD NORMALLY BE DUE ME. I HEREBY AUTHORIZE MY ATTORNEY TO PAY DIRECTLY TO THE PROVIDER SUCH SUMS WHICH MAY BE DUE AS A RESULT OF THIS ACCIDENT AND TO WITHHOLD SUCH SUMS FROM ANY SETTLEMENT, JUDGMENT OR VERDICT AS MAY BE NECESSARY TO ADEQUATELY PROTECT Radiology Consultants Midwest.

AGREEMENT TO PAYMENT TERMS I AGREE TO REMIT IN FULL ANY BALANCE WHICH IS NOT COVERED OR PAID IN FULL BY ANY INSURANCE CARRIERS OR OTHER PARTIES THAT MAY HAVE RESPONSIBILITY OR LIABILITY FOR THE SERVICES RENDERED.

PATIENT SIGNATURE ____________ PARENT/GUARDIAN ____________ DATE ____________

RADIOLOGY CONSULTANTS/MIDWEST
201 ENCHANTED PARKWAY
BALLWIN, MO 63021

(636)256-7779
(636)227-0624 FAX
FED ID # 43-1912520

DR. ____________

NPI: ____________

COMMENT or QUESTION:

RCM OFFICE USE ONLY

C/S 2 3 5 7 B ________

T/S 1 2 ________

L/S 2 3 4 5 B ________

PELVIS ________

F/S 1 2 ________

RADIOLOGIST 1 2 3