Dr. Martin Schmaltz - Chiropractic Physician
Quality Chiropractic & Auto Injury Care
7161 N Lindbergh Blvd - Hazelwood MO 63042 - (314) 731- 4383

_____ 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 _____

REVIEW OF SYSTEMS - HEALTH HISTORY

Below is a list of symptoms that may seem unrelated to your injury. However, these questions must be answered carefully as the problems can affect your overall course of care. Please check the symptoms you were

EXPERIENCING IN THE PAST 6 MONTHS BEFORE YOUR AUTO INJURY

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

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

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

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

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

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

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

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

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

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

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

Patient Name _____ Date _____

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

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

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

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

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

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

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

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

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

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

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

Have you previously been treated for injuries due to an auto collision? [ ] Yes [ ] No

Have you seen a doctor for any of the previous listed health problems? [ ] Yes [ ] No Yes, when?_____

Dr.'s Name: _____ Type of treatment: _____

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?

Patient Name _____ Date _____

Childhood Illnesses:	LIST all health conditions. CIRCLE ALL CURRENT conditions		
[ ] ADD	[ ] chicken pox	[ ] headaches	[ ] scoliosis
[ ] dermatitis	[ ] crohn's/colitis	[ ] hepatitis	[ ] seizure disorder
[ ] allergies/hay fever	[ ] depression	[ ] HIV	[ ] sickle cell anemia
[ ] anemia	[ ] diabetes	[ ] measles	[ ] spina bifida
[ ] asthma	[ ] ear infections	[ ] mumps	[ ] other _____
[ ] bedwetting	[ ] fetal drug exposure	[ ] psoriasis	_____
[ ] cerebral palsy	[ ] food allergies (list below)	[ ] rash	_____

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

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

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

					Illnesses/sickness
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:_____
your father's father	[ ] alive	[ ] deceased	[ ] normally developed	[ ] no significant disease	[ ] has/had:_____
your father's mother	[ ] alive	[ ] deceased	[ ] normally developed	[ ] no significant disease	[ ] has/had:_____
your mother's mother	[ ] alive	[ ] deceased	[ ] normally developed	[ ] no significant disease	[ ] has/had:_____
your mother's father	[ ] 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:_____

Patient Name _____ Date _____

Your Health Insurance Information:

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

[ ] Auto Insurance [ ] Medicare [ ] Other (be specific) _____

Personal Health Insurance Carrier: _____ Health ID Card #: _____

Policy Holder's Name: _____ Group #: _____

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

Insurance Company Phone: _____

Your Auto Insurance

Date Of Accident: ____/____/____ Time: _____ Where did accident happen? [ ] Missouri [ ] Illinois [ ] Other _____

Did the police come? [ ] Yes [ ] No Did you report the accident/injury to your insurance company? [ ] Yes [ ] No

Insurance Company: _____ Policy # _____

Insurance Phone #: (_____) _____ - _____ Adjuster: _____

Medical Claim #: _____ Attorney: _____

Person Who Hit You - Insurance

Persons Name:_____

Insurance Company: _____ Policy # _____

Insurance Phone #: (_____) _____ - _____ Adjuster: _____

Medical Claim #: _____ Attorney: _____

Patient Print Name: _____ Date: _____

Patient's Signature: _____ Date: _____

Dr. Martin Schmaltz, D.C.
7161 North Lindbergh Blvd., Hazelwood MO 63042
ph: 314.731.4383, fax: 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) named by the patient for the purpose of payment. This includes the named attorney of record representing you. 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. This includes release of medical & financial information to the patient's attorney.

Initial _____

Financial Obligation

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

Initial _____

Patient's Signature: _____ **Date:** _____

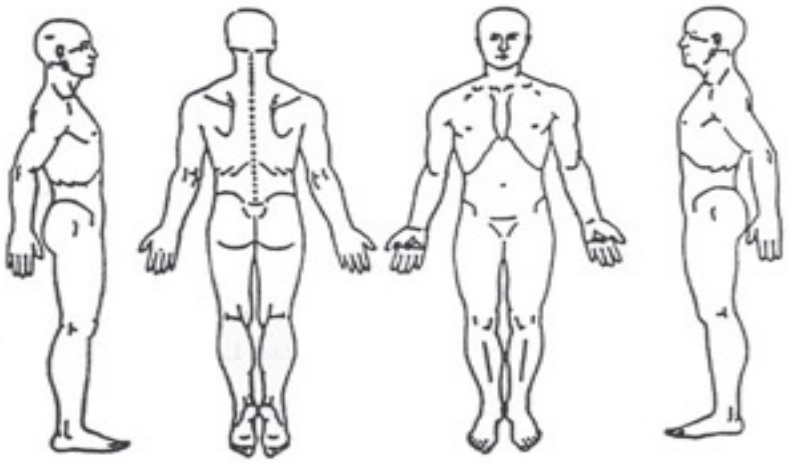
AUTO INJURY HISTORY **Date of Injury _____/_____/_____** **Time of Injury_____**

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 _____/_____/_____**

Please mark the area of your pain or discomfort:



1. Is your condition currently... [ ] worsening [ ] improving [ ] unchanged?
2. If your condition has worsened or is worsening, when did the increased symptoms start _____
3. When was the last time you experienced these symptoms?_____
4. Is your condition worse in the: [ ] Morning [ ] Afternoon [ ] Night [ ] With Activity
5. Is it mostly: [ ] Intermittent [ ] Constant throughout the day.
6. Is your condition better in: [ ] Warm Temp [ ] Cold Temp [ ] Neither
7. Is your condition worse in: [ ] Warm Temp [ ] Cold Temp [ ] Neither
8. 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

Patient Name _____ Date _____

What body areas are affected due to this injury? Circle each that apply below.

Please **use the following scale** to rate the intensity of **each** affected area that you circled below from 1-10.

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.

Circle each area that is affected by this injury	Where do you feel it	Intensity 1-10	How often 0-100% of the day	Sharp	Dull	Aching	Throbbing	Shooting	Stabbing	Burning	Numbness	Pins & Needles			
Example Neck	***right side of neck, more on back of neck***	***6***	***70***	***x***			***x***	***x***							
Head															
Jaw															
Neck															
Upper Back															
Mid Back															
Low Back															
Shoulder															
Elbow															
Wrist															
Fingers															
Hip															
Knee															
Ankle															
Foot															
Toes															

Patient Name _____ Date _____

Check only the symptoms you are experiencing AFTER the auto injury.
Please use the following scale to rate the intensity of each affected area that you circled below from 1-10.

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.

X		Where	0-100% of day	Intensity 0-10	
	Loss of smell				
	Mood swings				
	Confusion				
	Ringing in ears				
	Shortness of breath				
	Loss of consciousness				
	Blurred Vision				
	Depression				
	Irritability				
	Fainting				
	Concentration difficulties				
	Stiffness				
	Panic attacks				
	Cold limbs				
	Radiating symptoms				
	Weakness				
	Muscle spasm				
	Swelling				
	Pale/blue skin				
	Pins & Needles				
	Bruising				
	Nausea				
	Vomiting				
	Balance problems				
	Dizziness				
	Visual Problems				
	Fatigue				
	Sensitive to Light				
	Sensitive to noise				
	Numbness				
	Tingling				
	Headache				

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

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 (page 11) 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: _____ **Were X-rays taken? Y N**

Address:_____

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

Phone:_____ **When did you go?:**_____

Doctor: _____

Address:_____

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

Phone:_____ **When did you go?:**_____

Doctor: _____

Address:_____

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

Phone:_____ **When did you go?:**_____

Doctor: _____

Address:_____

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

Phone:_____ **When did you go?:**_____

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

REQUEST FOR MEDICAL RECORDS

Date:_____

REQUESTING FROM:

_____ **RECORDS FAX:** _____
Doctor or Hospital Name

_____ **RADIOLOGY FAX:** _____
Address

_____
City, State, Zip

PATIENT INFORMATION

_____
Patient Name

_____
SS#

_____
Date Of Birth

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

_____
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 MARTIN SCHMALTZ
NPI 1841552478

NORTH COUNTY PAIN RELIEF CENTER
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