CENTURY CHIROPRACTIC CENTER
Dr. Bahar Nehawandian
3151 Olin Avenue Suite #100
San Jose, CA 95117
408-261-2222

PATIENT INTAKE FORM

Last Name: _____ First Name: _____ Today's date: _____

Home Address: _____ City: _____ State: _____ Zip Code: _____

Home Phone: (___) _____ Work Phone: (___) _____ Cell Phone: (___) _____

E-mail: _____ Fax #: (___) _____ SS #: _____-_____-_____

Age: _____ Birth Date: _____ Marital Status: ☐ M ☐ D ☐ S ☐ W Sex: ☐ Male ☐ Female

Occupation: _____ Referred by: _____

Employer's name: _____ Address: _____

Employer's phone #: _____

City: _____ State: _____ Zip Code: _____ ☐ Full-time ☐ Part-time

Partner's name: _____ Date of Birth: _____ Employer: _____

Children: ☐ No ☐ Yes. Ages _____ Have they had their spines, feet, TMJ examined here? ☐ No ☐ Yes

Person financially responsible for office visits and supplements: _____

Contact person in case of emergency: _____ Phone number: (____)_____

Do you have an attorney that has advised you in this case? ☐ Yes ☐ No

If yes; Name: _____ Law Firm: _____

Address: _____ Phone: (___)_____-_____

The name of **YOUR** insurance carrier: _____

Policy Holder's Name: _____

Medical Claim # (not ploicy #) _____

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

PERSONAL HISTORY-please print clearly

Last Name: _____ First Name: _____ Middle Initial: _____

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

Cell Phone: _____ Home Phone: _____ Birthdate: _____ Age: _____

Employer Name: _____ Job Title: _____ Email: _____

Job Function (eg :sitting/standing/walking/bending/lifting etc) _____ # Hours at computer _____

Circle One: Married Single Divorced Widowed # of children _____

How did you hear about Dr. Bahar? Patient _____ Other _____

Have you had previous chiropractic care? Yes No When? _____ Name of Chiropractor _____

What are your hobbies/activites/exercises? _____

CURRENT HEALTH CONDITION

What is your Condition/Symptom (Describe)	Onset Gradual or Sudden? When?	What makes it better/worse?	How have you been treating? Eg: medications therapies	Pain Level at worst 1-10 (10 being worst	Pain Level at best 1-10 (1 being no pain)	

CURRENT MEDICATIONS (list prescription, non-prescription, vitamins, supplements)

Medication Name (current)	Dosage	Frequency

Medication Allergies	Reaction	Onset Date

Below is a list of conditions which may seem unrelated to the purpose of you appointment. However, these questions must be answered carefully as these problems can affect your overall diagnosis and treatment

__Headache/Migraines __Fatigue __Chest Pain/Shortness of breath __Diarrhea/Constipation

__Dizziness __Insomnia __Heart Palpitations/Murmur __Excess Gas

__Ear Infections __Loss of Memory __Stomach/Digestive Problems __Freq. Urination/UTI

__Sinus Problems __Cold/Burning/Itchy Hands __Asthma/Upper Resp Infection __Pain/Numb/Tingling down legs

__Allergies/Asthma __Depression/Anxiety __Bronchitis/Pneumonia __Cramping toes/feet/legs

__Blurry vision/eye pain __Thyroid Condition __Heartburn/Indigestion __Impotence/Infertility

__Sore Throats __Anxiety __Gassy/Bloating __Irregular Periods/Menstrual cramps

__Hi/Lo Blood pressure __Numb/tingling arms/fingers __Gallbladder problems __Hemorrhoids

	Never	Daily	Weekly	Occasionally
Alcohol				
Diet Food Products				
Processed Foods				
Homemade Foods				
Soft Drinks				
Water				
Caffeine				
Drugs				
Tobacco				
Exercise				

HEALTH HISTORY

PRIOR ILLNESS/SURGERY/HOSPITALIZATIONS/ACCIDENTS	DATE (or at what age?

WHAT IS YOUR FAMILY HISTORY (immediate family only)

Family Member	High Blood Pressure	Diabetes	Cancer (Describe type)	Alcohol	

INSURANCE

Health Insurance Co. Name_____ We will take a copy of your insurance card.

Policy Holder Name_____ Birth Date:_____

Patient Signature_____Date_____

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ACCIDENT INFORMATION

Date of accident: _____ Time: _____ ☐AM or ☐ PM

Location: _____

Were you: ( ) Driver ( ) Passenger ( ) Front Seat ( )Back Seat

How did the accident occur if **NOT** in an automobile? _____

Number of people in your vehicle: _____ Were you wearing seat belts? _____

What direction was your vehicle headed? ( ) North ( ) South ( ) East ( ) West

On (name of street) _____

What direction was the other vehicle headed? ( ) North ( ) South ( ) East ( ) West

On (name of street) _____

Were you struck from: ( ) Behind ( ) Front ( ) Left side ( ) Right side

YOUR car: Make: _____ Model: _____ Yr: _____ Approx speed of vehicle _____ mph

OTHER car: Make: _____ Model: _____ Yr: _____ Approx speed of vehicle _____ mph

OTHER car: Make: _____ Mode: _____ Yr: _____ Approx speed of vehicle _____ mph

Were you knocked unconscious? ( ) No ( ) Yes If yes, for how long? _____

Were police notified? ( ) Yes ( ) No

Was there a police report filed? ( ) Yes ( ) No

Do you have a copy of the police report? ( ) Yes ( ) No

In your own words, please describe the accident:

_____

_____

Did you have any Physical complaints BEFORE THIS ACCIDENT ( ) Yes Please describe in detail ( ) No

_____

_____

Please describe how you felt:

DURING the accident: _____

IMMEDIATELY AFTER the accident: _____

LATER THAT DAY: _____

THE NEXT DAY: _____

Have you lost any days of work due to your current condition? _____ What dates: _____

What are your PRESENT complaints and symptoms? _____

_____

_____

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Have you been treated by another doctor since the accident? ( ) Yes ( ) No

Date:_____

Doctor/Facility Name:_____ Address:_____

What type of treatment did you receive?_____

Date:_____

Doctor/Facility Name:_____ Address:_____

What type of treatment did you receive?_____

Do you have an attorney that has advised you in this case? ☐ Yes ☐ No

If yes, Attorney Name: _____

Law Firm:_____

Address: _____

Phone: (____)_____-_____

The name of **YOUR** insurance carrier: _____

Policy Holder's Name:_____

Is there Med Pay coverage on this policy? ( ) Yes ( ) No Amount of coverage $_____

Medical Claim # (not policy #)_____

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

Claims Mailing Address:_____ City:_____ State:_____ Zip:_____

Contact person in case of emergency:

Name:_____ Relationship:_____

Phone number: (_____)_____

I understand and agree that health and accident insurance policies are an arrangement between an insurance carrier and myself. I clearly understand and agree that all services rendered me are charged directly to me and that I am personally responsible for payment. I also understand that if I suspend or terminate my care and treatment, and fees for professional services rendered me will immediately be due and payable.

Patient's signature_____ Date:_____

SS #.: _____ Drivers License #:_____ State Issued:_____

Guardian/partner's signature authorizing care: _____ Relationship_____

Dear Auto Accident Patient,

You are about to begin Chiropractic care for spinal problems relating to an automobile accident. We , at Century Chiropractic Center, will do everything possible to see that you receive the highest quality care as well as process your insurance claims in an efficient manner. We do, however, need your cooperation in this matter. Because of the nature of an auto injury case, payments of doctor bills can go months or sometimes years in the event the case must be adjudicated.

In order for our office to accept your case on an assignment basis, we ask you to assign any or all of the following benefits that apply:

1. **Automobile Insurance Health Coverage**- sometimes referred to as **medical pay or med-pay** (your auto insurance agent can let you know if you have this type of coverage.)

2. **Any Major Medical (Group or Private) coverage** that is available. This offers 100% coverage (no deductible) in the event that the claim is accident related.

3. **A Doctor's Lien form signed by you and your attorney**, or you and the carrier of the other driver if you have no attorney. The lien is on the eventual settlement proceeds that will be available from an incourt or out of court settlement.

As you can see, we are requesting payment from all potential sources. We can collect only once for our charges, any excess payments that might result from this case are immediately refunded directly to you.

I have read the above mentioned requirements to become an auto accident patient and I understand fully that it is my responsibility to disclose any insurance of the above mentioned variety and assist in the filing of health claims for my chiropractic charges. I realize that failure to disclose and /or assist with the filing of these health claims will result in bringing my entire balance due and payable immediately, and that any costs incurred in the immediate collection of my charges will be my sole responsibility.

_____

Patient Signature Date

How to Finance your Treatment After an Auto Accident and Have your Damages Compensated

The typical accident victim, fortunately, does not sustain any fractures of the bones. Instead, the injuries suffered are multiple strains and sprains of the ligaments, muscles, and other soft tissues of the spine. These soft tissue injuries are difficult to diagnose and can be quite painful, severe, and long lasting. If not treated early and by the proper methods, these injuries can lead to chronic and disabling complications.

Treatment of Choice

The treatment of choice for soft tissue injuries, the most effective care, is chiropractic. As a patient, you have an absolute right to select the best type of care.. The right choice is to seek treatment from a doctor of chiropractic. This is my first and most important recommendation.

Financing Your Treatment

The first question facing you is how to finance your treatment. If you have been injured in an automobvile accident, the answer is from your automobile insurance policy through medical payments portion of your policy, called Med Pay.

My second and equally important recommendation is, in order to pay for your chiropractic and other treatment after and automobile accident—use your Med Pay.

Med Pay has two main advantages. It pays the medical bills as soon as your doctor submits them, and it pays them without regard to who was responsible for causing the accident.

With Med Pay, you can get the treatment you need and your Med Pay pays your medical bills as you go. You do not have to wait for a determination of how the accident happened, and you avoid the risk of having to pay the bills yourself if the outcome of your personal injury claim should be unfavorable. As long as the treatment is reasonable and necessary Med Pay will pay your bills. Med Pay is extremely important to your recovery. A patient with soft tissue injuries may require diagnostic procedures such as a CAT scan, an MRI, or a consultation with a specialist such as a neurologist or orthopedist. Diagnostic procedures and consultations are expensive and usually require immediate payment. Med Pay is often the only way to make sure you can receive the treatment you need.

Where Do I Find Med Pay?

To use Med Pay, you must first find it. Most people do not know whether they have Med Pay coverage or not. The only sure way to tell is to examine every policy of automobile insurance that may be involved.

Start with you own policy. Review the declarations page and if there is a question, call your insurance agent. If your policy does not have Med Pay, do not give up. You may still have coverage through someone else's automobile policy.

If you were driving someone else's car, also look at the policy of the registered owner. If you were a passenger, also look at the policy of the driver. You may also be covered by the automovile policy of a relative in whose household you are a permanent resident, even if you physically reside somewhere else. Finally, remember that Med Pay is not limited to injuries sustained in a car. For example, if while crossing the street you are struck by a car, your Med Pay will cover you.

"But," you may ask, "isn't it unfair to have my medical bills paid by the insurance of someone who did not cause the accident? Shouldn't the insurance of the person who caused the accident be the one to pay?" The only correct and fair answer is that both insurance companies should pay.

Your Med Pay insurance should pay because you paid the premiums. The other insurance should pay because, as the injured party, you have the right to bring a lawsuit against the person whose negligence caused the accident. If you are successful, the court will award you a judgement ordering the wrongdoer to pay your damages.

Settlement

When the wrongdoer's insurance company anticipates a judgement against them, they will attemp to negotiate a settlement with you. Should you settle the case early and then use the proceeds to finance your treament? The answer is absolutely not. You should not look for payment by the wrongdoer's insurance company until your treatment is completed.

Remember, a settlement is final! When you accept a settlement you must sign a release of all future claims

you may have that are related to your accident. If, after a settlement, your injury turns out to be worse that you expected, you cannot reopen your claim. The time to begin settlement negotiations is only after your treatment is completed.

"But" you may ask, "If I submit a claim for Med Pay, won't my insurance premiums be raised?" To answer this, it will not help to ask your insurance agent or the claims adjustor. Their responsibility is to sell policies and discourage or otherwise dispose of claims; they have nothing to do with setting or raising rates. This job belongs to the people in your insurance company's underwriting department. These are the ones to ask.

There is one important difference between what you can receive through Med Pay and what you can receive through a settlement from the wrongdoer's insurance companyMed Pay covers your medical bills, and nothing else. A settlement compensates you for all of your damages. In addition to medical bills, it includes loss of earnings, property damage, and the most valuable aspect of a personal injury claim, your pain and suffering.

Importance of Medical Records

To be compensated you must prove your damages, and for this, the most effective proof lies in your medical records. Your medical records establish your medical expenses, the nature and extent of your injuries, the type and duration of the treament required, and any disability from work. Your medical record helps to prove your losss of earnings, and it is the foundation of your claim for pain and suffering.

The importance of your medical records cannot be emphasized enough. Your personal injury claim is only as good as your medical records. To build a strong record, it is vital that you cooperate fully with your treating doctor. Follow to the letter your doctor's prescribed course of treatment. Avoid delays in seeking care and gaps in the course of treatment; and do not consult with other doctors without a proper referral from your own doctor.

Related Problems as a Result of Your Accident

To support your claim for loss of wages, inform your doctor of all your work-related problems so the problems are properly entered in your medical records. This will enable your doctor to document the duration of your disability, the extent of your restrictions, and the limitations on work activities, both during and after your recovery.

To enable your doctor to document your pain and suffering, you must also tell your doctor, without reservation, all the problems and difficulties you are experiencing. Problems may include much more than the pain and discomfort directly caused by your injuries. You may also suffer secondary complaints such as dizziness, loss of equilibrium, recurrent headaches, loss of memory, or inability to concentrate.

At home, there may be a disruption in your usual family routine, ordinary daily tasks, such as housecleaning, buying groceries, doing the laundry, making repairs, gardening, picking up your children, may become difficult or impossible.

At work, you may find that because of your medical leave or disability restrictions your performance and productivity are lower; rasies or promotions have been lost or postponed, or your seniority or job security has been jeopardized.

Treatment and legal compensation can alleviate all of these problems. To resolve your personal injury claim successfully, you must both recover your health and win compensation for your damamges.

My final recommendation is for you is to retain an experienced personal injury attorney, who understands and approves of chiropractic.

With your full commitment and cooperation, you and your doctor will be able to speed-up and maximize the recovery of your health. Working together, you will build a strong medical record that contains the full details of all your damages. Armed with such a record, your doctor will also be able to provide your attorney with a final narrative report that is well supported and convincingly documented.

You, your doctor and your attorney must work as a team. This is essential if your attorney is to win a settlement for you, which is both prompt and fair.

Prepared by Silvano Miracchi, Esq.
San Jose, CA
Published in the CCA Journal, March 1989

Auto Rates Cannot be Increased if Auto Accident is not Patient's Fault

California Insurance Code

§491. The rating plan of a motor vehicle liability insurer shall not provide for an increase in the premium if based upon an accident in which the insured is not at fault, in any manner, as determined by either the accident report or the insurer. In the event the insurer determines that its insured is at fault contrary to an accident report's specific finding that the insured is not at fault, the insurer shall reach its conclusion only after an investigation.

PROVIDER PRIVACY POLICY

Century Chiropractic Center is required, by law to maintain the privacy and confidentiality of your protected health information and to provide our patients with notice of our legal duties and privacy practices with respect to your protected health information.
PLEASE REVIEW IT CAREFULLY.

USES AND DISCLOSURES

Treatment. Your health information may be disclosed to other health care professionals for the purpose of evaluating your health and providing treatment. For example, customer service information may be available to all health professionals who may provide treatment or who may be consulted by staff members.

Payment. Your health information may be used to seek payment from your health plan, from other sources of coverage such as an automobile insurer, or from credit card companies that you may use to pay for services. For example, your health plan may request and receive information on dates of service, the services provided, and the medical condition being treated.

Health care operations. Your health information may be used as necessary to support the daily operation and management of Supplier. For example, information on the services you received may be used to support budgeting and financial reporting, and activities to evaluate and promote quality.

Law Enforcement. Your health information may be disclosed to law enforcement agencies to assist in government audits and inspections, to facilitate law enforcement investigations, and to comply with government-mandated reporting.

Public health reporting. Your health information may be disclosed to public health agencies as required by law. For example, we are required to report certain communicable diseases to the state's public health department.

Other uses and disclosures require your authorization. Disclosure of your health information or its use for any purpose other that those listed above requires your specific written authorization. If you change your mind after authorizing a use or disclosure of your information you may submit a written revocation of the authorization. However, your decision to revoke the authorization will not affect or undo any use or disclosure of information that occurred before you notified us of your decision to revoke your authorization.

Information about treatments. Your health information may be used to send you information that you may find interesting on the treatment and management of your medical condition. We may also send you information describing other health-related products and services that we believe may interest you.

Individual Rights. You have certain rights under the federal privacy standards. These include:

*The right to request restrictions on the use and disclosure of your protected health information
*The right to receive confidential communications concerning your medical condition and treatment
*The right to inspect and copy your protected health information
*The right to amend or submit corrections to your protected health information
*The right to receive an accounting of how and to whom your protected health information has been disclosed
*The right to receive a printed copy of this notice

Supplier's Duties. We are required by law to maintain the privacy of your protected health information and to provide you with this notice of privacy practices. We also are required to abide by the privacy policies and practices that are outlined in this notice.

Right to Revise Privacy Practices

As permitted by law, we reserve the right to amend or modify our privacy policies and practices. These changes in our policies and practices may be required by changes in federal and state laws and regulations. Upon request, we will provide you with the most recently revised notice. The revised policies and practices will be applies to all protected health information we maintain.

Requests to Inspect Protected Health Information

You may generally inspect or copy the protected health information that we maintain. As permitted by federal regulation, we require that requests to inspect or copy protected health information be submitted in writing. You may obtain a form to request access to your records by contacting Century Chiropractic Center. Your request will be reviewed and will generally be approved unless there are legal or medical reasons to deny the request.

Complaints

If you would like to submit a comment or complaint about our privacy practices, you can do so by sending a letter outlining your concerns to:

Century Chiropractic Center
3151 Olin Ave. Suite #100
San Jose, CA 95117

If you believe that your privacy rights have been violated, you should call the matter to our attention by sending a letter describing the cause of your concern to the same address. You will not be penalized or otherwise retaliated against for filing a complaint.

Contact Person

The name and address of the person you may contact for further information concerning our privacy practices is:

Bahar Nehawandian, DC
3151 Olin Ave. Suite #100
San Jose, CA 95117
408-261-2222

Effective Date

This notice is effective on or after January 1, 2009

The undersigned below hereby acknowledges that he/she has read and understood the policies of the Supplier

_____ Signature

_____ Date

_____ Printed Name

CENTURY CHIROPRACTIC CENTER
3151 Olin Ave. #100
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Professional Fee Schedule- Bahar Nehawandian, DC

Chiropratic Exam	$150-$225
Chiropractic Office Visit/Adjustment	$60-$110
Chiropractic X-ray Studies	$75-$150
Re-evaluation Exam	$150-$225
Missed Appointment Fee	$25
Nutrition Initial Consultation	$95
Nutritional Follow-Up	$60

Therapeutic Exercises	$68-$70
Myofascial Release/Therapy	$65
Muscle Stim	$35
Flexion/Traction	$35
Heat/Ice	$12
Ultrasound Therapy	$27
Therapeutic Massage- 1 Hour	$85
Package of 6	$480

Please read the following and choose which financial situation best identifies your situation.

_____**HEALTH INSURANCE**: If you have insurance that covers Chiropractic care, we can bill your insurance directly. Please provide us with a completed insurance claim form and a copy of your insurance ID card. Until we have verified the policy and chiropractic care coverage, you will be responsible for 100% of all charges. Once verification is complete, you will be responsible for any deductible and co-pay amount stated in your plan at the time services are rendered. Please note that most insurance plans do not pay for "maintenance care" and long term rehabilitation. Note that each plan offers exceptions. Most health care plans cover acute problems so you may have to cover your payments once you have overcome acute care or have reached maximum allowable visits or annual dollar allotments.

PATIENT'S OR AUTHORIZED SIGNATURE. I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below:
I authorize payment of medical benefits to the undersigned physician or supplier for services described below.

_____**CASH**: Payment is expected at time professional services are rendered. Payments can be made by cash, check, Visa, or Mastercard. Certain discounts are allowable with pre-paid plans.

_____**WORKERS COMPENSATION**: If you have been injured at work, please notify us immediately. State regulations apply. You must report your accident to your employer before receiving treatment in our office.

_____**MEDICARE**: Our office is a Participating Provider with the Medicare Program. Patient is responsible for co-pay and annual deductible if secondary insurance (Part B) does not cover.

_____**AUTO ACCIDENT INJURY**: Please supply us with a copy of the accident report (if any), your health insurance card, proof of auto insurance, and liable parties insurance, if applicable. There are four methods of payment if you have been involved in an auto accident:

_____**MEDPAY**: Medpay is a no-fault medical insurance that will pay your medical bills immediately. This coverage is provided through your auto policy, or the policy of the car you were in at the time of the accident. Medpay is usually 100% coverage. Please note that if you were not at fault, your insurance rates cannot be raised if you use your Medpay benefits in accordance with California law.

_____**HEALTH INSURANCE**: We can bill your regular health insurance. They will pay benefits according to your plan. You will be responsible for all deductibles and co-pays at the time of service.

_____**CASH**: Full payment is due at time of service. We will provide you with an itemized statement and report if necessary for reimbursement.

_____**ATTORNEY LIEN**: If you have retained an attorney, and we approve of the attorney, we may extend credit based on a documented and signed lien.

I understand and accept the financial situation I have checked. I also understand that I am personally responsible for all charges regardless of insurance coverage.

Patient Signature: _____ Date: _____

Patient Name (Printed): _____ (eff 2/18)

CHIROPRACTIC INFORMED CONSENT TO TREAT

I hereby request and consent to the performance of chiropractic procedures, including various modes of physio therapy, diagnostic x-rays, and any supportive therapies on me (or on the patient named below, for whom I am legally responsible) by the doctor of chiropractic indicated below and/or other licensed doctors of chiropractic and support staff who now or in the future treat me while employed by, working or associated with or serving as back-up for the doctor of chiropractic named below, including those working at the clinic or office listed below or any other office or clinic, whether signatories to this form or not.

I have had an opportunity to discuss with the doctor of chiropractic named below and/or with other office or clinic personnel the nature and purpose of chiropractic adjustments and procedures.

I understand and I am informed that, as is with all Healthcare treatments, results are not guaranteed and there is no promise to cure. I further understand and I am informed that, as is with all Healthcare treatments, in the practice of chiropractic there are some risks to treatment, including, but not limited to, muscle spasms for short periods of time, aggravating and/or temporary increase in symptoms, lack in improvement of symptoms, fractures, disc injuries, strokes, dislocations and sprains. I do not expect the doctor to be able to anticipate and explain all risks and complications, and I wish to rely on the doctor to exercise judgment during the course of the procedure which the doctor feels at the time, based upon the facts then known, is in my best interests.

I further understand that Chiropractic adjustments and supportive treatment is designed to reduce and/or correct subluxations allowing the body to return to improved health. It can also alleviate certain symptoms through a conservative approach with hopes to avoid more invasive procedures. However, like all other health modalities, results are not guaranteed and there is no promise to cure. Accordingly, I understand that all payment(s) for treatment(s) are final and no refunds will be issued. However, prorated fees for unused, prepaid treatments will be refunded if you wish to cancel the treatment.

I further understand that there are treatment options available for my condition other than chiropractic procedures. These treatment options include, but not limited self-administered, over the counter analgesics and rest; medical care with prescription drugs such as anti-inflammatories, muscle relaxants and painkillers; physical therapy; steroid injections; bracing; and surgery. I understand and have been informed that I have the right to a second opinion and secure other opinions if I have concerns as to the nature of my symptoms and treatment options.

I have read, or have had read to me, the above consent. I have also had an opportunity to ask questions about its content, and by signing below I agree to the above-named procedures. I intend this consent to cover the entire course of treatment for my present condition and for any future condition(s) for which I seek treatment.

Name of Patient:_____

Signature of Patient:_____

Name Printed of Guardian/Parental and Relationship to Patient:_____

Guardian/Parental Signature:_____

Date:_____

Doctor of Chiropractic Name: Bahar Nehawandian, D.C

Signature of Doctor of Chiropractic:_____

Date:_____

Dr.Bahar Nehawandian, D.C.
Century Chiropractic Center
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Upper Extremity Functional Index

Instructions

We are intersted in knowing whether you are having any difficulty at all with the activities listed below because of your upper limb problem for which you are currently seeking attention. Please provider an answer for each activity.

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

	Activities	Extreme difficulty or unable to perform activity	Quite a bit of difficulty	Moderate difficulty	A little bit of difficulty	No difficulty
1.	Any of your usual work, housework or school activities.	0	1	2	3	4
2.	Your usual hobbies, recreational or sporting activities.	0	1	2	3	4
3.	Lifting a bag of groceries to waist level.	0	1	2	3	4
4.	Lifting a bag of groceries above your head.	0	1	2	3	4
5.	Grooming your hair.	0	1	2	3	4
6.	Pushing up on your hands (eg from bathtub or chair).	0	1	2	3	4
7.	Preparing food (eg peeling, cutting).	0	1	2	3	4
8.	Driving.	0	1	2	3	4
9.	Vacuuming, sweeping or raking.	0	1	2	3	4
10.	Dressing.	0	1	2	3	4
11.	Doing up buttons.	0	1	2	3	4
12.	Using tools or appliances.	0	1	2	3	4
13.	Opening doors.	0	1	2	3	4
14.	Cleaning.	0	1	2	3	4
15.	Tying or lacing shoes.	0	1	2	3	4
16.	Sleeping.	0	1	2	3	4
17.	Laundering clothes (eg washing, ironing, folding).	0	1	2	3	4
18.	Opening a jar.	0	1	2	3	4
19.	Throwing a ball.	0	1	2	3	4
20.	Carrying a small suitcase with your affected limb.	0	1	2	3	4

Name:

Dr.Bahar Nehawandian, D.C.
Century Chiropractic Center
3151 Olin Ave. # 100
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Lower Extremity Functional Scale

Instructions

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

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

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

Name: