BROWARD SPINE & JOINT REHABILITATION

Dr. Harley J. Bofshever
Chiropractic Physician

New Patient Intake Form (PIP)

Patient Data:

First Name: _____ Last Name: _____ MI: _____

Social Security #: _____ Birth Date: _____ ❑ Male ❑ Female

Email Address: _____ Marital Status: _____

Address: _____

City: _____ State: _____ Zip Code: _____

Cell Phone #: _____ Work Phone: _____

Emergency Contact: _____

Relationship: _____ Emergency Contact Phone #: _____

Primary Insurance Info:

The automobile insurance is the primary payer when involved in an automobile accident. Please present your Automobile insurance card and driver's license. If you also have medical coverage, please provide a copy of your insurance card and complete the following information.

Secondary Insurance Info:

Medical Insurance Carrier: _____ Phone #: _____

Insured Name: _____ Insured Date of Birth: _____

Policy #: _____ Group # _____ ❑ HMO ❑ PPO ❑ POS

For Office Use Only:

❑ Participating ❑ Non-Par Authorization Required: ❑ Yes ❑ No Spoke with: _____

Verified By: _____ Date Verified: _____

Signatures:

I understand and agree that health/accident insurance policies are an arrangement between me and the insurance carrier. I understand and agree that all services rendered to me and charged are my personal responsibility for timely payment. I understand that if I suspend or terminate my care/treatment, any fees for professional services rendered to me will be immediately due and payable.

Patient / Legal Guardian Signature: _____ Date: _____

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BROWARD SPINE & JOINT REHABILITATION

Dr. Harley J. Bofshever
Chiropractic Physician

PIP QUESTIONNAIRE

Patient Name: _____

Date of Accident: _____ Was the injury reported to Auto Carrier? ❑ Yes ❑ No

Name of Automobile Insurance: _____

Policy #: _____

Claim #: _____

PIP Adjuster Name and Phone#: _____

Attorney Name: _____

Attorney Phone #: _____ Fax #: _____

Attorney Contact Person: _____

First date seen for medical care pertaining to this accident: _____

Name of Hospital where treated, if applicable: _____

Please provide a copy of your auto insurance card, driver's license, and police report.

If you do not have car insurance please answer the following....

1. Are you of legal driving age? ❑ Yes ❑ No
2. Do you have a current Driver's License or Permit? ❑ Yes ❑ No
3. Do you live with someone that has car insurance? ❑ Yes ❑ No
4. Name of Insured and Relationship?

Please Note, in the state of Florida, if you do not have automobile insurance and are of driving age, have a license or permit, and live with someone that has automobile insurance; you may fall under their coverage. If you are unsure, please ask your attorney immediately. Also, a patient must seek medical attention within 14 days of the accident for medical services to be covered under the automobile policy. Providing the incorrect insurance information or misrepresenting your information may result in the patient being responsible for the all charges incurred.

Patient Signature: _____ Date: _____

Witness: _____ Date: _____

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BROWARD SPINE & JOINT REHABILITATION

Dr. Harley J. Bofshever
Chiropractic Physician

Medical History Information

Last Name: _____ **First Name:** _____

Medical Care Information:

Do You Have a Family Doctor?: ❑ Yes ❑ No Name of Doctor: _____

Address: _____ Date of last visit: _____

Do You Have a Family Chiropractor?: ❑ Yes ❑ No Name of Chiropractor: _____

Address: _____ Date of last visit: _____

Have you had surgeries in the last 5 Years: ❑ Yes ❑ No If yes, Last Surgery Date: _____

Reason for Surgery: _____

Present illness /Conditions:

❑ AIDS
❑ Allergies
❑ Anemia
❑ Arthritis
❑ Asthma
❑ Bone Fracture
❑ Cancer
❑ Cardio Vascular Disease
❑ Cirrhosis/Hepatitis
❑ Diabetes
❑ Dislocated Joints
❑ Diverticulitis
❑ Epilepsy
❑ Hay Fever
❑ High Blood Pressure
❑ HIV/ARC
❑ Kidney Trouble
❑ Low Blood Pressure
❑ Mental/Emotional Difficulty
❑ Multiple Sclerosis
❑ Pacemaker
❑ Prostate trouble
❑ Rheumatic Fever
❑ Scoliosis
❑ Sinus trouble
❑ Spinal Disc Disease
❑ Thryoid Trouble
❑ Tuberculosis
❑ Ulcer
❑ Polio
❑ STD's

Are you pregnant?: ❑ Yes ❑ No Other: _____

Family History of Illness:

❑ AIDS
❑ Allergies
❑ Anemia
❑ Arthritis
❑ Asthma
❑ Bone Fracture
❑ Cancer
❑ Cirrhosis/Hepatitis
❑ Diabetes
❑ Dislocated Joints
❑ Diverticulitis
❑ Epilepsy
❑ Heart Problem
❑ High Blood Pressure
❑ HIV/ARC
❑ Kidney Trouble
❑ Low Blood Pressure
❑ Mental/Emotional Difficulty
❑ Multiple Sclerosis
❑ Prostate trouble
❑ Rheumatic Fever
❑ Scoliosis
❑ Sinus trouble
❑ Spinal Disc Disease
❑ Thryoid Trouble
❑ Tuberculosis
❑ Ulcer
❑ Polio

Other: _____

Type of Cancer: _____

Social History:

Alcohol?: ❑ Yes ❑ No Caffeine?: ❑ Yes ❑ No Cigarettes?: ❑ Yes ❑ No

Drinks per week? ____ Drinks per day? _____ Packs per day?_____

Excercise?: ❑ None ❑ Light ❑ Moderate ❑ Strenuous Hours per week? _____

Signature:_____

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

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BROWARD SPINE & JOINT REHABILITATION

Dr. Harley J. Bofshever
Chiropractic Physician

MEDICAL RELEASE AND ASSIGNMENT OF BENEFITS

Release authorization to BROWARD SPINE & JOINT REHABILITATION, to endorse checks and/or to sign any piece of paper which will enhance or expedite payment to the provider for services rendered. Including but, not limited to a release of MEDICAL RECORDS and ASSIGNMENT OF BENEFITS/ AUTHORIZATION TO PAY.

Know by all these present that: The undersigned has made, constituted and appointed, and by these presents does hereby make, constitute, and appoint BROWARD SPINE & JOINT REHABILITATION., and any of its duly authorized agents and employees as and to be the undersigned's true and lawful attorney for and in the undersigned's name, place and stead to endorse any and all checks, drafts or money orders which are made payable to the undersigned alone or to the undersigned and the said BROWARD SPINE & JOINT REHABILITATION. Which checks, drafts, or money orders are made payable for services which may have been made by BROWARD SPINE & JOINT REHABILITATION, which at the request or with the knowledge and approval of the undersigned and/or the maker of the check, draft, or money order.

Furthermore, the undersigned allows BROWARD SPINE & JOINT REHABILITATION, or any of its agents to sign any paper that will be necessary to enhance, expedite, and /or allow payment to said provider. This may include affidavits of non-ownership of vehicles, insurance forms, and other statements.

The undersigned by these presents does give and grant the said BROWARD SPINE & JOINT REHABILITATION, as the attorney the full power and authority to do and perform all and every act whatsoever requisite and necessary to be done in and about the premises as fully to all intents and purposes as the undersigned might or could do to personally present insofar as the endorsing and cashing of said checks are concerned as well as any other document.

MEDICAL RELEASE

A photocopy of this document shall be sufficient to authorize any person having records of medical treatment, services, or supplies pertaining to me to release true copies of same to BROWARD SPINE & JOINT REHABILITATION, or any insurer providing coverage to me in connection with the processing of any claim for benefits made by me or by the assignee herein. A photocopy of this document shall be as binding as an original signature page.

The undersigned does hereby ratify and confirm any and all actions taken by the said attorney in accordance with this special power and which the said attorney shall do or cause to be done by virtue of their presents.

ASSIGNMENT OF BENEFITS

I, _____ hereby authorize: _____

(Name of Insured/Patient) (Name of Insurance Carrier)

To make medical benefit payments otherwise payable to me for services rendered by BROWARD SPINE & JOINT REHABILITATION, Which but not to exceed the charges of those services, payable to, and mailed to:

BROWARD SPINE & JOINT REHABILITATION
4213 WEST HILLSBORO BLVD
COCONUT CREEK, FL 33073

I hereby instruct the insurance carrier that in the event the subject medical benefits are disputed for any reason, including medical reasonableness and/ or necessity that the amount of unpaid benefits claimed by BROWARD SPINE & JOINT REHABILITATION, is to be set aside and not disbursed until the dispute is resolved. Furthermore, I hereby IRREVOCABLY ASSIGN to BROWARD SPINE & JOINT REHABILITATION, the rights and benefits and any and all causes of action resulting from non-payment under any policy of insurance, indemnity agreement, or any other collateral source as defined in Florida Statutes for any service and/or charges provided by BROWARD SPINE & JOINT REHABILITATION.

IN WITNESS WHEREOF the undersigned have hereunto set their hands, this _____day of_____, 20____

_____ _____

PATIENT NAME (PLEASE PRINT) PATIENT SIGNATURE

BROWARD SPINE & JOINT REHABILITATION

Dr. Harley J. Bofshever
Chiropractic Physician

Informed Consent

The nature of the chiropractic adjustment:
The primary treatment used by the doctors of chiropractic is spinal manipulative therapy. The doctor will use his hands or a mechanical device in order to move your joints. You may feel a "click" or "pop", such as the noise when a knuckle is "cracked", and you may feel movement of the joint.

Analysis/Examination/Treatment:
As a part of the analysis, examination, and treatment, you are consenting to the following procedures:
· Spinal Manipulative Therapy · Palpation · Range of Motion Testing · Orthopedic Testing · Basic Neurological Testing
· Muscle Strength Testing · Posture Analysis · EMS · Radiographic Studies · Hot / Cold Therapy · Other: _____

Possible Risks:
As with any health care procedure, complications are possible following a chiropractic manipulation. Complications could include fractures of bone, muscular strain, ligamentous sprain, dislocations of joints, or injury to intervertebral discs, nerves or spinal cord. Cerebrovascular injury or stroke could occur upon severe injury to arteries of the neck. A minority of patients may notice stiffness or soreness after the first few days of treatment. The ancillary procedures could produce skin irritation, burns or minor complications. The Doctor will make every reasonable effort during the examination to screen for contraindications to care; however, if you have a condition that would otherwise not come to the Doctor's attention, it is your responsibility to inform the Doctor.

Probability of risks occurring:
The risks of complications due to chiropractic treatment have been described as "rare", about as often as complications are seen from the taking of a single aspirin tablet. The risk of cerebrovascular injury or stroke, has been estimated at one in one million to one in twenty million, and can be even further reduced by screening procedures. The probability of adverse reaction due to ancillary procedures is also considered "rare".

Other treatment options which could be considered may include the following:
· Self-Administered, over-the-counter analgesics and rest
· Medical care and prescription drugs such as anti-inflammatory, muscle relaxants, and pain killers · Hospitalization · Surgery

Risks of remaining untreated:
Delay of treatment allows formation of adhesions, scar tissue and other degenerative changes. These changes can further reduce skeletal mobility, and induce chronic pain cycles. It is quite probable that delay of treatment will complicate the condition and make future rehabilitation more difficult.

I have read the above explanation of the chiropractic adjustment and related treatment. I have discussed it with Dr. Harley Bofshever and have had my questions answered to my satisfaction. By signing below, I state that I have weighed the risks involved in undergoing treatment and have decided that it is in my best interest to undergo the treatment recommended. Have been informed my risks, I hereby give my full consent to treatment.

Patient or Legal Guardian Name: _____

Patient or Legal Guardian Signature: _____ Date: _____

Physician Name: Dr. Harley J. Bofshever, DC

Physician Signature: _____ Date: _____

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BROWARD SPINE & JOINT REHABILITATION

Dr. Harley J. Bofshever
Chiropractic Physician

Patient Consent for Use and Disclosure of Protected Health Information

I hereby give my consent for Broward Spine & Joint Rehabilitation, hereinafter referred to as the "Practice" to use and disclose protected health information (PHI) about me to carry out treatment, payment and healthcare operations (TPO).

The Practice's Notice of Privacy Practices provides a more complete description of such uses and disclosures. I have the right to review the Notice of Privacy Practices prior to signing this consent. The Practice reserves the right to revise its Notice of Privacy Practices at any time. A revised Notice of Privacy Practices may be obtained by forwarding a written request to Our Privacy Officer, at the following address:
Broward Spine & Joint Rehabilitation
4213 W. Hillsboro Blvd. , Coconut Creek, FL 33073

With this consent, the Practice may call my home or alternative location and leave a message on voice mail or in person in reference to any items that assist the Practice in carrying out TPO, such as appointment reminders, insurance items and any calls pertaining to my clinical care, including laboratory results among others. With this consent, the Practice may mail to my home or other alternative location any items that assist the Practice in carrying out TPO, such as appointment reminder cards and patient statements as long as they are marked Personal and Confidential.

With this consent, the Practice may email to my home or other alternative location any items that assist the practice in carrying out TPO, such as appointment reminder cards and patient statements. I have the right to request that the Practice restrict how it uses or discloses my PHI to carry out TPO. However, the Practice is not required to agree to my requested restrictions, but if it does, it is bound by this agreement.

By signing this form, I am consenting to the Practice's use and disclosure of my PHI to carry out TPO. I may revoke my consent in writing except to the extent that the Practice has already made disclosures in reliance upon my prior consent. If I do not sign this consent, or later revoke it, the Practice may decline to provide treatment to me.

_____
Signature of Patient or Legal Guardian

_____
Patient's Name

_____
Date

OFFICE OF INSURANCE REGULATION
Bureau of Property & Casualty Forms and Rates

Standard Disclosure and Acknowledgement Form
Personal Injury Protection - Initial Treatment or Service Provided

The undersigned insured person (or guardian of such person) affirms:

1. The services or treatment set forth below were **actually rendered.** This means that those services have **already been provided.**

_____

_____

2. I have the right and the **duty to confirm** that the services have already been provided.

3. I was **not solicited** by any person to seek any services from the medical provider of the services described above.

4. The medical provider has **explained** the services to me for which payment is being claimed.

5. If I notify the insurer in writing of a billing error, I may be entitled to a portion of any reduction in the amounts paid by my motor vehicle insurer. If entitled, my share would be at least 20% of the amount of the reduction, up to $500.

Insured Person (patient receiving treatment or services) or Guardian of Insured Person:

Name *(PRINT or TYPE)*	Signature	Date

The undersigned licensed medical professional or medical director, if applicable, affirms the statement numbered 1 above and also:

A. I have **not solicited** or caused the insured person, who was involved in a motor vehicle accident, to be solicited to make a claim for Personal Injury Protection benefits.

B. The treatment or services rendered were explained to the insured person, or his or her guardian, **sufficiently** for that person to sign this form with informed consent.

C. The accompanying statement or bill is **properly completed** in all material provisions and all relevant information has been provided therein. This means that each request for information has been responded to **truthfully, accurately**, and in a **substantially complete** manner.

D. The coding of procedures on the accompanying statement or bill is proper. This means that **no service has been upcoded, unbundled**, or constitutes an invalid **or not medically necessary diagnostic test** as defined by Section 627.732(14) and (15), Florida Statutes or Section 627.736(5)(b)6, Florida Statutes.

Licensed Medical Professional Rendering Treatment/Services or Medical Director, if applicable *(Signature by his/ her **own hand**):*

Harley J. Bofshever, DC		
Name *(PRINT or TYPE)*	Signature	Date

Any person who knowingly and with intent to injure, defraud, or deceive any insurer files a statement of Claim or an application containing any false, incomplete, or misleading information is guilty of a felony of the third degree per Section 817.234(1)(b), Florida Statutes.

Note: The **original** of this form must be furnished to the insurer pursuant to Section 627.736(4)(b), Florida Statutes and may **not** be electronically furnished. Failure to furnish this form may result in non-payment of the claim.

BROWARD SPINE & JOINT REHABILITATION

Dr. Harley J. Bofshever
Chiropractic Physician

Motor Vehicle Accident Information

Last Name: _____ **First Name:** _____

General Information

Date of Accident:_____ Were you the driver or the passenger? ❑ Yes ❑ No

If you were the Passenger: Location (select one) ❑ Front ❑ Middle ❑ Rear

Position (select one) ❑ Left ❑ Middle ❑ Right

Patients Vehicle : (select all those that apply)

Type : ❑ Car ❑ Van ❑ Pickup ❑ Truck ❑ Bus ❑ SUV ❑ Motorcycle Other: _____

Size : ❑ Mini ❑ Sub Compact ❑ Compact ❑ Mid Size ❑ Full Size

Action : ❑ Stopped ❑ Slowing ❑ Acceleration ❑ Cruising

Speed: (MPH) _____

Time of Accident: _____ (am / pm)

Road Conditions: ❑ Dry ❑ Damp ❑ Wet ❑ Snow ❑ Ice

Visibility: ❑ Good ❑ Fair ❑ Poor

Enter impact Information for up to three Vehicles or Objects

Impact Information:

Vehicle or Object (I): ❑ Vehicle ❑ Object

Name Object : _____

Type : ❑ Car ❑ Van ❑ Pickup ❑ Truck ❑ Bus ❑ SUV ❑ Motorcycle Other: _____

Size : ❑ Mini ❑ Sub Compact ❑ Compact ❑ Mid Size ❑ Full Size

Damage to Vehicle.: ❑ Minimal ❑ Moderate ❑ Extensive ❑ Totaled ❑ Unsure

Impact Location:_____

Vehicle or Object (II): ❑ Vehicle ❑ Object

Name Object : _____

Type : ❑ Car ❑ Van ❑ Pickup ❑ Truck ❑ Bus ❑ SUV ❑ Motorcycle Other: _____

Size : ❑ Mini ❑ Sub Compact ❑ Compact ❑ Mid Size ❑ Full Size

Damage to Vehicle.: ❑ Minimal ❑ Moderate ❑ Extensive ❑ Totaled ❑ Unsure

Impact Location:_____

Vehicle or Object (III): ❑ Vehicle ❑ Object

Name Object : _____

Type : ❑ Car ❑ Van ❑ Pickup ❑ Truck ❑ Bus ❑ SUV ❑ Motorcycle Other: _____

Size : ❑ Mini ❑ Sub Compact ❑ Compact ❑ Mid Size ❑ Full Size

Damage to Vehicle.: ❑ Minimal ❑ Moderate ❑ Extensive ❑ Totaled ❑ Unsure

Impact Location:_____

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BROWARD SPINE & JOINT REHABILITATION

Dr. Harley J. Bofshever
Chiropractic Physician

Motor Vehicle Accident Information (cont.)

During Impact Information:

Seat Belt? ❑ Yes ❑ No
Air Bag Deployed? ❑ Yes ❑ No
Headrest: (select one) ❑ Low ❑ Mid ❑ High ❑ None
Seat Back
Position Change?: ❑ Yes ❑ No
Brakes Applied?: ❑ Yes ❑ No
Seat Broken?: ❑ Yes ❑ No

Prepare for Accident: (select one) ❑ Unexpected ❑ Expected ❑ Expected and Braced
Body Position: (select one) ❑ Straight ❑ Rotated Left ❑ Rotated Right ❑ Unsure ❑ Other:
Body Thrown from seat? ❑ Yes ❑ No
Direction of Throw: (select one) ❑ Backwards ❑ Forward ❑ Outside ❑ Unsure ❑ Other:
Head Position : (select one) ❑ Straight ❑ Rotated Left ❑ Rotated Right ❑ Forward ❑ Unsure
Other : _____
Head Motion : (select one) ❑ Forward Backwards ❑ Backwards Forward ❑ Right Left ❑ Left Right ❑ Unsure
Other : _____

Body Impact:

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

❑ Head ❑ Mid Back ❑ Neck
❑ Left Arm ❑ Left Elbow ❑ Left Foot ❑ Left Hand ❑ Left Knee ❑ Left Leg ❑ Left Shoulder
❑ Right Arm ❑ Right Elbow ❑ Right Foot ❑ Right Hand ❑ Right Knee ❑ Right Leg ❑ Right Shoulder
❑ Lower Back ❑ Upper Back ❑ Mid Torso ❑ Lower Front Torso ❑ Upper Front Torso ❑ Other

After Accident Information:

Immediately After Accident: ❑ Dizzy ❑ Dazed ❑ Upset ❑ Weak ❑ Nervous
❑ Headaches ❑ Disoriented ❑ Unconscious ❑ Other

Pain:

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

❑ Head ❑ Mid Back ❑ Neck
❑ Left Arm ❑ Left Elbow ❑ Left Foot ❑ Left Hand ❑ Left Knee ❑ Left Leg ❑ Left Shoulder
❑ Right Arm ❑ Right Elbow ❑ Right Foot ❑ Right Hand ❑ Right Knee ❑ Right Leg ❑ Right Shoulder
❑ Lower Back ❑ Upper Back ❑ Mid Torso ❑ Lower Front Torso ❑ Upper Front Torso ❑ Other

Numbness:

Hand: ❑ Left ❑ Right
Arm: ❑ Left ❑ Right ❑ Upper ❑ Lower
Leg: ❑ Left ❑ Right ❑ Upper ❑ Lower
Foot: ❑ Left ❑ Right ❑ Upper ❑ Lower

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BROWARD SPINE & JOINT REHABILITATION

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Chiropractic Physician

Motor Vehicle Accident Information (cont.)

Medical Information :
(Did you get medical care for this accident before coming to our office)
Medical Care? ❑ Yes ❑ No
Time of care: ❑ At time of Accident ❑ Later that Day ❑ Next day ❑ Days Later: _____ (Specify) _____
Transported : ❑ Drove Self ❑ Ambulance ❑ Other: (Specify) _____
Type of Dr visited: ❑ Orthopedic ❑ Chiropractor ❑ Neurologist ❑ Family Dr ❑ ER
❑ Other: (Specify) _____
Admitted to Hospital? ❑ Yes ❑ No
Days Spent in Hospital:_____
Test (s): ❑ X-ray ❑ Lab Work ❑ MRI ❑ CT Scan ❑ Other: (Specify)
Treatment: ❑ Ice Pack ❑ Hot Pack ❑ Cervical Collar ❑ Medication ❑ None
❑ Other:(Specify) _____

Previous Injuries / Accidents: ❑ Yes ❑ No
if yes please specify: _____
Residual pain from
Previous Injuries / Accidents: ❑ Yes ❑ No
if yes please specify: _____

Later Symptoms:
(Please note any symptoms that started after the accident occurred)
❑ Head ❑ Headache ❑ Loss of Memory ❑ Lightheadedness ❑ Fainting
❑ Blurred Vision ❑ Double Vision ❑ Dizziness ❑ Pain in ear ❑ Loss of Vision

Neck: (with Movement) ❑ Pain in Neck ❑ Forward ❑ Backward ❑ Turn Left ❑ Turn Right
❑ Bend Left ❑ Bend Right ❑ Muscle Spasms ❑ Popping in Neck
❑ Other (Specify): _____

Shoulders: ❑ Pain in Shoulder joint ❑ Tension in shoulders ❑ Can't raise arms
❑ Pain across shoulder ❑ Muscle Spasms in shoulder ❑ Above shoulder level ❑ Over head
❑ Other: (Specify) _____

Mid back: ❑ Sharp Stabbing ❑ Mid pain back ❑ Pain From front to back ❑ Dull Ache ❑ Muscle Spasms
❑ Pain between shoulders ❑ Pain in Kidney Area
❑ Other: (Specify) _____

Lower Back: ❑ Low Back Pain ❑ Muscle Spasms

Low back pain is worse when: ❑ Working ❑ Lifting ❑ Stooping ❑ Standing
❑ Bending ❑ Coughing ❑ Lying Down ❑ Sitting

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BROWARD SPINE & JOINT REHABILITATION

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Chiropractic Physician

Motor Vehicle Accident Information (cont.)

Hips, Legs & Feet:

- ❑ Pain in buttocks
- ❑ Pain in hip joint
- ❑ Numbness in Toes
- ❑ Leg cramps
- ❑ Other (Specify):
- ❑ Pain and needles in legs
- ❑ Feet feeling cold
- ❑ Numbness of Leg
- ❑ Cramps in Feet
- ❑ Pain down leg
- ❑ Swollen feet
- ❑ Knee pain

Arms and Hands:

- ❑ Pain in Fingers
- ❑ Pin & needles in hands
- ❑ Swollen joints in Fingers
- ❑ Other (Specify):
- ❑ Numbness in Left Arm
- ❑ Pin & needles in fingers
- ❑ Numbness in Right Arm
- ❑ Numbness in Right Arm
- ❑ Cold Hands
- ❑ Loss of Grip Strength

Chest:

- ❑ Chest pain
- ❑ Breast pain
- ❑ Nausea
- ❑ Other (Specify):
- ❑ Pain Around Ribs
- ❑ Abdomen
- ❑ Diarrhea
- ❑ Shortness of Breath
- ❑ Nervous Stomach
- ❑ Gas
- ❑ Constipation

General:

- ❑ Nervousness
- ❑ Generally Feel Rundown
- ❑ Cramping
- ❑ Fatigue
- ❑ Prostate Pain/Swelling
- ❑ Irregularity
- ❑ Irritable
- ❑ Difficulty Urinating
- ❑ Depressed
- ❑ Night Urination

Loss of Sleep: _____ hrs per night

Loss of weight : _____ lbs.

Gain weight:_____ lbs.

❑ Other: _____

_____

Signature: _____ Date: _____

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

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BROWARD SPINE & JOINT REHABILITATION

Dr. Harley J. Bofshever
Chiropractic Physician

Notice of Doctor's Lien

Patient: _____ Date of Accident: _____

Attorney: _____

I do hereby authorize, **Harley J. Bofshever, D.C.**, to furnish you, my attorney, with a full report of his examinations, diagnosis, treatment, prognosis, etc. of myself in regard to the accident which I was recently involved in.

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

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

I agree to promptly notify said doctor of any change or addition of attorney(s) used by me, in connection with this accident, and instruct my attorney to do the same and to promptly deliver a copy of this Lien to any such substituted or added attorney(s).

Please acknowledge this letter by signing below and returning to the doctor's office. I have been advised that if my attorney does not wish to cooperate in protecting the doctor's interest, the doctor will not await payment but, may declare the entire balance due and payable.

Patient Signature: _____ Date: _____

The undersigned being attorney of record for the above patient does hereby agree to observe all the terms of the above and agrees to withhold such sums from any settlement, judgment, or verdict as may be necessary to adequately protect and fully compensate said doctor above –named. Attorney further agrees that in the event this lien is litigated that the prevailing party will be awarded attorney fees and cost.

Attorney Signature: _____ Date: _____

Please sign, date, and return a copy to our office. Also, please keep a copy for your records.

Doctor: Harley J. Bofshever, DC _____ Date: _____

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P: 954.246.3336 · F: 954.426.0643 · www.bofshever.com

BROWARD SPINE & JOINT REHABILITATION

Dr. Harley J. Bofshever
Chiropractic Physician

Activities of Daily Living

Instructions: Within each section, please indicate how your current symptoms are affecting your daily living by selecting one of the options.

Patient Name: _____ **Date:** _____

Normal Living - Sitting:

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

Normal Living - Lifting:

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

Social & Recreational Activities

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

Patient Signature: _____

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BROWARD SPINE & JOINT REHABILITATION

Dr. Harley J. Bofshever
Chiropractic Physician

Oswestry Low Back Questionnaire

Patient Name: _____ **Date:** _____

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 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

- ❑ The pain comes and goes and is very mild.
- ❑ The pain is mild and does not vary much.
- ❑ The pain comes and goes and is moderate.
- ❑ The pain is moderate and does not vary much.
- ❑ The pain comes and goes and is severe.
- ❑ The pain is severe and does not vary much.

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

- ❑ I would not have to change my way of washing or dressing in order to avoid pain.
- ❑ I do not normally change my way of washing or dressing even though it causes some pain.
- ❑ Washing and dressing increase the pain but I manage not to change my way of doing it.
- ❑ Washing and dressing increase the pain and I find it necessary to change my way of doing it.
- ❑ Because of the pain I am unable to do some washing and dressing without help.
- ❑ Because of the pain I am unable to do any washing and dressing without help.

Section 3 – Lifting

- ❑ I can lift heavy weights without extra pain.
- ❑ I can lift heavy weights but it gives extra pain.
- ❑ Pain prevents me from lifting heavy weights off the floor.
- ❑ 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 manage light to medium weights if they are conveniently positioned.
- ❑ I can only lift very light weights at the most.

Section 4 – Walking

- ❑ I have no pain on walking.
- ❑ I have some pain with walking but it does not increase with distance.
- ❑ I cannot walk more than One Mile without increasing pain.
- ❑ I cannot walk more than 1/2 Mile without increasing pain.
- ❑ I cannot walk more than 1/4 Mile without increasing pain.
- ❑ I cannot walk at all without increasing pain.

Section 5 – Sitting

- ❑ I can sit in any chair as long as I like.
- ❑ I can only sit in my favorite chair as long as I like.
- ❑ Pain prevents me from sitting more than one hour.
- ❑ Pain prevents me from sitting more than 30 minutes.
- ❑ Pain prevents me from sitting more than 10 minutes.
- ❑ I avoid sitting because it increases pain straight away.

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Oswestry Low Back Questionnaire (cont.)

Section 6 – Standing

- ❑ I can stand as long as I want without pain.
- ❑ I have some pain on standing but it does not increase with time.
- ❑ I cannot stand for longer than one hour without increasing pain.
- ❑ I cannot stand for longer than 1/2 hour without increasing pain.
- ❑ I cannot stand for longer than 10 minutes without increasing pain.
- ❑ I avoid standing because it increases pain straight away.

Section 7 – Sleeping

- ❑ I can do as much work as I want to.
- ❑ I can only do my usual work, but no more.
- ❑ I can do most of my usual work, but no more.
- ❑ I cannot do my usual work.
- ❑ I can hardly do any work at all.
- ❑ I cannot do any work at all.

Section 8 – Driving

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

Section 9 – Traveling

- ❑ I get no pain while traveling.
- ❑ I get some pain while traveling but none of my usual sorts of travel make it any worse.
- ❑ I get extra pain while traveling but it does not compel me to seek alternative forms of travel.
- ❑ I get extra pain while traveling which compels me to seek alternative forms of travel.
- ❑ Pain restricts all forms of travel.
- ❑ Pain prevents all forms of travel except that done lying down.

Section 10 – Changing Degree of Pain

- ❑ My pain is rapidly getting better.
- ❑ My pain fluctuates but overall is definitely getting better.
- ❑ My pain seems to be getting better but improvement is slow at the present.
- ❑ My pain is neither getting better or worse.
- ❑ My pain is gradually worsening.
- ❑ My pain is rapidly worsening.

Patient Signature: _____

BROWARD SPINE & JOINT REHABILITATION

Dr. Harley J. Bofshever
Chiropractic Physician

Neck Disability Index

Patient Name: _____ **Date:** _____

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 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.
- ❑ The pain is mild at the moment.
- ❑ The pain comes and goes and is moderate.
- ❑ The pain is moderate and does not vary much.
- ❑ The pain is severe but comes and goes.
- ❑ The pain is severe and does not vary much.

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

- ❑ I can look after myself without causing extra pain.
- ❑ I can look after myself normally but it causes extra pain.
- ❑ 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, I wash with difficulty and stay in bed.

Section 3 – Lifting

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

Section 4 – Reading

- ❑ I can read as much as I want to with no pain in my neck.
- ❑ I can read as much as I want to with slight pain in my neck.
- ❑ I can read as much as I want with moderate pain in my neck.
- ❑ I cannot read as much as I want because of moderate pain in my neck.
- ❑ I cannot read as much as I want because of severe pain in my neck.
- ❑ I cannot read at all.

Section 5 – Headaches

- ❑ I have no headaches at all.
- ❑ I have slight headaches which come infrequently.
- ❑ I have moderate headaches which come infrequently.
- ❑ I have moderate headaches which come frequently.
- ❑ I have severe headaches which come frequently.
- ❑ I have headaches almost all the time.
- ❑ I avoid sitting because it increases pain straight away.

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Neck Disability Index (cont.)

Section 6 – Concentration

❑ I can concentrate fully when I want to with no difficulty.
❑ I can concentrate fully when I want to with slight difficulty.
❑ I have a fair degree of difficulty in concentrating when I want to.
❑ I have a lot of difficulty in concentrating when I want to.
❑ I have a great deal of difficulty in concentrating when I want to.
❑ I cannot concentrate at all.

Section 7 – Work

❑ I can do as much work as I want to.
❑ I can only do my usual work, but no more.
❑ I can do most of my usual work, but no more.
❑ I cannot do my usual work.
❑ I can hardly do any work at all.
❑ I cannot do any work at all.

Section 8 – Driving

❑ I can drive my car without neck pain.
❑ I can drive my car as long as I want with slight pain in my neck.
❑ I can drive my car as long as I want with moderate pain in my neck.
❑ I cannot drive my car as long as I want because of moderate pain in my neck.
❑ I can hardly drive my car at all because of severe pain in my neck.
❑ I cannot drive my car at all.

Section 9 – Sleeping

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

Section 10 – Recreation

❑ I am able engage in all recreational activities with no pain in my neck at all.
❑ I am able engage in all recreational activities with some pain in my neck.
❑ I am able engage in most, but not all recreational activities because of pain in my neck.
❑ I am able engage in a few of my usual recreational activities because of pain in my neck.
❑ I can hardly do any recreational activities because of pain in my neck.
❑ I cannot do any recreation activities at all.

Patient Signature: _____