PATIENT HISTORY

Date of Birth _____ Age _____ Social Security # _____

Last _____ First _____ Middle Initial _____

Address _____ City _____ ST _____ Zip _____

Phone (H) _____ (W) _____ (C) _____

Email _____ May we send you our online newsletter? ☐yes ☐no

Your Occupation _____ Employer _____

Spouse's Name _____ Spouse DOB _____ Spouse SSN: _____

Contact in case of emergency _____ Phone _____

Have you been to another doctor for this problem? ☐yes ☐no Who/Where? _____

WHAT BRINGS YOU TO OUR OFFICE? Please provide as much detail as possible.

PRIMARY COMPLAINT: _____

Date when symptom first appeared _____ Did it begin: ☐ Gradual ☐Sudden ☐Progressive over time

What makes the symptoms increase? _____ What relieves the symptoms? _____

Type of Pain: ☐Sharp ☐Dull ☐Ache ☐Burn ☐Throb Does the Pain Radiate into your: ☐Arm ☐Leg ☐Does not radiate

Do you have Numbness or Tingling? ☐yes ☐no How often do you experience these symptoms? ☐100% ☐75% ☐50% ☐25% ☐ 10%

Please rate the intensity of your symptoms on a scale of 1-15 (1 being no symptoms, 15 being extreme) _____

Please list all previous treatments for this condition (give doctor's name and dates if possible) _____

_____

Do you have any family members who suffer from the same complaint? If so, who? _____

SECONDARY COMPLAINT: _____

Date when symptom first appeared _____ Did it begin: ☐ Gradual ☐Sudden ☐Progressive over time

What makes the symptoms increase? _____ What relieves the symptoms? _____

Type of Pain: ☐Sharp ☐Dull ☐Ache ☐Burn ☐Throb Does the Pain Radiate into your: ☐Arm ☐Leg ☐Does not radiate

Do you have Numbness or Tingling? ☐yes ☐no How often do you experience these symptoms? ☐100% ☐75% ☐50% ☐25% ☐ 10%

Please rate the intensity of your symptoms on a scale of 1-15 (1 being no symptoms, 15 being extreme) _____

Please list all previous treatments for this condition (give doctor's name and dates if possible) _____

_____

Do you smoke? ☐yes ☐no If yes, how many packs per week? _____

Have you ever smoked in the past? ☐yes ☐no If yes, when did you quit? _____

WOMEN ONLY: Do you take birth control? ☐yes ☐no Are you pregnant? ☐yes ☐no

Do you consume alcohol? ☐yes ☐no If yes, how many drinks per week? _____

Do you consume caffeine? ☐yes ☐no If yes, how many drinks per day? _____

Do you exercise? ☐yes ☐no If yes, how many times per week and what type? _____

Do you have a high stress level? ☐yes ☐no If yes, list reasons: _____

_____

Please list any medications or vitamins you are currently taking:

_____

_____

_____

_____

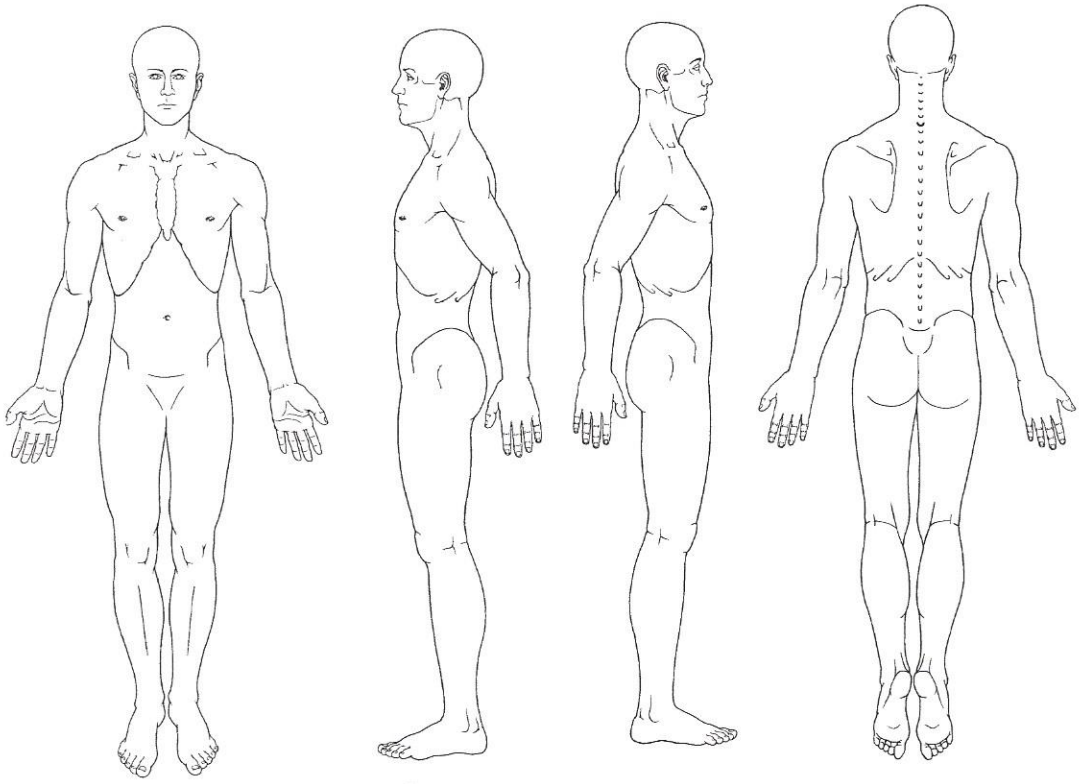
_____

PATIENT SIGNATURE _____ DATE _____

PATIENT HISTORY

Please mark off the areas of your complaint on the diagram above with the following indicators:

PPP = pain
NNN = numbness
TTT= tingling
BBB= burning
CCC= cramping
XXX = other



Please list all surgeries, injuries, accidents, falls, etc: _____

_____

_____

_____

_____

_____

Please check if you have had any of the following:

☐ AIDS/HIV	☐ Alcoholism	☐ Anemia	☐ Allergy Shots	☐ Anorexia
☐ Anorexia	☐ Arthritis	☐ Asthma	☐ Bleeding Disorders	☐ Breast Lump
☐ Bronchitis	☐ Bulimia	☐ Cancer	☐ Cataracts	☐ Chemical Dependency
☐ Chicken Pox	☐ Diabetes	☐ Disc Degeneration	☐ Emphysema	☐ Epilepsy
☐ Epilepsy	☐ Glaucoma	☐ Goiter	☐ Gonorrhea	☐ Gout
☐ Heart Attack	☐ Heart Disease	☐ Hepatitis	☐ Hernia	☐ Herpes
☐ High Blood Pressure	☐ High Cholesterol	☐ Kidney Disease	☐ Liver Disease	☐ Measles
☐ Migraine	☐ Miscarriage	☐ Mononucleosis	☐ MS	☐ Mumps
☐ Osteoporosis	☐ Pacemaker	☐ Parkinson's Disease	☐ Pinched Nerve	☐ Pneumonia
☐ Polio	☐ Prostate Problem	☐ Prosthesis	☐ Psychiatric Care	☐ Stroke
☐ Rheumatic Fever	☐ Scarlet Fever	☐ Suicide Attempt	☐ Thyroid Problems	☐ Tonsillitis
☐ Tuberculosis	☐ Tumors/Growths	☐ Typhoid Fever	☐ Ulcers	☐ Vascular Disease
☐ Vaginal Infections	☐ Venereal Disease	☐ Whooping Cough	☐ Rheumatoid Arthritis	
☐ Other:				

PATIENT SIGNATURE _____ **DATE** _____

PERSONAL INJURY QUESTIONNAIRE

NAME: _____ DATE OF ACCIDENT_____

Where did accident happen? Describe the accident in your own words:_____

_____

_____

_____

What was your position in the car?

☐ **Driver:** if Driver, were your hands on the steering wheel? ☐ Left ☐ Right ☐ Both
☐ **Passenger:** If passenger, were you sitting in ☐ Front ☐ Right Rear ☐ Left Rear
➢ Did your vehicle strike another vehicle ☐ Yes ☐ No
➢ Was your vehicle struck by another vehicle ☐ Yes ☐ No
➢ Angles of impact… First Collision: ☐ Front ☐ Back ☐ Left ☐ Right
If Second Collision: ☐ Front ☐ Back ☐ Left ☐ Right
➢ Were you wearing a seat belt? ☐ Yes ☐ No
➢ Did you brace for impact? ☐ Yes ☐ No ☐I braced with my hands ☐I braced with my feet
➢ Which way were you facing at the time of impact… ☐ straight ahead ☐ Left ☐ Right

Did you strike anything in vehicle at time of impact? ☐ Yes ☐ No

If yes, specify what part of your body (head,chest,chin,shoulder,knee) struck the...

☐ Steering Wheel _____ ☐ Dashboard _____
☐ Windshield _____ ☐ Roof_____
☐ Left Side Door _____ ☐ Right Side Door_____
☐ Left Side Window. _____ ☐ Right Window _____
☐ Other _____

Did the seat back bend / break ? ☐ Yes ☐ No

Immediately following the accident, how did you feel?

☐ dizzy/dazed ☐ disoriented ☐ unconscious ☐ nervous ☐ nauseous ☐ upset ☐ weak ☐ Other

_____

Did you go to hospital ☐ Yes ☐ No

➢ **Were you admitted to the hospital?** ☐ Yes ☐ No if yes how long? _____
If you went to hospital, when? ☐ At time of accident ☐ Next day
How did you get to hospital? ☐ Ambulance ☐ Police Car ☐ Private Transportation
Name of Hospital:_____
Attended by Dr. _____
➢ **What treatment was given?**
☐none ☐placed in a cervical collar ☐x-rayed ☐ given stitches ☐Bandaged
☐ given pain medication ☐given instructions regarding concussions
☐given instructions regarding sprains and strains ☐ Physical Therapy
☐instructed to call a Orthopedic Surgeon ☐instructed to call a private physician
☐referred to this office for treatment ☐ Other _____
_____

Have you seen any other doctor as a result of this accident? ☐ Yes ☐ No

Doctor's name(s):

_____

CHIEF Complaints or Symptoms as a result of this accident's injuries

☐ **Neck pain**

☐ **Headache**
☐ **Migraine Headache**
☐ **Upper back pain**

☐ **Low Back Pain**

Are you experiencing radiating pain from the neck? ☐ **yes** ☐ **no**
if YES, where does the pain travel? (check all that apply
☐ left shoulder ☐ left arm ☐ left forearm ☐ left hand
☐ right shoulder ☐ right arm ☐ right forearm ☐ right hand
☐ other _____

Are you experiencing radiating pain from the back? ☐ **yes** ☐ **no**
☐ none ☐ buttocks ☐ left buttock ☐ left thigh
☐ left knee ☐ left foot ☐ right buttock
☐ right thigh ☐ right knee ☐ right foot

☐ **Hip Pain**	☐ Left	☐ Right	☐ Both Sides
☐ **Knee Pain**	☐ Left	☐ Right	☐ Both Sides
☐ **Foot Pain**	☐ Left	☐ Right	☐ Both Sides

☐ **Numbness or Tingling :**

☐ Left Hand ☐ Left Upper Arm ☐ Right Hand ☐ Right Upper Arm
☐ Left Foot ☐ Left Leg ☐ Right Foot ☐ Right Leg

☐ **Other Symptoms (check all that apply)**

☐ **Ringing in Ears**	☐ Left	☐ Right	☐ Both Ears
☐ **Jaw Pain**	☐ Left	☐ Right	☐ Both Sides
☐ **Blurry Vision**	☐ Left	☐ Right	☐ Both Eyes
☐ **Wrist Pain**	☐ Left	☐ Right	☐ Both Wrists

☐ Dizziness ☐ nervousness ☐ fatigue ☐ anxiety ☐ depression ☐ excessive irritability
☐ fear of driving in a car ☐ a loss of concentration ☐ jaw clenching
☐ grinding of teeth ☐ nightmares ☐ difficulty with sleeping

Additional Symptoms/ Complaints:

Have You lost any time from work due to your injuries? ☐**Yes** ☐**No**
If yes please give dates: _____

Type of employment: _____

Have you had previous injuries or accidents? ☐**Yes** ☐ **No**

Description of previous Accident: _____

_____

Description of previous injuries: _____

_____

Is there any residual pain from the previous injury? ☐**Yes** ☐**No**
How much better did you feel prior to your current condition? (Example 100%, 80% etc.) _____

Insurance Information

Your Auto Insurance

Company Name_____

Address_____

City,ST,Zip_____

Policy #_____

Agency_____City_____

CLAIM #_____

Your Health Insurance

Company Name_____

Policy #_____

Group #_____

Employer_____

Name of Insured_____

Were You Driving or a Passenger in Someone Else's Vehicle? If "yes" complete below:

Vehicle Owner's Information

Name_____

Address_____

City,ST,Zip_____

Phone_____

Vehicle Owner's Auto Insurance

Company Name_____

Address_____

City, ST, Zip_____

Policy Number #_____

Agency_____City_____

CLAIM #_____

Was Another Car "At Fault" In This Accident? If "yes" complete below:

Vehicle Driver's Information

Name_____

Address_____

City,ST,Zip_____

Phone_____

Vehicle Driver's Auto Insurance

Company Name_____

Address_____

City, ST, Zip_____

Policy Number #_____

Agency_____City_____

CLAIM #_____

If the vehicle was owned by SOMEONE ELSE:

Vehicle Owner's Information

Name_____

Address_____

City,ST,Zip_____

phone_____

Vehicle Owner's Auto Insurance

Company Name_____

Address_____

City,. ST, Zip_____

Policy Number #_____

Agency_____City_____

CLAIM #_____

The Following Information Is Required of **ALL** Patients

Has this accident been reported to the police? ☐ Yes ☐ No

If yes, did they come to the scene of the accident? ☐ Yes ☐ No

If yes, did they cite anyone with a traffic violation? ☐ Yes ☐ No

If yes, whom? ☐ me ☐ my driver ☐ the other driver

Have you reported this accident to any insurance company? ☐ yes ☐ no

If yes, which one(s) ☐ my own ☐ my driver's ☐ the owner's

☐ the other driver's ☐ The owner's of other car

Has a claim number been assigned?_____

Have you hired an attorney? ☐ yes ☐ no

If yes, Attorney's name_____

Address_____

City_____ST_____Zip_____

Phone_____ fax_____

Injury Statement, Authorization and Benefits Assignment

THIS IS TO CERTIFY that I, _____was involved in:

☐ An Automobile Accident ☐ Work Related Accident

☐ A Slip and Fall Accident ☐ Other_____

On (mm/dd/yy)_____At or Near_____

That I was injured as a result of the described incident, that I have been and I am now in pain because of it, and that I have requested care for my injuries from Peter G. Lazarnick, D. C.

I request that the doctor file for benefits on my behalf with my insurance company. I authorize him to release information to my attorney or to any insurance company involved in this case and I assign all insurance benefits to Peter G. Lazarnick, D. C. to be applied toward my account for services rendered to me.

The information in this questionnaire is true an accurate to the best of my knowledge.

Signed_____**Date**_____

Witness_____

Peter G. Lazarnick, D. C.

486 Bankhead Avenue
Carrollton, GA 30117

Phone 770-834-7477
Fax 770-834-0251

Financial Policy
Personal Injury Cases

Our office policy is that payment is due in full at the time services are rendered unless other arrangements have been made. However, we are familiar with most auto insurance plans and will be glad to file claims and have the insurance company pay us directly after we have confirmed your benefits.

Medical Payments

"Medical Payments" is a type of auto insurance coverage that you buy on your policy to pay for treatment in the event you are injured in an accident, regardless of who is at fault. If you have "Med Pay" we will file our claims to YOUR auto insurance carrier and they will pay us directly, even if the accident is someone else's fault. Your auto carrier will be reimbursed by the "at fault" carrier when the case settles.

Health Insurance

If you do not have "medical payments" on your auto insurance, we may accept your health insurance. Once verified, we can submit claims and receive payment directly from your health insurance company. Any uncovered portion will need to be paid by you at the time services are rendered, unless other arrangements are made in advance.

Attorneys

If you have an attorney representing you, we will be happy to provide the office notes, documentation and letters of medical necessity to support your case. **We will not, however, wait for payment from an attorney with whom we do not have an established relationship.**

If you have a situation where you are not at fault and have no other insurance coverage, you must pay in full for all treatment at the time services are rendered unless you are retaining an attorney with whom we have a working relationship.

Arrangement

_____ I will pay for services as I go.
_____ Please file my "Med Pay"
_____ Please file my Major Medical Insurance
_____ Please accept a lien on my case with _____, Esq.

Signature _____ Date _____

Peter G. Lazarnick, D. C.

486 Bankhead Avenue
Carrollton, GA 30117
770-834-7477

Authorizations and Releases

NAME _____ CASE # _____

_____ Consent for Treatment

I, the undersigned, hereby authorize Peter G. Lazarnick, D. C., and whomever he may designate as his assistant(s), to perform diagnostic tests, including but not limited to radiographs, and to administer treatment as is necessary. I also certify that no guarantee or assurance has been made to the results that may be obtained.

I understand and agree that health and accident insurance policies are an arrangement between an insurance carrier and myself. Furthermore, I understand that this office will prepare any necessary reports and forms to assist me in making collection from my insurance company and that any amount authorized to be paid directly to this office will be credited to my account upon receipt. I permit this office to endorse remittances for the conveyance of credit to my account. HOWEVER, I CLEARLY UNDERSTAND AND AGREE THAT ALL SERVICES RENDERED TO ME ARE CHARGED DIRECTLY TO ME AND THAT I AM PERSONALLY RESPONSIBLE FOR PAYMENT.

Patient's Signature_____ Date _____ Witness _____

_____ Authorization to Release Medical Information

I authorize the release of any medical information necessary to process my insurance claim(s) and also certify that all insurance information given to this clinic is correct and complete.

Patient's Signature_____ Date _____ Witness _____

_____ Request for Payment of Benefits to Provider of Care

I hereby authorize the _____ Insurance Company/Insurance Administrator to pay by check, and for it to be mailed directly to Peter G. Lazarnick, D. C., the expense benefits allowable and otherwise payable to me under my current policy, as payment toward the total charges for professional services rendered. I have agreed to pay, in a current manner, any balance of said applicable charges. I agree that this office be given power of attorney to endorse/sign my name on any and all drafts for payment of my bill.

Patient's Signature_____ Date _____ Witness _____

_____ Attorney Representation and Protection of Balance

I, the undersigned patient, am directing my attorney, _____, to pay any outstanding bills out of my settlement and in effect, protecting any such balance. I hereby make and declare the instructions herein contained to be irrevocable. I fully understand that I am directly responsible for all medical bills and this agreement is made solely for the doctor's additional protection and 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 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 will require me to make payment on a current status.

Patient's Signature_____ Date _____ Witness _____

_____ Consent for Treatment of a Minor

I hereby authorize Peter G. Lazarnick, D. C., and whomever he may designate as his assistant(s), to perform diagnostic tests, including but not limited to radiographs, and to administer treatment as he deems necessary to my (son/daughter) _____ (child's name) _____.

Patient's Signature_____ Date _____ Witness _____

_____ X-ray/Medical Records Release

I have requested the release of records of (patient's name) _____, which are a part of the records at (facility) _____. I hereby request and authorize you, your employees and agents, to furnish to the person(s) listed below, or anyone designated in writing by them, all copies of records and reports, including copies of x-rays and photostatic copies, abstracts or excepts of all records and any other information they may request relating to any examination, treatment or opinion concerning any condition that I may have had in the past, now have, or may have in the future. Please forward this to: **Peter G. Lazarnick, D. C., 486 Bankhead Avenue, Carrollton, GA 30117**

Patient's Signature_____ Date _____ Witness _____

Peter G. Lazarnick, D. C.

486 Bankhead Avenue
Carrollton, GA 30117

Phone 770-834-7477
Fax 770-834-0251

INFORMED CONSENT TO CHIROPRACTIC ADJUSTMENTS AND CARE

I hereby request and consent to the performance of chiropractic adjustments and other chiropractic procedures, including various modes of physical therapy and diagnostic x-rays, on me (or on the patient named below, for whom I am legally responsible) by Peter G. Lazarnick, D. C. and/or other licensed doctors of chiropractic who now or in the future treat me while employed by, working or associated with serving as back up for Peter G. Lazarnick, D. C., including those working at the clinic or office listed below or any other office or clinic.

I have had an opportunity to discuss with Dr. Lazarnick and/or other office or clinic personnel the nature and purpose of chiropractic adjustments and other procedures. I understand that results are not guaranteed.

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, 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 on facts then known, is in my best interest.

I have read, or have 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 form to cover the entire course of treatment for my present condition and for any future condition(s) for which I seek treatment.

TO BE COMPLETED BY PATIENT OR PATIENT'S REPRESENTATIVE, IF NECESSARY; I.E., IF PATIENT IS A MINOR OR PHYSICALLY OR LEGALLY INCAPACITATED:

PRINT PATIENT'S NAME	SIGNATURE	DATE
REPRESENTATIVE	RELATIONSHIP	DATE
WITNESS TO PATIENT'S SIGNATURE		DATE

Security and Privacy Statement

The following statement is in response to the new federal guidelines known as HIPAA (Health Insurance Portability and Accountability Act). Public Law 104-191 August 16, 1996. This notice describes how medical information about you may be used and disclosed and how you can get access to this information. Our office utilizes an open floor plan; this allows greater interaction between individuals within the practice. Due to this arrangement, personal information concerning your symptoms and general condition may be overheard by other individuals in close proximity to you. X-ray view boxes may have films of your spine in indirect view of others while either being discussed with you, or are being viewed by the doctor for diagnostic purposes. No personal information will ever be intentionally shared. However, private reports containing any sensitive information will be discussed in a separate, private report room. Any private financial discussions can take place in private as well, at patient's request. Most financial arrangements are done this way initially. If you wish treatment in a private room, that is also an option. All patient files are kept under lock and key. No personal information is shared with anyone outside this office without prior written authorization by said patient; examples being attorney request or physician request. We currently do not file electronically so no information from this office is currently on the Internet. Patients may request copies of their records, but we are not legally responsible to supply the actual copy. Patients will need to supply their own copying devices to this office to receive such documents. Not all-patient information is subject to access. We will, on occasion, mail various letters or cards to our patients. This is to include recall cards, statements, newsletters, Christmas cards and personal letters to our patients. We may place a patient's name on our referral board as a thank you from time to time. In order to reschedule missed appointments and as a reminder of current appointments, phone calls will be made and/or messages left. At no time do we use these calls for the transfer of personal information. Patients may request that they are not contacted or be removed from mailing lists. We will make every effort to comply with these requests. This document may be updated as required by federal mandate. Your signature confers you have read and understand our privacy and confidentially policy. Complaints regarding our policies and procedures may be directed to Dr. Peter G. Lazarnick personally. Contact can be made during our normal business hours. We can be reached at 770-832-2226. This document will be kept on file. You may refuse to sign this document. A reason must be given and witnessed.

Signed _____ Date _____

Witness _____

Refusal _____

_____

DR. PETER G. LAZARNICK, C.M.P.
486 Bankhead Highway, Carrollton, GA 30117
Cell: (770) 853-7940 Telephone: (770) 832-2226 Fax: (770) 834-0251
www.askdrpete.com askdrpete@aol.com

DR. PETER G. LAZARNICK'S LIEN / MEDICAL RECORDS RELEASE

I, _____, hereby authorize this Clinic to furnish you, my attorney, with a full report of the examination, diagnosis, treatment, prognosis, etc., of myself, in regard to the injury/illness for which I was treated.

I hereby further authorize and direct you, my attorney of record, to pay to this Clinic all such sums as may be due and owing for professional services rendered to me, both by reason of this injury/illness and by reason of any other outstanding bills that are due to this Clinic and to withhold such sums from any settlement, judgment or verdict as may be necessary to adequately protect this Clinic. I further give a lien on my case to this Clinic against any and all proceeds of any settlement, judgment or verdict, which may be paid to you, my attorney of records, or myself, as the result of the injury/illness for which I have been treated or injuries in connection therewith.

I understand that I am directly and fully responsible to this Clinic for all professional bills for services rendered to me, and that this agreement is made solely for this Clinic's 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.

Patient's Signature _____ Date _____

Clinic Account # _____ DOI _____

The undersigned, being the attorney of record, or authorized representative 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 this Clinic.

Attorney's Signature _____ Date _____

Note to Attorney: Please sign, date and return the original to our office as soon as possible.

Dr. Peter G. Lazarnick

486 Bankhead Highway • Carrollton, GA 30117, 770-832-2226

NECK PAIN QUESTIONNAIRE

Patient Name: _____ Date: _____

Patient Signature: _____

This questionnaire is designed to enable us to understand how much your neck pain had affected your ability to manage your everyday activities. Please answer each section by checking the ONE CHOICE that most applies to you. Please select the one choice which most closely describes your problem right now.

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.

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.

Personal Care (Washing, Dressing, etc.)

- ☐ I can look after myself normally 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.

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.

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, but I can manage 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.

Driving

- ☐ I can drive my car without any 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 at all because of severe pain in my neck.
- ☐ I cannot drive my car at all.

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 to 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.

Sleeping

- ☐ I have no trouble sleeping.
- ☐ My sleep is slightly disturbed (less than 1 hour 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 hours sleepless).
- ☐ My sleep is completely disturbed (5-7 hours)

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.

Recreation

- ☐ I am able to engage in all of my recreational activities with no neck pain at all.
- ☐ I am able to engage in all of my recreational activities with some pain in my neck.
- ☐ I am able to engage in most, but not all of my recreational activities because of pain in my neck.
- ☐ I am able to engage in a few of my 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 recreational activities at all.

Dr. Peter G. Lazarnick

486 Bankhead Highway • Carrollton, GA 30117, 770-832-2226

LOW BACK PAIN QUESTIONNAIRE

Patient Name: _____ **Date:** _____

Patient Signature: _____

This questionnaire is designed to enable us to understand how much your low back pain had affected your ability to manage your everyday activities. Please answer each section by checking the ONE CHOICE that most applies to you. Please select the one choice which most closely describes your problem right now

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.

Personal Care

- ☐ 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 increases the pain, but I manage not to change my way of doing it.
- ☐ Washing and dressing increases 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 or dressing without help.

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.
- ☐ Pain prevents me from lifting heavy weights off the floor, but I can manage if they are conveniently positioned, eg. 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.

Walking

- ☐ Pain does not prevent me from walking any distance.
- ☐ Pain prevents me from walking more than one mile.
- ☐ Pain prevents me from walking more than 1/2 mile.
- ☐ Pain prevents me from walking more than 1/4 mile.
- ☐ I can only walk while using a cane or on crutches.
- ☐ I am in bed most of the time and have to crawl to the toilet.

Sitting

- ☐ I can sit in any chair as long as I like without pain.
- ☐ 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 1/2 hour.
- ☐ Pain prevents me from sitting more than ten minutes.
- ☐ Pain prevents me from sitting at all.

Standing

- ☐ I can stand as long as I want without pain.
- ☐ I have some pain while 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 ten minute without increasing pain.
- ☐ I avoid standing, because it increases the pain straight away.

Sleeping

- ☐ I get no pain in bed.
- ☐ I get pain in bed, but it does not prevent me from sleeping well.
- ☐ Because of pain, my normal night's sleep is reduced by less than one than one quarter.
- ☐ Because of pain, my normal night's sleep is reduced by less than one-half.
- ☐ Because of pain, my normal night's sleep is reduced by less than three-quarters.
- ☐ Pain prevents me from sleeping at all.

Social Life

- ☐ 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, My e.g., dancing, etc.
- ☐ Pain has restricted my social life and I do not go out very often.
- ☐ Pain has restricted my social life to my home.
- ☐ I have hardly any social life because of the pain.

Traveling

- ☐ I get no pain while traveling.
- ☐ I get some pain while traveling, but none of my usual forms 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.

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 present.
- ☐ My pain is neither getting better nor worse.
- ☐ My pain is gradually worsening.
- ☐ My pain is rapidly worsening.

ACKNOWLEGMENT *of* RECIEPT *of the*

NOTICE of PRIVACY PRACTICES *of*

PETER G. LAZARNICK

herein after referred to as *the Clinic*.

I acknowledge that I was provided a copy of the Notice of Privacy Practices and that I have read them or declined the opportunity to read them and understand the Notice of Privacy Practices. I understand that these privacy practices will be followed by ***the Clinic*** to ensure the privacy of my personal health information. I understand that this form will be placed in my patient chart and maintained for six years.

_____ _____

Patient Name (*please print*) **Date**

_____

Signature of Patient, Parent, Legal Guardian or Patient's Legal Representative

_____

Please list below the names and your relationship of people to whom you authorize *the Clinic* to release your private health information:

Print Name	**Relationship**

This form will be placed in the patient's chart and maintained for six years.

PETER G. LAZARNICK, D.C., C.M.P.
486 Bankhead Highway, Carrollton, GA 30117
Cell: (770) 853-7940 Telephone: (770) 832-2226 Fax: (770) 834-0251
www.askdrpete.com askdrpete@aol.com

AUTHORIZATION TO RELEASE MEDICAL INFORMATION

TO: (Provider) _____

FAX NO.: _____

PATIENT: _____

DOB: _____

D/A: _____

I, _____, request the following information:
(Patient's Name)

X-Rays _____ History _____ Diagnosis _____ Reports _____ Billing _____

Concerning my: Accident _____ Injury _____ Illness _____ Other _____

To be released to: Dr. Peter G. Lazarnick

Address: 486 Bankhead Highway, Carrollton, GA 30117

Fax #: 770-834-0251

For the purpose of: _____

Signed: _____ Date: _____