BRAIN FUNCTION ASSESSMENT

This questionnaire is designed to enable us to understand how much your brain function has affected your ability to manage your everyday activities. CHECK ALL THAT APPLY AND SIGN LAST PAGE

Section A: Brain Endurance

- ☐ A decrease in attention span
- ☐ Mental fatigue
- ☐ Difficulty learning new things
- ☐ Difficulty staying focused and concentrating for extended periods of time
- ☐ Experiencing fatigue when reading sooner than in the past
- ☐ Experiencing fatigue when driving sooner than in the past
- ☐ Need for caffeine to stay mentally alert
- ☐ Overall brain function impairs your daily life

Section B: Posture and Movement

- ☐ Twitching or tremor in your hands and legs when resting
- ☐ Handwriting has gotten smaller and more crowded together
- ☐ A loss of smell to foods
- ☐ Difficulty sleeping or fitful sleep
- ☐ Stiffness in shoulders and hips that goes away when you start to move
- ☐ Constipation
- ☐ Voice has become softer
- ☐ Facial expression that is serious or angry
- ☐ Episodes of dizziness or light-headedness upon standing
- ☐ A hunched over posture when getting up and walking

Section C: Memory and Cognition

- ☐ Memory loss that impacts daily activities
- ☐ Difficulty planning, problems solving, or working with numbers
- ☐ Difficulty completing daily tasks
- ☐ Confusion about dates, the passage of time, or place
- ☐ Difficulty understanding visual images and spatial relationships (addresses and locations)
- ☐ Difficulty finding words when speaking
- ☐ Misplacement of things and inability to retrace steps
- ☐ Poor judgment and bad decisions
- ☐ Disinterest in hobbies, social activities or work
- ☐ Personality or mood changes

Section D: Temporal Lobe

- ☐ Reduced function in overall hearing
- ☐ Difficulty understanding language with background or scatter noise
- ☐ Ringing or buzzing in the ear
- ☐ Difficulty comprehending language without perfect pronunciation
- ☐ Difficulty recognizing familiar faces
- ☐ Changes in comprehending the meaning of sentences, written or spoken
- ☐ Difficulty with verbal memory and finding words
- ☐ Difficulty remembering events
- ☐ Difficulty recalling previously learned facts and names
- ☐ Inability to comprehend familiar words when reading
- ☐ Difficulty spelling familiar words
- ☐ Monotone, unemotional speech
- ☐ Difficulty understanding the emotions of others when they speak (nonverbal cues)
- ☐ Disinterest in music and a lack of appreciation for melodies
- ☐ Difficulty with long-term memory
- ☐ Memory impairment when doing the basic activities of daily living
- ☐ Difficulty with directions and visual memory
- ☐ Noticeable differences in energy levels throughout the day

Section E: Occipital Lobe

- ☐ Difficulty coordinating visual inputs and hand movements, resulting in an inability to efficiently reach for objects
- ☐ Difficulty comprehending written text

BRAIN FUNCTION ASSESSMENT

- ☐ Floaters or halos in your visual field
- ☐ Dullness of colors in your visual field during different times of the day
- ☐ Difficulty discriminating similar shades of color

Section F: Frontal Cortex

- ☐ Difficulty with detailed hand coordination
- ☐ Difficulty with making decisions
- ☐ Difficulty with suppressing socially inappropriate thoughts
- ☐ Socially inappropriate behavior
- ☐ Decisions made based on desires, regardless of the consequences
- ☐ Difficulty planning and organizing daily evens
- ☐ Difficulty motivating yourself to start and finish tasks
- ☐ A loss of attention and concentration

Section G: Parietal Lobe

- ☐ Hypersensitivities to touch or pain
- ☐ Difficulty with spatial awareness when moving, laying back in a chair or leaning against a wall
- ☐ Frequently bumping into the wall or objects
- ☐ Difficulty with right-left discrimination
- ☐ Handwriting has become sloppier
- ☐ Difficulty finding words for written or verbal communication
- ☐ Difficulty recognizing symbols, words or letters

Section H: Pontomedullary Brainstem

- ☐ Difficulty swallowing supplements or large bites of food
- ☐ Bowel motility and movements slow
- ☐ BIoating after meals
- ☐ Dry eyes or dry mouth
- ☐ A racing heart
- ☐ A flutter in the chest or an abnormal heart rhythm

Section I: Basal Ganglia Direct Pathway

- ☐ A decrease in movement speed
- ☐ Difficulty initiating movement
- ☐ Stiffness in your muscles (not joints)
- ☐ A stooped posture when walking
- ☐ Cramping of your hand when writing

Section J: Basal Ganglia Indirect Pathway

- ☐ Abnormal body movements (such as twitching legs)
- ☐ Desires to flinch, clear your throat, or perform some type of movement
- ☐ Constant nervousness and a restless mind
- ☐ Compulsive behaviors
- ☐ Increased tightness and tone in specific muscles

Section K: Cerebellum

- ☐ Difficulty with balance, or balance that is noticeably worse on one side
- ☐ A need to hold the handrail or watch each step carefully when going down stairs
- ☐ Episodes of dizziness
- ☐ Nausea, car sickness, or seasickness
- ☐ A quick impact after consuming alcohol
- ☐ A slight hand shake when reaching for something
- ☐ Back muscles that tire quickly when standing or walking
- ☐ Chronic neck or back muscle tightness

_____ _____

Patient Signature Date

SPRING GROVE PHYSICAL MEDICINE & REHABILITATION

CANCELLATION FORM

Cancellation/No Show Policy

To get the most benefit from your rehabilitation, it is imperative that you attend all scheduled visits and keep to your scheduled appointment time. If you are unable to attend your appointment, you must give **24 hour notice**. If you cancel on the day of an appointment or do not show for an appointment **YOU**, not your insurance company, will be charged a $25 (adj., ½hr. mass, PT) or $50 (1 hr. mass, neuro.) no-show fee. If you cancel and/or do not show 3 times in a row you will be discharged from treatment.

***Re-Billing**

If you have an account balance and you have not made a payment after 30 days, you will be charged a rebilling fee of $20.00 each month until you start making monthly payments.
Payment arrangements are available if needed. Please ask for more information.

Past Due Account Notice

Your account is considered past due after 90 days without a payment. At this time we will send you notification of your account status along with a request for payment. If your account reaches 120 days and still no payment has been received on your account, it will be turned over to collections. You will then be held responsible for your original account balance plus 30% collections fee that the agency requires. To avoid this, please make a payment on your account monthly*.

Office policy is subject to change and may do so without notice

_____ _____

Patient Signature Date

SPRING GROVE PHYSICAL MEDICINE & REHABILITATION

INFORMED CONSENT FORM

INFORMED CONSENT FOR CHIROPRACTIC, MEDICAL, AND/OR PHYSICAL THERAPY TREATMENT AND CARE

I hereby consent to the performance of the medical treatment and therapy I will be receiving that may include, but not limited to, chiropractic adjustments, modalities, including various modes of physical therapy which may include GyroStim therapy (on the patient listed below, for whom I am legally responsible). These treatments may be performed by a licensed doctor of chiropractic, and/or chiropractic assistant who now or in the future treat me while employed by, working, or associated with or serving as back-up for the providers named below, including those working at the clinic or office listed below.

I have had an opportunity to discuss with Spring Grove Physical Medicine & Rehabilitation and/or any other office or clinical personnel the nature and the purpose of chiropractic adjustments and other procedures.

I understand and am informed that, as in the practice of medicine, in the practice of chiropractic and physical therapy 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 upon the facts then known, is in my best interests.

I have read or have had read to me, the above consent. I have also had the 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.

Patient's Name: _____
Patient's Signature: _____ Date: _____
Witness to Signature: _____ Date: _____

TO BE COMPLETED BY PATIENT'S REPRESENTATIVE IF PATIENT IS A MINOR OR PHYSICALLY OR LEGALLY INCAPACITITATED.

Signature of Representative:
_____Date:_____

Relationship: _____

Witness to Signature: _____Date: _____

SPRING GROVE PHYSICAL MEDICINE & REHABILITATION

HEALTH HISTORY

Have you ever had any of the following medical conditions? Please check yes or no. If yes, please explain.

	Yes	No	EXPLAIN IF YES
Allergies or hayfever			
Alcohol/drug abuse			
Anemia			
Arthritis			
Asthma			
Cardiac condition – heart murmur, congenital defect			
Cancer			
Chronic bronchitis or emphysema			
Chest pain or angina			
Depression or psychological concerns			
Diabetes			
Firbromyalgia or chronic pain syndrome			
Guillian - Barre Syndrome			
Gout			
Head injury or concussion			
Heart attack			
Heart surgery or pacemaker			
Hemophilia or other blood disorder			
High blood pressure or hypertension			
HIV positive or AIDS			
Hypoglycemia			
Kidney disease or stones			
Liver disease (Hepatitis, jaundice, cirrhosis)			
Migraine Headaches			
Multiple Sclerosis			
Parkinson's Disease			
Polio			
Pneumonia			
Rheumatic Fever or Scarlet Fever			
Seizure Disorder or Epilepsy			
Shortness of breath			
Stroke or TIA (transient ischemic attack)			
Thyroid problems			
Tuberculosis			
Ulcers or other stomach problems			
Other (please specify)			

WOMEN ONLY:
ARE YOU PREGNANT? ☐YES ☐NO IF YES, HOW FAR ALONG: _____
NURSING? ☐YES ☐NO

HEALTH HISTORY

Reason for this visit: work, sports, auto, trauma, or chronic.
Please explain:

_____

_____

Please describe the pain and its location:

_____

_____

When did this condition begin: _____/_____/_____
Is this condition interfering with your: work, sleep, or daily routine.
If yes, please explain:

_____

Have you had this or similar conditions in the past ☐ Yes ☐ No
If yes, please explain:

_____

Have you been seen elsewhere for this condition?

_____

_____

What x-rays, scans, CTs, or MRIs have you had recently: _____
Results:

_____

Goals for treatment:

_____

_____

Smoking Status: ☐ never smoked ☐ current daily ☐ current occasional ☐ former smoker.
List all previous operations/hospitalizations:

_____

_____

List any past serious accidents with dates:

_____

Are you wearing: ☐ heel lifts, ☐ sole lifts, ☐ inner soles, ☐ arch supports, ☐ orthotics What age is your mattress? _____ Is it comfortable? Yes ☐ No ☐
Have you had any illnesses in the last 3 weeks (cold, flu, urinary infection)? ☐ Yes ☐ No Do you have a pacemaker, implant, or organ transplant? ☐ Yes ☐ No_____ Current occupation: _____

Does your job involve: ☐ prolonged sitting, ☐ prolonged standing,
☐ Prolonged walking ☐ use of small equipment, ☐ use of large equipment,
☐ frequent lifting, ☐ bending, ☐ climbing or turning, ☐ repetitive movement.

I understand the above information and guarantee this for was completed correctly to the best of my knowledge and understand that it is my responsibility to inform this office of any changes in my medical status.

_____ _____
Patient Signature Date

Spring Grove Physical Medicine & Rehabilitation, 2100 Route 12, Suite 100, Spring Grove, IL 60081

SPRING GROVE PHYSICAL MEDICINE & REHABILITATION

MEDICATION LIST

Name: _____ DOB: _____

Allergies (include reaction and date):

_____
_____
_____
_____
_____

Medications / Supplements / Over the Counter:

Medication (brand and generic)	Dosage	Frequency	Route (oral/injection/topical)

_____ _____

Patient Signature Date

PAIN SCALE INFORMATION

This questionnaire is designed to enable us to understand how much your pain has affected your ability to manage your everyday activity. PLEASE ONLY MARK THE ONE 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

- ☐ I do not have to change the way I wash and dress to avoid pain.
- ☐ I do not normally change the way I wash or dress myself even though it causes pain.
- ☐ Washing and dressing increases the pain, but I can do it without changing my way of doing it.
- ☐ Because of my pain, I am partially unable to wash or dress myself without help.
- ☐ Because of my pain, I am completely unable to wash or dress myself without help.

Section 3 – Lifting

- ☐ I can lift heavy weights without increased pain.
- ☐ I can lift heavy weights but it causes increased pain.
- ☐ Pain prevents me from lifting heavy objects off the floor, but I can manage if they are conveniently places (i.e., on the 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 lighter weights.
- ☐ I cannot lift or carry anything at all.

Section 4 – Walking

- ☐ I have no pain when walking.
- ☐ I have some pain when walking, but can still walk my normal distances.
- ☐ Pain prevents me form walking long distances.
- ☐ Pain prevents me from walking intermediate distances.
- ☐ Pain prevents me from walking even short distances.
- ☐ Pain prevents me from walking at all.

Section 5 – Sitting

- ☐ Sitting does not cause me pain.
- ☐ I can sit as long as I need provided I have my choice of sitting surfaces.
- ☐ Pain prevents me from sitting more than 1 hour.
- ☐ Pain prevents me from sitting more than ½ hour.
- ☐ Pain prevents me from sitting more than 10 minutes.
- ☐ Pain prevents me from sitting at all.

Section 6 – Standing

- ☐ I can stand as long as I want without increased pain.
- ☐ I can stand as long as I want but my pain increased with time.
- ☐ Pain prevents me from standing more than 1 hour.
- ☐ Pain prevents me from standing more than ½ hour.z
- ☐ Pain prevents me from standing more than 10 minutes.
- ☐ Pain prevents me from standing.

Section 7 – Sleeping

- ☐ I get no pain while I am in bed.
- ☐ I get pain in bed but it does not prevent me from sleeping well.
- ☐ Because of my pain, my duration of sleep is ¾ of my normal amount.
- ☐ Because of my pain my duration of sleep is ½ my normal amount.
- ☐ Because of my pain my duration of sleep is ¼ my normal amount.
- ☐ Pain prevents me from sleeping at all.

Section 8 – Social Life

- ☐ My social life is normal and does not increase my pain.
- ☐ My social life is normal, but it increases my level of pain.
- ☐ Pain prevents me from participating in more energetic activities (i.e., sports, dancing, etc).
- ☐ Pain prevents me from going out very often.
- ☐ Pain has restricted my social life to my home.
- ☐ I hardly have any social life because of my pain.

Section 9 – Traveling

- ☐ I get no pain while traveling
- ☐ I get some pain while traveling, but it does not make travel worse.
- ☐ I get some pain while traveling, but it does not cause me to seek alternative forms of travel.
- ☐ I get increased pain while traveling which does require me to seek alternative forms of travel.
- ☐ Pain restricts all forms of travel.
- ☐ Pain prevents all forms of travel except for any lying down.

Section 10 – Employment/Home making

- ☐ My normal job/homemaking activities do not cause pain.
- ☐ My normal job/homemaking activities cause me extra pain, but I can still perform all that is required of me.
- ☐ I can perform most of my job/homemaking duties, but pain prevents me from performing more physically stressful activities.
- ☐ Pain prevents me from doing anything but light duties.
- ☐ Pain prevents me from even light duties.
- ☐ Pain prevents me from performing any job/homemaking chores

_____ _____

Patient Signature Date

SPRING GROVE PHYSICAL MEDICINE & REHABILITATION

PATIENT INFORMATION

Name: _____
Date: _____
Birthdate: _____
SS#: _____
Home Address: _____
City: _____ State: _____ Zipcode: _____
Home phone: _____ Cell phone: _____
Work phone: _____ Other phone: _____
Email: _____
Preferred method of contact: _____
Referred by: _____
Occupation: _____

Marital status: ☐single ☐married ☐divorce ☐separated ☐widowed.
Spouse's name: _____

Race: ☐ White ☐ Hispanic or Latino ☐ Black or African American ☐ Asian
☐ American Indian or Alaska Native ☐ Native Hawaiian or other Pacific Islander

Preferred Language: ☐ English ☐ Spanish ☐ Other (specify):

Insurance Information
Company name: _____
Phone number: _____ Ethnicity:
Insured's name: _____
Relation: _____ Date of birth: _____
Insured's ss#: _____
Member ID #: _____
Group #: _____

Emergency contact information
Who should we contact: _____
Relation: _____
Home phone number: _____
Work phone number: _____

I consent to receiving text/voice/unencrypted e-mail messages ☐ Yes

_____ _____
Patient Signature Date

SPRING GROVE PHYSICAL MEDICINE & REHABILITATION

PATIENT PRIVACY FORM

Patient consent for use and/or disclosure of protected health information to carry out treatment, payment and healthcare operations.

_____, hereby state that by signing this Consent, I acknowledge and agree

The Practice's Privacy Notice has been provided to me prior to my signing this Consent. The Privacy Notice includes a complete description of the uses and/or disclosures of my protected health information ("PHI") necessary for the Practice to provide treatment to me, and also necessary for the Practice to obtain payment for the treatment and to carry out its health operations. The Practice explained to me that the Privacy Notice will be available to me in the future at my request. The Practice has further explained my right to obtain a copy of the Privacy Notice prior to signing this Consent, and has encouraged me to read the Privacy Notice carefully prior to my signing this Consent.

The Practice reserves the right to change its privacy practices that are described in it Privacy Notice, in accordance with applicable law.I understand that, and consent to, the following appointment reminders that will be used by the Practice: a) a postcard mailed to me at the address provided by me; and b) telephoning my
home and leaving a message on my answering machine or with the individual answering the phone.

The Practice may use and/or disclose my PHI (which includes information about my health or condition and the treatment provided to me) in order for the Practice to treat me and obtain payment for that treatment, and as necessary for the Practice to conduct its specific healthcare operations.

I understand that I have the right to request that the Practice restrict how my PHI is used and/or disclosed to carry out treatment, payment and/or healthcare operations. However, the Practice is not required to agree to any restrictions that I have requested. If the Practice agrees to a requested restriction, then the restriction is binding on the Practice.
I understand that this Consent is valid for seven years. I further understand that I have the right to revoke this Consent, in writing, at any time for all future transactions, with the understanding that any such revocation shall not apply to the extent that the Practice has already taken action in reliance on this Consent.
I understand that if I revoke this Consent at any time, the Practice has the right to refuse to treat me.
I understand that if I do not sign this Consent evidencing my consent to the uses and disclosures described to me above and contained in the Privacy Notice, then the Practice will not treat me.

I have read and understand the foregoing notice, and all of my questions have been answered to my full satisfaction in a way that I can understand.

Patient's Name: _____
Patient's Signature: _____Date: _____
Signature of Legal Representative: _____
(ie. Attorney-In-Fact, Guardian, Parent if a minor)
Relationship: _____
Witness: _____Date_____

VEHICLE ACCIDENT INFORMATION

PATIENT INFORMATION

Date_____

Patient Name_____

Date of Accident_____ Time of Accident_____ ☐ a.m. ☐ p.m.

Please describe the accident in your own words:_____

_____

_____

_____

Were you the: ☐ Driver ☐ Front Passenger ☐ Rear Passenger ☐ Pedestrian

How many people were in the accident vehicle?_____

ACCIDENT SITE

Road/Street Name_____

City/State _____

Nearest intersection with road/street_____

Driving conditions ☐ Dry ☐ Wet ☐ Icy ☐ Other _____

Which direction were you headed? _____

Speed you were traveling?_____

VEHICLE

Make and model of vehicle you were in:

_____

Were you wearing a seatbelt? ☐ Yes ☐ No

If yes, what type? ☐ Lap ☐ Shoulder

Was vehicle equipped with airbags? ☐ Yes ☐ No

If yes, did it/they inflate properly? ☐ Yes ☐ No

Did your seat have a headrest? ☐ Yes ☐ No

If yes, what was the position of the headrest?

☐ Low ☐ Midposition ☐ High

IMPACT

Did your car impact another vehicle? ☐ Yes ☐ No

Did your car impact a structure? ☐ Yes ☐ No

If yes, explain_____

_____

Did any part of your body strike anything in the vehicle?

☐ Yes ☐ No If yes, explain_____

Was impact from :

☐ Front ☐ Rear ☐ Left ☐ Right ☐ Other_____

At the time of impact were you:

☐ Looking straight ahead ☐ Looking to the right

☐ Looking to the left ☐ Looking down

☐ Looking up

Were both hands on the steering wheel? ☐ Yes ☐ No

If no, which hand was on the wheel? ☐ Right ☐ Left

Was your foot on the brake? ☐ Yes ☐ No

If yes, which foot was on the brake? ☐ Right ☐ Left

Were you: ☐ Surprised by impact ☐ Braced for impact

OTHER VEHICLE
(if applicable)

Make and model of other vehicle_____

Which direction was other vehicle headed?_____

Speed other vehicle was traveling_____

POLICE

Did the police come to the accident site? ☐ Yes ☐ No

Were there any witnesses? ☐ Yes ☐ No

Was a police report filed? ☐ Yes ☐ No

Was a traffic violation issued? ☐ Yes ☐ No

If yes, to whom?_____

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PATIENT CONDITION

Were you unconscious immediately after the accident? ☐ Yes ☐ No If yes, for how long?_____

Please describe how you felt immediately after the accident:

_____

_____

TREATMENT

Did you go to the hospital? ☐ Yes ☐ No

When did you go? ☐ Immediately after accident ☐ Next day ☐ 2 days or more after the accident

How did you get to the hospital? ☐ Ambulance ☐ Private transportation

Name of hospital_____ Name of doctor_____

Diagnosis_____

_____

Treatment received_____

X-rays taken_____

SYMPTOMS/INJURIES

Have you been able to work since this injury? ☐ Yes ☐ No How many work days have you missed?_____

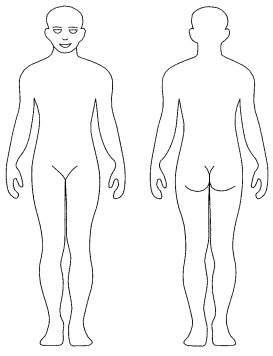
Prior to the injury were you able to work on an equal basis with others your age? ☐ Yes ☐ No

If you have had any of the following symptoms since your injury, please ☑ check:

☐ Arm/shoulder pain	☐ Feet/toe numbness	☐ Neck pain
☐ Back pain	☐ Hand/finger numbness	☐ Neck stiff
☐ Back stiffness	☐ Headaches	☐ Shortness of breath
☐ Chest pain	☐ Irritability	☐ Sleep difficulty
☐ Dizziness	☐ Jaw problems	☐ Stomach upset
☐ Ear buzzing	☐ Leg pain	☐ Tension
☐ Ear ringing	☐ Memory loss	☐ Vision blurred
☐ Fatigue	☐ Nausea	

Is this condition getting progressively worse? ☐ Yes ☐ No ☐ Unknown

Mark an X on the picture where you continue to have pain, numbness, or tingling.



Rate the severity of your pain on a scale from 1 (least pain) to 10 (severe pain)_____

Type of pain:

☐ Sharp	☐ Dull	☐ Throbbing	☐ Numbness
☐ Aching	☐ Shooting	☐ Burning	☐ Tingling
☐ Cramps	☐ Stiffness	☐ Swelling	☐ Other_____

How often do you have this pain?_____

Is it constant or does it come and go?_____

Does it interfere with your: ☐ Work ☐ Sleep ☐ Daily Routine ☐ Recreation

Movements that are painful to perform: ☐ Sitting ☐ Standing ☐ Walking ☐ Bending ☐ Lying Down

To the best of my knowledge, the above information is complete and correct. I understand that it is my responsibility to inform my doctor if I, or my minor child, ever have a change in health.

_____ _____

Signature of Patient, Parent, Guardian or Personal Representative Date

_____ _____

Please print name of Patient, Parent, Guardian or Personal Representative Relationship to Patient