Welcome to Colorado Springs Chiropractic
Patient and Contact Information & History

Dr. David Doyle, DC
2812 W. Colorado Ave. #104, Colorado Springs, CO 80904
Phone: (719) 358-5170 Fax: (719) 634-6770

Please fill out the following form in as much detail as possible. All your health information is kept confidential.

Name: Today's Date:

Address:

City State: Zip:

Gender: ☐ Male ☐ Female Height: Weight: DOB:

Home Phone: Cell Phone: Work Phone:

Occupation: Marital Status: ☐ Single ☐ Married ☐ Divorced

E-mail Address:

Emergency Contact Name: Phone:

Insurance Information:

Plan Name: Subscriber Name:

Subscriber ID #: Group #: Spouse Name:

How did you hear about our office?

Medication List: Please list the name of each current prescribed and over the counter medications, prescribed use and any side effects/reactions.

Medication	Purpose of Taking Medication	Any Side Effects

Doctors Notes:

NEUROLOGICAL & METABOLIC CASE HISTORY

What is the main problem/symptom that you are having?

List other symptoms you are currently experiencing even if not related to complaint listed above:

Describe what you are feeling (diffuse, dull, ache, sharp, burning, cramping)?

When did this begin? How did this begin?

Have you had this or similar conditions in the past? If yes, when?

No

What makes your condition worse?

What makes your condition better?

Do you experience Numbness or Tingling?

No

If yes, where? Does it radiate down the arm(s), leg(s), back or other?

SYMPTOM INTENSITY: Please choose the number describing the intensity of symptoms.

0/None

When you are awake, how often are you feeling these symptoms? (0-100%)

Does this affect you at night?

When do you experience this throughout the day (AM/PM/All Day)?

How many days per week do you experience your main complaint?

Is this progressively getting worse?

Is your condition: ☐ Constant ☐ Comes & Goes

Have you had any treatment for this problem in the past? If yes, when/by whom?

No

How did the previous method(s) work for you?

Are there any conditions that run in your family?

If yes, what condition(s) and what family member?

When was your last: Physical Blood/lab work X-ray MRI

Have you been treated for your current condition before? If yes, when/by whom?

No

Surgical History: Please list the type and reason of surgery, and year performed (e.g. left breast for cancer in 2004)

REVIEW OF SYSTEMS

Changes in or loss of smell? ☐ Normal ☐ Loss ☐ Increased ☐ Decreased

Monovision Correction?

Visual changes or loss of vision?

Difficulty with visual focus or activity?

Double vision? If yes, in which direction?

☐ Dry eyes? ☐ Dry Mouth? ☐ Excessive tearing or saliva?

Weakness or numbness of the face?

☐ Difficulty hearing ☐ Ringing in the ears?

Maintaining balance with or without head movements?

Light headedness/dizziness when rising from a lying or seated position?

Sensations of spinning? If yes, which direction?

Difficulty swallowing foods?

☐ Poor digestion? ☐ Constipation? ☐ Diarrhea? ☐ Abnormal bowel movements?

☐ Bladder control issues?

Changes in sexual function or ability?

Increasing food sensitivities? ☐ Gluten? ☐ Dairy? ☐ Other?

Excessive bloating?

Difficulty shrugging or raising your arms or shoulders?

Slurring your words or your tongue feeling thick?

Sweaty hands or feet?

Cold hands or feet?

Noticeable sweating difference on the right or the left?

Please check any of the following conditions or complaints that you have or are experiencing

☐ AD/HD	☐ Adrenal Disorder	☐ Anxiety	☐ Arthritis	☐ Asthma
☐ Atypical Facial Pain	☐ Arm or Leg Pain	☐ Autoimmune Condition	☐ Balance Problems	☐ Bleeding Disorder
☐ Blood Sugar Issues	☐ Blurred Vision	☐ Buzzing in Ear(s)	☐ Carpal Tunnel	☐ Cancer
☐ Celiac Disease	☐ Chest Pains	☐ Chronic Fatigue	☐ Colitis/Diverticulitis	☐ Compression Fractures
☐ Concussion	☐ Connective Tissue	☐ COPD	☐ Depression	☐ Diabetes: ☐ 1 ☐ 2
☐ Digestive Issues	☐ Dizziness	☐ Double Vision	☐ Dyslexia	☐ Ear Infections
☐ Fibromyalgia	☐ Food Sensitivity	☐ Fusions (Spinal)	☐ Gout	☐ Gall Bladder Issue
☐ Headache	☐ Heart Disease	☐ Hepatitis: ☐ A ☐ B ☐ C	☐ Herpes	☐ High Blood Pressure
☐ Hip Replacement	☐ HIV/AIDS	☐ Immune Deficiency	☐ Insomnia	☐ Joint Pain
☐ Kidney Disease	☐ Liver Disease	☐ Low Back Pain	☐ Migraine	☐ Multiple Sclerosis
☐ Neck Pain	☐ Osteoporosis/Pena	☐ Regional Pain Synd. (CRPS)	☐ Rotator Cuff Issues	☐ Shoulder Pain
☐ Stroke/TIA	☐ STI/STD	☐ Tremors	☐ Trigeminal Neuralgia	☐ TMJ
☐ Thyroid Issues	☐ Tuberculosis	☐ Tingling ☐ Burning ☐ Numbness in Hands or Feet		☐ Vertigo

PATIENT FINANCIAL RESPONSIBILITY PATIENT RECORD OF DISCLOSURES/HIPAA ACKNOWLEDGEMENT

Thank you for choosing Colorado Springs Chiropractic. We are committed to providing you with the highest quality healthcare. We ask that you read and sign this form to acknowledge your understanding of our Patient Financial Responsibility Policies and HIPPA Acknowledgment.

INSURANCE: The patient (or patient's guardian, if a minor) is ultimately responsible for the payment for treatment and care. We will bill your insurance for you; however, it is the patient's responsibility to know the details of their insurance in addition to any lapses in insurance coverage. If you do not inform us of special requirements required by your plan, and we provide medically necessary services that are not covered by your plan, we may bill you directly for those charges.

COPAYS, DEDUCTIBLES & CO-INSURANCE: All patients are responsible for their co-payments, deductibles, and past due balances at the time of service.

CANCELLATION/NO SHOW OF APPOINTMENTS: When an appointment is not kept, it creates an unused appointment slot that could have been used for another patient. It is very important that you call to cancel your appointment. **If for any reason you need to cancel or reschedule an appointment, please notify our office within 24 hours to avoid a fee of $30.00 for cancellation or $45 for no shows.**

RETURNED CHECKS: There will be a $25 service fee for any check returned for insufficient funds.

E-MAIL/TEXT MESSAGING: Patients in our office may be contacted via email and/or text messaging to remind you of an appointment, to obtain feedback on your experience and to provide general health reminders/information. If at anytime you provide an e-mail or text address at which you may be contacted, you are consent to receiving appointment reminders and other healthcare information/communications at that email/text address from the Practice. *This practice does not charge for this service, but standard text messaging rates may apply as provided in your wireless plan (contact your carrier for pricing plans and details).*

☐ I consent to receive text messages from the practice at my cell phone or e-mail as stated below I understand that this request to receive emails and text messages will apply to all future appointment reminders/feedback/health information.

PLEASE NOTE THAT ANY BENEFIT INFORMATION FURNISHED IS NOT A GUARANTEE OF PAYMENT NOR A DETERMINATION OF MEDICAL NECESSITY AND FINAL CLAIM DETERMINATION WILL BE MADE UPON RECEIPT AND REVIEW OF THE CLAIM. THE PATIENT IS RESPONSIBLE FOR ALL BALANCES OUTSTANDING.

In general, the HIPAA privacy rule gives individuals the right to request a restriction on uses and disclosures of their protected health information (PHI). The individual is also provided the right to request confidential communications or that a communication of PHI be made by alternative means, such as sending correspondence to the individual's office instead of the individual's home.

I wish to be contacted in the following manner(check all that apply):

- Home Phone:
- Cell Phone:
- E-Mail:

I authorize Dr. Doyle to discuss my protected health information with the following family members or healthcare providers that are caring for me. I authorize the release of my medical health records from/to other healthcare providers that are caring for me.

Name: Name:

Relationship: Relationship:

Phone: Phone:

I understand that I may revoke this authorization at any time, which will then apply to any future disclosures of my protected health information. I have been given the opportunity to review the Notice of Privacy Practices available in the office.

Signature of Patient/Guardian: Date:

Colorado Springs Chiropractic

Informed Consent Document

To the patient: Please read this entire document prior to signing it. It is important that you understand the information contained in this document. Please ask questions before you sign if there is anything that is unclear.

The nature of the chiropractic adjustment

The primary treatment we use as a Doctor of Chiropractic is spinal manipulative therapy (SMT, CMT). We will use this procedure to treat you. We may use our hands or a mechanical instrument upon your body in such a way as you move your joints. That may cause an audible "pop" or "click", much as you have experienced when you "crack" your knuckles. You may feel a sense of movement.

Analysis/Examination/Treatment

As part of the analysis, examination, and treatment, you are consenting to the following procedures:

--Spinal manipulative therapy --Palpation --Vital Signs
--Range of motion testing --Orthopedic testing --Neurological testing
--Postural analysis --EMS/TENS/Galvanic --Imaging and Lab studies as indicated
--hot/cold therapy --Stretching --massage therapy --exercise rehabilitation
--Microcurrent --low level laser therapy --SSEP --Functional medicine/supplements --Other_____

The material risks inherent in chiropractic care

As with any healthcare procedure, there are certain complications which may arise during chiropractic manipulation and physiotherapy. These complications include but are not limited to: fractures, disc injuries, dislocations, muscle strains, ligament sprains, cervical myelopathy, and burns. Some types of manipulation of the neck have been associated with injuries to the arteries in the neck leading to or contributing to complications including stroke (CVA). Some patients will feel some stiffness and soreness following the first few days of treatment. I 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 my attention, it is your responsibility to inform me. Cauda Equina Syndrome has been reported in rare cases which requires immediate medical care.

The probability of those risks occurring

Statistically, Chiropractic Care has been demonstrated to be one of the safest of all healthcare practices. Fractures are rare occurrences and generally result from some underlying weakness of the bone which I check for during the raking of your history and examination. CVA has been the subject of tremendous disagreement. The incidences of stroke are exceedingly rare and are estimated to occur one in five million cervical adjustments. Two major studies (2008, 2015) showed there was not causation between CMT and CVA but rather the patient was already presenting with arterial dissection. The other complications are also generally described as rare.

The availability and nature of other treatment options

Other treatment options for your condition may include:

-Self-administered, over-the-counter (OTC) analgesics, ice, head or rest.
-Medical care and prescription drugs such as anti-inflammatories, muscle relaxants and pain killers.
-Hospitalization/Surgery

If you choose to use on of the above noted "other treatment" options, you should be aware that there are severe risks associated with these treatments. Many patients taking OTC NSAID's such as Ibuprofen and Acetaminophen are not aware that every year there are thousands of deaths associated with their use. No medicine should ever be taken without discussing their side effects and inherent statistical danger with their primary care physician or pharmacist. The PDR is also a good reference regarding pharmaceutical use.

The risks and dangers attendant to remaining untreated

Remaining untreated may create adhesions or scar tissue that can weaken the area and reduce mobility. Further joint degeneration may occur as well as the development of chronic pain syndromes. Over time this process may complicate treatment making it more difficult and less effective the longer it is postponed.

DO NOT SIGN UNTIL YOU HAVE READ AND UNDERSTAND THE ABOVE.

I have read or have had read to me the above explanation of the chiropractic adjustment and related treatment. 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. Having been informed of the risks, I hereby give my consent to that treatment.

DATED: **PATIENTS NAME:** **SIGNATURE:**

SIGNATURE OF PARENT OR GUARDIAN (if minor):

DATED: **DOCTOR'S NAME:** **Dr.DavidDoyle** **SIGNATURE:** 

PERSONAL INJURY VERIFICATION

Patient Name: E-Mail:

Home Phone: Cell Phone:

Address: City: State: Zip:

Birthdate: Age: Marital Status: DIVORCED

Employer: Occupation:

Emergency Contact: Phone:

MED-PAY

Policy Holder: Insurance Company:

Policy #: Claim #:

Amount of Coverage Available: Adjuster Name:

Billing Address: City: State: Zip:

Phone #: Fax:

LIABILITY (3RD PARTY)

Policy Holder: Insurance Company:

Policy #: Claim #:

Amount of Coverage Available: Adjuster Name:

Billing Address: City: State: Zip:

Phone #: Fax:

ATTORNEY

Name:

Address: City: State: Zip:

Phone #: Fax:

Paralegal/Contact:

AUTO ACCIDENT PATIENT HISTORY

Patient Name: Date:

Accident Information

Date of Accident: Were you the: PASSENGER

What type of vehicle were you in: OTHER (Type Here) Whose vehicle was involved: SOMEONE ELSE'S

Were you wearing a seat belt: NO Your vehicle: HIT ANOTHER VEHICLE

Type of Accident: FRONT IMPACT (rear-end car in front)

Symptoms from the Accident

Did you get bleeding cuts or bruises: No

If YES, what bleeding cuts or bruises did you get?

Please describe how you felt. Be specific.

Immediately after the accident:

Later that day/night:

The next day:

Work Status

Occupation/Job Title:

Have you missed time from work? NO

If YES, full time off work: to

Returned to modified work: to

Have you been unable to work since the accident? NO

Medical Provider Lien

David Doyle, PC
2812 W Colorado Ave, #106
Colorado Springs, CO 80904

I do hereby authorize the above-mentioned provider to furnish you, my attorney, with a full report of the medical provider's examination, diagnosis, treatment, prognosis, etc., of myself regarding the accident of . I hereby authorize and direct you, my attorney, to pay directly to the above-mentioned medical provider such sums as may be due and owing for medical and related services rendered me by reason of this accident and to withhold such sums from any settlement, judgement or verdict as may be necessary to pay such obligations. I hereby further give a lien on my case to the above-mentioned medical provider against any and all proceeds of my settlement, judgement or verdict which may be paid to you, my attorney, or myself, as the result of the injuries for which I have been treated by the above-mentioned medical provider in connection with the above-mentioned accident.

I agree never to rescind this document and that a rescission will not be honored by my attorney. I hereby instruct that in the event another attorney is substituted in this matter, the new attorney honor this lien as inherent to the settlement and enforceable upon the case as if it were executed by him.

I fully understand that I am directly and fully responsible to the above-mentioned medical provider for all medical bills submitted for service rendered me and that this agreement is made solely for the above-mentioned medical provider's additional protection and in consideration of awaiting payment. And I further understand that such payment is not contingent on any settlement, judgement, or verdicts by which I may eventually recover said fee.

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 above-mentioned medical provider, said provider will not await payment and may declare the entire balance due and payable.

Dated

Patient Signature Patient's Printed Name

I acknowledge receipt of the above lien

_____ _____

Attorney Signature Date

COMPLAINTS

Patient Name: **Date:**

Please answer each of the below by putting a check mark in the appropriate box.

NECK OR CERVICAL SPINE

Neck Pain & Soreness	NONE
Loss of Pain with Movement	NONE
Pain/Numbness/Tingling in Arm or Hand	NONE
Weakness in Arm or Hand	NONE

MID-BACK OR THORACIC SPINE

Mid-Back Pain	NONE
Rib or Chest Pain	NONE

LOWER BACK OR LUMBAR SPINE

Lower Back Pain & Soreness	NONE
Loss of Pain with Movement	NONE
Pain into Hips or Buttocks	NONE
Pin into Legs, Knees or Feet	NONE
Numbness/Burning in Legs or Feet	NONE

OTHER COMPLAINTS

Headaches	NONE
Visual Disturbances/Blurry Vision	NONE
Ringing or Buzzing in Ears	NONE
Nausea or Vomiting	NONE
Difficulty Breathing	NONE
Dizziness	NONE
Recent Weight Loss	NONE
Bowel or Bladder Dysfunction	NONE

AGGRAVATED BY

Coughing	NONE
Sneezing	NONE
Prolonged Sitting	NONE
Prolonged Standing	NONE
Prolonged Riding in Car	NONE
Lying on Stomach	NONE

Other Injury Areas

NONE

NONE

NONE

Headache Disability Index

Patient Name: Date:

INSTRUCTIONS:

Please CHECK the correct response:

1. I have headache: ☐ 1x per month ☐ more than 1x but less than 4x per month ☐ more than 1x per week

2. My headache is: ☐ mild ☐ moderate ☐ severe

Please read carefully:
The purpose of the scale is to identify difficulties that you may be experiencing because of your headache. Please check off “YES”, “SOMETIMES”, or “NO” to each item. Answer each question as it pertains to your headache only.

NO	F1. Because of my headaches I feel handicapped.
NO	F2. Because of my headaches I feel restricted in performing my routine daily activities.
NO	E3. No one understands the effect my headaches have on my life.
NO	F4. I restrict my recreational activities (e.g., sports, hobbies) because of my headaches.
NO	E5. My headaches make me angry.
NO	E6. Sometimes I feel that I am going to lose control because of my headaches.
NO	F7. Because of my headaches I am less likely to socialize.
NO	E8. My spouse (significant other), or family and friends have no idea what I am going through because of my headaches.
NO	E9. My headaches are so bad that I feel that I am going to go insane.
NO	E10. My outlook on the world is affected by my headaches.
NO	E11. I am afraid to go outside when I feel that a headache is starting.
NO	E12. I feel desperate because of my headaches.
NO	F13. I am concerned that I am paying penalties at work or at home because of my headaches.
O	E14. My headaches place stress on my relationships with family or friends.
NO	F15. I avoid being around people when I have a headache.
NO	F16. I believe my headaches are making it difficult for me to achieve my goals in life.
NO	F17. I am unable to think clearly because of my headaches.
NO	F18. I get tense (e.g., muscle tension) because of my headaches.
NO	F19. I do not enjoy social gatherings because of my headaches.
NO	E20. I feel irritable because of my headaches.
NO	F21. I avoid traveling because of my headaches.
NO	E22. My headaches make me feel confused.
NO	E23. My headaches make me feel frustrated.
NO	F24. I find it difficult to read because of my headaches.
NO	F25. I find it difficult to focus my attention away from my headaches and on other things.

For Office use Only: TOTAL SCORE: Scoring Yes = 4 Points No = 2 Points Sometimes = 0 Points

Other Comments:

I certify that I have completed this form accurately to the best of my knowledge

Neck Pain Disability Index Questionnaire

Patient Name: Date:

Please read: This questionnaire is designed to enable us to understand how much your back pain has affected your ability to manage everyday life. Please answer each section by selecting the **ONE CHOICE** that most applies to you. We realize that you may feel that more than one statement may relate to you, but please **just select the one choice which closely describes your problem right now.**

SECTION 1 – Pain Intensity F

A I have no pain at the moment.
B The pain is very mild at the moment.
C The pain is moderate at the moment.
D The pain is fairly severe at the moment.
E The pain is very severe at the moment.
F The pain is the worst imaginable at the moment.

SECTION 2 – Personal Care F

A I can look after myself normally without causing extra pain.
B I can look after myself normally, but it causes extra pain.
C It is painful to look after myself and I am slow and careful.
D I need some help but can manage most of my personal care.
E I need help every day in most aspects of self-care.
F I do not get dressed, I wash with difficulty and stay in bed.

SECTION 3 – Lifting F

A I can lift heavy weights without extra pain.
B I can lift heavy weights, but it causes extra pain.
C Pain prevents me from lifting heavy weights off the floor, but I can manage if they are conveniently place, for example on a table.
D Pain prevents me from lifting heavy weights off the floor, but I can manage if they are conveniently positioned, e.g., on a table.
E I can only lift very light weights at the most.
F I cannot lift or carry anything.

SECTION 4 – Reading F

A I can read as much as I want to with no pain in my neck.
B I can read as much as I want to with slight pain in my neck.
C I can read as much as I want with moderate pain in my neck.
D I can't read as much as I want because of moderate pain in my neck.
E I can hardly read at all because of severe pain in my neck.
F I cannot read at all.

SECTION 5 – Headache F

A I have no headaches at all.
B I have slight headaches, which come infrequently.
C I have moderate headaches, which come infrequently.
D I have moderate headaches, which come frequently.
E I have severe headaches, which come frequently.
F I have headaches almost all the time.

SECTION 6 – Concentration F

A I can concentrate fully when I want to with no difficulty.
B I can concentrate fully when I want to with slight difficulty.
C I have a fair degree of difficulty in concentrating when I want to.
D I have a lot of difficulty in concentrating when I want to.
E I have a great deal of difficulty in concentrating when I want to.
F I cannot concentrate at all.

SECTION 7 – Work F

A I can do as much work as I want to.
B I can only do my usual work, but no more.
C I can do most of my usual work, but no more.
D I cannot do my usual work.
E I cab hardly do any work at all.
F I can't do any work at all.

SECTION 8 – Driving F

A I can drive my car without any neck pain.
B My social life is normal but increases the degree of my pain.
C Pain has no significant effect on my social life apart from limiting my more energetic interests, e.g., dancing, etc.
D Pain has restricted my social life, and I do not go out very often.
E Pain has restricted my social life to my home.
F I have hardly any social life because of the pain.

SECTION 9 – Sleeping F

A I have no trouble sleeping.
B My sleep is slightly disturbed (less than 1 hr sleepless)
C My sleep is mildly disturbed (1-2 hrs sleepless)
D My sleep is moderately disturbed (2-3 hrs sleepless)
E My sleep is greatly disturbed (3-5 hrs sleepless)
F My sleep is completely disturbed (5-7 hrs sleepless)

SECTION 10 – Recreation F

A I am able to engage in all of my recreational activities with no neck pain at all.
B I am able to engage in all of my recreational activities with some pain in my neck.
C I am able to engage in most, but not all of my recreational activities because of pain in my neck.
D I am able to engage in a few of my recreational activities because of pain in my neck.
E I can hardly do any recreational activities because of pain in my neck.
F I cannot do any recreational activities at all.

I certify that I have completed this form accurately to the best of my knowledge

Revised Oswestry
Low Back Pain Questionnaire

Patient Name: Date:

Please read: This questionnaire is designed to enable us to understand how much your back pain has affected your ability to manage everyday life. Please answer each section by selecting the **ONE CHOICE** that most applies to you. We realize that you may feel that more than one statement may relate to you, but please **just select the one choice which closely describes your problem right now.**

SECTION 1 – Pain Intensity F

A The pain comes and goes and is very mild.
B The pain is mild and does not vary much.
C The pain comes and goes and is moderate.
D The pain is moderate and does not vary much.
E The pain comes and goes and is severe.
F The pain is severe and does not vary much.

SECTION 2 – Personal Care F

A I do not have to change my way of washing or dressing to avoid pain.
B I do not normally change my way of washing or dressing even though it causes some pain.
C Washing and dressing increases the pain, but I manage not to change my way of doing it.
D Washing and dressing increases the pain and I find it necessary to change my way of doing it
E Because of the pain I am unable to do some washing and dressing without help
F Because of the pain I am unable to do any washing and dressing without help.

SECTION 3 – Lifting F

A I can lift heavy weights without extra pain.
B I can lift heavy weights, but it causes extra pain.
C Pain prevents me from lifting heavy weights off the floor.
D Pain prevents me from lifting heavy weights off the floor, but I can manage if they are conveniently positioned, e.g., on a table.
E Pain prevents me from lifting heavy weights, but I can manage light to medium weights if they are conveniently positioned.
F I can only lift very light weights at the most.

SECTION 4 – Walking F

A I have no pain on walking.
B I have some pain on walking, but it does not increase with distance.
C I cannot walk more than one mile without increasing pain.
D I cannot walk more than 1/2 mile without increasing pain.
E I cannot walk more than 1/4 mile without increasing pain.
F I cannot walk at all without increasing pain

SECTION 5 – Sitting F

A I can sit in any chair as long as I like.
B I can sit only in my favorite chair as long as I like.
C Pain prevents me from sitting more than one hour.
D Pain prevents me from sitting more than 1/2 hour.
E Pain prevents me from sitting more than 10 minutes.
F I avoid sitting because it increases pain straight away.

SECTION 6 – Standing F

A I can stand as long as I want without pain.
B I have some pain on standing but it does not increase with time.
C I cannot stand for longer than one hour without increasing pain.
D I cannot stand for longer than 1/2 hour without increasing pain.
E I cannot stand for longer than 10 minutes without increasing pain.
F I avoid standing because it increases the pain immediately.

SECTION 7 – Sleeping F

A I get no pain in bed.
B I get pain in bed, but it does not prevent me from sleeping well.
C Because of pain my normal night's sleep is reduced by less than 1/4.
D Because of pain my normal night's sleep is reduced by less than 1/2.
E Because of pain, my normal night's sleep is reduced by less than 3/4.
F Pain prevents me from sleeping at all.

SECTION 8 – Social Life F

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

SECTION 9 – Traveling F

A I get no pain while traveling.
B I get some pain while traveling, but none of my usual forms of travel make it any worse.
C I get extra pain while traveling, but it does not compel me to seek alternative forms of travel.
D I get extra pain while traveling, which compels me to seek alternative forms of travel.
E Pain restricts all forms of travel.
F Pain prevents all forms of travel except that done lying down.

SECTION 10 – Changing Degree of Pain F

A My pain is rapidly getting better.
B My pain fluctuates but overall is getting better.
C My pain seems to be getting better, but improvement is slow at present.
D My pain is neither getting better nor worse.
E My pain is gradually worsening.
F My pain is rapidly worsening.

I certify that I have completed this form accurately to the best of my knowledge

ACNC Concussion Symptom Score Sheet

If you are unsure of a question or do not feel well enough to complete this form you may leave it blank and ask for assistance from one of our staff members.

Patient Name: Date of Injury: Today's Date:

(0 = No Symptoms) (1-2 = Very Mild) (3-4 = Mild) (5-6 = Moderate) (7-8 = Severe) (9-10 = Worst Ever)

Please indicate the number that best matches the way you feel right now.

Headache:	10
Nausea:	10
Vomitting:	10
Balance Problems:	10
Dizziness:	10
Fatigue/Drowsiness:	10
Trouble Falling Asleep:	10
Needing More Sleep:	10
Sensitivity to Light:	10
Sensitivity to Noise:	10
Irritability:	10
Sadness:	10
Nervousness:	10
Feeling Emotional:	10
Numbness or Tingling:	10
Feeling Slowed Down:	10
Feeling Mentally Foggy:	10
Trouble Concentrating:	10
Memory Issues:	10

I certify that I have completed this form accurately to the best of my knowledge

Concussion Questionnaire

Patient Name: Date of Injury: Today's Date:

Please answer the following questions in good detail.

Have you ever had: NONE NONE NONE

Specifically, what symptoms or stressful situations were going on BEFORE, DURING and IMMEDIATELY FOLLOWING your concussion?

(Examples: I was going through a divorce, then I got a 24 gut bug, I was under immense amounts of stress at work/school, I was dealing with IBS, constipation/diarrhea, anxiety/depression, an autoimmune condition, diabetes, type A personality, I was on day 20 of my menstrual cycle)

BEFORE:

DURING:

IMMEDIATELY FOLLOWING:

I certify that I have completed this form accurately to the best of my knowledge