

Motor Vehicle Accident Information

Last Name:	Social Security no.:
First Name:	Middle:

General Information

Date of Accident:			
Location (circle one)	Driver		
	Passenger	Location (circle one)	Front / Middle / Rear
		Position (circle one)	Left / Middle / Right

Work from Left to Right and Circle One

Patients Vehicle	Type :	Car / Van / Pickup / Truck / Bus / SUV / M. Cycle / Other:
	Size :	Mini / Sub Comp / compact / Mid Size / Full Size
	Action :	Stopped / Slowing / Acceleration / Cruising
	Speed : (MPH)	
	Time of Accident:	Day Light / Dawn / Dusk / Dark
	Road Condition :	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)

(Select one)	Name Object :		
<input type="checkbox"/> Vehicle	Vehicle Type :	Car / Van / Pickup / Truck / Bus / SUV / M. Cycle / Other:	
	Size :	Mini / Sub Comp / compact / Mid Size / Full Size	
<input type="checkbox"/> Object	Damage to Veh.:	Minimal / Moderate / Extensive / Totaled / Unsure	
Impact Location			

Impact Information: Vehicle or Object (II)

(Select one)	Name Object :		
<input type="checkbox"/> Vehicle	Vehicle Type :	Car / Van / Pickup / Truck / Bus / SUV / M. Cycle / Other:	
	Size :	Mini / Sub Comp / compact / Mid Size / Full Size	
<input type="checkbox"/> Object	Damage to Veh.:	Minimal / Moderate / Extensive / Totaled / Unsure	
Impact Location			

Impact Information: Vehicle or Object (III)

(Select one)	Name Object :		
<input type="checkbox"/> Vehicle	Vehicle Type :	Car / Van / Pickup / Truck / Bus / SUV / M. Cycle / Other:	
	Size :	Mini / Sub Comp / compact / Mid Size / Full Size	
<input type="checkbox"/> Object	Damage to Veh.:	Minimal / Moderate / Extensive / Totaled / Unsure	
Impact Location			

Bentree Clinic
13153 N. Dale Mabry Hwy
Suite 109
Tampa, Florida 33618-2410

During Impact Information:

Seat Belt?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Brakes Applied ?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Air Bag Deployed?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Seat Broken ?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Seat Back position Changed?	<input type="checkbox"/> Yes	<input type="checkbox"/> No			

Head Rest : (Circle one)	Low / Mid / High / None
Prepare for Accident: (Circle One)	Un-expected / Expected / Expected and Braced
Body Position : (Circle one)	Straight / Rotated Left / Rotated Right / Unsure / Other:
Body Thrown?	<input type="checkbox"/> Yes / <input type="checkbox"/> No
Direction of Throw :(Circle One)	Backwards / Forward / Outside / Unsure / Other:

(Circle One)

Head Position :	Straight / Rotated Left / Rotated Right / Forward / Unsure / Other:
Head Motion :	Forward Backwards / Backwards Forward / Right Left / Left Right / Unsure / Other:

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

<input type="checkbox"/> Head	<input type="checkbox"/> Upper Back	<input type="checkbox"/> Right hand	<input type="checkbox"/> Lower Back
<input type="checkbox"/> Left Shoulder	<input type="checkbox"/> Left Leg	<input type="checkbox"/> Mid Torso	<input type="checkbox"/> Right Foot
<input type="checkbox"/> Left Arm	<input type="checkbox"/> Right Leg	<input type="checkbox"/> Mid Back	<input type="checkbox"/> Left Foot
<input type="checkbox"/> Left Elbow	<input type="checkbox"/> Right Shoulder	<input type="checkbox"/> Right Knee	<input type="checkbox"/> Other :
<input type="checkbox"/> Left hand	<input type="checkbox"/> Right Arm	<input type="checkbox"/> Left Knee	
<input type="checkbox"/> Upper Front Torso	<input type="checkbox"/> Right Elbow	<input type="checkbox"/> Lower Front Torso	

After Accident Information:

Immediately After Accident:	<input type="checkbox"/> Dizzy/dazed <input type="checkbox"/> Upset <input type="checkbox"/> Weak <input type="checkbox"/> Nervous <input type="checkbox"/> Headache <input type="checkbox"/> Disoriented <input type="checkbox"/> Unconscious
	<input type="checkbox"/> /Other:

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

<input type="checkbox"/> Head	<input type="checkbox"/> Left foot	<input type="checkbox"/> Right foot	<input type="checkbox"/> Left Knee
<input type="checkbox"/> Left Hand	<input type="checkbox"/> Left Shoulder	<input type="checkbox"/> Right Shoulder	<input type="checkbox"/> Right knee
<input type="checkbox"/> Right Arm	<input type="checkbox"/> Left Elbow	<input type="checkbox"/> Left Arm	<input type="checkbox"/> Other :
<input type="checkbox"/> Upper Front Torso	<input type="checkbox"/> Mid Torso	<input type="checkbox"/> Right elbow	
<input type="checkbox"/> Upper Back	<input type="checkbox"/> Mid back	<input type="checkbox"/> Lower Front Torso	
<input type="checkbox"/> Left Leg	<input type="checkbox"/> Right Leg	<input type="checkbox"/> Lower Back	

Numbness:	<input type="checkbox"/> Left Hand <input type="checkbox"/> Right Hand <input type="checkbox"/> Left Leg <input type="checkbox"/> Right Leg <input type="checkbox"/> Left Upper Arm
	<input type="checkbox"/> Right Upper Arm <input type="checkbox"/> Left Foot <input type="checkbox"/> Right Foot <input type="checkbox"/> Other:

Medical Information (Did you get medical care for this accident before coming to our office)

Medical Care?	<input type="checkbox"/> Yes <input type="checkbox"/> No
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Time of care	Next day / At time of Accident / Later that Day / Days Later: (Specify)
Transported	Drove Self / Ambulance / Other
Went To	Orthopedic / Chiropractor / Neurologist / Family Doc / ER / Other:(Specify)
Admitted to Hospital?	<input type="checkbox"/> Yes <input type="checkbox"/> No Days Spent in Hospita:
Test:	<input type="checkbox"/> X-ray <input type="checkbox"/> Lab Work <input type="checkbox"/> MRI <input type="checkbox"/> CT Scan <input type="checkbox"/> Other:(Specify)
Treatment:	<input type="checkbox"/> Ice Pack <input type="checkbox"/> Hot Pack <input type="checkbox"/> None <input type="checkbox"/> Cervical Collar <input type="checkbox"/> Medication <input type="checkbox"/> Other:(Specify)

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Previous Injuries

Previous Injuries / Accidents	<input type="checkbox"/> No <input type="checkbox"/> Yes, Specify:
Residual pain from Previous Injuries/Accidents	<input type="checkbox"/> No <input type="checkbox"/> Yes, Specify:

Later Symptoms (Please note any symptoms that started after the accident occurred)

Head	<input type="checkbox"/> Headache <input type="checkbox"/> Dizziness <input type="checkbox"/> Blurred Vision <input type="checkbox"/> Light Headedness <input type="checkbox"/> Loss of Vision <input type="checkbox"/> Fainting <input type="checkbox"/> Loss of Memory <input type="checkbox"/> Pain in ear <input type="checkbox"/> Double Vision <input type="checkbox"/> Other Specify:
Neck (with Movement)	<input type="checkbox"/> Pain in Neck <input type="checkbox"/> Forward <input type="checkbox"/> Backward <input type="checkbox"/> Turn Left <input type="checkbox"/> Popping in Neck <input type="checkbox"/> Muscle Spasms <input type="checkbox"/> Turn Right <input type="checkbox"/> Bend Left <input type="checkbox"/> bend Right <input type="checkbox"/> Other Specify:
Shoulders	<input type="checkbox"/> Pain in Shoulder joint <input type="checkbox"/> Tension in shoulders <input type="checkbox"/> Muscle Spasms in Shoulder <input type="checkbox"/> Pain across shoulder <input type="checkbox"/> Cant raise arms above [] Above shoulder level [] Over head <input type="checkbox"/> Other Specify:
Arms and Hands	<input type="checkbox"/> Pain in Fingers <input type="checkbox"/> Numbness in Left Arm <input type="checkbox"/> Hands Cold <input type="checkbox"/> Pin & needles in hands <input type="checkbox"/> Numbness in Right Arm <input type="checkbox"/> Loss of Grip Strength <input type="checkbox"/> Pin & needles in fingers <input type="checkbox"/> Swollen joints in Fingers <input type="checkbox"/> Other Specify:
Chest	<input type="checkbox"/> Chest pain <input type="checkbox"/> Pain Around Ribs <input type="checkbox"/> Shortness of Breadth <input type="checkbox"/> Breast Pain <input type="checkbox"/> Other Specify:
Abdomen	<input type="checkbox"/> Nervous Stomach <input type="checkbox"/> Nausea <input type="checkbox"/> Diarrhea <input type="checkbox"/> Gas <input type="checkbox"/> Constipation <input type="checkbox"/> Other Specify:
Mid back	<input type="checkbox"/> Sharp Stabbing <input type="checkbox"/> Mid pain back <input type="checkbox"/> Pain From front to back <input type="checkbox"/> Dull Ache <input type="checkbox"/> Pain in Kidney Area <input type="checkbox"/> Muscle Spasms <input type="checkbox"/> Pain between shoulders <input type="checkbox"/> Other Specify:
Lower Back	<input type="checkbox"/> Low Back Pain Low back pain is worse when <input type="checkbox"/> Working <input type="checkbox"/> Lifting <input type="checkbox"/> Stooping <input type="checkbox"/> Standing <input type="checkbox"/> Sitting <input type="checkbox"/> Bending <input type="checkbox"/> Coughing <input type="checkbox"/> Lying Down <input type="checkbox"/> Muscle Spasms <input type="checkbox"/> Other Specify:
Hips, Legs & Feet	<input type="checkbox"/> Pain in Buttocks <input type="checkbox"/> Pain and needles in Legs <input type="checkbox"/> Pain down leg <input type="checkbox"/> Pain in hip joint <input type="checkbox"/> Feet feel Cold <input type="checkbox"/> Swollen Feet <input type="checkbox"/> Numbness in Toes <input type="checkbox"/> Numbness of Leg <input type="checkbox"/> Knee pain <input type="checkbox"/> Leg cramps <input type="checkbox"/> Cramps in Feet <input type="checkbox"/> Other Specify:
General	<input type="checkbox"/> Nervousness <input type="checkbox"/> Fatigue <input type="checkbox"/> Irritable <input type="checkbox"/> Depressed <input type="checkbox"/> Generally Feel Rundown <input type="checkbox"/> Prostate Pain/Swelling <input type="checkbox"/> Difficulty Urinating <input type="checkbox"/> Night Urination <input type="checkbox"/> Cramping <input type="checkbox"/> Irregularity Loss of Sleep : [_____] hrs per night Loss of weight : [_____] lbs Gain weight : [_____] lbs Other: <div style="text-align: right; margin-top: 20px;"> Bentree Clinic 13153 N. Dale Mabry Hwy Suite 109 Tampa, Florida 33618-2410 </div>

Signature: _____

Date: _____

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

Medical History Information

Last Name: _____ Middle: _____
 First Name: _____
 Email: _____ Birth date: _____ Age: _____ Sex: _____
 Address: _____ City: _____ State: _____
 ZIP Code: _____ Social Security No.: _____ Home Phone: _____
 Occupation: _____ Employer: _____ Employer phone: _____

Mr. Miss
 Mrs. Ms.

Marital status (circle one)
 Single / Mar / Div / Sep /
 Widow

Medical Care Information

Do You Have a Family Doctor?: No Yes, Name of Doctor: _____
 Address: _____ City: _____ State: _____ ZIP Code: _____
 Date of last Visit: ____ / ____ / ____ Date of last exam: ____ / ____ / ____
 Do You Have a Family Chiropractor?: No Yes, Name of Chiropractor: _____
 Address: _____ City: _____ State: _____ ZIP Code: _____
 Date of last Visit: ____ / ____ / ____ Date of last exam: ____ / ____ / ____
 Have you had surgeries in the last 5 Years: Yes No If yes, Last Surgery Date: _____
 Reason for Surgery: _____

Present illness /Conditions:

<input type="checkbox"/> AIDS	<input type="checkbox"/> Cancer	<input type="checkbox"/> Heart Problem	<input type="checkbox"/> Multiple Sclerosis	<input type="checkbox"/> Spinal Disc Disease	
<input type="checkbox"/> Allergies	<input type="checkbox"/> Cirrhosis/hepatitis	<input type="checkbox"/> High blood pressure	<input type="checkbox"/> Pacemaker	<input type="checkbox"/> Thyroid trouble	<input type="checkbox"/> Epilepsy
<input type="checkbox"/> Anemia	<input type="checkbox"/> Diabetes	<input type="checkbox"/> HIV/ARC	<input type="checkbox"/> Prostate trouble	<input type="checkbox"/> Tuberculosis	<input type="checkbox"/>
<input type="checkbox"/> Arthritis	<input type="checkbox"/> Dislocated joints	<input type="checkbox"/> Kidney trouble	<input type="checkbox"/> Rheumatic fever	<input type="checkbox"/> Ulcer	<input type="checkbox"/>
<input type="checkbox"/> Asthma	<input type="checkbox"/> Diverticulitis	<input type="checkbox"/> Low Blood Pressure	<input type="checkbox"/> Scoliosis	<input type="checkbox"/> Polio	<input type="checkbox"/>
<input type="checkbox"/> Bone fracture	<input type="checkbox"/> Hay Fever	<input type="checkbox"/> Mental/ Emotional Difficulty	<input type="checkbox"/> Sinus trouble	<input type="checkbox"/> STD'S	<input type="checkbox"/>

Other: _____

Family History of illness:

<input type="checkbox"/> AIDS	<input type="checkbox"/> Cancer	<input type="checkbox"/> Multiple Sclerosis	<input type="checkbox"/> Spinal Disc Disease	<input type="checkbox"/> STD'S	
<input type="checkbox"/> Allergies	<input type="checkbox"/> Bone fracture	<input type="checkbox"/> Heart Problem	<input type="checkbox"/> Low Blood Pressure	<input type="checkbox"/> Sinus trouble	<input type="checkbox"/> Ulcer
<input type="checkbox"/> Anemia	<input type="checkbox"/> Cirrhosis/hepatitis	<input type="checkbox"/> HIV/ARC	<input type="checkbox"/> Mental/ Emotional Difficulty	<input type="checkbox"/> Epilepsy	<input type="checkbox"/> Polio
<input type="checkbox"/> Arthritis	<input type="checkbox"/> Diabetes	<input type="checkbox"/> High blood pressure	<input type="checkbox"/> Prostate trouble	<input type="checkbox"/> Thyroid trouble	<input type="checkbox"/> Scoliosis
<input type="checkbox"/> Asthma	<input type="checkbox"/> Dislocated joints	<input type="checkbox"/> Kidney trouble	<input type="checkbox"/> Rheumatic fever	<input type="checkbox"/> Tuberculosis	<input type="checkbox"/> Diverticulitis

Other: _____

Type of Cancer: Breast Lung Other: _____

Social History:

Alcohol? No Yes Cigarettes? No Yes Caffeine? No Yes Exercise? No Yes Hours per week?
 Drinks per week? Packs per day? Drinks per day? (circle one) Light / Moderate / Strenuous

Misc.: _____

Signature: _____ Date: _____

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

HISTORY OF SYMPTOMS

Patient's Name: _____

Date: _____

HEADACHES	
Location	<input type="checkbox"/> Left <input type="checkbox"/> Right <input type="checkbox"/> Both <input type="checkbox"/> Center
Specifics	<input type="checkbox"/> Frontal <input type="checkbox"/> Coronal <input type="checkbox"/> Occipital <input type="checkbox"/> Parietal <input type="checkbox"/> Temporal <input type="checkbox"/> Throughout
Pain Ratings	<input type="checkbox"/> 0 <input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4 <input type="checkbox"/> 5 <input type="checkbox"/> 6 <input type="checkbox"/> 7 <input type="checkbox"/> 8 <input type="checkbox"/> 9 <input type="checkbox"/> 10 (Excruciating)
Frequency	<input type="checkbox"/> Infrequent < 25% <input type="checkbox"/> Occasional 25% to 50% <input type="checkbox"/> Frequent 50% to 75% <input type="checkbox"/> Constant > 75%
Pain/Severity	<input type="checkbox"/> No Pain <input type="checkbox"/> Pain <input type="checkbox"/> Numbness <input type="checkbox"/> Tingling / <input type="checkbox"/> Mild <input type="checkbox"/> Moderate <input type="checkbox"/> Severe
Associated with	<input type="checkbox"/> Dizziness <input type="checkbox"/> Nausea <input type="checkbox"/> Visual Problems <input type="checkbox"/> Ringing/Buzzing ears <input type="checkbox"/> Bright light <input type="checkbox"/> Sensitivity <input type="checkbox"/> Loss of balance
Radiates to	<input type="checkbox"/> Neck <input type="checkbox"/> Right Eye <input type="checkbox"/> Left Eye <input type="checkbox"/> Right Ear <input type="checkbox"/> Left Ear <input type="checkbox"/> Right Jaw <input type="checkbox"/> Left Jaw
Described as	<input type="checkbox"/> Aching <input type="checkbox"/> Dull <input type="checkbox"/> Sharp <input type="checkbox"/> Stabbing <input type="checkbox"/> Throbbing
At it's worst	<input type="checkbox"/> Morning <input type="checkbox"/> Afternoon <input type="checkbox"/> Evening <input type="checkbox"/> Night After Activities: <input type="checkbox"/> Light <input type="checkbox"/> Moderate
What makes it better?	<input type="checkbox"/> Medication <input type="checkbox"/> Lying Down <input type="checkbox"/> Standing <input type="checkbox"/> Sitting <input type="checkbox"/> Stretching <input type="checkbox"/> Range of Motion <input type="checkbox"/> Nothing
What makes it worse?	<input type="checkbox"/> Bright lights <input type="checkbox"/> Housework <input type="checkbox"/> Loud noises <input type="checkbox"/> Neck movements <input type="checkbox"/> Watching T.V. <input type="checkbox"/> Reading <input type="checkbox"/> Working

Comments: _____

HEAD	
Location	<input type="checkbox"/> Left <input type="checkbox"/> Right <input type="checkbox"/> Both <input type="checkbox"/> Center
Pain Ratings	<input type="checkbox"/> 0 <input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4 <input type="checkbox"/> 5 <input type="checkbox"/> 6 <input type="checkbox"/> 7 <input type="checkbox"/> 8 <input type="checkbox"/> 9 <input type="checkbox"/> 10 (Excruciating)
Frequency	<input type="checkbox"/> Infrequent < 25% <input type="checkbox"/> Occasional 25% to 50% <input type="checkbox"/> Frequent 50% to 75% <input type="checkbox"/> Constant > 75%
Pain/Severity	<input type="checkbox"/> No Pain <input type="checkbox"/> Pain <input type="checkbox"/> Numbness <input type="checkbox"/> Tingling / <input type="checkbox"/> Mild <input type="checkbox"/> Moderate <input type="checkbox"/> Severe
Associated with	<input type="checkbox"/> Ringing/Buzzing ears <input type="checkbox"/> Decreased ROM <input type="checkbox"/> Dizziness <input type="checkbox"/> Increased Sensitivity <input type="checkbox"/> Inflammation <input type="checkbox"/> Sensitivity to Bright Light <input type="checkbox"/> shallow Breathing
Radiates to	<input type="checkbox"/> Ears <input type="checkbox"/> Eyes <input type="checkbox"/> Face <input type="checkbox"/> Left Ear <input type="checkbox"/> Left Eye <input type="checkbox"/> Left Jaw <input type="checkbox"/> Neck <input type="checkbox"/> Right Ear <input type="checkbox"/> Right Eye <input type="checkbox"/> Right Jaw <input type="checkbox"/> Shoulder
Described as	<input type="checkbox"/> Aching <input type="checkbox"/> Dull <input type="checkbox"/> Sharp <input type="checkbox"/> Stabbing <input type="checkbox"/> Throbbing
At it's worst	<input type="checkbox"/> Afternoon <input type="checkbox"/> During Night <input type="checkbox"/> Evening <input type="checkbox"/> Light Activities <input type="checkbox"/> Moderate Activities
What makes it better?	<input type="checkbox"/> Medication <input type="checkbox"/> Lying Down <input type="checkbox"/> Standing <input type="checkbox"/> Sitting <input type="checkbox"/> Stretching <input type="checkbox"/> Range of Motion <input type="checkbox"/> Nothing
What makes it worse?	<input type="checkbox"/> Bending <input type="checkbox"/> Bright lights <input type="checkbox"/> Chewing <input type="checkbox"/> Closing mouth <input type="checkbox"/> Deep Breathing <input type="checkbox"/> Extension <input type="checkbox"/> Grasping <input type="checkbox"/> Housework <input type="checkbox"/> Loud Noises <input type="checkbox"/> Neck Movement <input type="checkbox"/> Pushing

Comments: _____

JAW (TMJ)	
Location	<input type="checkbox"/> Left <input type="checkbox"/> Right <input type="checkbox"/> Both
Pain Ratings	<input type="checkbox"/> 0 <input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4 <input type="checkbox"/> 5 <input type="checkbox"/> 6 <input type="checkbox"/> 7 <input type="checkbox"/> 8 <input type="checkbox"/> 9 <input type="checkbox"/> 10 (Excruciating)
Frequency	<input type="checkbox"/> Infrequent < 25% <input type="checkbox"/> Occasional 25% to 50% <input type="checkbox"/> Frequent 50% to 75% <input type="checkbox"/> Constant > 75%
Pain/Severity	<input type="checkbox"/> No Pain <input type="checkbox"/> Pain <input type="checkbox"/> Numbness <input type="checkbox"/> Tingling / <input type="checkbox"/> Mild <input type="checkbox"/> Moderate <input type="checkbox"/> Severe
Associated with	<input type="checkbox"/> Clicking <input type="checkbox"/> Popping <input type="checkbox"/> Grinding <input type="checkbox"/> Locking <input type="checkbox"/> Tightness
Radiates to	<input type="checkbox"/> Head <input type="checkbox"/> Neck <input type="checkbox"/> Ears <input type="checkbox"/> Face
Described as	<input type="checkbox"/> Aching <input type="checkbox"/> Dull <input type="checkbox"/> Sharp <input type="checkbox"/> Stabbing <input type="checkbox"/> Throbbing
At it's worst	<input type="checkbox"/> Morning <input type="checkbox"/> Afternoon <input type="checkbox"/> Evening <input type="checkbox"/> Night After Activities: <input type="checkbox"/> Light <input type="checkbox"/> Moderate
What makes it better?	<input type="checkbox"/> Lying Down <input type="checkbox"/> Medication <input type="checkbox"/> Nothing <input type="checkbox"/> Sitting <input type="checkbox"/> Stretching <input type="checkbox"/> Range of Motion <input type="checkbox"/> Standing
What makes it worse?	<input type="checkbox"/> Chewing <input type="checkbox"/> Yawning <input type="checkbox"/> Opening mouth <input type="checkbox"/> Closing mouth

Comments: _____

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NECK	
Location	<input type="checkbox"/> Right Front <input type="checkbox"/> Left Front <input type="checkbox"/> Right Back <input type="checkbox"/> Left Back <input type="checkbox"/> Center
Pain Ratings	<input type="checkbox"/> 0 <input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4 <input type="checkbox"/> 5 <input type="checkbox"/> 6 <input type="checkbox"/> 7 <input type="checkbox"/> 8 <input type="checkbox"/> 9 <input type="checkbox"/> 10 (Excruciating)
Frequency	<input type="checkbox"/> Infrequent < 25% <input type="checkbox"/> Occasional 25% to 50% <input type="checkbox"/> Frequent 50% to 75% <input type="checkbox"/> Constant > 75%
Pain/Severity	<input type="checkbox"/> No Pain <input type="checkbox"/> Pain <input type="checkbox"/> Numbness <input type="checkbox"/> Tingling / <input type="checkbox"/> Mild <input type="checkbox"/> Moderate <input type="checkbox"/> Severe
Associated with	<input type="checkbox"/> Numbness <input type="checkbox"/> Tingling <input type="checkbox"/> Increased sensitivity <input type="checkbox"/> Stiffness <input type="checkbox"/> Tightness <input type="checkbox"/> ROM
Radiates to	<input type="checkbox"/> Head <input type="checkbox"/> Forehead <input type="checkbox"/> Back of head <input type="checkbox"/> Right side of head <input type="checkbox"/> Left side of head <input type="checkbox"/> Both sides of head <input type="checkbox"/> Right shoulder blade <input type="checkbox"/> Left shoulder blade <input type="checkbox"/> Right shoulder <input type="checkbox"/> Left shoulder <input type="checkbox"/> Right arm <input type="checkbox"/> Left arm <input type="checkbox"/> Right forearm <input type="checkbox"/> Left forearm <input type="checkbox"/> Right hand <input type="checkbox"/> Left hand <input type="checkbox"/> Right fingers <input type="checkbox"/> Left fingers
Described as	<input type="checkbox"/> Aching <input type="checkbox"/> Dull <input type="checkbox"/> Sharp <input type="checkbox"/> Stabbing <input type="checkbox"/> Throbbing
At it's worst	<input type="checkbox"/> Morning <input type="checkbox"/> Afternoon <input type="checkbox"/> Evening <input type="checkbox"/> Night <input type="checkbox"/> Light Activities <input type="checkbox"/> Moderate Activities
What makes it better?	<input type="checkbox"/> Medication <input type="checkbox"/> Lying Down <input type="checkbox"/> Standing <input type="checkbox"/> Sitting <input type="checkbox"/> Stretching <input type="checkbox"/> Range of Motion <input type="checkbox"/> Nothing
What makes it worse?	<input type="checkbox"/> Neck Movement <input type="checkbox"/> Sneezing <input type="checkbox"/> Prolonged Sitting <input type="checkbox"/> Prolonged Standing <input type="checkbox"/> Walking

Comments: _____

SHOULDER	
Location	<input type="checkbox"/> Left Front <input type="checkbox"/> Right Front <input type="checkbox"/> Left Back <input type="checkbox"/> Right Back <input type="checkbox"/> Both sides
Pain Ratings	<input type="checkbox"/> 0 <input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4 <input type="checkbox"/> 5 <input type="checkbox"/> 6 <input type="checkbox"/> 7 <input type="checkbox"/> 8 <input type="checkbox"/> 9 <input type="checkbox"/> 10 (Excruciating)
Frequency	<input type="checkbox"/> Infrequent < 25% <input type="checkbox"/> Occasional 25% to 50% <input type="checkbox"/> Frequent 50% to 75% <input type="checkbox"/> Constant > 75%
Pain/Severity	<input type="checkbox"/> No Pain <input type="checkbox"/> Pain <input type="checkbox"/> Numbness <input type="checkbox"/> Tingling / <input type="checkbox"/> Mild <input type="checkbox"/> Moderate <input type="checkbox"/> Severe
Associated with	<input type="checkbox"/> Numbness <input type="checkbox"/> Tingling <input type="checkbox"/> Increased sensitivity <input type="checkbox"/> Weaker ROM <input type="checkbox"/> Decreased ROM
Radiates to	<input type="checkbox"/> Neck <input type="checkbox"/> Right Shoulder blade <input type="checkbox"/> Left Shoulder blade <input type="checkbox"/> Trapezius muscle <input type="checkbox"/> Right upper arm <input type="checkbox"/> Left upper arm <input type="checkbox"/> Right Elbow <input type="checkbox"/> Left Elbow <input type="checkbox"/> Right Forearm <input type="checkbox"/> Left Forearm <input type="checkbox"/> Right Wrist <input type="checkbox"/> Left Wrist <input type="checkbox"/> Right Hand <input type="checkbox"/> Left Hand <input type="checkbox"/> Right fingers <input type="checkbox"/> Left fingers
Described as	<input type="checkbox"/> Aching <input type="checkbox"/> Dull <input type="checkbox"/> Sharp <input type="checkbox"/> Stabbing <input type="checkbox"/> Throbbing
At it's worst	<input type="checkbox"/> Morning <input type="checkbox"/> Afternoon <input type="checkbox"/> Evening <input type="checkbox"/> Night After Activities: <input type="checkbox"/> Light <input type="checkbox"/> Moderate
What makes it better?	<input type="checkbox"/> Medication <input type="checkbox"/> Lying Down <input type="checkbox"/> Standing <input type="checkbox"/> Sitting <input type="checkbox"/> Stretching <input type="checkbox"/> Range of Motion <input type="checkbox"/> Nothing
What makes it worse?	<input type="checkbox"/> Driving <input type="checkbox"/> Housework <input type="checkbox"/> Lifting <input type="checkbox"/> Pulling <input type="checkbox"/> Pushing <input type="checkbox"/> Range of Motion <input type="checkbox"/> Working

Comments: _____

ARM	
Location	<input type="checkbox"/> Right Arm <input type="checkbox"/> Left Arm <input type="checkbox"/> Both Arms
Pain Ratings	<input type="checkbox"/> 0 <input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4 <input type="checkbox"/> 5 <input type="checkbox"/> 6 <input type="checkbox"/> 7 <input type="checkbox"/> 8 <input type="checkbox"/> 9 <input type="checkbox"/> 10 (Excruciating)
Frequency	<input type="checkbox"/> Infrequent < 25% <input type="checkbox"/> Occasional 25% to 50% <input type="checkbox"/> Frequent 50% to 75% <input type="checkbox"/> Constant > 75%
Pain/Severity	<input type="checkbox"/> No Pain <input type="checkbox"/> Pain <input type="checkbox"/> Numbness <input type="checkbox"/> Tingling / <input type="checkbox"/> Mild <input type="checkbox"/> Moderate <input type="checkbox"/> Severe
Associated with	<input type="checkbox"/> Numbness <input type="checkbox"/> Bruises/Abrasions <input type="checkbox"/> Tingling <input type="checkbox"/> Increased sensitivity <input type="checkbox"/> Weakness
Radiates to	<input type="checkbox"/> Right Shoulder <input type="checkbox"/> Left Shoulder <input type="checkbox"/> Right Elbow <input type="checkbox"/> Left Elbow <input type="checkbox"/> Right Forearm <input type="checkbox"/> Left Forearm <input type="checkbox"/> Right Hand <input type="checkbox"/> Left Hand <input type="checkbox"/> Right Fingers <input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4 <input type="checkbox"/> 5 <input type="checkbox"/> Left Fingers <input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4 <input type="checkbox"/> 5
Described as	<input type="checkbox"/> Aching <input type="checkbox"/> Dull <input type="checkbox"/> Sharp <input type="checkbox"/> Stabbing <input type="checkbox"/> Throbbing
At it's worst	<input type="checkbox"/> Afternoon <input type="checkbox"/> Evening <input type="checkbox"/> Light Activities <input type="checkbox"/> Moderate Activities <input type="checkbox"/> Morning
What makes it better?	<input type="checkbox"/> Medication <input type="checkbox"/> Lying Down <input type="checkbox"/> Standing <input type="checkbox"/> Sitting <input type="checkbox"/> Stretching <input type="checkbox"/> Range of Motion <input type="checkbox"/> Nothing
What makes it worse?	<input type="checkbox"/> Movement <input type="checkbox"/> Housework <input type="checkbox"/> Lifting <input type="checkbox"/> Driving <input type="checkbox"/> Working

Comments: _____

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ELBOW	
Location	<input type="checkbox"/> Right Elbow <input type="checkbox"/> Left Elbow <input type="checkbox"/> Both Elbows
Pain Ratings	<input type="checkbox"/> 0 <input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4 <input type="checkbox"/> 5 <input type="checkbox"/> 6 <input type="checkbox"/> 7 <input type="checkbox"/> 8 <input type="checkbox"/> 9 <input type="checkbox"/> 10 (Excruciating)
Frequency	<input type="checkbox"/> Infrequent < 25% <input type="checkbox"/> Occasional 25% to 50% <input type="checkbox"/> Frequent 50% to 75% <input type="checkbox"/> Constant > 75%
Pain/Severity	<input type="checkbox"/> No Pain <input type="checkbox"/> Pain <input type="checkbox"/> Numbness <input type="checkbox"/> Tingling / <input type="checkbox"/> Mild <input type="checkbox"/> Moderate <input type="checkbox"/> Severe
Associated with	<input type="checkbox"/> Bruises <input type="checkbox"/> Numbness <input type="checkbox"/> Tingling <input type="checkbox"/> Increased sensitivity <input type="checkbox"/> Weakness <input type="checkbox"/> Decreased ROM
Radiates to	<input type="checkbox"/> Right Upper arm <input type="checkbox"/> Left Upper arm <input type="checkbox"/> Right Forearm <input type="checkbox"/> Left Forearm <input type="checkbox"/> Right Wrist <input type="checkbox"/> Left Wrist <input type="checkbox"/> Right Hand <input type="checkbox"/> Left Hand <input type="checkbox"/> Right Fingers <input type="checkbox"/> Left Fingers
Described as	<input type="checkbox"/> Aching <input type="checkbox"/> Dull <input type="checkbox"/> Sharp <input type="checkbox"/> Stabbing <input type="checkbox"/> Throbbing
At it's worst	<input type="checkbox"/> Morning <input type="checkbox"/> Afternoon <input type="checkbox"/> Evening <input type="checkbox"/> Night <input type="checkbox"/> Light Activities <input type="checkbox"/> Moderate Activities
What makes it better?	<input type="checkbox"/> Medication <input type="checkbox"/> Lying Down <input type="checkbox"/> Standing <input type="checkbox"/> Sitting <input type="checkbox"/> Stretching <input type="checkbox"/> Range of Motion <input type="checkbox"/> Nothing
What makes it worse?	<input type="checkbox"/> Flexion <input type="checkbox"/> Extension <input type="checkbox"/> Pronation/Supination <input type="checkbox"/> Housework <input type="checkbox"/> Lifting <input type="checkbox"/> Driving <input type="checkbox"/> Working

Comments: _____

FOREARM	
Location	<input type="checkbox"/> Right Forearm <input type="checkbox"/> Left Forearm <input type="checkbox"/> Both Forearms
Pain Ratings	<input type="checkbox"/> 0 <input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4 <input type="checkbox"/> 5 <input type="checkbox"/> 6 <input type="checkbox"/> 7 <input type="checkbox"/> 8 <input type="checkbox"/> 9 <input type="checkbox"/> 10 (Excruciating)
Frequency	<input type="checkbox"/> Infrequent < 25% <input type="checkbox"/> Occasional 25% to 50% <input type="checkbox"/> Frequent 50% to 75% <input type="checkbox"/> Constant > 75%
Pain/Severity	<input type="checkbox"/> No Pain <input type="checkbox"/> Pain <input type="checkbox"/> Numbness <input type="checkbox"/> Tingling / <input type="checkbox"/> Mild <input type="checkbox"/> Moderate <input type="checkbox"/> Severe
Associated with	<input type="checkbox"/> Numbness <input type="checkbox"/> Bruises <input type="checkbox"/> Tingling <input type="checkbox"/> Increased sensitivity <input type="checkbox"/> Weakness <input type="checkbox"/> Burns <input type="checkbox"/> Abrasions
Radiates to	<input type="checkbox"/> Right Upper arm <input type="checkbox"/> Left Upper arm <input type="checkbox"/> Right Elbow <input type="checkbox"/> Left Elbow <input type="checkbox"/> Right Wrist <input type="checkbox"/> Left Wrist <input type="checkbox"/> Right Hand <input type="checkbox"/> Left Hand <input type="checkbox"/> Right Fingers <input type="checkbox"/> Left Fingers
Described as	<input type="checkbox"/> Aching <input type="checkbox"/> Dull <input type="checkbox"/> Sharp <input type="checkbox"/> Stabbing <input type="checkbox"/> Throbbing
At it's worst	<input type="checkbox"/> Morning <input type="checkbox"/> Afternoon <input type="checkbox"/> Evening <input type="checkbox"/> Night After Activities: <input type="checkbox"/> Light <input type="checkbox"/> Moderate
What makes it better?	<input type="checkbox"/> Medication <input type="checkbox"/> Lying Down <input type="checkbox"/> Standing <input type="checkbox"/> Sitting <input type="checkbox"/> Stretching <input type="checkbox"/> Range of Motion <input type="checkbox"/> Nothing
What makes it worse?	<input type="checkbox"/> Grasping <input type="checkbox"/> Housework <input type="checkbox"/> Lifting <input type="checkbox"/> Driving <input type="checkbox"/> Working

Comments: _____

WRIST	
Location	<input type="checkbox"/> Right Wrist <input type="checkbox"/> Left Wrist <input type="checkbox"/> Both Wrists
Pain Ratings	<input type="checkbox"/> 0 <input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4 <input type="checkbox"/> 5 <input type="checkbox"/> 6 <input type="checkbox"/> 7 <input type="checkbox"/> 8 <input type="checkbox"/> 9 <input type="checkbox"/> 10 (Excruciating)
Frequency	<input type="checkbox"/> Infrequent < 25% <input type="checkbox"/> Occasional 25% to 50% <input type="checkbox"/> Frequent 50% to 75% <input type="checkbox"/> Constant > 75%
Pain/Severity	<input type="checkbox"/> No Pain <input type="checkbox"/> Pain <input type="checkbox"/> Numbness <input type="checkbox"/> Tingling / <input type="checkbox"/> Mild <input type="checkbox"/> Moderate <input type="checkbox"/> Severe
Associated with	<input type="checkbox"/> Numbness <input type="checkbox"/> Swelling <input type="checkbox"/> Tingling <input type="checkbox"/> Increased sensitivity <input type="checkbox"/> Weakness <input type="checkbox"/> Stiffness <input type="checkbox"/> ROM
Radiates to	<input type="checkbox"/> Right Elbow <input type="checkbox"/> Left Elbow <input type="checkbox"/> Right Forearm <input type="checkbox"/> Left Forearm <input type="checkbox"/> Right Hand <input type="checkbox"/> Left Hand <input type="checkbox"/> Right Fingers <input type="checkbox"/> Left Fingers
Described as	<input type="checkbox"/> Aching <input type="checkbox"/> Dull <input type="checkbox"/> Sharp <input type="checkbox"/> Stabbing <input type="checkbox"/> Throbbing
At it's worst	<input type="checkbox"/> Morning <input type="checkbox"/> Afternoon <input type="checkbox"/> Evening <input type="checkbox"/> Night After Activities: <input type="checkbox"/> Light <input type="checkbox"/> Moderate
What makes it better?	<input type="checkbox"/> Medication <input type="checkbox"/> Lying Down <input type="checkbox"/> Standing <input type="checkbox"/> Sitting <input type="checkbox"/> Stretching <input type="checkbox"/> Range of Motion <input type="checkbox"/> Nothing
What makes it worse?	<input type="checkbox"/> Driving <input type="checkbox"/> Extension <input type="checkbox"/> External Rotation <input type="checkbox"/> Flexion <input type="checkbox"/> Grasping <input type="checkbox"/> Housework <input type="checkbox"/> Internal rotation <input type="checkbox"/> Lifting <input type="checkbox"/> Writing

Comments: _____

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HANDS AND FINGERS	
Location	<input type="checkbox"/> Right Hand <input type="checkbox"/> Left Hand <input type="checkbox"/> Both Hands <input type="checkbox"/> Right Fingers <input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4 <input type="checkbox"/> 5 <input type="checkbox"/> Left Fingers <input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4 <input type="checkbox"/> 5
Pain Ratings	<input type="checkbox"/> 0 <input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4 <input type="checkbox"/> 5 <input type="checkbox"/> 6 <input type="checkbox"/> 7 <input type="checkbox"/> 8 <input type="checkbox"/> 9 <input type="checkbox"/> 10 (Excruciating)
Frequency	<input type="checkbox"/> Infrequent < 25% <input type="checkbox"/> Occasional 25% to 50% <input type="checkbox"/> Frequent 50% to 75% <input type="checkbox"/> Constant > 75%
Pain/Severity	<input type="checkbox"/> No Pain <input type="checkbox"/> Pain <input type="checkbox"/> Numbness <input type="checkbox"/> Tingling / <input type="checkbox"/> Mild <input type="checkbox"/> Moderate <input type="checkbox"/> Severe
Associated with	<input type="checkbox"/> Numbness <input type="checkbox"/> Swelling <input type="checkbox"/> Tingling <input type="checkbox"/> Stiffness <input type="checkbox"/> ROM
Radiates to	<input type="checkbox"/> Right Forearm <input type="checkbox"/> Left Forearm <input type="checkbox"/> Right Wrist <input type="checkbox"/> Left Wrist
Described as	<input type="checkbox"/> Aching <input type="checkbox"/> Dull <input type="checkbox"/> Sharp <input type="checkbox"/> Stabbing <input type="checkbox"/> Throbbing
At it's worst	<input type="checkbox"/> Morning <input type="checkbox"/> Afternoon <input type="checkbox"/> Evening <input type="checkbox"/> Night After Activities: <input type="checkbox"/> Light <input type="checkbox"/> Moderate
What makes it better?	<input type="checkbox"/> Medication <input type="checkbox"/> Lying Down <input type="checkbox"/> Standing <input type="checkbox"/> Sitting <input type="checkbox"/> Stretching <input type="checkbox"/> Range of Motion <input type="checkbox"/> Nothing
What makes it worse?	<input type="checkbox"/> Movement <input type="checkbox"/> Housework <input type="checkbox"/> Lifting <input type="checkbox"/> Driving <input type="checkbox"/> Working <input type="checkbox"/> Grasping <input type="checkbox"/> Writing

Comments: _____

CHEST	
Location	<input type="checkbox"/> Left Chest <input type="checkbox"/> Right Chest <input type="checkbox"/> Both sides of chest
Pain Ratings	<input type="checkbox"/> 0 <input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4 <input type="checkbox"/> 5 <input type="checkbox"/> 6 <input type="checkbox"/> 7 <input type="checkbox"/> 8 <input type="checkbox"/> 9 <input type="checkbox"/> 10 (Excruciating)
Frequency	<input type="checkbox"/> Infrequent < 25% <input type="checkbox"/> Occasional 25% to 50% <input type="checkbox"/> Frequent 50% to 75% <input type="checkbox"/> Constant > 75%
Pain/Severity	<input type="checkbox"/> No Pain <input type="checkbox"/> Pain <input type="checkbox"/> Numbness <input type="checkbox"/> Tingling / <input type="checkbox"/> Mild <input type="checkbox"/> Moderate <input type="checkbox"/> Severe
Associated with	<input type="checkbox"/> Numbness <input type="checkbox"/> Tingling <input type="checkbox"/> Increased sensitivity <input type="checkbox"/> Shallow breathing
Radiates to	<input type="checkbox"/> Right Ribs <input type="checkbox"/> Left Ribs <input type="checkbox"/> Right Upper back <input type="checkbox"/> Left Upper back <input type="checkbox"/> Right Lower back <input type="checkbox"/> Left Lower back
Described as	<input type="checkbox"/> Aching <input type="checkbox"/> Dull <input type="checkbox"/> Sharp <input type="checkbox"/> Stabbing <input type="checkbox"/> Throbbing
At it's worst	<input type="checkbox"/> Morning <input type="checkbox"/> Afternoon <input type="checkbox"/> Evening <input type="checkbox"/> Night After Activities: <input type="checkbox"/> Light <input type="checkbox"/> Moderate
What makes it better?	<input type="checkbox"/> Medication <input type="checkbox"/> Lying Down <input type="checkbox"/> Standing <input type="checkbox"/> Sitting <input type="checkbox"/> Stretching <input type="checkbox"/> Range of Motion <input type="checkbox"/> Nothing
What makes it worse?	<input type="checkbox"/> Deep breathing <input type="checkbox"/> Upper body movement <input type="checkbox"/> Coughing <input type="checkbox"/> Sneezing <input type="checkbox"/> Palpation

Comments: _____

RIBS	
Location	<input type="checkbox"/> Right Collar bone <input type="checkbox"/> Left Collar bone <input type="checkbox"/> Right Pectoral <input type="checkbox"/> Left Pectoral <input type="checkbox"/> Right Sternum <input type="checkbox"/> Left Sternum <input type="checkbox"/> Right Ribs <input type="checkbox"/> Left Ribs
Pain Ratings	<input type="checkbox"/> 0 <input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4 <input type="checkbox"/> 5 <input type="checkbox"/> 6 <input type="checkbox"/> 7 <input type="checkbox"/> 8 <input type="checkbox"/> 9 <input type="checkbox"/> 10 (Excruciating)
Frequency	<input type="checkbox"/> Infrequent < 25% <input type="checkbox"/> Occasional 25% to 50% <input type="checkbox"/> Frequent 50% to 75% <input type="checkbox"/> Constant > 75%
Pain/Severity	<input type="checkbox"/> No Pain <input type="checkbox"/> Pain <input type="checkbox"/> Numbness <input type="checkbox"/> Tingling / <input type="checkbox"/> Mild <input type="checkbox"/> Moderate <input type="checkbox"/> Severe
Associated with	<input type="checkbox"/> Numbness <input type="checkbox"/> Tingling <input type="checkbox"/> Increased sensitivity <input type="checkbox"/> Shallow breathing <input type="checkbox"/> Soreness
Radiates to	<input type="checkbox"/> Right Upper back <input type="checkbox"/> Left Upper back <input type="checkbox"/> Right Chest <input type="checkbox"/> Left Chest <input type="checkbox"/> Right Shoulder <input type="checkbox"/> Left Shoulder <input type="checkbox"/> Right Arm <input type="checkbox"/> Left Arm <input type="checkbox"/> Right Lower back <input type="checkbox"/> Left Lower back
Described as	<input type="checkbox"/> Aching <input type="checkbox"/> Dull <input type="checkbox"/> Sharp <input type="checkbox"/> Stabbing <input type="checkbox"/> Throbbing
At it's worst	<input type="checkbox"/> Morning <input type="checkbox"/> Afternoon <input type="checkbox"/> Evening <input type="checkbox"/> Night After Activities: <input type="checkbox"/> Light <input type="checkbox"/> Moderate
What makes it better?	<input type="checkbox"/> Medication <input type="checkbox"/> Lying Down <input type="checkbox"/> Standing <input type="checkbox"/> Sitting <input type="checkbox"/> Stretching <input type="checkbox"/> Range of Motion <input type="checkbox"/> Nothing
What makes it worse?	<input type="checkbox"/> Deep breathing <input type="checkbox"/> Upper body movement <input type="checkbox"/> Lifting <input type="checkbox"/> Working <input type="checkbox"/> Palpation <input type="checkbox"/> Housework

Comments: _____

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UPPER BACK	
Location	<input type="checkbox"/> Left <input type="checkbox"/> Right <input type="checkbox"/> Both <input type="checkbox"/> Center
Pain Ratings	<input type="checkbox"/> 0 <input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4 <input type="checkbox"/> 5 <input type="checkbox"/> 6 <input type="checkbox"/> 7 <input type="checkbox"/> 8 <input type="checkbox"/> 9 <input type="checkbox"/> 10 (Excruciating)
Frequency	<input type="checkbox"/> Infrequent < 25% <input type="checkbox"/> Occasional 25% to 50% <input type="checkbox"/> Frequent 50% to 75% <input type="checkbox"/> Constant > 75%
Pain/Severity	<input type="checkbox"/> No Pain <input type="checkbox"/> Pain <input type="checkbox"/> Numbness <input type="checkbox"/> Tingling / <input type="checkbox"/> Mild <input type="checkbox"/> Moderate <input type="checkbox"/> Severe
Associated with	<input type="checkbox"/> Numbness <input type="checkbox"/> Tingling <input type="checkbox"/> Increased sensitivity <input type="checkbox"/> Tightness <input type="checkbox"/> Stiffness <input type="checkbox"/> ROM
Radiates to	<input type="checkbox"/> Neck <input type="checkbox"/> Right Ribs <input type="checkbox"/> Left Ribs <input type="checkbox"/> Lower back
Described as	<input type="checkbox"/> Aching <input type="checkbox"/> Dull <input type="checkbox"/> Sharp <input type="checkbox"/> Stabbing <input type="checkbox"/> Throbbing
At it's worst	<input type="checkbox"/> Morning <input type="checkbox"/> Afternoon <input type="checkbox"/> Evening <input type="checkbox"/> Night After Activities: <input type="checkbox"/> Light <input type="checkbox"/> Moderate
What makes it better?	<input type="checkbox"/> Medication <input type="checkbox"/> Lying Down <input type="checkbox"/> Standing <input type="checkbox"/> Sitting <input type="checkbox"/> Stretching <input type="checkbox"/> Range of Motion <input type="checkbox"/> Nothing
What makes it worse?	<input type="checkbox"/> Upper body movement <input type="checkbox"/> Lifting <input type="checkbox"/> Working <input type="checkbox"/> Sneezing <input type="checkbox"/> Housework <input type="checkbox"/> Coughing <input type="checkbox"/> Bending Prolonged: <input type="checkbox"/> Sitting <input type="checkbox"/> Standing <input type="checkbox"/> Walking

Comments: _____

MID BACK	
Location	<input type="checkbox"/> Left <input type="checkbox"/> Right <input type="checkbox"/> Both <input type="checkbox"/> Center
Pain Ratings	<input type="checkbox"/> 0 <input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4 <input type="checkbox"/> 5 <input type="checkbox"/> 6 <input type="checkbox"/> 7 <input type="checkbox"/> 8 <input type="checkbox"/> 9 <input type="checkbox"/> 10 (Excruciating)
Frequency	<input type="checkbox"/> Infrequent < 25% <input type="checkbox"/> Occasional 25% to 50% <input type="checkbox"/> Frequent 50% to 75% <input type="checkbox"/> Constant > 75%
Pain/Severity	<input type="checkbox"/> No Pain <input type="checkbox"/> Pain <input type="checkbox"/> Numbness <input type="checkbox"/> Tingling / <input type="checkbox"/> Mild <input type="checkbox"/> Moderate <input type="checkbox"/> Severe
Associated with	<input type="checkbox"/> Numbness <input type="checkbox"/> Tingling <input type="checkbox"/> Increased sensitivity <input type="checkbox"/> Tightness <input type="checkbox"/> Stiffness <input type="checkbox"/> Decreased ROM
Radiates to	<input type="checkbox"/> Neck <input type="checkbox"/> Right Ribs <input type="checkbox"/> Left Ribs <input type="checkbox"/> Lower back
Described as	<input type="checkbox"/> Aching <input type="checkbox"/> Dull <input type="checkbox"/> Sharp <input type="checkbox"/> Stabbing <input type="checkbox"/> Throbbing
At it's worst	<input type="checkbox"/> Morning <input type="checkbox"/> Afternoon <input type="checkbox"/> Evening <input type="checkbox"/> During Night <input type="checkbox"/> Light Activities <input type="checkbox"/> Moderate Activity
What makes it better?	<input type="checkbox"/> Medication <input type="checkbox"/> Lying Down <input type="checkbox"/> Standing <input type="checkbox"/> Sitting <input type="checkbox"/> Stretching <input type="checkbox"/> Range of Motion <input type="checkbox"/> Nothing
What makes it worse?	<input type="checkbox"/> Upper body movement <input type="checkbox"/> Lifting <input type="checkbox"/> Working <input type="checkbox"/> Sneezing <input type="checkbox"/> Housework <input type="checkbox"/> Coughing <input type="checkbox"/> Bending Prolonged: <input type="checkbox"/> Sitting <input type="checkbox"/> Standing <input type="checkbox"/> Walking

Comments: _____

LOWER BACK	
Location	<input type="checkbox"/> Left <input type="checkbox"/> Right <input type="checkbox"/> Both <input type="checkbox"/> Center
Pain Ratings	<input type="checkbox"/> 0 <input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4 <input type="checkbox"/> 5 <input type="checkbox"/> 6 <input type="checkbox"/> 7 <input type="checkbox"/> 8 <input type="checkbox"/> 9 <input type="checkbox"/> 10 (Excruciating)
Frequency	<input type="checkbox"/> Infrequent < 25% <input type="checkbox"/> Occasional 25% to 50% <input type="checkbox"/> Frequent 50% to 75% <input type="checkbox"/> Constant > 75%
Pain/Severity	<input type="checkbox"/> No Pain <input type="checkbox"/> Pain <input type="checkbox"/> Numbness <input type="checkbox"/> Tingling / <input type="checkbox"/> Mild <input type="checkbox"/> Moderate <input type="checkbox"/> Severe
Associated with	<input type="checkbox"/> Numbness <input type="checkbox"/> Tingling <input type="checkbox"/> Increased sensitivity <input type="checkbox"/> Tightness <input type="checkbox"/> Stiffness <input type="checkbox"/> ROM
Radiates to	<input type="checkbox"/> Right Upper back <input type="checkbox"/> Left Upper back <input type="checkbox"/> Right Buttock <input type="checkbox"/> Left Buttock <input type="checkbox"/> Both Buttocks <input type="checkbox"/> Right Hip <input type="checkbox"/> Left Hip <input type="checkbox"/> Right Thigh <input type="checkbox"/> Left Thigh <input type="checkbox"/> Right Calf <input type="checkbox"/> Left Calf <input type="checkbox"/> Right Foot <input type="checkbox"/> Left Foot <input type="checkbox"/> Right Toes <input type="checkbox"/> Left Toes
Described as	<input type="checkbox"/> Aching <input type="checkbox"/> Dull <input type="checkbox"/> Sharp <input type="checkbox"/> Stabbing <input type="checkbox"/> Throbbing
At it's worst	<input type="checkbox"/> Morning <input type="checkbox"/> Afternoon <input type="checkbox"/> Evening <input type="checkbox"/> Night After Activities: <input type="checkbox"/> Light <input type="checkbox"/> Moderate
What makes it better?	<input type="checkbox"/> Medication <input type="checkbox"/> Lying Down <input type="checkbox"/> Standing <input type="checkbox"/> Sitting <input type="checkbox"/> Stretching <input type="checkbox"/> Range of Motion <input type="checkbox"/> Nothing
What makes it worse?	<input type="checkbox"/> Range of motion <input type="checkbox"/> Lifting <input type="checkbox"/> Bending <input type="checkbox"/> Lying down <input type="checkbox"/> Working <input type="checkbox"/> Housework <input type="checkbox"/> Coughing. <input type="checkbox"/> Sneezing Prolonged: <input type="checkbox"/> Sitting <input type="checkbox"/> Standing <input type="checkbox"/> Walking

Comments: _____

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ABDOMEN	
Location	
Pain Ratings	<input type="checkbox"/> 0 <input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4 <input type="checkbox"/> 5 <input type="checkbox"/> 6 <input type="checkbox"/> 7 <input type="checkbox"/> 8 <input type="checkbox"/> 9 <input type="checkbox"/> 10 (Excruciating)
Frequency	<input type="checkbox"/> Infrequent < 25% <input type="checkbox"/> Occasional 25% to 50% <input type="checkbox"/> Frequent 50% to 75% <input type="checkbox"/> Constant > 75%
Pain/Severity	<input type="checkbox"/> No Pain <input type="checkbox"/> Pain <input type="checkbox"/> Numbness <input type="checkbox"/> Tingling / <input type="checkbox"/> Mild <input type="checkbox"/> Moderate <input type="checkbox"/> Severe
Associated with	<input type="checkbox"/> Bloating <input type="checkbox"/> Constipation <input type="checkbox"/> Diarrhea <input type="checkbox"/> Nausea <input type="checkbox"/> Rigidity <input type="checkbox"/> Paresthesia <input type="checkbox"/> Bruises <input type="checkbox"/> Skin changes <input type="checkbox"/> Vomiting
Radiates to	<input type="checkbox"/> Right Chest <input type="checkbox"/> Left Chest <input type="checkbox"/> Right Lower back <input type="checkbox"/> Left Lower back <input type="checkbox"/> Right Groin <input type="checkbox"/> Left Groin <input type="checkbox"/> Right Thigh <input type="checkbox"/> Left Thigh
Described as	<input type="checkbox"/> Aching <input type="checkbox"/> Dull <input type="checkbox"/> Sharp <input type="checkbox"/> Stabbing <input type="checkbox"/> Throbbing
At it's worst	<input type="checkbox"/> Morning <input type="checkbox"/> Afternoon <input type="checkbox"/> Evening <input type="checkbox"/> Night After Activities: <input type="checkbox"/> Light <input type="checkbox"/> Moderate
What makes it better?	<input type="checkbox"/> Medication <input type="checkbox"/> Lying Down <input type="checkbox"/> Standing <input type="checkbox"/> Sitting <input type="checkbox"/> Stretching <input type="checkbox"/> Range of Motion <input type="checkbox"/> Nothing
What makes it worse?	<input type="checkbox"/> Palpation <input type="checkbox"/> Bending <input type="checkbox"/> Lifting <input type="checkbox"/> Walking

Comments: _____

HIP	
Location	<input type="checkbox"/> Right Hip <input type="checkbox"/> Left Hip <input type="checkbox"/> Both Hips
Pain Ratings	<input type="checkbox"/> 0 <input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4 <input type="checkbox"/> 5 <input type="checkbox"/> 6 <input type="checkbox"/> 7 <input type="checkbox"/> 8 <input type="checkbox"/> 9 <input type="checkbox"/> 10 (Excruciating)
Frequency	<input type="checkbox"/> Infrequent < 25% <input type="checkbox"/> Occasional 25% to 50% <input type="checkbox"/> Frequent 50% to 75% <input type="checkbox"/> Constant > 75%
Pain/Severity	<input type="checkbox"/> No Pain <input type="checkbox"/> Pain <input type="checkbox"/> Numbness <input type="checkbox"/> Tingling / <input type="checkbox"/> Mild <input type="checkbox"/> Moderate <input type="checkbox"/> Severe
Associated with	<input type="checkbox"/> Numbness <input type="checkbox"/> Tingling <input type="checkbox"/> Increased sensitivity <input type="checkbox"/> Tightness <input type="checkbox"/> Stiffness <input type="checkbox"/> ROM
Radiates to	<input type="checkbox"/> Left Lower back <input type="checkbox"/> Right Lower back <input type="checkbox"/> Left Buttocks <input type="checkbox"/> Right Buttocks <input type="checkbox"/> Right Knee <input type="checkbox"/> Left Knee <input type="checkbox"/> Right Calf <input type="checkbox"/> Left Calf
Described as	<input type="checkbox"/> Aching <input type="checkbox"/> Dull <input type="checkbox"/> Sharp <input type="checkbox"/> Stabbing <input type="checkbox"/> Throbbing
At it's worst	<input type="checkbox"/> Morning <input type="checkbox"/> Afternoon <input type="checkbox"/> Evening <input type="checkbox"/> Night After Activities: <input type="checkbox"/> Light <input type="checkbox"/> Moderate
What makes it better?	<input type="checkbox"/> Medication <input type="checkbox"/> Lying Down <input type="checkbox"/> Standing <input type="checkbox"/> Sitting <input type="checkbox"/> Stretching <input type="checkbox"/> Range of Motion <input type="checkbox"/> Nothing
What makes it worse?	<input type="checkbox"/> Movement <input type="checkbox"/> Lifting <input type="checkbox"/> Bending <input type="checkbox"/> Straining <input type="checkbox"/> Walking Prolonged: <input type="checkbox"/> Sitting <input type="checkbox"/> Standing <input type="checkbox"/> Walking

Comments: _____

BUTTOCKS	
Location	<input type="checkbox"/> Right Buttock <input type="checkbox"/> Left Buttock <input type="checkbox"/> Both Buttocks
Pain Ratings	<input type="checkbox"/> 0 <input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4 <input type="checkbox"/> 5 <input type="checkbox"/> 6 <input type="checkbox"/> 7 <input type="checkbox"/> 8 <input type="checkbox"/> 9 <input type="checkbox"/> 10 (Excruciating)
Frequency	<input type="checkbox"/> Infrequent < 25% <input type="checkbox"/> Occasional 25% to 50% <input type="checkbox"/> Frequent 50% to 75% <input type="checkbox"/> Constant > 75%
Pain/Severity	<input type="checkbox"/> No Pain <input type="checkbox"/> Pain <input type="checkbox"/> Numbness <input type="checkbox"/> Tingling / <input type="checkbox"/> Mild <input type="checkbox"/> Moderate <input type="checkbox"/> Severe
Associated with	<input type="checkbox"/> Decreased ROM <input type="checkbox"/> Increased Sensitivity <input type="checkbox"/> Loss of Balance <input type="checkbox"/> Soreness
Radiates to	<input type="checkbox"/> Left Lower back <input type="checkbox"/> Right Lower back <input type="checkbox"/> Right Mid-back <input type="checkbox"/> Left Mid-back <input type="checkbox"/> Right Knee <input type="checkbox"/> Left Knee <input type="checkbox"/> Right Calf <input type="checkbox"/> Left Calf <input type="checkbox"/> Right Thigh <input type="checkbox"/> Left Thigh
Described as	<input type="checkbox"/> Aching <input type="checkbox"/> Dull <input type="checkbox"/> Sharp <input type="checkbox"/> Stabbing <input type="checkbox"/> Throbbing
At it's worst	<input type="checkbox"/> Morning <input type="checkbox"/> Afternoon <input type="checkbox"/> Evening <input type="checkbox"/> Night After Activities: <input type="checkbox"/> Light <input type="checkbox"/> Moderate
What makes it better?	<input type="checkbox"/> Medication <input type="checkbox"/> Lying Down <input type="checkbox"/> Standing <input type="checkbox"/> Sitting <input type="checkbox"/> Stretching <input type="checkbox"/> Range of Motion <input type="checkbox"/> Nothing
What makes it worse?	<input type="checkbox"/> Bending <input type="checkbox"/> Extension <input type="checkbox"/> Flexion <input type="checkbox"/> Lying Down <input type="checkbox"/> Walking Downstairs <input type="checkbox"/> Walking Upstairs Prolonged: <input type="checkbox"/> Sitting <input type="checkbox"/> Standing <input type="checkbox"/> Walking

Comments: _____

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GROIN	
Location	<input type="checkbox"/> Left Groin <input type="checkbox"/> Right Groin <input type="checkbox"/> Both Groins
Pain Ratings	<input type="checkbox"/> 0 <input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4 <input type="checkbox"/> 5 <input type="checkbox"/> 6 <input type="checkbox"/> 7 <input type="checkbox"/> 8 <input type="checkbox"/> 9 <input type="checkbox"/> 10 (Excruciating)
Frequency	<input type="checkbox"/> Infrequent < 25% <input type="checkbox"/> Occasional 25% to 50% <input type="checkbox"/> Frequent 50% to 75% <input type="checkbox"/> Constant > 75%
Pain/Severity	<input type="checkbox"/> No Pain <input type="checkbox"/> Pain <input type="checkbox"/> Numbness <input type="checkbox"/> Tingling / <input type="checkbox"/> Mild <input type="checkbox"/> Moderate <input type="checkbox"/> Severe
Associated with	<input type="checkbox"/> Numbness <input type="checkbox"/> Tingling <input type="checkbox"/> Increased sensitivity <input type="checkbox"/> Tightness <input type="checkbox"/> Stiffness <input type="checkbox"/> ROM
Radiates to	<input type="checkbox"/> Left Lower back <input type="checkbox"/> Right Lower back <input type="checkbox"/> Right Buttocks <input type="checkbox"/> Left Buttocks <input type="checkbox"/> Right Knee <input type="checkbox"/> Left Knee <input type="checkbox"/> Right Calf <input type="checkbox"/> Left Calf
Described as	<input type="checkbox"/> Aching <input type="checkbox"/> Dull <input type="checkbox"/> Sharp <input type="checkbox"/> Stabbing <input type="checkbox"/> Throbbing
At it's worst	<input type="checkbox"/> Morning <input type="checkbox"/> Afternoon <input type="checkbox"/> Evening <input type="checkbox"/> Night After Activities: <input type="checkbox"/> Light <input type="checkbox"/> Moderate
What makes it better?	<input type="checkbox"/> Medication <input type="checkbox"/> Lying Down <input type="checkbox"/> Standing <input type="checkbox"/> Sitting <input type="checkbox"/> Stretching <input type="checkbox"/> Range of Motion <input type="checkbox"/> Nothing
What makes it worse?	<input type="checkbox"/> Movement <input type="checkbox"/> Lifting <input type="checkbox"/> Bending <input type="checkbox"/> Straining <input type="checkbox"/> Walking Prolonged: <input type="checkbox"/> Sitting <input type="checkbox"/> Standing <input type="checkbox"/> Walking

Comments: _____

THIGH	
Location	<input type="checkbox"/> Left Thigh <input type="checkbox"/> Right Thigh <input type="checkbox"/> Both Thighs
Pain Ratings	<input type="checkbox"/> 0 <input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4 <input type="checkbox"/> 5 <input type="checkbox"/> 6 <input type="checkbox"/> 7 <input type="checkbox"/> 8 <input type="checkbox"/> 9 <input type="checkbox"/> 10 (Excruciating)
Frequency	<input type="checkbox"/> Infrequent < 25% <input type="checkbox"/> Occasional 25% to 50% <input type="checkbox"/> Frequent 50% to 75% <input type="checkbox"/> Constant > 75%
Pain/Severity	<input type="checkbox"/> No Pain <input type="checkbox"/> Pain <input type="checkbox"/> Numbness <input type="checkbox"/> Tingling / <input type="checkbox"/> Mild <input type="checkbox"/> Moderate <input type="checkbox"/> Severe
Associated with	<input type="checkbox"/> Numbness <input type="checkbox"/> Tingling <input type="checkbox"/> Increased sensitivity <input type="checkbox"/> Tightness <input type="checkbox"/> Stiffness <input type="checkbox"/> Decreased ROM
Radiates to	<input type="checkbox"/> Left Lower back <input type="checkbox"/> Right Lower back <input type="checkbox"/> Right Buttocks <input type="checkbox"/> Left Buttocks <input type="checkbox"/> Right Knee <input type="checkbox"/> Left Knee <input type="checkbox"/> Right Calf <input type="checkbox"/> Left Calf
Described as	<input type="checkbox"/> Aching <input type="checkbox"/> Dull <input type="checkbox"/> Sharp <input type="checkbox"/> Stabbing <input type="checkbox"/> Throbbing
At it's worst	<input type="checkbox"/> Morning <input type="checkbox"/> Afternoon <input type="checkbox"/> Evening <input type="checkbox"/> Night After Activities: <input type="checkbox"/> Light <input type="checkbox"/> Moderate
What makes it better?	<input type="checkbox"/> Medication <input type="checkbox"/> Lying Down <input type="checkbox"/> Standing <input type="checkbox"/> Sitting <input type="checkbox"/> Stretching <input type="checkbox"/> Range of Motion <input type="checkbox"/> Nothing
What makes it worse?	<input type="checkbox"/> Movement <input type="checkbox"/> Lifting <input type="checkbox"/> Bending <input type="checkbox"/> Straining Prolonged: <input type="checkbox"/> Sitting <input type="checkbox"/> Standing <input type="checkbox"/> Walking

Comments: _____

KNEE	
Location	<input type="checkbox"/> Left Knee <input type="checkbox"/> Right Knee <input type="checkbox"/> Both Knees
Pain Ratings	<input type="checkbox"/> 0 <input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4 <input type="checkbox"/> 5 <input type="checkbox"/> 6 <input type="checkbox"/> 7 <input type="checkbox"/> 8 <input type="checkbox"/> 9 <input type="checkbox"/> 10 (Excruciating)
Frequency	<input type="checkbox"/> Infrequent < 25% <input type="checkbox"/> Occasional 25% to 50% <input type="checkbox"/> Frequent 50% to 75% <input type="checkbox"/> Constant > 75%
Pain/Severity	<input type="checkbox"/> No Pain <input type="checkbox"/> Pain <input type="checkbox"/> Numbness <input type="checkbox"/> Tingling / <input type="checkbox"/> Mild <input type="checkbox"/> Moderate <input type="checkbox"/> Severe
Associated with	<input type="checkbox"/> Numbness <input type="checkbox"/> Pain <input type="checkbox"/> Inflammation <input type="checkbox"/> Bruising <input type="checkbox"/> Swelling
Radiates to	<input type="checkbox"/> Left Ankle <input type="checkbox"/> Right Ankle <input type="checkbox"/> Right Buttocks <input type="checkbox"/> Left Buttocks <input type="checkbox"/> Right Foot <input type="checkbox"/> Left Foot <input type="checkbox"/> Right Calf <input type="checkbox"/> Left Calf
Described as	<input type="checkbox"/> Aching <input type="checkbox"/> Dull <input type="checkbox"/> Sharp <input type="checkbox"/> Stabbing <input type="checkbox"/> Throbbing
At it's worst	<input type="checkbox"/> Morning <input type="checkbox"/> Afternoon <input type="checkbox"/> Evening <input type="checkbox"/> Night After Activities: <input type="checkbox"/> Light <input type="checkbox"/> Moderate
What makes it better?	<input type="checkbox"/> Medication <input type="checkbox"/> Lying Down <input type="checkbox"/> Standing <input type="checkbox"/> Sitting <input type="checkbox"/> Stretching <input type="checkbox"/> Range of Motion <input type="checkbox"/> Nothing
What makes it worse?	<input type="checkbox"/> Twisting R/L <input type="checkbox"/> Walking up or downstairs <input type="checkbox"/> Weight bearing Prolonged: <input type="checkbox"/> Sitting <input type="checkbox"/> Standing <input type="checkbox"/> Walking

Comments: _____

Bentree Clinic
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CALF	
Location	<input type="checkbox"/> Left Calf <input type="checkbox"/> Right Calf <input type="checkbox"/> Both Calves
Pain Ratings	<input type="checkbox"/> 0 <input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4 <input type="checkbox"/> 5 <input type="checkbox"/> 6 <input type="checkbox"/> 7 <input type="checkbox"/> 8 <input type="checkbox"/> 9 <input type="checkbox"/> 10 (Excruciating)
Frequency	<input type="checkbox"/> Infrequent < 25% <input type="checkbox"/> Occasional 25% to 50% <input type="checkbox"/> Frequent 50% to 75% <input type="checkbox"/> Constant > 75%
Pain/Severity	<input type="checkbox"/> No Pain <input type="checkbox"/> Pain <input type="checkbox"/> Numbness <input type="checkbox"/> Tingling / <input type="checkbox"/> Mild <input type="checkbox"/> Moderate <input type="checkbox"/> Severe
Associated with	<input type="checkbox"/> Burning <input type="checkbox"/> Decreased ROM <input type="checkbox"/> Increased Sensitivity <input type="checkbox"/> Numbness <input type="checkbox"/> Stiffness <input type="checkbox"/> Swelling <input type="checkbox"/> Weakness
Radiates to	<input type="checkbox"/> Right Thigh <input type="checkbox"/> Left Thigh <input type="checkbox"/> Right Knee <input type="checkbox"/> Left Knee <input type="checkbox"/> Right Ankle <input type="checkbox"/> Left Ankle <input type="checkbox"/> Left Foot <input type="checkbox"/> Right Foot
Described as	<input type="checkbox"/> Aching <input type="checkbox"/> Dull <input type="checkbox"/> Sharp <input type="checkbox"/> Stabbing <input type="checkbox"/> Throbbing
At it's worst	<input type="checkbox"/> Morning <input type="checkbox"/> Afternoon <input type="checkbox"/> Evening <input type="checkbox"/> Night After Activities: <input type="checkbox"/> Light <input type="checkbox"/> Moderate
What makes it better?	<input type="checkbox"/> Medication <input type="checkbox"/> Lying Down <input type="checkbox"/> Standing <input type="checkbox"/> Sitting <input type="checkbox"/> Stretching <input type="checkbox"/> Range of Motion <input type="checkbox"/> Nothing
What makes it worse?	Prolonged: <input type="checkbox"/> Sitting <input type="checkbox"/> Standing <input type="checkbox"/> Walking <input type="checkbox"/> Bending <input type="checkbox"/> Weight bearing

Comments: _____

ANKLE	
Location	<input type="checkbox"/> Left <input type="checkbox"/> Right <input type="checkbox"/> Both
Pain Ratings	<input type="checkbox"/> 0 <input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4 <input type="checkbox"/> 5 <input type="checkbox"/> 6 <input type="checkbox"/> 7 <input type="checkbox"/> 8 <input type="checkbox"/> 9 <input type="checkbox"/> 10 (Excruciating)
Frequency	<input type="checkbox"/> Infrequent < 25% <input type="checkbox"/> Occasional 25% to 50% <input type="checkbox"/> Frequent 50% to 75% <input type="checkbox"/> Constant > 75%
Pain/Severity	<input type="checkbox"/> No Pain <input type="checkbox"/> Pain <input type="checkbox"/> Numbness <input type="checkbox"/> Tingling / <input type="checkbox"/> Mild <input type="checkbox"/> Moderate <input type="checkbox"/> Severe
Associated with	<input type="checkbox"/> Decreased ROM <input type="checkbox"/> Increased Sensitivity <input type="checkbox"/> Numbness <input type="checkbox"/> Stiffness <input type="checkbox"/> Swelling <input type="checkbox"/> Tingling <input type="checkbox"/> Weakness
Radiates to	<input type="checkbox"/> Right Calf <input type="checkbox"/> Left Calf <input type="checkbox"/> Left Foot <input type="checkbox"/> Right Foot <input type="checkbox"/> Right Toes <input type="checkbox"/> Left Toes
Described as	<input type="checkbox"/> Aching <input type="checkbox"/> Dull <input type="checkbox"/> Sharp <input type="checkbox"/> Stabbing <input type="checkbox"/> Throbbing
At it's worst	<input type="checkbox"/> Morning <input type="checkbox"/> Afternoon <input type="checkbox"/> Evening <input type="checkbox"/> Night After Activities: <input type="checkbox"/> Light <input type="checkbox"/> Moderate
What makes it better?	<input type="checkbox"/> Lying Down <input type="checkbox"/> Medication <input type="checkbox"/> Nothing <input type="checkbox"/> Range of Motion <input type="checkbox"/> Sitting <input type="checkbox"/> Standing <input type="checkbox"/> Stretching
What makes it worse?	<input type="checkbox"/> Range of motion <input type="checkbox"/> Walking upstairs <input type="checkbox"/> Walking downstairs <input type="checkbox"/> Weight bearing Prolonged: <input type="checkbox"/> Sitting <input type="checkbox"/> Standing <input type="checkbox"/> Walking

Comments: _____

FOOT/TOES	
Location	<input type="checkbox"/> Left <input type="checkbox"/> Right <input type="checkbox"/> Both <input type="checkbox"/> Toes <input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4 <input type="checkbox"/> 5
Pain Ratings	<input type="checkbox"/> 0 <input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4 <input type="checkbox"/> 5 <input type="checkbox"/> 6 <input type="checkbox"/> 7 <input type="checkbox"/> 8 <input type="checkbox"/> 9 <input type="checkbox"/> 10 (Excruciating)
Frequency	<input type="checkbox"/> Infrequent < 25% <input type="checkbox"/> Occasional 25% to 50% <input type="checkbox"/> Frequent 50% to 75% <input type="checkbox"/> Constant > 75%
Pain/Severity	<input type="checkbox"/> No Pain <input type="checkbox"/> Pain <input type="checkbox"/> Numbness <input type="checkbox"/> Tingling / <input type="checkbox"/> Mild <input type="checkbox"/> Moderate <input type="checkbox"/> Severe
Associated with	<input type="checkbox"/> Decreased ROM <input type="checkbox"/> Increased sensitivity <input type="checkbox"/> Numbness <input type="checkbox"/> Swelling <input type="checkbox"/> Tingling
Radiates to	<input type="checkbox"/> Right Ankle <input type="checkbox"/> Left Ankle <input type="checkbox"/> Right Calf <input type="checkbox"/> Left Calf <input type="checkbox"/> Right Knee <input type="checkbox"/> Left Knee <input type="checkbox"/> Right Thigh <input type="checkbox"/> Left Thigh <input type="checkbox"/> Lower Back <input type="checkbox"/> Left Lower Back <input type="checkbox"/> Right Lower Back
Described as	<input type="checkbox"/> Aching <input type="checkbox"/> Dull <input type="checkbox"/> Sharp <input type="checkbox"/> Stabbing <input type="checkbox"/> Throbbing
At it's worst	<input type="checkbox"/> Morning <input type="checkbox"/> Afternoon <input type="checkbox"/> Evening <input type="checkbox"/> Night After Activities: <input type="checkbox"/> Light <input type="checkbox"/> Moderate
What makes it better?	<input type="checkbox"/> Lying Down <input type="checkbox"/> Medication <input type="checkbox"/> Nothing <input type="checkbox"/> Sitting <input type="checkbox"/> Standing <input type="checkbox"/> Stretching <input type="checkbox"/> Decreased ROM
What makes it worse?	Prolonged: <input type="checkbox"/> Sitting <input type="checkbox"/> Standing <input type="checkbox"/> Walking <input type="checkbox"/> Movement <input type="checkbox"/> Weight bearing <input type="checkbox"/> Working

Comments: _____

OTHER COMPLAINTS:

- Balance loss Fatigue Irritability Memory loss Nervousness Tension Shortness of breath

Patient's Signature

Bentree Clinic
13153 N. Dale Mabry Hwy
Suite 109
Tampa, Florida 33618-2410

NOTICE OF INFORMATION PRACTICES

Protecting the privacy of your personal health information is important to us. This notice describes how information about you may be used and disclosed and how you can get access to this information. Please review it carefully.

Disclosure of your protected health information without authorization is strictly limited to defined situations that include emergency care, quality assurance activities, public health, research, and law enforcement activities. Any other disclosures for the purposes of treatment, payment, or practice operations will be made only after obtaining your consent. You may request restrictions on disclosures.

Disclosures of protected health information are limited to the minimum necessary for the purpose of the disclosure. This provision does not apply to the transfer of medical records for treatment.

You may inspect and receive copies of your records within 30 days a request to do so. There may be a reasonable cost-based fee for photocopying, postage and preparation.

You may request changes to your records. Our practice has the right to accept or deny your request.

We maintain a history of protected health information disclosures that is accessible to you.

In the future, we may contact you for appointment reminders, announcements, and to inform you about our practice and its staff.

Our practice is required to abide by this notice. We have the right to change this notice in the future. Any revisions will be prominently displayed in a clearly visible location in our office.

You may file a complaint about privacy violations by contacting our Office Manager.

Name _____ Phone _____

The effective date of this Notice of Information Practices is _____

Thank you.

Bentree Clinic
13153 N. Dale Mabry Hwy
Suite 109
Tampa, Florida 33618-2410

Benttree Clinic

Informed Consent for Examination and Treatment

I (we) hereby consent to the performance of examination and treatment on me or on _____, by the licensed doctors of chiropractic, medical doctors, and/or licensed physical therapists who may be employed by or engaged in practice in this clinic.

I have had an opportunity to discuss with the doctor(s) or other clinic personnel the nature and purpose of the different physical therapy procedures and chiropractic treatment (manipulation/adjustment). I understand that neither chiropractic nor medical treatment is an exact science and that my care may involve judgments based upon facts and information known to the doctor. The doctor uses this judgment to attempt to anticipate or explain risks and complications and an undesirable result does not necessarily indicate an error in judgment. No guarantee for results can be made or expected but rather I wish to rely on the doctor to choose and recommend a best course of treatment based upon facts known that is in my best interests.

I further understand that there are certain degrees of risk associated with chiropractic health care and physical therapy, which includes rarely, but not limited to fractures, disc injuries, strokes, and strain/sprains and am therefore willing to accept and consent to the risk associated with the care that I am about to receive.

I have read, or the above information has been explained regarding consent. I have had an opportunity to ask questions about my examination and treatment. By signing below, I agree and intend this consent form to cover the procedures prescribed for my condition and for any future conditions for which I seek treatment.

Female Patients: By my signature on this form I do hereby state that to the best of my knowledge, I am not pregnant, nor is pregnancy suspected or confirmed at this particular time.
Date of last menstrual period _____.

Patient's Name (Print)

Patient's Signature

Date

Relationship or authority if not signed
By patient

Witness

Benttree Clinic

OFFICE FINANCIAL POLICY

Our policy is to extend to you the courtesy of allowing you to assign your insurance benefits directly to us. This policy reduces your out-of-pocket expense and allows you to place your family under care.

1. **If You Do Not Have Insurance:** All payments are expected at the time of service or by an authorized payment plan. Your personal balance may not exceed \$100 at any time or care may be terminated. Our payment plans make care an affordable part of your family budget.
2. **If You Have Insurance:** All deductibles and co-payments are expected at the time of service or by an authorized payment plan. Your co-insurance balance may not exceed \$100 or care may be terminated. Our payment plans make care an affordable part of your family budget.

You are considered a cash patient until you bring in your completed insurance forms, and we qualify and accept your insurance coverage. We do not accept assignment for secondary insurance carriers, but will be happy to provide you with a claim form for your secondary carrier.

Our fees are considered usual, customary and reasonable by most companies, and therefore are covered up to the maximum allowance determined by each carrier. This statement does not apply to companies who reimburse based on an arbitrary schedule of fees bearing no relationship to the current standard and of care in this area.

If your carrier has not paid a claim within sixty (60) days of submission, you agree to take an active part in the recovery of your claim. If your insurance carrier has not paid within ninety (90) days of submission, you accept responsibility for payment in full of any outstanding balance and authorize us to use your credit card to collect full payment.

When your schedule of visits is once per month or longer, you will not be eligible for insurance assignment. Charges for services rendered will be due as they are rendered. We will continue to provide you with an insurance claim form.

If you discontinue care for any reason other than discharge by the doctor, all balances will become immediately due and payable in full by you, regardless of any claim submitted.

Patient's Printed Name: _____

Signature: _____ Date: _____

Finance Counselor: _____ Date: _____

Front Desk: _____ Date: _____

Bentree Clinic
13153 N. Dale Mabry Hwy
Suite 109
Tampa, Florida 33618-2410

NOTICE OF INITIATION OF TREATMENT

DATE: _____
PHYSICIAN: _____
PATIENT NAME: _____
INSURED: _____
DATE OF LOSS: _____
INSURANCE COMPANY: _____
CLAIM NUMBER: _____
POLICY NUMBER: _____
TO WHOM IT MAY CONCERN:

Please be advised that I have been consulted by and have been rendering medical treatment to the above referenced patient, with the patient's first date of treatment occurring on _____.

Enclosed, please find a direction to pay, which the patient has directed you to send all payments for services rendered to the undersigned. The patient has also granted us a lien on the benefits:

In accordance with F.S.627.736 (5) (b), I will be timely submitting the bills.

Thank you,

Authorized Representative
Signature

Patient

ASSIGNMENT OF BENEFITS, LIENS, DIRECT PAYMENT AUTHORIZATION, AUTHORIZATION TO RELEASE INSURANCE INFORMATION, AND AUTHORIZATION TO ESCROW UNPAID MEDICAL & PIP BENEFITS

MEDICAL PROVIDER:

INSURANCE CARRIER: _____ POLICY NUMBER: _____ DATE OF LOSS: _____

For and in consideration of CON-40 WELLNESS CENTER, INC. DBA BENTTREE CLINIC, agreeing to pursue the responsible automobile insurance carrier for payment of benefits due and not requiring prepayment for services, I hereby irrevocably assign all rights and benefits to CON-40 WELLNESS CENTER, INC. DBA BENTTREE CLINIC for Personal Injury Protection, extended Personal Injury Protection, Medical Payment Coverage, and other benefits which I may have in accordance with Florida Statute §627.736. This includes any benefits from my insurance company and any other entity which may be responsible for medical expenses incurred. I further authorize CON-40 WELLNESS CENTER, INC. DBA BENTTREE CLINIC to collect payments & prosecute any necessary actions to collect payment for services as they see fit and allowable by law and contract. THIS DOCUMENT CONSTITUTES AN ASSIGNMENT OF RIGHTS AND BENEFITS.

I hereby further give a lien to CON-40 WELLNESS CENTER, INC. DBA BENTTREE CLINIC against any and all insurance benefits named herein, and any and all proceeds of any settlement, judgment or verdict which may be paid to me as a result of the injuries or illness for which I have been treated by CON-40 WELLNESS CENTER, INC. DBA BENTTREE CLINIC as a result of the above stated loss date. This document acts as an irrevocable assignment of my rights and benefits to the extent of the charges for services provided. I agree to cooperate with CON-40 WELLNESS CENTER, INC. DBA BENTTREE CLINIC and their attorney's (at their choosing), and to do all things reasonable to effect payment of the bills by the insurance company or other entity to CON-40 WELLNESS CENTER, INC. DBA BENTTREE CLINIC including, but not limited to, disclosing my medical condition, being available for factual discovery or other cooperation.

This assignment concerns only the bills for CON-40 WELLNESS CENTER, INC. DBA BENTTREE CLINIC and those costs including, but not limited to, attorney's fees, other costs, and interest necessary in procuring payment from the above-named insurance company and/or other entities. This assignment is not intended to assign any other causes of action that may belong to the undersigned patient. I agree to pay any applicable deductible or co-payment not covered by any policy of insurance cited above. I understand that as a benefit and convenience to me, CON-40 WELLNESS CENTER, INC. DBA BENTTREE CLINIC will bill and pursue collection against the insurance company or other responsible entity on my behalf. I hereby instruct and direct my insurance company to pay my benefits directly to CON-40 WELLNESS CENTER, INC. DBA BENTTREE CLINIC at the address provided on the bill. If my current policy prohibits direct payment to doctors, then I hereby instruct and direct my insurance company or other responsible entity to make the check payable to me and mail it to CON-40 WELLNESS CENTER, INC. DBA BENTTREE CLINIC at the address on the bill. CON-40 WELLNESS CENTER, INC. DBA BENTTREE CLINIC's medical care is being provided for a reasonable fee for treatment causally related to the above loss date and is medically necessary. I instruct my insurance carrier or other responsible entity to pay these bills to the full extent of my available benefits under the insurance policy and Florida law. If any portion of the charge for these services is either reduced or denied in whole or in part, my insurance company or other entity is to place funds equal to the amount of the reduced or denied charges into escrow and hold the escrowed funds until agreement or resolution of legal action by CON-40 WELLNESS CENTER, INC. DBA BENTTREE CLINIC. I further instruct my insurance company to make payment for charges submitted by CON-40 WELLNESS CENTER, INC. DBA BENTTREE CLINIC in priority to any other requests to escrow benefits, including a request by myself to reserve benefits for pending disability claims. I hereby give CON-40 WELLNESS CENTER, INC. DBA BENTTREE CLINIC limited power of attorney to endorse and sign my name on any draft for payment to either CON-40 WELLNESS CENTER, INC. DBA BENTTREE CLINIC or myself if said draft represents payment for charges related to services rendered by CON-40 WELLNESS CENTER, INC. DBA BENTTREE CLINIC.

I further direct my insurance carrier or responsible other entity to provide information to CON-40 WELLNESS CENTER, INC. DBA BENTTREE CLINIC which is otherwise available to me including but not limited to a copy of any applicable insurance policy, declaration page, all applicable endorsements, transcripts and/or copies of any recorded statements, examinations under oath, independent medical evaluations, peer review reports, and a listing of all PIP benefits paid to date which shall include when claims were made, when the claims were received, the payment or denial of each claim, the amount of the deductible and the claims applied thereto, and whether benefits have been exhausted and the amount of PIP benefits available, commonly known as a "PIP log". This request includes the name of other medical providers to whom payments have been under my policy of insurance. This agreement is intended to serve as an assignment of rights and benefits under my policy of insurance in favor of CON-40 WELLNESS CENTER, INC. DBA BENTTREE CLINIC. If any language within this agreement has the effect of invalidating this agreement, that language shall be deemed void and the remainder of the assignment shall maintain full force and effect. A photocopy of this assignment shall be considered as effective and valid as the original.

Patient Signature

Date

Patient Name

If patient is incapacitated or under the age of 18, please indicate the patient name, guardian name and relation to patient, and obtain guardian signature.



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 (<i>PRINT or TYPE</i>)	Signature	Date
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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 (15) and (16), 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*):

Name (<i>PRINT or TYPE</i>)	Signature	Date
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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.