Welcome to Alliance Health Partners and Optima Rehabilitation!

You are scheduled with	❑ Chad Abercrombie, DC ❑ James Thatcher, DC ❑ Scott Oliphant, DC ❑ Olivia Stanzer, PT	on _____ at _____.

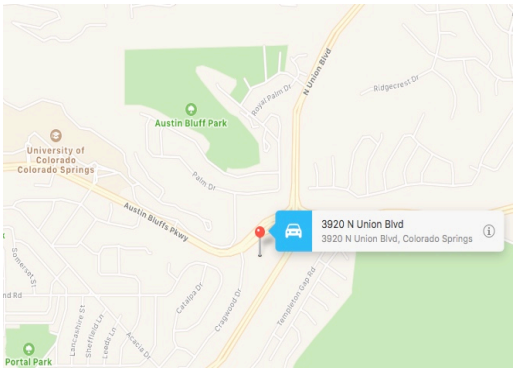
Enclosed is your initial patient paperwork. Please fill it out as completely as you can and sign by the X's. If you cannot finish your paperwork, please arrive ***at least 15 – 30 minutes*** prior to your scheduled appointment time to complete it before seeing the doctor or physical therapist. If you have any question prior to your appointment regarding your new patient paperwork, please feel free to call us. If possible, you should call your insurance carrier, prior to your scheduled appointment, to verify if you have chiropractic or physical therapy benefits. This will prevent you from acquiring any unnecessary charges.
It is very important to obtain and supply us with as much insurance information as you can. We cannot process your claims without it. ***Please bring with you to the appointment***:

Your Driver's License or Identification Card
Insurance Card of the Health Insurance your claims will be sent to
Insurance Card of the Auto Insurance your claims will be sent to (f applicable)
We MUST have a copy of these cards in your file.

In addition, please have the following information with you at your initial appointment, or indicate it on your new patient paperwork:

Health Insurance Carrier's Name, Address, Phone Number, and Policy Number
Auto Insurance Carrier's Name, Address, Phone Number, and Claim Number (if applicable)
Adjuster's Name and Phone Number (if applicable)
Name and Social Security Number of Insured
Attorney's Name, Address, and Phone Number (if applicable)

As we only have a limited number of appointments available, ***attending your initial evaluation at the scheduled day and time above is extremely important***. With your initial evaluation, the doctors and/or physical therapist will establish an appropriate plan of care, including the initial frequency and duration of your treatment. If we determine that you are a candidate for our care, it may take at least 4 – 12 visits to properly stabilize your condition. The most important factor in your treatment is consistency, thus missed or cancelled appointments are rarely tolerated.
We are located in the Premier Health Plaza, at the corner of Austin Bluffs Pkwy and Union Blvd, at 3920 N Union Blvd, Suite 160.



Thank you for your attention to this important matter. We look forward to meeting you and participating in your health care.
If you should have any questions, please contact us at: *Alliance Health Partners (719) 632-4754 info@ahpchiro.com*
Optima Rehabilitation (719) 471-4221 pt@optimarehab.com

The Doctors and Staff,
Alliance Health Partners and Optima Rehabilitation

New Patient Checklist

Dear Patient:

Listed below are the items, corresponding to your patient type, which you will need to complete prior to starting care in our office. Thank you for your cooperation in completing all items are to ensure that your care goes as smooth as possible. If you have any questions please call us at 471-4221 or 632-4754.

Please bring the following items to your first appointment:

Personal Pay Patients

- ❑ Your paperwork, with all areas filled out and signed
  **If you cannot complete the paperwork prior to your visit please arrive 15-30 minutes early.*
- ❑ Your Driver's License or Identification Card
- ❑ Doctor's Referral/Prescription, if applicable

Health Insurance Patients

- ❑ Your paperwork, with all areas filled out and signed
  **If you cannot complete the paperwork prior to your visit please arrive 15-30 minutes early.*
- ❑ Your Driver's License or Identification Card
- ❑ Your Health Insurance Card
- ❑ Doctor's Referral/Prescription, if applicable
- ❑ Please call our office to verify your benefits for our services, so we can explain what your out of pocket co-pays, co-insurance, deductibles, or other costs will be prior to your first visit.

Workers Compensation Patients

- ❑ Your paperwork, with all areas filled out and signed
  **If you cannot complete the paperwork prior to your visit please arrive 15-30 minutes early.*
- ❑ Your Driver's License or Identification Card
- ❑ Your Workers Compensation Insurance information, including:
  - ❑ Insurance Company Name
  - ❑ Adjuster's Name
  - ❑ Address
  - ❑ Phone Number
  - ❑ Fax Number
  - ❑ Claim Number
- ❑ Doctor's Referral/Prescription, if applicable

Auto Accident and Personal Injury Patients

- ❑ Your paperwork, with all areas filled out and signed
  **If you cannot complete the paperwork prior to your visit please arrive 15-30 minutes early.*
- ❑ Your Driver's License or Identification Card
- ❑ Your Auto Insurance Card
- ❑ Your Auto Insurance information, including:
  - ❑ Insurance Company Name
  - ❑ Adjuster's Name
  - ❑ Address
  - ❑ Phone Number
  - ❑ Fax Number
  - ❑ Claim Number
- ❑ Liability Limits of at-fault policy
- ❑ Doctor's Referral/Prescription, if applicable
- ❑ A copy of the accident report, if available.
- ❑ The At-Fault party's insurance information, including:
  - ❑ Insurance Company Name
  - ❑ Adjuster's Name
  - ❑ Address
  - ❑ Phone Number
  - ❑ Fax Number
  - ❑ Claim Number
  - ❑ Liability Limits of at-fault policy

INDEPENDENT MEDICAL EVALUATION QUESTIONNAIRE

Date: _____

1. What is your full name?_____
2. What is your date of birth? _____
3. Are you? ❑ Right Handed ❑ Left Handed ❑ Either
4. What is the date of your injury?_____
5. Have you ever had any previous problems or injuries, including any other work-related, recreational, or motor vehicle injuries?
   ❑ Yes ❑ No ❑ Not sure
   If yes, please describe:_____
   _____
6. Have you ever had any difficulties prior to the date of your injury that were similar to those you are now experiencing?
   ❑ Yes ❑ No ❑ Not sure
   If yes, please describe: _____
7. Please describe how your injury occurred: _____
   _____
8. What problems did you have at that time? _____
   _____
9. What did you do following the injury? _____
   _____
10. Briefly describe what has occurred since that time to this date: _____
    _____
11. What is your greatest concern at this time? _____
    _____

If you are not having difficulty with pain, proceed to question 18.

12. Where is your pain located? _____
    _____
13. How would you describe your pain? _____
    _____
14. What makes your pain worse?_____
    _____
15. What makes your pain better?_____
    _____
16. How frequent is your pain?
    ❑ Constant (present ¾ to all of the time)
    ❑ Frequent (present ½ to ¾ of the time)
    ❑ Occasional (present ¼ to ½ of the time)
    ❑ Intermittent (present less than ½ of the time)

17. On a scale from 0 (no pain) to 10 (excruciating pain):
    a. What number would you put on your pain at this time? _____
    b. During the past month, what has it averaged? _____
    c. During the past month, what is the highest it has been? _____
    d. During the past month, what is the lowest it has been? _____

18. Are you having any other difficulties? ❑ Yes ❑ No ❑ Not sure
    If yes, please describe these difficulties in detail: _____
    _____

19. Are any tasks difficult for you to perform? ❑ Yes ❑ No ❑ Not sure
    If yes, please describe the tasks that are most difficult for you: _____
    _____

If your injury is not work-related, please proceed to question 28.

20. Who employed you when you were injured? _____
    _____

21. How long had you been working there? _____

22. What was your job? _____

23. What did this job involve? _____

24. What type of work have you performed previously? _____
    _____

25. What is your level of education? _____

26. Are you working now? ❑ Yes ❑ No
    Please describe: _____

27. Has your doctor, or anyone, prescribed any work restrictions? ❑ Yes ❑ No ❑ Not sure
    If yes, please describe these restrictions: _____
    _____

28. Where do you live? _____

29. Who lives with you? _____

30. Please describe your typical day: _____
    _____

31. Are you involved in any work activities or any significant recreational pursuits? ❑ Yes ❑ No ❑ Not sure
    If yes, please describe: _____
    _____

32. Do you smoke? ❑ No ❑ Yes, in the past, but I quit ❑ Yes, _____ packs per day

33. How many alcoholic beverages do you have per week? _____

34. Have you had any medical hospitalizations? ❑ Yes ❑ No ❑ Not sure
    If yes, please describe: _____
    _____

35. Have you had any operations? ❑ Yes ❑ No ❑ Not sure
    If yes, please describe: _____

36. Are you taking any prescribed medications? ❑ Yes ❑ No ❑ Not sure
    If yes, please describe: _____
    _____

37. Are you allergic to any medications? ❑ Yes ❑ No ❑ Not sure
    If yes, please describe: _____
    _____

38. Have you had any other medical problems? ❑ Yes ❑ No ❑ Not sure
    If yes, please describe: _____
    _____

39. Do any diseases run in your family? ❑ Yes ❑ No ❑ Not sure
    If yes, please describe: _____
    _____

40. Please provide any other comments that may assist us in understanding your situation. Thanks for your assistance. At the time of the visit, we will review this information in further detail. _____
    _____
    _____
    _____
    _____

I understand that I am being seen for an Independent Medical Evaluation and no treating physician/patient relationship is established. I understand that the information I discuss will be included in a report that is prepared for the requesting client. I consent to this report being sent to this client and to participating in the assessment. I agree to advise the physician immediately if I experience any difficulties during the examination.

Signature: _____

Date: _____

Witness: _____

PATIENT PAIN PROFILE

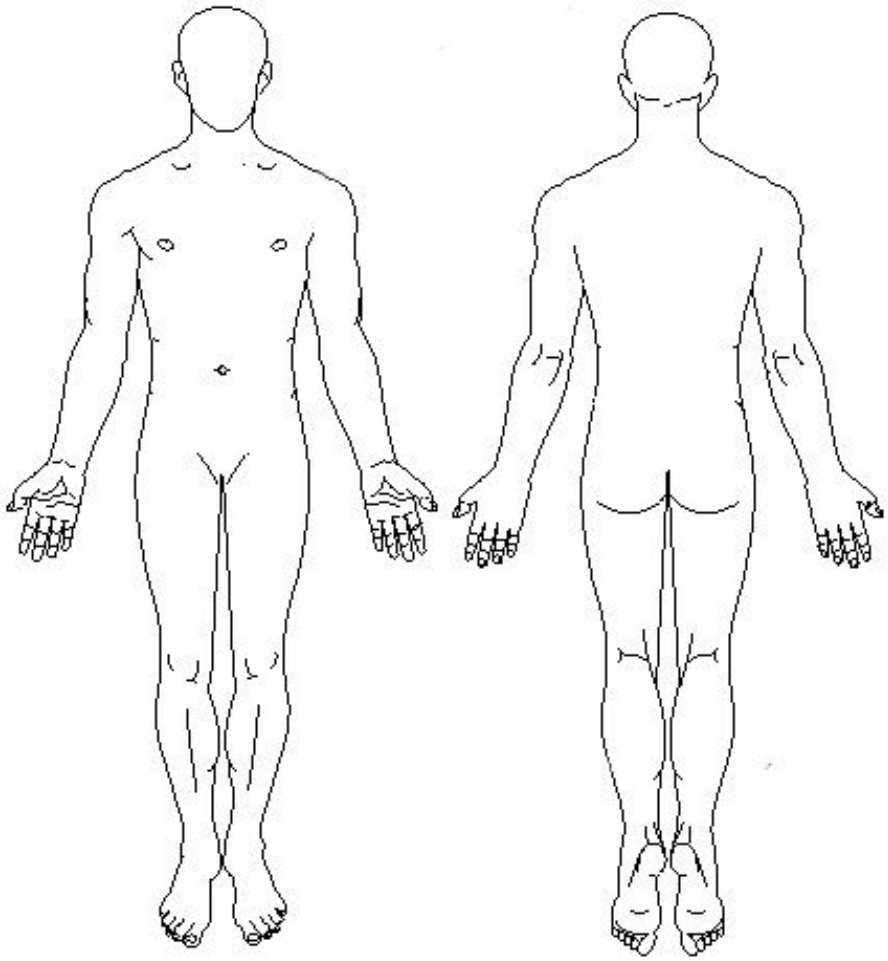
Name: _____ **Date:** _____

On the following illustration, use the letter keys below to mark the areas on your body where you feel the described sensation:

KEY

A = ACHE N = NUMBNESS P = PINS & NEEDLES B = BURNING S = STABBING

O = OTHER (Please describe):_____



What percent of the time is your pain present? If your pain is there all the time, in varying degrees, that would indicate 100%. _____%

Rate the intensity level of your pain. Refer to the color chart we have provided to rate your pain intensity. 10/10 is considered "Emergency Room" pain.

Average day: _____/10 Good day: _____/10 Bad day: _____/10 Today: _____/10

Rate the level of functional deficit you experience due to your pain. A rating of 10/10 would indicate severe disability where you are bedridden or should be in the emergency room. _____/10

Complete the following chart to assess your present symptoms, which resulted from your injuries:

	Symptom Description *Describe each symptom, including area, as clearly as possible.*	Frequency *Enter the amount of time, on a percentage basis, that the symptom is present during your waking hours*	Intensity Range *Using a scale of 0-10, where 10 is the worst pain imaginable, rate the pain intensity level for each symptom.*
1		%	/10
2		%	/10
3		%	/10
4		%	/10