ATTORNEY'S LIEN

To:_____

_____

_____

RE: Medical Reports and Attorney's Lien

I hereby authorize and direct you to pay directly to the said doctor such sums as may be due and owing him for medical service rendered me both by reason of this accident and by reason of any other bills that are due his office and to withhold such sums from settlement, judgment or verdict as may be necessary to adequately protect said doctor. And I hereby further give a lien on my on my case to said doctor against any and all proceeds of any settlement, judgment or verdict which may be paid to you or myself as the result of the injuries for which I have been treated or injuries in connection therewith.

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

Dated:_____Patient's Signature_____

The undersigned does hereby agree to observe all the terms of the above and agrees to withhold such sums from anysettlement, judgment or verdict as may be necessary to adequately protect said doctor above named.

Dated:_____Signature_____

Please date, sign and return one copy to doctor's office at once.

Reply envelope attached.

Keep one copy for your records.

ACCIDENTAL INJURY FORM

NAME________________________________ DATE_____ ______________

Date of Accident:__________ Time: ___am ___pm Location of Accident ________________

UTO INJURY

Were You: () Driver () Passenger () Pedestrian

Were you struck from: () Behind () Right Side () Left Side () Front () Parked

Did your car strike the others involved: () Yes () No () Undertermined

Did the other car strike yours: () Yes () No () Undetermined

As a result of the Accident, were traffic citations issued to you? () Yes () No

N-THE-JOB INJURY

How did the injury occur?________________________________

Did you report the injury to your foreman or employer? () Yes () No

Employer:______________________ Address______________________

THER

Describe the circumstances of the accident (Be Specific)________________________________

____

* *

HECK SYMPTOMS YOU HAVE NOTICED SINCE THE ACCIDENT

() Headache	() Sleeping Problems	() Lights Bother Eyes	() Diarrhea
() Neck Pain	() Head Too Heavy	() Loss of Memory	() Feet Cold
() Neck Stiff	() Pins & Needles in Arms	() Ears Ringing	() Hands Cold
() Dizziness	() Pins & Needles in Legs	() Face Flushed	() Stomach Upset
() Back Pain	() Numbness in Fingers	() Buzzing in Ears	() Constipation
() Nervousness	() Numbness in Toes	() Loss of Balance	() Cold Sweats
() Tension	() Shortness of Breath	() Fainting	() Fever
() Irritability	() Fatigue	() Loss of Smell	() Other
() Chest Pain	() Depression	() Loss of Taste	

Did you require post-accident hospitalization? () Yes () No

Have you lost any days of work? () Yes () No. If Yes, ________through__________

INSURANCE INFORMATION

Your Insurance Company______________________ Address______________________

Other Parties Name______________________ Address______________________

Other Parties Ins. Co.______________________ Address______________________

Have You been contacted by an insurance adjustor regarding this claim () Yes () No

If yes, name of adjustor______________________ Company______________________

Do you have an attorney that has advised you in this case: () Yes () No

If yes, attorney's name______________________ Adresss______________________

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Signature______________________

FRONT RANGE CENTER for BRAIN & SPINE SURGERY, P.C. 1313 Riverside Ave., Ft. Collins, CO 80524
(970) 493-1292

Oswestry Neck Disability Index

This questionnaire is designed to help us better understand how your neck pain affects your ability to manage everyday life activities. Please check the box for ***the one statement*** in each section that applies to you. Although you may consider that two of the statements in any one section relate to you, please mark the box that ***most closely*** describes your present-day situation. Thank you.

Patient name _____ Date _____

Please check one box in each section.

Section 1–Pain Intensity

- ☐ 0 I have no pain at the moment.
- ☐ 1 The pain is very mild at the moment.
- ☐ 2 The pain is moderate at the moment.
- ☐ 3 The pain is fairly severe at the moment.
- ☐ 4 The pain is very severe at the moment.
- ☐ 5 The pain is the worst imaginable at the moment.

Section 2–Personal Care (washing, dressing, etc.)

- ☐ 0 I can look after myself normally without causing extra pain.
- ☐ 1 I can look after myself normally, but it causes extra pain.
- ☐ 2 It is painful to look after myself; I am slow and careful.
- ☐ 3 I need some help but manage most of my personal care.
- ☐ 4 I need help every day in most aspects of self-care.
- ☐ 5 I do not get dressed; I wash with difficulty and stay in bed.

Section 3–Lifting

- ☐ 0 I can lift heavy weights without extra pain.
- ☐ 1 I can lift heavy weights, but it gives me extra pain.
- ☐ 2 Pain prevents me from lifting heavy weights off the floor, but I can manage if they are conveniently positioned—for example on a table.
- ☐ 3 Pain prevents me from lifting heavy weights, but I can manage light to medium weights if they are conveniently positioned.
- ☐ 4 I can lift only very light weights.
- ☐ 5 I cannot lift or carry anything at all.

Section 4–Reading

- ☐ 0 I can read as much as I want to with no pain in my neck.
- ☐ 1 I can read as much as I want to with slight pain in my neck.
- ☐ 2 I can read as much as I want with moderate neck pain.
- ☐ 3 I can't read as much as I want because of moderate neck pain.
- ☐ 4 I can hardly read at all because of severe pain in my neck.
- ☐ 5 I cannot read at all.

Section 5–Headaches

- ☐ 0 I have no headaches at all.
- ☐ 1 I have slight headaches that come infrequently.
- ☐ 2 I have moderate headaches that come infrequently.
- ☐ 3 I have moderate headaches that come frequently.
- ☐ 4 I have severe headaches that come frequently.
- ☐ 5 I have headaches almost all the time.

Score: _____ (50) Benchmark -5= _____

Section 6–Concentration

- ☐ 0 I can concentrate fully when I want to with no difficulty.
- ☐ 1 I can concentrate fully when I want to with slight difficulty.
- ☐ 2 I have a fair degree of difficulty in concentrating when I want to.
- ☐ 3 I have a lot of difficulty in concentrating when I want to.
- ☐ 4 I have a great deal of difficulty in concentrating when I want to.
- ☐ 5 I cannot concentrate at all.

Section 7–Work

- ☐ 0 I can do as much work as I want to.
- ☐ 1 I can only do my usual work, but no more.
- ☐ 2 I can do most of my usual work, but no more.
- ☐ 3 I cannot do my usual work.
- ☐ 4 I can hardly do any work at all.
- ☐ 5 I can't do any work at all.

Section 8–Driving

- ☐ 0 I can drive my car without any neck pain.
- ☐ 1 I can drive my car as long as I want with slight pain in my neck.
- ☐ 2 I can drive my car as long as I want with moderate pain in my neck.
- ☐ 3 I can't drive my car as long as I want because of moderate pain in my neck.
- ☐ 4 I can hardly drive at all because of severe pain in my neck.
- ☐ 5 I can't drive my car at all.

Section 9–Sleeping

- ☐ 0 I have no trouble sleeping.
- ☐ 1 My sleep is slightly disturbed (less than 1 hour sleepless).
- ☐ 2 My sleep is mildly disturbed (1-2 hours sleepless).
- ☐ 3 My sleep is moderately disturbed (2-3 hours sleepless).
- ☐ 4 My sleep is greatly disturbed (3-5 hours sleepless).
- ☐ 5 My sleep is completely disturbed (5-7 hours sleepless).

Section 10–Recreation

- ☐ 0 I am able to engage in all my recreation activities with no neck pain at all.
- ☐ 1 I am able to engage in all my recreation activities, with some pain in my neck.
- ☐ 2 I am able to engage in most, but not all of my usual recreation activities because of pain in my neck.
- ☐ 3 I am able to engage in a few of my recreation activities because of pain in my neck.
- ☐ 4 I can hardly do any recreation activities because of pain in my neck
- ☐ 5 I can't do any recreation activities at all.

Oswestry Low Back Pain Scale

Please rate the severity of your pain by circling a number below:

No pain | 0 1 2 3 4 5 6 7 8 9 10 | *Unbearable pain*

Name _____ **Date** _____

Instructions: Please circle the **ONE NUMBER** in each section which most closely describes your problem.

Section 1 – Pain Intensity
0. The pain comes and goes and is very mild.
1. The pain is mild and does not vary much.
2. The pain comes and goes and is moderate.
3. The pain is moderate and does not vary much.
4. The pain comes and goes and is severe.
5. The pain is severe and does not vary much.

Section 2 – Personal Care (Washing, Dressing, etc.)
0. I would not have to change my way of washing or dressing in order to avoid pain.
1. I do not normally change my way of washing or dressing even though it causes some pain.
2. Washing and dressing increase the pain but I manage not to change my way of doing it.
3. Washing and dressing increase the pain and I find it necessary to change my way of doing it.
4. Because of the pain I am unable to do some washing and dressing without help.
5. Because of the pain I am unable to do any washing and dressing without help.

Section 3 – Lifting
0. I can lift heavy weights without extra pain.
1. I can lift heavy weights but it gives extra pain.
2. Pain prevents me lifting heavy weights off the floor.
3. Pain prevents me lifting heavy weights off the floor, but I can manage if they are conveniently positioned, e.g., on a table.
4. Pain prevents me lifting heavy weights but I can manage light to medium weights if they are conveniently positioned.
5. I can only lift very light weights at most.

Section 4 – Walking
0. I have no pain on walking.
1. I have some pain on walking but it does not increase with distance.
2. I cannot walk more than 1 mile without increasing pain.
3. I cannot walk more than ½ mile without increasing pain.
4. I cannot walk more than ¼ mile without increasing pain.
5. I cannot walk at all without increasing pain.

Section 5 – Sitting
0. I can sit in any chair as long as I like.
1. I can sit only in my favorite chair as long as I like.
2. Pain prevents me from sitting more than 1 hour.
3. Pain prevents me from sitting more than ½ hour.
4. Pain prevents me from sitting more than 10 minutes.
5. I avoid sitting because it increases pain immediately.

Section 6 – Standing
0. I can stand as long as I want without pain.
1. I have some pain on standing but it does not increase with time.
2. I cannot stand for longer than 1 hour without increasing pain.
3. I cannot stand for longer than ½ hour without increasing pain.
4. I cannot stand for longer than 10 minutes without increasing pain.
5. I avoid standing because it increases the pain immediately.

Section 7 – Sleeping
0. I get no pain in bed.
1. I get pain in bed but it does not prevent me from sleeping well.
2. Because of pain my normal nights sleep is reduced by less than one-quarter.
3. Because of pain my normal nights sleep is reduced by less than one-half.
4. Because of pain my normal nights sleep is reduced by less than three-quarters.
5. Pain prevents me from sleeping at all.

Section 8 – Social Life
0. My social life is normal and gives me no pain.
1. My social life is normal but it increases the degree of pain.
2. Pain has no significant effect on my social life apart from limiting my more energetic interests, e.g., dancing, etc.
3. Pain has restricted my social life and I do not go out very often.
4. Pain has restricted my social life to my home.
5. I have hardly any social life because of the pain.

Section 9 – Traveling
0. I get no pain when traveling.
1. I get some pain when traveling but none of my usual forms of travel make it any worse.
2. I get extra pain while traveling but it does not compel me to seek alternate forms of travel.
3. I get extra pain while traveling which compels to seek alternative forms of travel.
4. Pain restricts me to short necessary journeys under ½ hour.
5. Pain restricts all forms of travel.

Section 10 – Changing Degree of Pain
0. My pain is rapidly getting better.
1. My pain fluctuates but is definitely getting better.
2. My pain seems to be getting better but improvement is slow.
3. My pain is neither getting better or worse.
4. My pain is gradually worsening.
5. My pain is rapidly worsening.

TOTAL _____