

# NEW PATIENT PERSONAL QUESTIONNAIRE

Today's date: \_\_\_\_\_

Name: \_\_\_\_\_ Street: \_\_\_\_\_  
City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_ SSI # \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_  
Home Phone: \_\_\_\_\_ Cell Phone: \_\_\_\_\_ Work Phone: \_\_\_\_\_  
e-mail: \_\_\_\_\_ Marital Status: \_\_\_\_\_ Spouse's Name: \_\_\_\_\_  
Occupation: \_\_\_\_\_ Employer: \_\_\_\_\_  
Date of Birth: (mm/dd/yyyy) \_\_\_\_\_ Age: \_\_\_\_\_ Male / Female (circle) \_\_\_\_\_  
\_\_\_\_\_

Insurance Carrier: \_\_\_\_\_ Policy No. \_\_\_\_\_  
Group/claim No. \_\_\_\_\_ Name of Primary Insured: \_\_\_\_\_

Please describe your chief complaint use back of the sheet if needed: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Health History (surgeries, fractures, accidents, serious illnesses, conditions etc.) use back of the sheet if needed:

Present medications – use back of the sheet if needed: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Is there anything else related to your health that you would like Dr. Indelicato to know?  
\_\_\_\_\_  
\_\_\_\_\_

## **FILL OUT ONLY FOR INJURY RELATED TO A CAR ACCIDENT:**

Insurance carrier for vehicle you were in: \_\_\_\_\_ Date of Accident: \_\_\_\_\_  
Policy No. \_\_\_\_\_ Claim No. if reported: \_\_\_\_\_  
Driver of vehicle if you were a passenger: \_\_\_\_\_ Have you retained an attorney? \_\_\_\_\_  
Name and Phone No. of Insurance Adjuster: \_\_\_\_\_  
Name and Phone No. of Attorney (if applicable) \_\_\_\_\_

## **FILL OUT ONLY FOR WORK-RELATED INJURY:**

Date of Accident: \_\_\_\_\_ Was it reported: Yes / No (circle) \_\_\_\_\_  
Name and Address of Employer: \_\_\_\_\_  
Did you stay at work? Yes / No (circle) If no, when did you return to work? \_\_\_\_\_  
Name and Phone No. of Supervisor etc.: \_\_\_\_\_  
Did you consult a Physician? Yes / No \_\_\_\_\_  
If yes, name and specialty of Doctor: \_\_\_\_\_  
Did you retain an attorney? Yes / No (circle) \_\_\_\_\_  
If yes, the Name and Phone No. \_\_\_\_\_  
Have you ever had a Workers' Comp claim before? Yes / No – If so, when? \_\_\_\_\_



**Butterfly Family Chiropractic**

645 E Venice Ave  
Venice, FL 34285  
941-484-0008



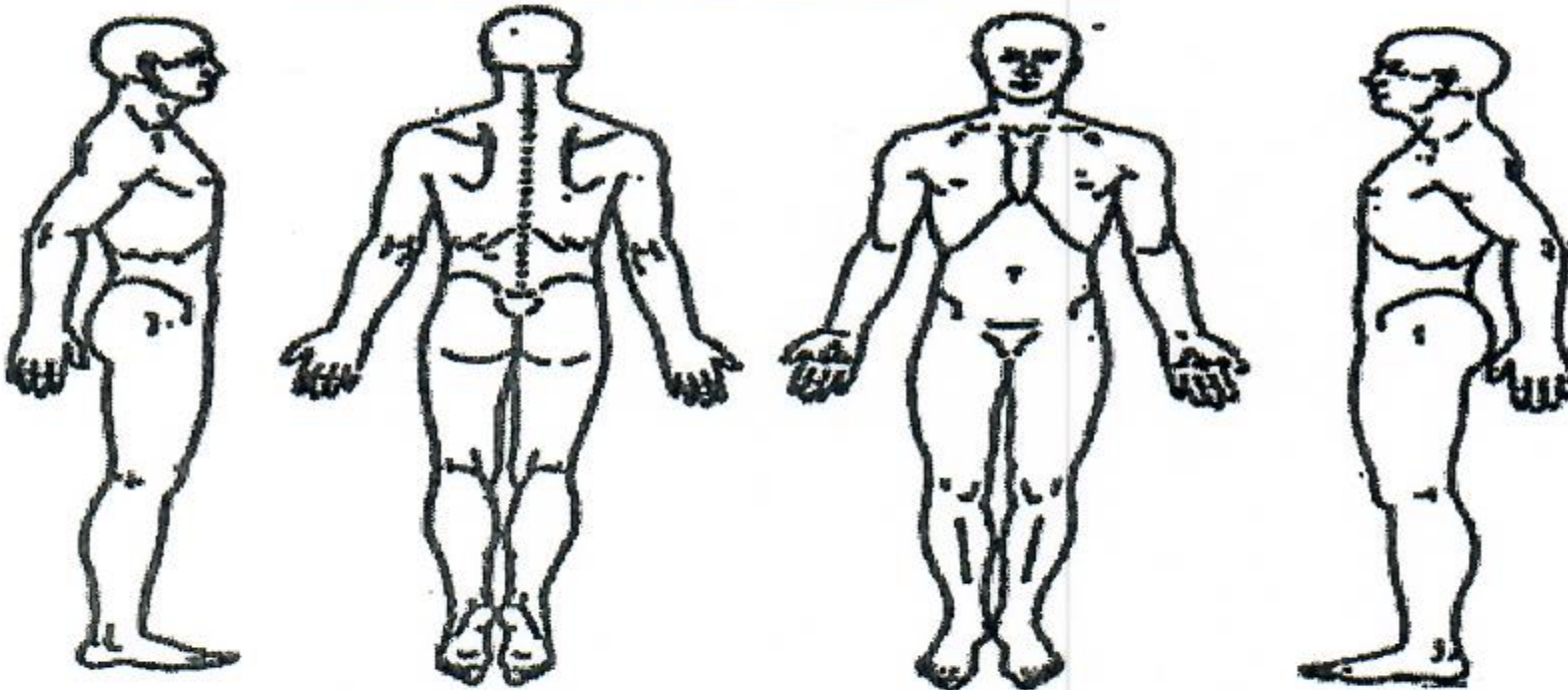
## PATIENT INTAKE FORM

Patient Name: \_\_\_\_\_

Date: \_\_\_\_\_

1. Is today's problem caused by: ☐ Auto Accident ☐ Workers Compensation

2. Indicate on the drawings below where you have pain/symptoms



3. How often do you experience your symptoms?

- ☐ Constantly (76-100% of the time) ☐ Occasionally (26-50% of the time)  
☐ Frequently (51-75% of the time) ☐ Intermittently (1-25% of the time)

4. How would you describe the type of pain?

- |                                   |  |
|-----------------------------------|--|
| <input type="checkbox"/> Sharp    | <input type="checkbox"/> Numb                      |
| <input type="checkbox"/> Dull     | <input type="checkbox"/> Tingly                    |
| <input type="checkbox"/> Diffuse  | <input type="checkbox"/> Sharp with motion         |
| <input type="checkbox"/> Achy     | <input type="checkbox"/> Shooting with motion      |
| <input type="checkbox"/> Burning  | <input type="checkbox"/> Stabbing with motion      |
| <input type="checkbox"/> Shooting | <input type="checkbox"/> Electric like with motion |
| <input type="checkbox"/> Stiff    | <input type="checkbox"/> Other: _____              |

5. How are your symptoms changing with time?

- ☐ Getting Worse ☐ Staying the Same ☐ Getting Better

6. Using a scale from 0-10 (10 being the worst), how would you rate your problem?

0 1 2 3 4 5 6 7 8 9 10 (Please circle)

7. How much has the problem interfered with your work?

- ☐ Not at all ☐ A little bit ☐ Moderately ☐ Quite a bit ☐ Extremely

8. How much has the problem interfered with your social activities?

- ☐ Not at all ☐ A little bit ☐ Moderately ☐ Quite a bit ☐ Extremely

9. Who else have you seen for your problem?

- |  |   |   |
|--|---|---|
| <input type="checkbox"/> Chiropractor      | <input type="checkbox"/> Neurologist        | <input type="checkbox"/> Primary Care Physician |
| <input type="checkbox"/> ER physician      | <input type="checkbox"/> Orthopedist        | <input type="checkbox"/> Other: _____           |
| <input type="checkbox"/> Massage Therapist | <input type="checkbox"/> Physical Therapist | <input type="checkbox"/> No one                 |

10. How long have you had this problem? \_\_\_\_\_

11. How do you think your problem began?

12. Do you consider this problem to be severe?

- ☐ Yes ☐ Yes, at times ☐ No

13. What aggravates your problem?

13a. What decreases your problem? Please state BOTH.

14. What concerns you the most about your problem; what does it prevent you from doing?

15. What is your: Height \_\_\_\_\_ Weight \_\_\_\_\_ Date of Birth \_\_\_\_\_



Occupation \_\_\_\_\_

**16. How would you rate your overall Health?**

☐ Excellent    ☐ Very Good    ☐ Good    ☐ Fair    ☐ Poor

**17. What type of exercise do you do?**

☐ Strenuous    ☐ Moderate    ☐ Light    ☐ None

**18. Indicate if you have any immediate family members with any of the following:**

☐ Rheumatoid Arthritis    ☐ Diabetes    ☐ Lupus  
☐ Heart Problems    ☐ Cancer    ☐ ALS

**19. For each of the conditions listed below, place a check in the "past" column if you have had the condition in the past. If you presently have a condition listed below, place a check in the "present" column.**

Past	Present	Past	Present	Past	Present
<input type="checkbox"/>	<input type="checkbox"/> Headaches	<input type="checkbox"/>	<input type="checkbox"/> High Blood Pressure	<input type="checkbox"/>	<input type="checkbox"/> Diabetes
<input type="checkbox"/>	<input type="checkbox"/> Neck Pain	<input type="checkbox"/>	<input type="checkbox"/> Heart Attack	<input type="checkbox"/>	<input type="checkbox"/> Excessive Thirst
<input type="checkbox"/>	<input type="checkbox"/> Upper Back Pain	<input type="checkbox"/>	<input type="checkbox"/> Chest Pains	<input type="checkbox"/>	<input type="checkbox"/> Frequent Urination
<input type="checkbox"/>	<input type="checkbox"/> Mid Back Pain	<input type="checkbox"/>	<input type="checkbox"/> Stroke	<input type="checkbox"/>	<input type="checkbox"/> Smoking/Tobacco Use
<input type="checkbox"/>	<input type="checkbox"/> Low Back Pain	<input type="checkbox"/>	<input type="checkbox"/> Angina	<input type="checkbox"/>	<input type="checkbox"/> Drug/Alcohol Dependence
<input type="checkbox"/>	<input type="checkbox"/> Shoulder Pain	<input type="checkbox"/>	<input type="checkbox"/> Kidney Stones	<input type="checkbox"/>	<input type="checkbox"/> Allergies
<input type="checkbox"/>	<input type="checkbox"/> Elbow/Upper Arm Pain	<input type="checkbox"/>	<input type="checkbox"/> Kidney Disorders	<input type="checkbox"/>	<input type="checkbox"/> Depression
<input type="checkbox"/>	<input type="checkbox"/> Wrist Pain	<input type="checkbox"/>	<input type="checkbox"/> Bladder Infection	<input type="checkbox"/>	<input type="checkbox"/> Systemic Lupus
<input type="checkbox"/>	<input type="checkbox"/> Hand Pain	<input type="checkbox"/>	<input type="checkbox"/> Painful Urination	<input type="checkbox"/>	<input type="checkbox"/> Epilepsy
<input type="checkbox"/>	<input type="checkbox"/> Hip Pain	<input type="checkbox"/>	<input type="checkbox"/> Loss of Bladder Control	<input type="checkbox"/>	<input type="checkbox"/> Dermatitis/Eczema/Rash
<input type="checkbox"/>	<input type="checkbox"/> Upper Leg Pain	<input type="checkbox"/>	<input type="checkbox"/> Prostate Problems	<input type="checkbox"/>	<input type="checkbox"/> HIV/AIDS
<input type="checkbox"/>	<input type="checkbox"/> Knee Pain	<input type="checkbox"/>	<input type="checkbox"/> Abnormal Weight Gain/Loss	<b>For Females Only</b>	
<input type="checkbox"/>	<input type="checkbox"/> Ankle/Foot Pain	<input type="checkbox"/>	<input type="checkbox"/> Loss of Appetite		
<input type="checkbox"/>	<input type="checkbox"/> Jaw Pain	<input type="checkbox"/>	<input type="checkbox"/> Abdominal Pain		
<input type="checkbox"/>	<input type="checkbox"/> Joint Pain/Stiffness	<input type="checkbox"/>	<input type="checkbox"/> Ulcer		
<input type="checkbox"/>	<input type="checkbox"/> Arthritis	<input type="checkbox"/>	<input type="checkbox"/> Hepatitis	<input type="checkbox"/>	<input type="checkbox"/> Birth Control Pills
<input type="checkbox"/>	<input type="checkbox"/> Rheumatoid Arthritis	<input type="checkbox"/>	<input type="checkbox"/> Liver/Gall Bladder Disorder	<input type="checkbox"/>	<input type="checkbox"/> Hormonal Replacement
<input type="checkbox"/>	<input type="checkbox"/> Cancer	<input type="checkbox"/>	<input type="checkbox"/> General Fatigue	<input type="checkbox"/>	<input type="checkbox"/> Pregnancy
<input type="checkbox"/>	<input type="checkbox"/> Tumor	<input type="checkbox"/>	<input type="checkbox"/> Muscular Incoordination		
<input type="checkbox"/>	<input type="checkbox"/> Asthma	<input type="checkbox"/>	<input type="checkbox"/> Visual Disturbances		
<input type="checkbox"/>	<input type="checkbox"/> Chronic Sinusitis	<input type="checkbox"/>	<input type="checkbox"/> Dizziness		
<input type="checkbox"/>	<input type="checkbox"/> Other: _____				

\_\_\_\_\_ When was your last medical check up?

**20. List all prescription medications you are currently taking:**

**21. List all of the over-the-counter medications AND vitamins you are currently taking:**

**22. List all surgical procedures you have had:**

**23. What activities do you do at work?**

<input type="checkbox"/> Sit:	<input type="checkbox"/> Most of the day	<input type="checkbox"/> Half the day	<input type="checkbox"/> A little of the day
<input type="checkbox"/> Stand:	<input type="checkbox"/> Most of the day	<input type="checkbox"/> Half the day	<input type="checkbox"/> A little of the day
<input type="checkbox"/> Computer work:	<input type="checkbox"/> Most of the day	<input type="checkbox"/> Half the day	<input type="checkbox"/> A little of the day
<input type="checkbox"/> On the phone:	<input type="checkbox"/> Most of the day	<input type="checkbox"/> Half of the day	<input type="checkbox"/> A little of the day

**24. What activities do you do outside of work?**

**25. Have you ever been hospitalized?**    ☐ No    ☐ Yes  
if yes, why \_\_\_\_\_

**26. Have you had significant past trauma?**    ☐ No    ☐ Yes

**27. Anything else pertinent to your visit today?** \_\_\_\_\_ Did you receive  
Chiropractic care before when? \_\_\_\_\_

**Patient Signature** \_\_\_\_\_ **Date:** \_\_\_\_\_



# Back Index

Form BI100

rev 3/27/2003

Patient Name \_\_\_\_\_

Date \_\_\_\_\_

*This questionnaire will give your provider information about how your back condition affects your everyday life. Please answer every section by marking the one statement that applies to you. If two or more statements in one section apply, please mark the one statement that most closely describes your problem.*

## Pain Intensity

- ① The pain comes and goes and is very mild.
- ② The pain is mild and does not vary much.
- ③ The pain comes and goes and is moderate.
- ④ The pain is moderate and does not vary much.
- ⑤ The pain comes and goes and is very severe.
- ⑥ The pain is very severe and does not vary much.

## Sleeping

- ① I get no pain in bed.
- ② I get pain in bed but it does not prevent me from sleeping well.
- ③ Because of pain my normal sleep is reduced by less than 25%.
- ④ Because of pain my normal sleep is reduced by less than 50%.
- ⑤ Because of pain my normal sleep is reduced by less than 75%.
- ⑥ Pain prevents me from sleeping at all.

## Sitting

- ① I can sit in any chair as long as I like.
- ② I can only sit in my favorite chair as long as I like.
- ③ Pain prevents me from sitting more than 1 hour.
- ④ Pain prevents me from sitting more than 1/2 hour.
- ⑤ Pain prevents me from sitting more than 10 minutes.
- ⑥ I avoid sitting because it increases pain immediately.

## Standing

- ① I can stand as long as I want without pain.
- ② I have some pain while standing but it does not increase with time.
- ③ I cannot stand for longer than 1 hour without increasing pain.
- ④ I cannot stand for longer than 1/2 hour without increasing pain.
- ⑤ I cannot stand for longer than 10 minutes without increasing pain.
- ⑥ I avoid standing because it increases pain immediately.

## Walking

- ① I have no pain while walking.
- ② I have some pain while walking but it doesn't increase with distance.
- ③ I cannot walk more than 1 mile without increasing pain.
- ④ I cannot walk more than 1/2 mile without increasing pain.
- ⑤ I cannot walk more than 1/4 mile without increasing pain.
- ⑥ I cannot walk at all without increasing pain.

## Personal Care

- ① I do not have to change my way of washing or dressing in order to avoid pain.
- ② I do not normally change my way of washing or dressing even though it causes some pain.
- ③ Washing and dressing increases the pain but I manage not to change my way of doing it.
- ④ Washing and dressing increases the pain and I find it necessary to change my way of doing it.
- ⑤ Because of the pain I am unable to do some washing and dressing without help.
- ⑥ Because of the pain I am unable to do any washing and dressing without help.

## Lifting

- ① I can lift heavy weights without extra pain.
- ② I can lift heavy weights but it causes extra pain.
- ③ Pain prevents me from lifting heavy weights off the floor.
- ④ Pain prevents me from lifting heavy weights off the floor, but I can manage if they are conveniently positioned (e.g., on a table).
- ⑤ Pain prevents me from lifting heavy weights off the floor, but I can manage light to medium weights if they are conveniently positioned.
- ⑥ I can only lift very light weights.

## Traveling

- ① I get no pain while traveling.
- ② I get some pain while traveling but none of my usual forms of travel make it worse.
- ③ I get extra pain while traveling but it does not cause me to seek alternate forms of travel.
- ④ I get extra pain while traveling which causes me to seek alternate forms of travel.
- ⑤ Pain restricts all forms of travel except that done while lying down.
- ⑥ Pain restricts all forms of travel.

## Social Life

- ① My social life is normal and gives me no extra pain.
- ② My social life is normal but increases the degree of pain.
- ③ Pain has no significant affect on my social life apart from limiting my more energetic interests (e.g., dancing, etc).
- ④ Pain has restricted my social life and I do not go out very often.
- ⑤ Pain has restricted my social life to my home.
- ⑥ I have hardly any social life because of the pain.

## Changing degree of pain

- ① My pain is rapidly getting better.
- ② My pain fluctuates but overall is definitely getting better.
- ③ My pain seems to be getting better but improvement is slow.
- ④ My pain is neither getting better or worse.
- ⑤ My pain is gradually worsening.
- ⑥ My pain is rapidly worsening.

Sign: \_\_\_\_\_

Back  
Index  
Score

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# Neck Index

Form N1-100

rev 3/27/2003

Patient Name \_\_\_\_\_

Date \_\_\_\_\_

*This questionnaire will give your provider information about how your neck condition affects your everyday life. Please answer every section by marking the one statement that applies to you. If two or more statements in one section apply, please mark the one statement that most closely describes your problem.*

## Pain Intensity

- ① I have no pain at the moment.
- ② The pain is very mild at the moment.
- ③ The pain comes and goes and is moderate.
- ④ The pain is fairly severe at the moment.
- ⑤ The pain is very severe at the moment.
- ⑥ The pain is the worst imaginable at the moment.

## Personal Care

- ① I can look after myself normally without causing extra pain.
- ② I can look after myself normally but it causes extra pain.
- ③ It is painful to look after myself and I am slow and careful.
- ④ I need some help but I manage most of my personal care.
- ⑤ I need help every day in most aspects of self care.
- ⑥ I do not get dressed, I wash with difficulty and stay in bed.

## Sleeping

- ① I have no trouble sleeping.
- ② My sleep is slightly disturbed (less than 1 hour sleepless).
- ③ My sleep is mildly disturbed (1-2 hours sleepless).
- ④ My sleep is moderately disturbed (2-3 hours sleepless).
- ⑤ My sleep is greatly disturbed (3-5 hours sleepless).
- ⑥ My sleep is completely disturbed (5-7 hours sleepless).

## Lifting

- ① I can lift heavy weights without extra pain.
- ② I can lift heavy weights but it causes extra pain.
- ③ Pain prevents me from lifting heavy weights off the floor, but I can manage if they are conveniently positioned (e.g., on a table).
- ④ Pain prevents me from lifting heavy weights off the floor, but I can manage light to medium weights if they are conveniently positioned.
- ⑤ I can only lift very light weights.
- ⑥ I cannot lift or carry anything at all.

## Reading

- ① I can read as much as I want with no neck pain.
- ② I can read as much as I want with slight neck pain.
- ③ I can read as much as I want with moderate neck pain.
- ④ I cannot read as much as I want because of moderate neck pain.
- ⑤ I can hardly read at all because of severe neck pain.
- ⑥ I cannot read at all because of neck pain.

## Driving

- ① I can drive my car without any neck pain.
- ② I can drive my car as long as I want with slight neck pain.
- ③ I can drive my car as long as I want with moderate neck pain.
- ④ I cannot drive my car as long as I want because of moderate neck pain.
- ⑤ I can hardly drive at all because of severe neck pain.
- ⑥ I cannot drive my car at all because of neck pain.

## Concentration

- ① I can concentrate fully when I want with no difficulty.
- ② I can concentrate fully when I want with slight difficulty.
- ③ I have a fair degree of difficulty concentrating when I want.
- ④ I have a lot of difficulty concentrating when I want.
- ⑤ I have a great deal of difficulty concentrating when I want.
- ⑥ I cannot concentrate at all.

## Recreation

- ① I am able to engage in all my recreation activities without neck pain.
- ② I am able to engage in all my usual recreation activities with some neck pain.
- ③ I am able to engage in most but not all my usual recreation activities because of neck pain.
- ④ I am only able to engage in a few of my usual recreation activities because of neck pain.
- ⑤ I can hardly do any recreation activities because of neck pain.
- ⑥ I cannot do any recreation activities at all.

## Work

- ① I can do as much work as I want.
- ② I can only do my usual work but no more.
- ③ I can only do most of my usual work but no more.
- ④ I cannot do my usual work.
- ⑤ I can hardly do any work at all.
- ⑥ I cannot do any work at all.

## Headaches

- ① I have no headaches at all.
- ② I have slight headaches which come infrequently.
- ③ I have moderate headaches which come infrequently.
- ④ I have moderate headaches which come frequently.
- ⑤ I have severe headaches which come frequently.
- ⑥ I have headaches almost all the time.

Sign: \_\_\_\_\_

Neck  
Index  
Score

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## CHIROPRACTIC INFORMED CONSENT TO TREAT

I hereby request and consent to the performance of chiropractic adjustments and other chiropractic procedures, including various modes of physical therapy and diagnostic x-rays and/or other tests on me (or the patient named below, for whom I am legally responsible) by the doctor or chiropractor named below and/or other licensed doctors of chiropractic who now or in the future treat me while employed by, working or associated with or serving as back-up for the doctor or chiropractic named below, including those working at the clinic or office listed below or any other office or clinic, whether signatories to this form or not.

I have had an opportunity to discuss with the doctor of chiropractic named below and/or with other office or clinic personnel the nature and purpose of chiropractic adjustments and procedures. I understand that results are not guaranteed.

I understand and am informed that, as in the practice of medicine, in the practice of chiropractic there are some risks to treatment, including, but not limited to, fractures, disc injuries, strokes, dislocations, falls, dizziness, headaches, burns with modalities and sprains. I do not expect the doctor to be able to anticipate and explain all risks and complications, and I wish to rely on the doctor to exercise judgment during the course of the procedure which the doctor feels at the time, based upon the facts then known, and is in my best interests.

I have read, or have had read to me, the above consent. I have also had an opportunity to ask questions about its content, and by signing below I agree to the above-named procedures. I intend this consent form to cover the entire course of treatment for my present condition and for any future condition(s) for which I seek treatment

Dr. Joseph Indelicato

X

\_\_\_\_\_  
Patient Signature – or signature of Patient's Representative

\_\_\_\_\_  
Date

[Indicate relationship if signing for the patient \_\_\_\_\_]



**ACKNOWLEDGMENT OF RECEIPT  
OF  
NOTICE OF PRIVACY PRACTICES**

I acknowledge that I was provided a copy of the Notice of Privacy Practices and that I have read them or declined the opportunity to read them and understand the Notice of Privacy Practices. I understand that this form will be placed in my patient chart and maintained for six years.

By checking the lines below I authorize being contacted for practice reminders by:

Mail \_\_\_\_\_;

Email \_\_\_\_\_; at email address

\_\_\_\_\_;  
Telephone numbers \_\_\_\_\_;

\_\_\_\_\_;  
By voice mail \_\_\_\_\_;

By text message \_\_\_\_\_;

By FaceBook address \_\_\_\_\_.

By checking this checking the lines below I authorize being contacted for birthday greetings or promotions about the practice by:

Mail \_\_\_\_\_;

Email \_\_\_\_\_ at email address

\_\_\_\_\_;  
Telephone numbers \_\_\_\_\_;

\_\_\_\_\_;  
By voice mail \_\_\_\_\_;

By text message \_\_\_\_\_;

By FaceBook address \_\_\_\_\_.

By checking this checking the lines below I authorize the doctor to personally discuss with me products that may benefit my health or condition.

\_\_\_\_\_  
Patient Name (please print)

\_\_\_\_\_  
Date

\_\_\_\_\_  
Name of Parent, Guardian or Patient's legal representative

\_\_\_\_\_  
Signature of Patient, Parent, Guardian or Patient's legal representative

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**THIS FORM WILL BE PLACED IN THE PATIENT'S CHART AND  
MAINTAINED FOR SIX YEARS.**

List below the names and relationship of people to whom you authorize the Practice to  
release PHI.

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BUTTERFLY FAMILY CHIROPRACTIC  
645 EAST VENICE AVE  
VENICE, FL 34285

Addendum:

**Open Room:** We utilize an open therapy room. We make good faith attempts to keep our conversations at a low level. We offer every patient the opportunity to be treated in a private room if requested

Sign \_\_\_\_\_

Date \_\_\_\_\_