

NEW PATIENT PERSONAL QUESTIONNAIRE

Name: _____ Today's Date: _____
Street: _____
City: _____ State: _____ Zip: _____
SS #: _____ - _____ - _____ (optional)
Home Phone: _____ Cell Phone: _____
Work Phone: _____ Email: _____
Marital Status: _____ Spouses Name: _____
Occupation(s): _____
Employer: _____
Date of Birth: _____ Age: _____ Male/ Female/ Other (Circle)

Insurance Carrier: _____ Policy Number: _____
Group/Claim Number: _____ Name of Primary Insured: _____

Please describe your primary complaint. Use back of sheet if needed:

Is there anything else related to your health that you would like the Dr. 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 of Insurance Adjuster: _____
Name and phone of Attorney: _____

FILL OUT ONLY FOR WORK-RELATED INJURY:

Date of Accident: _____ Was it reported? Yes/ No (Circle)
Name of Employer: _____
Did you stay at work? Yes/ No (Circle) If no, when did you return to work? _____
Name and Phone of Supervisor, etc: _____
Did you consult a physician? Yes/ No (Circle) If yes, name and specialty of Doctor: _____

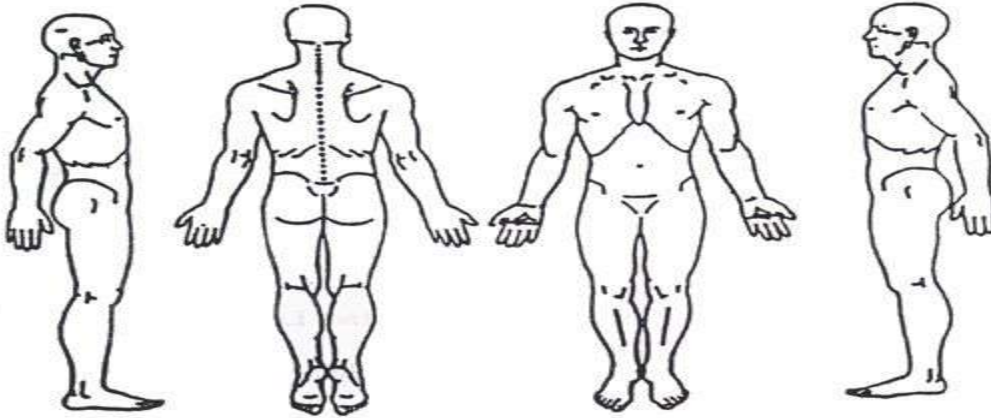
Did you retain an attorney? Yes/ No (Circle) If yes, name and phone: _____
Have you ever had a Worker's Comp. Claim before? Yes/ No (Circle) If so, when? _____

Patient Intake Form

Patient Name: _____ Date: _____

1. Is today's problem caused by: Auto Accident or Worker's Compensation **(Circle)**

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



3. How often do you experience your symptoms? **(Circle):**

* Constantly(75-100% of the time)

* Occasionally(25-50% of the time)

* Frequently(50-75% of the time)

* Intermittently(0-25% of the time)

4. How would you describe the type of pain?

* Sharp

* Achy

* Stiff

* Sharp with Motion

* Electric like with motion

* Dull

* Burning

* Numb

* Shooting with Motion

* Other: _____

* Diffuse

* Shooting

* Tingly

* Stabbing with Motion

5. How are your symptoms changing with time? **(Circle):**

* Getting Worse

* Staying the Same

* Getting Better

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

0

1

2

3

4

5

6

7

8

9

10

7. Who else have you seen about this problem? **(Circle):**

* Chiropractor * Neurologist * Primary Care Physician

* ER Physician * Orthopedist * Other: _____

* Massage Therapist * Physical Therapist * No One

8. How long have you had this problem? _____

9. How do you think this problem began? _____

10. Do you consider this problem to be severe? **(Circle):**

* Yes * Yes, at times * No

11. What aggravates and what alleviates your problem(s)?

Aggravates: _____

Alleviates: _____

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

13. What is your: Height: _____ Weight: _____ Date of Birth: _____

14. Indicate if you have any immediate family members with any of the following **(Circle):**

* Rheumatoid Arthritis * Diabetes * Lupus

* Heart Problems * Cancer * ALS

15. For each of the conditions listed below, **CIRCLE in the “past” column** if you have had the condition in the past. If you presently have a condition listed below, **CIRCLE in the “present” column.**

Past:	Present:	Past:	Present:	Past:	Present:
*	* Headaches	*	* High Blood Pressure	*	* Diabetes
*	* Neck Pain	*	* Heart Attack	*	* Allergies
*	* Upper Back Pain	*	* Chest Pain	*	* Smoking
*	* Mid Back Pain	*	* Stroke	*	* Drinking
*	* Lower Back Pain	*	* Angina	*	* Drug use
*	* Shoulder Pain	*	* Kidney Stones	*	* Depression
*	* Elbow/Upper Arm Pain	*	* Kidney Disorder	*	* Lupus
*	* Wrist Pain	*	* Bladder Infection	*	* Epilepsy
*	* Hand Pain	*	* Painful Urination	*	* HIV
*	* Hip Pain	*	* Loss of Bladder Control	*	* AIDS
*	* Upper Leg Pain	*	* Prostate Problems	*	* Pregnancy
*	* Knee Pain	*	* Abnormal Weight Gain/Loss	*	*Other:_____
*	* Ankle/Foot Pain	*	* Loss of Appetite		
*	* Jaw Pain	*	* Abdominal Pain		
*	* Joint Pain/Stiffness	*	* Ulcer		
*	* Arthritis	*	* Hepatitis		
*	* Rheumatoid Arthritis	*	* Liver/Gall Bladder Disorder		
*	* Cancer	*	* General Fatigue		
*	* Tumor	*	* Muscular Incoordination		
*	* Asthma	*	* Visual Disturbances		
*	* Chronic Sinusitis	*	* Dizziness		
*	* Birth Control Pills	*	* Hormonal Replacement		

16. Do you have a Pacemaker or any electrical device?_____

17. When was your last medical check-up? _____

18. What activities do you do outside of work?_____

19. Have you had significant past trauma? Yes or No (**Circle**)

If yes, specify incident:_____

20. Anything else pertinent to your visit today?_____

21. Have you received chiropractic care before?_____

Patient Signature_____Date:_____

Medication List

Name: _____ Date of Birth: _____ Date: _____

Please list all medications and what they are used for:

Medications / Vitamins:

1. _____
2. _____
3. _____
4. _____
5. _____
6. _____
7. _____
8. _____
9. _____
10. _____

List all surgeries or procedures with date it was completed:

1. _____
2. _____
3. _____
4. _____
5. _____

List any current or past health conditions:

1. _____
2. _____
3. _____
4. _____
5. _____

Have you had any of the following? If yes, please state when.

- Medical exam _____
- Colonoscopy _____
- Cardiac exam _____
- Pacemaker _____
- GYN Exam (Female) _____
- Bone density _____
- Prostate Exam (Male) _____
- Spinal X-rays _____
- MRI's _____
- CT scans _____

Name: _____ Date of Birth: _____ Date: _____

Signature: _____

Neck Index

Patient Name: _____ Date: _____
Signature: _____

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

Pain Intensity

0. I have no pain at the moment.
1. The pain is very mild at the moment.
2. The pain comes and goes and is moderate.
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.

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).

Reading

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

Concentration

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

Work

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

Personal Care

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

Lifting

0. I can lift heavy weights without pain.
1. I can lift heavy weights but it causes pain.
2. Pain prevents me from lifting unless conveniently placed.
3. Pain prevents me from lifting unless light and conveniently placed.
4. I can only lift very light weights.
5. I cannot lift or carry anything at all.

Driving

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

Recreation

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

Headaches

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

For Clinic Use:

Index Score = [Sum of all statements selected / (# of sections with a statement selected x 5)] x 100

Neck Index Score: _____

Back Index

Patient Name: _____ Date: _____

Signature: _____

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 circle the one statement that most clearly describes your problem.

Pain Intensity

0. I have no pain at the moment.
1. The pain is very mild at the moment.
2. The pain comes and goes and is moderate.
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.

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).

Sitting

0. I can sit in any chair as long as I like.
1. I can only sit 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.

Standing

0. I can stand as long as I want without pain.
1. I have pain while standing but it doesn't increase with time.
2. I cannot stand for longer than 1 hour without pain.
3. I cannot stand for longer than ½ hour without pain.
4. I cannot stand for longer than 10 minutes without pain.
5. I avoid standing because it increases pain immediately.

Walking

0. I have no pain while walking.
1. I have pain while walking but it doesn't 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.

Personal Care

0. I can look after myself without causing extra pain.
1. I can look after myself but it causes pain.
2. It is painful to look after myself and I am slow.
3. I need some help but I manage most of my personal care.
4. I need help everyday in most aspects of self care.
5. I don't get dressed, wash with difficulty and stay in bed.

Lifting

0. I can lift heavy weights without pain.
1. I can lift heavy weights but it causes pain.
2. Pain prevents me from lifting unless conveniently placed.
3. Pain prevents me from lifting unless light/convenient.
4. I can only lift very light weights.
5. I cannot lift or carry anything at all.

Traveling

0. I get no pain while traveling.
1. I get pain while traveling but it doesn't make any of my travels worse.
2. I get pain while traveling but doesn't make me seek other forms of travel.
3. I get pain while traveling which causes me to seek other forms of travel.
4. Pain restricts all form of travel except that done while lying down.
5. Pain restricts all forms of travel.

Social Life

0. My social life is normal and gives me no extra pain.
1. My social life is normal but increases my pain.
2. Pain has no affect on my life apart from limiting more active interests.
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 my pain.

Changing Degree of Pain

0. My pain is getting better.
1. My pain fluctuates but overall is definitively 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.

For Clinic Use:

Index Score = [Sum of all statements selected / (# of sections with a statement selected x 5)] x 100

Back Index Score: _____

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 chiropractor 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.

I hereby acknowledge that no guarantees have been made to me as to the effect of such examinations or treatments of my condition.

Dr. Michael Spinelli Dr. Vimarelis Rivera Contes

Patient Signature, or signature of Patient's Representative

Date

Print Patient Name _____

**ACKNOWLEDGMENT OF RECEIPT
NOTICES OF PRIVATE PRACTICES**

I acknowledge that a copy of the Notice of Privacy Practices was made available to me, and that I have read it (or declined to do so) and that I understand it. I am aware 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 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 completing the lines below, I authorize the doctor to personally discuss with me products that may benefit my health or condition.

Date: _____

Patient Name (Print): _____

Name of Parent, Guardian, or Patients Legal Representative (Print):

Signature of Patient, Parent, Guardian, or Patients Legal Representative:

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.

_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____

Patient Signature: _____

Print Name: _____

Date: _____

Date of Birth: _____

Open Room Policy Patient Acknowledgment

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

Signature: _____

Date: _____