Chiropractic Pain-Wellness Care, P.C.

2220 Vestal Pkway East, 1st Floor. Vestal, NY 13850

PATIENT INTRODUCTION FORM

Date___________________ Social Security Number ______________________

Name ____ Phone No. (Home) ___________ (Work) ______________
(first) (last) (M)

Address____ Age________________Marital Status___________

City____ Number of Children _______________________

State_______________ Zip ____________________ Occupation / Profession ______________________

Date of Birth_______________________________________ Employer ______________________________
(month) (day) (year)

Name of Spouse __________________________________ Primary Care Physician ______________________________

Name of Children ____________________ Email Address ________________________________

Briefly describe complaints ____
____

Are these complaints related to: ➀ Auto Accident? ➀ Work Injury? ➀ None ➀ Other ______________________

Referred By: ____

Have you had previous chiropractic care? ➀ Yes ➀ No Where? ____

Do you have health insurance? ➀ Yes ➀ No Name of company? ______________________________

ALLERGIES

Are you allergic to any medication(s)?

- Yes - No

If yes, which medications? ___________________________

Are you allergic to any of the following?

❑ Bee Sting - Latex - Peanuts - Shellfish - Dairy - Mold

❑ Pollen - Wheat - Eggs - Nuts - Other___________

Describe the reaction:__________________

SMOKING HISTROY

Do you currently smoke tobacco of any kind?

- Yes - Former smoke - Never been a smoker

If yes, how often do you smoke:

- Current every day smoker
- Current sometimes smoker

EMERGENCY CONTACT INFORMATION

Full Name:_____________________________________ Home:______________________ Mobile:________________________

Relationship: Child / Parent / Spouse / Other: ______________

PATIENT AGREEMENT ASSIGNMENT AND RELEASE

I, the undersigned, assign directly to Chiropractic Pain-Wellness Care, P.C.,. all medical benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I hereby authorize this clinic to release all information necessary to secure the payment of benefits. I authorize the use of this signature on all my insurance submissions.

____ _______________________________

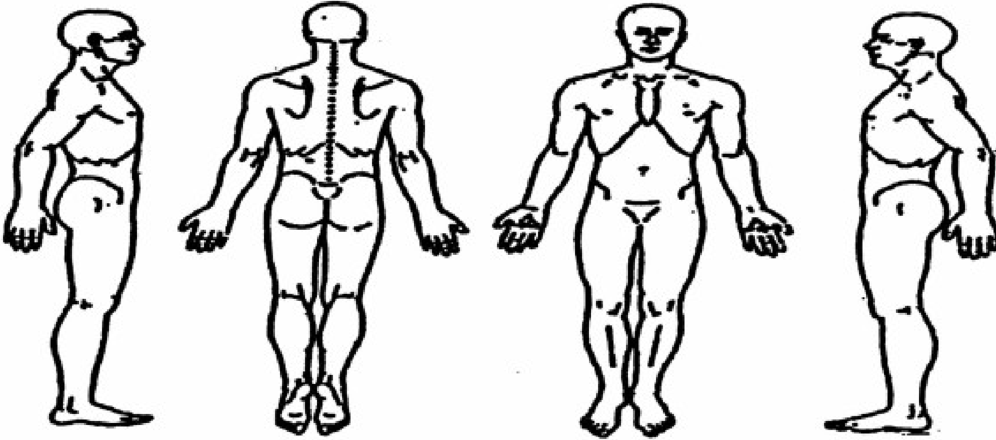
Signature of Insured/Guardian Date

PATIENT INTAKE FORM

Patient Name: ______________________________ Date: _______________

1. Is today's problem caused by: □ Auto Accident □ Workman's 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?

□ Sharp □ Numb □ Dull □ Tingly
□ Diffuse □ Sharp with motion
□ Achy □ Shooting with motion
□ Burning □ Stabbing with motion
□ Shooting □ Electric like with motion
□ Stiff □ 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?

□ Chiropractor □ Neurologist □ Primary Care Physician □ ER physician
□ Orthopedist □ Other:____________ □ Massage Therapist □ Physical Therapist □ 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?

____

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?
□ Stenuous □ 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
□	□ Headaches	□	□ High Blood Pressure	□	□ Diabetes
□	□ Neck Pain	□	□ Low Blood Pressure	□	□ Excessive Thirst
□	□ Upper Back Pain	□	□ Chest Pains	□	□ Frequent Urination
□	□ Mid Back Pain	□	□ Stroke	□	□ Smoking/Tobacco Use
□	□ Low Back Pain	□	□ Angina	□	□ Drug/Alcohol Dependance
□	□ Shoulder Pain	□	□ Kidney Stones	□	□ Allergies
□	□ Elbow/Upper Arm Pain	□	□ Kidney Disease	□	□ Depression
□	□ Wrist Pain	□	□ Bladder Infection	□	□ Systemic Lupus
□	□ Hand Pain	□	□ Painful Urination	□	□ Epilepsy
□	□ Hip Pain	□	□ Loss of Bladder Control	□	□ Dermatitis/Eczema/Rash
□	□ Upper Leg Pain	□	□ Prostate Problems	□	□ HIV/AIDS
□	□ Knee Pain	□	□ Fatigue	□	□ Carpel Tunnel
□	□ Ankle/Foot Pain	□	□ Loss of Appetite	**For Females Only**	
□	□ Jaw Pain	□	□ Abdominal Pain	□	□ Birth Control Pills
□	□ Joint Pain/Stiffness	□	□ Ulcer	□	□ Hormonal Replacement
□	□ Arthritis	□	□ Hepatitis	□	□ Pregnancy
□	□ Rheumatoid Arthritis	□	□ Liver/Gall Bladder Disorder		
□	□ Cancer	□	□ General Fatigue		
□	□ Tumor	□	□ Muscular Incoordination		
□	□ Asthma	□	□ Visual Disturbances		
□	□ Chronic Sinusitis	□	□ Abnormal Weight Gain/Loss		
□	□ Fainting	□	□ Ringing in Ears		
□	□ Head feels heavy	□	□ Wear Glasses		
□	□ Lights bother eyes	□	□ Shortness of Breath		
□	□ Loss of Balance	□	□ Arthritis		
□	□ Loss of Smell	□	□ Dizziness		
□	□ Irritability	□	□ Heart Attack		
□	□ Numbness in Arms	□	□ Nausea		
□	□ Numbness in Hands	□	□ Nervous Stomach		
□	□ Tingling in Arms	□	□ Constipation		
□	□ Tingling in Hands	□	□ Menstrual Cramps/Pain		
□	□ Numbness in Feet	□	□ Cold Hands		
□	□ Numbness in Legs	□	□ Cold Feet		
□	□ Tingling in Feet	□	□ Cold Sweats		
□	□ Tingling in Legs	□	□ Lack of Energy		
□	□ Other:______________________________				

20. List all prescription medications you are currently taking:

____

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

____

22. List all surgical procedures you have had:

____

23. What activities do you do at work?
□ **Sit:** □ Most of the day □ Half the day □ A little of the day
□ **Stand:** □ Most of the day □ Half the day □ A little of the day
□ **Computer work:** □ Most of the day □ Half the day □ A little of the day
□ **On the phone:** □ Most of the day □ Half of the day □ 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?____

Patient Signature_________________________________ **Date:**___________________

COMPLAINT	PRIMARY COMPLAINT	SECONDARY COMPLAINT	TERTIARY COMPLAINT	ADDITIONAL COMPLAINT
SYMPTOMS	☐ Headache ☐ Neck Pain ☐ Arm Pain ☐ Left ☐ Right ☐ Shoulder Pain ☐ Left ☐ Right ☐ Back Pain ☐ Mid ☐ Upper ☐ Lower Back Pain ☐ Hip Pain ☐ Left ☐ Right ☐ Leg Pain ☐ Left ☐ Right	☐ Headache ☐ Neck Pain ☐ Arm Pain ☐ Left ☐ Right ☐ Shoulder Pain ☐ Left ☐ Right ☐ Back Pain ☐ Mid ☐ Upper ☐ Lower Back Pain ☐ Hip Pain ☐ Left ☐ Right ☐ Leg Pain ☐ Left ☐ Right	☐ Headache ☐ Neck Pain ☐ Arm Pain ☐ Left ☐ Right ☐ Shoulder Pain ☐ Left ☐ Right ☐ Back Pain ☐ Mid ☐ Upper ☐ Lower Back Pain ☐ Hip Pain ☐ Left ☐ Right ☐ Leg Pain ☐ Left ☐ Right	☐ Headache ☐ Neck Pain ☐ Arm Pain ☐ Left ☐ Right ☐ Shoulder Pain ☐ Left ☐ Right ☐ Back Pain ☐ Mid ☐ Upper ☐ Lower Back Pain ☐ Hip Pain ☐ Left ☐ Right ☐ Leg Pain ☐ Left ☐ Right
SEVERITY	☐ Mild ☐ Moderate ☐ Severe	☐ Mild ☐ Moderate ☐ Severe	☐ Mild ☐ Moderate ☐ Severe	☐ Mild ☐ Moderate ☐ Severe
QUALITY	☐ Dull ☐ Sharp ☐ Burning ☐ Stiffness/ Tightness ☐ Achy ☐ Throbbing ☐ Shooting ☐ Numbness ☐ Tingling	☐ Dull ☐ Sharp ☐ Burning ☐ Stiffness/ Tightness ☐ Achy ☐ Throbbing ☐ Shooting ☐ Numbness ☐ Tingling	☐ Dull ☐ Sharp ☐ Burning ☐ Stiffness/ Tightness ☐ Achy ☐ Throbbing ☐ Shooting ☐ Numbness ☐ Tingling	☐ Dull ☐ Sharp ☐ Burning ☐ Stiffness/ Tightness ☐ Achy ☐ Throbbing ☐ Shooting ☐ Numbness ☐ Tingling
RADIATING	☐ Left ☐ Right Shoulder ☐ Left ☐ Right Arm ☐ Left ☐ Right Fingers ☐ Left ☐ Right Buttock ☐ Left ☐ Right Hip ☐ Left ☐ Right Thigh ☐ Left ☐ Right Knee ☐ Left ☐ Right Leg ☐ Left ☐ Right Ankle ☐ Left ☐ Right Foot ☐ Left ☐ Right Toes	☐ Left ☐ Right Shoulder ☐ Left ☐ Right Arm ☐ Left ☐ Right Fingers ☐ Left ☐ Right Buttock ☐ Left ☐ Right Hip ☐ Left ☐ Right Thigh ☐ Left ☐ Right Knee ☐ Left ☐ Right Leg ☐ Left ☐ Right Ankle ☐ Left ☐ Right Foot ☐ Left ☐ Right Toes	☐ Left ☐ Right Shoulder ☐ Left ☐ Right Arm ☐ Left ☐ Right Fingers ☐ Left ☐ Right Buttock ☐ Left ☐ Right Hip ☐ Left ☐ Right Thigh ☐ Left ☐ Right Knee ☐ Left ☐ Right Leg ☐ Left ☐ Right Ankle ☐ Left ☐ Right Foot ☐ Left ☐ Right Toes	☐ Left ☐ Right Shoulder ☐ Left ☐ Right Arm ☐ Left ☐ Right Fingers ☐ Left ☐ Right Buttock ☐ Left ☐ Right Hip ☐ Left ☐ Right Thigh ☐ Left ☐ Right Knee ☐ Left ☐ Right Leg ☐ Left ☐ Right Ankle ☐ Left ☐ Right Foot ☐ Left ☐ Right Toes
PAIN FREQUENCY	☐ Occasional ☐ Intermittent ☐ Frequent ☐ Constant	☐ Occasional ☐ Intermittent ☐ Frequent ☐ Constant	☐ Occasional ☐ Intermittent ☐ Frequent ☐ Constant	☐ Occasional ☐ Intermittent ☐ Frequent ☐ Constant
ONSET	☐ 1 2 3 4 5 6 days ☐ 1 2 3 weeks ☐ 1 2 3 4 5 6 7 8 9 10 11 months ☐ 1 2 3 4 5 6 7 8 9 10 11 12+ years	☐ 1 2 3 4 5 6 days ☐ 1 2 3 weeks ☐ 1 2 3 4 5 6 7 8 9 10 11 months ☐ 1 2 3 4 5 6 7 8 9 10 11 12+ years	☐ 1 2 3 4 5 6 days ☐ 1 2 3 weeks ☐ 1 2 3 4 5 6 7 8 9 10 11 months ☐ 1 2 3 4 5 6 7 8 9 10 11 12+ years	☐ 1 2 3 4 5 6 days ☐ 1 2 3 weeks ☐ 1 2 3 4 5 6 7 8 9 10 11 months ☐ 1 2 3 4 5 6 7 8 9 10 11 12+ years
PALLIATIVE	☐ Nothing ☐ Lying down ☐ Standing ☐ Sitting ☐ Movement ☐ Rest	☐ Nothing ☐ Lying down ☐ Standing ☐ Sitting ☐ Movement ☐ Rest	☐ Nothing ☐ Lying down ☐ Standing ☐ Sitting ☐ Movement ☐ Rest	☐ Nothing ☐ Lying down ☐ Standing ☐ Sitting ☐ Movement ☐ Rest
PROVOKED	☐ Nothing ☐ Lying down ☐ Standing ☐ Sitting ☐ Movement ☐ Rest ☐ Coughing ☐ Sneezing ☐ Straining on stool	☐ Nothing ☐ Lying down ☐ Standing ☐ Sitting ☐ Movement ☐ Rest ☐ Coughing ☐ Sneezing ☐ Straining on stool	☐ Nothing ☐ Lying down ☐ Standing ☐ Sitting ☐ Movement ☐ Rest ☐ Coughing ☐ Sneezing ☐ Straining on stool	☐ Nothing ☐ Lying down ☐ Standing ☐ Sitting ☐ Movement ☐ Rest ☐ Coughing ☐ Sneezing ☐ Straining on stool
MECHANISM	☐ Auto accident ☐ Work injury ☐ Fall ☐ Lifting ☐ Insidious onset ☐ Gradual onset ☐ Over did it ☐ Sports injury	☐ Auto accident ☐ Work injury ☐ Fall ☐ Lifting ☐ Insidious onset ☐ Gradual onset ☐ Over did it ☐ Sports injury	☐ Auto accident ☐ Work injury ☐ Fall ☐ Lifting ☐ Insidious onset ☐ Gradual onset ☐ Over did it ☐ Sports injury	☐ Auto accident ☐ Work injury ☐ Fall ☐ Lifting ☐ Insidious onset ☐ Gradual onset ☐ Over did it ☐ Sports injury

1. Do you have a history of: ☐Stroke ☐Osteoporosis ☐Diabetes ☐Cancer (type:______________) ☐ Heart Disease ☐HBP ☐Arterial Sclerosis
2. Has your ☐Mother ☐Father ☐Grandparent ☐Brother ☐Sister had: ☐Stroke ☐Osteoporosis ☐Diabetes ☐Cancer ☐Heart Disease ☐HBP ☐Arterial Sclerosis ☐Back Problems ☐Sclerosis ☐Disc Disease ☐Back Surgery ☐Neck Problems ☐Headaches
3. In the past, have you had any of the following? ☐Auto Accident ☐Work Injuries ☐Recreational/ Sports Injuries ________________________
4. In the past, have you had similar episodes of your current problems? ☐Yes ☐No
5. Does your back feel stiff, tight or sore frequently? ☐Yes ☐No
6. How did your past back/health problems affect recreational activities, work or sleep?______________________________
7. How does your current back/health problems affect recreational activities, work or sleep?____________________________
8. Are you looking to correct your problem or looking for pain relief only? ______________________________________
9. Additional information, comments or concerns: ____

____

____

Informed Consent to Chiropractic Treatment

The nature of chiropractic treatment: The doctor will use his/her hands or a mechanical device in order to move your joints. You may feel a "click" or "pop", such as the noise when a knuckle is "cracked", and you may feel movement of the joint. Various ancillary procedures, such as hot or cold packs, electric muscle stimulation, therapeutic ultrasound or dry hydrotherapy may also be used.

Possible Risks: As with any health care procedure, complications are possible following a chiropractic manipulation. Complications could include fractures of bone, muscular strain, ligamentous sprain, dislocations of joints, or injury to intervertebral discs, nerves or spinal cord. Cerebrovascular injury or stroke could occur upon severe injury to arteries of the neck. A minority of patients may notice stiffness or soreness after the first few days of treatment. The ancillary procedures could produce skin irritation, burns or minor complications.

Probability of risks occurring: The risks of complications due to chiropractic treatment have been described as "rare", about as often as complications are seen from the taking of a single aspirin tablet. The risk of cerebrovascular injury or stroke, has been estimated at one in one million to one in twenty million, and can be even further reduced by screening procedures. The probability of adverse reaction due to ancillary procedures is also considered "rare".

Other treatment options which could be considered may include the following:

- *Over-the-counter analgesics.* The risks of these medications include irritation to stomach, liver and kidneys, and other side effects in a significant number of cases.

- *Medical care,* typically anti-inflammatory drugs, tranquilizers, and analgesics. Risks of these drugs include a multitude of undesirable side effects and patient dependence in a significant number of cases.

- *Hospitalization* in conjunction with medical care adds risk of exposure to virulent communicable disease in a significant number of cases.

- *Surgery* in conjunction with medical care adds the risks of adverse reaction to anesthesia, as well as an extended convalescent period in a significant number of cases.

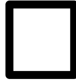
Risks of remaining untreated: Delay of treatment allows formation of adhesions, scar tissue and other degenerative changes. These changes can further reduce skeletal mobility, and induce chronic pain cycles. It is quite probable that delay of treatment will complicate the condition and make future rehabilitation more difficult.

Unusual risks: I have had the following unusual risks of my case explained to me.
I have read the explanation above of chiropractic treatment. I have had the opportunity to have any questions answered to my satisfaction. I have fully evaluated the risks and benefits of undergoing treatment. I have freely decided to undergo the recommended treatment, and herby give my full consent to treatment.

____________________	____________________	__________
Printed Name	**Signature**	**Date**

WITNESS:

____________________	____________________	__________
Printed Name	**Signature**	**Date**



CHIROPRACTIC PAIN-WELLNESS CARE, P.C

Financial Policy

Insurance Coverage

￼

Payments

￼

Missed Appointments

￼

I understand that all health services rendered to me and charged to me are my personal financial responsibility. I understand and agree to the conditions of this policy.

Signature Date

2220 Vestal Parkway E. · Vestal, NY 13850 ·Phone: 607-235-2662 ·E-mail: drslodi@hotmail.com

Welcome to Chiropractic Pain-Wellness Care, P.C. Your insurance policy is an agreement between you and your insurer, not between your insurer and this clinic. Like all types of care, coverage for chiropractic services varies from insurer to insurer and plan to plan. Most insurance policies require the beneficiary to pay co-insurance, co-payment and/or a deductible. For example: if you have a deductible of $100, and your insurance pays 80%, you are responsible for 20% of all charges incurred during the year after you have paid your $100 at the beginning of the year. Our clinic will call your insurer to verify your benefits, however, we are not responsible for your insurer's final payment and benefit determinations.

It is the policy of Chiropractic Pain-Wellness Care, P.C. to assess a **$____** missed visit fee to patients who cancel appointments with less than a 24-hour notice. One missed visit will not result in the assessment of a fee, but you will be charged for any additional missed visits. This clinic provides care for many individuals and missed visits result in time lost that could have been used to provide care for others.

My initials here indicate that I understand the above missed visit policy.

In order to help you determine your responsibility toward payment for services, please read the following, and initial your preference for the method of payment of your account. Please notify this office if the status of your insurance changes.

Private Pay: (please initial)

A As I have no insurance, I agree to assume all responsibility and to keep my account current by paying for services when they are rendered.

B I have insurance, but I wish to file my claims personally, and I agree to assume all responsibility and to keep my account current by paying for each visit at the time services are rendered.

Health Insurance: (please initial)

C I would like this clinic to bill my insurance. I understand I am responsible for the costs of treatment.

HIPAA NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

This Notice of Privacy describes how we may use and disclose your protected health information (PHI) to carry our treatment, payment or health care operations (TPO) for other purposes that are permitted or required by law. "Protected Health Information" is information about you, including demographic information that may identify you and that related to your past, present, or future physical or mental health or condition and related care services.

Use and Disclosures of Protected Health Information:
Your protected health information may be used and disclosed by your physician, our staff and others outside of our office that are involved in your care and treatment for the purpose of providing health care services to you, pay your health care bills, to support the operations of the physician's practice, and any other use required by law.

Treatment: We will use and disclose your protected health information to provide, coordinate, or manage your health care and any related services. This includes the coordination or management of your health care with a third party. For example, we would disclose your protected health information, as necessary, to a home health agency that provides care to you. For example, your health care information may be provided to a physician to whom you have been referred to ensure that the physician has the necessary information to diagnose or treat you.

Payment: Your protected health information will be used, as needed, to obtain payment for your health care services. For example, obtaining approval for a hospital stay may require that your relevant protected health information be disclosed to the health plan to obtain approval for the hospital admission.

Healthcare Operations: We may disclose, as needed, your protected health information in order to support the business activities of your physician's practice. These activities include, but are not limited to, quality assessment activities, employee review activities, training of medical students, licensing, marketing, and fund raising activities, and conduction or arranging for other business activities. For example, we may disclose your protected health information to medical school students that see patients at our office. In addition, we may use a sign-in sheet at the registration desk where you will be asked to sign your name and indicate your physician. We may also call you by name in the waiting room when your physician is ready to see you. We may use or disclose your protected health information, as necessary, to contact you to remind you of your appointment.

We may use or disclose your protected health information in the following situations without your authorization. These situations included as required by law, public health issues, communicable diseases, health oversight, abuse or neglect, food and drug administration requirements, legal proceedings, law enforcement, coroners, funeral directors, and organ donation. Required uses and disclosures under the law, we must make disclosures to you when required by the Secretary of the Department of Health and Human Services to investigate or determine our compliance with the requirements of Section 164.500.

OTHER PERMITTED AND REQUIRED USES AND DISCLOSURES WILL BE MADE ONLY WITH YOUR CONSENT, AUTHORIZATION OR OPPORTUNITY TO OBJECT UNLESS REQUIRED BY LAW.

You may revoke this authorization, at any time, in writing, except to the extent that your physician or the physician's practice has taken an action in reliance on the use or disclosure indicated in the authorization.

________________________________ ______________________

Signature of Patient of Representative Date

____

Printed Name

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Vestal, NY 13850
Phone: 607-235-2662
Fax: (888) 390- 0157