Proactive
Chiropractic
PLLC

Welcome to PROACTIVE Chiropractic!

Please fill out the information below as completely and accurately as possible. Additional information at the bottom of the form is optional. However, it will help us to better serve your needs and ensure that you have the best possible experience in our office!

PERSONAL INFORMATION

NAME_____ DATE_____

ADDRESS:_____ CITY:_____ ZIP:_____

PHONE:_____(H) _____ (W) E-MAIL_____

DATE OF BIRTH:_____ AGE___ SS#:_____

EMPLOYER:_____ OCCUPATION:_____

INSURANCE CARRIER:_____ POLICY#_____ GROUP#_____

PRIMARY CARE PROVIDER/ FAMILY DOCTOR'S NAME: _____

Is your complaint: ☐sports related ☐work related ☐personal injury/auto accident ☐other

If personal injury, attorney name/address/phone:_____

_____

Are you interested in (check all that apply) ☐Symptom/pain relief
☐Rehabilitation/Restoration/Return to play
☐Prevention/Development
☐Performance enhancement

OPTIONAL INFORMATION:

Spouse_____ Pets_____
Children_____
Sports_____
Hobbies/interests_____

How did you hear about PROACTIVE Chiropractic?

What are your expectations and/or goals for care at PROACTIVE Chiropractic?

Name _____ **Date**_____

Current Health Concern_____
Date of Onset_____
Cause of Injury_____

Pain description
☐Sharp ☐Dull
☐Ache ☐Cramp
☐Spasm ☐Stabbing
☐Shooting ☐Radiating
☐Local ☐Pin point
☐Referred ☐Burning
☐Throbbing ☐Deep
☐Tingling ☐Numbness

Length of day in pain
☐Intermittent (<25%) ☐Frequent (>50%)
☐Occasional (>25%) ☐Constant (>75%))

Pain interference with activities
☐Minimal (annoy) ☐Moderate (~ impair)
☐Slight (tolerate) ☐Marked (preclude)

What makes it better?
☐Lying down ☐Standing
☐Walking ☐Anti-inflammatory pills
☐Muscle relaxant ☐Injections
☐Sitting ☐Nothing
☐Heat ☐Ice
☐Other _____

What makes it worse?
☐Exercise ☐Bending forward
☐Bending back ☐Sitting
☐Standing ☐Walking
☐Coughing ☐Sneezing
☐Other _____

Care to date
☐None ☐Self
☐Other HCP_____ ☐Rx Meds_____
☐OTC Meds_____ ☐Surgery_____
☐Rest ☐Physical Therapy

Testing
☐X-ray ☐MRI
☐CT Scan ☐Ultrasound
Results_____

Related problems
☐headache ☐dizziness
☐visual disturbance ☐ringing in ears
☐short of breath ☐chest pain/tightness
☐back ache ☐Shoulder pain
☐flank pain ☐groin pain
☐stomach ache ☐nausea
☐vomiting ☐intestinal pain
☐pain – urination ☐difficulty - urination
☐pain – defecation_____

Have you ever experienced this pain before?
☐Yes ☐No
If yes, when and what was the outcome?
_____

What medications are you currently taking?
_____
_____
_____

Allergies: ☐Yes ☐No
Smoker: ☐Yes ☐No

Current Status
☐Worsening ☐Improving
☐No Change ☐Slight
☐Moderate ☐Significant

Goals for Care
☐Symptom Relief ☐Rehabilitation
☐Prevention ☐All

Patient Name _____ Date ____/____/____

How long have you had your symptoms? _____days _____ weeks _____ months _____years

On the diagram below, please indicate where, and what type of symptoms that you are experiencing, right now. Write the appropriate abbreviations (see the key below) over the area of the body where those symptoms are occurring.

A = ACHE

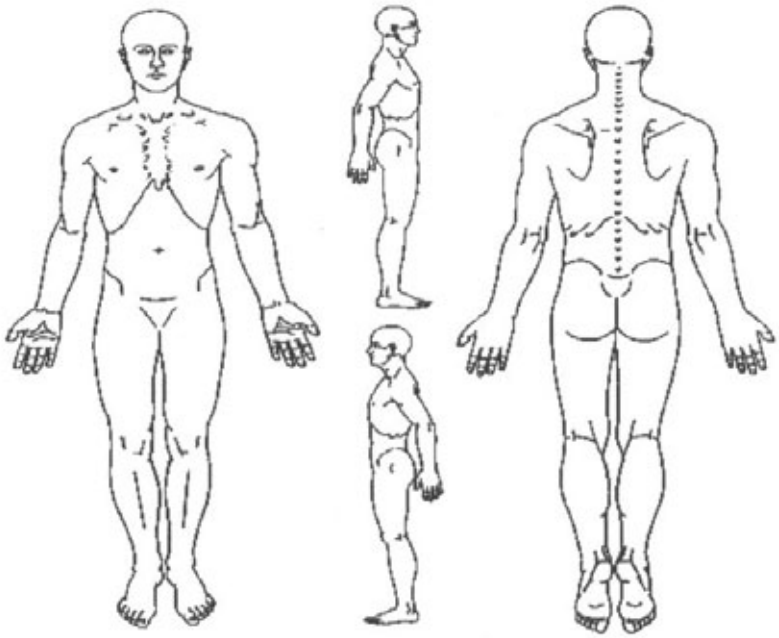
B = BURNING

N = NUMBNESS

P = PINS & NEEDLES

S = STABBING

O = OTHER_____



Instructions: Please fill in the bubble that corresponds to the pain level that you are experiencing.

Note: If you have more than one complaint, please indicate your pain levels for each complaint. Please indicate your pain level for ① your pain at its worst, ② your pain at its least and ③ your average pain level.

Example:

No Pain ⓪①②③④●⑥⑦⑧⑨⑩ **Worst Possible**

① My pain when it is at its worst is:

No Pain ⓪ ① ② ③ ④ ⑤ ⑥ ⑦ ⑧ ⑨ ⑩ **Worst Possible**

②My pain when it is at its least is:

No Pain ⓪ ① ② ③ ④ ⑤ ⑥ ⑦ ⑧ ⑨ ⑩ **Worst Possible**

③ My average pain level is:

No Pain ⓪ ① ② ③ ④ ⑤ ⑥ ⑦ ⑧ ⑨ ⑩ **Worst Possible**

Patient/Other Signature _____ Relationship to Patient_____

Provider Signature _____ Date_____

Please answer each section by circling the ONE CHOICE that most applies to you. You may feel that more than one statement relates to you, but only circle the <u>one</u> choice that closely describes your problem right now.

SECTION 1 - Pain Intensity **A. The pain comes and goes and is very mild.** **B. The pain is mild and does not vary much.** **C. The pain comes and goes and is moderate.** **D. The pain is moderate and does not vary much.** **E. The pain is severe but comes and goes.** **F. The pain is severe and does not vary much.**	***SECTION 7 -Sleeping*** **A. I get no pain in bed.** **B. I get pain in bed, but it does not prevent me from sleeping.** **C. Because of pain, my normal night's sleep is reduced by less than one-quarter.** **D. Because of pain, my normal night's sleep is reduced by less than one-half.** **E. Because of pain, my normal night's sleep is reduced by less than three-quarters.** **F. Pain prevents me from sleeping at all.**
SECTION 2 -Personal Care **A. I would not have to change my way of washing or dressing in order to avoid pain.** **B. I do not normally change my way of washing or dressing even though it causes some pain.** **C. Washing and dressing increases the pain, but I manage not to change my way of doing it.** **D. Washing and dressing increase the pain, but I manage not to change my way of doing it.** **E. Because of the pain, I am occasionally unable to do any washing and dressing without help.** **F. Because of the pain, I am always unable to do any washing or dressing without help.**	***SECTION 8 – Social Life*** **A. My social life is normal and gives me no pain.** **B. My social life is normal, but increases the degree of my pain.** **C. Pain has no significant effect on my social life apart from limiting my more energetic interests. e.g. dancing, etc.** **D. Pain has restricted my social life and I do not go out very often.** **E. Pain has restricted my social life to my home.** **F. Pain prevents me from social activity at all.**
SECTION 3 - Lifting **A. I can lift heavy weights without extra pain.** **B. I can lift heavy weights, but it gives extra pain.** **C. Pain prevents me from lifting heavy weights off the floor.** **D. Pain prevents me from lifting heavy weights, but I can manage if they are conveniently positioned, e.g. on the table** **E. Pain prevents me from lifting heavy weights, but I can manage light to medium weights if they are conveniently positioned.** **F. I can only lift very light weights, at the most.**	***SECTION 9 - Traveling*** **A. I get no pain while traveling.** **B. I get some pain while traveling, but none of my usual forms of travel makes it any worse.** **C. I get extra pain while traveling, but it does not compel me to seek alternative forms of travel.** **D. I get extra pain while traveling which compels me to seek alternative forms of travel.** **E. Pain restricts all forms of travel.** **F. Pain prevents all forms of travel except that done lying down.**
SECTION 4 - Walking **A. Pain does not prevent me from walking any distance.** **B. Pain prevents me from walking more than one mile.** **C. Pain prevents me from walking more than ½ mile.** **D. Pain prevents me from walking more than ¼ mile.** **E. I can only walk while using a cane or crutches.** **F. I am in bed most of the time and have to crawl to the toilet.**	***SECTION 10 – Changing Degree of Pain*** **A. My pain is rapidly getting better.** **B. My pain fluctuates, but overall is definitely getting better.** **C. My pain seems to be getting better, but improvement is slow at present.** **D. My pain is neither getting better nor worse.** **E. My pain is gradually worsening.** **F. My pain is rapidly worsening.**
SECTION 5 – Sitting **A. I can sit in any chair as long as I like without any pain.** **B. I can only sit in my favorite chair as long as I like despite pain.** **C. Pain prevents me from sitting more than one hour.** **D. Pain prevents me from sitting more than ½ hour.** **E. Pain prevents me from sitting more than 10 minutes.** **F. Pain prevents me from sitting at all.**	***SECTION 11 - Work*** **A. I can do as much work as I want.** **B. I can only do my usual work, but no more.** **C. I can do most of my usual work, but no more.** **D. I cannot do my usual work.** **E. I can hardly do my work at all.** **F. I cannot do any work at all.**
SECTION 6 - Standing **A. I can stand as long as I want without pain.** **B. I have some pain while standing, but it does not increase with time.** **C. I cannot stand for longer than one hour without increasing pain.** **D. I cannot stand for longer than ½ hour without increasing pain.** **E. I can't stand for more than 10 minutes without increasing pain.** **F. I cannot stand at all due to pain.**	***SECTION 12 – Reading*** **A. I can read as much as I want with no pain.** **B. I can read as much as I want with slight pain.** **C. I can read as much as I want with moderate pain.** **D. I cannot read as much as I want because of moderate pain.** **E. I cannot read as much as I want because of severe pain.** **F. I cannot read at all due to pain.**

Patient Name: _____ **Patient/Other Signature: _____**

Date ____/___/____ **Relationship to Patient:_____**

HS&E

HARTER · SECREST & EMERY · LLP
ATTORNEYS AND COUNSELORS

CONSENT FOR USE AND/OR DISCLOSURE OF PROTECTED HEALTH INFORMATION TO CARRY OUT TREATMENT, PAYMENT AND/OR HEALTHCARE OPERATIONS

Through the use of this consent form, _____ (referred to as the or this "office") is notifying you and you agree that:

1. Protected health information may be used and/or disclosed in order to carry out treatment, payment or healthcare operations.[1]

2. If you do not consent to the above use and/or disclosure, Federal Rules do not require or oblige this office/practice to treat you in the absence of your consent.[2]

3. A notice containing the office's privacy practice, including a more complete description of uses and/or disclosures necessary to carry out treatment, payment and/or healthcare operations, is available for you to read, and you are hereby encouraged to do so prior to signing this consent form.[3]

4. The following appointment reminders will be used by this office: a) a postcard mailed to you at the address provided by you; and b) telephoning your home and leaving a message on your answering machine or with the individual answering the phone.[4]

5. This office reserves the right to change its privacy practices that are described in the above-referenced notice, in accordance with applicable law, and will make available to all patients any and all revised and current notices.[5]

6. You have a right to request that this office restrict how protected health information is used and/or disclosed to carry out treatment, payment and/or healthcare operations.[6]

7. This office is <u>not</u> required to agree to any restrictions on your health information that you have requested.[7]

8. If this office agrees to a requested restriction, then the restriction will be binding on this office/practice.[8]

9. This consent is valid for seven years. You have the right to revoke this consent, in writing, at any time for all *future* transactions with the understanding that any revocation will not apply to the extent that this office/practice has already taken action in reliance of a previously signed consent.[9]

10. Should you revoke this consent at any time, the office retains its right to refuse treatment based upon the revocation and the future lack of such consent.[10]

11. You must sign and date all consents and authorizations requested to which you agree.

I have read and understand the foregoing notice, and all of my questions have been answered to my full satisfaction in a way that I can understand.

_____	_____
Name of Patient/Individual (Please print)	Signature of Patient/Individual
_____	_____
Signature of Legal Representative (e.g., Attorney-In-Fact, Guardian, Parent if a minor)	Relationship to Patient
_____	_____
Date Signed	Witness

Proactive Chiropractic PLLC

Acceptance of Terms & Consent to Care

Medicare Limits and Responsibilities

The only charge for chiropractic that is covered is manipulation of the spine. I accept responsibility to know the current Medicare guidelines and limits for covered services. I understand that Medicare may reimburse me for chiropractic adjustments, and that the Medicare program frequently does not consider treatments to me medically necessary. I accept responsibility to pay for all covered, non-covered and denied services. My physician has notified me that he or she believes that in my case Medicare is likely to deny payment for some or all services. If Medicare denies payment, I agree to be personally and fully responsible for payment. I understand that I must pay for services at the time of service. I also understand that Proactive Chiropractic will bill all charges directly to Medicare as required by law. I authorize the release of my records as necessary for Medicare billing.

Statement of Acknowledgement of Financial Responsibility

I understand that I may be responsible for any charges incurred at this office, including co-pays, deductibles, and any services denied or not covered by my insurance company. I realize my care may be subject to pre-authorization by the insurance company, and I accept any responsibility for charges not approved. The insurance company will review any/all documentation submitted by Proactive Chiropractic for their assessment of medical necessity and base their approval/denial upon this documentation.

I understand that this office agrees to notify me as soon as possible if a service is not covered and will notify me if my insurance company does not approve my care. If a treatment plan is approved, this office will make me aware of the number of office visits allowed and the timeframe of the authorization. Initial visits may be denied and this may be beyond the office's ability to notify the patient prior to rendering acute care, while waiting for insurance coverage approval. These charges will be the patients' responsibility if denied by the insurance company.

This office may seek payment from you for any services your health insurance determines to be not medically necessary or not covered by your plan. Signing below indicates that you have read and understand your obligations for payment for care in the absence of insurance coverage.

Informed Consent/Consent to Treat

I have been informed of the nature, purpose and scope of care to be provided by the doctors of Proactive Chiropractic, the possible limitations and consequences of that care, and the possibility that the care given by Proactive Chiropractic may not completely resolve my complaint, dysfunction or condition. I consent to care and recommendations made by the doctors of Proactive Chiropractic for myself (or my children, if minors) including, but not limited to examinations, x-rays, chiropractic adjustments, adjunctive therapies and rehabilitation. Understand that my care will be individualized and therefore may not be comparable with standards or guidelines required by insurance companies, Medicare, professional associations and/or consensus groups. I understand that my treatment will comply with the standard of care defined by the laws in the State of New York. I recognize that all health care procedures, including those used in this clinic, have risks associated with them. Risks, although rare, associated with chiropractic adjusting procedures may include minor aggravation of symptoms, musculoskeletal sprain/strain, neurological deficits, osseous fracture, vertebral artery syndrome, including cerebrovascular accident (stroke) or death through complicating factors. I hereby accept the risks associated with any care by the doctors and staff of Proactive Chiropractic and release Proactive Chiropractic of any liability for any injury or loss directly related to care I have received at this clinic. In the even of emergency, I grant the doctors and staff of Proactive Chiropractic permission to provide emergency care and any follow-up necessary, including referral to Emergency Medical Services.

I am signing this consent and acceptance of terms after having been fully informed to my satisfaction of the risks and benefits of proceeding with care and declining care. I have been informed and fully understand that there are not guarantees of treatment success. By my presence and continuation of appointments, I consent and elect to care provided by Proactive Chiropractic.

Patient Name (please print)

Patient Signature *Date*

I have reviewed the above terms of acceptance and consent with the patient named above and I am satisfied that he/she fully understands the nature and content of the agreement.

Doctor Signature *Date*

HEALTH HISTORY

Confidential

Patient Name _____ Today's Date _____

Age _____ Birthdate _____ Date of last physical examination _____

What is your reason for visit? _____

SYMPTOMS Check (✓) symptoms you currently have or have had in the past year.

GENERAL

- ☐ Chills
- ☐ Depression
- ☐ Dizziness
- ☐ Fainting
- ☐ Fever
- ☐ Forgetfulness
- ☐ Headache
- ☐ Loss of sleep
- ☐ Loss of weight
- ☐ Nervousness
- ☐ Numbness
- ☐ Sweats

MUSCLE/JOINT/BONE

Pain, weakness, numbness in:

- ☐ Arms
- ☐ Back
- ☐ Feet
- ☐ Hands
- ☐ Hips
- ☐ Legs
- ☐ Neck
- ☐ Shoulders

GENITO-URINARY

- ☐ Blood in urine
- ☐ Frequent urination
- ☐ Lack of bladder control
- ☐ Painful urination

GASTROINTESTINAL

- ☐ Appetite poor
- ☐ Bloating
- ☐ Bowel changes
- ☐ Constipation
- ☐ Diarrhea
- ☐ Excessive hunger
- ☐ Excessive thirst
- ☐ Gas
- ☐ Hemorrhoids
- ☐ Indigestion
- ☐ Nausea
- ☐ Rectal bleeding
- ☐ Stomach pain
- ☐ Vomiting
- ☐ Vomiting blood

CARDIOVASCULAR

- ☐ Chest pain
- ☐ High blood pressure
- ☐ Irregular heart beat
- ☐ Low blood pressure
- ☐ Poor circulation
- ☐ Rapid heart beat
- ☐ Swelling of ankles
- ☐ Varicose veins

EYE, EAR, NOSE, THROAT

- ☐ Bleeding gums
- ☐ Blurred vision
- ☐ Crossed eyes
- ☐ Difficulty swallowing
- ☐ Double vision
- ☐ Earache
- ☐ Ear discharge
- ☐ Hay fever
- ☐ Hoarseness
- ☐ Loss of hearing
- ☐ Nosebleeds
- ☐ Persistent cough
- ☐ Ringing in ears
- ☐ Sinus problems
- ☐ Vision – Flashes
- ☐ Vision – Halos

SKIN

- ☐ Bruise easily
- ☐ Hives
- ☐ Itching
- ☐ Change in moles
- ☐ Rash
- ☐ Scars
- ☐ Sore that won't heal

MEN only

- ☐ Breast lump
- ☐ Erection difficulties
- ☐ Lump in testicles
- ☐ Penis discharge
- ☐ Sore on penis
- ☐ Other

WOMEN only

- ☐ Abnormal Pap Smear
- ☐ Bleeding between periods
- ☐ Breast lump
- ☐ Extreme menstrual pain
- ☐ Hot flashes
- ☐ Nipple discharge
- ☐ Painful intercourse
- ☐ Vaginal discharge
- ☐ Other

Date of last menstrual period _____

Date of last Pap Smear _____

Have you had a mammogram? _____

Are you pregnant? _____

Number of children _____

CONDITIONS Check (✓) conditions you have or have had in the past.

- ☐ AIDS
- ☐ Alcoholism
- ☐ Anemia
- ☐ Anorexia
- ☐ Appendicitis
- ☐ Arthritis
- ☐ Asthma
- ☐ Bleeding Disorders
- ☐ Breast Lump
- ☐ Bronchitis
- ☐ Bulimia
- ☐ Cancer
- ☐ Cataracts
- ☐ Chemical Dependency
- ☐ Chicken Pox
- ☐ Diabetes
- ☐ Emphysema
- ☐ Epilepsy
- ☐ Glaucoma
- ☐ Goiter
- ☐ Gonorrhea
- ☐ Gout
- ☐ Heart Disease
- ☐ Hepatitis
- ☐ Hernia
- ☐ Herpes
- ☐ High Cholesterol
- ☐ HIV Positive
- ☐ Kidney Disease
- ☐ Liver Disease
- ☐ Measles
- ☐ Migraine Headaches
- ☐ Miscarriage
- ☐ Mononucleosis
- ☐ Multiple Sclerosis
- ☐ Mumps
- ☐ Pacemaker
- ☐ Pneumonia
- ☐ Polio
- ☐ Prostate Problem
- ☐ Psychiatric Care
- ☐ Rheumatic Fever
- ☐ Scarlet Fever
- ☐ Stroke
- ☐ Suicide Attempt
- ☐ Thyroid Problems
- ☐ Tonsillitis
- ☐ Tuberculosis
- ☐ Typhoid Fever
- ☐ Ulcers
- ☐ Vaginal Infections
- ☐ Venereal Disease

MEDICATIONS List medications you are currently taking.

_____

_____

_____

_____

_____

Pharmacy Name Phone

ALLERGIES To medications or substances

All information is strictly confidential

FAMILY HISTORY Fill in health information about your immediate family.

Relation	Age	State of Health	Age at Death	Cause of Death
Father				
Mother				
Brothers				
Sisters				

Check (✓) if, your blood relatives had any of the following: Disease	Relationship to you
☐ Arthritis, Gout	
☐ Asthma, Hay Fever	
☐ Cancer	
☐ Chemical Dependency	
☐ Diabetes	
☐ Heart Disease, Strokes	
☐ High Blood Pressure	
☐ Kidney Disease	
☐ Tuberculosis	
☐ Other	

HOSPITALIZATIONS

Year	Hospital	Reason for Hospitalization and Outcome

Have you ever had a blood transfusion? ☐ Yes ☐ No

If yes, please give approximate dates. _____

SERIOUS ILLNESS/INJURIES

SERIOUS ILLNESS/INJURIES	DATE	OUTCOME

PREGNANCY HISTORY

Year of Birth	Sex of Birth	Complications if any

HEALTH HABITS Check (✓) which substances you use and describe how much you use.

	Caffeine	
	Tobacco	
	Street Drugs	
	Other	

OCCUPATIONAL CONCERNS

Check (✓) if your work exposes you to the following:

	Stress
	Hazardous Substances
	Heavy Lifting
	Other

Your occupation:

To the best of my knowledge, the above information is complete and correct. I understand that it is my responsibility to inform my doctor if I, or my minor child, ever have a change in health.

_____ _____

Signature of Patient, Parent, Guardian or Personal Representative — Date

_____ _____

Please print name of Patient, Parent, Guardian or Personal Representative — Relationship to Patient

_____ _____

Reviewed By — Date