



CONFIDENTIAL HEALTH INFORMATION

Proactive Chiropractic, PLLC
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Clifton Park, NY 12065
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email: info@chiro1539.com

Please allow our staff to photocopy your driver's license and insurance details.
All information you supply is confidential. We comply with all federal privacy standards.
Please print clearly.

Today's Date (MM/DD/YYYY)

Have you consulted a chiropractor before?

Patient Number (office use only)

No Yes

Whom may we thank for referring you?

When?

If so, whom?

Age

Gender

Male Female

Race

American Indian Alaskan Native Asian Black or African American
 Native Hawaiian Other Pacific Islander Other White
 Decline to answer

Ethnicity

Hispanic or Latino
 Not Hispanic or Latino
 Decline to specify

Birth Date (MM/DD/YYYY)

Your Last Name

Your Social Security Number

Smoking Status (age 13 and over)

Never A Smoker Former Smoker
 Current Every Day Smoker Current Some Day Smoker
 Heavy Smoker Light Smoker

Your First Name

Your Middle Name (or Initial)

Address

Marital Status Married

Single Divorced

City

State/Province

ZIP/Postal Code

Widowed Separated

Preferred Language

Home Phone

Cell Phone

Spouse's Name

Email Address

Child's Name and Age

Emergency Contact

Emergency Contact's Phone

Child's Name and Age

Your Occupation

Child's Name and Age

Your Employer

Work Phone

Address

May we contact you at work?

Yes No

City

State/Province

ZIP/Postal Code

Preferred method of contact?

Home Phone Cell Phone
 Work Phone Email

Primary Care Provider's Name

Insurance Carrier

Policy Number

Insured's Last Name

Birth Date (MM/DD/YYYY)

Who carries this policy?

Self Spouse Parent

Insured's First Name

Insured's Middle Name (or Initial)

Insured's Employer

Address

City

State/Province

ZIP/Postal Code

Employer's Phone

CONFIDENTIAL HEALTH INFORMATION

Please describe your Primary Complaint in the space below. Use the Secondary and Additional Complaint boxes if they apply.

Primary Complaint

The primary symptom that prompted me to seek care today is: _____

And are the result of (darken circle):

- An accident or injury
 Work Auto Other _____

- A worsening long-term problem
 An interest in: Wellness Other _____

Onset (When did you first notice your current symptoms?) _____

Prior interventions (What have you done to relieve the symptoms?)

- Prescription medication Acupuncture
 Over-the-counter drugs Chiropractic
 Homeopathic remedies Massage
 Physical therapy Ice
 Surgery Heat
 Other _____

Secondary Complaint

The secondary symptom that prompted me to seek care today is: _____

And are the result of (darken circle):

- An accident or injury
 Work Auto Other _____

- A worsening long-term problem
 An interest in: Wellness Other _____

Onset (When did you first notice your current symptoms?) _____

Prior interventions (What have you done to relieve the symptoms?)

- Prescription medication Acupuncture
 Over-the-counter drugs Chiropractic
 Homeopathic remedies Massage
 Physical therapy Ice
 Surgery Heat
 Other _____

Additional Complaint

The additional symptom that prompted me to seek care today is: _____

And are the result of (darken circle):

- An accident or injury
 Work Auto Other _____

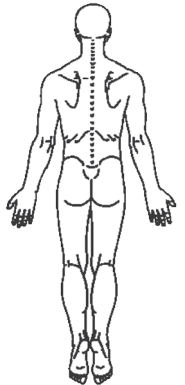
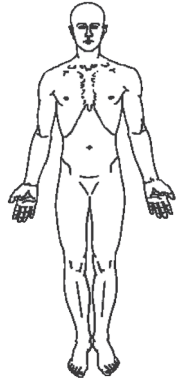
- A worsening long-term problem
 An interest in: Wellness Other _____

Onset (When did you first notice your current symptoms?) _____

Prior interventions (What have you done to relieve the symptoms?)

- Prescription medication Acupuncture
 Over-the-counter drugs Chiropractic
 Homeopathic remedies Massage
 Physical therapy Ice
 Surgery Heat
 Other _____

Location
 (Where does it hurt?)
 Circle the area(s) on the illustration.
 "O" for current condition
 "X" for conditions experienced in the past



1. What else should Proactive Chiropractic know about your current condition? _____

2. How does your current condition interfere with your:

Work or career: _____

Recreational activities: _____

Household responsibilities: _____

Personal relationships: _____

3. Review of Systems

Chiropractic care focuses on the integrity of your nervous system, which controls and regulates your entire body. Please darken the circle beside any condition that you've Had or currently Have and initial to the right.

a. Musculoskeletal

- | | | | | | | |
|--|--|--|--|--|--|----------------------------|
| Had <input type="radio"/> Have <input type="radio"/> | Had <input type="radio"/> Have <input type="radio"/> | Had <input type="radio"/> Have <input type="radio"/> | Had <input type="radio"/> Have <input type="radio"/> | Had <input type="radio"/> Have <input type="radio"/> | Had <input type="radio"/> Have <input type="radio"/> | NONE <input type="radio"/> |
| <input type="radio"/> Osteoporosis | <input type="radio"/> Arthritis | <input type="radio"/> Scoliosis | <input type="radio"/> Neck pain | <input type="radio"/> Back problems | <input type="radio"/> Hip disorders | Initials _____ |
| <input type="radio"/> Knee injuries | <input type="radio"/> Foot/ankle pain | <input type="radio"/> Shoulder problems | <input type="radio"/> Elbow/wrist pain | <input type="radio"/> TMJ issues | <input type="radio"/> Poor posture | |

b. Neurological

- | | | | | | | |
|--|--|--|--|--|--|----------------------------|
| Had <input type="radio"/> Have <input type="radio"/> | Had <input type="radio"/> Have <input type="radio"/> | Had <input type="radio"/> Have <input type="radio"/> | Had <input type="radio"/> Have <input type="radio"/> | Had <input type="radio"/> Have <input type="radio"/> | Had <input type="radio"/> Have <input type="radio"/> | NONE <input type="radio"/> |
| <input type="radio"/> Anxiety | <input type="radio"/> Depression | <input type="radio"/> Headache | <input type="radio"/> Dizziness | <input type="radio"/> Pins and needles | <input type="radio"/> Numbness | Initials _____ |

c. Cardiovascular

- | | | | | | | |
|--|--|--|--|--|--|----------------------------|
| Had <input type="radio"/> Have <input type="radio"/> | Had <input type="radio"/> Have <input type="radio"/> | Had <input type="radio"/> Have <input type="radio"/> | Had <input type="radio"/> Have <input type="radio"/> | Had <input type="radio"/> Have <input type="radio"/> | Had <input type="radio"/> Have <input type="radio"/> | NONE <input type="radio"/> |
| <input type="radio"/> High blood pressure | <input type="radio"/> Low blood pressure | <input type="radio"/> High cholesterol | <input type="radio"/> Poor circulation | <input type="radio"/> Angina | <input type="radio"/> Excessive bruising | Initials _____ |

d. Respiratory

- | | | | | | | |
|--|--|--|--|--|--|----------------------------|
| Had <input type="radio"/> Have <input type="radio"/> | Had <input type="radio"/> Have <input type="radio"/> | Had <input type="radio"/> Have <input type="radio"/> | Had <input type="radio"/> Have <input type="radio"/> | Had <input type="radio"/> Have <input type="radio"/> | Had <input type="radio"/> Have <input type="radio"/> | NONE <input type="radio"/> |
| <input type="radio"/> Asthma | <input type="radio"/> Apnea | <input type="radio"/> Emphysema | <input type="radio"/> Hay fever | <input type="radio"/> Shortness of breath | <input type="radio"/> Pneumonia | Initials _____ |

e. Digestive

- | | | | | | | |
|--|--|--|--|--|--|----------------------------|
| Had <input type="radio"/> Have <input type="radio"/> | Had <input type="radio"/> Have <input type="radio"/> | Had <input type="radio"/> Have <input type="radio"/> | Had <input type="radio"/> Have <input type="radio"/> | Had <input type="radio"/> Have <input type="radio"/> | Had <input type="radio"/> Have <input type="radio"/> | NONE <input type="radio"/> |
| <input type="radio"/> Anorexia/bulimia | <input type="radio"/> Ulcer | <input type="radio"/> Food sensitivities | <input type="radio"/> Heartburn | <input type="radio"/> Constipation | <input type="radio"/> Diarrhea | Initials _____ |

f. Sensory

- | | | | | | | |
|--|--|--|--|--|--|----------------------------|
| Had <input type="radio"/> Have <input type="radio"/> | Had <input type="radio"/> Have <input type="radio"/> | Had <input type="radio"/> Have <input type="radio"/> | Had <input type="radio"/> Have <input type="radio"/> | Had <input type="radio"/> Have <input type="radio"/> | Had <input type="radio"/> Have <input type="radio"/> | NONE <input type="radio"/> |
| <input type="radio"/> Blurred vision | <input type="radio"/> Ringing in ears | <input type="radio"/> Hearing loss | <input type="radio"/> Chronic ear infection | <input type="radio"/> Loss of smell | <input type="radio"/> Loss of taste | Initials _____ |

g. Skin

- | | | | | | | |
|--|--|--|--|--|--|----------------------------|
| Had <input type="radio"/> Have <input type="radio"/> | Had <input type="radio"/> Have <input type="radio"/> | Had <input type="radio"/> Have <input type="radio"/> | Had <input type="radio"/> Have <input type="radio"/> | Had <input type="radio"/> Have <input type="radio"/> | Had <input type="radio"/> Have <input type="radio"/> | NONE <input type="radio"/> |
| <input type="radio"/> Skin cancer | <input type="radio"/> Psoriasis | <input type="radio"/> Eczema | <input type="radio"/> Acne | <input type="radio"/> Hair loss | <input type="radio"/> Rash | Initials _____ |

Patient name

Patient Number
 (office use only)

Doctor's Initials

Proactive Chiropractic, PLLC

(Continued from previous page)

h. Endocrine

- Had Have Thyroid issues Had Have Immune disorders Had Have Hypoglycemia Had Have Frequent infection Had Have Swollen glands Had Have Low energy NONE

Initials _____

i. Genitourinary

- Had Have Kidney stones Had Have Infertility Had Have Bedwetting Had Have Prostate issues Had Have Erectile dysfunction Had Have PMS symptoms NONE

Initials _____

j. Constitutional

- Had Have Fainting Had Have Low libido Had Have Poor appetite Had Have Fatigue Had Have Sudden weight gain/loss (circle one) Had Have Weakness NONE

Initials _____

Patient name _____

Patient Number (office use only) _____

All other systems negative

Past Personal, Family and Social History

Please identify your past health history, including accidents, injuries, illnesses and treatments. Please complete each section fully.

PERSONAL	4. Illnesses Check the illnesses you have Had in the past or Have now.	5. Operations Surgical interventions, which may or may not have included hospitalization.	6. Treatments Check the ones you've received in the Past or are receiving Currently .
	Had <input type="radio"/> Have <input type="radio"/> AIDS	Had <input type="radio"/> Have <input type="radio"/> Tuberculosis	Past <input type="radio"/> Currently <input type="radio"/> Acupuncture
	Had <input type="radio"/> Have <input type="radio"/> Alcoholism	Had <input type="radio"/> Have <input type="radio"/> Typhoid fever	<input type="radio"/> Antibiotics
	Had <input type="radio"/> Have <input type="radio"/> Allergies	Had <input type="radio"/> Have <input type="radio"/> Ulcer	<input type="radio"/> Birth control pills
	Had <input type="radio"/> Have <input type="radio"/> Arteriosclerosis	Had <input type="radio"/> Have <input type="radio"/> Other: _____	<input type="radio"/> Blood transfusions
	Had <input type="radio"/> Have <input type="radio"/> Cancer		<input type="radio"/> Chemotherapy
	Had <input type="radio"/> Have <input type="radio"/> Chicken pox		<input type="radio"/> Chiropractic care
	Had <input type="radio"/> Have <input type="radio"/> Diabetes	7. Allergies Are you allergic to any medications?	<input type="radio"/> Dialysis
	Had <input type="radio"/> Have <input type="radio"/> Epilepsy	Yes <input type="radio"/> No <input type="radio"/> If Yes please list: _____	<input type="radio"/> Herbs
	Had <input type="radio"/> Have <input type="radio"/> Glaucoma		<input type="radio"/> Homeopathy
	Had <input type="radio"/> Have <input type="radio"/> Goiter		<input type="radio"/> Hormone replacement
	Had <input type="radio"/> Have <input type="radio"/> Gout		<input type="radio"/> Inhaler
	Had <input type="radio"/> Have <input type="radio"/> Heart disease		<input type="radio"/> Massage therapy
	Had <input type="radio"/> Have <input type="radio"/> Hepatitis		<input type="radio"/> Physical therapy
	Had <input type="radio"/> Have <input type="radio"/> HIV Positive		<input type="radio"/> Medications
Had <input type="radio"/> Have <input type="radio"/> Malaria		(Please list below all prescription, over-the-counter, natural supplements, enzymes, vitamins and minerals): _____	
Had <input type="radio"/> Have <input type="radio"/> Measles			
Had <input type="radio"/> Have <input type="radio"/> Multiple Sclerosis			
Had <input type="radio"/> Have <input type="radio"/> Mumps			
Had <input type="radio"/> Have <input type="radio"/> Polio	8. Injuries Have you ever...		
Had <input type="radio"/> Have <input type="radio"/> Rheumatic fever	<input type="radio"/> Had a fractured or broken bone	<input type="radio"/> Used a crutch or other support	
Had <input type="radio"/> Have <input type="radio"/> Scarlet fever	<input type="radio"/> Had a spine or nerve disorder	<input type="radio"/> Used neck or back bracing	
Had <input type="radio"/> Have <input type="radio"/> Sexually transmitted disease	<input type="radio"/> Been knocked unconscious	<input type="radio"/> Received a tattoo	
Had <input type="radio"/> Have <input type="radio"/> Stroke	<input type="radio"/> Been injured in an accident	<input type="radio"/> Had a body piercing	

Consultation Notes

9. Family History

Some health issues are hereditary. Tell Proactive Chiropractic about the health of your immediate family members.

FAMILY	Relative	Age (If living)	State of health		Illnesses	Age at death	Cause of death	
			Good	Poor			Natural	Illness
	Mother	_____	<input type="radio"/>	<input type="radio"/>	_____	_____	<input type="radio"/>	<input type="radio"/>
	Father	_____	<input type="radio"/>	<input type="radio"/>	_____	_____	<input type="radio"/>	<input type="radio"/>
	Sister 1	_____	<input type="radio"/>	<input type="radio"/>	_____	_____	<input type="radio"/>	<input type="radio"/>
	Sister 2	_____	<input type="radio"/>	<input type="radio"/>	_____	_____	<input type="radio"/>	<input type="radio"/>
	Brother 1	_____	<input type="radio"/>	<input type="radio"/>	_____	_____	<input type="radio"/>	<input type="radio"/>
	Brother 2	_____	<input type="radio"/>	<input type="radio"/>	_____	_____	<input type="radio"/>	<input type="radio"/>
	_____	_____	<input type="radio"/>	<input type="radio"/>	_____	_____	<input type="radio"/>	<input type="radio"/>

10. Are there any other hereditary health issues that you know about? _____

11. Social History

Tell Proactive Chiropractic about your health habits and stress levels.

SOCIAL	Alcohol use	<input type="radio"/> Daily <input type="radio"/> Weekly	How much? _____	Prayer or meditation?	<input type="radio"/> Yes <input type="radio"/> No
	Coffee use	<input type="radio"/> Daily <input type="radio"/> Weekly	How much? _____	Job pressure/stress?	<input type="radio"/> Yes <input type="radio"/> No
	Tobacco use	<input type="radio"/> Daily <input type="radio"/> Weekly	How much? _____	Financial peace?	<input type="radio"/> Yes <input type="radio"/> No
	Exercising	<input type="radio"/> Daily <input type="radio"/> Weekly	How much? _____	Vaccinated?	<input type="radio"/> Yes <input type="radio"/> No
	Pain relievers	<input type="radio"/> Daily <input type="radio"/> Weekly	How much? _____	Mercury fillings?	<input type="radio"/> Yes <input type="radio"/> No
	Soft drinks	<input type="radio"/> Daily <input type="radio"/> Weekly	How much? _____	Recreational drugs?	<input type="radio"/> Yes <input type="radio"/> No
	Water intake	<input type="radio"/> Daily <input type="radio"/> Weekly	How much? _____		
	Hobbies:	_____			

Doctor's Initials _____

Proactive Chiropractic, PLLC

12. Activities of Daily Living

How does this condition currently interfere with your life and ability to function?

	No Effect	Mild Effect	Moderate Effect	Severe Effect
Sitting	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Rising out of chair	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Standing	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Walking	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Lying down	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Bending over	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Climbing stairs	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Using a computer	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Getting in/out of car	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Driving a car	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Looking over shoulder	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Caring for family	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

	No Effect	Mild Effect	Moderate Effect	Severe Effect
Grocery shopping	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Household chores	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Lifting objects	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Reaching overhead	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Showering or bathing	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Dressing myself	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Love life	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Getting to sleep	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Staying asleep	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Concentrating	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Exercising	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Yard work	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

Patient name _____

Patient Number
(office use only) _____

13. What is the major stressor in your life? _____ 14. How much sleep do you average per night? _____ Hours

15. What is the type and approximate age of your mattress and pillow? _____ 16. What is your preferred sleeping position? _____

17. Describe your typical eating habits: Skip breakfast Two meals a day Three meals a day Snacking between meals

18. What would be the most significant thing that you could do to improve your health? _____

19. In addition to the main reason for your visit today, what additional health goals do you have? _____

Acknowledgements

To set clear expectations, improve communications and help you get the best results in the shortest amount of time, please read each statement and initial your agreement.

Initials _____ **I instruct the chiropractor to deliver the care that, in his or her professional judgement, can best help me in the restoration of my health. I also understand that the chiropractic care offered in this practice is based on the best available evidence and designed to reduce or correct vertebral subluxation. Chiropractic is a separate and distinct healing art from medicine and does not proclaim to cure any named disease or entity.**

Initials _____ **I may request a copy of the Privacy Policy and understand it describes how my personal health information is protected and released on my behalf for seeking reimbursement from any involved third parties.**

Initials _____ **I realize that an X-ray examination may be hazardous to an unborn child and I certify that to the best of my knowledge I am not pregnant. Date of last menstrual period (MM/DD/YYYY): _____**

Initials _____ **I grant permission to be called to confirm or reschedule an appointment and to be sent occasional cards, letters, emails or health information to me as an extension of my care in this office.**

Initials _____ **I acknowledge that any insurance I may have is an agreement between the carrier and me and that I am responsible for the payment of any covered or non-covered services I receive.**

Initials _____ **To the best of my ability, the information I have supplied is complete and truthful. I have not misrepresented the presence, severity or cause of my health concern.**

Consultation Notes

Doctor's Initials _____

Proactive Chiropractic, PLLC

Patient (or Guardian's) signature

Date (MM/DD/YYYY)

Name _____ Date _____

Current Health Concern _____

Date of Onset _____

Cause of Injury _____

Pain description

- Ache
- Burning
- Cramp
- Deep
- Dull
- Local
- Numbness
- Pin Point
- Radiating
- Referred
- Sharp
- Shooting
- Spasm
- Stabbing
- Tingling
- Throbbing

Related problems

- Back ache
- Chest pain/tightness
- Difficulty-urination
- Dizziness
- Flank pain
- Groin pain
- Headache
- Intestinal pain
- Nausea
- Pain- defecation
- Pain- urination
- Ringing in ears
- Short of breath
- Shoulder pain
- Stomach ache
- Visual disturbance
- Vomiting
- Difficulty- urination

Length of day in pain

- Intermittent (<25%)
- Occasional (>25%)
- Frequent (>50%)
- Constant (>75%)

Have you ever experienced this pain before?

- Yes
 - No
- If yes, when and what was the outcome?
- _____

Pain interference with activities

- Minimal (annoy)
- Slight (tolerate)
- Moderate (impair)
- Marked (preclude)

- Allergies:** Yes No
- Smoker:** Yes No

What makes it better?

- Having adjustments
- Hot showers
- Massage
- Rubbing heat liniment
- Rubbing mineral ice
- Taking OTC Meds
- Taking Rx Meds
- Other _____
- Heat
- Ice
- Resting
- Sitting
- Sleeping
- Walking
- Tub soaking

Care to date

- None
- OTC Meds
- Other HCP
- Rest
- Rx Meds
- Self
- Surgery
- Physical Therapy

Testing

- X-ray
- CT Scan
- MRI
- Ultrasound

Results _____

What makes it worse?

- Arising from a chair
- Carrying
- Climbing a ladder
- Climbing stairs
- Exercising
- Getting in & out of car
- Getting out of bed
- Pushing
- Repetitious movements
- Sleeping
- Stress
- Walking
- Walking uphill
- Looking up or down
- Turning head L or R
- Bending
- Cold
- Coughing
- Driving
- Heat
- Lifting
- Pulling
- Reclining
- Sitting
- Standing
- Throwing

Current Status

- Worsening
- No change
- Moderate
- Improving
- Slight
- Significant

Goals for care

- Symptom relief
- Prevention
- Rehabilitation
- All

Please rate your pain on a scale from 0 - 10 at this moment
(0 = no pain and 10 = worst possible pain)



The Primary Care Low Back Disability Questionnaire (PCLBDQ)

Patient Last Name	Patient First Name	Patient ID	Date of Birth (MM/DD/YYYY) ____/____/____
Provider Last Name	Provider First Name	Provider Phone (area code first)	

Instructions: This questionnaire has been designed to give the doctor information as to how your low back pain has affected your ability to manage in everyday life. In each section, please **circle the choice which most closely describes your problem.**

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 comes and goes and is very severe.
- F. The pain is severe and does not vary much.

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 increases the pain and I find it necessary to change my way of doing it.
- E. Because of the pain, I am unable to do some washing and dressing without help.
- F. Because of the pain, I am unable to do any washing or dressing without help.

SECTION 3 – Lifting

- A. I can lift heavy weight without extra pain.
- B. I can lift heavy weight, but it gives me extra pain.
- C. Pain prevents me from lifting heavy weights off the floor.
- D. Pain prevents me from lifting heavy weights off the floor, but I can manage if they are conveniently positioned- e.g., on a table.
- E. Pain prevents me from lifting heavy weights, but I can manage light-medium weights if they are conveniently positioned.
- F. I can only lift very light weights at the most.

SECTION 4 – Walking

- A. Pain does not prevent me from walking any distance.
- B. Pain prevents me from walking more than 1 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 using a stick or crutches.
- F. I am in bed most of the time and have to crawl to the toilet.

SECTION 5 – Sitting

- A. I can sit in any chair as long as I like without pain.
- B. I can only sit in my favorite chair as long as I like.
- C. Pain prevents me from sitting more than 1 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 6 – Standing

- A. I can stand as long as I want without pain.
- B. I have some pain on 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 cannot stand for longer than 10 minutes without increasing pain.
- F. Pain prevents me from standing at all.

SECTION 7 – Sleeping

- A. I get no pain in bed.
- B. I get pain in bed but it doesn't prevent me from sleeping well.
- C. Because of my pain my normal night's sleep is reduced by <¼.
- D. Because of my pain my normal night's sleep is reduced by <½.
- E. Because of my pain my normal night's sleep is reduced by <¾.
- F. Pain prevents me from sleeping at all.

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 by social life and I do not go out very often.
- E. Pain has restricted my social life to my home.
- F. I have hardly any social life because of the pain.

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 make 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 restricts all forms of travel except that done lying down.

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.

Office Use Only PCLBDQ SCORE: _____

I understand that the information I have provided above is current and correct to the best of my knowledge.

Signature _____ Date _____

THE PRIMARY CARE LOW BACK DISABILITY QUESTIONNAIRE (PCLBDQ)

SCORING AND INTERPRETATION

Patient Name _____ Date _____

Examiner _____

Scoring

The six statements are scored from 0 – 5 with the first statement scoring 0 through to the last at 5, e.g.,

Section 1 – Pain Intensity	Score
<input type="checkbox"/> The pain comes and goes and is very mild	0
<input type="checkbox"/> The pain is mild and does not vary much	1
<input type="checkbox"/> The pain comes and goes and is moderate	2
<input type="checkbox"/> The pain is moderate and does not vary much	3
<input type="checkbox"/> The pain comes and goes and is severe	4
<input type="checkbox"/> The pain is severe and does not vary much	5

If more than one box is marked in each section, take the highest score.

The ODI score (index) is calculated as:
$$\left(\frac{\text{Total score}}{5 \times \text{Number of questions answered}} \right) \times 100$$

For example:

If all 10 sections are completed the score is calculated as follows:
$$\left(\frac{16}{5 \times 10} \right) \times 100 = 32\%$$

If one section is missed (or not applicable) the score is calculated:
$$\left(\frac{16}{5 \times 9} \right) \times 100 = 35.5\%$$

We suggest rounding the percentage to a whole number for convenience.

Interpretation of Primary Care Low Back Disability Questionnaire Scores

Score	Interpretation
0-10 Minimal Disability (0-20% disability)	Patients can cope with most activities of daily living. No treatment may be indicated except for suggestions on lifting, posture, physical fitness and diet. Patients with sedentary occupations (e.g., secretaries) may experience more problems than others.
11-20 Moderate Disability (20-40% disability)	Patients may experience more pain and problems with sitting, lifting, and standing. Travel and social life are more difficult. Patients may be off work. Personal care, sleeping and sexual activity may not be grossly affected. Conservative treatment may be sufficient.
21-30 Severe Disability (40-60% disability)	Pain is a primary problem for these patients, but they may also be experiencing significant problems in travel, personal care, social life, sexual activity and sleep. A detailed evaluation is appropriate.
31-40 Crippled (60-80% disability)	Back pain has an impact on all aspects of daily living and work. Active treatment is required.
41-50 (80-100% disability)	These patients may be bed bound or exaggerating their symptoms. Careful evaluation is recommended.

Sources:

Fairbank, J., Davies, J., et. al. The Oswestry Low Back Pain Disability Questionnaire. *Physiother.*, 1980, 66 (18), 271-273.

Hudson-Cook N, Tomes-Nicholson K, Breen AC. A Revised Oswestry Back Disability Questionnaire. Manchester Univ Press, 1989.

Baker, D. J., Pynsent, P. B. and Fairbank, J. C. T. The Oswestry Disability Index revisited: Its reliability, repeatability and validity, and a comparison with the St. Thoma's Disability Index.



HEALTHCARE INFORMATION PRIVACY POLICIES & PRACTICES H.I.P.P.A. of 1996, 45 CFR Parts 160 & 164

THIS NOTICE DESCRIBES HOW HEALTH INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. THE PRIVACY OF YOUR HEALTH INFORMATION IS IMPORTANT TO US. PLEASE REVIEW CAREFULLY.

OUR LEGAL DUTY:

We are required by applicable federal and state law to maintain the privacy of your health information. We are also required to give you this notice about our privacy practices, our legal duties, and your rights concerning your health information. We must follow the privacy practices that are described in this notice while it is in effect. This notice takes effect March 3, 2003 and remains in effect until we replace it.

We reserve the right to change our privacy practices and the terms of this notice at any time, provided such changes are permitted by law. We reserve the right to make changes in our privacy practices and the new terms of our notice effective for all health information that we maintain, including health information we created or received before we made the changes. Before we make a significant change in our privacy practices, we will change this notice and make the new notice available upon request.

USES AND DISCLOSURES OF HEALTH INFORMATION:

We use and disclose health information about you for treatment, payment, and healthcare operations. We will not use or disclose your information for purposes not listed below.

Treatment: We may use or disclose your health information to a physician or other healthcare provider providing treatment to you.

Payment: We may use and disclose your health information to obtain payment for services we provide to you.

Healthcare Operations: We may use and disclose your health information in connection with our healthcare operations. Healthcare operations include (but not limited to): electric medical record operations and security, quality assessment and improvement activities, reviewing the competence or qualifications of healthcare professionals, evaluating practitioner and provider performance, conducting training programs, accreditation, certification, licensing or credentialing activities.

Your Authorization: In addition to our use of your health information for treatment, payment, or healthcare operations, you may give us written authorization to use your health information or to disclose it to anyone for any purpose. If you give us authorization, you may revoke it in writing at any time. Your revocation will not affect any use or disclosures permitted by your authorization while it was in effect. Unless you give us a written authorization, we cannot use or disclose your health information for any reason except described in this notice.

Your Family and Friends: We must disclose your health information to you, as described in the Patient Rights section of this notice. We may disclose your health information to a family member, friend or other person to the extent necessary to help with your healthcare or with payment for your healthcare, but only if you agree that we may do so.

Revised September 20, 2017

Persons Involved in Care: We may use or disclose health information to notify, or assist in the notification of (including identifying or locating) a family member, your personal representative or another person responsible for your care, of your location, your general condition, or death. If you are present, then prior to use of disclosure of your health information, we will provide you with an opportunity to object to such uses of disclosure. In the event of your incapacity or emergency circumstances, we will disclose health information based on a determination using our professional judgment disclosing only health information that is directly relevant to the person's involvement in your healthcare.

Marketing Health-Related Services: We will not use your health information for marketing communications without your written authorization.

Required by Law: We may use or disclose your health information when we are required to do so by law.

Abuse or Neglect: We may disclose your health information to appropriate authorities if we reasonably believe that you are a possible victim of abuse, neglect, or domestic violence or the possible victim of other crimes. We may disclose your health information to the extent necessary to avert a serious threat to your health or safety or the health or safety of others.

National Security: We may disclose to military authorities the health information of Armed Forces personnel under certain circumstances. We may disclose to authorized federal officials health information required for lawful intelligence, counterintelligence, and other national security activities. We may disclose to correctional institution or law enforcement official having lawful custody of protected health information of inmate or patient under certain circumstances.

Appointment Reminders: We may use or disclose your health information to provide you with appointment reminders (such as voicemail messages, postcards, or letters).

PATIENT RIGHTS:

Access: You have the right to look at or get copies of your health information, with limited exceptions. You may request that we provide copies in a format other than photocopies. We will use the format you request unless we cannot reasonably do so. You must make a request in writing to obtain access to your health information. We will charge you a reasonable cost-based fee for expenses such as copies and staff time. If you request copies, we may charge you \$1.00/page and postage if you want your copies mailed to you. If you request an alternative format, we will charge a cost-based fee for providing your health information in that form. If you prefer, we will prepare a summary of an explanation of your health information for a fee. Contact us using the information listed below for a full explanation of our fee structure.

Disclosure Accounting: You have a right to receive a list of instances in which we or our business associates disclosed your health information for purposes, other than treatment, payment, healthcare operations and certain other activities, for the last 6 years, but not before March 3, 2003. If you request this accounting more than once in 12-month period, we may charge you a reasonable cost-based fee for responding to these additional requests.

Restrictions: You have the right to request that we place additional restrictions on our use or disclosure of your health information. We are not required to agree to these additional restrictions, but if we do, we will abide by our agreement (except in an emergency).

Alternative Communications: You have the right to request that we communicate with you about your health information by alternative means or to alternative locations. (You must make your request in writing.) Your request must specify the alternative means or location, and provide satisfactory explanation how payments will be handled under the alternative means or location you request.

Amendment: You have the right to request that we amend your health information. (Your request must be in writing, and it must explain why the information should be amended.) We may deny your request under certain circumstances.

QUESTIONS AND COMPLAINTS:

If you want more information about our privacy practices or have questions or concerns, please contact us. The designated Privacy Officer to whom you should address your concerns is Anne-Marie Nelson, D.C. If you are concerned that we may have violated your privacy rights, you may complain to us using the contact information listed below. You may submit a written complaint to the U.S. Department of Health and Human Services. We support your right to the privacy of your health information. We will not retaliate in any way if you choose to file a complaint with us or with the U.S. Department of Health and Human Services.

Contact Information:

Anne-Marie Nelson, D.C.
Proactive Chiropractic, PLLC
1539 Crescent Road
Clifton Park, NY 12065-7701
P: (518) 373-9999



Proactive
Chiropractic
PLLC

1539 Crescent Road, Clifton Park NY 12065
Phone: 518.373.9999 & Fax: 518.373.8887

ACKNOWLEDGMENT OF RECEIPT OF NOTICE OF HEALTHCARE INFORMATION PRIVACY
POLICIES AND PRACTICES

**** You may refuse to sign this acknowledgement****

“I have been given an opportunity to review this offices Healthcare Information Privacy Policies & Practices”

Print Name: _____

Signature: _____

Date: _____

FOR OFFICE USE ONLY:

We attempted to obtain written acknowledgement of receipt of our Notice of Healthcare Information Privacy Policies and Practices, but we were unable to do so because:

_____ Individual refused to sign

_____ Communication barriers prohibited obtaining the acknowledgement

_____ Other (please specify)



1539 Crescent Road, Clifton Park, NY 12065

PATIENT INFORMED CONSENT

All health care professionals (anesthesiologist, chiropractors, dentists, medical doctors, osteopaths, pharmacists, surgeons, etc.) are regulated by laws and boards. These health care professionals are required to give you, the patient, advanced notice of any risks of treatment, because health care is not an exact science. It is not reasonable to expect any doctor to foresee all risks and/or complications.

It is important that you understand, as with all health care approaches, results are not guaranteed and there is no promise of a cure. As with all types of health care interventions, there are some risks to care, including but not limited to: muscle spasms, aggravating and/ or temporary increase in symptoms, lack of improvement of symptoms, burns and/or scarring from electrical muscle stimulation, hot/cold therapy and therapeutic ultrasound. There are risks, although rare, of fractures (broken bones), disc injuries, strokes, dislocations, strains, and sprains or death through complicating factors. With respects to strokes, there is a rare but serious condition known as arterial dissection that involves an abnormal change in the wall of the artery that may cause the development of a thrombus (clot) with the potential of causing a stroke. This may occur in 3-4 of every 100,000 people whether they are receiving health care or not. Patients who experience this condition often, but not always, present to their medical doctor or chiropractor with neck pain and headache. Unfortunately, a percentage of these patients will experience a stroke. As chiropractic can involve manually and/or mechanically adjusting the cervical spine, it has been reported that chiropractic care may be a risk for developing this type of stroke. The association between neck manipulation and vertebral artery dissection is estimated to be less than 1 in 1,000,000 (1).

Chiropractic care does not use drugs or surgery. This practice is staffed with graduate chiropractors that are licensed and recognized by government agencies regulating all the aforementioned healing arts.

Chiropractic is a system of noninvasive therapy that holds that certain musculoskeletal disorders result from nervous system dysfunction arising from misalignment of the spine and joints. Treatment focuses on manual adjustment or manipulation of the altered joints. Your treatment may also include exercise, therapeutic ultrasound, electric muscle stimulation, soft tissue techniques and/or low-level laser therapy (LLLT). This practice often addresses the relationship of the joint dysfunction and the surrounding soft tissue and how it relates to biomechanical changes throughout the body.

It is also important that you understand there are treatment options available for your condition other than chiropractic procedures. These options may include, but are not limited to: self-administered care, over-the-counter pain relievers, physical measures and rest, medical care with prescription drugs, physical therapy, bracing, injections, and surgery.

I have read, or had read to me, the above consent. I appreciate that it is not possible to consider every possible complication to care. I have also had an opportunity to ask questions about consent, and by signing below, I agree with the current or future recommendation to receive chiropractic care as is deemed appropriate for my circumstance. I hereby accept the risks associated with any care by the doctors and staff at this office and release Proactive Chiropractic, PLLC of any liability for any injury or loss directly related to care I have received at this clinic. In the event of emergency, I grant the doctors and staff of Proactive Chiropractic, PLLC permission to provide emergency care and any follow-up necessary, including Emergency Medical Services. I intend this consent to cover the entire course of care from all the providers in this office for my present condition and for my future condition(s) for which I seek chiropractic treatment from this office.

Patient Name Printed: _____ Date: _____

Patient/ Guardian Signature (if minor): _____

1. Haldeman S, Carey P, Townsend M, Papadopoulos C: Arterial dissections following cervical manipulation: the chiropractic experience. CMAJ 2001;165:905.



Patient Financial Responsibility Disclosure and Acknowledgment

Your signature on the line below forms a legally binding agreement between Proactive Chiropractic, PLLC and the undersigned patient (the “Patient”) who is receiving medical services, or the responsible party for minor patients (those patients under 18 years of age). The Responsible Party is the individual who is financially responsible for payment of medical bills associated with the medical services provided by Proactive Chiropractic, PLLC, and is the individual indicated on the form below as the Responsible Party in the space provided. **All charges for services rendered are due and payable at the time of service.**

Proactive Chiropractic, PLLC has contracts with numerous third party insurance companies and Proactive Chiropractic, PLLC will bill such third party insurance companies for services rendered to you by Proactive Chiropractic, PLLC as a service to you. The Responsible Party is responsible for payment for services rendered in the event that your insurance declines to make payment for any services rendered for any reason whatsoever. The Responsible Party shall also be responsible for making any and all required co-pays and deductibles. The Responsible Party shall also be responsible for paying any additional amount owing after claim submission to the Patient’s insurance and will be billed for any such deficit after Proactive Chiropractic, PLLC receives an explanation of benefits (EOB) from the Patient’s insurance company.

The Responsible Party shall:

- Provide, and update to maintain current, the Responsible Party’s current address and phone number for both the Responsible Party and the Patient.
- Present all current insurance cards prior to each of the Patient’s office visits.
- Verify at each office visit that the information, including address, phone number, and insurance information is accurate and current by signing Proactive Chiropractic, PLLC’s data sheet.
- Pay any required co-pay at the time of each office visit.
- Pay any additional amount owing within thirty (30) days of receiving a statement from Proactive Chiropractic PLLC; it being understood that Proactive Chiropractic, PLLC will bill the Responsible Party for any amounts not paid by the insurance company as set forth on the EOB received from the Patient’s insurance company.

Returned Checks – If payment is made by check and the check is returned unpaid for insufficient funds, or unpaid for any other reason, the Responsible Party shall be financially responsible to Proactive Chiropractic, PLLC for the original face amount of the returned check plus a service charge equal to \$25.00 (the “Service Charge”). If payment of the face amount of the check plus the Service Charge is not received within 15 days of notification, then Proactive Chiropractic, PLLC may turn the account over to Proactive Chiropractic, PLLC’s collection agency for collection of the same. The Responsible Party shall be responsible for all costs of collection in addition to the face amount of the check and Service Charge.

Non-Payment – In the event that Proactive Chiropractic, PLLC should initiate collection proceedings or other legal action to collect an overdue account, the Patient and Responsible Party each acknowledge and understand that Proactive Chiropractic, PLLC has the right to and shall disclose to its outside collections agency all relevant personal and account information necessary to collect payment for services rendered, including any applicable service charges and applicable costs of collections. You agree to reimburse Proactive Chiropractic, PLLC the fees of any collection agency, which may be based on a percentage at a maximum of 33% of the debt, and all costs, and expenses, including attorneys’ fees, we incur in such collection efforts.

Patient Signature: _____ Date: _____

Responsible Party Signature (if patient is a minor): _____ Date: _____