# ChiroclinicHK

## *New Patient Information*

### *Please answer every question for Insurance Coverage of Treatment*

Name _____ Sex: Male / Female / Other Date: _____

What you prefer to be called: _____ Age: _____ Date of Birth: _____

Address: _____ Apt #_____ City: _____ State: _____ Zip: _____

Home Phone: _____ Cell Phone: _____

Email Address: _____ @ _____

Employer:_____

Occupation: _____ Work Phone: _____

Emergency Contact: _____ ___Relation: _____ Phone: _____

How did you hear about our office? _____

Have you had chiropractic care before? YES NO

Primary Physician Name: _____

Address/ City, State:_____

## Health Insurance:

Do you have Health Insurance? YES NO

Name: _____

Do you have chiropractic coverage? YES NO

Limited yearly visits? YES NO If yes, how many per year? _____

Do you need authorization for treatment? YES NO

Have you seen a Chiropractor this year? YES NO If yes, how many times? _____

Co-Payment amount? _____ OR Co-Insurance Amount? _____

Do you have a deductible to meet? YES NO If yes, how much? _____

# Health Questionnaire

## Patient Information

Date: _____

Patient Name: _____ Date of Birth: _____

Height: _____ Weight: _____

List all prescription, non prescription medications and other supplements you take as well as the associated condition:

_____

_____

_____

List any surgeries or hospitalizations you have had complete with the month and year for each:

_____

_____

_____

List anything you are allergic to: _____

Family History (list all major diseases such as cancer, diabetes, heart problems, bone/joint diseases and the relation to you of the individual):

_____

_____

_____

Do you exercise? □ Yes □ No Hours per week _____What activity(s)? _____

_____

Are you dieting? □ Yes □ No Since:_____ Do you smoke? □ Yes □ No _____packs per day.

How many years have you been smoking? _____ Do you drink alcoholic beverages? □ Yes □ No _____drinks per day.

Do you wear? □ Heal lifts □ Arch supports □ Prescription Orthotics

For women: Are you pregnant or nursing? □ Yes □ No If pregnant, How many weeks? _____

Date of last menstrual period: _____

## Medical History

Describe the reason(s) for your doctor visit today:

_____

_____

_____

_____

Are you here because of an accident? _____What type? _____

When did your symptoms start? _____ How did your symptoms begin? _____

_____

How often do you experience symptoms? (Circle one) Constantly Frequently Occasionally Intermittently

Describe your symptoms? (circle all that apply) Sharp Dull ache Numbing Burning Tingling Shooting

Are your symptoms? (Circle one) Getting better Staying the same Getting worse

How do your symptoms interfere with your work or normal activities?_____

_____

_____

Have you experienced these symptoms in the past?_____

_____

_____

## History of Treatment

Primary care physician: _____ Phone: _____

Date last seen: _____ May we update them on your condition? ___Yes ____ No

Have you seen a chiropractor before? ____Yes ____ No Who referred you to us? _____

Have you seen another doctor for these symptoms? If yes, indicate name and type of medical provider: _____

_____

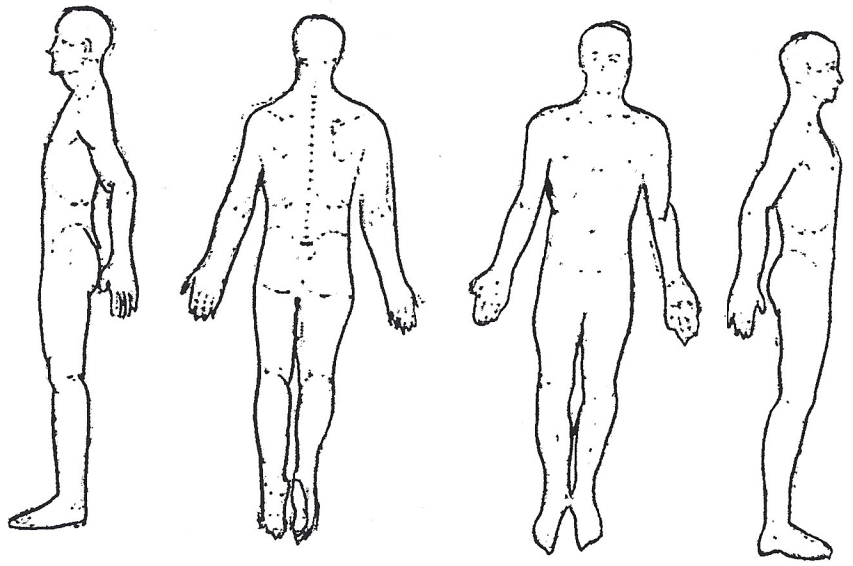
_____

_____

## Description of Condition

Mark any area(s) of discomfort with the following key:

A =Ache N =Numbness B = Burning T = Tingling S = Stiffness O = Other



Left Back Front Right

On a scale of one to ten how intense are your symptoms? Not intense ⓪①②③④⑤⑥⑦⑧⑨⑩ Unbearable

**For the conditions below please indicate if you have had the condition in the past or if you presently have the condition.**

| Past | Present | Condition | Past | Present | Condition | Past | Present | Condition |
|---|---|---|---|---|---|---|---|---|
| O | O | Abdominal Pain | O | O | Elbow/upper arm pain | O | O | Liver/Gall Bladder Disorder |
| O | O | Abnormal Weight gain/loss | O | O | Epilepsy | O | O | Loss of Bladder Control |
| O | O | Allergies Headache | O | O | Excessive thirst | O | O | Low back pain |
| O | O | Angina | O | O | Frequent Urination | O | O | Mid back pain |
| O | O | Ankle/foot pain | O | O | General Fatigue | O | O | Neck pain |
| O | O | Arthritis | O | O | Hand pain | O | O | Painful Urination |
| O | O | Asthma | O | O | Heart attack | O | O | Prostate Problems |
| O | O | Bladder Infection | O | O | Hepatitis | O | O | Shoulder pain |
| O | O | Birth Control Pills | O | O | High blood pressure | O | O | Smoking/tobacco Use |
| O | O | Cancer | O | O | Hip/upper leg pain | O | O | Stroke |
| O | O | Chest Pains | O | O | HIV/AIDS | O | O | Systematic Lupus |
| O | O | Chronic Sinusitis | O | O | Hormone Therapy | O | O | Thoracic Outlet Syndrome |
| O | O | Depression | O | O | Jaw pain | O | O | Tumor |
| O | O | Dermatitis/Eczema | O | O | Joint swelling/stiffness | O | O | Ulcer |
| O | O | Dizziness | O | O | Kidney Stones | O | O | Upper back pain |
| O | O | Drug/Alcohol Use | O | O | Knee/lower leg pain | O | O | Wrist pain |

**Additional comments you would like the doctor to know:** _____

_

_

_

**Patient's signature:** _____ **Doctor's signature:** _____

## ASSIGNMENT OF BENEFITS / ERISA AUTHORIZED REPRESENTATIVE FORM

Financial Responsibility
I have requested professional services from Dr. Gerard V. Rosato, D.C. ("Provider") on behalf of myself and/or my dependents, and understand that by making this request, I am responsible for all charges incurred during the course of said services. I understand that all fees for said services are due and payable on the date services are rendered and agree to pay all such charges incurred in full immediately upon presentation of the appropriate statement unless other arrangements have been made in advance.

Assignment of Insurance Benefits
I hereby assign all applicable health insurance benefits to which I and/or my dependents are entitled to Provider. I certify that the health insurance information that I provided to Provider is accurate as of the date set forth below and that I am responsible for keeping it updated.

I hereby authorize Provider to submit claims, on my and/or my dependent's behalf, to the benefit plan (or its administrator) listed on the current insurance card I provided to Provider, in good faith. I also hereby instruct my benefit plan (or its administrator) to pay Provider directly for services rendered to me or my dependents. To the extent that my current policy prohibits direct payment to Provider, I hereby instruct and direct my benefit plan (or its administrator) to provide documentation stating such non-assignment to myself and Provider upon request. Upon proof of such non-assignment, I instruct my benefit plan (or its administrator) to make out the check to me and mail it directly to Provider.

I am fully aware that having health insurance does not absolve me of my responsibility to ensure that my bills for professional services from Provider are paid in full. I also understand that I am responsible for all amounts not covered by my health insurance, including co-payments, co-insurance, and deductibles.

Authorization to Release Information
I hereby authorize Provider to: (1) release any information necessary to my health benefit plan (or its administrator) regarding my illness and treatments; (2) process insurance claims generated in the course of examination or treatment; and (3) allow a photocopy of my signature to be used to process insurance claims. This order will remain in effect until revoked by me in writing.

ERISA Authorization
I hereby designate, authorize, and convey to Provider to the full extent permissible under law and under any applicable insurance policy and/or employee health care benefit plan, as my Authorized Representative: (1) the right and ability to act on my behalf in connection with any claim, right, or cause in action that I may have under such insurance policy and/or benefit plan; and (2) the right and ability to act on my behalf to pursue such claim, right, or cause of action in connection with said insurance policy and/or benefit plan (including but not limited to, the right to act on my behalf in respect to a benefit plan governed by the provisions of ERISA as provided in 29 *C.F.R.* §2560.5031(b)(4)) with respect to any healthcare expense incurred as a result of the services I received from Provider and, to the extent permissible under the law, to claim on my behalf, such benefits, claims, or reimbursement, and any other applicable remedy, including fines.

A photocopy of this Assignment/Authorization shall be as effective and valid as the original.

Patient's Signature _____ Date _____

## CANCELLATION POLICY

It is important to your health to maintain your treatment plan and attend your scheduled appointments. We do understand there may be circumstances which prevent you from calling us to cancel or reschedule within the 24-hour requirement that most doctors' offices expect. The policy of this office is to accept schedule changes and cancellations prior to 10:00 a.m. on the day of your appointment. Please be advised there is a $25 fee for any missed appointments, or those changed or cancelled after 10:00 a.m. You may leave a voice message or email us if the office is closed. We check both frequently. By signing below, you acknowledge and accept this office policy.

Patient's Signature _____ Date _____

## ACKNOWLEDGEMENT OF RECEIPT OF PRIVACY PRACTICES

I understand and have been provided with a Notice of Information Practices that provides a more complete description of information uses and disclosures. I understand that I have the following rights and privileges: the right to review the notice prior to signing this consent; the right to object to the use of my health information for directory purposes; and the right to request restrictions as to how my health information may be used or disclosed to carry out treatment, payment or health care operations.

Patient's Signature _____ Date _____

# OSWESTRY DISABILITY INDEX 2.0

NAME_____ DATE_____ SCORE_____

***PLEASE READ:*** Could you please complete this questionnaire

Please answer ***every section.*** Mark ***one box only*** in each section that most closely describes you ***today.***

*SECTION 1 - Pain Intensity*
- A ☐ I have no pain at the moment.
- B ☐ The pain is very mild at the moment.
- C ☐ The pain is moderate at the moment.
- D ☐ The pain is fairly severe at the moment.
- E ☐ The pain is very severe at the moment.
- F ☐ The pain is the worst imaginable at the moment.

*SECTION 2 - Personal Care (washing, dressing, etc.)*
- A ☐ I can look after myself normally without causing extra pain.
- B ☐ I can look after myself normally but it is very painful.
- C ☐ It is painful to look after myself and I am slow and careful.
- D ☐ I need some help but manage most of my personal care.
- E ☐ I need help every day in most aspects of self care.
- F ☐ I do not get dressed, wash with difficulty and stay in bed.

*SECTION 3 - Lifting*
- A ☐ I can lift heavy weights without extra pain.
- B ☐ I can lift heavy weights, but it causes extra pain.
- C ☐ Pain prevents me from lifting heavy weights off the floor, but I can manage if they are conveniently positioned, e.g. on a table.
- D ☐ Pain prevents me from lifting heavy weights, but I can manage light to medium weights if they are conveniently positioned.
- E ☐ I can only lift very light weights, at the most.
- F ☐ I cannot lift or carry anything at all.

*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 1/4 mile.
- D ☐ Pain prevents me from walking more than 100 yards.
- E ☐ I can only walk while 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.
- 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 1/2 hour.
- E ☐ Pain prevents me from sitting more than ten minutes.
- F ☐ Pain prevents me from sitting at all.

*SECTION 6 - Standing*
- A ☐ I can stand as long as I want without extra pain.
- B ☐ I can stand as long as I want but it gives me extra pain.
- C ☐ Pain prevents me from standing for more than 1 hour.
- D ☐ Pain prevents me from standing for more than 1/2 hour.
- E ☐ Pain prevents me from standing for more than 10 minutes.
- F ☐ Pain prevents me from standing at all.

*SECTION 7 - Sleeping*
- A ☐ My sleep is never disturbed by pain.
- B ☐ My sleep is occasionally disturbed by pain.
- C ☐ Because of pain I have less than 6 hours' sleep.
- D ☐ Because of pain I have less than 4 hours' sleep.
- E ☐ Because of pain I have less than 2 hours' sleep.
- F ☐ Pain prevents me from sleeping at all.

*SECTION 8 - Sex Life (if applicable)*
- A ☐ My sex life is normal and causes me no extra pain.
- B ☐ My sex life is normal, but causes some extra pain.
- C ☐ My sex life is nearly normal but is very painful.
- D ☐ My sex life is severely restricted by pain.
- E ☐ My sex life is nearly absent because of pain.
- F ☐ Pain prevents any sex life at all.

*SECTION 9 - Social Life*
- A ☐ My social life is normal and causes me no extra pain.
- B ☐ My social life is normal, but increases the degree of pain.
- C ☐ Pain has no significant effect on my social life apart from limiting my more energetic interests, e.g., sport, etc.
- D ☐ Pain has restricted my social life and I do not go out as often.
- E ☐ Pain has restricted my social life to my home.
- F ☐ I have no social life because of the pain.

*SECTION 10 - Traveling*
- A ☐ I can travel anywhere without pain.
- B ☐ I can travel anywhere but I gives extra pain.
- C ☐ Pain is bad but I manage journeys over 2 hours.
- D ☐ Pain restricts me to journeys of less than 1 hour.
- E ☐ Pain restricts me to short necessary journeys under 30 minutes.
- F ☐ Pain prevents me from traveling except to receive treatment.

**COMMENTS:** _____

*Roland, M. and J. Fairbank (2000). "The Roland-Morris Disability Questionnaire and the Oswestry Disability Questionnaire." Spine 25(24): 3115-24.*

# NECK DISABILITY INDEX QUESTIONNAIRE

NAME_____ AGE_____ DATE_____ SCORE_____

***PLEASE READ:*** This questionnaire is designed to enable us to understand how much your neck pain has affected your ability to manage your everyday activities. Please answer each section by circling the ONE CHOICE that most applies to you. We realize that you may feel that more than one statement may relate to you, but ***PLEASE JUST CIRCLE THE ONE CHOICE THAT MOST CLOSELY DESCRIBES YOUR PROBLEM RIGHT NOW.***

| | |
|---|---|
| *SECTION 1 - Pain Intensity*<br>A. I have no pain at the moment.<br>B. The pain is very mild at the moment.<br>C. The pain is moderate at the moment.<br>D. The pain is fairly severe at the moment.<br>E. The pain is very severe at the moment.<br>F. The pain is the worst imaginable at the moment. | *SECTION 6 - Concentration/*<br>A. I can concentrate fully when I want to with no difficulty.<br>B. I can concentrate fully when I want to with slight difficulty.<br>C. I have a fair degree of difficulty in concentrating when I want to.<br>D. I have a lot of difficulty in concentrating when I want to.<br>E. I have a great deal of difficulty in concentrating when I want to.<br>F. I cannot concentrate at all. |
| *SECTION 2 -Personal Care (Washing, Dressing, etc.)*<br>A. I can look after myself normally without causing extra pain.<br>B. I can look after myself normally, but it causes extra pain.<br>C. It is painful to look after myself and I am slow and careful.<br>D. I need some help, but manage most of my personal care.<br>E. I need help every day in most aspects of self care.<br>F. I do not get dressed, I wash with difficulty and stay in bed. | *SECTION 7 - Work*<br>A. I can do as much work as I want to.<br>B. I can only do my usual work, but no more.<br>C. I can do most of my usual work, but no more.<br>D. I cannot do my usual work.<br>E. I can hardly do any work at all.<br>F. I cannot do any work at all. |
| *SECTION 3 - Lifting*<br>A. I can lift heavy weights without extra pain.<br>B. I can lift heavy weights, but it gives extra pain.<br>C. Pain prevents me from lifting heavy weights off the floor, but I can manage if they are conveniently positioned, for example, on a table.<br>D. Pain prevents me from lifting heavy weights, but I can manage light to medium weights if they are conveniently positioned.<br>E. I can lift very light weights.<br>F. I cannot lift or carry anything at all. | *SECTION 8 – Driving*<br>A. I can drive my car without any neck pain.<br>B. I can drive my car as long as I want with slight pain in my neck.<br>C. I can drive my car as long as I want with moderate pain in my neck.<br>D. I cannot drive my car as long as I want because of moderate pain in my neck.<br>E. I can hardly drive at all because of severe pain in my neck.<br>F. I cannot drive my car at all. |
| *SECTION 4 - Reading*<br>A. I can read as much as I want to with no pain in my neck.<br>B. I can read as much as I want to with slight pain in my neck.<br>C. I can read as much as I want to with moderate pain in my neck.<br>D. I cannot read as much as I want because of moderate pain in my neck.<br>E. I cannot read as much as I want because of severe pain in my neck.<br>F. I cannot read at all. | *SECTION 9 – Sleeping*<br>A. I have no trouble sleeping.<br>B. My sleep is slightly disturbed (less than 1 hour sleepless).<br>C .My sleep is mildly disturbed (1-2 hours sleepless).<br>D. My sleep is moderately disturbed (2-3 hours sleepless).<br>E. My sleep is greatly disturbed (3-5 hours sleepless).<br>F. My sleep is completely disturbed (5-7 hours) |
| *SECTION 5 – Headaches*<br>A. I have no headaches at all.<br>B. I have slight headaches which come infrequently.<br>C. I have moderate headaches which come infrequently.<br>D. I have moderate headaches which come frequently.<br>E. I have severe headaches which come frequently.<br>F. I have headaches almost all the time. | *SECTION 10 – Recreation*<br>A. I am able to engage in all of my recreational activities with no neck pain at all.<br>B. I am able to engage in all of my recreational activities with some pain in my neck.<br>C. I am able to engage in most, but not all of my recreational activities because of pain in my neck.<br>D. I am able to engage in a few of my recreational activities because of pain in my neck.<br>E. I can hardly do any recreational activities because of pain in my neck.<br>F. I cannot do any recreational activities at all. |

**COMMENTS:** _____

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*Vernon H, Mior S. The Neck Disability Index: A study of reliability and validity. J Manipulative Physiol Ther 1991;14:409-415.*