

Patient Information

Date _____ Patient # _____ Doctor Agostino, Manes, McCandles, McDonagh

Name _____ Social Security # _____ Home Phone _____

Address _____ City _____ State _____ Zip _____

E-mail address: _____ Fax # _____ Cell Phone _____

Age _____ Birth Date _____ Race _____ Marital: M S W D How many children? _____

Occupation _____ Employer _____

Employer's Address _____ Office Phone _____

Spouse _____ Occupation _____ Employer _____

Name of Nearest Relative _____ Address _____ Phone _____

How were you referred to our office? _____

Purpose of this appointment _____

Date symptoms appeared or accident happened _____

Have you had previous chiropractic care? Yes No Date of Last Adjustment _____

Reasons for Previous Chiropractic Care _____

Family Medical Doctor (include location) _____

Date of last physical examination _____

What surgeries have you had? (Include dates) _____

Serious illnesses (include dates) _____

Have you been treated for any health condition by a physician in the last year? Yes No

If yes, describe: _____

What medications or drugs are you taking? _____

What vitamins or supplements are you taking? _____

Please check any and all insurance coverage that may be applicable in this case.

Major Medical Worker's Compensation Medicaid Medicare Auto Accident Other

HEALTH SAVINGS/HEALTH REIMBURSEMENT ACCOUNTS/FLEX PLANS:

Do you plan on using any of these for your future care? Yes No

Name of Primary Insurance Company _____

Name of Secondary Insurance Company (if any) _____

AUTHORIZATION AND RELEASE: I authorize payment of insurance benefits directly to the chiropractor or chiropractic office. I authorize the doctor to release all information necessary to communicate with personal physicians and other healthcare providers and payors and to secure the payment of benefits. I understand that I am responsible for all costs of chiropractic care, regardless of insurance coverage. I also understand that if I suspend or terminate my schedule of care as determined by my treating doctor, any fees for professional services will be immediately due and payable. I understand that interest is charged on overdue accounts at the annual rate of 16%.

The patient understands and agrees to allow this chiropractic office to use their Patient Health Information for the purpose of treatment, payment, healthcare operations, and coordination of care. We want you to know how your Patient Health Information is going to be used in this office and your rights concerning those records. If you would like to have a more detailed account of our policies and procedures concerning the privacy of your Patient Health Information we encourage you to read the HIPAA NOTICE that is available to you at the front desk before signing this consent. If there is anyone you do not want to receive your medical records, please inform our office.

Patient's Signature _____ Date _____

Guardian's Signature Authorizing Care _____ Date _____

SOCIAL HISTORY

Please indicate beside each activity whether you engage in it:
OFTEN= "O" SOMETIMES= "S" NEVER= "N"

_____ Vigorous Exercise	_____ Family Pressures
_____ Moderate Exercise	_____ Financial Pressures
_____ Alcohol Use	_____ Other Mental Stresses
_____ Drug Use	_____ Other (specify)_____
_____ Tobacco Use	_____
_____ Caffeine	_____
_____ High Stress Activity	

FAMILY HISTORY

Please review the below-listed diseases and conditions and indicate those that are current health problems of the family member. Leave blank those spaces that do not apply.

CONDITION	FATHER	MOTHER	SPOUSE	BROTHER(S)		SISTERS		CHILDREN	
	Age []	Age []	Age []	Age []	Age []	Age []	Age []	Age []	Age []
Arthritis									
Asthma-Hay Fever									
Back Trouble									
Bursitis									
Cancer									
Constipation									
Diabetes									
Disc Problem									
Emphysema									
Epilepsy									
Headaches									
Heart Trouble									
High Blood Pressure									
Insomnia									
Kidney Trouble									
Liver Trouble									
Migraine									
Nervousness									
Neuritis									
Neuralgia									
Pinched Nerve									
Scoliosis									
Sinus Trouble									
Stomach Trouble									
Other:									

If any of the above family members are deceased, please list their age at death and cause:

Patient's Signature _____

PATIENT PERSONAL HISTORY

Patient _____ Date _____

Childhood Diseases: Measles _____ Mumps _____ Chicken Pox _____ Others _____

Unusual Childhood Diseases: _____

Adult Illnesses or Conditions: _____

Hospitalizations: _____

Fractures: _____

Are you allergic to any drugs or medications? _____

Describe Your Symptoms

Date symptoms appeared _____
Have you ever had the same or similar condition? Yes _____ No _____ If yes, when and describe _____

What other treatment have you had for this condition? _____

Is the condition due to injury or sickness arising out of employment? _____

Is the condition due to injury or sickness arising out of an auto or other accident? _____

Date accident happened _____ Days lost from work? _____

Have you had or do you now have any of the following symptoms? Please indicate with the letter **N** if you have these conditions now or **P** if you have had these conditions previously.

N = Now

P = Previously

Headaches _____	Frequency _____	Loss of Balance	_____
Neck Pain	_____	Fainting	_____
Stiff Neck	_____	Loss of Smell	_____
Sleeping Problems	_____	Loss of Taste	_____
Back Pain	_____	Unusual Bowel Patterns	_____
Nervousness	_____	Feet Cold	_____
Tension	_____	Hands Cold	_____
Irritability	_____	Arthritis	_____
Chest Pains/Tightness	_____	Muscle Spasms	_____
Dizziness	_____	Frequent Colds	_____
Shoulder/Neck/Arm Pain	_____	Fever	_____
Numbness in Hands/Fingers	_____	Sinus Problems	_____
Numbness in Feet/Toes	_____	Diabetes	_____
High Blood Pressure	_____	Indigestion Problems	_____
Difficulty Urinating	_____	Joint Pain/Swelling	_____
Weakness in Extremities	_____	Menstrual Difficulties	_____
Breathing Problems	_____	Weight Loss/Gain	_____
Fatigue	_____	Depression	_____
Lights Bother Eyes	_____	Loss of Memory	_____
Ears Ring	_____	Buzzing in Ears	_____

Women: Are you pregnant? _____

Name _____ No. _____ Date _____

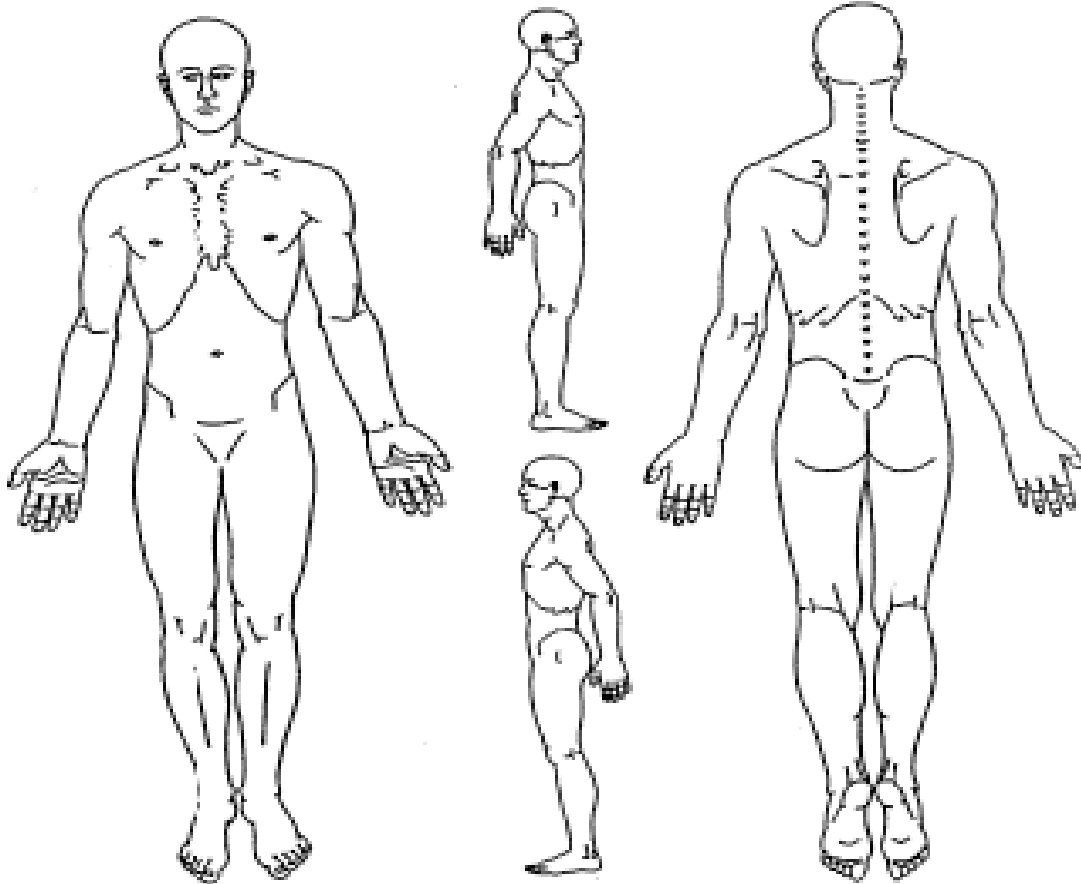
Please read carefully:

Mark the areas on your body where you have symptoms, using the appropriate symbols below. Include all affected areas. If your pain radiates, draw an arrow from where it starts to where it stops, extending the arrow as far as the pain travels.

Ache >>>>>
Burning x x x x x

Numbness = = = = =
Stabbing ////

Pins & Needles ° ° ° ° °
Throbbing ~ ~ ~ ~ ~



Patient Health Information Consent Form

We want you to know how your Patient Health Information (**PHI**) is going to be used in this office and your rights concerning those records. Before we will begin any health care operations we must require you to read and sign this consent form stating that you understand and agree with how your records will be used. If you would like to have a more detailed account of our policies and procedures concerning the privacy of your Patient Health Information we encourage you to read the HIPAA NOTICE that is available to you at the front desk before signing this consent.

1. The patient understands and agrees to allow this chiropractic office to use their Patient Health Information (**PHI**) for the purpose of treatment, payment, healthcare operations, and coordination of care. As an example, the patient agrees to allow this chiropractic office to submit requested PHI to the Health Insurance Company (or companies) provided to us by the patient for the purpose of payment. Be assured that this office will limit the release of all PHI to the minimum needed for what the insurance companies require for payment.
2. The patient has the right to examine and obtain a copy of his or her own health records at any time and request corrections. The patient may request to know what disclosures have been made and submit in writing any further restrictions on the use of their PHI. Our office is obligated to agree to those restrictions only to the extent they coincide with state and federal law.
3. A patient's written consent need only be obtained one time for all subsequent care given the patient in this office.
4. The patient may provide a written request to revoke consent at any time during care. This would not effect the use of those records for the care given prior to the written request to revoke consent but would apply to any care given after the request has been presented.
5. Our office may contact you periodically regarding appointments, treatments, products, services, or charitable work performed by our office. You may choose to opt-out of any marketing or fundraising communications at any time.
6. For your security and right to privacy, all staff has been trained in the area of patient record privacy and a privacy official has been designated to enforce those procedures in our office. We have taken all precautions that are known by this office to assure that your records are not readily available to those who do not need them.
7. Patients have the right to file a formal complaint with our privacy official and the Secretary of HHS about any possible violations of these policies and procedures without retaliation by this office.
8. Our office reserves the right to make changes to this notice and to make the new notice provisions effective for all protected health information that it maintains. You will be provided with a new notice at your next visit following any change.
9. This notice is effective on the date stated below.
10. If the patient refuses to sign this consent for the purpose of treatment, payment and health care operations, the chiropractic physician has the right to refuse to give care.

I have read and understand how my Patient Health Information will be used and I agree to these policies and procedures.

Name of Patient

Date

For further information regarding this notice, please contact our Doctor at (724)779-0001

Back Oswestry Disability Index

This questionnaire has been designed to give the doctor information as to how your back pain has affected your ability to manage in everyday life. Please answer every section and mark in each section only the ONE box which applies to you. We realize you may consider that two of the statements in any one section relate to you, but please just mark the box which most closely describes your problem.

Section 1 – Pain Intensity

- I have no pain at the moment.
- The pain is very mild at the moment.
- The pain is moderate at the moment.
- The pain is fairly severe at the moment.
- The pain is very severe at the moment.
- The pain is the worst imaginable at the moment.

Section 2 – Personal Care (washing, dressing, etc.)

- I can look after myself normally without causing extra pain.
- I can look after myself normally but it is very painful.
- It is painful to look after myself and I am slow and careful.
- I need some help but manage most of my personal care.
- I need help every day in most aspects of my personal care.
- I need help every day in most aspects of self-care.
- I do not get dressed, wash with difficulty, and stay in bed.

Section 3 - Lifting

- I can lift heavy weights without extra pain.
- I can lift heavy weights but it gives extra pain.
- Pain prevents me from lifting heavy weights off the floor, but I can manage if they are conveniently positioned (i.e. on a table).
- Pain prevents me from lifting heavy weights, but I can manage light to medium weights if they are conveniently positioned.
- I can lift only very light weights.
- I cannot lift or carry anything at all.

Section 4 – Walking

- Pain does not prevent me walking any distance.
- Pain prevents me walking more than 1 mile.
- Pain prevents me walking more than ¼ of a mile.
- Pain prevents me walking more than 100 yards.
- I can only walk using a stick or crutches.
- I am in bed most of the time and have to crawl to the toilet.

Section 5 – Sitting

- I can sit in any chair as long as I like.
- I can sit in my favorite chair as long as I like.
- Pain prevents me from sitting for more than 1 hour.
- Pain prevents me from sitting for more than ½ hour.
- Pain prevents me from sitting for more than 10 minutes.
- Pain prevents me from sitting at all.

Section 6 – Standing

- I can stand as long as I want without extra pain.
- I can stand as long as I want but it gives me extra pain.
- Pain prevents me from standing more than 1 hour.
- Pain prevents me from standing for more than ½ an hour.
- Pain prevents me from standing for more than 10 minutes.
- Pain prevents me from standing at all.

Section 7 – Sleeping

- My sleep is never disturbed by pain.
- My sleep is occasionally disturbed by pain.
- Because of pain, I have less than 6 hours sleep.
- Because of pain, I have less than 4 hours sleep.
- Because of pain, I have less than 2 hours sleep.
- Pain prevents me from sleeping at all.

Section 8 – Sex life (if applicable)

- My sex life is normal and causes no extra pain.
- My sex life is normal but causes some extra pain.
- My sex life is nearly normal but is very painful.
- My sex life is severely restricted by pain.
- My sex life is nearly absent because of pain.
- Pain prevents any sex life at all.

Section 9 – Social Life

- My social life is normal and cause me no extra pain.
- My social life is normal but increases the degree of pain.
- Pain has no significant effect on my social life apart from limiting my more energetic interests, i.e. sports.
- Pain has restricted my social life and I do not go out as often.
- Pain has restricted social life to my home.
- I have no social life because of pain.

Section 10 – Traveling

- I can travel anywhere without pain.
- I can travel anywhere but it gives extra pain.
- Pain is bad but I manage journeys of over two hours.
- Pain restricts me to short necessary journeys under 30 minutes.
- Pain prevents me from traveling except to receive treatment.

Section 11 - Previous Treatment

Over the past three months have you received treatment, tablets or medicines of any kind for your back or leg pain? Please check the appropriate box.

- No
- Yes (if yes, please state the type of treatment you have received)

Name and ID#: _____

Date: _____

Reserved for Office Use:

Score: _____

Neck Disability Index

This questionnaire has been designed to give the doctor information as to how your neck pain has affected your ability to manage in everyday life. Please answer every section and mark in each section only the ONE box which applies to you. We realize you may consider that two of the statements in any one section relate to you, but please just mark the box which most closely describes your problem.

Section 1 – Pain Intensity

- I have no pain at the moment. (0)
- The pain is very mild at the moment. (1)
- The pain is moderate at the moment. (2)
- The pain is fairly severe at the moment. (3)
- The pain is very severe at the moment. (4)
- The pain is the worst imaginable at the moment. (5)

Section 2 – Personal Care (Washing, Dressing, etc.)

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

Section 3 – Lifting

- I can lift heavy weights without extra pain. (0)
- I can lift heavy weights but it gives extra pain. (1)
- Pain prevents me from lifting heavy weights off the floor, but I can manage if they are conveniently positioned, for example on a table. (2)
- Pain prevents me from lifting heavy weights, but I can manage light to medium weights if they are conveniently positioned. (3)
- I can lift very light weights. (4)
- I cannot lift or carry anything at all. (5)

Section 4 – Reading

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

Section 5 – Headaches

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

Section 6 – Concentration

- I can concentrate fully when I want to with no difficulty. (0)
- I can concentrate fully when I want to with slight difficulty. (1)
- I have a fair degree of difficulty in concentrating when I want to. (2)
- I have a lot of difficulty in concentrating when I want to. (3)

- I have a great deal of difficulty in concentrating when I want to. (4)
- I cannot concentrate at all. (5)

Section 7 – Work

- I can do as much work as I want to. (0)
- I can do my usual work, but no more. (1)
- I can do most of my usual work, but no more. (2)
- I cannot do my usual work. (3)
- I can hardly do any work at all. (4)
- I cannot do any work at all. (5)

Section 8 – Driving

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

Section 9 – Sleeping

- I have no trouble sleeping. (0)
- My sleep is slightly disturbed (less than 1 hour sleepless). (1)
- My sleep is mildly disturbed (1-2 hours sleepless). (2)
- My sleep is moderately disturbed (2-3 hours sleepless). (3)
- My sleep is greatly disturbed (3-5 hours sleepless). (4)
- My sleep is completely disturbed (5-7 hours sleepless). (5)

Section 10 – Recreation

- I am able to engage in all my recreation activities with no neck pain at all. (0)
- I am able to engage in all my recreation activities, with some pain in my neck. (1)
- I am able to engage in most, but not all, of my usual recreation activities because of pain in my neck. (2)
- I am able to engage in a few of my usual recreation activities because of pain in my neck. (3)
- I can hardly do any recreation activities because of pain in my neck. (4)
- I cannot do any recreation activities at all. (5)

Name and ID#: _____

Date: _____

Reserved for Office Use:

Score: _____

