WELCOME

PATIENT INFORMATION

Date _____

SS/HIC/Patient ID # _____

Patient Name _____
Last Name

_____
First Name Middle Initial

Address _____

City _____

State _____ Zip _____

E-mail _____

Sex ☐ M ☐ F Age _____

Birthdate _____

☐ Married ☐ Widowed ☐ Single ☐ Minor

☐ Separated ☐ Divorced ☐ Partnered for _____ years

Occupation _____

Patient Employer/School _____

Employer/School Address _____

_____

Employer/School Phone (_____) _____

Spouse's Name _____

Birthdate _____

SS# _____

Spouse's Employer _____

Whom may we thank for referring you? _____

INSURANCE

Who is responsible for this account? _____

Relationship to Patient _____

Insurance Co. _____

Group # _____

Is patient covered by additional insurance? ☐ Yes ☐ No

Subscriber's Name _____

Birthdate _____ SS# _____

Relationship to Patient _____

Insurance Co. _____

Group # _____

ASSIGNMENT AND RELEASE

I certify that I, and/or my dependent(s), have insurance coverage with

_____ and assign directly to
Name of Insurance Company(ies)

Dr. _____ all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I authorize the use of my signature on all insurance submissions.

The above-named doctor may use my health care information and may disclose such information to the above-named Insurance Company(ies) and their agents for the purpose of obtaining payment for services and determining insurance benefits or the benefits payable for related services. This consent will end when my current treatment plan is completed or one year from the date signed below.

_____
Signature of Patient, Parent, Guardian or Personal Representative

_____
Please print name of Patient, Parent, Guardian or Personal Representative

_____ _____
Date Relationship to Patient

PHONE NUMBERS

Home Phone (_____) _____

Cell Phone (_____) _____

Best time and place to reach you _____

IN CASE OF EMERGENCY, CONTACT

Name _____

Relationship _____

Home Phone (_____) _____

Work Phone (_____) _____

ACCIDENT INFORMATION

Is condition due to an accident? ☐ Yes ☐ No

Date _____

Type of accident ☐ Auto ☐ Work ☐ Home ☐ Other

To whom have you made a report of your accident?
☐ Auto Insurance ☐ Employer ☐ Worker Comp. ☐ Other

Attorney Name (if applicable)

_____

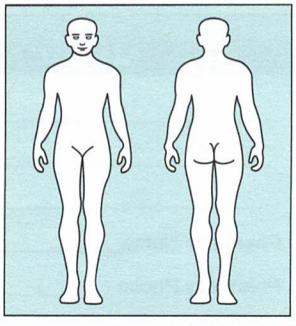
PATIENT CONDITION

Reason for Visit _____

When did your symptoms appear? _____

Is this condition getting progressively worse? ☐ Yes ☐ No ☐ Unknown

Mark an X on the picture where you continue to have pain, numbness, or tingling.



Rate the severity of your pain on a scale from 1 (least pain) to 10 (severe pain) _____

Type of pain: ☐ Sharp ☐ Dull ☐ Throbbing ☐ Numbness ☐ Aching ☐ Shooting
☐ Burning ☐ Tingling ☐ Cramps ☐ Stiffness ☐ Swelling ☐ Other

How often do you have this pain? _____

Is it constant or does it come and go? _____

Does it interfere with your ☐ Work ☐ Sleep ☐ Daily Routine ☐ Recreation

Activities or movements that are painful to perform ☐ Sitting ☐ Standing ☐ Walking ☐ Bending ☐ Lying Down

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HEALTH HISTORY

What treatment have you already received for your condition? ☐ Medications ☐ Surgery ☐ Physical Therapy

☐ Chiropractic Services ☐ None ☐ Other _____

Name and address of other doctor(s) who have treated you for your condition _____

Date of Last: Physical Exam_____ Spinal X-Ray_____ Blood Test_____

Spinal Exam_____ Chest X-Ray _____ Urine Test _____

Dental X-Ray_____ MRI, CT-Scan, Bone Scan _____

Place a mark on "Yes" or "No" to indicate if you have had any of the following:

AIDS/HIV	☐ Yes	☐ No	Diabetes	☐ Yes	☐ No	Liver Disease	☐ Yes	☐ No	Rheumatic Fever	☐ Yes	☐ No
Alcoholism	☐ Yes	☐ No	Emphysema	☐ Yes	☐ No	Measles	☐ Yes	☐ No	Scarlet Fever	☐ Yes	☐ No
Allergy Shots	☐ Yes	☐ No	Epilepsy	☐ Yes	☐ No	Migraine Headaches	☐ Yes	☐ No	Sexually Transmitted Disease	☐ Yes	☐ No
Anemia	☐ Yes	☐ No	Fractures	☐ Yes	☐ No	Miscarriage	☐ Yes	☐ No	Stroke	☐ Yes	☐ No
Anorexia	☐ Yes	☐ No	Glaucoma	☐ Yes	☐ No	Mononucleosis	☐ Yes	☐ No	Suicide Attempt	☐ Yes	☐ No
Appendicitis	☐ Yes	☐ No	Goiter	☐ Yes	☐ No	Multiple Sclerosis	☐ Yes	☐ No	Thyroid Problems	☐ Yes	☐ No
Arthritis	☐ Yes	☐ No	Gonorrhea	☐ Yes	☐ No	Mumps	☐ Yes	☐ No	Tonsillitis	☐ Yes	☐ No
Asthma	☐ Yes	☐ No	Gout	☐ Yes	☐ No	Osteoporosis	☐ Yes	☐ No	Tuberculosis	☐ Yes	☐ No
Bleeding Disorders	☐ Yes	☐ No	Heart Disease	☐ Yes	☐ No	Pacemaker	☐ Yes	☐ No	Tumors, Growths	☐ Yes	☐ No
Breast Lump	☐ Yes	☐ No	Hepatitis	☐ Yes	☐ No	Parkinson's Disease	☐ Yes	☐ No	Typhoid Fever	☐ Yes	☐ No
Bronchitis	☐ Yes	☐ No	Hernia	☐ Yes	☐ No	Pinched Nerve	☐ Yes	☐ No	Ulcers	☐ Yes	☐ No
Bulimia	☐ Yes	☐ No	Herniated Disk	☐ Yes	☐ No	Pneumonia	☐ Yes	☐ No	Vaginal Infections	☐ Yes	☐ No
Cancer	☐ Yes	☐ No	Herpes	☐ Yes	☐ No	Polio	☐ Yes	☐ No	Whooping Cough	☐ Yes	☐ No
Cataracts	☐ Yes	☐ No	High Blood Pressure	☐ Yes	☐ No	Prostate Problem	☐ Yes	☐ No	Other _____		
Chemical Dependency	☐ Yes	☐ No	High Cholesterol	☐ Yes	☐ No	Prosthesis	☐ Yes	☐ No			
Chicken Pox	☐ Yes	☐ No	Kidney Disease	☐ Yes	☐ No	Psychiatric Care	☐ Yes	☐ No			
						Rheumatoid Arthritis	☐ Yes	☐ No			

EXERCISE

☐ None
☐ Moderate
☐ Daily
☐ Heavy

WORK ACTIVITY

☐ Sitting
☐ Standing
☐ Light Labor
☐ Heavy Labor

HABITS

☐ Smoking Packs/Day _____
☐ Alcohol Drinks/Week _____
☐ Coffee/Caffeine Drinks Cups/Day _____
☐ High Stress Level Reason _____

Are you pregnant? ☐ Yes ☐ No Due Date_____

Injuries/Surgeries you have had	Description	Date
Falls		
Head Injuries		
Broken Bones		
Dislocations		
Surgeries		

MEDICATIONS

_____
_____
_____

Pharmacy Name_____

Pharmacy Phone (_____)_____

ALLERGIES

VITAMINS/HERBS/MINERALS

INITIAL EVALUATION FORM

NAME: _____

Age: _____ **Today's Date:** _____

Date of Birth: _____

Height: _____ **Weight:** _____

Who referred you to us?
If yes, please give name/address of person/physician:

_____

Occupation? _____

Where is your problem? (please circle)

Shoulder	Elbow	Wrist/Hand
Knee	Hip	Ankle/foot
Back	Neck	Other

Which side(s)? Right / Left / Both

Dominant Arm? Right / Left

Problem(s) (please check all that apply):

- Pain
- Weakness
- Instability /giving way /dislocation
- Stiffness
- Swelling
- Other _____

How did you injure yourself?

- No injury
- Sports (which sport?) _____
- Motor vehicle accident
- Work/ job -
  - Workers claim? Yes / No

Date of injury? _____

Sports level: none/recreational/college/ professional

How long have you had symptoms?
_____**Days** _____**Mos.** _____ **Yrs.**

Please briefly describe the injury:

_____

_____

Diagnosis (if you know or have been told)?

_____

_____

Previous treatments (other than surgery)?
(medications, physical therapy, injections, bracing)

_____

_____

Previous surgery for this problem (include dates)

_____

_____

How severe is the pain? (*0 = none, 10 = severe pain)*

At rest? 0 1 2 3 4 5 6 7 8 9 10

At its worst? 0 1 2 3 4 5 6 7 8 9 10

Do you have night pain? Yes / No

Does it waken you from sleep? Yes / No

Are you currently working? Yes / No / Retired
Normal job? Limited duty?

What makes your problem better?

_____

What makes your problem worse?

_____

Please describe your current limitations?

_____

Have you had any previous imaging studies?

X-rays	Yes / No	date: _____
MRI	Yes / No	date: _____
CT scan	Yes / No	date: _____
Other	Yes / No	date: _____

INITIAL EVALUATION FORM

PAST MEDICAL HISTORY:

- ☐ High blood pressure _____
- ☐ Heart problems _____
- ☐ History of heart attack _____
- ☐ Stroke _____
- ☐ Kidney disease _____
- ☐ History of Cancer _____
- ☐ Osteoporosis _____
- ☐ Blood clot/embolus _____
- ☐ Blood clotting disorder _____
- ☐ Diabetes _____
- ☐ Skin infections _____
- ☐ MRSA _____
- ☐ Other _____

ALLERGIES:

- ☐ NO KNOWN DRUG ALLERGIES
- ☐ Penicillin
- ☐ Sulfa
- ☐ Other _____

SOCIAL HISTORY:

Marital status: _____

Alcohol use: ☐ Daily ☐Socially ☐ Never

Tobacco use: ☐ Yes - Packs per day _____

☐ No

MEDICATIONS: (please list all medications you are currently taking)

_____

_____

FAMILY HISTORY: (list diseases that run in your family)

☐ Blood clots_____

☐Bleeding disorders _____

☐Other _____

PAST SURGICAL HISTORY: (include dates)

_____

_____

_____

REVIEW OF SYSTEMS:

-GENERAL ☐ None ☐ Recent weight change ☐ Fever ☐ Weakness/fatigue
☐ Other _____

-EYES ☐ None ☐ Vision change ☐ Glasses/Contacts ☐ Glaucoma ☐ Cataracts
☐ Other _____

-EARS, NOSE, THROAT ☐ None ☐ Loss of hearing ☐ Ear ache/infection ☐ Ringing in ear ☐ Hoarseness
☐ Other _____

-CARDIOVASCULAR ☐ None ☐ Chest pain ☐ Swelling in legs ☐ Shortness in breath ☐ Palpitations
☐ Other _____

-RESPIRATORY ☐ None ☐ Shortness of breath ☐ Wheezing/Asthma ☐ Frequent Cough
☐ Other _____

-GASTROINTESTINAL ☐ None ☐ Heartburn ☐ Acid Reflux ☐ Nausea or Vomiting ☐ Abdominal pain
☐ Other _____

-MUSCULOSKELETAL ☐ None ☐ Arthritis/joint stiffness ☐ Muscle Aches ☐Swelling of Joints
☐ Other _____

-SKIN ☐ None ☐ Rash ☐ Ulcers ☐ Abdominal Scars ☐ Sores
☐ Other _____

-NEUROLOGICAL ☐ None ☐ Headaches ☐ Fainting/Blackouts ☐ Numbness, tingling, loss of sensation ☐ Dizziness
☐ Other _____

-PSYCHIATRIC ☐ None ☐ Depression ☐ Nervousness ☐ Anxiety ☐ Mood Swing
☐ Other _____

-ENDOCRINE ☐ None ☐ Excessive thirst or hunger ☐ Hot/cold intolerance ☐ Hot Flashes
☐ Other _____

-HEMATOLOGICAL ☐ None ☐ Easy bruising ☐ Easy bleeding ☐ Anemia
☐ Other _____

Signature: _____ **Date:** _____

NECK DISABILITY INDEX QUESTIONNAIRE

Patient Name _____ **Date** _____

Please read carefully:

This questionnaire has been designed to enable us to understand how your neck pain has affected your ability to manage everyday life. Please answer every section, and mark in each section only ***ONE CHOICE 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 one box, which most closely describes your problem right now.***

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 without causing extra pain.
B. I can look after myself normally but it causes extra pain.
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 gives extra pain.
C. Pain prevents me from lifting heavy objects 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 lift very light weights.
F. I cannot lift or carry anything at all.

SECTION 4 – Reading

A. I can read as much as I want with no pain in my neck.
B. I can read as much as I want with slight pain in my neck.
C. I can read as much as I want with moderate pain in my neck.
D. I cannot read as much as I want because of moderate pain in my neck.
E. I can hardly read at all because of severe pain in my neck.
F. I cannot read at all.

SECTION 5 - Headaches

A. I have no headaches at all.
B. I have slight headaches which come infrequently.
C. I have moderate headaches which come infrequently.
D. I have moderate headaches which come frequently.
E. I have severe headaches which come frequently.
F. I have headaches almost all the time.

SECTION 6 – Concentration

A. I can concentrate fully when I want to with no difficulty.
B. I can concentrate fully when I want to with slight difficulty.
C. I have a fair degree of difficulty in concentrating when I want to.
D. I have a lot of difficulty in concentrating when I want to.
E. I cannot concentrate at all.

SETION 7 – Work

A. I can do as much work as I want to.
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 any work at all.
F. I cannot do any work at all.

SECTION 8 – Driving

A. I can drive without any neck pain.
B. I can drive as long as I want with slight pain in my neck.
C. I can drive as long as I want with moderate pain in my neck.
D. I cannot drive as long as I want because of moderate pain in my neck.
E. I can hardly drive at all because of severe pain in my neck.
F. I cannot drive my car at all.

SECTION 9 – Sleeping

A. I have no trouble sleeping.
B. My sleep is slightly disturbed (less than 1 hr. sleepless).
C. My sleep is mildly disturbed (1-2 hrs. sleepless).
D. My sleep is moderately disturbed (2-5 hrs. sleepless).
E. My sleep is greatly disturbed (3-5 hrs. sleepless).
F. My sleep is completely disturbed (5-7 hrs. sleepless).

SECTION 10 – Recreation

A. I am able to engage in all my recreation activities with no neck pain at all.
B. I am able to engage in all my recreation activities with some pain in my neck.
C. I am able to engage in most, but not all of my usual recreation activities because of pain in my neck.
D. I am able to engage in a few of my usual recreation activities because of pain in my neck.
E. I can hardly do any recreation activities because of pain in my neck.
F. I cannot do any recreation activities at all.

OTHER COMMENTS:

_____

_____

_____

_____
Examiner

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

THE UPPER EXTREMITY FUNCTIONAL INDEX (UEFI)

We are interested in knowing whether you are having any difficulty at all with the activities listed below because of your upper limb problem for which you are currently seeking attention. Please provide an answer for **each** activity.

Today, do you or would you have any difficulty at all with:

(Circle one number on each line)

	Activities	Extreme Difficulty or Unable to Perform Activity	Quite a Bit of Difficulty	Moderate Difficulty	A Little Bit of Difficulty	No Difficulty
1	Any of your usual work, housework, or school activities	0	1	2	3	4
2	Your usual hobbies, re creational or sporting activities	0	1	2	3	4
3	Lifting a bag of groceries to waist level	0	1	2	3	4
4	Lifting a bag of groceries above your head	0	1	2	3	4
5	Grooming your hair	0	1	2	3	4
6	Pushing up on your hands (eg from bathtub or chair)	0	1	2	3	4
7	Preparing food (eg peeling, cutting)	0	1	2	3	4
8	Driving	0	1	2	3	4
9	Vacuuming, sweeping or raking	0	1	2	3	4
10	Dressing	0	1	2	3	4
11	Doing up buttons	0	1	2	3	4
12	Using tools or appliances	0	1	2	3	4
13	Opening doors	0	1	2	3	4
14	Cleaning	0	1	2	3	4
15	Tying or lacing shoes	0	1	2	3	4
16	Sleeping	0	1	2	3	4
17	Laundering clothes (eg washing, ironing, folding)	0	1	2	3	4
18	Opening a jar	0	1	2	3	4
19	Throwing a ball	0	1	2	3	4
20	Carrying a small suitcase with your affected limb	0	1	2	3	4
	Column Totals:					

Minimum Level of Detectable Change (90% Confidence): 9 points

SCORE: _____/80

Source: Stratford PW, Binkley, JM, Stratford DM (2001): Development and initial validation of the upper extremity functional index. Physiotherapy Canada. 53(4):259-267.

OSWESTRY LOW BACK DISABILITY QUESTIONNAIRE

Instructions: this questionnaire has been designed to give us information as to how your back pain has affected your ability to manage everyday life. Please answer every section and mark in each section only the ONE box which applies to you at this time. We realize you may consider 2 of the statements in any section may relate to you, but please mark the box which most closely describes your current condition.

1. PAIN INTENSITY
- ☐ I can tolerate the pain I have without having to use pain killers
- ☐ The pain is bad but I manage without taking pain killers
- ☐ Pain killers give complete relief from pain
- ☐ Pain killers give moderate relief from pain
- ☐ Pain killers give very little relief from pain
- ☐ Pain killers have no effect on the pain and I do not use them

2. PERSONAL CARE (e.g. Washing, Dressing)
- ☐ I can look after myself normally without causing extra pain
- ☐ I can look after myself normally but it causes extra pain
- ☐ 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 self care
- ☐ I don't get dressed, I was with difficulty and stay in bed

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 very light weights
- ☐ I cannot lift or carry anything at all

4. WALKING
- ☐ Pain does not prevent me walking any distance
- ☐ Pain prevents me walking more than one mile
- ☐ Pain prevents me walking more than ½ mile
- ☐ Pain prevents me walking more than ¼ mile
- ☐ I can only walk using a stick or crutches
- ☐ I am in bed most of the time and have to crawl to the toilet

5. SITTING
- ☐ I can sit in any chair as long as I like
- ☐ I can only sit in my favorite chair as long as I like
- ☐ Pain prevents me from sitting more than one hour
- ☐ Pain prevents me from sitting more than ½ hour
- ☐ Pain prevents me from sitting more than 10 minutes
- ☐ Pain prevents me from sitting at all

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 for more than one hour
- ☐ Pain prevents me from standing for more than 30 minutes
- ☐ Pain prevents me from standing for more than 10 minutes
- ☐ Pain prevents me from standing at all

7. SLEEPING
- ☐ Pain does not prevent me from sleeping well
- ☐ I can sleep well only by using medication
- ☐ Even when I take medication, I have less than 6 hrs sleep
- ☐ Even when I take medication, I have less than 4 hrs sleep
- ☐ Even when I take medication, I have less than 2 hrs sleep
- ☐ Pain prevents me from sleeping at all

8. SOCIAL LIFE
- ☐ My social life is normal and gives 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. dancing, etc.
- ☐ Pain has restricted my social life and I do not go out as often
- ☐ Pain has restricted my social life to my home
- ☐ I have no social life because of pain

9. TRAVELLING
- ☐ I can travel anywhere without extra pain
- ☐ I can travel anywhere but it gives me extra pain
- ☐ Pain is bad, but I manage journeys over 2 hours
- ☐ Pain restricts me to journeys of less than 1 hour
- ☐ Pain restricts me to short necessary journeys under 30 minutes
- ☐ Pain prevents me from traveling except to the doctor or hospital

10. EMPLOYMENT/ HOMEMAKING
- ☐ My normal homemaking/ job activities do not cause pain.
- ☐ My normal homemaking/ job activities increase my pain, but I can still perform all that is required of me.
- ☐ I can perform most of my homemaking/ job duties, but pain prevents me from performing more physically stressful activities (e.g. lifting, vacuuming)
- ☐ Pain prevents me from doing anything but light duties.
- ☐ Pain prevents me from doing even light duties.
- ☐ Pain prevents me from performing any job or homemaking chores.

Lower Extremity Functional Index

We are interested in knowing whether you are having any difficulty at all with the activities listed below because of your lower limb problem for which you are currently seeking attention. Please provide an answer for each activity.

Today, do you or would you have any difficulty at all with:

(Circle one number on each line)

Activities	Extreme Difficulty or unable to perform activity	Quite a bit of difficulty	Moderate difficulty	A little bit of difficulty	No difficulty
a. Any of your usual work, housework or school activities.	0	1	2	3	4
b. Your usual hobbies, recreational or sporting activities	0	1	2	3	4
c. Getting into or out of the bath.	0	1	2	3	4
d. Walking between rooms.	0	1	2	3	4
e. Putting on your shoes or socks.	0	1	2	3	4
f. Squatting.	0	1	2	3	4
g. Lifting an object, like a bag of groceries from the floor.	0	1	2	3	4
h. Performing light activities around your home.	0	1	2	3	4
i. Performing heavy activities around your home.	0	1	2	3	4
j. Getting into or out of a car.	0	1	2	3	4
k. Walking 2 blocks.	0	1	2	3	4
l. Walking a mile.	0	1	2	3	4
m. Going up or down 10 stairs (about 1 flight of stairs).	0	1	2	3	4
n. Standing for 1 hour.	0	1	2	3	4
o. Sitting for 1 hour.	0	1	2	3	4
p. Running on even ground.	0	1	2	3	4
q. Running on uneven ground.	0	1	2	3	4
r. Making sharp turns while running fast.	0	1	2	3	4
s. Hopping.	0	1	2	3	4
t. Rolling over in bed.	0	1	2	3	4
COLUMN TOTALS					

Score variation ± 6 LEFTS points
MDC & MCID = 9 LEFS points

Score _____/80

STRESS SURVEY

PURPOSE: To determine if any health problems you may be having are due to stress.

Name _____ Age _____ Phone (Home) _____ (Work) _____

Address _____ City _____ State/Prov. _____ Zip/Postal _____

E-mail address _____ Cell Phone _____

Occupation _____ # Hours per week currently working _____

1 Check off any of the following symptoms you have experienced in the past 30 days:

- ☐ Headaches/Migraines
- ☐ Fatigue
- ☐ Pain/Tension/Numbness
  - ☐ Neck ☐ Legs
  - ☐ Shoulders ☐ Arms
  - ☐ Low Back ☐ Hands
- ☐ Insomnia/Sleep Problems
- ☐ Irritability
- ☐ Digestive Trouble
  - ☐ Constipation
  - ☐ Diarrhea ☐ Gas
  - ☐ Bloating
- ☐ Sinus Problems/Allergies
- ☐ Menstrual/Hormone Problems
- ☐ Asthma
- ☐ Stress/Anxiety
- ☐ Bladder Trouble
- ☐ Ringing in Ears
- ☐ Nervousness
- ☐ Dizziness
- ☐ Weight Trouble
- ☐ Other _____

Which of the above bothers you the most? _____

How long have you been bothered by the condition? _____

2 Does this problem affect your ability to enjoy work?

☐ Yes
☐ No

3 Does this problem affect your ability to enjoy family and friends?

☐ Yes
☐ No

4 Does this problem affect your ability to sleep?

☐ Yes
☐ No

If you checked any of the above items, then you could be suffering from:

- **UNDETECTED NERVE DAMAGE**
- **DESTRUCTIVE EFFECTS OF STRESS**
- **CHEMICAL TOXICITY**

If you could eliminate one of the above which would it be? _____

There are several alternatives available to you. Please check the item most appropriate for you.

❑ I would like to come to the Doctor's office for a free in depth consultation and testing to determine the cause of my problems.

❑ I would like the Doctor to call me to discuss my health problems before making an appointment.

❑ I would like to come in on: ❑ Monday ❑ Tuesday ❑ Wednesday ❑ Thursday ❑ Friday ❑ A.M. ❑ P.M.

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Fair Lawn Spine & Injury Center

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Phone (201) 773-0909 • Fax (201) 625-6505

HIPAA Patient Privacy Statement

We may use and disclose your PHI (private health information) in response to a court administrative order, if you are involved in a lawsuit or similar proceeding. We may also disclose your PHI in response to a discovery request, subpoena, or other lawful process by another party involved in the dispute.

We may use or disclose your PHI for workers compensation and similar programs.

We may use a sign-in sheet at the front desk and we may call you in to see the doctor by name.

We may contact you by mail or phone, at your residence, to remind you of appointments or to provide information about treatment alternatives. Unless you instruct us otherwise, we may mail you a postcard reminding you to make an appointment and we may leave a message for you on any answering device or with any person who answers the phone at your residence.

You can make a reasonable request for us to use alternative methods of communicating with you in a confidential manner. These requests must be submitted in writing in a clear and concise fashion. We are not required to agree to your request. However, if we do agree, we are bound by our agreement except when otherwise required by law, in emergencies or when information is necessary to treat you.

Rights that you have:
You have the right to inspect and obtain copies of your medical information. (A fee for the costs of copying, mailing, labor and supplies associated with your request will be charged.)

You have the right to request amendments to your medical information. Such requests must be submitted in writing, and must state the reason for the requested amendment. We will notify you as to whether we agree or disagree with the requested amendment. If we disagree with any requested amendment, we will further notify you of your rights.

You have the right to request an accounting of any disclosure we make of your medical information except for disclosures we make to you, to carry out treatment, payment or healthcare operations, as requested by your written authorization, as permitted or required under 45 CFR 164.502, for emergency or notification purposes, for national security or intelligence purposes as permitted by law, or to correctional facilities or law enforcement officials as permitted by law.

You have the right to receive a paper copy of this notice. To obtain a paper copy of this notice, please contact our office manager.

You have the right to file a complaint if you believe your privacy rights have been violated. You may file a complaint with our practice or with the Secretary of the Department of Health and Human Services. All complaints must be submitted in writing and addressed to this office at the above address. You will not be penalized for filing a complaint.

This privacy policy is subject to change as circumstances dictate. Any changes will be effective upon the release of a revised privacy policy, which will be made available to patients upon request.

Please sign and date below to acknowledge that you have read this policy and that you consent to the terms of our privacy policy as stated in this notice.

_____ _____
(Print Patient Name) (Date)

_____ _____
(Signature of Patient or Legal Guardian) (If Legal Guardian, Relationship to Patient)

Fair Lawn Spine & Injury Center, LLC

Vincent Taffuri, DC
23-00 Route 208 South Suite 2-6
Fair Lawn, NJ 07410
Phone: (201) 773-0909
Fax (201) 625-6505

Vincent M. Taffuri, DC, DAAMLP
Nick Kuzmanovski, DPT

CHIROPRACTIC AND PHYSICAL THERAPY INFORMED CONSENT TO TREAT

I hereby request and consent to the performance of chiropractic adjustments and other chiropractic procedures, including various modes of physical therapy and diagnostic x-rays and/or other tests on me (or the patient named below, for whom I am legally responsible) by the doctors of chiropractic and physical therapy named above, including those working at the clinic or office listed above or any other office or clinic, whether signatories to this form or not.

I have had an opportunity to discuss with the above-named doctors and/or with other office or clinic personnel, the nature and purpose of chiropractic adjustments and physical therapy procedures. I understand that results are not guaranteed.

I understand and am informed that, as in the practice of medicine, in the practice of chiropractic there are some risks to treatment, including, but not limited to, fracture, disc injuries, stroke, dislocations, falls, dizziness, headaches, burns with modalities and sprains. I do expect the doctor to exercise judgment during the course of the procedure which the doctor feels at the time, based upon the facts then known, is in my best interest.

I have read, or had read to me, the above consent. I have also had an opportunity to ask questions about its content, and by signing below I agree to the above-named procedures. I intend this consent form to cover the entire course of treatment for my present condition and for any future condition(s) for which I seek treatment.

_____ _____
(Print Patient Name) (Date)

_____ _____
(Signature of Patient or Legal Guardian) (If Legal Guardian, Relationship to Patient)

Taffuri *Integrated Wellness Centers*

23-00 Route 208 South, Suite 2-6
Fair Lawn, NJ 07410
https://taffuriwellness.com
Ph: (201) 773-0909 • F: (201) 625-6505

Vincent M. Taffuri, DC, DAAMLP
Nick Kuzmanovski, DPT

WAIVER

I have responded to an advertisement for a free consultation at Taffuri Integrated Wellness Centers. Dr. Taffuri has explained to me that, pursuant to the regulations of the New Jersey Board of Chiropractic Examiners, he cannot charge for any service rendered during a period of 24 hours from the time he gives me the free consultation unless there is an immediate need for service and I sign this waiver.

I have what I believe is a need for immediate chiropractic care and/or physical therapy. Therefore, I agree to sign this waiver and pay for the immediate chiropractic care and/or physical therapy rendered within the 24-hour period.

_____ _____
(Print Patient Name) (Date)

_____ _____
(Signature of Patient or Legal Guardian) (If Legal Guardian, Relationship to Patient)

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Patient Financial Responsibility Form

I _____ have been made aware that Taffuri Integrated Wellness Centers (**TIWC**) is an **OUT-OF-NETWORK PROVIDER**.

I am financially responsible for a co-insurance payment of $_____ ***per visit*** for chiropractic / physical therapy services provided. Please choose one of the following options:

- ❑ In order to save time at the end of each appointment, I would like to prepay for _____ visits at $_____ per visit, totaling $_____.
- ❑ I agree to bring payment with me at the time of each appointment, with no exceptions.

I will receive an **Explanation of Benefits (EOB)** with or without **checks** from my insurance company for services provided.

I must bring all **CHECKS AND EOB's TO TIWC. I agree to endorse any checks received from my insurance company and turn them all over to TIWC as payment for services rendered.** I understand that I will not receive an itemized invoice from **TIWC** but I can request copies of all insurance documents for services rendered.

TIWC reserves the right to collect on balances due. If checks are not brought into the office within one week after receipt, I give my permission for **TIWC** to charge my credit card on file for the amount of the insurance check.

I acknowledge I may be charged a "Missed Appointment" fee of $50.00 if I do not show up for my appointment or I do not cancel/reschedule the appointment 24 hours in advance for reasons outside of illness or emergency. My credit card will be on file, and my signature on this form will act as permission to run my card should the above situation occur.

I UNDERSTAND THAT I AM PERSONALLY RESPONSIBLE FOR CHARGES INCURRED FOR SERVICES RENDERED BY THE OFFICE OF **TIWC** IF ANY OF THE FOLLOWING APPLY:

1. I have chosen not to use my medical coverage at the time services are rendered.
2. My health plan does not cover 100% of the services rendered for any reason.
3. I did not provide **TIWC** with the correct insurance information.
4. I have not obtained the proper referral or authorization for the services provided.
5. My benefit parameters limit or exclude therapy services for any reason.
6. My coverage changes during the course of therapy.
7. I exceeded my benefit limitations.

I agree to provide **TIWC** with a copy of a current credit card to remain on file, in a secure location, for the duration of services, only to be used in the above circumstances. If the card becomes invalid for any reason, I will promptly contact **TIWC** to provide a valid credit card which will remain on file.

I agree to the terms outlined above.

_____ _____
(Patient Signature) (Date)

_____
(Witness – TIWC)

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Authorization for Credit Card Use

ALL INFORMATION WILL REMAIN CONFIDENTIAL

Name on Card: _____

Billing Address: _____

_____

Credit Card Type: _____ VISA _____Mastercard _____ Discover _____ AMEX

Credit Card Number: _____

Expiration Date: _____

Card Identification Number: _____ (last 3 digits located on the back of the credit card)

I agree to provide **TIWC** with a copy of a current credit card to remain on file, in a secure location, for the duration of services, only to be used for the circumstances mentioned in the Patient Financial Responsibility Form. If the card becomes invalid for any reason, I will promptly contact **TIWC** to provide a valid credit card which will remain on file.

Cardholder – Please Sign and Date:

Signature: _____

Date: _____

Print Name: _____