6605 Pittsford-Palmrya Road, #E9 Fairport, NY 14450 P: 585-223-1580 F: 585-223-1582 PT Initials:_____DOB:_____

Proactive Chiropractic
PATIENT INFORMATION

Date:_____ Main Phone: _____ Email: _____

Last Name: _____First Name:_____Initial:____

Address:_____

City: _____ State: _____ Zip: _____ Age: _____ DOB: _____

Sex: ☐ Male ☐ Female

INSURANCE INFORMATION

Insurance company or health care plan name: _____

Name of Primary Subscriber:_____ID#:_____

Date of Birth of Primary subscriber:_____Effective Date:_____

Medical Information

Family Physician or Primary Doctor:_____

Contact Person for emergency:_____ PH: _____

Patient Agreement & Authorization For The Release Of Medical And Health Plan Documents For The Claims Processing & Reimbursement As Required by Federal and State Laws

All types of health care require sharing information. Correspondence between doctor and patient may need to be shared with insurance carriers. Some insurance policies require office notes. The doctor and staff may seek imaging reports, blood work & other doctor notes to better understand your condition. Sometimes a note to an employer or school may be necessary. All children under 18 must be accompanied by parent or guardian with signature. I hereby authorize the above named provider(s) to release all medical information necessary to process my claims under HIPAA.

INFORMED CONSENT

The following is a description and agreement to your understanding of the care we recommend, the benefits and risks associated with that care, its alternatives, and the potential effect on your health if you choose not to receive the care. Chiropractic care can involve what is known as a chiropractic adjustment. There may be additional supportive procedures or recommendations as well. When providing an adjustment, we use our hands or instruments to reposition anatomical structures such as vertebrae. Potential benefits include restoring normal joint motion, reducing swelling and inflammation, decreased pain in the joint and improved neurological function.

It is important you understand, as with all health approaches, results are not guaranteed. There is no promise to cure. Also as with all health care interventions there are risks involved which include but are not limited to; muscle spasm, aggravating or temporary increase in symptoms, lack of improvement of symptoms, fractures, disc injuries, strokes, strains and sprains. With strokes, there is a very rare but serious condition known as cervical arterial dissection that involves an abnormal change in the artery wall. This abnormality can lead to a clot in the vessel and ultimately a possible stroke. This medical condition can occur in anybody seeking care from a medical doctor or chiropractor. The chiropractic adjustment association with stroke is exceedingly rare and is estimated to be 1:1,000,000 to 1:2,000,000.

Alternative treatment to chiropractic care includes: drugs, surgery, injections, massage, exercise, physical therapy or nothing. By initiating care here you are choosing a trial of chiropractic care.

I agree and consent to the treatment plan to deliver the care that, in his or her professional judgment, 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. It doesn't claim to cure any named disease.

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.

I have read the above consent and have asked any questions. By signing I agree with the current or future recommendations to receive chiropractic care as deemed appropriate for my circumstance. This consent will cover my entire course of care here in the office.

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.

PATIENT SIGNATURE: _____ Date: _____

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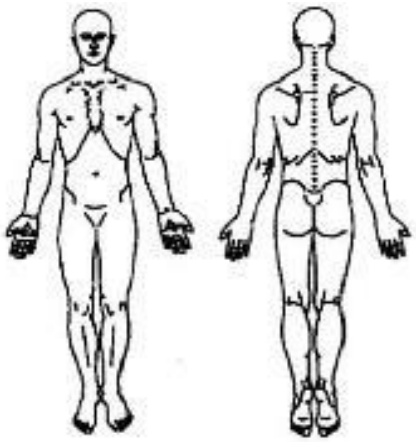
1. What is bothering you today?: _____
2. Onset: When/how did you first notice your symptoms:_____

   _____
3. How often do you experience pain: ☐ Constant ☐ Frequent ☐ Occasional
4. Intensity of Symptoms: Absent 0 – 1 – 2 – 3 – 4 – 5 – 6 – 7 – 8 – 9 – 10 Agonizing
5. Quality of Symptoms:

Numbness____	Tingling_____
Stiffness____	Dull_____
Aching_____	Cramps_____
Nagging_____	Sharp_____
Burning_____	Shooting____
Throbbing_____	Stabbing____
Other:_____	

Where does it hurt?



Please draw on diagram

6. Radiation- Does it affect other areas? Does the pain radiate or travel?

_____

7. What tends to lessen or relieve the problem?

_____

8. What tends to increase or aggravate the problem?

_____

9. Prior treatment or intervention: _____

What else should we know about your current condition?

_____ Dr. Initials

Effects on sleep: Does pain wake you up? _____

HEALTH GOAL: What is one activity you wish to do pain free to improve your quality of life?

_____

Effects on Daily Living: Circle for each activity listed below if applicable:

Sitting	mild	moderate	severe	**Standing**	mild	moderate	severe
Walking	mild	moderate	severe	**lying down**	mild	moderate	severe
Bending over	mild	moderate	severe	**Climbing stairs**	mild	moderate	severe
Driving	mild	moderate	severe	**Caring for family**	mild	moderate	severe
House work	mild	moderate	severe	**Lifting objects**	mild	moderate	severe
Sleep	mild	moderate	severe	**Working**	mild	moderate	severe

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Review of Systems: Please check any symptoms you've HAD or currently HAVE

Osteoporosis ___ Scoliosis___ Neck Pain ___ Low Back Pain__ Hip Disorders___
Headaches___ Numbness___ Dizziness___ Degenerative Joint Disease___ Other: _____

MEDICAL HISTORY

A. Surgeries or Operations:_____ Arthritis/Rheumatoid:_____
B. Past Injuries: Fractured bone:_____Spine or Nerve Disorder_____
C. Knocked unconscious:_____Used neck/back Bracing:_____ Smoker: **Y /N** Injured in an accident:_____
D. List all current medications/supplements: _____Blood Thinner: **Y or N**
E. Family/hereditary Spine Problems:_____

BACK PAIN QUESTIONAIRE FOR INSURANCE- PLEASE "X" ONE CIRCLE IN EACH BOX

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	I can stand as long as I want without extra pain I can stand as long as I want but, gives me extra pain Pain prevents me from standing for more than 1hr Pain prevents me from standing for more than 30min Pain prevents me from standing for more than 10min Pain prevents me from standing at all
I can look after myself normally without 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 do not get dressed, I wash with difficulty/stay in bed	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
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 placed Pain prevents me from lifting heavy weights, but I can manage light/medium weights if conveniently placed I can lift very light weights I cannot lift or carry anything at all	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 Pain has restricted my social life, I do not go out as often Pain has restricted my social life to my home I have no social life because of pain
Pain does not prevent me walking any distance Pain prevents me from walking more than 1 mile Pain prevents me from walking more than ½ mile Pain prevents me from walking more than 100 yards I can only walk using a stick or crutches I am in bed most of the time	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 sitting more than one hour Pain prevents me from sitting more than 30 minutes Pain prevents me from sitting more than 10 minutes Pain prevents me from sitting at all
My normal home/job activites do not cause pain My home/job activites do cause pain but can still perform My normal home/job activites cause pain and prevents me from more physically demanding activities Pain prevents me from doing anything but light duties Pain prevents me from performing even light duties Pain prevents me from doing and job or house chore	I can travel anywhere without pain I can travel anywhere but it gives me extra pain Pain is bad but I manage journeys over two hours Pain restricts me to journeys of less than one hour Pain restricts me to short necessary journeys under ½ hr Pain prevents me from travelling except for treatment