



**NORTH CASTLE CHIROPRACTIC**  
**ORTHOPEDICS - REHABILITATION**

*Restoring wellness and vitality, naturally.*

**CONFIDENTIAL PATIENT CASE HISTORY**

Name \_\_\_\_\_ Social Security # \_\_\_\_\_

Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Home Phone \_\_\_\_\_ Work Phone \_\_\_\_\_ Cell Phone \_\_\_\_\_

E-mail: \_\_\_\_\_ D.O.B.: \_\_\_\_\_ Age: \_\_\_\_\_

Sex: M F Marital Status: M S W D # Children: \_\_\_\_\_

Employer \_\_\_\_\_ Occupation \_\_\_\_\_

Spouse's Name \_\_\_\_\_ Spouse's Office Telephone \_\_\_\_\_

Spouse's Employer \_\_\_\_\_ Occupation \_\_\_\_\_

Referred by \_\_\_\_\_ Nearest Relative & Telephone \_\_\_\_\_

**INSURANCE INFORMATION:**

Is your condition due to an auto accident or job related injury? YES NO

Do you have Health Insurance? YES NO If yes:

Name of Company \_\_\_\_\_ Policy # \_\_\_\_\_

Phone # \_\_\_\_\_ Insured's Name \_\_\_\_\_ Insured's D.O.B. \_\_\_\_\_

**I AUTHORIZE PAYMENT OF BENEFITS DIRECTLY TO SETH M. WOLIN, D.C.** \_\_\_\_\_

**Signature**

Are you covered by Medicare? YES NO Medicare # \_\_\_\_\_

I understand and agree that health and accident policies are an arrangement between an insurance carrier and myself. Furthermore, I understand that this Chiropractic Office will prepare any necessary reports and forms to assist me in making collection from the insurance company and that any amount authorized to be paid directly to this Chiropractic Office will be credited to my account upon receipt. I authorize the release of any medical or other information necessary to process this claim. I clearly understand and agree that all services rendered me are charged directly to me and that I am personally responsible for payment. I also understand that if I suspend or terminate my care and treatment, any fees for professional services rendered me will be immediately due and payable. All accounts not paid within 30 days will be subject to interest and a rebilling fee of \$5 monthly. Your balance will be charged to your credit card or may be sent to collection. If your account is sent to a collection agency, you agree to reimburse us 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 that we incur in such collection efforts. Bounced checks will incur a reprocessing fee.

Patients Signature \_\_\_\_\_ Date \_\_\_\_\_

**I will be paying today by: Cash Check Credit Card- circle one: MC – Visa – Discover**

**Card# \_\_\_\_\_ Exp. Date \_\_\_\_\_ Vcode \_\_\_\_\_**

Patients Signature (for credit card) \_\_\_\_\_ Date \_\_\_\_\_

Guardian or Spouse's Signature \_\_\_\_\_ S.S.# \_\_\_\_\_

# Patient Health Questionnaire

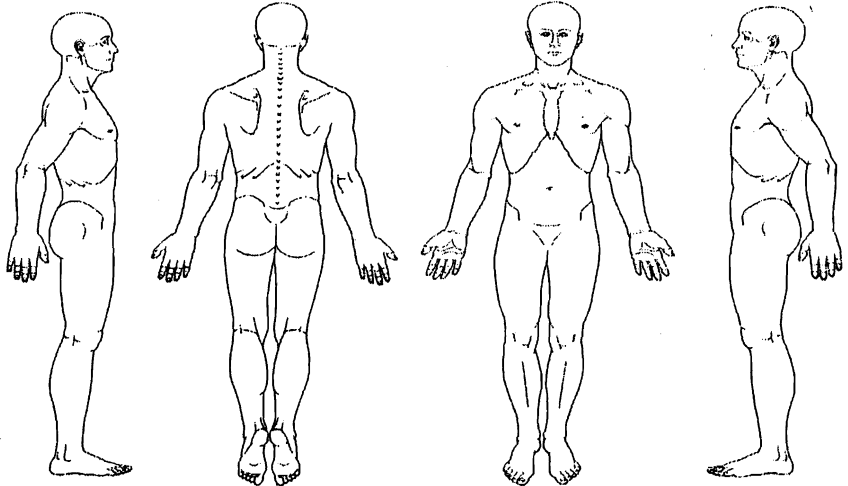
Patient Name \_\_\_\_\_

Date \_\_\_\_\_

1. When did your symptoms start: \_\_\_\_\_ Describe your symptoms and how they began: \_\_\_\_\_

2. How often do you experience your symptoms? Indicate where you have pain or other symptoms

- ① Constantly (76-100% of the day)
- ② Frequently (51-75% of the day)
- ③ Occasionally (26-50% of the day)
- ④ Intermittently (0-25% of the day)



3. What describes the nature of your symptoms?

- ① Sharp
- ② Dull ache
- ③ Numb
- ④ Shooting
- ⑤ Burning
- ⑥ Tingling

4. How are your symptoms changing?

- ① Getting Better
- ② Not Changing
- ③ Getting Worse

5. How bad are your symptoms at their:

- None Unbearable
- a. worst: ① ② ③ ④ ⑤ ⑥ ⑦ ⑧ ⑨ ⑩
- b. best: ① ② ③ ④ ⑤ ⑥ ⑦ ⑧ ⑨ ⑩

6. How do your symptoms affect your ability to perform daily activities?

- ① No complaints      ② Mild, forgotten with activity      ③ Moderate, interferes with activity      ④ Limiting, prevents full activity      ⑤ Intense, preoccupied with seeking relief      ⑥ Severe, no activity possible

7. What activities make your symptoms worse: \_\_\_\_\_

8. What activities make your symptoms better: \_\_\_\_\_

9. Who have you seen for your symptoms?

- ① No One
- ② Other Chiropractor
- ③ Medical Doctor
- ④ Physical Therapist
- ⑤ Other

a. When and what treatment? \_\_\_\_\_

b. What tests have you had for your symptoms and when were they performed?

- ① Xrays date: \_\_\_\_\_
- ② MRI date: \_\_\_\_\_
- ③ CT Scan date: \_\_\_\_\_
- ④ Other date: \_\_\_\_\_

10. Have you had similar symptoms in the past?

- ① Yes
- ② No

a. If you have received treatment in the past for the same or similar symptoms, who did you see?

- ① This Office
- ② Other Chiropractor
- ③ Medical Doctor
- ④ Physical Therapist
- ⑤ Other

11. What is your occupation?

- ① Professional/Executive
- ② White Collar/Secretarial
- ③ Tradesperson
- ④ Laborer
- ⑤ Homemaker
- ⑥ FT Student
- ⑦ Retired
- ⑧ Other

a. If you are not retired, a homemaker, or a student, what is your current work status?

- ① Full-time
- ② Part-time
- ③ Self-employed
- ④ Unemployed
- ⑤ Off work
- ⑥ Other

12. What do you hope to get from your visit/treatment (select all that apply):

- ① Reduce symptoms
- ② Resume/increase activity
- ③ Explanation of condition/treatment
- ④ Learn how to take care of this on my own
- ⑤ How to prevent this from occurring again
- ⑥

Patient Signature \_\_\_\_\_

Date \_\_\_\_\_



# Patient Health Questionnaire - page 2

American Chiropractic Network

ACN Use Only rev 4/23/99

Patient Name \_\_\_\_\_ Date \_\_\_\_\_

What type of regular exercise do you perform?      ① None      ② Light      ③ Moderate      ④ Strenuous

What is your height and weight?      Height 

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      Weight 

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 lbs.  
Feet      Inches

**For each of the conditions listed below, place a check in the Past column if you have had the condition in the past. If you presently have a condition listed below, place a check in the Present column.**

Past	Present	Past	Present	Past	Present
<input type="checkbox"/>	<input type="checkbox"/> Headaches	<input type="checkbox"/>	<input type="checkbox"/> High Blood Pressure	<input type="checkbox"/>	<input type="checkbox"/> Diabetes
<input type="checkbox"/>	<input type="checkbox"/> Neck Pain	<input type="checkbox"/>	<input type="checkbox"/> Heart Attack	<input type="checkbox"/>	<input type="checkbox"/> Excessive Thirst
<input type="checkbox"/>	<input type="checkbox"/> Upper Back Pain	<input type="checkbox"/>	<input type="checkbox"/> Chest Pains	<input type="checkbox"/>	<input type="checkbox"/> Frequent Urination
<input type="checkbox"/>	<input type="checkbox"/> Mid Back Pain	<input type="checkbox"/>	<input type="checkbox"/> Stroke	<input type="checkbox"/>	<input type="checkbox"/> Smoking/Use Tobacco Products
<input type="checkbox"/>	<input type="checkbox"/> Low Back Pain	<input type="checkbox"/>	<input type="checkbox"/> Angina	<input type="checkbox"/>	<input type="checkbox"/> Drug/Alcohol Dependence
<input type="checkbox"/>	<input type="checkbox"/> Shoulder Pain	<input type="checkbox"/>	<input type="checkbox"/> Kidney Stones	<input type="checkbox"/>	<input type="checkbox"/> Allergies
<input type="checkbox"/>	<input type="checkbox"/> Elbow/Upper Arm Pain	<input type="checkbox"/>	<input type="checkbox"/> Kidney Disorders	<input type="checkbox"/>	<input type="checkbox"/> Depression
<input type="checkbox"/>	<input type="checkbox"/> Wrist Pain	<input type="checkbox"/>	<input type="checkbox"/> Bladder Infection	<input type="checkbox"/>	<input type="checkbox"/> Systemic Lupus
<input type="checkbox"/>	<input type="checkbox"/> Hand Pain	<input type="checkbox"/>	<input type="checkbox"/> Painful Urination	<input type="checkbox"/>	<input type="checkbox"/> Epilepsy
<input type="checkbox"/>	<input type="checkbox"/> Hip/Upper Leg Pain	<input type="checkbox"/>	<input type="checkbox"/> Loss of Bladder Control	<input type="checkbox"/>	<input type="checkbox"/> Dermatitis/Eczema/Rash
<input type="checkbox"/>	<input type="checkbox"/> Knee/Lower Leg Pain	<input type="checkbox"/>	<input type="checkbox"/> Prostate Problems	<input type="checkbox"/>	<input type="checkbox"/> HIV/AIDS
<input type="checkbox"/>	<input type="checkbox"/> Ankle/Foot Pain	<input type="checkbox"/>	<input type="checkbox"/> Abnormal Weight Gain/Loss	<input type="checkbox"/>	
<input type="checkbox"/>	<input type="checkbox"/> Jaw Pain	<input type="checkbox"/>	<input type="checkbox"/> Loss of Appetite	<input type="checkbox"/>	<b>Females Only</b>
<input type="checkbox"/>	<input type="checkbox"/> Joint Swelling/Stiffness	<input type="checkbox"/>	<input type="checkbox"/> Abdominal Pain	<input type="checkbox"/>	<input type="checkbox"/> Birth Control Pills
<input type="checkbox"/>	<input type="checkbox"/> Arthritis	<input type="checkbox"/>	<input type="checkbox"/> Ulcer	<input type="checkbox"/>	<input type="checkbox"/> Hormonal Replacement
<input type="checkbox"/>	<input type="checkbox"/> Rheumatoid Arthritis	<input type="checkbox"/>	<input type="checkbox"/> Hepatitis	<input type="checkbox"/>	<input type="checkbox"/> Pregnancy
<input type="checkbox"/>	<input type="checkbox"/> General Fatigue	<input type="checkbox"/>	<input type="checkbox"/> Liver/Gall Bladder Disorder	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/> Muscular Incoordination	<input type="checkbox"/>	<input type="checkbox"/> Cancer	<input type="checkbox"/>	<b>Other Health Problems/Issues</b>
<input type="checkbox"/>	<input type="checkbox"/> Visual Disturbances	<input type="checkbox"/>	<input type="checkbox"/> Tumor	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/> Dizziness	<input type="checkbox"/>	<input type="checkbox"/> Asthma	<input type="checkbox"/>	<input type="checkbox"/>
		<input type="checkbox"/>	<input type="checkbox"/> Chronic Sinusitis	<input type="checkbox"/>	<input type="checkbox"/>

**Indicate if an immediate family member has had any of the following:**

- Rheumatoid Arthritis   
  Heart Problems   
  Diabetes   
  Cancer   
  Lupus   
  \_\_\_\_\_

**List all prescription and over-the-counter medications, and nutritional/herbal supplements you are taking:**

\_\_\_\_\_

\_\_\_\_\_

**List all the surgical procedures you have had and times you have been hospitalized:**

\_\_\_\_\_

\_\_\_\_\_

Patient Signature \_\_\_\_\_ Date \_\_\_\_\_

Doctor's Additional Comments

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Doctors Signature \_\_\_\_\_ Date \_\_\_\_\_

# The Neck Disability Index

Patient name: \_\_\_\_\_ File# \_\_\_\_\_ Date: \_\_\_\_\_

Please read instructions:

This questionnaire has been designed to give the doctor information as to how your neck pain has affected your ability to manage everyday life. Please answer every section and mark in each section only the ONE box that applies to you. We realize that you may consider that two of the statements in any one section relate to you, but please just mark the box that 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 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 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, for example, on a table.
- Pain prevents me from lifting heavy weights off the floor, 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.

## SECTION 4-READING

- I can read as much as I want to, with no pain in my neck.
- I can read as much as I want to, with slight pain in my neck.
- I can read as much as I want to, with moderate pain in my neck.
- I can't read as much as I want, because of moderate pain in my neck.
- I can hardly read at all, because of severe pain in my neck.
- I cannot read at all.

## SECTION 5-HEADACHES

- I have no headaches at all.
- I have slight headaches that come infrequently.
- I have moderate headaches that come infrequently.
- I have moderate headaches that come frequently.
- I have severe headaches that come frequently.
- I have headaches almost all the time.

Instructions:

1. The NDI is scored in the same way as the Oswestry Disability Index.

2. Using this system, a score of 10-28% (i.e., 5-14 points) is considered by the authors to constitute mild disability; 30-48% is moderate; 50-68% is severe; 72% or more is complete.

## SECTION 6-CONCENTRATION

- I can concentrate fully when I want to, with no difficulty.
- I can concentrate fully when I want to, with slight difficulty.
- I have a fair degree of difficulty in concentrating when I want to.
- I have a lot of difficulty in concentrating when I want to.
- I have a great deal of difficulty in concentrating when I want to.
- I cannot concentrate at all.

## SECTION 7-WORK

- I can do as much work as I want to.
- I can do my usual work, but no more.
- I can do most of my usual work, but no more.
- I cannot do my usual work.
- I can hardly do any work at all.
- I can't do any work at all.

## SECTION 8-DRIVING

- I can drive my car without any neck pain.
- I can drive my car as long as I want, with slight pain in my neck.
- I can drive my car as long as I want, with moderate pain in my neck.
- I can't drive my car as long as I want, because of moderate pain in my neck.
- I can hardly drive at all, because of severe pain in my neck.
- I can't drive my car at all.

## SECTION 9-SLEEPING

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

## SECTION 10-RECREATION

- I am able to engage in all my recreation activities, with no neck pain at all.
- I am able to engage in all my recreation activities, with some neck pain at all.
- I am able to engage in most, but not all, of my usual recreation activities, because of pain in my neck.
- I am able to engage in few of my recreation activities, because of pain in my neck.
- I can hardly do any recreation activities, because of pain in my neck.
- I can't do any recreation activities at all.

## The Revised Oswestry Disability Index (for low back pain/dysfunction)

Patient name: \_\_\_\_\_ File # \_\_\_\_\_ Date: \_\_\_\_\_

This questionnaire has been designed to give the doctor 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 that applies to you. We realize that you may consider that two of the statements in any one section relate to you, but please just mark the box that most closely describes your problem.

### SECTION 1-PAIN INTENSITY

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

### SECTION 2-PERSONAL CARE

- I would not have to change my way of washing or dressing in order to avoid pain.
- I do not normally change my way of washing or dressing even though it causes some pain.
- Washing and dressing increases the pain, but I manage not to change my way of doing it.
- Washing and dressing increases the pain and I find it necessary to change my way of doing it.
- Because of the pain, I am unable to do some washing and dressing without help.
- Because of the pain, I am unable to do any washing and dressing without help.

### SECTION 3-LIFTING

- I can lift heavy weights without extra pain.
- I can lift heavy weights, but it causes extra pain.
- Pain prevents me from lifting heavy weights off the floor, but I manage if they are conveniently positioned (e.g., on a table).
- Pain prevents me from lifting heavy weights off the floor.
- Pain prevents me from lifting heavy weights, but I can manage light to medium weights if they are conveniently positioned.
- I can only lift very light weights at the most.

### SECTION 4-WALKING

- I have no pain on walking.
- I have some pain on walking, but it does not increase with distance.
- I cannot walk more than one mile without increasing pain.
- I cannot walk more than 1/2 mile without increasing pain.
- I cannot walk more than 1/4 mile without increasing pain.
- I cannot walk at all without increasing pain.

### SECTION 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 1/2 hour.
- Pain prevents me from sitting more 10 minutes.
- I avoid sitting because it increases pain right away.

### SECTION 6-STANDING

- I can stand as long as I want without pain.
- I have some pain on standing, but it does not increase with time.
- I cannot stand for longer than one hour without increasing pain.
- I cannot stand for longer than 1/2 hour without increasing pain.
- I cannot stand for longer than 10 minutes without increasing pain.
- I avoid standing because it increases the pain right away.

### SECTION 7-SLEEPING

- I get no pain in bed.
- I get pain in bed, but it does not prevent me from sleeping well.
- Because of pain, my normal night's sleep is reduced by less than 1/4.
- Because of pain, my normal night's sleep is reduced by less than 1/2.
- Because of pain, my normal night's sleep is reduced by less than 3/4.
- Pain prevents me from sleeping at all.

### SECTION 8-SOCIAL LIFE

- My social life is normal and gives me no 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, e.g., dancing, etc.
- Pain has restricted my social life and I do not go out very often.
- Pain has restricted my social life to my home.
- I have hardly any social life because of the pain.

### SECTION 9-TRAVELLING

- I get no pain while travelling.
- I get some pain while travelling, but none of my usual forms of travel makes it any worse.
- I get extra pain while travelling, but it does not compel me to seek alternative forms of travel.
- I get extra pain while travelling, which compels me to seek alternative forms of travel.
- Pain restricts all forms of travel.
- Pain prevents all forms of travel except that done lying down.

### SECTION 10-CHANGING DEGREE OF PAIN

- My pain is rapidly getting better.
- My pain fluctuates, but is definitively getting better.
- My pain seems to be getting better, but improvement is slow at present.
- My pain is neither getting better nor worse.
- My pain is gradually worsening.
- My pain is rapidly worsening.

**NORTH CASTLE CHIROPRACTIC  
HEALTH GOAL AND ORIENTATION QUESTIONNAIRE**

*What are your goals regarding your health?*

- A. Pain relief only
- B. Correction of the structural and functional problems causing your complaint
- C. Total health and wellness

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- D. Do you exercise regularly?  **yes**  **no**  
If yes, please describe what form, how often and how long per session.

- E. Do you take nutritional supplements?  **yes**  **no**  
If yes, what do you take?

North Castle Chiropractic  
Seth M. Wolin, D.C., D.A.B.C.O.  
2 Byram Brook Place  
Armonk, NY 10504

Cancellation Policy

As a courtesy to all our patients, please remember to call us as soon as you know that you will be unable to make your scheduled appointment and we'd be happy to reschedule it for you. If we are not in the office, be sure to leave a message.

Please Note: If you miss an appointment, or fail to give us at least 24 hours notice, you will be required to pay a \$50 fee.

Monday appointments must be cancelled by Friday at noon.

We greatly appreciate your understanding and assistance.

Please sign below to consent to these terms.

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Patient's Signature (Parent/Guardian if under 18)

Date \_\_\_\_\_