



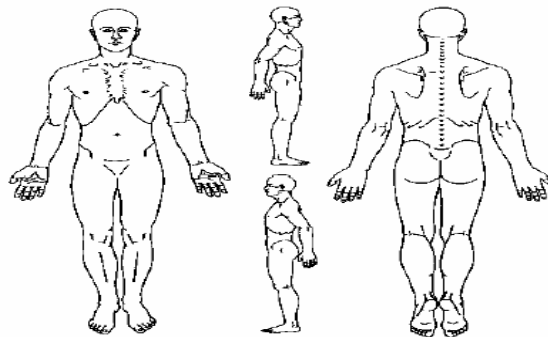
810 CENTER ROAD, WEST SENECA, NY 14224 (716) 674-4254 FAX: (716) 674-4392
WWW.WNYCHIROPRACTIC.COM

Name: _____ Sex: _____
First Last Middle Initial
 Home Address _____ Home Phone: _____
Street & Number City State Zip Code
 Birth date: ____/____/____ Age: ____ SS#: _____ Cell Phone: _____
 E-Mail Address: _____ Marital Status: S M D W Spouse; _____
 Employer _____ Occupation _____

Will this case be covered by any insurance company? Y N (circle) BC/BS / Univera / W. Comp / N. Fault / IHA / Other
 Insurance Card ID #: _____ Group #: (BC/BS Only) _____
 How did you hear about WNY Chiropractic? (circle) Staff Ph. Bk. Screen/Health Fair Web Location Ad **OR**
 Referred By: _____
Patients Name and Relationship

Your Chief Complaint: _____ Other complaints: _____
 How & when did this occur: (must be specific) _____
 Have you been treated by anyone else for this condition? Y N If yes, by whom? _____
 Is this condition interfering with ____ Work ____ Sleep ____ Daily living routine?
 Treatment Objective: (circle) Relief Correction Strengthen/Rehab Prevention Maintenance of Health/Wellness

- A = ACHE
- B = BURNING
- N = NUMBNESS
- P = PINS & NEEDLES
- S = STABBING
- O = OTHER _____



On the diagram, please indicate where, and what type of symptoms that you are experiencing, right now. Write the appropriate abbreviations (See next to diagram) over the area of the body where those symptoms are occurring.

My Pain Level right now: No Pain ① ② ③ ④ ⑤ ⑥ ⑦ ⑧ ⑨ ⑩ Worst Possible

****All chiropractic treatment MUST BE PRE-AUTHORIZED for BC/BS or Univera patients and must satisfy the requirements set fort by the carrier which are subject to review. Only "Acute and Medically Necessary" treatment is covered for a specific condition. Maintenance care, Wellness care, treatment for a Chronic condition or for non Spine related conditions are NOT COVERED. I understand that I am responsible for these services, or those services that have been denied by the carrier.**

Signature: _____ Date: _____

For Doctor's Use Only			C2	C3	C4	C5	L2	L4	T2	P1
C	TH	L	Right	Left	Wt. _____	Ht. _____	BP _____			
Does Patient Smoke?			Yes	No	Discussed smoking cessation:		Yes	No		
					Will Attempt?		Yes	No		

THIS IS A CONFIDENTIAL HEALTH REPORT

Please circle any of the following symptoms which you now have or have had previously

ALLERGIES

None

- Environmental _____
- Food _____
- Medications _____
- Other _____

Gastro-Intestinal

None

- Abdominal Pain
- Black Stool
- Bloody Stool
- Constipation
- Diarrhea
- Gall Bladder
- Hemorrhoids
- Liver Trouble
- Nausea
- Poor Appetite
- Vomiting Blood
- Vomiting Food
- Excessive Weight loss

Genital-Urinary System

None

- Bladder Trouble
- Burning
- Cloudy Urine
- Discharge
- Discolored Urine
- Dribbling
- Excessive Urination
- Impotence
- Painful Urination
- Scanty Urination

Eyes

None

- Blurred Vision
- Burning Eyes
- Cataracts
- Dryness
- Glasses
- Glaucoma
- Itchy Eyes
- Tearing
- Vision Headaches

Respiratory System

None

- Congestion
- Coughing up Blood
- Difficulty Breathing
- Inhalant Exposure
- Non Productive Cough
- Phlegm
- Productive Cough
- Short of Breath
- Wheezing

Cardiovascular

None

- Chest Pain
- Coughing Blood
- Coughing Phlegm
- Difficulty Breathing
- Heart Problem
- High Blood Pressure
- Low Blood Pressure
- Lung Problem
- Pain over heart
- Persistent cough
- Rapid Heart Beat
- Varicose Veins

Ear, Nose, Throat

None

- Bleeding gums
- Dental Problems
- Deviated Septum
- Dry Mouth
- Ear Discharge
- Ear Noises
- Ear Pain
- Eye Inflammation
- Eye Strain
- Hearing Loss
- Hoarseness
- Nose Bleeding
- Nasal Discharge
- Recurrent infections
- Sore Gums
- Sore Throat
- Throat Pain
- Ulcers

Nervous System

None

- Confusion
- Convulsions
- Depression
- Dizziness
- Fainting
- Hand Trembling
- Headaches
- Loss of Feeling
- Loss of Balance
- Loss of Memory
- Numbness
- Paralysis
- Seizures
- Tingling
- Weak grip

FAMILY HISTORY: Have you, your mother, father, brother or sister had any of the following:

Mother	Father	Brother / Sister	You	
				HIV
				Alcoholism
				Anemia
				Arteriosclerosis
				Cancer
				Diabetes
				Epilepsy
				Heart Disease
				High Blood Pressure
				Kidney Disease
				Scoliosis
				Stroke
				Thyroid Disease
				Tuberculosis
				Ulcers
				Sexually Transmitted Disease

Any surgeries / fractures: _____

Medications: _____

Give dates you have had any of the following: (if exact dates are unknown, give approximate date):

Physical Exam _____ Blood Test _____ X-ray _____ Urine Test _____

Habits: (please check)

	None	Light	Moderate	Heavy	
<u>Alcohol</u>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	drinks/day _____
<u>Smoke</u>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	pack/day _____
<u>Tobacco</u>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	type _____
<u>Coffee</u>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	cups/day _____
<u>Drugs</u>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	type _____
<u>Exercise</u>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	times/week _____
<u>Soft Drinks</u>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	drinks/day _____

INFORMED CONSENT FOR CHIROPRACTIC TREATMENT

I understand and grant permission and authority to the doctors and staff of Western New York Chiropractic, LLC to provide chiropractic evaluation, treatment and other clinical office procedures. I understand that results are not guaranteed. I understand that chiropractic treatment, like all forms of healthcare, while offering considerable benefit, may provide some level of risk. I have had the opportunity to discuss with office personnel regarding the aforementioned benefits, risks, and alternatives. I agree to authorize any treatment which may be necessary, covering the entire course of care for which I seek. I realize that I will be included in the treatment and planning of my chiropractic care and compliance to my outlined course of treatment and other recommendations is commensurate with case success.

SIGNATURE _____ DATE _____

If you are having problems with you neck or shoulder please fill out this form

NECK DISABILITY INDEX QUESTIONNAIRE

Please Read: This questionnaire is designed to enable us to understand how much your neck pain has affected your ability to manage 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 related to you, but **PLEASE JUST CIRCLE THE ONE CHOICE THAT MOST CLOSELY DESCRIBES YOUR PROBLEM RIGHT NOW.**

SECTION 1--Pain Intensity

- A. I have no pain at the moment
- B. The pain is mild at the moment.
- C. The pain comes and goes and is moderate.
- D. The pain is moderate and does not vary much.
- E. The pain is severe but comes and goes.
- F. The pain is severe and does not vary much.

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 have a great deal of difficulty in concentrating when I want to.
- F. I cannot concentrate at all.

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; I wash with difficulty and stay in bed.

SECTION 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 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 if they are conveniently positioned, for example 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 8--Driving

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

SECTION 4 --Reading

- A. I can read as much as I want to 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 cannot read as much as I want because of severe pain in my neck.
- F. I cannot read at all.

SECTION 9--Sleeping

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

SECTION 5--Headache

- 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 10--Recreation

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

SIGNATURE: _____

DATE: _____

DISABILITY INDEX SCORE: _____

If you are having problems with you back/legs please fill out this form

OSWESTRY DISABILITY INDEX

Name: _____ Age: _____ Date: _____ Raw Score: _____

Please complete this questionnaire by circling **one** answer in each section. It is designed to give us information as to how your back (or leg) trouble has affected your ability to manage in everyday life.

<p>SECTION 1 – Pain Intensity</p> <p>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.</p>	<p>SECTION 6 –Standing</p> <p>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 one hour. D. Pain prevents me from standing for more than half an hour. E. Pain prevents me from standing for more than ten minutes. F. Pain prevents me from standing at all.</p>
<p>SECTION 2 – Personal Care</p> <p>A. I can look after myself normally without causing extra pain. B. I can look after myself normally but it is 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.</p>	<p>SECTION 7 – Sleeping</p> <p>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.</p>
<p>SECTION 3 – Lifting</p> <p>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 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 lift only very light weights. F. I cannot lift or carry anything at all.</p>	<p>SECTION 8 – Social Life</p> <p>A. My social life is normal and gives 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. dancing, etc. D. Pain has restricted my social life and I do not go out as often. E. Pain has restricted social life to my home. F. I have no social life because of pain.</p>
<p>SECTION 4 –Walking</p> <p>A. Pain does not prevent me walking any distance. B. Pain prevents me walking more than one mile. C. Pain prevents me walking more than a quarter of a mile. D. Pain prevents me from walking more than 100 yards. E. I can only walk using a stick or crutches. F. I am in bed most of the time and have to crawl to the toilet.</p>	<p>SECTION 9 – Traveling</p> <p>A. I can travel anywhere without pain. B. I can travel anywhere but it gives extra pain. C. Pain is bad but I manage journeys over two hours. D. Pain restricts me to journeys of less than one hour. E. Pain restricts me to journeys of less than 30 minutes. F. Pain prevents me from traveling except to receive treatment.</p>
<p>SECTION 5 –Sitting</p> <p>A. I can sit in any chair as long as I like. B. I can sit in my favorite chair as long as I like. C. Pain prevents me from sitting for more than one hour. D. Pain prevents me from sitting for more than half an hour. E. Pain prevents me from sitting for more than ten minutes. F. Pain prevents me from sitting at all.</p>	<p>SECTION 10 – Changing Degree of Pain</p> <p>A. My pain is rapidly getting better. B. My pain fluctuates, but overall is definitely getting better. C. My pain seems to be getting better, but improvement is slow at present. D. My pain is neither getting better nor worse. E. My pain is gradually worsening. F. My pain is rapidly worsening.</p>

Patient Signature _____ Date _____

Western New York Chiropractic Associates
Medical Privacy Notice

Notice of western New York Chiropractic associates' Privacy Policy

At Western New York Chiropractic Associates, we share your concerns for privacy and security of personal information. Because we value your privacy, we do not sell or trade any personal information that you have entrusted to us. To help you better understand our privacy and practices; we have prepared this notice for you. This notice describes how medical information about you may be used and disclosed and how you can access this information. Please review carefully

1. *Understanding Your Health Record / Information*

Each time you visit a hospital, physician or other health care provider, a record of your visit is made. Typically, this record contains your symptoms, examination and test results, diagnosis, treatment and a plan for future care of treatment. It may also contain correspondence or other administrative documents. Your medical records are used by medical providers and facilities to bill for Western New York Chiropractic Associates, obtain preauthorization, and verify medical necessity.

Western New York Chiropractic Associates receives and stores this information to provide you with medical care. Personal health information (or PHI) is any personally identifying information which when linked to health data could be used to identify an individual. This information may be stored or transmitted in any form (for example, paper, electronics, verbal, etc.) All of this information, often referred to as your health or medical record, serves as a:

- Basis for planning your care and treatment
- Mean of communicating among the many health professionals who contribute to your care
- Legal document describing the care you received
- Means by which you or a third-party payer can verify that services billed were actually provided
- Tool in educating health professionals
- Source of data for medical research
- Source of information for public health officials charged with improving the health of the nation
- Source of data for facility planning and marketing
- Tool by which we can access and monitor the health care being provided and the outcomes achieved

2. *Your Health Information Rights*

Although your health record is the property of the health care practitioner or facility that compiled it, the information belongs to you. Federal law gives you the right to:

- Inspect and obtain a copy of your health record
- Amend your record
- Request a restriction on certain uses and disclosures of your information
- Obtain a paper copy of the notice of information practices upon request
- Obtain and accounting of disclosures of your health information (other than purposes of treatment, payment and health care operations)
- Request communications of your health information by alternative means or at alternative locations
- Revoke your authorization to use or disclose health information except to the extent that action has already been taken.

3. *Our Responsibilities*

Our organization is required to:

- Maintain the privacy of your health information
- Provide with the notice of our legal duties and privacy practices regarding information we collect and maintain about you
- Abide by the terms of this notice
- Notify you if we are unable to agree to a requested restriction
- Accommodate reasonable requests you may have to communicate health information by alternative means or at alternative locations

We will not use or disclose your personal health information without your authorization, except as provided by law.

Federal Standards for Privacy of and Individual Identifiable Health Information go into effect on or after April 14, 2003. Therefore, we reserve the right to change our practices and make new provisions effective for all PHI we maintain. If our information practices change, we will make the new version available to you. We are required to abide by the terms of the written Privacy Notice currently in effect. We reserve the right to change the terms of our Privacy Notice from time to time and to amend or make new notice provisions effective for all PHI we maintain. Anytime Western New York Chiropractic Associates makes such revisions, we will distribute revised notices by mail to all members in any plans currently administered by Western New York Chiropractic Associates. A material change (except where required by law) may not be implemented before the effective date of the notice in which the material change is reflected.

4. *For More Information or to Report a Problem*

If you have any questions or if you would like additional information, you may contact Western New York Chiropractic Associates by telephone (716-674-4254) by mail (810 Center Rd. West Seneca, NY 14224) or by fax (716-674-4392)

If you believe your privacy rights have been violated, you can file a complaint with Western New York Chiropractic Associates or with the Office for Civil Rights (OCR). Complaints must be in writing and can be filed by mail. OCR will provide further information on its web site about how to file a complaint (www.hhs.gov/ocr/hipaa/) Please note; there will be no retaliation for filing a complaint.

5. *Examples of Disclosures for Treatment and Health Care Operations*

Pursuant to law and the authorization form which you have signed:

- Treatment, payment, and health care operations: We may use your health information for treatment, payment and health care operations. For example, information obtained by a nurse, physician or other member of your health care team will be recorded in your record and used to determine the course of treatment that should work best for you. We will use that information for Pre-authorization purposes.

We may use your health information for payment. For example, a bill may be sent to you or a third-party payer. The information on or accompanying the bill may include information that identifies you, as well as you diagnosis, procedures and supplies used. In the event that payment is not made, we may also provide limited information to collect from agencies, attorneys, credit reporting agencies, and other organizations as necessary to collect for services rendered.

- Food and Drug Administration (FDA): we may disclose to the FDA health information relative to adverse events with respect to food, supplements, product and product defects, or post-marketing surveillance information to enable product recalls, repairs or replacement.
- Worker's Compensation: We may disclose health information to the extent authorized by and to the extent necessary to comply with laws relating to worker's compensation or other similar programs established by law.
- Public Health: As required by law, we may disclose your PHI to public health or authorities charged with preventing or controlling disease, injury, or disability.
- Correctional Institution: If you're an inmate of a correctional institution, we may disclose to the institution or agents thereof PHI necessary for your health and for the health and safety of others.
- Law Enforcement: We may disclose certain PHI for law enforcement purposes as required by law or in response to a valid subpoena.

I have read and fully understand the above outlined Medical Privacy Notice and have been provided a copy of this notice to keep for my records. The original signed Medical Privacy Notice will be made part of my permanent record.

Patient Name _____

Signed: _____ Date: _____

Website Membership Enrollment

The information on our website will help you

Get Well and Stay Well.

Please provide the following details so we can establish you as a member of our website today:



First name: _____

Last name: _____

Date of birth: ____ / ____ / ____

Email address: _____

Please check the health subjects that most interest you:

- | | |
|---|--|
| <input type="checkbox"/> Headaches and Neck Pain | <input type="checkbox"/> Diet and Nutrition |
| <input type="checkbox"/> Backaches and Sciatica | <input type="checkbox"/> Stress Management |
| <input type="checkbox"/> Children's Health Issues | <input type="checkbox"/> Wellness Topics |
| <input type="checkbox"/> Exercise and Fitness | <input type="checkbox"/> Women's Health Issues |

By joining our website, you authorize us to send occasional health care related emails to you. Naturally, you may opt-out at any time. Please review our complete privacy policy on our website.

Lifecycle:	
Chiropractor:	