WELCOME

Suburban Chiropractic Associates

Patient Information

Today's Date: _____

Soc. Sec. #: _____

Patient Name: _____
Last

_____
First Middle Initial

Address: _____

City: _____

State: _____ Zip: _____

E-Mail: _____

Date of Birth: _____

() Male () Female Age: _____

() Married () Single () Widowed () Divorced () Separated

() Minor () Partnered for _____Years

Home Phone: ( ) _____

Cell Phone: ( ) _____

Employer: _____

Employer Phone: ( ) _____

Employer Address: _____

Occupation: _____

Spouse's Name: _____

Spouse's Date of Birth: _____

Insurance Information

Who is responsible for this account? _____

Relationship to Patient: _____

Ins. Co. _____

Policy Number: _____

Group #: _____

Subscriber (Policy Holder) Info if it is not You

Name: _____

D.O.B. _____ SS#: _____

Address: _____

Primary Care Physician (PCP): _____

PCP Address: _____

Is Patient Covered By Additional Insurance? () Yes () No

In Event Of Emergency

Who Should We Contact? _____

Relation: _____

Home Phone: _____

Cell Phone: _____

Work Phone: _____

Accident Information

Is Condition Due To An Accident? () Yes () NO Date: _____ Type of Accident: () Auto () Work () Home () Other

Did You Report Your Accident? () Yes () No If Yes, To Whom? () Auto Ins () Employer () Worker Comp () Other

Attorney Name (If Applicable): _____

Reason For Visit

Reason for your visit: _____

When did your symptoms appear? _____

Is this condition getting better or worse? () Yes () NO Is the pain constant or come and go? _____

Does the pain interfere with your () Work () Daily Routine () Recreation () Sleep

Type of Pain: () Sharp () Dull () Throb () Ache () Numb () Tingle () Shooting () Pinch () Pressure

Where is the pain? _____ Pain Level 0 (No Pain) to 10 (Worst Pain Ever) _____

Assignment And Release

I certify that I, and/or my dependent(s), have insurance coverage with (Ins Co)_____ and assign directly to Dr. Acquisto all 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 and their agents for the purpose of obtaining payment for services and determining insurance benefits of the benefits payable for related services.

Signature of Patient/Guardian _____ **Relationship to Patient** _____

Date _____ **Print name of Guardian** _____

HABITS:

Suburban Chiropractic Associates

Did/Do you smoke? Y / N _____
Did/Do you drink alcohol? Y / N _____
Exercise Regularly? Y / N _____
Eye Problems? Y / N _____
High Stress Levels? Y / N _____
Have you been in any accidents/trauma? Y / N _____
Sports Injuries? Y / N _____
Do you sleep well, hours of sleep? Y / N _____

Name & address of doctors who have treated you: _____

What activities make condition feel better? _____
What activities make condition feel worse? _____

WORK ACTIVITY:

() Sitting () Standing () Light Labor () Heavy Labor

FEMALE ONLY:

Are You Pregnant? () Yes () No Due Date: _____

INJURIES/SURGERIES You Have Had	**Description**	**Date**
Falls	_____	_____
Broken Bones	_____	_____
Head Injuries	_____	_____
Surgeries	_____	_____

Please Mark Any Of The Following Conditions You Have Now Or Have Had In The Past:

AIDS/HIV	()	Cataracts	()	High Cholesterol	()	Headache	()
Alcoholism	()	Chicken Pox	()	Kidney Disease	()	Psychiatric Care	()
Allergy Shots	()	Diabetes	()	Liver Disease	()	Rheumatic Fever	()
Anemia	()	Emphysema	()	Measles	()	Stroke	()
Appendicitis	()	Fractures	()	Multiple Sclerosis	()	Tuberculosis	()
Arthritis	()	Glaucoma	()	Osteoporosis	()	Tumors/Growths	()
Asthma	()	Gout	()	Pacemaker	()	Ulcers	()
Bleeding Disorder	()	Heart Disease	()	Parkinson's	()	SexuallyTransmitted Infxn	()
Bowel/Bladder	()	Hepatitis	()	Polio	()	Thyroid	()
Bronchitis	()	Hernia	()	Prostate Problem	()	High Blood Pressure	()
Cancer	()	Herniated Disc	()	Prosthesis	()	Miscarriage	()
Epilepsy	()	Herpes	()	Eating Disorders	()		
Rheumatoid Arthritis	()	Pneumonia	()	Other:_____			

MEDICATIONS

_____ _____ _____ _____ _____

VITAMINS

_____ _____ _____ _____ _____

ALLERGIES:

_____ _____ _____ _____ _____

FAMILY HISTORY ___ Auto-immune Disorder ____Cancer ____Diabetes ____G.I. ____High Blood Pressure ___Heart Disease ___Kidney Disease ___Lung Disease ____Seizure Disorder ____Stroke ____Thyroid Disorder _____Other: _____

Patient Name: _____ ***Signature:*** _____ ***Date:*** _____

Authorization to Call, Text, E-mail

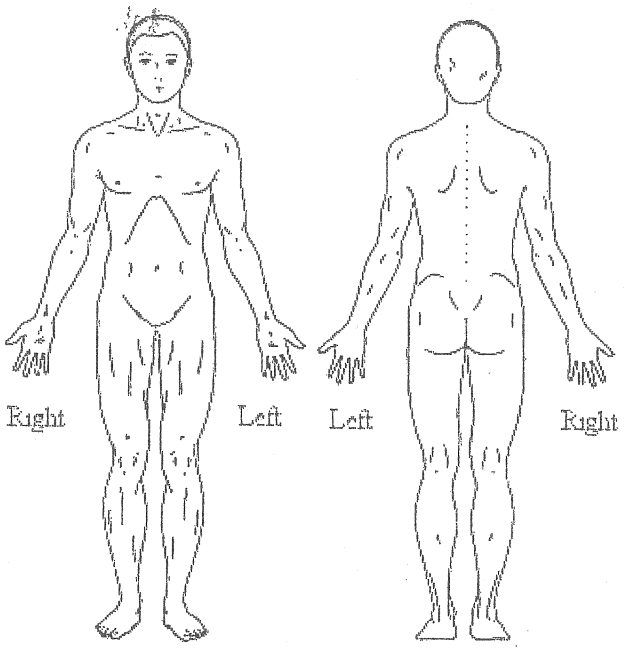
I authorize the office and the doctors of Suburban Chiropractic Associates to contact all phone numbers, including text messages and email addresses listed on file. In addition, I am requesting appointment reminder calls or other non-personal matters to be sent via text/email to the following:

PRINTED PATIENT NAME: _____
TEXT: Cell Phone: ( )_____ Cell Phone Carrier: _____
E-mail Address: _____

_____ I choose not to be contacted by _____Email, _____ TEXT, or _____email/text. I may withdraw this authorization at anytime by submitting in a request in writing to this office.

Patient Name _____

Please Circle where you are at: (No Complaint/Pain) 0 1 2 3 4 5 6 7 8 9 10 (Worst Possible Complaint/Pain)
Using the symbols below, mark on the pictures where you feel pain.



Numbness N

Dull Ache A

Burning B

Sharp/Stabbing S

Pins, Needles P

Other _____ O

Please circle the appropriate number that corresponds to the pain level that you are **CURRENTLY** experiencing.

1. My pain when it is at its worst is:

   No pain 0 1 2 3 4 5 6 7 8 9 10 Worst Possible

2. My pain when it is at its least is:

   No pain 0 1 2 3 4 5 6 7 8 9 10 Worst Possible

3. My average pain level is:

   No Pain 0 1 2 3 4 5 6 7 8 9 10 Worst Possible

I hereby certify that the statements and answers given on this form are accurate to the best of knowledge and understand it is my responsibility to inform this office of any changes in my health.
I agree to allow this office to examine me for further evaluation.

Patient
Signature_____Date_____

Back Index

Form BI100

rev 3/27/2003

Patient Name _____ **Date** _____

This questionnaire will give your provider information about how your back condition affects your everyday life. Please answer every section by marking the one statement that applies to you. If two or more statements in one section apply, please mark the one statement that most closely describes your problem.

Pain Intensity

⓪ The pain comes and goes and is very mild.
① The pain is mild and does not vary much.
② The pain comes and goes and is moderate.
③ The pain is moderate and does not vary much.
④ The pain comes and goes and is very severe.
⑤ The pain is very severe and does not vary much.

Sleeping

⓪ I get no pain in bed.
① I get pain in bed but it does not prevent me from sleeping well.
② Because of pain my normal sleep is reduced by less than 25%.
③ Because of pain my normal sleep is reduced by less than 50%.
④ Because of pain my normal sleep is reduced by less than 75%.
⑤ Pain prevents me from sleeping at all.

Sitting

⓪ I can sit in any chair as long as I like.
① I can only sit in my favorite chair as long as I like.
② Pain prevents me from sitting more than 1 hour.
③ Pain prevents me from sitting more than 1/2 hour.
④ Pain prevents me from sitting more than 10 minutes.
⑤ I avoid sitting because it increases pain immediately.

Standing

⓪ I can stand as long as I want without pain.
① I have some pain while standing but it does not increase with time.
② I cannot stand for longer than 1 hour without increasing pain.
③ I cannot stand for longer than 1/2 hour without increasing pain.
④ I cannot stand for longer than 10 minutes without increasing pain.
⑤ I avoid standing because it increases pain immediately.

Walking

⓪ I have no pain while walking.
① I have some pain while walking but it doesn't increase with distance.
② I cannot walk more than 1 mile without increasing pain.
③ I cannot walk more than 1/2 mile without increasing pain.
④ I cannot walk more than 1/4 mile without increasing pain.
⑤ I cannot walk at all without increasing pain.

Personal Care

⓪ I do not have to change my way of washing or dressing in order to avoid pain.
① I do not normally change my way of washing or dressing even though it causes some pain.
② Washing and dressing increases the pain but I manage not to change my way of doing it.
③ Washing and dressing increases the pain and I find it necessary to change my way of doing it.
④ Because of the pain I am unable to do some washing and dressing without help.
⑤ Because of the pain I am unable to do any washing and dressing without help.

Lifting

⓪ I can lift heavy weights without extra pain.
① I can lift heavy weights but it causes extra pain.
② Pain prevents me from lifting heavy weights off the floor.
③ Pain prevents me from lifting heavy weights off the floor, but I can manage if they are conveniently positioned (e.g., on a table).
④ Pain prevents me from lifting heavy weights off the floor, but I can manage light to medium weights if they are conveniently positioned.
⑤ I can only lift very light weights.

Traveling

⓪ I get no pain while traveling.
① I get some pain while traveling but none of my usual forms of travel make it worse.
② I get extra pain while traveling but it does not cause me to seek alternate forms of travel.
③ I get extra pain while traveling which causes me to seek alternate forms of travel.
④ Pain restricts all forms of travel except that done while lying down.
⑤ Pain restricts all forms of travel.

Social Life

⓪ My social life is normal and gives me no extra pain.
① My social life is normal but increases the degree of pain.
② Pain has no significant affect on my social life apart from limiting my more energetic interests (e.g., dancing, etc).
③ Pain has restricted my social life and I do not go out very often.
④ Pain has restricted my social life to my home.
⑤ I have hardly any social life because of the pain.

Changing degree of pain

⓪ My pain is rapidly getting better.
① My pain fluctuates but overall is definitely getting better.
② My pain seems to be getting better but improvement is slow.
③ My pain is neither getting better or worse.
④ My pain is gradually worsening.
⑤ My pain is rapidly worsening.

Index Score = [Sum of all statements selected / (# of sections with a statement selected x 5)] x 100

Back Index Score

Neck Index

Form N1-100

rev 3/27/2003

Patient Name _____ **Date** _____

This questionnaire will give your provider information about how your neck condition affects your everyday life. Please answer every section by marking the one statement that applies to you. If two or more statements in one section apply, please mark the one statement that most closely describes your problem.

Pain Intensity

⓪ I have no pain at the moment.
① The pain is very mild at the moment.
② The pain comes and goes and is moderate.
③ The pain is fairly severe at the moment.
④ The pain is very severe at the moment.
⑤ The pain is the worst imaginable at the moment.

Sleeping

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

Reading

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

Concentration

⓪ I can concentrate fully when I want with no difficulty.
① I can concentrate fully when I want with slight difficulty.
② I have a fair degree of difficulty concentrating when I want.
③ I have a lot of difficulty concentrating when I want.
④ I have a great deal of difficulty concentrating when I want.
⑤ I cannot concentrate at all.

Work

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

Personal Care

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

Lifting

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

Driving

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

Recreation

⓪ I am able to engage in all my recreation activities without neck pain.
① I am able to engage in all my usual recreation activities with some neck pain.
② I am able to engage in most but not all my usual recreation activities because of neck pain.
③ I am only able to engage in a few of my usual recreation activities because of neck pain.
④ I can hardly do any recreation activities because of neck pain.
⑤ I cannot do any recreation activities at all.

Headaches

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

Neck Index Score

Index Score = [Sum of all statements selected / (# of sections with a statement selected x 5)] x 100

The Keele STarT Back Screening Tool

Patient name: _____ Date: _____

Thinking about the **last 2 weeks** tick your response to the following questions:

		No 0	Yes 1
1	Has your back pain spread down your leg(s) at some time in the last 2 weeks?	☐	☐
2	Have you had pain in the shoulder or neck at some time in the last 2 weeks?	☐	☐
3	Have you only walked short distances because of your back pain?	☐	☐
4	In the last 2 weeks, have you dressed more slowly than usual because of back pain?	☐	☐
5	Do you think it's not really safe for a person with a condition like yours to be physically active?	☐	☐
6	Have worrying thoughts been going through your mind a lot of the time?	☐	☐
7	Do you feel that your back pain is terrible and it's never going to get any better?	☐	☐
8	In general have you stopped enjoying all the things you usually enjoy?	☐	☐

9. Overall, how **bothersome** has your back pain been in the last 2 weeks?

Not at all	Slightly	Moderately	Very much	Extremely
☐	☐	☐	☐	☐
0	0	0	1	1

Total score (all 9): _____ **Sub Score (Q5-9):** _____

Funded by Arthritis Research UK

Suburban Chiropractic Associates
2577 Sheridan Drive
Tonawanda, NY 14150
Ph: 716-874-2040 Fax: 716-832-0124

AUTHORIZATION FOR RELEASE OF HEALTH INFORMATION PURSUANT TO HIPAA

Patient Name: _____

Date of Birth: _____

Patient Address: _____

I, or my authorized representative, request that health information regarding my care and treatment be released as set forth on this form to Dr. Acquisto and/or Suburban Chiropractic Associates:

[ ] Re-evaluation Reports: _____

[ ] Imaging Reports: _____

[ ] Test Results: _____

[ ] Medical Records From: _____ To: _____

[ ] Other: _____

AUTHORIZATION TO DISCUSS HEALTH INFORMATION:

* By initialing here, _____, I authorize Dr. Acquisto and/or Suburban Chiropractic Associates
Initials
To discuss my health information with the following checked individuals:

[ ] Primary Doctor: _____

[ ] Family Members: _____

[ ] Attorney: _____

[ ] Specialists: _____

[ ] Other: _____

_____ _____
Signature of patient or representative authorized by law. *Date*