WELCOME Suburban Chiropractic Associates

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atient Information		Insurance Inf	ormatica de la compania della compan

Today's Date:	Who is responsible for this account?
Soc. Sec. #:	Relationship to Patient:
Patient Name:Last	Ins. Co
Last	
First Middle Initial	Policy Number:
Address:	Group #:
City:	Subscriber (Policy Holder) Info if it is not You
State: Zip:	Name:
E-Mail:	D.O.B SS#:
Date of Birth:	Address:
() Male () Female Age:	Primary Care Physician (PCP):
() Married () Single () Widowed () Divorced ()	Separated PCP Address:
() Minor () Partnered forYears	Is Patient Covered By Additional Insurance? () Yes () N
Home Phone: ()	In Event Of Emergency
Cell Phone: ()	Who Should We Contact?
Employer:	Relation:
Employer Phone: ()	Home Phone:
Employer Address:	Cell Phone:
Occupation:	Work Phone:
Spouse's Name:	
Spouse's Date of Birth:	
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:	
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 Rout	tine () 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 payable to me for services rendered. I understand that I am finar on all insurance submissions. The above named doctor may use and their agents for the purpose of obtaining payment for services.	e with (Ins Co) and assign directly to Dr. Acquisto all benefits, if any, otherw neially responsible for all charges whether or not paid by insurance. I authorize the use of my signature my health care information and may disclose such information to the above named insurance company es and determining insurance benefits of the benefits payable for related services.
Signature of Patient/Guardian	Relationship to Patient
Date Print name of Crowdi	ton.

HABITS:			Suburban Chirop	ractic Associates
Did/Do you smoke? Did/Do you drink alcohol? Exercise Regularly? Eye Problems? High Stress Levels? Have you been in any accidents/traus. Sports Injuries? Do you sleep well, hours of sleep?	Y/N Y/N Y/N ma? Y/N			
Name & address of doctors who hav				
What activities make condition feel what activities make condition feel was activities activities was activities which was activities activities activities activities was activities activities activities was activities activities activities activities was activities ac	petter? worse?			
WORK ACTIVITY:				
() Sitting () Standing () L	ight Labor () Heavy Lab	oor		
FEMALE ONLY:				
Are You Pregnant? () Yes () No	Due Date:	-		
INJURIES/SURGERIES You Have Ha	ad Description		Date	
Falls				
Broken Bones				
Head Injuries				
Surgeries				
Please Mark Any Of The Followin	g Conditions You Have Nov	v Or Have Had In The Past:		
AIDS/HIV () Alcoholism () Allergy Shots () Anemia () Appendicitis () Arthritis () Asthma () Bleeding Disorder () Bowel/Bladder () Bronchitis () Cancer () Epilepsy () Rheumatoid Arthritis () MEDICATIONS	Cataracts () Chicken Pox () Diabetes () Emphysema () Fractures () Glaucoma () Gout () Heart Disease () Hepatitis () Hernia () Herniated Disc () Herpes () Pneumonia ()	High Cholesterol Kidney Disease Liver Disease Measles Multiple Sclerosis Osteoporosis Pacemaker Parkinson's Polio Prostate Problem Prosthesis Eating Disorders Other:	() Rheum () Stroke () Tubero () Tumor () Ulcers () Sexuall () Thyroi () High B () Miscan	atric Care () natic Fever () culosis () cs/Growths () yTransmitted Infxn () d () lood Pressure ()
			and the second s	
VITAMINS				
ALLERGIES:				
FAMILY HISTORY Auto-immurLung Diseas		_DiabetesG.IHigh Bl _StrokeThyroid Disorder		
Patient Name:	S	gnature:	D	ate:
Authorization to Call, Text, E-mai				
I authorize the office and the doctors listed on file. In addition, I am reque	s of Suburban Chiropractic Assting appointment reminder of	sociates to contact all phone num alls or other non-personal matters	abers, including text message to be sent via text/email to	es and email addresses the following:
PRINTED PATIENT NAME: TEXT: Cell Phone: () E-mail Address:		Cell Phone Carrier		_
		T, oremail/text. I may with		nytime by submitting

Compl	aint/Pain)	•		•		-					2 3 4 5 6 feel pain.	7 8 9 10 (Worst Possible
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Please	circle the My pain	app who	oropi en it	riate is a	numl t its w	oer th	nat c	orre	espo	nds	to th	ne pain level that y	you are CURRENTLY experiencing.
	No pain	0	1	2	3 4	5	6	7	8	9	10	Worst Possible	
2.	My pain	whe	en it	is a	t its le	ast is	S:						
	No pain	0	1	2	3 4	5	6	7	8	9	10	Worst Possible	
3.	My aver	age	pain	lev	el is:								
	No Pain	.0	1	2	3 4	5	6	7	8	9	10	Worst Possible	
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Signati	are	***************************************				esternista terreja kandissena						TO POTENTIAL TO THE POTENTIAL OF THE POT	Date

Patient Name



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

- 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.
- The pain comes and goes and is very severe.
- (5) The pain is very severe and does not vary much.

Sleeping

- @ 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%.
- Because of pain my normal sleep is reduced by less than 75%.
- ⑤ Pain prevents me from sleeping at all.

Sitting

- ① I can sit in any chair as long as I like.
- 1 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.
- Pain prevents me from sitting more than 10 minutes.
- ⑤ I avoid sitting because it increases pain immediately.

Standing

- ① 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

- ① 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

- 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.
- 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

- ① 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).
- 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

- ① 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.
- Pain restricts all forms of travel except that done while lying down.
- ⑤ Pain restricts all forms of travel.

Social Life

- 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.
- Pain has restricted my social life to my home.
- (5) I have hardly any social life because of the pain.

Changing degree of pain

- My pain is rapidly getting better.
- 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.
- My pain is gradually worsening.
- My pain is rapidly worsening.

Back	
Index	
Score	

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

Neck Index

Form N1-100

anii 0/07/0000

Patient Name Date	
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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

- ① 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.
- The pain is very severe at the moment.
- The pain is the worst imaginable at the moment.

Sleeping

- ① 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).
- My sleep is greatly disturbed (3-5 hours sleepless).
- My sleep is completely disturbed (5-7 hours sleepless).

Reading

- ① 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

- ① I can concentrate fully when I want with no difficulty.
- ① I can concentrate fully when I want with slight difficulty.
- 2 | 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

- ① 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 | cannot do my usual work.
- I can hardly do any work at all.
- (5) I cannot do any work at all.

Personal Care

- O 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

- ① 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

- ① 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

- ① 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.
- cannot do any recreation activities at all.

Headaches

- 1 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

NEW YORK MOTOR VEHICLE NO-FAULT INSURANCE LAW ASSIGNMENT OF BENEFITS FORM

(FOR ACCIDENTS ON AND AFTER 3/1/02)

I. ("Assignor") here	by assign to, Christopher J. Acquisto, D.C. , ("Assignee")
(Print patient's name)	(Print hospital or health care provider name)
all rights privileges and remedies to payment for he entitled under Article 51 (the No-Fault statute) of the	ealth care services provided by assignee to which I am the Insurance Law.
	ceived any payment from or on behalf of the Assignor and r for services provided by said Assignee for injuries sustained n, not withstanding any other agreement (Print accident date)
This agreement may be revoked by the assignee who of coverage and/or violation of a policy condition of	en benefits are not payable based upon the assignor's lack lue to the actions or conduct of the assignor.
FILES AN APPLICATION FOR COMMERCIAL INSUFPERSONAL INSURANCE BENEFITS CONTAINING APURPOSE OF MISLEADING, INFORMATION CONCEIN CONNECTION WITH SUCH APPLICATION OR CISOLICITS OR CONSPIRES WITH ANOTHER TO MAINTONVERSION OF ANY MOTOR VEHICLE TO A LAVUEHICLES OR AN INSURANCE COMPANY, COMM	NT TO DEFRAUD ANY INSURANCE COMPANY OR OTHER PERSON RANCE OR A STATEMENT OF CLAIM FOR ANY COMMERCIAL OR ANY MATERIALLY FALSE INFORMATION, OR CONCEALS FOR THE ERNING ANY FACT MATERIAL THERETO, AND ANY PERSON WHO, LAIM, KNOWINGLY MAKES OR KNOWINGLY ASSISTS, ABETS, KE A FALSE REPORT OF THE THEFT, DESTRUCTION, DAMAGE OR WENFORCEMENT AGENCY, THE DEPARTMENT OF MOTOR ITS A FRAUDULENT INSURANCE ACT, WHICH IS A CRIME, AND OT TO EXCEED FIVE THOUSAND DOLLARS AND THE VALUE OF M FOR EACH VIOLATION.
(Print name of Patient)	(Signature of Patient)
	(Date of signature)
(Address of Patient)	
•	
Christopher J. Acquisto, D.C. (Print Name of Provider) 220 1-1941and Pl	(Signature of Provider)
Tongwanda NY 14	(Date or Signature)

NYS FORM NF-AOB (Rev 1/2004)

NEW YORK MOTOR VEHICLE NO-FAULT INSURANCE LAW VERIFICATION OF TREATMENT BY ATTENDING PHYSICIAN OR OTHER PROVIDER OF HEALTH SERVICE (This form is NOT for verification of hospital treatment)

Nar	ne and Address of Ins	surer or Self-Insurer		Name,	Address & Phone Number of Insurer's Claims Representative
Date	Policyholder		Policy No.	Date of Accident	Claim Number
Provider's Name and Address Suburban Chiroproctic Associates 220 Highland Pkwy. Tonawanda, NY 14223 KINDLY COMPLETE AND SUBMIT THIS FORM AS SOON AS POSSIBLE. PLEASE NOTE, THIS COMPLETED FORM MUST BE SUBMITTED THE INSURER AS SOON AS REASONABLY POSSIBLE BUT NO LATER THAN 45 DAYS OR 180 DAYS AFTER THE TREATMENT DAY DEFENDING UPON THE POLICY ENDORSEMENT IN EFFECT AT THE TIME OF THE ACCIDENT. IF YOU ARE UNSURE OF THE APPLICAB CLAIM. IF YOU HAVE PREVIOUSLY SUBMITTED AN EARLIER REPORT ON THIS ACCIDENT, YOU NEED ONLY NOTE ANY CHAMGES FROM TO INFORMATION PREVIOUSLY FURNISHED AND ADDITIONAL CHARGES. 2. Date of Birth 3. Sex 4. Occupation (if known) 5. Diagnosis and Concurrent Conditions:					OMPLETED FORM MUST BE SUBMITTED TO 180 DAYS AFTER THE TREATMENT DATE, 1 IF YOU ARE UNSURE OF THE APPLICABLE WHICH DEADLINE IS APPLICABLE TO THIS
6. When did sym	ptoms first appear?			7. When did patient first con condition? Date	nsult you for this
	∍r had same or similar lely a result of this au		es No IF "Y	ES", state when and describe: IF "NO", explain:	·
	ue to injury arising ou			No	
11. Will injury res ☐ Yes [If "Yes", de	- Common	igurement or perman determinable at this t			
12. Patient was dis	abled (unable to worl	k)	No.	13. If still disabled the patien return to work on :	nt should be able to
From		Through	9 .9		(DATE)
lf "Yes", descr	t require rehabilitation	n and/or occupationa	ii therapy as a result of th	e injuries sustained in this acc	ident? 🗌 Yes 🗷 No

VERIFICATION OF TREATMENT BY ATTENDING PHYSICIAN OR OTHER PROVIDER OF HEALTH SERVICE

	15. RE	PORT OF SERVICE	S RENDERED - ATTACH	ADDITIONAL SUBSTRE	TAMORGOADII		
Date of	Place of Service	Description	of Treatment or Health	Fee Schedul			
Service	Including Zip Code		rvice Rendered	Treatment Co	- }	Charges	
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				Employee	Independer Contractor		
						•	
17 If the provid	er of service is a professio	nol namina	1 1				
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40.7							
18. Is patient stil	l under your care for this	condition? 🔀 Yes	No No				
19. Estimated du	ration of fixure treatment						
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