OPTIMUM CHIROPRACTIC

2577 Sheridan Drive
Tonawanda, NY 14150
(716) 833-1926
www.optimumchirowny.com

Welcome!

These forms help us gather information on your medical history and current state of your health. Please make sure to fill this form out completely, including signing and dating at the bottom of each page.

ABOUT YOU:
Name:
Date of Birth: Age:
Social Security Number:
Address:
City, State, Zip:
Home Phone #: ( )
Cell Phone #: ( )
Cell Phone Carrier:
Email Address:
Marital Status/Spouse's Name:
Primary Medical Doctor:
Referred By:

IN EVENT OF EMERGENCY:
Emergency Contact:
Relationship:
Emergency Phone # 1: ( )
Emergency Phone # 2: ( )

INSURANCE INFORMATION:
Policy Holder:
Date of Birth: Age:
Social Security Number:
Address:
City, State, Zip:
Relationship:
Company Name:
Policy #:
Group #:

EMPLOYMENT:
Are you a student? Yes, full time / Yes, part time / No, I am not
Are you employed? Yes, full time / Yes, part time / No, I am not
Title:
Employer:
Address:
City, State, Zip:
Work Phone # : ( )

PERSONAL INJURY:
Are you seeking care due to an accident you were involved in? Yes No (if no, skip this section)
Date, time and location of accident:
Type of accident: Motor Vehicle Workplace Fall Other
Who did you report the injury to?
Were you evaluated and/or treated at a hospital or by another health care provider for your injuries? Yes No
If so, where were evaluated and/or treated for your injuries?
List any diagnoses from this encounter:
What treatments/surgeries/prescriptions were provided, if any?
Have you lost any days of work due to this accident? Yes No Dates:
Insurance Company Contact:
Firm: Name: Phone: ( )
Do you have an Attorney representing you in this case?
Firm: Name: Phone: ( )

Patient Signature: _____ Date: _____ / _____ / _____

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Please complete this questionnaire by answering each section as completely as possible, to the best of your knowledge, and as you feel right now. It is designed to give us information as to how your condition has affected your ability to manage in everyday life.

Show where it hurts on the diagrams on the right → → →

A = ACHE

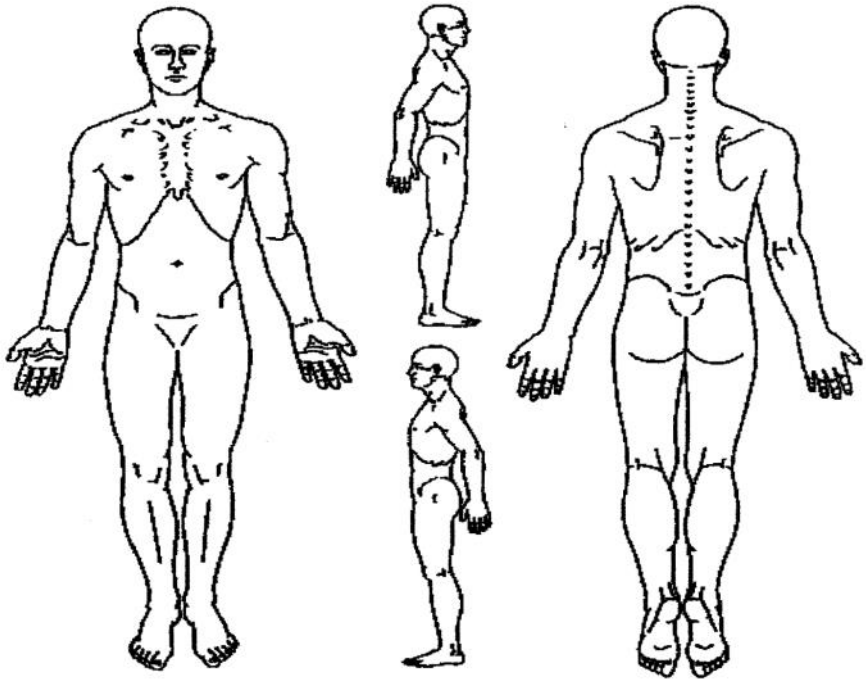
B = BURNING

N = NUMBNESS

P = PINS & NEEDLES

S = STABBING

O = OTHER_____



Briefly describe your symptoms: _____

_____

When/how did your symptoms start? _____

_____

How has the severity of your condition changing, since its onset? (circle)

Much worse Worse A little worse No change A little better Better Much better

My pain when at its worst is (circle): No pain 1 2 3 4 5 6 7 8 9 10 Worst Pain

My pain when at its least is (circle): No pain 1 2 3 4 5 6 7 8 9 10 Worst Pain

My average pain level is (circle): No pain 1 2 3 4 5 6 7 8 9 10 Worst Pain

How often do you experience your symptoms? (circle)

Constantly (100-76% of the time) Frequently (75-51% of the time)

Occasionally (50-26% of the time) Intermittently (25-0% of the time)

Does this pain shoot, radiate or travel in your body? Where?_____

What activities/treatments aggravate your condition/pain?_____

What activities/treatments lessen your condition/pain?_____

Are you experiencing any numbness, tingling or spasms? Where?_____

How much have your symptoms interfered with your usual daily activities? (circle)

Not at all A little bit Moderately Quite a bit Extremely

Is there anything else we should know about your condition? _____

Patient Signature: _____ Date: _____ / _____ / _____

Modified George's Cerebrovascular Craniocervical Function History:

Have you ever been diagnosed with or treated for any of the following?	
1. High Blood Pressure (hypertension)	☐Yes ☐ No
2. Hardening of the arteries (arteriosclerosis)	☐Yes ☐ No
3. Diabetes	☐Yes ☐ No
4. Heart or blood vessel diseases	☐Yes ☐ No
5. Bone spurs on the neck bones (cervical spondylosis)	☐Yes ☐ No
6. Whiplash injury (flexion-extension injury of the cervical spine)	☐Yes ☐ No
7. Have you or any of your immediate relatives ever suffered a stroke or mini-stroke (CVA or TIA)?	☐Yes ☐ No
8. Were you ever a smoker? If yes, from _____ to _____	☐Yes ☐ No
9. Do you take blood-thinning or anti-platelet medications? If so, which?_____	☐Yes ☐ No
10. (Women Only) Have you ever taken oral Contraceptives? If yes, from _____ to _____	☐Yes ☐ No

Have you ever had any of the following, even as short or temporary attacks?	
1. Dizziness, unsteadiness, giddiness, or vertigo?	☐Yes ☐ No
2. Drop attacks, loss of consciousness, even momentary blackouts or sudden collapse without loss of consciousness?	☐Yes ☐ No
3. Diploplia - Blurred or Double Vision? Partial or complete loss of vision in one or both eyes?	☐Yes ☐ No
4. Dysarthria- Slurred speech or other speech problems/difficulties?	☐Yes ☐ No
5. Dysphagia - Difficulty swallowing?	☐Yes ☐ No
6. Ataxia of gait - Difficulty walking due to lack of coordination of extremities, falling to one side, or any of the following: weakness, clumsiness or loss of strength in the face, finger, hands, arms, or legs?	☐Yes ☐ No
7. Nausea – Associated with movement or other symptoms listed here?	☐Yes ☐ No
8. Numbness on one side of the face and/or body?	☐Yes ☐ No
9. Nystagmus – abnormal involuntary eye movements?	☐Yes ☐ No
10. Altered mental status including lack of understanding?	☐Yes ☐ No
11. Hearing loss, ringing, buzzing or any noise in one or both ears?	☐Yes ☐ No
12. Sudden severe pain in the side of the head and/or neck which is different from any other pain you have ever had?	☐Yes ☐ No

Patient Signature: _____ Date: _____ / _____ / _____

Informed Consent Release:

Chiropractic as well as other types of health care is associated with potential risks in the delivery of treatment. Therefore, it is necessary to inform you of risks prior to initiating care. While Chiropractic treatment is remarkably safe, you need to be informed about potential risks related to your care to allow you to be fully informed in consenting to treatment.

Specific risk possibilities associated with Chiropractic care include:

1. Chiropractic adjustments are sometimes accompanied with **soreness**, with manipulation or later (post treatment soreness). Many things that can be done to minimize it. Specifically, we will instruct you with what you can do after treatment. Some post treatment soreness is common, not usually lasting more than 24 hours. Occasionally, Chiropractic treatment may aggravate or cause minor joint, ligament, tendon, disc or other soft tissue injury. Heat therapies can cause **burns**. Cryotherapy (ice) can cause **frostbite**. Interferential and Ultrasound can cause minor burns. Soft tissue therapies can cause **bruising** and discomfort. While all of these side effects are uncommon, they should be reported to us immediately as well as any other side effects you may be experiencing.
2. In rare cases, manual adjustments may **fracture** a bone such as rib injury or fracture from thoracic spine adjustment. Precautions such as pre-adjustment x-rays may be taken on patients when we suspect someone is at risk. Treatment is performed carefully to minimize such risk.
3. **Stroke** is the most serious complication of Chiropractic Treatment but it is very rare. Vertebral arteries which supply the brain with blood are located within the bones of the cervical spine, therefore cervical manipulation may pose a very small risk for stroke, which may result in temporary, or permanent brain dysfunction, and in extremely rare occasions, death. According to the Journal of CCA, VOL. 37, NO.2, @ 1993, Studies estimate the risk of stroke to be 1 in every 3 million upper cervical adjustments. Other studies show that mechanical forces similar to those used in cervical manipulation are unlikely to cause harm to the vertebral artery. The American Chiropractic Association has concluded that "there is sufficient evidence to establish that a stroke or a cervical arterial dissection is NOT a risk or side effect of a joint mobilization, manipulation or adjustment of the cervical spine."

The following are part of our ongoing in-house risk management program:

1. You complete a comprehensive case history form, and we attempt to gather diagnostic testing and other medical records. We review all the available information in consultation and correlate it with your symptoms and past history to identify possible risks as part of your condition.
2. Communicate with your physician(s) whenever appropriate.
3. We render the most conservative and safest treatments before resorting to more aggressive forms of care, and then only as appropriate. When risk exceeds benefit, we do not render care in the interest of your safety, nor do we assume any unnecessary risks.

Alternatives to Chiropractic care include, but are not limited to:

1. Pain **medications** mask symptoms rather than attempt to fix the problem causing them, and can hold the risk of dependence and/or liver and kidney damage over time.
2. **Surgery** is very beneficial when indicated but can be over used, does not always succeed, and can result in chronic pain syndromes. More conservative treatments, like Chiropractic, should usually be attempted first.
3. **Physical Therapy** is an excellent choice for rehabilitation and prevention of a reoccurrence, but patients may find its active care model to be uncomfortable for acute complaints, and it has the potential to worsen unhealed injuries.
4. The major risk with receiving **no treatment whatsoever** is having a more complicated or emergent case that requires treatment go unrecognized. No treatment also leads to longer healing times with a higher likelihood of an incomplete recovery.

Chiropractic is a system of health care delivery. Although there is a wealth of scientific evidence supporting its efficacy, we cannot guarantee a cure for any symptom, condition, or disease. Our goal is to provide the best Chiropractic care possible . If we are not successful, we will refer you to another Healthcare provider.

My doctor has taken the time to respond to all of my requests for information and questions about the proposed treatment, and I have read or have had read to me the above consent. I have also had the opportunity to ask any other questions concerning my treatment and its content. I have fully evaluated the risks and benefits associated with chiropractic treatment. I have freely decided to undergo the recommended treatment and by signing below, I consent to chiropractic treatment.

Patient Signature: _____ Date: _____ / _____ / _____

Past Medical History: *Check all boxes that apply*

1. General Health:
- ☐ Recent weight change
- ☐ On-going fever/chills
- ☐ Unexplained sweats
- ☐ Reoccurring allergies
- ☐ Anemia
- ☐ Unusual bleeding/bruising
- ☐ Malaise / fatigue / weakness
- ☐ Cancer
- ☐ Difficulty breathing with exertion
- ☐ Other_____

2. Skin / Hair / Nails:
- ☐ Change in skin color or texture
- ☐ Rashes / itching / lesions
- ☐ Skin growths
- ☐ Change in hair growth
- ☐ Change in shape of nails
- ☐ Change in condition of nails
- ☐ Other_____

3. Eyes / Ears / Nose / Throat:
- ☐ Visual problems
- ☐ Corrective lenses
- ☐ Redness / tearing / itching
- ☐ Pain in eyes
- ☐ Glaucoma
- ☐ Detached retina
- ☐ Difficulty hearing / deafness
- ☐ Ringing in ears / dizziness
- ☐ Ear pain
- ☐ Nosebleeds
- ☐ Changes in ability to smell
- ☐ Excessive sneezing
- ☐ Nasal growths / discharge
- ☐ Nose pain
- ☐ Sinus infection
- ☐ Change in voice / hoarseness
- ☐ Enlarged / painful glands
- ☐ Changes in ability to taste
- ☐ Other_____

4. Cardiovascular System:
- ☐ Heart attack
- ☐ Shortness of breath from exercise
- ☐ Chest discomfort / pain
- ☐ Palpitations
- ☐ Edema
- ☐ Fainting
- ☐ Calf pain when walking
- ☐ High blood pressure
- ☐ Past heart disease
- ☐ Other_____

5. Respiratory System:
- ☐ Difficulty breathing
- ☐ Abnormal cough
- ☐ Coughing up blood
- ☐ Asthma
- ☐ C.O.P.D. / emphysema
- ☐ Tuberculosis
- ☐ Smoke / tobacco use
- ☐ Other_____

6. Gastrointestinal System:
- ☐ Changes in appetite
- ☐ Food allergy / intolerance
- ☐ Nausea / vomiting
- ☐ Vomiting blood
- ☐ Peptic / duodenal ulcer
- ☐ Indigestion / heart burn
- ☐ Abdominal pain
- ☐ Abnormal flatulence (gas)
- ☐ Changes in bowel habits
- ☐ Diarrhea
- ☐ Hernia
- ☐ Hemorrhoids
- ☐ Gallbladder surgery
- ☐ Liver disease
- ☐ Pancreas disease
- ☐ Excessive alcohol use
- ☐ Other_____

7. Musculoskeletal System:
- ☐ Arthritis (Type:_____)
- ☐ Joint stiffness / pain
- ☐ Joint swelling
- ☐ Change in range of motion
- ☐ Joint dislocation
- ☐ Muscle cramps
- ☐ Muscle weakness
- ☐ Muscle wasting
- ☐ Muscle pain
- ☐ Strain / sprain
- ☐ Fractured bone
- ☐ Other_____

8. Neurological System:
- ☐ Headaches
- ☐ Seizures
- ☐ Dizziness/fainting
- ☐ Sensory disturbances
- ☐ Localized weakness
- ☐ Stroke / CVA / TIA
- ☐ Vertebral disc herniation
- ☐ Brain / spinal cord injury
- ☐ Other_____

9. Endocrine System:
- ☐ Heat / cold intolerance
- ☐ Thyroid problems
- ☐ Diabetes
- ☐ Other_____

10. Renal / Urinary System:
- ☐ Frequent urination
- ☐ Increased thirst
- ☐ Urinary urgency / pain
- ☐ Unusual urine color or smell
- ☐ Blood in urine
- ☐ Difficulty holding urine
- ☐ Difficulty passing urine
- ☐ Urethral discharge
- ☐ Flank / side pain
- ☐ Urinary tract infection
- ☐ Kidney disease / stone
- ☐ Dialysis
- ☐ Other_____

Patient Signature: _____ Date: _____ / _____ / _____

Past Medical History (continued) : *Check all boxes that apply*

11. Psychological:
- ☐ Anxiety
- ☐ Depression
- ☐ Bipolar
- ☐ Schizophrenia
- ☐ Post Traumatic Stress
- ☐ Anorexia/bulimia
- ☐ Other_____

12. Breasts (Male & Female):
- ☐ Breast lumps / masses / growths / pain / tenderness
- ☐ Dimples in breast
- ☐ Changes in color/shape/size
- ☐ Nipple discharge/bleeding
- ☐ Breast implants
- ☐ Other_____

13. Reproductive System:
- ☐ Unusual/missed periods
- ☐ Genital lesions
- ☐ Genital mass/growth/pain
- ☐ Sexually transmitted disease
- ☐ H.I.V./A.I.D.S.
- ☐ Other_____

List all medications, herbal supplements, vitamins and minerals you take and their doses:

_____

_____

_____

List all surgeries, dates and reasons:

_____

_____

_____

List all hospitalizations, dates and reasons:

_____

_____

_____

Authorization and Acknowledgement

I have received a copy of my **Informed Consent Release.** I have read this authorization and I understand that it explains: (1) the risks and benefits of chiropractic care, (2) the risks and benefits of alternative treatments and (3) risks and benefits of not receiving or undergoing any treatment. I have also had an opportunity to ask questions about its content, and by signing below I agree to chiropractic care.

I have received a copy of the **Protected Health Information** policy. I have read this authorization and I understand that it explains circumstances in which I permit my health information to be used and shared with others. I authorize the uses and disclosures described in this authorization.

I have received a copy of the **Financial Policy.** I have read this policy and understand that it explains my responsibilities as a client of Optimum Chiropractic and agree to abide by the Financial Policy.

I authorize a **Release of Healthcare Information** to Optimum Chiropractic for any records relevant to my physical condition including but not limited to X-ray, CT, or MRI reports and/or Emergency Room or physician treatment records.

I authorize Optimum Chiropractic to communicate with me via **telephone, voice mail, standard mail, electronic mail, and/or text messaging** regarding various aspects of my health care including, but not limited to, test results, appointments and billing.

I understand all portions of this questionnaire and all answers are true and accurate to the best of my knowledge. My initials elsewhere in this document are equivalent to signatures.

Patient Signature: _____ Date: _____ / _____ / _____

Doctor Signature: _____ Date: _____ / _____ / _____

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Modified Oswestry ***Back*** Disability Index

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

This form is designed to give us information as to how your back (or leg) condition has affected your ability to manage in everyday life. Please select the statement that ***best*** describes your condition today. Please answer ***every*** question.

1. Pain Intensity
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 at the moment.

2. Personal Care
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.

3. Lifting
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.

4. Walking
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 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.

5. Sitting
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.

6. Standing
A. I can stand as long as I want with out 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.

7. Sleeping
A. My sleep is not 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.

8. Social Life
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 my social life to my home.
F. I have no social life because of pain.

9. Traveling
A. I can travel anywhere without pain.
B. I can travel anywhere but it gives me 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 form traveling except to receive treatment.

10. Changing Degree of Pain
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.

Patient Signature: _____ Date: _____ / _____ / _____

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Modified Oswestry ***Neck*** Disability Index

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

This form is designed to give us information as to how your neck (or arm) condition has affected your ability to manage in everyday life. Please select the statement that ***best*** describes your condition today. Please answer ***every*** question.

1. Pain Intensity
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 at the moment.

2. Personal Care
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.

3. Lifting
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.

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 to with slight pain in my neck.
C. I can read as much as I want with moderate pain in my neck.
D. I can't read as much as I want because of moderate pain in my neck.
E. I can hardly read at all because of severe pain in my neck.
F. I cannot read at all.

5. Headaches
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.

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.

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 can't do any work at all.

8. Driving
A. I can drive my car without any 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 can't drive my car as long as I want because of moderate pain in my neck.
E. I can hardly drive at all because of severe pain in my neck.
F. I can't drive my car at all.

9. Sleeping
A. My sleep is not 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.

10. Social Life
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 my social life to my home.
F. I have no social life because of pain.

Patient Signature: _____ Date: _____ / _____ / _____