Coykendall Chiropractic Office

WELCOME

PERSONAL INFORMATION

PLEASE PRINT

First Name:_____**M.I.**____**Last Name:**_____**Preferred Name:**_____

Address:_____**City:**_____**State:**_____**Zip:** _____

Birthdate:_____/_____/_____ **Age**_____ **Gender: □ Male □ Female □ Unspecified**

Home Phone #:_____ **Cell Phone #/Carrier:** _____

Email: _____

Status: (check one) □ Single □ Married □ Divorced □ Widowed □ Separated Children?: □ Yes □ No How Many:_____ **Spouse's Name:** _____

Occupation:_____**Employer:** _____

Emergency Contact: (Name, Relationship, Phone #): _____

Primary Physician Name: _____

How were you referred to Coykendall Chiropractic Office? □ Patient Name_____ **□ Physician** _____
□ Website □ Facebook □ Sign □ Other _____

Name of previous chiropractor (if applicable): _____

Type of Insurance: □ Private Ins. □ Medicare □ Other _____

SOCIAL HISTORY

Height _____Ft. _____In. **Weight:** _____Lbs.

Do you exercise? ☐ Yes ☐ No **Times per week?** **Intensity?** ☐ Light ☐ Moderate ☐ Strenuous ☐ Type?:

Do you currently smoke tobacco of any kind? ☐ Yes ☐ Former smoker ☐ Never been a smoker
If "Yes", how often do you smoke: ☐ Everyday ☐ Sometimes **Circle Level Below**
If "Yes", what is your level of interest in quitting smoking? (0=NO interest, 10=very interested) 1 2 3 4 5 6 7 8 9 10

Do you drink alcohol? ☐ Yes ☐ No **How many drinks per week?** **For how many years?**

Do you take pain killers? ☐ Yes ☐ No **How often?** ☐ Daily ☐ Weekly ☐ Monthly ☐ Rarely
What type? ☐ Aspirin ☐ Ibuprofen ☐ Tylenol ☐ Other: _____

What do your work duties include? ☐ Sitting ☐ Standing ☐ Light Labor ☐ Heavy Labor ☐ Other:

Please describe your overall health right now. ☐ Excellent ☐ Very Good ☐ Good ☐ Fair ☐ Poor

What is your current stress level? ☐ Mild ☐ Moderate ☐ High

What are your hobbies?

X_____ DATE:_____

Signature of Patient, Parent or Legal Guardian (if minor)

2050 Latta Road, Rochester NY, 14612
Phone: 585-621-2540

HEALTH HISTORY

Please check ALL of the health conditions below that apply to you currently or in the past				Family History: Mark ALL conditions that run in your family		Relationship:
☐	Osteoarthritis/Degenerative Joint Disease	☐	Whiplash Injury *Date of Injury:*	☐	Cancer *Type:*	
☐	Asthma	☐	Headaches	☐	Anemia	
☐	Diabetes ☐ Type I ☐ Type II Was your blood/lab work test for hemoglobin A1c > 7.0%? ☐ Yes ☐ No ☐ Not Sure	☐	Joint Pain: circle location of pain Shoulder, Elbow, Hip, Knee, Ankle, Other_____	☐	Diabetes (check one) ☐ Type I ☐ Type II	
☐	Anemia	☐	Migraines	☐	Heart Problems/Stroke	
☐	Cancer/Tumor	☐	Osteoporosis/Osteopenia	☐	High Blood Pressure	
☐	Rheumatoid Arthritis	☐	Epilepsy/Seizures	☐	Genetic Disorders	
☐	Depression/Anxiety	☐	Fibromyalgia/Chronic Fatigue	☐	Rheumatoid Arthritis	
☐	Disc Herniation	☐	Genetic Disorders	☐	Other (List):	
☐	High Blood Pressure/ Hypertension	☐	Please list any other medical conditions:	☐		
☐	Heart Disease/Stroke			☐		

WOMEN ONLY: Currently Pregnant? □ Yes □No **Painful/Abnormal Menstrual Cycle? □ Yes □ No** **Menopause? □ Yes □ No**

Do you have children? □ Yes □ No **If "Yes",type of birth? Circle Vaginal or C-Section**

FRACTURES (Broken Bones, Sprains, Strains, Major Trauma/Injury (List and Date:)

_____

_____

SURGERIES and/or HOSPITALIZATIONS (List and Date):

_____

_____

Have you had an X-ray or CT scan or MRI of your low back spine in the past 2 years? □ Yes □ No

List current prescription medications, including frequency and dosage if known. If there are NO current medications, check here □

Name of prescription medication	Dosage/Start Date	3	
1		4	
2		5	

List any know allergies you have had to prescription medications. If NO medication allergies are known, check here □

_____

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REASON FOR VISIT

What is the reason for your visit today? ▫ Headache ▫ Neck Pain ▫ Mid-Back Pain ▫ Low Back Pain ▫ Other _____

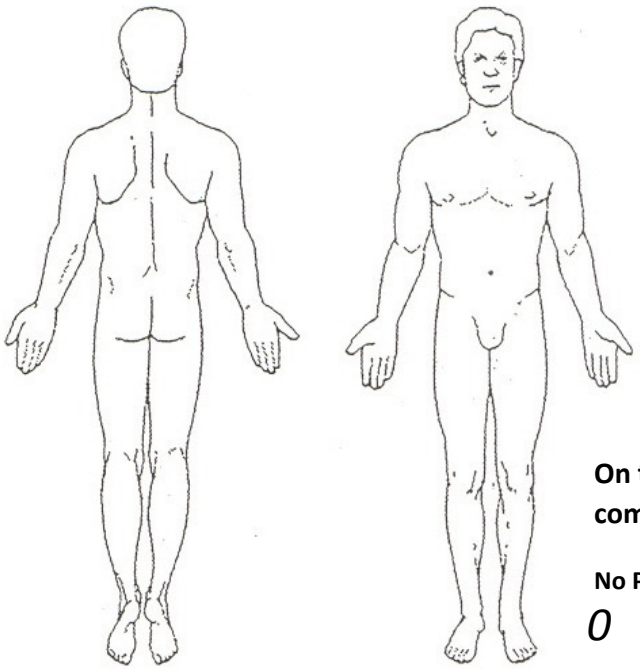
What caused this complaint(s): _____

When did this complaint begin? _____/_____/_____ **Is it getting worse? □ Yes □ No □ Constant □ Comes and goes**

Have you had this or similar complaint in the past? □ Yes □ No If "Yes", when?_____

What does your complaint (s) feel like? Circle all that apply: Sharp / Dull / Sore / Stiff / Tight / Aching / Spasms / Throbbing /

Stabbing / Shooting / Burning / Cramping / Nagging / Tingling / Numbness / Other _____



←Please Circle or make an "X" on the body diagram to the left where you have pain or other symptoms.

Area for doctor's notes:

On the scale below, please circle the severity of your main complaint right now:

No Pain **Moderate Pain** **Worst Possible Pain**

0 1 2 3 4 5 6 7 8 9 10

What aggravates this complaint? Circle all that apply: Sitting / Standing / Walking / Getting up from seat / Walking stairs / Inactivity / Sleeping / Physical Activity / Exercise / Movement / Bending forward / Bending backward / Twisting / Reaching / Lifting / Desk work / Sneezing / Coughing / Everything / Unknown / Other:_____

What relieves this complaint? Circle all that apply: Sitting / Standing / Walking / Resting / Exercise / Movement / Stretching / Massage / Chiropractic / Heat / Ice / Laying down / Medication / Nothing / Unknown / Other: _____

How often do you experience your symptoms? □ 25% of the day □ 50% of the day □ 75% of the day □ 100% of the day

Timing of complaint: Check appropriate box: □ Morning □ As day progresses □ Afternoon □ Evening □ While sleeping □ During activities □ After activities □ Symptoms are constant and do not change □ Other: _____

With time are your symptoms: □ Improving □ Worsening □ Not changing

Previous Treatment for this Condition_____**□ Yes □ No If "Yes", please provide the following information:**
Providers's name:_____ **Date consulted:**_____

Is this condition interfering with your: (Circle all that apply) Sleep / Getting in or out of bed or chair / Personal care / Travel / Work / Recreation / Lifting / Walking / Standing / Daily Routine / Social Activities / Exercise / Other: _____

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INFORMED CONSENT

To the patient: Please read this entire document prior to signing it. It is important that you understand the information contained in this document. Please ask questions before you sign if there is anything that is unclear.

The nature of the chiropractic adjustment:

The primary treatment I use as a Doctor of Chiropractic is spinal manipulative therapy. I will use that procedure to treat you. I will use a mechanical instrument upon your body in such a way as to move your joints. You may feel a sense of movement.

Analysis / Examination / Treatment

As part of the analysis, examination, and treatment, your are consenting to the following procedures:

- spinal manipulative therapy
- palpation
- vital signs
- range of motion testing
- orthopedic testing
- basic neurological testing
- muscle strength testing
- postural analysis.
- EMS
- ultrasound
- hot/cold therapy
- radiographic studies
- Other (please explain)_____

The material risks inherent in chiropractic adjustment.

As with any healthcare procedure, there are certain complications which may arise during chiropractic manipulation and therapy. These complications include but are not limited to: fractures, disc injuries, dislocations, muscle strain, cervical myelopathy, costovertebral strains and separations, and burns. Some types of manipulation of the neck have been associated with injuries to the arteries in the neck leading to or contributing to serious complications including stroke. Some patients will feel some stiffness and soreness following the first few days of treatments. I will make every reasonable effort during the examination to screen for contraindications to care; however, if you have a condition that would otherwise not come to my attention, it is your responsibility to inform me.

The probability of those risks occurring.

Stroke has been the subject of tremendous disagreement. The incidences of stroke are exceedingly rare and are estimated to occur between one in one million and one in five million cervical adjustments. The other complications are also generally described as rare.

The availability and nature of other treatment options.

Other treatment options for your condition may include:
1-Self-administered, over-the-counter analgesics and rest 2-Medical care and prescription drugs such as anti-inflammatory, muscle relaxants and painkillers 3-Hospitalization 4-Surgery

If you chose to use one of the above noted “other treatment” options, you should be aware that there are risks and benefits of such options and you may wish to discuss these with your primary medical physician.

The risks and dangers attendant to remaining untreated.

Remaining untreated may allow the formation of adhesions and reduce mobility which may set up a pain reaction further reducing mobility. Over time this process may complicate treatment making it more difficult and less effective the longer it is postponed.

DO NOT SIGN UNTIL YOU HAVE READ AND UNDERSTAND THE ABOVE.

I have read the above explanation of the chiropractic adjustment and related treatment. I have discussed it with the Doctor Coykendall at Coykendall Chiropractic Office and have had my questions answered to my satisfaction. I certify that the information I have provided is correct to the best of my knowledge. I will not hold my doctor or any staff member at Coykendall Chiropractic Office responsible for any errors or omissions that I may have made in the completion of this form. By signing below, I state that I have weighed the risks involved in undergoing treatment and have decided that it is in my best interest to undergo the treatment recommended. Having been informed of the risks, I hereby give my consent to that treatment.

Dated:_____ Dated:_____

_____ _____

Patient’s Name (Please print) Witness’s Name (Please print)

X_____ _____

Signature of Patient, Parent, or Legal Guardian (if a minor) Witness’s Signature (Please print)

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HIPPA DISCLOSURE AUTHORIZATION FORM

Coykendall Chiropractic Office

Patient consent for use and/or disclosure of protected health information to carry out treatment, payment, and healthcare operations.

_____ hereby states that by signing this consent, I acknowledge and agree as follows:

1. The practice's privacy notice has been provided to me prior to my signing this consent. The privacy notice includes a complete description of the uses and/or disclosures of my protected health information (PHI) necessary for the practice to provide treatment to me, and also necessary for the practice to obtain payment for that treatment and to carry out its health care operations. The practice explained to me that the privacy notice will be available to me in the future at my request. The practice has further explained my right to obtain a copy of the privacy notice prior to signing this consent, and has encouraged me to read the privacy notice carefully prior to my signing this consent.

2. The practice reserves the right to change its privacy practices that are described in its privacy notice, in accordance with applicable law.

3. I understand that, and consent to, the following appointment reminders that will be used by the practice: telephoning my home and leaving a message on my answering machine or with the individual answering the phone.

4. The practice may use and/or disclose my PHI (which includes information about my health or condition and the treatment provided to me) in order for the practice to treat me and obtain payment for that treatment, and as necessary for the practice to conduct its specific health care operations.

5. I understand that I have a right to request the practice restrict how my PHI is used and/or disclosed to carry out treatment, payment, and/or healthcare operations. However the practice is not required to agree to any restrictions that I have requested. However, if the practice agrees to a requested restriction, then the restriction is binding on the practice.

6. I understand that this consent is valid for seven (7) years. I further understand that I have the right to revoke this consent, in writing, at any time for all future transactions, with the understanding that any such revocation will not apply to the extent that the practice has already taken action in reliance on this consent.

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CANCELLATION POLICY/NO SHOW POLICY

1. Cancellation/No Show Policy

We understand that there are times when you must miss an appointment due to emergencies or obligations for work of family. However, when you do not call to cancel an appointment, you may be preventing another patient from getting much needed treatment. Conversely, the situation may arise where another patient fails to cancel and we are unable to schedule you for a visit, due to a seemingly "full" appointment book.

If an appointment is not cancelled at least 24 hours in advance you will be charged a twenty five dollar ($25) fee; this will not be covered by your insurance company.

2. Scheduled Appointments

We understand that delays can happen, however we must try to keep the other patients and doctor on time. **If a patient is 15 minutes past their scheduled time, we may have to reschedule the appointment.**

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THE REVISED OSWESTRY NECK PAIN QUESTIONNAIRE

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

SECTION 1-Pain Intensity

A I have no neck pain at the moment.
B The pain is very 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 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 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 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 very light weights.
F I cannot lift or carry anything 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 at all.
F I cannot walk at all without increasing pain.

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 in-frequently.
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 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 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 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 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 10-Recreation

A I am able to engage in all recreational activities with no pain in my neck at all.
B I am able to engage in all recreational activities with some pain in my neck.
C I am able to engage in most, but not all recreational activities because of pain in my neck.
D I am able to 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 at all.

Disability Index Score %_____

X_____ DATE:_____

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