

CONFIDENTIAL PATIENT INFORMATION

Name _____ Social Security # _____
 Address _____ City _____ State _____ Zip _____
 Home Telephone _____ Age _____ Birthdate _____ Marital Status: M S W D
 Work Telephone _____ # Children _____ Spouse's Name _____
 Occupation _____ Your E-mail Address _____
 Name and Address of Employer _____ Health Administrator's Name _____

HEALTH INFORMATION

Have you had previous chiropractic care? Yes No
 Main Complaint _____
 Other Complaints _____
 Are you pregnant? Yes No
 Are you taking any medication? Yes No If yes, what? _____
 Sign here to authorize x-rays and necessary tests _____
 How long have you had this condition? _____
 Have you had similar conditions in the past? _____
 Does this condition affect your family or social life? Yes No
 What aggravates this condition? _____

 Other Doctors seen for this condition _____

 What helps your symptoms? _____
 Have you had any surgery, falls or accidents? Yes No
 When? _____ Please describe _____

 Date of last physical examination _____

INSURANCE INFORMATION

Is this condition due to:
 A work-related injury? Yes No An automobile accident? Yes No
 If you answer yes to either of the above questions, please complete other side of form.
 Do you have Major Medical Health Insurance? Yes No
 Company _____
 Address _____
 Does your insurance company require a referral from your Primary Care Physician? Yes No
 If yes, name of PCP _____ Telephone _____

Do You Suffer From:

	YES	NO
Headaches	<input type="checkbox"/>	<input type="checkbox"/>
Neck Pain	<input type="checkbox"/>	<input type="checkbox"/>
Arm or Shoulder Pain	<input type="checkbox"/>	<input type="checkbox"/>
Back Pain	<input type="checkbox"/>	<input type="checkbox"/>
Hip or Leg Pain	<input type="checkbox"/>	<input type="checkbox"/>
Chest Pain	<input type="checkbox"/>	<input type="checkbox"/>
Abdominal Pain	<input type="checkbox"/>	<input type="checkbox"/>
Sinus Trouble	<input type="checkbox"/>	<input type="checkbox"/>
Heart Trouble	<input type="checkbox"/>	<input type="checkbox"/>
Palpitation	<input type="checkbox"/>	<input type="checkbox"/>
Circulatory	<input type="checkbox"/>	<input type="checkbox"/>
High or Low Blood Pressure	<input type="checkbox"/>	<input type="checkbox"/>
Female Problems	<input type="checkbox"/>	<input type="checkbox"/>
Prostate Disorder	<input type="checkbox"/>	<input type="checkbox"/>
Kidney Problems	<input type="checkbox"/>	<input type="checkbox"/>
Bladder Problems	<input type="checkbox"/>	<input type="checkbox"/>
Lung or Bronchial Disorders	<input type="checkbox"/>	<input type="checkbox"/>
Digestive Disorder	<input type="checkbox"/>	<input type="checkbox"/>
Constipation	<input type="checkbox"/>	<input type="checkbox"/>
Loose Stool	<input type="checkbox"/>	<input type="checkbox"/>
Diabetes	<input type="checkbox"/>	<input type="checkbox"/>
Swollen Joints	<input type="checkbox"/>	<input type="checkbox"/>
Insomnia	<input type="checkbox"/>	<input type="checkbox"/>
Dizziness	<input type="checkbox"/>	<input type="checkbox"/>
Numbness	<input type="checkbox"/>	<input type="checkbox"/>
Nervousness	<input type="checkbox"/>	<input type="checkbox"/>
Depression	<input type="checkbox"/>	<input type="checkbox"/>
General Fatigue	<input type="checkbox"/>	<input type="checkbox"/>
Morning Fatigue	<input type="checkbox"/>	<input type="checkbox"/>
Anemia	<input type="checkbox"/>	<input type="checkbox"/>
Poor Memory	<input type="checkbox"/>	<input type="checkbox"/>
Hot Flashes	<input type="checkbox"/>	<input type="checkbox"/>

I understand and agree that health and accident insurance policies are an arrangement between an insurance carrier and myself. Furthermore, I understand that Dudick Chiropractic will prepare any necessary reports and forms to assist me in making collection from the insurance company and that any amount authorized to be paid directly to Dudick Chiropractic will be credited to my account on receipt. However, I clearly understand and agree that all services rendered me are charged directly to me and that I am personally responsible for payment. I also understand that if I suspend or terminate my care or treatment, any fees for professional services rendered me will be immediately due and payable.

Patient's Signature _____ Date: _____
 Guardian or Spouse's Signature _____ Date: _____
 Information Taken By: _____ Date: _____

Complete only for:

JOB INJURY INFORMATION: Date _____ Time _____ Location _____

Description of accident _____

Workman's Compensation Case # _____

Insurance Company _____ Address _____

Insurance Company Case # _____

Employer's Name _____ Address _____

Hospitalized? _____ Name of Hospital _____ X-rays taken _____

Other Doctors seen _____

Are you working now? _____

Time lost from work _____ to _____ (dates)

Complete only for:

ACCIDENT INFORMATION: Date _____ Time _____ Location _____

How did accident occur? Auto Collision Other _____

If auto accident, were you Driver Passenger Pedestrian

If auto collision, were you struck from Behind Right Side Left Side Front Auto was Parked

Did your car strike the other(s) involved? Yes No

Or did the other car strike yours? Yes No Undetermined

As a result of the accident, were traffic citations issued to you? Yes No

To the driver of the other car? Yes No

To the driver of your car? Yes No

List the extent of the injuries as you know them _____

Did you require post-accident hospitalization? Yes No

Check symptoms you have noticed since accident:

- | | | | |
|--|---|--|--|
| <input type="checkbox"/> Headache | <input type="checkbox"/> Dizziness | <input type="checkbox"/> Light Bother Eyes | <input type="checkbox"/> Diarrhea |
| <input type="checkbox"/> Neck Pain | <input type="checkbox"/> Head Seems Too Heavy | <input type="checkbox"/> Loss of Memory | <input type="checkbox"/> Feet Cold |
| <input type="checkbox"/> Neck Stiff | <input type="checkbox"/> Pins and Needles in Arms | <input type="checkbox"/> Ears Ring | <input type="checkbox"/> Hands Cold |
| <input type="checkbox"/> Sleeping Problems | <input type="checkbox"/> Pins and Needles in Legs | <input type="checkbox"/> Face Flushed | <input type="checkbox"/> Stomach Upset |
| <input type="checkbox"/> Back Pain | <input type="checkbox"/> Numbness in Fingers | <input type="checkbox"/> Buzzing in Ears | <input type="checkbox"/> Constipation |
| <input type="checkbox"/> Nervousness | <input type="checkbox"/> Numbness in Toes | <input type="checkbox"/> Loss of Balance | <input type="checkbox"/> Cold Sweats |
| <input type="checkbox"/> Tension | <input type="checkbox"/> Shortness of Breath | <input type="checkbox"/> Fainting | <input type="checkbox"/> Fever |
| <input type="checkbox"/> Irritability | <input type="checkbox"/> Fatigue | <input type="checkbox"/> Loss of Smell | <input type="checkbox"/> _____ |

Symptoms other than above _____

Have you lost any days of work? Yes No Dates: _____

Insurance Companies involved:

My Company _____

Company of person responsible for injuries _____

Have you been contacted by an insurance adjuster or company representative regarding this claim? Yes No

Do you have an attorney that has advised you in this care? Yes No

Name _____

Address _____

Telephone: _____



RE: Name of Patient _____

D.O.B.: _____

SS # _____

RECORDS RELEASE

1) I hereby authorize Dudick Health to release and to permit the examination or copying of any of my medical records, X-rays, laboratory reports, and the results of all tests of any type or character to such persons as Dudick Health deems appropriate, including the information necessary to process a claim.

2) I hereby authorize my doctor or supplier of service to release and to permit the copying of any of my medical records, X-rays, insurance information, laboratory reports and the results of all tests of any type to Dudick Health, at 1789 Route 9, Clifton Park, NY 12065.

SIGNED _____ DATE _____

ASSIGNMENT OF BENEFITS

I authorize payment of medical benefits to Dudick Health for services provided.

SIGNED _____ DATE _____

ACCEPTANCE OF PATIENT RESPONSIBILITY

I understand that I am financially responsible for any charges incurred at this office, including copays, deductibles, and charges denied or not covered by my insurance company. I realize my care may be subject to pre-authorization by the insurance company, and I accept any responsibility for charges which may not be approved, including the initial visits while waiting for approval. The insurance company will review any/all documentation submitted by Dudick Health for review for medical necessity and base their approval/denial upon this documentation.

SIGNED _____ DATE _____

B Please answer each Section by circling the **ONE CHOICE** that most applies to you. You may feel that more than one statement relates to you, but only circle the one choice that closely describes your problem *right now*.

DC

SECTION 1--Pain Intensity
 A. The pain comes and goes and is very mild.
 B. The pain is mild and does not vary much.
 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
 A. I would not have to change my way of washing or dressing in order to avoid pain.
 B. I do not normally change my way of washing or dressing even though it causes some pain.
 C. Washing and dressing increase the pain, but I manage not to change my way of doing it.
 D. Washing and dressing increase the pain and I find it necessary to change my way of doing it.
 E. Because of the pain, I am occasionally unable to do any washing and dressing without help.
 F. Because of the pain, I am always unable to do any washing or dressing without help.

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.
 D. Pain prevents me from lifting heavy weights off the floor, but I can manage if they are conveniently positioned, e.g. on the table.
 E. Pain prevents me from lifting heavy weights, but I can manage light to medium weights if they are conveniently positioned.
 F. I can only lift very light weights, at the most.

SECTION 4 --Walking
 A. Pain does not prevent me from walking any distance.
 B. Pain prevents me from walking more than a one mile.
 C. Pain prevents me from walking more than a 1/2 mile.
 D. Pain prevents me from walking more than 1/4 mile.
 E. I can only walk while using a cane or on crutches.
 F. I am in bed most of the time and have to crawl to the toilet.

SECTION 5--Sitting
 A. I can sit in any chair as long as I like without pain.
 B. I can only sit in my favorite chair as long as I like despite pain.
 C. Pain prevents me from sitting more than one hour.
 D. Pain prevents me from sitting more than 1/2 hour.
 E. Pain prevents me from sitting more than ten minutes.
 F. Pain prevents me from sitting at all.

SECTION 6 -- Standing
 A. I can stand as long as I want without pain
 B. I have some pain while standing, but it does not increase with time.
 C. I cannot stand for longer than one hour without increasing pain.
 D. I cannot stand for longer than 1/2 hour without increasing pain.
 E. I can't stand for more than 10 minutes without increasing pain.
 F. I avoid standing because it increases pain right away.

SECTION 7--Sleeping
 A. I get no pain in bed.
 B. I get pain in bed, but it does not prevent me from sleeping.
 C. Because of pain, my normal night's sleep is reduced by less than one-quarter.
 D. Because of pain, my normal night's sleep is reduced by less than one-half.
 E. Because of pain, my normal night's sleep is reduced by less than three-quarters.
 F. Pain prevents me from sleeping at all.

SECTION 8--Social Life
 A. My social life is normal and gives me no pain.
 B. My social life is normal, but increases the degree of my 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 very often.
 E. Pain has restricted my social life to my home.
 F. Pain prevents me from any social activity at all.

SECTION 9--Traveling
 A. I get no pain while traveling.
 B. I get some pain while traveling, but none of my usual forms of travel make it any worse.
 C. I get extra pain while traveling, but it does not compel me to seek alternative forms of travel.
 D. I get extra pain while traveling which compels me to seek alternative forms of travel.
 E. Pain restricts all forms of travel.
 F. Pain prevents all forms of travel except that done lying down.

SECTION 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.

SECTION 11--Work
 A. I can do as much work as I want.
 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 work at all.
 F. I cannot do any work at all.

SECTION 12--Reading
 A. I can read as much as I want with no pain.
 B. I can read as much as I want with slight pain.
 C. I can read as much as I want with moderate pain.
 D. I cannot read as much as I want because of moderate pain.
 E. I cannot read as much as I want because of severe pain.
 F. I cannot read at all due to pain.

Patient Name _____ Patient/Other Signature _____

Date ____ / ____ / ____ Relationship to Patient _____

C
DC

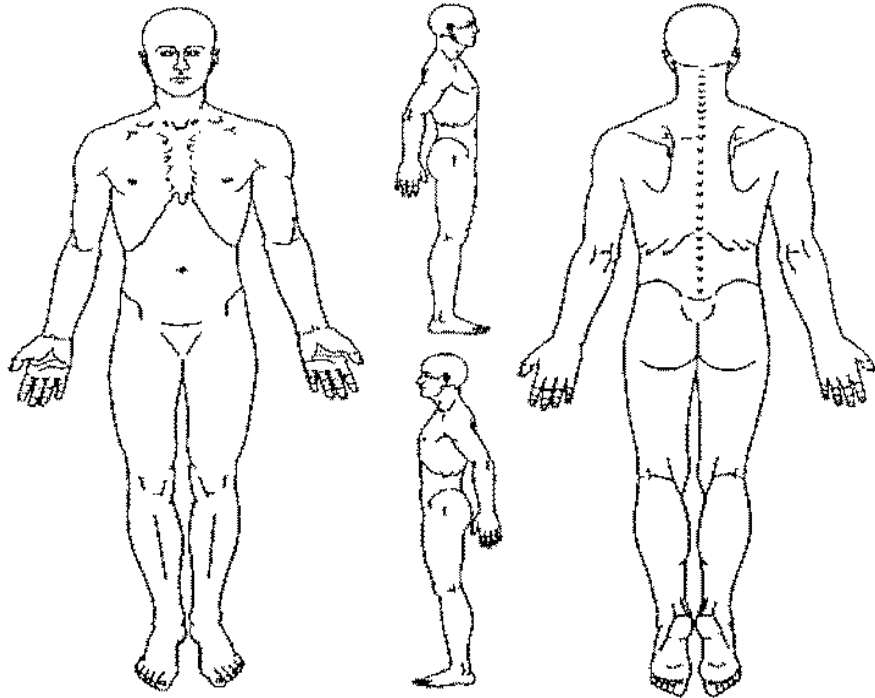
Patient Name _____

Date ____/____/____

How long have you had your symptoms? ____ days ____ weeks ____ months ____ years

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

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



Instructions: Please fill in the bubble that corresponds to the pain level that you are experiencing.

Note: If you have more than one complaint, please indicate your pain levels for each complaint. Please indicate your pain level for ① your pain at its worst, ② your pain at its least and ③ your average pain level.

Example:

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

① My pain when it is at its worst is:

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

② My pain when it is at its least is:

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

③ My average pain level is:

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

Patient/Other Signature _____ Relationship to Patient _____

Provider Signature _____ Date _____