WELCOME

Date: _____

PATIENT INFORMATION

Name: _____
Last First MI What do you prefer to be called?

Email address: _____

Mailing Address: _____

_____
CITY STATE ZIP

Phone # (H)_____ (W)_____ (Cell) _____

Can we call you at work? ❑ Yes ❑ No Can we send you text message reminders? ❑ Yes ❑ No

Date of Birth: _____ Sex: ❑ Male ❑ Female SS#: _____

Marital Status: ❑ Single ❑ Married ❑ Divorced ❑ Widowed ❑ Separated ❑ Minor

Occupation: _____ Employer: _____

Employer Address: _____

_____
CITY STATE ZIP

Employer Phone: _____

How did you hear about our practice? _____

Emergency contact: Name: _____ Relation: _____ Phone #: _____

HEALTH HISTORY

Who is your primary care physician? (Doctor and/or practice) _____
Phone: _____

Have you been to a chiropractor in the past? If so, what was your experience? _____

What have you heard about chiropractic, positive or negative? _____

Will you use chiropractic as (please check one): ❑ A temporary form of symptom relief **OR** ❑ to maximize your health & avoid the problem from returning?

Are you interested in nutritional/supplemental counseling (please check one): ❑ yes **OR** ❑ no?

Please check to indicate if you are currently experiencing any of the following conditions:

❑ Neck Pain/Stiffness	❑ Pins/Needles in Arms	❑ Light Bothers Eyes	❑ Sudden Weight Loss	❑ Nausea
❑ Back Pain/Stiffness	❑ Pins/Needles in Legs	❑ Depression	❑ Loss of Taste	❑ Cold Feet
❑ Arm/Hand Pain	❑ Fatigue	❑ Nervousness	❑ Loss of Memory	❑ Chest Pain
❑ Leg/Knee Pain	❑ Sleeping Difficulties	❑ Tension	❑ Jaw Problems	❑ Fever
❑ Shoulder Pain	❑ Loss of Smell	❑ Cold Sweats	❑ Constipation	❑ Fainting
❑ Dizziness	❑ Allergies	❑ Stomach Problems	❑ Shortness of Breath	❑ Bowel/Bladder Changes
❑ Headaches	❑ Blurred Vision	❑ Night Pain	❑ Asthma	❑ Abdominal Pain

Please check to indicate if you have ever had any of the following:

❑ Aids/HIV	❑ Cancer	❑ Hepatitis	❑ Osteoporosis	❑ Stroke
❑ Alcoholism	❑ Cataracts	❑ Hernia	❑ Pacemaker	❑ Suicide Attempt
❑ Allergy Shots	❑ Chemical Dependency	❑ Herniated Disc(s)	❑ Parkinson's Disease	❑ Thyroid Problems
❑ Anemia	❑ Chicken Pox	❑ Herpes	❑ Pinched Nerve	❑ Tonsillitis
❑ Anorexia	❑ Diabetes	❑ High Cholesterol	❑ Pneumonia	❑ Tuberculosis
❑ Appendicitis	❑ Emphysema	❑ kidney disease	❑ Polio	❑ Tumors/Growths
❑ Arthritis	❑ Epilepsy	❑ Liver Disease	❑ Prostate Problems	❑ Typhoid Fever
❑ Asthma	❑ Fracture(s)	❑ Measles	❑ Prosthesis	❑ Ulcers
❑ Bleeding Disorders	❑ Glaucoma	❑ Migraines	❑ Psychiatric Care	❑ Vaginal Infections
❑ Breast Lump	❑ Goiter	❑ Miscarriage	❑ Rheumatoid Arthritis	❑ Venereal Disease
❑ Bronchitis	❑ Gonorrhea	❑ Mononucleosis	❑ Rheumatic Fever	❑ Whooping Cough
❑ Bulimia	❑ Gout	❑ Multiple Sclerosis	❑ Scarlet Fever	❑ Heart Disease
❑ Mumps	❑ Other _____			

Are you currently under medical care? ❑ Yes ❑ No If yes, for what? _____

Please list any medications and/or birth control you are currently taking:_____

_____

Please list any supplements you are currently taking (vitamins/herbs/minerals/protein powder): _____

_____

Please list any surgeries and/or hospitalizations you have had (type & date): _____

_____

Have you had COVID-19 in the past? Have you been vaccinated? How many boosters have you received? _____

_____

Please list any allergies: _____

Is there a family history of any of the following conditions? (Indicate family member including parents, grandparents & siblings)

❑ Heart Disease _____ ❑ Diabetes _____
❑ Cancer _____ ❑ Arthritis _____ ❑ Other _____

How often do you exercise:	❑ Frequently	❑ Moderately	❑ Occasionally	❑ None
How often do you utilize alcohol:	❑ Frequently	❑ Moderately	❑ Occasionally	❑ None
How often do you smoke cigarettes:	❑ Frequently	❑ Moderately	❑ Occasionally	❑ None

By signing, I certify that the above questions were answered accurately. I understand that providing incorrect information can be dangerous to my health.

SIGNATURE (X) _____ **DATE** _____

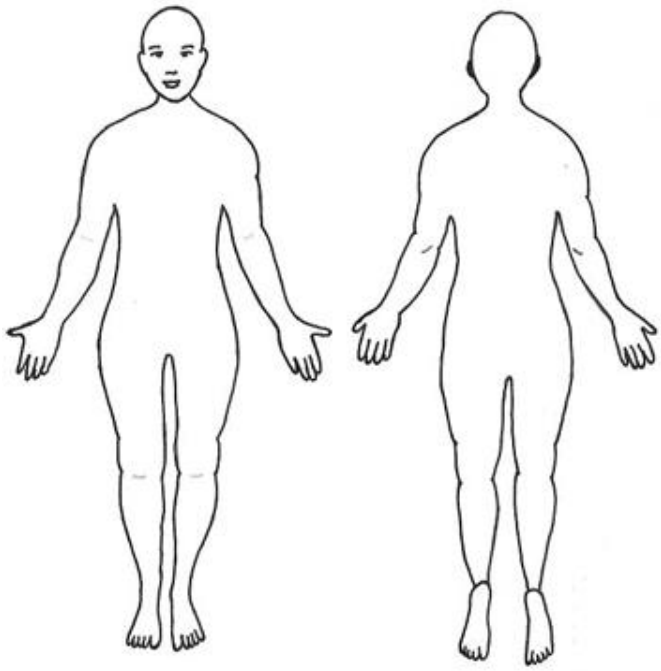
Doctor Initials/Date: _____

PATIENT PAIN DIAGRAM

Name:_____ Date:_____

Using the symbols given below, **mark the areas on your body where you feel the described sensations**. Include all affected areas.

Aching	Numbness	Pins and Needles	Burning	Stabbing	Other
++++++	========	••••••	XXXXX	ΔΔΔΔΔ	ooooo



Is your pain aggravated by any of the following?

__ Coughing or sneezing
__ Walking a distance
__ When you wake up
__ Lying flat on your back
__ Sitting in a chair
__ Bending forward
__ Lying flat on your stomach
__ In the middle of the night
__ Standing too long

Height: _____ **Weight: _____** **Right or Left-Handed: _____**

Rate your symptoms on a scale of zero to ten, ten being the worst:

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

How often do you feel your symptoms:

❑ Constantly (76-100%) ❑ Frequently (51-75%) ❑ Intermittently (26-50%) ❑ Occasionally (0-25%)

If you didn't have these symptoms, what is the first thing you would do? _____

Have you had any recent imaging? (X-ray, MRI, etc.) Type: _____ Body Part: _____

Facility who performed imaging: _____

A patient coming to the doctor gives him/ her permission and authority to care for them in accordance with appropriate test, diagnosis, and analysis. The clinical procedures performed are usually beneficial and seldom cause any problem. In rare cases underlying physical defects, deformities, or pathologies, may render the patient susceptible for injury. The doctor, of course, will not provide specific healthcare, if he/ she is aware that such care may be contraindicated. It is the responsibility of the patient to make it known or to learn through health care procedures from whatever he/ she is suffering from: latent pathological defects, illnesses, or deformities, which would otherwise not come to the attention of the doctor.

I have read and understand the foregoing.

_____

Patients Signature

Doctor Initials/Date: _____

X-RAY QUESTIONNAIRE: FOR WOMEN ONLY

Our consultation and examination may indicate that x-rays are necessary to accurately diagnose and analyze your condition. Should x-rays be necessary we would like to confirm that you are not pregnant at this time.

Name: _____

☐ There is a possibility that I a may be pregnant at this time.

☐ Yes, I am definitely pregnant

☐ No, I am definitely not pregnant at this time

☐ I request that x-ray films not be taken because: _____
_____
_____

Date of last menstrual period: _____

NOTICE OF PRIVACY PRACTICES

This notice describes how medical information about you may be used and disclosed and how you can get access to this information.

We care about our patients' privacy and strive to protect the confidentiality of your medical information at this practice. New federal legislation requires that we issue this official notice of our privacy practices. You have the right to the confidentiality of your medical information, and this practice is required by law to maintain the privacy of that information.

This practice is required to abide by the terms of the Notice of Privacy Practices currently in effect, and to provide notice of its legal duties and privacy practices with respect to protected health information. If you have any questions about this Notice, please contact the Privacy Officer at this practice.

Who will follow this notice?

Any health care professional authorized to enter information into your medical record, all employees, staff, and other personnel at this practice who may need access to your information must abide by this Notice. All subsidiaries, business associates (e.g., a billing service), sites and location of this practice may share medical information with each other for treatment, payment purposes or heath car operation as stated in this Notice. Except where treatment is involved, only the minimum necessary information needed to accomplish the task will be shared.

How We May Use and Disclose Medical Information About You

The following categories describe different ways that we may use and disclose medical information without your specific consent or authorization. Examples are provided for each category of uses or disclosures. Not all possible uses or disclosures are listed.

For Treatment. We may use medical information about you to provide you with medical treatment or services. Example: In treating you for a specific condition, we may need to know if you have allergies or prior injuries or surgeries that could influence our treatment process.

For Payment. We may use and disclose medical information about you so that the treatment and services you receive from us may be billed and payment collected from you, an insurance company or a third party. Example: We may need to send your protected health information, such as your name, address, office visit date, and codes identifying your diagnosis and treatment to your insurance company for payment.

For Health Care Operations. We may use and disclose medical information about you for health care operations to assure that you receive quality care. Example: We may use medical information to review our treatment and services and evaluate the performance of our staff in caring for you.

Other Uses or Disclosures That Can be Made Without Your Consent or Authorization

- As required during an investigation by law enforcement agencies
- To avert a serious threat to public health or safety

- As required by military command authorities for their medical records
- To worker's compensation or similar programs for processing of claims
- In response to a legal proceeding
- To a coroner or medical examiner for identification of a body
- If an inmate, to the correctional institution or law enforcement official
- As required by the US Food and Drug Administration (FDA)
- Other healthcare providers treatment activities
- Other covered entities' and providers' payment activities
- Other covered entities' healthcare operations activities (to the extent permitted under HIPAA)
- Uses and disclosures required by law
- Uses and disclosures in domestic violence or neglect situations
- Health oversight activities
- Other public health activities

We may contact you to provide appointment reminders or information about treatment and other health related benefits and services that may be of interest to you.

Uses and Disclosures of Protected Health Information Requiring Your Written Authorization

Other uses and disclosures of medical information not covered by this Notice or the laws that apply to us will be made only with your written authorization. If you give us authorization to use or disclose medial information about your, you may revoke that authorization, in writing, at any time. IF you revoke your authorization, we will thereafter no longer use or disclose medical information about you for the reasons covered by your written authorization. We are unable to take back any disclosures we have already made with your authorization, and we are required to retain our records of the care we have provided you.

YOUR INDIVIDUAL RIGHTS REGARDING:

Disclosures and Changes to Your Medical Information

Right to Request Restrictions. You have the right to request a restriction or limitation on the medical information we use or disclose about you for treatment, payment or heath care operations or to someone who is involved in your care or the payment of your care. We are not required to agree to your request. If we do agree, we will comply with your request unless the information is needed to provide you with emergency treatment. To request restrictions, you must submit your request in writing to the Privacy Officer at this practice. In your request you must tell us what information you want to limit.

Right to an Accounting of Non-Standard Disclosures. You have the right to request a list of the disclosures we made of medical information about you. To request this list, you must submit your request in writing to the Privacy Officer at this practice. Your request must state the time period for which you want to receive a list of disclosures that is no longer than six years and may not include dates before April 14, 2003. Your request should indicate in what form you want the list (example: paper or electronically). The first list you request within a 12-month period will be free. For additional lists, we reserve the right to charge you for the cost of providing the list.

Right to Amend. If you feel that medical information we have about you is incorrect or incomplete, you may ask us to amend the information. You have the right to request an amendment for as long as the information is kept. To request an amendment, your request must be made in writing and submitted to the Privacy Officer at this practice. In addition, you must provide a reason that supports your request. We may deny your request for an amendment if it is not in writing or does not include a reason to support the request. In addition, we may deny your request if the information was not created by us, is not part of the medical information kept at this practice, is not part of the information which you would be permitted to inspect and copy, or which we deem to be accurate and complete. If we deny your request for amendment, you have the right to file a statement of disagreement with us. We may prepare a rebuttal to your statement and will provide you with a copy of any such rebuttal. Statements of disagreement and any corresponding rebuttals will be kept on file and sent out with any future authorized requests for information pertaining to the appropriate portion of your record.

Your Access to Medical Information

Right to Inspect and Copy. You have the right to inspect and copy medical information that may be used to make decisions about your care. Usually this includes medical and billing records but does not include psychotherapy notes, information compiled for use in a civil, criminal, or administrative action or proceeding, and protected health information to which access is prohibited by law. To inspect and copy medical information that may be used to make decisions about your, you must submit your request in writing to the privacy officer at this practice. If you request a copy of the information, we reserve the right to charge a fee for the costs of copying, mailing or other supplies associated with your request. We may deny your request to inspect and copy in certain very limited circumstances. If you are denied access to medical information, you may request that the denial be reviewed. Another licensed heath care professional chosen by this practice will review your request and the denial. The person conducting the review will not be that person who denied your request. We will comply with the outcome of the review.

Right to a Paper Copy of This Notice. You have the right to a paper copy of this Notice at any time. Even if you have agreed to receive this notice electronically, you are still entitled to a paper copy. To obtain a paper copy of the current Notice, please request one in writing from the Privacy Office at this practice.

Right to Request Confidential Communications. You have the right to request how we should send communications to you about medical matters, and where you would like those communication sent. To request confidential communication, you must make your request in writing to the Privacy Officer at this practice. We will not ask you the reason for your request. We will accommodate all reasonable requests. Your request must specify how or where you wish to be contacted. We reserve the right to deny a request if it imposes an unreasonable burden on the practice.

Complaints. If you believe your privacy rights have been violated, you may file a complaint with the Privacy Officer at this practice or with the Secretary of the Department of Health and Human Services. All complains must be submitted in writing. You will not be penalized or discriminated against for filing a complaint.

I have read and understand the Notice of Privacy Practices.

_____ _____

Patient's Signature Date

PLEASE READ THOROUGHLY, INITIAL AT EACH SECTION AND SIGN AT THE BOTTOM. THANK YOU.

Authorization to Release Information

_____ I authorize Chiro One Wellness P.C. to release all information related to the care I receive to my HMO, insurance company, third party payor or their designee. I understand that this may be necessary for the payment of my bill, determining benefits or for utilization and quality review purposes

Information about Possible Risk of Chiropractic Treatment

_____You have the right, as a patient, to be informed about your condition and the recommended integrative and complementary procedure to be used so that you make an informed decisio0n whether or not to undergo the procedure after knowing the risk and hazards involved. This disclosure is not meant to scare or alarm you; it is simply an effort to make you better informed so that you may give or withhold your consent to the procedure. Two different types of adjustment techniques are used in this office. Primarily, for a large majority of our patients, our office is currently utilizing state- of- the- art technology; therefore, safety is not a concern. In addition to spinal manipulation, treatment can also involve other forms of therapy including ultrasound, electrical stimulation, traction, hot and cold packs, hydrotherapy, infrared heat, low level laser, trigger point, massage, exercise, topical pain relieving gel, nutritional supplement, and spinal decompression. As with any health procedure complication may arise during treatment. These complications include soreness, muscle or ligament strain, dislocation, fractures, stroke, disc injuries or physiotherapy burns. These are extremely rare occurrences.

Assignment of Benefits

_____I assign all benefits payable to me for my care to Chiro One Wellness, PC. I understand that this health care facility will be paid directly by the insurance company or other payor. This assignment will remain in effect until revoked by me in writing. A photocopy of this assignment is considered as valid as the original.

Guarantee of Payment

_____I guarantee payment of all charges incurred for treatment in accordance with the rates and terms of this health care.

Consent for Treatment

_____I authorize the performance of diagnostic tests, procedure and treatment deemed necessary by personnel involved in my care.

Authorization to Treat a Minor

_____ I hereby request my doctor at this clinic to perform diagnostic test and render chiropractic adjustment and other treatment to my minor son/daughter. This authorization also extends to all other doctors in this clinic and is intended to include radiographic examination at the doctor's discretion. As of this date, I have legal right to select and authorize health care services for the minor child named above. Under the terms and condition of my divorce (if applicable), separation or other authorization, the consent of a spouse/former spouse or other parent is not required. If my authority to so select and authorize this care should be revoked or modified in any way, I will immediately notify Disc Doctor.

Signature of Patients or responsible party: _____ **Date:** _____

Relationship to Patient:_____

Workers Compensation Injury Report

all information required

Name: _____ DOB: _____

Social Security #: _____

Date of Injury: _____ Time of Incident: _____:_____ AM/PM

Employer Name: _____

Employer's Address: _____
Street City State Zip

Employer's Phone: _____ Fax: _____

Worker's Compensation Insurance Company: _____

Workers' Comp Board Case #: _____

Carrier Case #: _____

Adjuster's Name: _____

Adjuster's Phone: _____ Fax: _____

Body part affected by incident: _____

Is this case open? ❑YES ❑NO

Are you currently working? ❑YES ❑NO

If not, what was your last date of work? _____

Do you have a lawyer? If yes what is their contact information:

_____

Describe in detail how this injury happened: _____

_____

_____

_____

_____

_____

_____

_____

_____

Describe your job responsibilities:_____

_____

_____

_____

REQUEST FOR RELEASE OF MEDICAL RECORDS

Patient Name: _____
Patient DOB: _____
Patient Phone Number: _____

TO: _____
Physician's Name/Office

_____
Street City State Zip

TO BE RELEASED TO:

Dr. Mohamed Munassar
Chiro First Wellness Center
4214 Clinton St.
West Seneca NY 14224

Phone: 716-675-2225
Fax: 716-675-2222
Email: info@chirofirstwellnesscenter.com

_____ _____
Patient's Name (Printed) *Date*

_____
Patient's Name (Signature)

Additional Comments:

Chiro First Wellness Center

Patient Name: _____ Date: _____

Check which applies: ❑Worker's Comp ❑No Fault ❑Personal Injury

According to the NF/WC fee schedule patients with no fault, worker's comp, or personal injury are only allotted 3 units of service per billing day. This letter states that I, the patient, am in agreeance that I will not receive any other treatments on the same day as another service.

Example: I will not receive chiropractic care on the same day as physical therapy.

If I, the patient, schedule 2 services within the same day and my service provider does not receive payment; I understand that I will be responsible for the payment of the service for that date.

INDEPENDENT MEDICAL EXAMS (IME) ACKNOWLEDGEMENT

New York state requires what is called and Independent Medical Exam (IME) for patient with workers compensation and no fault injuries. These exams are scheduled at any point at a different providers office. They are to determine your eligibility for care by the insurance carrier.

You must attend your scheduled IME or it will result in denial of care to your provider. Any result of non-payment due to a missed IME will be your financial responsibility.

I understand and acknowledge the terms of this agreement.

Print Name: _____

Signature: _____

Patient's Name _____ Number _____ Date _____

LOW BACK DISABILITY QUESTIONAIRE (REVISED OSWESTRY)

This questionaire has been designed to give the doctor information as to how your neck pain has affected your ability to manage in everyday life. Please answer every section and mark in each section only ONE box which applies to you. We realize you may consider that two of the statements in any one section relate to you, but please just mark the box which **MOST CLOSELY** describes your problem.

Section 1 - Pain Intensity

- ☐ I can tolerate the pain without having to use painkillers.
- ☐ The pain is bad but I can manage without taking painkillers.
- ☐ Painkillers give complete relief from pain.
- ☐ Painkillers give moderate relief from pain.
- ☐ Painkillers give very little relief from pain.
- ☐ Painkillers have no effect on the pain and I do not use them.

Section 2 - Personal Care (Washing, Dressing, etc.)

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

Section 3 - Lifting

- ☐ I can lift heavy weights without extra pain.
- ☐ I can lift heavy weights but it gives extra pain.
- ☐ Pain prevents me from lifting heavy weights off the floor, but I can manage if they are conveniently positioned, for example on a table.
- ☐ Pain prevents me from lifting heavy weights, but I can manage light to medium weights if they are conveniently positioned.
- ☐ I can lift very light weights.
- ☐ I cannot lift or carry anything at all.

Section 4 - Walking

- ☐ Pain does not prevent me from walking any distance.
- ☐ Pain prevents me from walking more than one mile.
- ☐ Pain prevents me from walking more than one-half mile.
- ☐ Pain prevents me from walking more than one-quarter mile.
- ☐ I can only walk using a stick or crutches.
- ☐ I am in bed most of the time and have to crawl to the toilet.

Section 5 - Sitting

- ☐ I can sit in any chair as long as I like.
- ☐ I can only sit in my favorite chair as long as I like.
- ☐ Pain prevents me from sitting more than one hour.
- ☐ Pain prevents me from sitting more than 30 minutes.
- ☐ Pain prevents me from sitting more than 10 minutes.
- ☐ Pain prevents me from sitting almost all the time.

Scoring: Questions are scored on a vertical scale of 0-5. Total scores and multiply by 2. Divide by number of sections answered multiplied by 10. A score of 22% or more is considered significant activites of daily living disability.

(Score ___ x 2) / (___ Sections x 10) = _____ %ADL

(Score ___ x 2) / (___ Sections x 10) = _____ %ADL

Section 6 - Standing

- ☐ I can stand as long as I want without extra pain.
- ☐ I can stand as long as I want but it gives extra pain.
- ☐ Pain prevents me from standing more than 1 hour.
- ☐ Pain prevents me from standing more than 30 minutes.
- ☐ Pain prevents me from standing more than 10 minutes.
- ☐ Pain prevents me from standing at all.

Section 7 - Sleeping

- ☐ Pain does not prevent me from sleeping well.
- ☐ I can sleep well only by using tablets.
- ☐ Even when I take tablets I have less than 6 hours sleep.
- ☐ Even when I take tablets I have less than 4 hours sleep.
- ☐ Even when I take tablets I have less than 2 hours sleep.
- ☐ Pain prevents me from sleeping at all.

Section 8 - Social Life

- ☐ My social life is normal and gives me no extra pain.
- ☐ My social life is normal but increases the degree of pain.
- ☐ Pain has no significant effect on my social life apart from limiting my more energetic interests, e.g. dancing.
- ☐ Pain has restricted my social life and I do not go out as often.
- ☐ Pain has restricted my social life to my home.
- ☐ I have no social life because of pain.

Section 9 - Traveling

- ☐ I can travel anywhere without extra pain.
- ☐ I can travel anywhere but it gives me extra pain.
- ☐ Pain is bad but I manage journeys over 2 hours.
- ☐ Pain is bad but I manage journeys less than 1 hour.
- ☐ Pain restricts me to short necessary journeys under 30 minutes.
- ☐ Pain prevents me from traveling except to the doctor or hospital.

Section 10 - Changing Degree of Pain

- ☐ My pain is rapidly getting better.
- ☐ My pain fluctuates but overall is definitely getting better.
- ☐ My pain seems to be getting better but improvement is slow at the present.
- ☐ My pain is neither getting better nor worse.
- ☐ My pain is gradually worsening.
- ☐ My pain is rapidly worsening.

Comments _____

%ADL