

# Westside Chiropractic & Wellness, PLLC

Please fill out forms as completely as possible. Thank you!

Last Name: \_\_\_\_\_ First Name: \_\_\_\_\_ MI: \_\_\_\_\_

Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip Code: \_\_\_\_\_

Home Phone: \_\_\_\_\_ Work Phone: \_\_\_\_\_ Cellular: \_\_\_\_\_

Employer: \_\_\_\_\_ E-mail: \_\_\_\_\_

Date of Birth: \_\_\_\_\_ Social Security Number: \_\_\_\_\_

Date of Injury: \_\_\_\_\_

Dominant Hand (circle one): Left/Right/Both      Marital Status (circle one): M-S-D-W

Gender (circle one): Male/Female

Insurance Information:

Policy Holder: \_\_\_\_\_ Policy#: \_\_\_\_\_

Person Responsible for the Account: \_\_\_\_\_

Primary Care Physician: \_\_\_\_\_ Phone #: \_\_\_\_\_

Address: \_\_\_\_\_

Person to notify in case of an Emergency:

Name: \_\_\_\_\_ Relationship to patient: \_\_\_\_\_

Phone #: \_\_\_\_\_

Authorization:

I affirm that the information I have provided above is correct to the best of my knowledge, and that it is my responsibility to inform this office of any changes in my medical status that take place.

Sign Name: \_\_\_\_\_ Date: \_\_\_\_\_

1. Description: Please Enter a full Description of the accident, injury or the onset of the injury in the space below:

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2. During & After the Accident Details: Please enter the Details of your condition during and After the accident or injury.

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Present Weight: \_\_\_\_\_ pounds Height \_\_\_\_\_ Feet \_\_\_\_\_ Inches

Current Medications: \_\_\_\_\_

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Hospitalizations/Surgical Procedures: \_\_\_\_\_

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Do you have a permanent disability rating: Yes/No Rating Percentage: \_\_\_\_\_ %

Location: \_\_\_\_\_ Date Rating Received: \_\_\_\_ / \_\_\_\_ / \_\_\_\_

### Family Medical History

If a Family Member has had any of the following, please mark the appropriate box:

Condition:	Family Member:	Condition:	Family Member:
Cancer		High Blood Pressure	
Chronic Back Problems		Lung Problems	
Chronic Headaches		Lupus	
Diabetes		Osteoporosis	
Heart Problems		Rheumatoid Arthritis	

## Medical History

**If you have ever had a listed symptom/diagnosis in the past, please check the past column. If you are presently experiencing or were diagnosed with one of the following conditions please check the present column. KNOWLEDGE OF THESE CONDITIONS MAY INFLUENCE THE TYPE OF TREATMENT or THERAPY YOU MAY RECEIVE. THANK YOU!**

<u>Past</u>	<u>Present</u>	<u>Condition:</u>	<u>Past</u>	<u>Present</u>	<u>Condition:</u>
___	___	Neck Pain	___	___	Liver/Gallbladder Problems
___	___	Shoulder Pain	___	___	Ulcer
___	___	Upper Arm or Elbow Pain	___	___	Muscular In coordination
___	___	Hand Pain	___	___	Swelling, Stiffness of Joints
___	___	Wrist Pain	___	___	Arthritis
___	___	Upper Back Pain	___	___	Rheumatoid Arthritis
___	___	Lower Back Pain	___	___	Heartburn/Indigestion
___	___	Upper Leg Pain	___	___	Angina
___	___	Hip Pain	___	___	Heart Attack, Date: _____
___	___	Lower Leg Pain	___	___	Aortic Aneurysm
___	___	Knee Pain	___	___	High Blood Pressure
___	___	Ankle Pain	___	___	Rapid Heart Beat
___	___	Foot Pain	___	___	Stroke, Date: _____
___	___	General Fatigue	___	___	Loss of Appetite
___	___	Depression	___	___	Abnormal Weight Gain/Loss
___	___	Dermatitis/Eczema/Rash	___	___	Anorexia/Bulimia
___	___	Asthma	___	___	Blood Disorder, Type _____
___	___	Chronic Cough	___	___	Tumor, explain _____
___	___	Emphysema (Chronic Lung Disorder)	___	___	Cancer, explain _____
___	___	Chronic Sinusitis	___	___	HIV/AIDS
___	___	Difficulty Swallowing	___	___	Epilepsy
___	___	Excessive Thirst	___	___	Fainting
___	___	Diabetes	___	___	Convulsions
___	___	Headaches	___	___	Osteoporosis
___	___	Jaw pain/TMJ	___	___	Other: _____
___	___	Tinnitus(ringing in ear)	___	___	Caffeinated Drinks: cups per day _____
___	___	Visual Disturbances	___	___	Drug or Alcohol Dependence
___	___	Dizziness	___	___	Tobacco, Frequency _____
___	___	Abdominal Pain	___	___	Alcohol Frequency _____
___	___	Bladder Infection	___	___	Birth Control, Type _____
___	___	Frequent Urination	___	___	Brest Soreness
___	___	Painful Urination	___	___	Breast Lumps
___	___	Prostate Problems	___	___	Irregular Menstrual Flow
___	___	Kidney Disorder	___	___	Profuse Menstrual Flow
___	___	Loss of Bladder Control	___	___	PMS
___	___	Loss of Bowel Control	___	___	Endometriosis
___	___	Constipation	___	___	Number of Pregnancies _____
___	___	Irregular Bowel Habits	___	___	Number of Births _____
___	___	Irritable Colon	<b><u>ALLERGIC TO:</u></b>		
___	___	Colitis	Penicillin _____		
___	___	Hepatitis, Type _____	Codeine _____		
			Sulfa Drugs _____		
			Other _____		

## PLEASE CIRCLE

### *What you need to do*

Your doctor or nurse will ask, "on a scale of 1 to 10 how bad does your pain feel?" Tell them a number that describes your pain. Use the numbers below.

- 0                      Means no pain
- 1 - 2                    **Mild Pain** - Means you have pain but you have to stop to think about it. You feel at ease.
- 3 - 4                    Means you notice your pain at rest and/or daily routine.
- 5 - 7                    **Moderate Pain** - Means your pain distracts you but you are still able to focus on something else. You may be "gritting your teeth" when you do your normal routine.
- 8 - 9                    **Severe Pain** - Means your pain is severe enough you have to stop what you are doing. You may feel it at rest, It hard to think of anything else.
- 10                      **Worst Pain** - Means this is the worst pain you have ever

# ONE COMPLAINT PER SECTION !

Description of Symptoms (Describe your worst symptom in first section, 2nd worst in 2nd section and 3rd worst in 3rd section)

**I. WORST CURRENT SYMPTOM:** (Please check off the boxes below that describe your worst symptom. Describe only ONE symptom per section).

**1. Check only one location below**

Head & Back	Left	Right	Both
<input type="checkbox"/> Jaw	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Eye	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Neck	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Upper Back	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Mid Back	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Low Back	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<b>Torso</b>			
<input type="checkbox"/> Chest	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Abdomen	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Ribs	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Buttocks	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<b>Upper Extremity</b>			
<input type="checkbox"/> Shoulder	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Upper Arm	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Forearm	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Hand	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<b>Lower Extremity</b>			
<input type="checkbox"/> Hip	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Leg	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Foot	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Other locations: _____			

**2. Types of pain** Other types of pain: \_\_\_\_\_

Dull     Sharp     Aching     Cutting  
 Throbbing     Burning     Numbing     Tingling     Cramping  
 Spasm     Stinging     Shooting     Pounding     Constricting

**3. Pain Frequency**

Up to 1/4 of awake time     1/4 to 1/2 of time  
 1/2 to 3/4 of awake time     Most all the time

**4. Pain Intensity (How it affects your daily activities)**

Doesn't affect     Somewhat affects  
 Seriously affects     Prevents activities

**5. Does this pain radiate into other body parts?**

	Left	Right	Both
<input type="checkbox"/> Head	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Neck	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Shoulder	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Arm	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Hand	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Hip	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Leg	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Foot	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Other locations of radiation: \_\_\_\_\_

**6. Actions affecting this pain**

	Brings On	Aggravates	Relieves
<input type="checkbox"/> In the A.M.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> In the P.M.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Bending forward	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Bending back	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Bending left	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Bending right	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Twisting left	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Twisting right	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Coughing	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Sneezing	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Straining	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Standing	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Sitting	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Lifting	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<b>Other Actions:</b>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

**II. SECOND WORST CURRENT SYMPTOM:** (Please check off the boxes below that describe your 2nd worst symptom)

**1. Check only one location below**

Head & Back	Left	Right	Both
<input type="checkbox"/> Jaw	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Eye	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Neck	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Upper Back	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Mid Back	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Low Back	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<b>Torso</b>			
<input type="checkbox"/> Chest	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Abdomen	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Ribs	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Buttocks	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<b>Upper Extremity</b>			
<input type="checkbox"/> Shoulder	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Upper Arm	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Forearm	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Hand	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<b>Lower Extremity</b>			
<input type="checkbox"/> Hip	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Leg	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Foot	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Other locations: _____			

**2. Types of pain** Other types of pain: \_\_\_\_\_

Dull     Sharp     Aching     Cutting  
 Throbbing     Burning     Numbing     Tingling     Cramping  
 Spasm     Stinging     Shooting     Pounding     Constricting

**3. Pain Frequency**

Up to 1/4 of awake time     1/4 to 1/2 of time  
 1/2 to 3/4 of awake time     Most all the time

**4. Pain Intensity (How it affects your daily activities)**

Doesn't affect     Somewhat affects  
 Seriously affects     Prevents activities

**5. Does this pain radiate into other body parts?**

	Left	Right	Both
<input type="checkbox"/> Head	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Neck	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Shoulder	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Arm	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Hand	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Hip	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Leg	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Foot	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Other locations of radiation: \_\_\_\_\_

**6. Actions affecting this pain**

	Brings On	Aggravates	Relieves
<input type="checkbox"/> In the A.M.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> In the P.M.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Bending forward	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Bending back	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Bending left	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Bending right	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Twisting left	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Twisting right	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Coughing	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Sneezing	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Straining	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Standing	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Sitting	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Lifting	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<b>Other Actions:</b>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

**III. THIRD WORST CURRENT SYMPTOM:** (Please check off the boxes below that describe your 3rd worst symptom)

**1. Check only one location below**

Head & Back	Left	Right	Both
<input type="checkbox"/> Jaw	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Eye	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Neck	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Upper Back	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Mid Back	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Low Back	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<b>Torso</b>			
<input type="checkbox"/> Chest	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Abdomen	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Ribs	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Buttocks	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<b>Upper Extremity</b>			
<input type="checkbox"/> Shoulder	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Upper Arm	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Forearm	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Hand	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<b>Lower Extremity</b>			
<input type="checkbox"/> Hip	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Leg	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Foot	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Other locations: _____			

**2. Types of pain** Other types of pain: \_\_\_\_\_

Dull     Sharp     Aching     Cutting  
 Throbbing     Burning     Numbing     Tingling     Cramping  
 Spasm     Stinging     Shooting     Pounding     Constricting

**3. Pain Frequency**

Up to 1/4 of awake time     1/4 to 1/2 of time     1/2 to 3/4 of awake time     Most all the time

**4. Pain Intensity (How it affects your daily activities)**

Doesn't affect     Somewhat affects     Seriously affects     Prevents activities

**5. HEADACHES**

Part of head	How much awake time is affected by headaches ?			How does it affect daily living?				
	up to 1/4	1/4 to 1/2	1/2 to 3/4	3/4 to all	1 Minimal Doesn't affect	2 Slight Some effect	3 Moderate Seriously affects	4 Marked Prevents activities
Front	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Top & Sides	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Back	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

**6. Additional symptoms information (write any additional symptoms information not covered above here and/or on the back of this page, if needed.)** \_\_\_\_\_

### Activities of Daily Living Assessment

Rate your current difficulties, resulting from your accident/illness, with regard to the various activities listed below. Use the following 1 to 5 scale and **WRITE IN THE APPROPRIATE NUMBER** that most closely describes your current degree of difficulty.

**1** = "I can do it without any difficulty", **2** = "I can do it without much difficulty, despite some pain", **3** = "I manage to do it by myself, despite marked pain", **4** = "I manage to do it, despite the pain, but only if I have help", **5** = "I cannot do it all, because of the pain"  
**Only fill in areas affected.**

#### Difficulties with Self Care and Personal Hygiene Activities

Bathing_____	Drying hair_____	Brushing teeth_____	Putting on shoes_____	Preparing meals_____	Taking out trash_____
Showering_____	Combing hair_____	Making bed_____	Tying shoes_____	Eating_____	Doing laundry_____
Washing hair_____	Washing face_____	Putting on shirt_____	Putting on pants_____	Cleaning dishes_____	Going to toilet_____

#### Difficulties with Physical Activities

Standing_____	Walking_____	Kneeling_____	Bending back_____	Twisting left_____	Leaning back_____
Sitting_____	Stooping_____	Reaching_____	Bending left_____	Twisting right_____	Leaning left_____
Reclining_____	Squatting_____	Bending forward_____	Bending right_____	Leaning forward_____	Leaning right_____
Standing for long periods_____	Sitting for long periods_____	Walking for long periods_____	Kneeling for long periods_____		

#### Difficulties with Functional Activities

Carrying small objects_____	Lifting weights off floor_____	Pushing things while seated_____	Exercising upper body_____
Carrying large objects_____	Lifting weights off table_____	Pushing things while standing_____	Exercising lower body_____
Carrying brief case_____	Climbing stairs_____	Pulling things while seated_____	Exercising arms_____
Carrying large purse_____	Climbing inclines_____	Pulling things while standing_____	Exercising legs_____

#### Difficulties with Social and Recreational Activities

Bowling_____	Jogging_____	Swimming_____	Ice Skating_____	Competitive Sports_____	Dating_____
Golfing_____	Dancing_____	Skiing_____	Roller Skating_____	Hobbies_____	Dining out_____

#### Difficulties with Traveling

Driving a motor vehicle_____	Riding as a passenger in a motor vehicle_____	Riding as a passenger on a train_____
Driving for long periods of time_____	Riding as a passenger on an airplane_____	Riding as a passenger for long periods_____

Use the following 1 to 5 scale to describe the difficulties below:

**1** = "This area is not affected by my condition", **2** = "This area is slightly affected by my condition", **3** = "My condition moderately restricts my ability in this area", **4** = "My condition seriously limits my ability in this area", **5** = "My condition prevents me from using this ability"

#### Difficulties with Different Forms of Communication

Concentrating\_\_\_\_\_ Hearing\_\_\_\_\_ Listening\_\_\_\_\_ Speaking\_\_\_\_\_ Reading\_\_\_\_\_ Writing\_\_\_\_\_ Using a keyboard\_\_\_\_\_

#### Difficulties with the Senses

Seeing\_\_\_\_\_ Hearing\_\_\_\_\_ Sense of touch\_\_\_\_\_ Sense of taste\_\_\_\_\_ Sense of smell\_\_\_\_\_

#### Difficulties with Hand Functions

Grasping\_\_\_\_\_ Holding\_\_\_\_\_ Pinching\_\_\_\_\_ Percussive movements\_\_\_\_\_ Sensory discrimination\_\_\_\_\_

#### Difficulties with Sleep and Sexual Function

Being able to have normal, restful nights sleep\_\_\_\_\_ Being able to participate in desired sexual activity\_\_\_\_\_

**Write in below any additional information regarding your Activities of Daily Living (that wasn't covered above):**

#### Prior Symptom History

##### **Prior Similar Symptoms**

I have NOT had prior symptoms similar to my current complaints.  
 My current complaints DID exist before, but had not been bothering me.  
 My current complaints ALREADY existed and were worsened.

My most recent prior similar symptoms (if applicable) occurred\_\_\_\_\_

##### **Has your History Contributed to your Current Symptoms?**

My history HAS contributed to my current symptoms.  
 My history HAS NOT contributed to my current symptoms.  
 I'm NOT SURE if my history has contributed to my current symptoms.

months ago /  years ago OR on Date: \_\_\_/\_\_\_/\_\_\_

**Write in below any other Prior Symptom History, not covered above:**

## **Westside Chiropractic and Wellness PLLC**

Joseph C. Brongo, D.C.  
Christine Sullivan-Shaw, D.C.  
Nicole M. Clemente, D.C.  
835 Spencerport Road  
Rochester, New York 14606

### **Signature On File**

I authorize use of this form on all my insurance submissions.

I authorize release of information to all my insurance companies.

I understand that I am responsible for my bills.

I authorize my doctor to act as my agent in helping me obtain payment from my insurance companies.

I authorize direct payment to my doctor.

I permit a copy of this authorization to be used in place of the original.

**Signature** \_\_\_\_\_

**Date** \_\_\_\_\_

**Medicare # (if applicable)** \_\_\_\_\_

**Westside Chiropractic and Wellness PLLC**

Joseph C. Brongo D.C.  
Christine Sullivan-Shaw D.C.  
Nicole M. Clemente, D.C.  
835 Spencerport Road  
Rochester, NY 14606

PH: (585-247-1080) FAX: (585) 429-5220

**CASH PATIENTS:** Unless arrangements are made in advance, payment is expected at the time service is rendered.

- Cash, Check, Debit, Mastercard, Visa, Discover and American Express are accepted forms of payment.
- If necessary, and if done in advance, we are willing to set up a payment agreement that is mutually satisfactory to both the patient and the office manager.

**INSURED PATIENTS:** There are many forms of insurance and many different payment requirements. Most insurances require the patient to be responsible for a copayment. The amount of your copayment is determined in your contract with your insurance company. To coincide with office policy, the copayment will be collected at each visit. If you are scheduled for more than once per week, you may make arrangements at the start of the week to pay a cumulative amount at the beginning or end of that week.

If your insurance company requires you to meet a deductible, the deductible must be paid in full before the copayment will go into effect.

**I have read and fully understand this policy and acknowledge below.**

---

**Patient Signature**

---

**Date**

Westside Chiropractic and Wellness, PLLC  
835 Spencerport Road  
Rochester, New York 14606

Dr. Joseph C. Brongo, Dr. Christine Sullivan-Shaw, Dr. Nicole Clemente

### INFORMED CONSENT

I hereby request and consent to the performance of chiropractic adjustments and other chiropractic procedures, including various modes of physical therapy and diagnostic x-rays on me (or on the patient named below, for whom I am legally responsible) by the doctor of chiropractic named above and/or other licensed doctors of chiropractic who now or in the future treat me while employed by, working or associated with or serving as backup for the doctor of chiropractic named above, including those working at the clinic or office listed above or any other office or clinic, whether signatories to this form or not.

I have had the opportunity to discuss with the doctor of chiropractic named above and/or with other office of clinic personnel the nature and purpose of chiropractic adjustments and procedures. I understand that results are not guaranteed.

I understand and am informed that, as in the practice of medicine, in the practice of chiropractic, there are some risks to treatment, including, but not limited to, fractures, disc injuries, strokes, dislocations and sprains. I do not expect the doctor to be able to anticipate and explain all risks and complications, and I wish to rely on the doctor to exercise judgment during the course of the procedure which the doctor feels at the time, based upon the facts then known, is in my best interests.

I have read or have had read to me, the above consent. I have also had the opportunity to ask questions about its content and by signing below I agree to the above named procedures. I intend this consent form to cover the entire course of treatment for my present condition and any future condition(s) for which I seek treatment.

Patient's Name \_\_\_\_\_  
PLEASE PRINT

Patient Signature \_\_\_\_\_ Date \_\_\_\_\_  
(or patient representative)

Relationship if signing for patient \_\_\_\_\_

Office Signature \_\_\_\_\_ Date \_\_\_\_\_

*Westside Chiropractic and Wellness PLLC*

**Joseph C. Brongo, D.C.  
Christine Sullivan-Shaw, D.C.  
Nicole M. Clemente, D.C.  
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:

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. The Practice reserves the right to change its privacy practices that are described in its Privacy Notice, in accordance with applicable law

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I understand that, and consent to, the following appointment reminders that will be used by the Practice:

- a) a postcard mailed to me at the address provided by me; and
- b) telephoning my home and/or work leaving a message on my answering machine or with the individual answering the phone.

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.

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

I understand that this Consent is valid for seven 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 shall not apply to the extent that the Practice has already taken action in reliance on this consent.

I understand that if I revoke this consent at any time, the Practice has the right to refuse to treat me.

I understand that if I do not sign this Consent evidencing my consent to the uses and disclosures described to me above and contained in the Privacy Notice, then the Practice will not treat me.

**I have read and understand the foregoing notice, and all of my questions have been answered to my full satisfaction in a way that I can understand.**

\_\_\_\_\_  
Name of Individual (Printed)

\_\_\_\_\_  
Signature of Individual

\_\_\_\_\_  
**Signature of Legal Representative Relationship  
(e.g., Attorney-In-Fact, Guardian, Parent if a minor):**

Date Signed \_\_\_\_ / \_\_\_\_ / \_\_\_\_

Witness \_\_\_\_\_