Westside Chiropractic Intake Form
835 Spencerport Road
Spencerport, NY 14606
585-247-1080

Today's Date: _____

PATIENT DEMOGRAPHICS

Name: _____ Birth Date: ___-___-_____ ___ Male __ Female

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

E-mail Address: _____ Home phone: _____ Mobile: _____

Cell phone provider: _____ Marital Status: __ Single __ Married

Do you have insurance: ___ yes ___no SS #: _____

Employer: _____ Occupation: _____

Spouse's Name: _____ Employer: _____

Name & number of emergency contact: _____Relationship: _____

Primary Care Physician: _____ Phone number: _____

Current Medications (dosage and frequency): _____

_____

Any Allergies: _____

SOCIAL HISTORY

1. Smoking: ___ cigars ___ pipes ___ cigarettes How often? __ daily __weekends __occasional __never
2. Alcoholic Beverage: consumption occurs __ daily __ weekends __ occasional __never
3. Recreational Drug use: __ daily __ weekends __ occasional __ never

FAMILY HISTORY

1. Does anyone in your family suffer with the same condition(s)? ___ No ___ Yes
   If yes, whom? __ grandmother __ grandfather __ mother __ father __sister(s) __ brother(s) __ son(s) __ daughter(s)
   Have they ever been treated for their condition? __ No __ Yes __ I don't know
2. Any other hereditary conditions the doctor should be aware of? ___ No ___ Yes: _____

HISTORY OF COMPLAINT

Please identify the condition(s) that brought you to this office: Primary: _____

Secondary: _____ Third: _____ Fourth: _____

When did the problem(s) begin? _____

What time of day is the problem at its worst? __ AM __ PM __ mid-day __ late PM
How long does it last? __ it's constant OR __ I experience it on and off during the day OR __ it comes and goes throughout the week

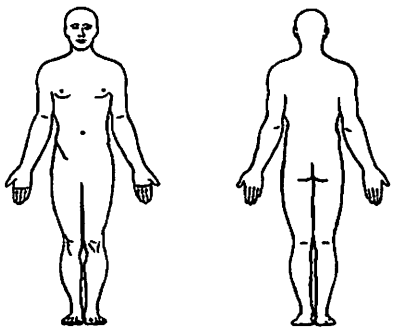
How did the injury happen? _____
Has this ever been treated by someone in the past? __ yes __ no If yes, When? ____ Who? _____
How long were you under care? _____ What were the results? _____

Name of previous chiropractor? _____ N/A ____

What relieves your symptoms? _____

What makes your symptoms feel worse? _____

Please mark the areas on the diagram with the following letters to describe your symptoms:
R- radiating B-burning D-dull A-aching N-numbness S-sharp/stabbing T-tingling



List Restricted Activity:	Current Activity Level:	Usual Activity Level:
_____	_____	_____
_____	_____	_____
_____	_____	_____

Identify any other injury(s) to your spine, major or minor, that the doctor should know about:

_____

_____

PAST HISTORY

Have you suffered with any of this or a similar problem in the past? __ yes __ no If yes, how many times? _____
When was the last episode? _____ How did the injury occur? _____

Other forms of treatment tried? __ yes __ no If yes, what type of treatment? _____, and
Who provided it? _____ How long ago? _____
What were the results? _____

Please identify any and all types of jobs you have had in the past that have imposed any physical stress on you or your body: _____

Please identify ALL PAST and any CURRENT conditions you feel may be contributing to your present problem:

	HOW LONG AGO	TYPE OF CARE RECEIVED	BY WHOM
INJURIES			
SURGERIES			
CHILDHOOD DISEASES			
ADULT DISEASES			

If you have ever been diagnosed with any of the following conditions, please indicate with a P for in the past, C for currently have and N for never had:

__ Broken Bone __ Dislocations __ Tumors __ Rheumatoid Arthritis __ Fracture __ Disability

__Heart Attack __ Osteo Arthritis __ Diabetes __ Cerebral Vascular __ Cancer __ Headache

__ Pregnant(now) __ Dizziness __ Prostate problems __ Ulcers __ Neck pain __ Frequent cold/flu

__ Loss of balance __ Impotence/Sexual Dysfun. __ Heartburn __ Jaw pain, TMJ __ Convulsions/epilepsy

__ Fainting __ Digestive Problems __ Heart problem __ Shoulder pain __ Tremors

__ Double Vision __ Colon Trouble __ High Blood Pressure __ Upper back pain __Chest pain

__ Blurred vision __ Diarrhea/Constipation __ Low Blood Pressure __ Mid Back Pain __ Pain w/ cough/sneeze

__ Ringing in Ears __ Menopausal problems __ Asthma __ Low Back pain __ Foot or Knee problem

__ Hearing Loss __ Menstrual problem __ Difficulty Breathing __ Hip Pain __ Depression

__ Sinus/drainage problem __ PMS __ Lung Problems __ Back Curvature __Swollen/painful joints

__ Irritable __ Bed wetting __ Kidney Trouble __ Scoliosis __ Skin Problems

__ Mood changes __ Learning Disability __ Gall Bladder Trouble __ ADD/ADHD __ Eating Disorder

__Numb/Tingling arms, hands, fingers __ Numb/Tingling legs, feet, toes __ Liver Trouble __Allergies

__ Trouble Sleeping __ Hepatitis (A,B,C)

ACTIVITIES OF LIFE

Please identify how your current condition is affecting your ability to carry out activities that are routinely part of your life:

ACTIVITIES:	EFFECT:			
Carry Children/Groceries	☐ No Effect	☐ Painful (can do)	☐ Painful (limits)	☐ Unable to Perform
Sit to Stand	☐ No Effect	☐ Painful (can do)	☐ Painful (limits)	☐ Unable to Perform
Climb Stairs	☐ No Effect	☐ Painful (can do)	☐ Painful (limits)	☐ Unable to Perform
Pet Care	☐ No Effect	☐ Painful (can do)	☐ Painful (limits)	☐ Unable to Perform
Extended Computer Use	☐ No Effect	☐ Painful (can do)	☐ Painful (limits)	☐ Unable to Perform
Lift Children/Groceries	☐ No Effect	☐ Painful (can do)	☐ Painful (limits)	☐ Unable to Perform
Read/Concentrate	☐ No Effect	☐ Painful (can do)	☐ Painful (limits)	☐ Unable to Perform
Getting Dressed	☐ No Effect	☐ Painful (can do)	☐ Painful (limits)	☐ Unable to Perform
Shaving	☐ No Effect	☐ Painful (can do)	☐ Painful (limits)	☐ Unable to Perform
Sexual Activities	☐ No Effect	☐ Painful (can do)	☐ Painful (limits)	☐ Unable to Perform
Sleep	☐ No Effect	☐ Painful (can do)	☐ Painful (limits)	☐ Unable to Perform
Static Sitting	☐ No Effect	☐ Painful (can do)	☐ Painful (limits)	☐ Unable to Perform
Static Standing	☐ No Effect	☐ Painful (can do)	☐ Painful (limits)	☐ Unable to Perform
Yard work	☐ No Effect	☐ Painful (can do)	☐ Painful (limits)	☐ Unable to Perform
Walking	☐ No Effect	☐ Painful (can do)	☐ Painful (limits)	☐ Unable to Perform
Washing/Bathing	☐ No Effect	☐ Painful (can do)	☐ Painful (limits)	☐ Unable to Perform
Sweeping/Vacuuming	☐ No Effect	☐ Painful (can do)	☐ Painful (limits)	☐ Unable to Perform
Dishes	☐ No Effect	☐ Painful (can do)	☐ Painful (limits)	☐ Unable to Perform
Laundry	☐ No Effect	☐ Painful (can do)	☐ Painful (limits)	☐ Unable to Perform
Garbage	☐ No Effect	☐ Painful (can do)	☐ Painful (limits	☐ Unable to Perform
Driving	☐ No Effect	☐ Painful (can do)	☐ Painful (limits)	☐ Unable to Perform
Other: _____	☐ No Effect	☐ Painful (can do)	☐ Painful (limits)	☐ Unable to Perform

INFORMED CONSENT

I have been advised that chiropractic care, like all forms of health care, hold certain risks. While the risk are most often very minimal, in rare cases, complications such as sprain/strain injuries, irritation of a disc condition, and although rare, minor fractures, and possible stroke, which occurs at a rare between one instance per one million to one per two million, have been associated with chiropractic adjustments.
Treatment objectives as well as the risks associated with chiropractic adjustments and, all other procedures provided at Westside Chiropractic have been explained to my satisfaction and I have conveyed my understanding of both to the doctor. After careful consideration, I do hereby consent to treatment by any means, method, and or techniques, the doctor deems necessary to treat my condition at any time throughout the entire clinical course of my care.

_____ _____ _____

Patient or Authorized Persons Signature Date Witness

INSURANCE CONSENT

I agree to be responsible for any service fees that are deems non-covered by an insurance carrier for services rendered at our facility by Dr Joseph Brongo or Dr. Christine Shaw.

Print Patient Name: _____

Signature of Patient: _____

Signature of legal representative/relationship: _____

Witness: _____ Date: _____

HIPPA RELEASE CONSENT

Release of information:

( ) I authorize the release of information including diagnosis, records; examination rendered to me and claims information. This information may be released to:

Name _____ Relationship: _____

_____ Relationship: _____

_____ Relationship: _____

This RELEASE OF INFORMATION will remain in effect until terminated by me in writing.

Signature: _____ Date: _____

PATIENT PRIVACY NOTICE

I have declined a copy of Westside Chiropractic Patient Privacy Notice, but I know that a copy is available if I choose to view one. I understand my rights as well as the practice's duty to protect my health information, and have conveyed my understanding of these rights and duties to the doctor. I further understand that this office reserves the right to amend this "Notice of Privacy Practice" at a time in the future and will make the new provision effective for all information that it maintains past and present.
I am aware a more comprehensive version of this "Notice" is available to me and several copies kept in the reception area. At this time, I do not have any questions regarding my rights or any of the information I have received.

Patient Name: _____ DOB: _____

Patient Signature: _____

Witness: _____ Date: _____

QUADRUPLE VISUAL ANALOGUE SCALE

Instructions: Please circle the number that best describes the question being asked.

Note: If you have more than one complaint, please answer for each individual complain and indicate the score for each complaint.

Example:

No pain Headache Neck Low Back worst possible pain

0 1 (2) 3 4 (5) 6 7 (8) 9 10

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1. What is your pain right now?

No pain _____ worst pain possible

0 1 2 3 4 5 6 7 8 9 10

2. What is your typical or average pain?

No pain _____ worst pain possible

0 1 2 3 4 5 6 7 8 9 10

3. What is your pain level at its best? (how close to "0" does your pain get at its best)

No pain _____ worst pain possible

0 1 2 3 4 5 6 7 8 9 10

4. What is your pain level at its worst? (how close to "10" does your pain get at its worst)

No pain _____ worst pain possible

0 1 2 3 4 5 6 7 8 9 10