ANTONIOTTI
CHIROPRACTIC

1820 S. Westnedge Ave. Suite #1. Kalamazoo, MI 49008

269.344.5551 antoniottichiropractic.com

PATIENT INTRODUCTION FORM & PAIN INDEX

INTRODUCTION

Date: _____

Patient name: _____ S.S. # _____

Address: _____ Home Phone: _____ ☐

City, State, Zip: _____ Work Phone: _____ ☐

Email address: _____ Cell Phone: _____ ☐

Birth date: _____ Age_____ Male ☐ Female ☐ Marital Status: _____ Check preferred method of contact

Occupation: _____ Employer: _____ Employer Address: _____

Spouse: _____ S.S. # _____ Birth date: _____ Spouse Occupation: _____

Spouse Employer: _____ Employer Address: _____

Who is responsible for your bill? Self ☐ Spouse ☐ Other ☐ Insurance Company: _____ Policy #_____

Referred by: _____

Previous Chiropractic Care: ☐ Yes ☐ No Date: _____ Doctor: _____

Were X-rays taken: ☐ Yes ☐ No Date: _____

Emergency Contact: _____ Phone: _____

MEDICAL HISTORY

Please list any/all medications you are taking at this time and precise dosage per day in mg. Please include prescription drugs, over the counter medications, and any vitamins and supplements.

1. _____
2. _____
3. _____
4. _____
5. _____
6. _____
7. _____
8. _____
9. _____
10. _____

Please attach additional sheet if necessary.

Do you have any known medication allergies? ☐ Yes ☐ No

Please list and explain reaction: _____

_____

Do you use tobacco? ☐ No ☐ Yes What Type? _____

Former smoker? ☐ No ☐ Yes Current smoker? ☐ No ☐ Yes

Cigarettes, how many packs per day? _____

Cigars, how many do you smoke per day? _____

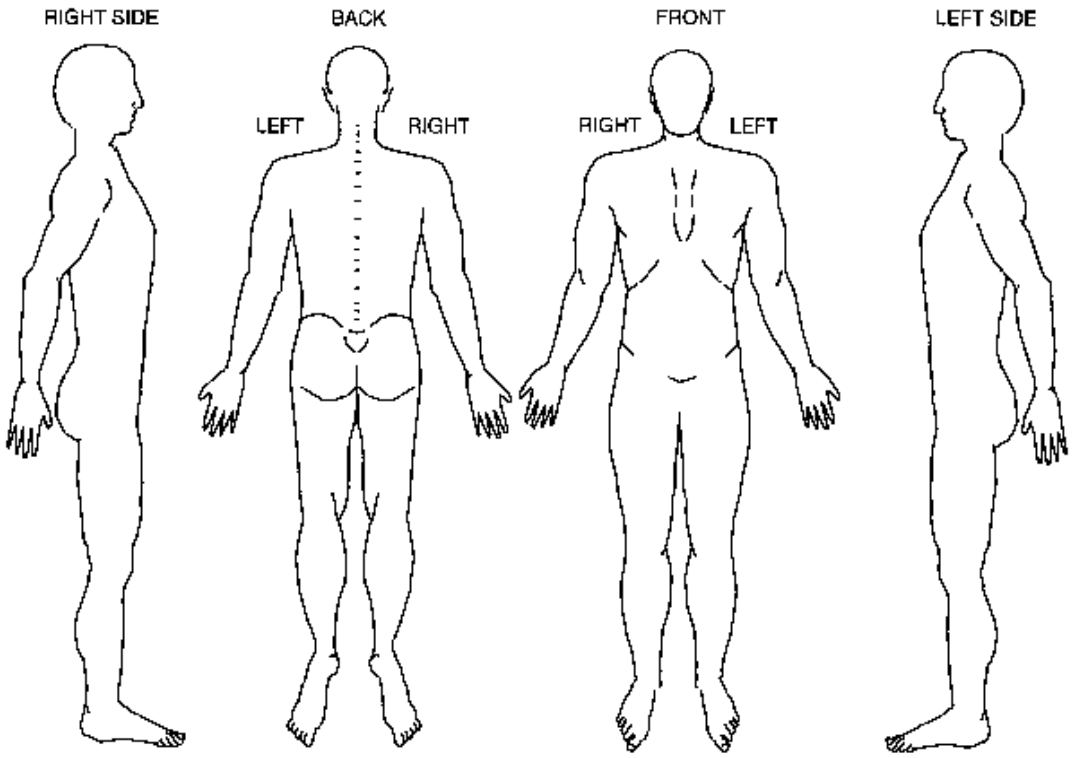
Please specify if any other form of tobacco is used: _____

PATIENT PAIN INDEX

PAIN INDICATOR

How long have you had pain? _____ Years _____ Months _____ Weeks

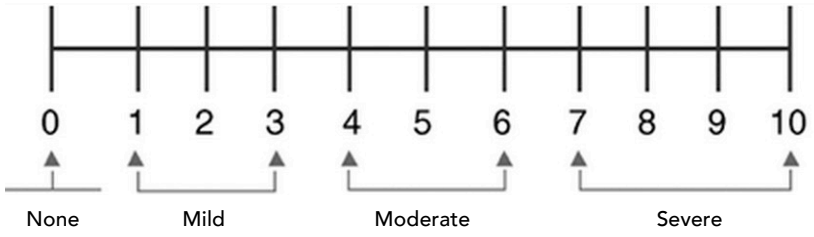
On the diagram below, please indicate where you are experiencing pain or other symptoms:



A = Ache **B** = Burning **N** = Numbness **P** = Pins & Needles **S** = Stabbing **O** = Other

PAIN SCALE

On a scale from **0** to **10** please indicate the severity of your pain: _____



In your own words please explain what your main health concern is: _____

_____

PAIN INDEX: NECK QUESTIONNAIRE

This questionnaire is designed to enable us to understand how much your neck pain ***(from your shoulders up)*** has affected your ability to manage 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 ONE** choice that closely describes your pain ***right now.***

SECTION 1

PAIN INTENSITY:

A. I have no pain at the moment.
B. The pain is 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. I need help every day in most aspects of self-care.
E. 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 if they are conveniently positioned, for example 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 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 as much as I want because of severe pain in my neck.
F. I cannot read at all.

SECTION 5

HEADACHES:

A. I have no headaches at all.
B. I have slight headaches, which come infrequently.
C. I have moderate headaches, which come infrequently.
D. I have moderate headaches, which come frequently.
E. I have severe headaches, which come frequently.
F. I have headaches almost all of 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 have 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 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: %_____

PAIN INDEX: BACK QUESTIONNAIRE

This questionnaire is designed to enable us to understand how much your back pain ***(from your shoulders down)*** has affected your ability to manage 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 ONE** choice that closely describes your pain ***right now.***

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 (WASHING, DRESSING, ETC.):

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 it is necessary to change my way of doing it.
E. Because of the pain, I am unable to do any washing and dressing without help.
F. Because of the pain, I am unable to do any washing and 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, but I can if they are conveniently positioned, for example on a table.
D. Pain prevents me from lifting heavy weights, but I can manage if they are conveniently positioned.
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 one mile.
C. Pain prevents me from walking no more than one mile.
D. Pain prevents me from walking more than ½ 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.
C. Pain prevents me from sitting more than one hour.
D. Pain prevents me from sitting more than ½ 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 ½ hour without increasing pain.
E. I cannot 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

TRAVELING:

A. I get no pain while traveling.
B. I get some pain while traveling, but none of my usual forms of travel makes 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 9

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.

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.

DISABILITY INDEX SCORE: %_____

GEORGE'S CEREBROVASCULAR CRANIOCERVICAL FUNCTIONAL TEST

Please circle the correct response. Sign and date when completed.

DOCTOR'S NOTES:

HISTORICAL INFORMATION

Have you ever been diagnosed or told you had any of the following?

1.	High blood pressure (hypertension)	☐ Yes ☐ No
2.	Hardening of the arteries (arteriosclerosis)	☐ Yes ☐ No
3.	Diabetes	☐ Yes ☐ No
4.	Heart or blood vessel disease	☐ Yes ☐ No
5.	Bone spurs on the neck bones (cervical spondylosis)	☐ Yes ☐ No
6.	Whiplash injury (flexion-extension injury or cervical sprain)	☐ Yes ☐ No
7.	Have any of your relatives ever suffered a stroke?	☐ Yes ☐ No
8.	Where you ever a smoker? From ____ To ____	☐ Yes ☐ No
9.	Do you take any medication on a regular basis? What? _____	☐ Yes ☐ No
10.	(Women only) Have you ever taken oral contraceptives? From _____ To _____	☐ Yes ☐ No

Have you ever experienced any of the following, even short temporary attacks?

1.	Blurred vision	☐ Yes ☐ No
2.	Double vision	☐ Yes ☐ No
3.	Diminished or partial loss of vision in one or both eyes	☐ Yes ☐ No
4.	Complete loss of vision in one or both eyes	☐ Yes ☐ No
5.	Ringing, buzzing, or any noise in the ear(s)	☐ Yes ☐ No
6.	Hearing loss in one or both ears	☐ Yes ☐ No
7.	Slurred speech or other speech problems	☐ Yes ☐ No
8.	Difficulty swallowing	☐ Yes ☐ No
9.	Dizziness	☐ Yes ☐ No
10.	Temporary lack of understanding	☐ Yes ☐ No
11.	Loss of consciousness, even momentary blackouts	☐ Yes ☐ No
12.	Numbness or loss of sensation in the face, fingers, hands, arms, legs, or other parts of your body	☐ Yes ☐ No
13.	Any other abnormal sensations in any part of your body	☐ Yes ☐ No
14.	Weakness, clumsiness, or loss of strength in the face, fingers, hands, arms, or legs	☐ Yes ☐ No
15.	Sudden collapses without loss of consciousness	☐ Yes ☐ No

_____ _____

Patient's Signature Date

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CONSENT FOR PURPOSES OF TREATMENT/ PAYMENT & HEALTHCARE OPERATIONS

I acknowledge that Antoniotti Chiropractic Offices "Notice of Privacy Practices" has been provided to me.

I understand I have a right to review Antoniotti Chiropractic Offices Notice of Privacy Practices prior to signing this document. Antoniotti Chiropractic Offices Notice of Privacy Practices has been provided to me. The Notice of Privacy Practices describes the types of uses and disclosures of my protected health information that will occur in my treatment, payment of my bills, or in the performance of health care operations of Antoniotti Chiropractic Offices. The Notice of Privacy Practices for Antoniotti Chiropractic Offices is also provided on request at the main administration desk of this practice. This Notice of Privacy Practices also describes my rights and Antoniotti Chiropractic Offices duties with respect to my protected health information.

Antoniotti Chiropractic Offices reserves the right to change the privacy practices that are described in the Notice of Privacy Practices. I may obtain a revised notice of privacy practices by calling the office and requesting a revised copy be sent in the mail or asking for one at the time of my next appointment.

_____ _____

Signature of Patient or Personal Representative Date

_____

Name of Patient or Personal Representative

_____

Description of Personal Representative's Authority

ABOUT FINANCIAL ARRANGEMENTS & HEALTH INSURANCE

PAYMENT POLICY

We are committed to providing you with the best possible care. If you have health insurance, we are eager to help you receive your maximum allowable benefits. In order to achieve these goals, we need your assistance, and your understanding of our payment policy.

Payment for services is due at the time services are rendered until all insurance coverage has been verified; we accept cash, check, MasterCard, Visa, and Discover. We will be happy to help process your insurance claims for your reimbursement. A completed insurance form must accompany any such requests.

INSURANCE CONTRACTS

Once insurance coverage has been verified we will gladly accept your insurance assignment for that portion of your bill estimated to be covered. Any services provided by our office, not covered by your insurance company, are due following notification of denial from your insurance carrier.

We will gladly discuss your proposed treatment and answer any questions relating to your insurance. You must realize, however, that:

1. *Your insurance is a contract between you, your employer, and the insurance company. We are not a party to that contract.*
2. *Our fees are generally considered to fall within the acceptable range by most companies. This applies only to companies who pay a percentage (such as 50% or 80%) of "U.C.R.". Most insurance companies define "U.C.R." as Usual, Customary, and Reasonable.*
3. *Not all services are covered benefits in all contracts. Some insurance companies arbitrarily select certain services they will not cover.*

We must emphasize that as health care providers, our relationship is with you, not your insurance company. While the filing of insurance claims is a courtesy that we extend to our patients, all changes are your responsibility from the date the services are rendered. We realize that temporary financial problems may affect timely payment of your account. If such problems do arise, we encourage you to contact us promptly for assistance in the management of your account.

If you have any questions about the above information or any uncertainty regarding insurance coverage, PLEASE do not hesitate to ask us. We are here to help you.

I understand that if I suspend or terminate my care and treatment, any fees for professional services rendered me will be immediately due and payable.

I hereby authorize the doctor to treat my condition, as he deems appropriate. I understand and agree that x-ray negatives will remain the property of this office, being on file where they may be seen at any time while a patient of this office. The doctor will not be held responsible for any pre-existing medically diagnosed conditions, nor for any medical diagnosis.

_____ _____

Patient's Signature Date

_____

Guardian or Spouse's Signature Authorizing Care

ASSIGNMENT OF BENEFITS

I hereby instruct and direct my insurance company to pay, by check made out and mailed directly to this clinic, the professional or medical expense benefits allowable, and otherwise payable to me under my current insurance policy, as payment toward the total charges for professional services rendered by this clinic.

A photocopy of this assignment shall be considered as effective and valid as the original.

Patient's Signature _____ Date _____

RELEASE OF INFORMATION

I authorize this clinic to release any information pertinent to my case to any insurance company, adjuster and attorney involved in this case; and hereby release this clinic of any consequences thereof.

Patient's Signature _____ Date _____

FINANCIAL RESPONSIBILITY

I agree to be financially responsible for all charges incurred at this clinic including my insurance deductible, co-payment, and any services rejected by my insurance company.

Patient's Signature _____ Date _____

INFORMED CONSENT

We encourage and support a **shared decision making process** between us regarding your health needs. As a part of that process you have a right to be informed about the condition of your health and the recommended care and treatment to be provided to you so that you can make the decision whether or not to undergo such care with full knowledge of the known risks. This information is intended to make you better informed so that you can knowledgably give or withhold your consent.

Chiropractic is based on the science, which concerns itself with the relationship between structures (primarily the spine) and function (primarily of the nervous system) and how this relationship can affect the restoration and preservation of health.

Adjustments are made by chiropractors in order to correct or reduce spinal and extremity joint subluxations. **Vertebral subluxation** is a disturbance to the nervous system and is a condition where one or more vertebra in the spine is misaligned and/or does not move properly causing interference and/or irritation to the nervous system. The primary goal in chiropractic care is the removal and/or reduction of nerve interference caused by vertebral subluxation.

A chiropractic examination will be performed which may include spinal and physical examination, orthopedic and neurological testing, palpation, specialized instrumentation, radiological examination (x-rays), and laboratory testing.

The chiropractic adjustment is the application of a precise movement and/or force into the spine in order to reduce or correct vertebral sublixation(s). There are a number of different methods or techniques by which the chiropractic adjustment is delivered

but are typically delivered by hand. Some may require the use of an instrument or other specialized equipment. In addition, physiotherapy or rehabilitative procedures may be included in the management protocol. Among other things, chiropractic care may reduce pain, increase mobility, and improve quality of life.

In addition to the benefits of chiropractic care and treatment, one should also be aware of the existence of some risks and limitations of this care. The risks are seldom high enough to contraindicate care and all health care procedures have some risk associated with them.

Risks associated with some chiropractic treatment may include soreness, musculoskeletal sprain/strain, and fracture. Risks associated with physiotherapy may include the preceding as well as allergic reaction and muscle and/or joint pain. In addition there are reported cases of stroke associated with visits to medical doctors and chiropractors. Research and scientific evidence does not establish a cause and effect relationship between chiropractic treatment and the occurrence of stroke; rather, recent studies indicate that patients may be consulting medical doctors and chiropractors when they are in the early stages of a stroke. In essence, there is a stroke already in process. However, you are being informed of this reported association because a stroke may cause serious neurological impairment.

I have been informed of the nature and purpose of chiropractic care, the possible consequences of care, and the risks of care, including the risk that the care may not accomplish the desired objective. Reasonable alternative treatments have been explained, including the risks, consequences, and probable effectiveness of each. I have been advised of the possible consequences if no care is received. I acknowledge that no guarantees have been made concerning the results of the care and treatment.

I HAVE READ THE ABOVE PARAGRAPH. I UNDERSTAND THE INFORMATION PROVIDED. ALL QUESTIONS I HAVE ABOUT THIS INFORMATION HAVE BEEN ANSWERED TO MY SATISFACTION. HAVING THIS KNOWLEDGE, I KNOWINGLY AUTHORIZE ANTONIOTTI CHIROPRACTIC TO PROCEED WITH CHIROPRACTIC CARE AND TREATMENT.

_____ _____

Patient Name Date

_____

Patient's Signature

_____

Guardian or Spouse's Signature Authorizing Care

In addition, by signing below, I give permission for the above named minor patient to be managed by the doctor even when I am not present to observe such care.

_____ _____ _____

Guardian or Spouse's Signature Authorizing Care Relationship to Patient Date