

First Visit Date: \_\_\_\_\_

### Patient Information

Tri-County Chiropractic, PC, at Soulitudes Wellness Center, 1387 Fairport Road, Building 500, Suite 520, Fairport, NY 14450

**Patient to complete the following sections:**

Patient Last Name	First Name	MI	Gender <input type="checkbox"/> M <input type="checkbox"/> F	Age	Date of Birth
Patient Address		City		State	Zip Code
Home Phone #	Work Phone #		Height	Weight	
In case of emergency contact:	Marital Status <input type="checkbox"/> M <input type="checkbox"/> D <input type="checkbox"/> S <input type="checkbox"/> W	# of Children		Social Security #	
Referred By:	Previous chiropractic care? <input type="checkbox"/> Yes <input type="checkbox"/> No	Patient Email: (Always Kept Private)			

**Insurance Information:**

Insured Last Name	First Name	MI	Insurance ID #	Date of Birth
Employer		Insurance Company Name		
Is Illness or injury related to: <input type="checkbox"/> Work <input type="checkbox"/> Auto <input type="checkbox"/> Other	Do you have secondary insurance that might cover this injury/illness: <input type="checkbox"/> Yes <input type="checkbox"/> No		If yes, other insurance company name:	

**Primary Care Physician Information:**

Doctor's Last Name	First Name	Have you seen your primary doctor for this complaint? <input type="checkbox"/> Yes <input type="checkbox"/> No      Date: _____		
Address	City	State	Zip Code	Phone Number

**History of Injury or Current Complaint:**

Please briefly describe your injury or current complaint and date of onset: \_\_\_\_\_

When does your complaint feel worse? AM PM Please explain: \_\_\_\_\_

Does your pain interrupt your sleep? No Yes Please explain: \_\_\_\_\_

What activity is affected most due to this complaint? \_\_\_\_\_

**Previous Conditions and Treatment:**

Please briefly list any previous medical conditions and treatment: \_\_\_\_\_

List all medications and supplements: \_\_\_\_\_

Do you have any allergies NO YES Please explain: \_\_\_\_\_

List all dates of hospital visits and/or types of surgeries: \_\_\_\_\_

Are any of these conditions in your family history?  Autoimmune disorders  Cancer  GI disorders  
 Heart disease  Neurological  Arthritis  Diabetes  Kidney disease  Seizures

I certify that the above information is true and correct to the best of my knowledge and I hereby consent to the release of my confidential medical and patient information in the possession of the practitioner named above to other health professionals to whom I am referred and to the insurance company or other entity responsible for payment, utilization and/or quality review for all or a portion of my care.

Signature \_\_\_\_\_ Today's date: \_\_\_\_/\_\_\_\_/\_\_\_\_

If patient required assistance to complete this form, sign your name and state relationship ( i.e.,parent, translator)

Name \_\_\_\_\_ Relationship \_\_\_\_\_ Today's date: \_\_\_\_/\_\_\_\_/\_\_\_\_

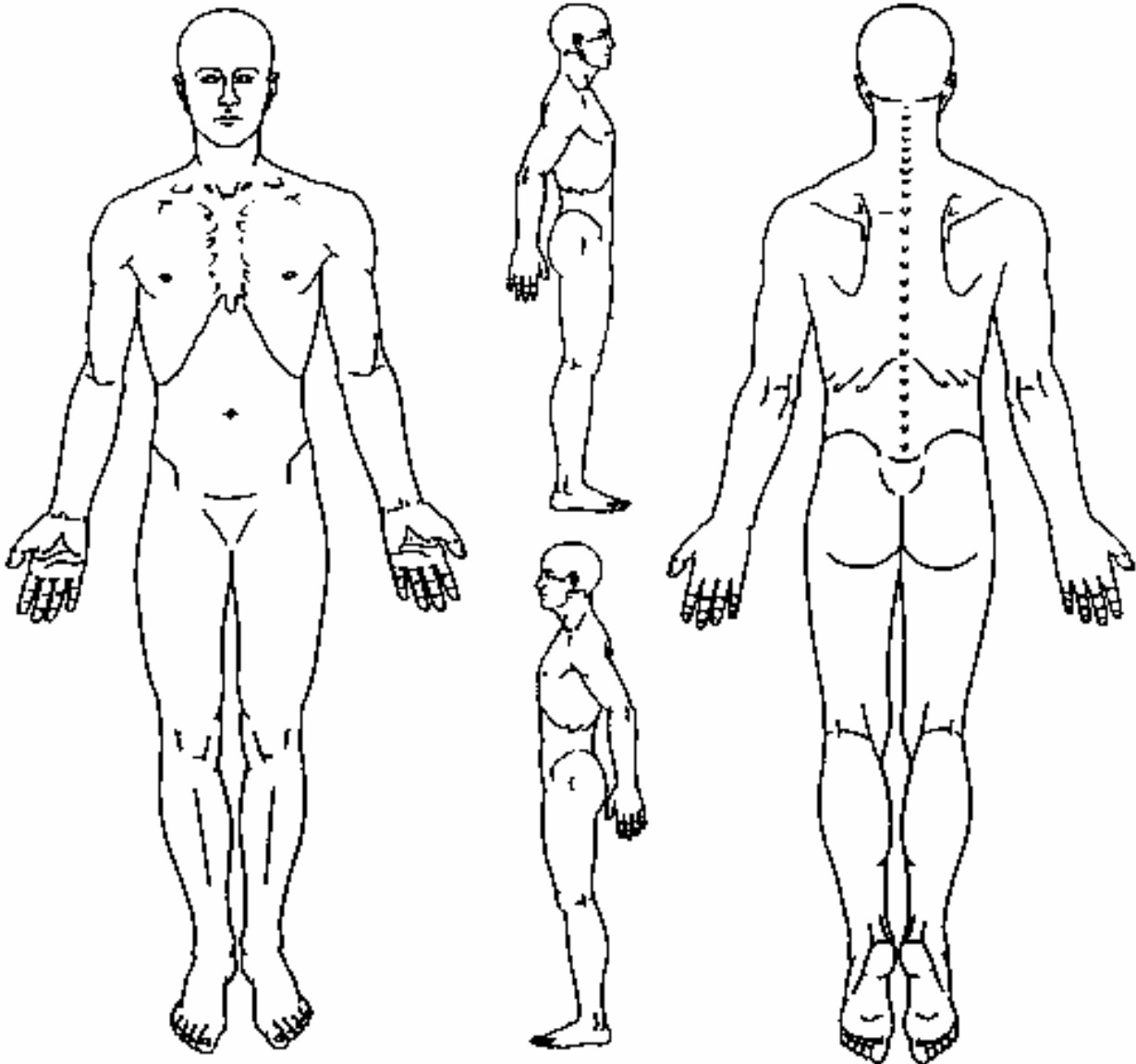
# Pain Diagram

NAME \_\_\_\_\_

DATE \_\_\_\_\_

How long have you had neck pain \_\_\_\_\_ years \_\_\_\_\_ months \_\_\_\_\_ weeks

On the diagram below, please indicate where you are experiencing pain or other symptoms, right now. Please complete both sides of this form.



**A** = ACHE

**B** = BURNING

**N** = NUMBNESS

**P** = PINS & NEEDLES

**S** = STABBING

**O** = OTHER

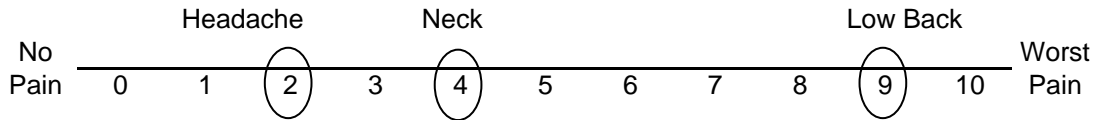
\_\_\_\_\_  
Patient Signature

# Quadruple Visual Analogue Scale

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

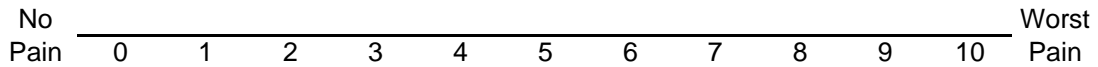
**NOTE:** If you have more than one complaint, please answer each question for each individual complaint and indicate the score for each complaint. Please indicate your average pain levels and pain at min/max using the last 3 months as your reference. If you have completed this form before, indicate you average pain level since the last time you completed this form.

**Example:**

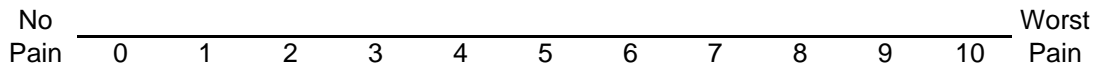


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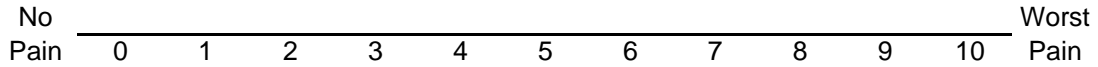
1. What is your pain **RIGHT NOW**?



2. What is your **TYPICAL** or **AVERAGE** pain?

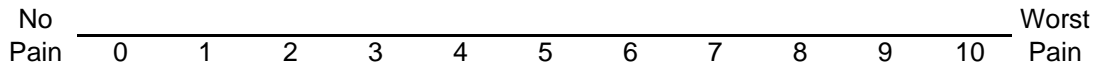


3. What is your pain level **AT ITS BEST** (How close to "0" does your pain get at its best?)



What percentage of your awake hours is your pain at its best? \_\_\_\_\_ %

4. What is your pain level **AT ITS WORST** (How close to "10" does your pain get at its worst?)



What percentage of your awake hours is your pain at its worst? \_\_\_\_\_ %

Name \_\_\_\_\_ Age \_\_\_\_\_ Date \_\_\_\_\_ Score \_\_\_\_\_

Score: #1 \_\_\_\_\_ + #2 \_\_\_\_\_ + #4 \_\_\_\_\_ = \_\_\_\_\_ /3x10= \_\_\_\_\_  Low Intensity = <50  
 High Intensity = >50

# Back Index

ACN Group, Inc. Form BI-100

ACN Group, Inc. Use Only rev 3/27/2003

**Patient Name** \_\_\_\_\_ **Date** \_\_\_\_\_

*This questionnaire will give your provider information about how your back condition affects your everyday life. Please answer every section by marking the one statement that applies to you. If two or more statements in one section apply, please mark the one statement that most closely describes your problem.*

## **Pain Intensity**

- ⓪ The pain comes and goes and is very mild.
- ① The pain is mild and does not vary much.
- ② The pain comes and goes and is moderate.
- ③ The pain is moderate and does not vary much.
- ④ The pain comes and goes and is very severe.
- ⑤ The pain is very severe and does not vary much.

## **Sleeping**

- ⓪ I get no pain in bed.
- ① I get pain in bed but it does not prevent me from sleeping well.
- ② Because of pain my normal sleep is reduced by less than 25%.
- ③ Because of pain my normal sleep is reduced by less than 50%.
- ④ Because of pain my normal sleep is reduced by less than 75%.
- ⑤ Pain prevents me from sleeping at all.

## **Sitting**

- ⓪ I can sit in any chair as long as I like.
- ① I can only sit in my favorite chair as long as I like.
- ② Pain prevents me from sitting more than 1 hour.
- ③ Pain prevents me from sitting more than 1/2 hour.
- ④ Pain prevents me from sitting more than 10 minutes.
- ⑤ I avoid sitting because it increases pain immediately.

## **Standing**

- ⓪ I can stand as long as I want without pain.
- ① I have some pain while standing but it does not increase with time.
- ② I cannot stand for longer than 1 hour without increasing pain.
- ③ I cannot stand for longer than 1/2 hour without increasing pain.
- ④ I cannot stand for longer than 10 minutes without increasing pain.
- ⑤ I avoid standing because it increases pain immediately.

## **Walking**

- ⓪ I have no pain while walking.
- ① I have some pain while walking but it doesn't increase with distance.
- ② I cannot walk more than 1 mile without increasing pain.
- ③ I cannot walk more than 1/2 mile without increasing pain.
- ④ I cannot walk more than 1/4 mile without increasing pain.
- ⑤ I cannot walk at all without increasing pain.

## **Personal Care**

- ⓪ I do not have to change my way of washing or dressing in order to avoid pain.
- ① I do not normally change my way of washing or dressing even though it causes some pain.
- ② Washing and dressing increases the pain but I manage not to change my way of doing it.
- ③ Washing and dressing increases the pain and I find it necessary to change my way of doing it.
- ④ Because of the pain I am unable to do some washing and dressing without help.
- ⑤ Because of the pain I am unable to do any washing and dressing without help.

## **Lifting**

- ⓪ I can lift heavy weights without extra pain.
- ① I can lift heavy weights but it causes extra pain.
- ② Pain prevents me from lifting heavy weights off the floor.
- ③ Pain prevents me from lifting heavy weights off the floor, but I can manage if they are conveniently positioned (e.g., on a table).
- ④ Pain prevents me from lifting heavy weights off the floor, but I can manage light to medium weights if they are conveniently positioned.
- ⑤ I can only lift very light weights.

## **Traveling**

- ⓪ I get no pain while traveling.
- ① I get some pain while traveling but none of my usual forms of travel make it worse.
- ② I get extra pain while traveling but it does not cause me to seek alternate forms of travel.
- ③ I get extra pain while traveling which causes me to seek alternate forms of travel.
- ④ Pain restricts all forms of travel except that done while lying down.
- ⑤ Pain restricts all forms of travel.

## **Social Life**

- ⓪ My social life is normal and gives me no extra pain.
- ① My social life is normal but increases the degree of pain.
- ② Pain has no significant affect on my social life apart from limiting my more energetic interests (e.g., dancing, etc).
- ③ Pain has restricted my social life and I do not go out very often.
- ④ Pain has restricted my social life to my home.
- ⑤ I have hardly any social life because of the pain.

## **Changing degree of pain**

- ⓪ My pain is rapidly getting better.
- ① My pain fluctuates but overall is definitely getting better.
- ② My pain seems to be getting better but improvement is slow.
- ③ My pain is neither getting better or worse.
- ④ My pain is gradually worsening.
- ⑤ My pain is rapidly worsening.

Index Score = [Sum of all statements selected / (# of sections with a statement selected x 5)] x 100

Back  
Index  
Score

# Neck Index

ACN Group, Inc. Form NI-100

ACN Group, Inc. Use Only rev 3/27/2003

Patient Name \_\_\_\_\_ Date \_\_\_\_\_

*This questionnaire will give your provider information about how your neck condition affects your everyday life. Please answer every section by marking the one statement that applies to you. If two or more statements in one section apply, please mark the one statement that most closely describes your problem.*

## Pain Intensity

- ⓪ I have no pain at the moment.
- ① The pain is very mild at the moment.
- ② The pain comes and goes and is moderate.
- ③ The pain is fairly severe at the moment.
- ④ The pain is very severe at the moment.
- ⑤ The pain is the worst imaginable at the moment.

## Sleeping

- ⓪ I have no trouble sleeping.
- ① My sleep is slightly disturbed (less than 1 hour sleepless).
- ② My sleep is mildly disturbed (1-2 hours sleepless).
- ③ My sleep is moderately disturbed (2-3 hours sleepless).
- ④ My sleep is greatly disturbed (3-5 hours sleepless).
- ⑤ My sleep is completely disturbed (5-7 hours sleepless).

## Reading

- ⓪ I can read as much as I want with no neck pain.
- ① I can read as much as I want with slight neck pain.
- ② I can read as much as I want with moderate neck pain.
- ③ I cannot read as much as I want because of moderate neck pain.
- ④ I can hardly read at all because of severe neck pain.
- ⑤ I cannot read at all because of neck pain.

## Concentration

- ⓪ I can concentrate fully when I want with no difficulty.
- ① I can concentrate fully when I want with slight difficulty.
- ② I have a fair degree of difficulty concentrating when I want.
- ③ I have a lot of difficulty concentrating when I want.
- ④ I have a great deal of difficulty concentrating when I want.
- ⑤ I cannot concentrate at all.

## Work

- ⓪ I can do as much work as I want.
- ① I can only do my usual work but no more.
- ② I can only do most of my usual work but no more.
- ③ I cannot do my usual work.
- ④ I can hardly do any work at all.
- ⑤ I cannot do any work at all.

## Personal Care

- ⓪ I can look after myself normally without causing extra pain.
- ① I can look after myself normally but it causes extra pain.
- ② It is painful to look after myself and I am slow and careful.
- ③ I need some help but I manage most of my personal care.
- ④ I need help every day in most aspects of self care.
- ⑤ I do not get dressed, I wash with difficulty and stay in bed.

## Lifting

- ⓪ I can lift heavy weights without extra pain.
- ① I can lift heavy weights but it causes extra pain.
- ② Pain prevents me from lifting heavy weights off the floor, but I can manage if they are conveniently positioned (e.g., on a table).
- ③ Pain prevents me from lifting heavy weights off the floor, but I can manage light to medium weights if they are conveniently positioned.
- ④ I can only lift very light weights.
- ⑤ I cannot lift or carry anything at all.

## Driving

- ⓪ I can drive my car without any neck pain.
- ① I can drive my car as long as I want with slight neck pain.
- ② I can drive my car as long as I want with moderate neck pain.
- ③ I cannot drive my car as long as I want because of moderate neck pain.
- ④ I can hardly drive at all because of severe neck pain.
- ⑤ I cannot drive my car at all because of neck pain.

## Recreation

- ⓪ I am able to engage in all my recreation activities without neck pain.
- ① I am able to engage in all my usual recreation activities with some neck pain.
- ② I am able to engage in most but not all my usual recreation activities because of neck pain.
- ③ I am only able to engage in a few of my usual recreation activities because of neck pain.
- ④ I can hardly do any recreation activities because of neck pain.
- ⑤ I cannot do any recreation activities at all.

## Headaches

- ⓪ I have no headaches at all.
- ① I have slight headaches which come infrequently.
- ② I have moderate headaches which come infrequently.
- ③ I have moderate headaches which come frequently.
- ④ I have severe headaches which come frequently.
- ⑤ I have headaches almost all the time.

Index Score = [Sum of all statements selected / (# of sections with a statement selected x 5)] x 100

Neck  
Index  
Score

TRI-COUNTY CHIROPRACTIC, PC  
DR. SCOTT D. COON, CHIROPRACTOR  
1387 FAIRPORT ROAD, BUILDING 500, SUITE 520  
FAIRPORT, NY 14450

**NOTICE OF PRIVACY PRACTICES  
(MEDICAL)  
THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU  
MAY BE USED  
AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS  
INFORMATION. PLEASE  
REVIEW IT CAREFULLY.**

The Health Insurance Portability & Accountability Act of 1996 ("HIPAA") is a federal program that requires that all medical records and other individually identifiable health information used or disclosed by us in any form, whether electronically, on paper, or orally, are kept properly confidential. This Act gives you, the patient, significant *new* rights to understand and control how your health information is used. "HIPAA" provides penalties for covered entities that misuse personal health information.

As required by "HIPAA", we have prepared this explanation of how we are required to maintain the privacy of your health information and how we may use and disclose your information.

We may use and disclosed your medical records only for each of the following purposes: treatment, payment and health care operations.

- Treatment means providing, coordinating, or managing health care and related services by one or more health care providers. An example of this would include a physical examination.
- Payment means such activities as obtaining reimbursement for services, confirming coverage, billing or collection activities, and utilization review. An example of this would be sending a bill for your visit to your insurance company for payment.
- Health care operations include the business aspects of running our practice, such as conducting quality assessment and improvement activities, auditing functions, cost-management analysis, and customer service. An example would be an internal quality assessment review.

We may also create and distribute de-identified health information by removing all references to individually identifiable information.

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

Any other uses and disclosures will be made only with your written authorization. You may revoke such authorization in writing and we are required to honor and abide by that written request, except to the extent that we have already taken actions relying on your authorization.

You have the following rights with respect to your protected health information, which you can exercise by presenting a written request to the Privacy Officer:

- The right to request restrictions on certain uses and disclosures of protected health information, including those related to disclosures to family members, other relatives, close personal friends, or any other person identified by you. We are, however, not required to agree to a requested restriction. If we do agree to a restriction, we must abide by it unless you agree in writing to remove it.
- The right to reasonable requests to receive confidential communications of protected health information from us by alternative means or at alternative locations.
- The right to inspect and copy your protected health information.
- The right to amend your protected health information.
- The right to receive an accounting of disclosures of protected health information.
- The right to obtain a paper copy of this notice from us upon request.

We are required by law to maintain the privacy of your protected health information and to provide you with notice of our legal duties and privacy practices with respect to protected health information.

This notice is effective as of April 14th, 2003 and we are required to abide by the terms of the Notice of Privacy Practices currently in effect. We reserve the right to change the terms of our Notice of Privacy Practices and to make the new notice provisions effective for all protected health information that we maintain. We will post and you may request a written copy of a revised Notice of Privacy Practices from this office.

You have recourse if you feel that your privacy protections have been violated. You have the right to file a written complaint with our office, or with the Department of Health & Human Services, Office of Civil Rights, about violations of the provisions of this notice or the policies and procedures of our office. We will not retaliate against you for filing a complaint.

Please contact us for more information: 585-425-9820

For more information about HIPAA or to file a complaint write to The U.S. Department of Health & Human Services Office of Civil Rights 200 Independence Avenue, S.W. Washington, D.C. 20201 (202) 619-696-6775  
Toll Free: 1-877-696-6775

**Acknowledgement of Receipt of Notice of Privacy Practices**

Please sign and print your name and provide the date below to acknowledge that you have received, read, and understand our Notice of Privacy Practices. Please return it to our front office staff at your next visit or mail it to Tri-County Chiropractic, PC, 1387 Fairport Road, Fairport, NY 14450

Patient Name: \_\_\_\_\_

Relation to Patient: \_\_\_\_\_

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

**NOTICE OF PATIENT PRIVACY RIGHTS**

By signing below, I acknowledge that I have received a copy of the “Notice of Patient Privacy Rights” and a copy will be available for me at the reception desk upon my request. The Health Insurance Portability and Accountability Act (HIPPA) ensures a patient’s right to privacy regarding personal health information and it is this office’s policy to maintain confidentiality to the highest degree.

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Patient/Legal Guardian Signature Date:

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Doctor’s Signature: Date:

**INFORMED CONSENT**

Any procedure intended to help may also do harm. While Chiropractic examination and therapeutic procedures are usually considered to be remarkably safe and effective, please understand that occasionally there may be adverse reactions. Although the chances of experiencing any of these complications are extremely small, it is the practice of this office to fully inform and educate all of our patients.

By signing below, I understand that these complications include, but are not limited to, post-adjustment soreness, muscle strain and sprain, fractures, dislocations, disc injuries, and strokes. I do not expect the doctor to be able to anticipate or explain all possible risks and complications. I wish to rely on the doctor to exercise judgment during the course of my treatments which they feel at the time, based upon the facts then known, is in my best interests.

I understand that there is not guarantee or warranty for a specific cure or result. I understand that at any time, I can request further explanation regarding risks and benefits of care in this office, alternative courses of care, and the consequences of not having the proposed treatment. Further, I agree to notify the doctor immediately with any concerns, if I were ever to become uncomfortable for any reason – treatment is too much to tolerate, personal issues with space or touch, religious, etc.

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Patient/Legal Guardian Signature Date:

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Doctor’s Signature: Date:

**OFFICE POLICIES**

**I agree to take full financial responsibility for my care** in the event that the assumed coverage (Worker’s Compensation, No Fault Insurance, HMO, etc) is denied for any reason. I further understand that the office charges a **\$20 fee for returned checks**. I also understand that this office operates on a **fee-for-service basis**. If payment is not made at the time services are rendered, I understand that the office reserves the right to charge a \$10 fee.

**The office reserves the right to charge for appointments canceled without 24 hours notice and for not attending scheduled appointments.** One “no show” is allowed for every patient per six months of care. After that allowance is made the office will charge up to 100% of the *cash value* of the scheduled appointment, *not just a copay*. Patients *late* for appointments have the option of either using the remainder of the time scheduled at the full price as scheduled, or the patient may reschedule the appointment and be charged for the missed visit.

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Patient/Legal Guardian Signature Date:

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Doctor’s Signature: Date: