Welcome! **Patient Information** Chart # _____

Please Complete the information below as complete as possible

First Name		MI	Last Name		Title Suffix
Street				SS# D0B	
City				Marital Status	Sex
State	Zip	Work Phone	Home Phone	Cell Phone	Email address

Employment Information

Employer's Name	Position
What do you do there?	Spouse Name
Spouse's Employer	Time Employed?

Insurance Information

Primary Insurance Company			Insured's Name	
Address			Relationship to Insured	
City	State	Zip	SS#	DOB
Secondary Insurance Company			Insured's Name	
Address			Relationship to Insured	
City	State	Zip	SS #	D0B

Account Information

Desired Method of Payment: Circle One Cash Check Visa Mastercard Amex

Card Number	EXP, Date		Name of Person to be Billed	
Billing Address			Relationship	
City	Stale	Zip	SS#	Driver's License #
Who Referred you to our Office?				

Attorney

Have you retained an attorney? **Yes** No

Attorney's Name			
Address			Phone
City	State	Zip	Copywrite 1989

Dr Nixdorf ___ Dr. Stabile _X__ Covid-19 Patient Screening

Patient's Name_____ Date_____

Temperature _____ Washed Hands ___ Wearing Gloves ___ Wearing Mask ___

Do You have any of the following symptoms?

1. Fever and/or chills Yes ___ No ___
2. Cough (usually dry) Yes ___ No ___
3. Shortness of breath or difficulty breathing Yes ___ No ___
4. Tiredness (sometimes) Yes ___ No ___
5. Aches and pains (sometimes) Yes ___ No ___
6. Headaches (sometimes) Yes ___ No ___
7. Sore throat (sometimes) Yes ___ No ___
8. Upper respiratory symptoms, like runny nose and sinus congestion, are very uncommon in COVID-19. Yes ___ No ___
9. In the past two to three weeks have you been in contact with anyone that has tested positive for the COVID-19 Virus? Yes ___ No ___
10. Have you received the Covid Vaccine Yes___ No ___
11. If this is your follow-up visit and you have answered these questions at your last visit then have any of your answer's changed since that visit?
12. Yes ___ No ___

I have read the above and certify that it is correct to the best of my knowledge. The doctor is compliant with the necessary, accepted, and recommended precautions as they relate to the Covid 19 guidelines. I agree that if at any time on future visits any of the answers to the above questions should change I will notify the doctor immediately.

I was instructed to wash my hands prior to and after my encounter. I am socially distanced from any other patient in the office during my visit. The doctor has hand sanitizer, antiseptic spray, is wearing a N 95 Face masks and Surgical gloves. The office was sanitized prior to my entering and as I am leaving. My temperature was taken, and I was asked the above questions. I indemnify the doctor for any health problems I may have prior to and after my visit to the office.

Patient's Signature _____ Date _____

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THE IMPORTANCE OF ATTENDING YOUR

APPOINTMENTS ON A REGULAR BASIS

We have serious concerns regarding the frequency of missed appointments. The treatment plan that we recommended at your Report of Findings is a prescription for care that is no different than any other prescription from your medical doctor. If a Doctor of Medicine prescribes 3 pills per day for 12 days or a total of 36 pills, that is no different than our prescription for 3 treatments per week for 12 weeks or 36 treatments. The difference lies in the fact that you are taking the medication and in a sense self treating. The treatment we deliver can only be delivered by the doctor with you being present in our office. To have the best possible results you must follow the recommendations we made to you. If you miss a prescribed medication you slow down, stop your recovery or sometimes cause your condition to worsen. If you miss your chiropractic treatment you slow down or stop and sometimes cause your condition to worsen as well. Missing a treatment may take an additional few treatment 0 to make up for the loss. The improper treatment or lack of treatment in the manner we recommended can often times cause the quality of your life to become compromised. This may cause difficulty performing necessary tasks which may affect your daily activities, entertainment, and work. Make your appointments for a time that you will not be having to cancel or change. We work by appointment in an effort to enable patients to spend as little time as possible receiving the necessary treatment. When you cancel or miss an appointment you not only lose out on the benefits of the treatment but affect others who could have taken that appointment time. Being late or early for an appointment without calling may cause increased waiting time for other patients who are on time for their appointments.

Missed Appointments

To enable us to efficiently attend to our patients, appointments for the following week are scheduled at the end of each week. Our Office Policy requires our patients to make appointments in advance. When an appointment time needs to be changed it is **COMMON COURTESY** that you make the change in person or by telephone prior to the scheduled appointment that is being changed. If you are running late or wish to come in earlier, we require that you call and change your scheduled appointment time. Missed appointments are required to be made up the same week or the following week. Missed appointments (i.e. "no show, no call") may result in a $50.00 charge after the first incident. Attending your appointments are to your advantage as they will enable you to heal faster and more completely preventing complications and long-lasting chronic problems.

Financial Plans:

If you have been given the Privilege of paying for your treatment with our Interest Free Financial Plan, you are being given the Privilege of receiving your necessary treatment in a manner that is to your financial advantage as noted in the Financial Agreement. You are receiving treatment that would cost you more than three to four times the fees included in your plan. We offer these Financial Plans to enable our patients to receive the necessary treatment and achieve optimal results without the burden of unknown costs. Enabling the cost of treatment to be distributed monthly over a one-year time period results in reduced up-front payments.

Administering a practice is complicated and time consuming. The requirements imposed on the Doctor's Office by the Insurance Companies has become burdensome and takes time away from patient treatment. Contacting the Insurance Companies/Governmental Agencies requires that we leave a message and wait for a call back which can take days or even weeks. We must answer the call backs immediately or we lose the opportunity to receive answers to questions that affect our patient's treatment and payment. Unfortunately, many of these calls necessitate the doctor's attention and, in some instances, may require the patient to wait. Each of you may be in this situation at some time or another and we hope you can be patient and understand when this happens.

YOUR HEALTH IS OUR PRIMARY CONCERN AND IT SHOULD BE YOURS AS WELL. "WHEN YOU HAVE YOUR HEALTH, YOU HAVE EVERYTHING"! PLEASE MAKE EVERY EFFORT TO COMPLY WITH YOUR TREATMENT RECOMMENDATIONS!!!

I hereby state that I have read the above and understand its content and agree to abide by the Office Procedures and Rules.

_____ _____ _____ _____

Printed Name Date Signature Witness

ASSIGNMENT OF INSURANCE BENEFITS

PATIENT'S NAME: _____

DATE OF ACCIDENT or Start of Condition: _____

In consideration for services rendered to me or to be rendered to me in the future, I hereby authorize payment to the above-referenced provider of any and all insurance benefits to which I may otherwise be entitled for services rendered by the provider.

In the event that the provider's charges are outstanding, I hereby assign and authorize the provider to institute arbitration proceedings or other litigation for the purpose of the provider realizing payment for services rendered. It is also my intent that the provider receives payment directly from the insurance carrier, whether payment is issued prior to or as a result of arbitration proceedings or litigation.

This authorization and assignment or photocopy thereof shall authorize you to furnish all information you may have concerning my condition while under your observation or treatment, including, but not limited to the history obtained, x-ray, MRI, physical findings, diagnosis and prognosis.

SIGNATURE: _____

RELATIONSHIP TO PATIENT: _____

DATED: _____

Claim # _____

First Date of Treatment _____

Emergency Contact Information

In the rare case that an emergency involving you may occur I our office, we would like to know who to contact regarding your care; this person would be contacted immediately after we notify emergency services. For this reason, we wish to have an emergency contact on file for every patient in our office. Please provide us with the information for whom we may call in the event of an emergency.

Name of Emergency Contact: _____

Relationship: _____ Best way to contact: _____

Phone Number: _____ Extension: _____

By signing this form, you are authorizing a representative of this office to contact the above-mentioned person in case we deem and there is an emergency regarding your safety, as well as to disclose any information we may have that we deem medically necessary to th situation regarding your safety to th above mentioned person and necessary medical personnel.

GENERAL RELEASE OF RECORDS AND/OR RELEASE OF X-RAYS

KNOW BY ALL MEN THAT I HAVE REQUESTED THE RELEASE OF X-RAYS AND/OR RECORDS OF _____, (Patient's Name)

WHICH IS A PART OF THE RECORDS OF _____.

I hereby acknowledge the receipt of these x-rays and/or records. In consideration of the foregoing, I hereby release and forever discharge the aforesaid from any and all responsibility or liability of any kind, nature or character whatsoever arising from said treatment.

_____ _____

PATIENT OR LEGAL REPRESENTATIVE DATE

_____ _____

WITNESS DATE

INFORMED CONSENT

To the patient: Please read this entire document prior to signing it. It is important that you understand the information contained in this document. Please ask questions before you sign if there is anything that is unclear.

The nature of the chiropractic adjustment.

The primary treatment I use as a Doctor of Chiropractic is spinal manipulative therapy. I will use that procedure to treat you. I may use hands or a mechanical instrument upon your body in such a way as to move your joints. That may cause an audible "pop" or "click," much as you have experienced when you "crack" your knuckles. You may feel a sense of movement.

Analysis/Examination/Treatment

As part of the analysis, examination, and treatment, you are consenting to the following:

Patient should initial the procedures they are consenting to.

X Spinal Manipulation X Palpation X Vital Signs

X Range of Motion Testing X Orthopedic Testing X Basic Neurological Testing

X Muscle Strength Testing X Postural Testing X Ultrasound

X Hot/Cold Packs X EMS X Radiographic Studies

___Other (please explain) _____

The material risk inherent in chiropractic adjustment.

As with any healthcare procedure, there are certain complications, which may arise during chiropractic manipulation and therapy. These complications include but are not limited to fractures, disc injuries, dislocations, muscle strain, cervical myelopathy, costovertebral strains and separations, and burns. Some types of manipulation of the neck have been associated with injuries to the arteries in the neck leading to or contributing to serious complications including stroke. Some patients will feel some stiffness and soreness following the first few days of treatment. I will make every reasonable effort during the examination to screen for contraindications of care; however, if you have a condition that would otherwise not come to my attention, it is your responsibility to inform me.

The probability of those risks occurring.

Fractures are rare occurrences and generally result from some underlying weakness of the bone, which I check during he is taking of your history and during examination and X-ray. Stroke has been the subject of tremendous disagreement. The incidence of stroke is exceedingly rare and are estimated to occur between one in one million and one in five million in cervical adjustments. The other complications are also generally described as rare.

The availability and nature of other treatment options.

Other treatment options for your condition may include:

Self-administered, over-the-counter analgesics and rest

Medical care and prescription drugs such as anti-inflammatory, muscle relaxants and painkillers.

Hospitalization

Surgery

If you choose to use one of the above noted "other treatment" options, you should be aware that there are risks and benefits of such options and you may wish to discuss these with your primary medical physician.

The risks and dangers attendant to remaining untreated.

Remaining untreated may allow the formation of adhesions and reduce mobility, which may set up a pain reaction further reducing mobility. Over time the process may complicate treatment making it more difficult and less effective the longer it is postponed.

DO NOT SIGN UNTIL YOU HAVE READ AND UNDERSTAND THE ABOVE. PLEASE CHECK THE APPROPRIATE BLOCK AND SIGN.

I have read [X] or have had read to me [ ] the above explanation of the chiropractic adjustment and related treatment. I have discussed it with Dr. Stabile and have had my questions answered to my satisfaction. By my signature below I state that I have weighed the risks involved n undergoing treatment and have decided that it is in my best interest to undergo the treatment recommended. Having been informed of the risks, I hereby give my consent to that treatment.

_____ _____ _____

Patient Signature Date Doctor's Signature

HIPA Notification

NOTICE OF PRIVACY PRACTICES AS REQUIRED BY THE PRIVACY REGULATIONS CREATED AS A RESULT OF THE HEALTH INSURANCE PORTABILITY AND ACCOUNTABILITY ACT OF 1996 (HlPAA)

Dr. Albert Stabile Jr. Chiropractic Physician

FFECTIVE DATE OF THIS NOTICE: THIS NOTICE DESCRIBES HOW HEALTH INFORMATION ABOUT YOU (AS A PATIENT OF THIS PRACTICE) MAYBE USED AND DISCLOSED, AND HOW YOU CAN GET ACCESS TO YOUR INDIVIDUAL IDENTIFIABLE HEALTH INFORMATION.

PLEASE REVIEW THIS NOTICE CAREFULLY.

Our practice is dedicated to maintaining the privacy of your individually identifiable health information (PHI). In conducting our business, we will create records regarding you and the treatment and services we provide to you. We are required by law to maintain the confidentiality of health information that identifies you. We also are required by law to provide you with this notice of our legal duties and the privacy practices that we maintain in our practice concerning your .PHI. By federal and state law, we must follow the terms of the notice of privacy practices that we have in effect at the time.

We realize that these laws are complicated, but we must provide you with the following important information:

- How we may use and disclose your PHI.
- Your privacy rights in your PHI.
- Our obligations concerning the use and disclosure of your PHI. .

The terms of this notice apply to all records containing your PHI that are created or retained by our practice. We reserve the right to revise or amend this Notice of Privacy Practices. Any revision or amendment to this notice will be effective for all of your records that our practice has created or maintained in. the past, and for any of your records that we may create or maintain in the future. Our practice will always post a copy of our current Notice in our offices in a visible location, and you may request a copy of our most current Notice at any time.

B. IF YOU HAVE at QUESTIONS ABOUT THIS NOTICE, PLEASE CONTACT:

Dr. Albert Stabile Jr. Chiropractic Physician

C. WE MAY USE AND DISCLOSE YOUR INDIVIDUALLY IDENTIFIABLE HEALTH INFORMATION (PHI) IN THE FOLLOWING WAYS

The following categories describe the different ways in which we may use and disclose your PHI.

1. **Treatment.** The information in your medical records will be used to determine which treatment option best addresses your health needs. The treatment selected will be documented in your medical records so that other health care professionals can make informed decisions about your care. For example, we may disclose your PHI to others who may assist in your care, such as your spouse, children, or parents. Finally, we may also disclose your PHI to other, health care providers for purposes related to your treatment.

2. **Payment** Our practice may use and disclose your PHI in order to bill and collect payment for the services and items you may receive from us. For example, we may contact your health insurer to certify that you are eligible for benefits (and for what range of benefits), and we may provide your insurer with details regarding your treatment to determine if your insurer will cover, or pay for, your treatment. We also may use and disclose your PHI to obtain payment from third parties that may be responsible for such costs, such as family members. Also, we may use your PHI to bill you directly for services and items. We may disclose your PHI to other health care providers and entities to assist in their billing and collection efforts.

3. **Health Care Operations**. Our practice may use and disclose your PHI to operate our business. As examples of the ways in which we may use and disclose your information for our operations, our practice may use your PHI to evaluate the quality of care you received from us, or to conduct cost-management and business planning activities for our practice. We may disclose your PHI to other health care providers and entities to assist in their health care operations.

4. **Appointments and Reminders**. Our practice may use and disclose your PHI to contact you and remind you of an appointment or as a follow up on treatment.

5. **Non-Medical Communications**. Our practice may use your PHI to contact you for non-medical reasons. For example,', we may send you a birthday card or a holiday greeting via mail.

6. **Health-Related Benefits and Services** Our practice may use and disclose your PHI to inform you of health-related benefits or services that may be of interest to you for example, we may send you newsletters that may include information about our practice, health related issues and products and services.

8. **Release of Information to**. Family/Friends. Our practice may release your PHI to a friend or family member that is involved in your care, or who assists in taking care of you. For example, a parent or guardian may ask that a babysitter take their child to the pediatrician's office for treatment of a cold. In this example, the babysitter may have access to this child's medical information.

9. **Disclosures Required By Law**, Our practice will use and disclose your PHI when we are required to do so by federal, state or local law.

D. **USE AND DISCLOSURE OF YOUR PHI IN CERTAIN SPECIAL CIRCUMSTANCES**

The; following categories describe unique scenarios in which we may use or disclose your Identifiable health information.

1. **Public Health Risks**: Our practice may disclose your PHI to public health authorities that are authorized by law to collect information for the purpose of:

A. Maintaining vital records, such as births and deaths.

B. Reporting child abuse or neglect

C. Preventing or controlling disease, Injury or disability.

D. Notifying a person regarding potential exposure to a communicable disease.

E. Notifying a person regarding a potential risk for spreading or contracting a disease or condition.

F. Reporting reactions to drugs or problems with products or diseases

G. Notifying individuals of a product or device they may be using has been recalled.

H. Notifying appropriate government agency and authority regarding the potential abuse or neglect of an adult patient (Including domestic violence): however, we will only disclose this information if the patient agrees, or we are required or authorized by law to disclose this information; and

I**. Notifying your employer** Under limited circumstances related primarily to workplace Injury or Illness or medical surveillance.

2. **Health Oversight Activities**: Our practice may disclose your PHI to a health oversight agency for activities authorized by law. Oversight activities can include, for example, investigations, inspections, audits, surveys, licensure and disciplinary actions; civil, administrative, and criminal procedure~ or actions; or other activities necessary for the government to monitor government programs, compliance With Civil rights laws and the health care system In general.

3. **Lawsuits and Similar Proceedings** Our practice may use and disclose your PHI In response to court or administrative order, if you are involved in a lawsuit or similar proceeding. We also may disclose your PHI In response to a discovery request, subpoena, or other lawful process by another party Involved in the dispute, but only if we have made an effort to inform you of the request or to obtain an order protecting the information the party has requested.

6. **Workers' Compensation**: Our practice may release your PHI for workers' compensation and similar programs.

E. **YOUR RIGHTS REGARDING YOUR PHI**

You have the following rights regarding the PHI that we maintain about you:

1. **Confidential Communications**. You have the right to request that our practice communicate with you about your health and related issues in a particular manner or at a certain location. For instance, you may ask that we contact you at home, rather than work. In order to request a type of confidential communication, you must make a written request specifying the requested method of contact, or the location where you wish to be contacted. Our practice will accommodate reasonable requests. You do not need to give a reason for your request.

2. **Requesting Restrictions.** You have the right to request a restriction in our use or disclosure of your PHI for treatment, payment or health care operations. Additionally, you have the right to request that we restrict our disclosure of your PHI to only certain individuals involved in your care or the payment for your care, such as family members and friends. We are not required to agree to your request; however, if we do agree, we are bound by our agreement except when otherwise required by law, in emergencies, or when the information is necessary to treat you. In order to request a restriction in our use or disclosure of your PHI, you must make your request in writing your request must describe in a clear and concise fashion.

A. The information you wish restricted.

B. Whether you are requesting to limit our practice's use, disclosure, or both; and

C. To whom you want the limits to apply.

3. **Inspection and Copies**. You have the right to inspect and obtain a copy of the PHI that may be used to make decisions about you, including patient medical records and billing records, but not including psychotherapy notes. You

must submit your request in writing to Dr. Stabile Jr., D.C. at 179 Cedar Lane Suite B Teaneck, NJ 07666 in order to inspect and/or obtain a copy of your PHI. Our practice may charge a fee for the costs of copying, mailing, labor and supplies associated with your request. Our practice may deny your request to inspect and/or copy in certain limited circumstances; however, you may request a review of our denial. Another licensed health care professional chosen by us will conduct reviews.

4. **Amendment.** You may ask us to amend your health information if you believe it is incorrect or incomplete, and you may request an amendment for as long as the information is kept by or for our practice. To request an amendment, your request must be made in writing and submitted Dr. Stabile Jr., D.C. at 179 Cedar Lane Suite B Teaneck, NJ 07666 You must provide us with a reason that supports your request for amendment. Our practice will deny your request if you fail to submit your request (and the reason supporting your request) in writing. Also, we may deny your request if you ask us to amend information that is in our opinion: (a) accurate and complete; (b) not part of the PHI kept by or for the 'practice; (c) not part of the PHI which you would be permitted to inspect and copy; or (d) not created by our practice, unless the individual or entity that created the information is not available to amend the information.

5. **Accounting of Disclosures**. All of our patients have the right to request an "accounting of disclosures." An "accounting of disclosures" is a list of certain non-routine disclosures our practice has made of your PHI for non-treatment, non-payment or non-operations purposes. Use of your PHI as part of the routine patient care in our practice is not required to be documented. For example, the billing department using your information to file your insurance claim in order to obtain an accounting of disclosures, you must submit your request in writing to Dr. Stabile Jr., D.C. at 179 Cedar Lane Suite B Teaneck, NJ 07666

. **Right to a Paper Copy of This Notice.** You are entitled to receive a paper copy of our notice of privacy practices. You may ask us to give you a copy of this notice at any time. To obtain a paper copy of this notice, contact Dr. Stabile Jr., D.C. at 179 Cedar Lane Suite B Teaneck, NJ 07666

7. **Right to File a Complaint**. If you believe your privacy fights have been violated; you may file a complaint with our practice or with the Secretary of the Department of Health and Human Services. To file a complaint with our practice, contact Dr. Stabile Jr., D.C. at 179 Cedar Lane Suite B Teaneck, NJ 07666All complaints must be submitted in writing. You will not be penalized for filing a complaint.

8. **Right to Provide an Authorization for other Uses and Disclosures·** Our practice will maintain your Written authorization for uses and disclosures that are not Identified by this notice or permitted by applicable law Any authorization you provide to us regarding the use and disclosure of your PHI may be revoked at any time in writing after you revoke your authorization, we VviI1 no longer use or disclose your PHI for the reasons described in the authorization. **Please note, we are required to retain records of your care.**

Again. If you have any questions regarding this notice or our health information privacy policies, please contact Dr. Stabile Jr., D.C. at 179 Cedar Lane Suite B Teaneck, NJ 07666

I have read a copy of the notice of privacy practices document.

HIPPA Waiver for Modalities:

Aware of the HIPPA requirements for patient privacy, and I am consenting to waive a portion of this privacy and consent to receive my various modalities in a multi- patient area with same sex patients.

Yes ____ No____

_____ _____

Patient Signature Date

_____ _____

Patient Name Printed Witness

OFFICE POLICY

PATIENT NAME: _____DATE: _____

ADDRESS: _____

SOCIAL SECURITY NUMBER: _____ DATE OF BIRTH: _____

PLEASE READ ALL TEXT, IF YOU UNDERSTAND WHAT YOU HAVE READ, PLEASE SIGN WHERE INDICATED AT THE BOTTOM OF THIS FORM.

AUTHORIZATION TO RELEASE INFORMATION ---I hereby authorize any provider insurance company, physician, employer or organization to release any information regarding history, treatment, or benefits payable and related information concerning this claim, to the plan administrator or it's authorized agent, for the purpose of validating and determining benefits in connection with this claim and to any reviewer that Dr. Lori Ann G. Palumbo, Chiropractic Physician and Albert Stabile Jr., Chiropractic Physician may deem necessary to perform a file review for the purposes of payment, rebuttal of treatment denial, retroactive review, current denial of care, payment or nonpayment of my claims.

PAYMENT AUTHORIZATION---I authorize payment of all benefits for services rendered from Chiropractic Physician and Albert Stabile Jr., Chiropractic Physician and/or the offices known as indicated on the enclosed bills.

This statement applies to insurance assignment and/or an Attorney Lien against any settlement made in conjunction with the above named for condition or injuries which I am being treated for in the offices of the above-named physicians.

OFFICE POLICY REGARDING APPOINTMENTS --- Multiple appointments may be given to you for your convenience, to minimize waiting and to facilitate incorporating these appointments into your daily schedule. Regardless of how many appointments are scheduled for you each week, please remember that it is frequency of the visits that is important, and not the days. If you are unable to keep an appointment for any reason, we require that you call immediately to reschedule your visit. IF YOU NEGLECT TO CALL TO RE-SCHEDULE AN APPOINTMENT THAT YOU CAN NOT MAKE, AND DO NOT SHOW UP FOR THAT APPOINTMENT, YOU WILL BE CHARGED. If you are late for an appointment you may have to wait for the next available opening. If you have any questions please ask the receptionist.

OFFICE POLICY REGARDING ASSIGNMENT ---Our office is pleased to accept your insurance assignment, as soon as your exact coverage is verified by the responsible party. We will file your claim forms and assist you in any way that we can. However, it must be fully understood that the Contract is between you and your insurance company, and you are fully responsible for the amount that is not paid by your insurance company.

Our Policy is as follows:

1. Since, by taking your insurance assignment, we have to wait for payment, this courtesy may be withdrawn at any time if the situation warrants it.
2. If you discontinue care without the doctor's consent, the balance of your account is due to be paid in full, even if insurance has been filed. (You will be reimbursed if your balance is zero)
3. Your insurance company should pay within 30 days. If they do not pay within 60 days, you must pay the balance due and be reimbursed by the insurance company.

4. We will bill your insurance company in 15-day cycles, for as long as you receive care.
5. All deductible payments MUST be made prior to insurance submittal. You are required to pay your co-payment as you go along.
6. You are required to sign for "Authorization to Pay the Provider" (above) and any other documents required by your insurance company, on your first visit.
7. Our office does not guarantee that your insurance company will pay. We will make every attempt to verify your coverage and collect, but all claims are your responsibility.
8. Since we do not own your policy, and occasionally, we have trouble in collecting from the carrier, we may ask for your active assistance in rectifying this situation.
9. Returned checks and balances over 30 days may be subject to additional collection fees and interest charges of 1½% per month. Charges may also be made for missed appointments and those canceled without 24 hours' notice.
10. All patients whose visitation schedule is once per month (or longer) will not be eligible for insurance assignment. Charges for services rendered will again be due as they are received.
11. This office does not promise that an insurance company will reimburse you for the usual and customary charges submitted by this office, nor will we enter into any dispute with an insurance company over the amount of reimbursement.
12. Should you discontinue care for any reason other than discharge by the doctor, any and all balances due will become immediately payable in full, regardless of any claims submitted. Any over payments will be refunded to you.
13. This office does not file for or accept co-payment for secondary Insurance coverage.
14. The privilege of Insurance assignment begins when our office receives your insurance forms, and your insurance is "Qualified" for coverage. You are considered a cash patient until our office "qualifies" your coverage to determine the extent of benefits under your policy.
15. Lastly, it is the goal of this office to provide you with the finest quality Chiropractic care available. If you have any questions with regard to your health care, or any of our policies, please let us know. We look forward to your referrals and to a doctor-patient relationship that works for our mutual benefit.

_____ _____ _____

PATIENT SIGNATURE DATE Witness

All accounts not paid within 90 days will automatically be put through your personal credit card for collection.

I_____ hereby authorize Albert Stabile Jr., Chiropractic Physician to charge my AMEX___ VISA___ MC ____Credit card account #_____ for the following services and or supplies:

_____

_____ _____ _____

Signature, Please Print Name Date

Form#201 Revised 1.2.2020

INITIAL HEALTH HISTORY

Patient Name _____ **Date**_____

FAMILY HISTORY:

Do you feel that your family history has had an effect on your current condition?

Yes ☐ **No** ☐

If yes, explain why _____

Are your parents alive? **Yes** ☐ **No** ☐

If deceased at what age? Mother _____ Cause of death? _____

Father _____ Cause of death? _____

Are your parents healthy? **Yes** ☐ **No** ☐

If not what conditions do they have? Mother _____

Father _____

Do you have brothers and sisters? **Yes** ☐ **No** ☐

How many? Brothers?_____ Ages? _____ Sisters? _____ Ages? _____

Are they healthy? Brothers **Yes** ☐ **No** ☐ Sisters **Yes** ☐ **No** ☐

If not healthy what illnesses do they have? Brothers? _____

Sisters? _____

Are they alive? **Yes** ☐ **No** ☐

If not at what ages did they die and what was the cause of death?

Brothers? Ages? _____ Cause of death? _____

Sisters ? Ages? _____ Cause of death? _____

Do you have children? **Yes** ☐ **No** ☐

How Many? _____ Boys ____ Ages_____ Girls ____ Ages _____

Are they all healthy? **Yes** ☐ **No** ☐

If not healthy, what illness do they have? _____

SOCIAL HISTORY:

What is your **occupation**? _____

Do you feel that your **Social History** has had an effect on your current condition? **Yes** ☐ **No** ☐

Do you drink **alcoholic** beverages? **Yes** ☐ **No** ☐

Do you use **tobacco** products? **Yes** ☐ **No** ☐

Do you use **recreational drugs**? **Yes** ☐ **No** ☐

Do you drink beverages with **caffeine**? **Yes** ☐ **No** ☐

Do you take **vitamin** supplements? **Yes** ☐ **No** ☐

Why? _____

Do you go to a **gym or Health Club**? **Yes** ☐ **No** ☐

Why? _____

Do you drink **Bottled water**? **Yes** ☐ **No** ☐

Why? _____

PAST MEDICAL HISTORY:

Have you been to a **Chiropractor**? **Yes** ☐ **No** ☐

How Long Ago? _____ Name of Chiropractor? _____Do Not Recall☐

What were you treated for? _____

Do you have any **drug or other allergies**? **Yes** ☐ **No** ☐

What drugs? _____

Do you have any **other allergies**? **Yes** ☐ **No** ☐

What are they? _____

Other than for your current problem, have you been **hospitalized** in the past **five years**?

Yes ☐ **No** ☐

Date / / Reason

How Long ?

Have you had any other accidents? **Yes** ☐ **No** ☐

Slip and Fall **Yes** ☐ **No** ☐

Workers Compensation? **Yes** ☐ **No** ☐

Auto? **Yes** ☐ **No** ☐

If Yes please describe:

Describe any treatment:

Have you had any significant **health problems** in the past? **Yes** ☐ **No** ☐

If you have had any of the following health problems in the past please check any of the following that may pertain to you. If not continue to the next topic.

☐ Heart Attack	☐ Heart Surgery/Pacemaker	☐ Heart Murmur
☐ Stroke	☐ Mitral Valve Prolapse	☐ Artificial Valves
☐ Congenital Heart Defect	☐ Venereal Disease	☐ Hepatitis
☐ Alcohol Abuse	☐ Shingles	☐ Cancer
☐ Drug Abuse	☐ Emphysema	☐ Anemia
☐ HIV/AIDS	☐ Glaucoma	☐ Rheumatic Heart
☐ Frequent Neck Pain	☐ Psychiatric Problems	☐ Ulcers
☐ High Blood Pressure	☐ Kidney Problems	☐ Asthma
☐ Low Blood Pressure	☐ Sinus Problems	☐ Chemotherapy
☐ Severe/Frequent Headaches	☐ Difficulty Breathing	☐ Arthritis
☐ Fainting/Seizures/Epilepsy	☐ Artificial Bones/Joints	☐ Tuberculosis

☐ Lower Back Problems ☐ Diabetes ☐ Colitis
☐ Other-Describe:_____

WOMEN ONLY

To the best of your knowledge are you pregnant? **Yes** ☐ **No** ☐
Have your past pregnancies been normal? **Yes** ☐ **No** ☐
If not, why? _____
I have never been pregnant. **Yes** ☐ **No** ☐
Do you consult an OB/GYN regularly? **Yes** ☐ **No** ☐

If Yes what is the OB/GYN's Name? _____

Date of Onset of your Current Condition? When did it start? ___ / ___ / ___

Description of Accident/Injury/Condition?
How did it happen?
_____
_____
_____

Type: ☐ **Automobile Accident** ☐ **Slip/Fall Accident**

☐ **Pedestrian Accident** ☐ **Workmen's Compensation**

☐ **Not an Accident -Explain** _____

Were you treated by any other doctors for this condition? Yes ☐ **No** ☐

Name of treating doctors and Specialists:_____

Are you currently taking any medications? Yes ☐ **No** ☐

☐ Anti-Inflammatory ☐ Tranquilizers ☐ Insulin Injection ☐ Diabetes medication Pills

☐ Muscle Relaxants ☐ Pain Medication ☐ Antibiotics ☐ Blood Thinners

☐ Thyroid Medication ☐ Birth Control Pills ☐ Blood Pressure Medications

☐ Other List: _____

Please complete the following indicating those items that pertain to your current health:

☐ Heart Attack	☐ Heart Surgery/Pacemaker	☐ Heart Murmur
☐ Stroke	☐ Mitral Valve Prolapse	☐ Artificial Valves
☐ Congenital Heart Defect	☐ Venereal Disease	☐ Hepatitis
☐ Alcohol Abuse	☐ Shingles	☐ Cancer
☐ Drug Abuse	☐ Emphysema	☐ Anemia
☐ HIV/AIDS	☐ Glaucoma	☐ Rheumatic Heart
☐ Frequent Neck Pain	☐ Psychiatric Problems	☐ Ulcers
☐ High Blood Pressure	☐ Kidney Problems	☐ Asthma
☐ Low Blood Pressure	☐ Sinus Problems	☐ Chemotherapy
☐ Severe/Frequent Headaches	☐ Difficulty Breathing	☐ Arthritis
☐ Fainting/Seizures/Epilepsy	☐ Artificial Bones/Joints	☐ Tuberculosis
☐ Lower Back Problems	☐ Diabetes	☐ Colitis

☐ Other-Describe:_____

Did you receive treatment in a hospital for your current condition? Yes ☐ **No** ☐

When did you go to the hospital? ☐ **Immediately** ☐ **Next day** ☐ **Days later**

☐ **Later that day**

How did you get to the hospital? ☐ **Ambulance** ☐ **Police** ☐ **Drove Self** ☐ **Someone else**

What hospital **emergency room** were you taken to?

Were you **admitted**? **Yes** ☐ **No** ☐ How many days were you hospitalized?

What treatment was given?

☐ **Oral Medication** ☐ **Injection** ☐ **Topical Antiseptics** ☐ **Bandages** ☐ **Sutures**

☐ **Ice Packs** ☐ **Hot Packs** ☐ **Splint** ☐ **Cast** ☐ **Brace**

☐ **Collar** ☐ **Surgery-explain**_____

Were x-rays taken? Yes ☐ **No** ☐ Taken by? ☐ **Doctor** ☐ **Hospital** ☐ **Radiologist**

Areas x-rayed?

☐ **Head** ☐ **Neck** ☐ **Upper/mid back** ☐ **Lower back**

☐ **Shoulder** ☐ **Elbow** ☐ **Wrist** ☐ **Hand**

☐ **Hip** ☐ **Arm** ☐ **Knee** ☐ **Ankle**

Were MRIs performed? Yes ☐ **No** ☐ Taken by? ☐ **Doctor** ☐ **Hospital** ☐ **Radiologist**

Areas?

☐ **Head** ☐ **Neck** ☐ **Upper/mid back** ☐ **Lower back**

☐ **Shoulder** ☐ **Elbow** ☐ **Wrist** ☐ **Hand**

☐ **Hip** ☐ **Arm** ☐ **Knee** ☐ **Ankle**

Were CT scans performed? Yes ☐ **No** ☐ Taken by? ☐ **Doctor** ☐ **Hospital** ☐ **Radiologist**

Areas?

☐ **Head** ☐ **Neck** ☐ **Upper/mid back** ☐ **Lower back**

☐ **Shoulder** ☐ **Elbow** ☐ **Wrist** ☐ **Hand**

☐ **Hip** ☐ **Arm** ☐ **Knee** ☐ **Ankle**

Instructions given at discharge.

☐ no further care necessary ☐ See Chiropractor ☐ See family doctor

☐ See Physical Therapist ☐ **See Neurologist** ☐ See Orthopedist

☐ Use Ice ☐ **No Work** ☐ Take Pain medication

☐ Take Anti-inflammatory ☐ Take Tranquilizers ☐ Take Antibiotics

☐ **Use** Heat ☐ **Rest** ☐ **None**

If you had these symptoms before please describe:

DIFFICULTY IN:

☐ Bending ☐ Standing ☐ Walking ☐ Lying ☐ Reaching

☐ Lifting ☐ Twisting ☐ Coughing ☐ Sitting ☐ Sneezing

☐ Rising to walk after sitting or lying down

PAIN IS RELIEVED BY:

☐ Rest ☐ Nothing ☐ Ice ☐ Heat ☐ Sitting

☐ Aspirin ☐ Advil ☐ Standing ☐ Exercise ☐ Tylenol

SYMPTOMS ARE:

☐ Improving Slowly ☐ Improving Moderately ☐ Improving Greatly

☐ Recurrent ☐ Getting Worse ☐ Not Improving

Have you missed work due to this accident/condition? ☐ Missed No Work ☐ Limited

Work Activity ☐ Missed Work From / / to / / /

I ☐ **Have** ☐ **Have Not** had these symptoms before.

I ☐ **Was** ☐ **Was Not** symptomatic prior to the start of this condition or injury.

Did you self-treat your symptoms? ☐ Yes ☐ No

☐ Ice ☐ Heat ☐ Bed Rest ☐ Over-The-Counter Medication

ACTIVITIES OF DAILY LIVING GENERAL PAIN DISABILITY INDEX

The rating scales are designed to measure the degree to which several aspects of the patient's life are presently disrupted by acute or chronic pain. In other words, we determine how much the pain the patient is experiencing is preventing the patient from doing what would normally be done, or-from doing it as well as the patient normally would. Each category was responded to by indicating the overall impact of pain in the patient's life, not just when the pain is at its worst.

For each of the six categories of daily living listed, the patient writes the number, which best described the typical level of activities.
A score of 0 means no disruption in functioning at all, and a score of 10 signifies that all of the activities in the specific category in which the patient would normally be involved have been totally disrupted or prevented by the pain.

FAMILY/HOME RESPONSIBILITIES: This category refers to activities related to the home or family. It includes chores and duties performed around the house and errands or favors for other family members (e.g., driving the children to school, Travel, Driving, Riding as a passenger, Driving for more than 15-20 minutes, Riding as a passenger for more than 15-20 minutes, Sitting, Climbing stairs, Getting in/out of auto, Kneeling, Lifting children, Using telephone, Using computer, Yard Work, Mowing lawn, Raking leaves, Gardening, Housework, Doing Laundry, Making beds, Bending, Running, Walking, Walking for long distance, Sitting for long periods of time, Lifting more than a few pounds, Vacuuming, Washing dishes, Ironing, Carrying groceries, Caring for pets, Cooking.)

The patient indicated that Family/Home Responsibilities were affected at a level of ____.

RECREATIONAL ACTIVITIES: This category includes hobbies, Reading, Playing piano, Exercising, Swimming, sports and other similar leisure time activities.
The patient indicated that Recreation Activities were affected at a level of ____.

SOCIAL ACTIVITY: This category refers to activities, which involve participation with friends and acquaintances other than family members, it includes parties, theater, concerts, dining out, and other social functions.
The patient indicated that Social Activities were affected at a level of ____.

OCCUPATIONAL ACTIVITIES: This category refers to activities that are a part of our directly related to one's job. This includes non-paying jobs as well, such as that of a homemaker or volunteer worker.
The patient indicated that Occupational Activities were affected at a level of ____.

SELF CARE ACTIVITIES: This category includes activities which involve personal maintenance and independent daily living (e.g., taking a shower, Personal Grooming, combing hair, Shaving, In/out bathtub, brushing teeth, Getting dressed, etc.)
The patient indicated that Social Care Activities were affected at a level of ____.

LIFE-SUPPORT ACTIVITY: This category refers to basic life-supporting behaviors such as eating, sleeping, lying in bed, Chewing, Sitting in recliner and breathing.
The patient indicated that Life-Support Activities were affected at a level of ____.

The above Activities of Daily Living Pain Indexes totaled .
By dividing the sum total of all the Activities of Daily Living Ratings by the total of possible Total Disability you arrive at a percentage of Total Activities of Daily Living Disability. The patient was given a Activities of Daily Living General Pain Disability Index Questionnaire on and had a score of ____/60 and a percentage of General Pain Disability of ___% . The percentage of disability is rated 0-20%, No Disability to Minimal disability, 21-40% Moderate disability, 41-60% Severe disability, 61-80% Crippling disability, 81-100% Bed-bound or exaggerating.

INITIAL COMPLAINTS

PAIN SCALE - BASED ON A SCALE OF 0 TO 10, WITH 10 BEING THE MOST SEVERE and 0 being no pain.
1-2=Mild 3-4=Mild to Moderate 5-6=Moderate 7-8+ Moderate to Severe 9-10=Severe

PLEASE RATE EACH SYMPTOM ACCORDINGLY.

JAW PAIN: ☐ Right ☐ Left ☐ **Both Jaw Pops** ☐ Right ☐ Left ☐ ☐ Both

PAIN SCALE ☐ 0 ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ 7 ☐ 8 ☐ 9 ☐ 10

☐ Mild ☐ Mild to Moderate ☐ Moderate ☐ Moderate to Severe ☐ Severe

☐ Constant ☐ Frequent ☐ Occasional ☐ Intermittent

NECK PAIN: ☐ Right ☐ Left ☐ Both

PAIN SCALE ☐ 0 ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ 7 ☐ 8 ☐ 9 ☐ 10

☐ Mild ☐ Mild to Moderate ☐ Moderate ☐ Moderate to Severe ☐ Severe

PAIN INCREASED BY MOVEMENT:

ROTATION ☐ Right ☐ Left

BENDING ☐ Forward ☐ Backward ☐ Right ☐ Left

☐ Neck Stiffness ☐ Muscle Spasm ☐ Grinding and Grating Sounds

☐ Constant ☐ Frequent ☐ Occasional ☐ Intermittent

HEADACHES:

PAIN SCALE ☐ 0 ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ 7 ☐ 8 ☐ 9 ☐ 10

☐ Mild ☐ Mild to Moderate ☐ Moderate ☐ Moderate to Severe ☐ Severe

LOCATED:
☐ Front ☐ Back ☐ Temples ☐ Forehead ☐ Behind Eyes

☐ Constant ☐ Frequent ☐ Occasional ☐ Intermittent

SHOULDER PAIN: ☐ Right ☐ Left ☐ Both

PAIN SCALE ☐ 0 ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ 7 ☐ 8 ☐ 9 ☐ 10

☐ Mild ☐ Mild to Moderate ☐ Moderate ☐ Moderate to Severe ☐ Severe

☐ Constant ☐ Frequent ☐ Occasional ☐ Intermittent

SHOULDER LIMITED MOVEMENT: ☐ Right ☐ Left ☐ Both

PAIN SCALE ☐ 0 ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ 7 ☐ 8 ☐ 9 ☐ 10

☐ Mild ☐ Mild to Moderate ☐ Moderate ☐ Moderate to Severe ☐ Severe

☐ Constant ☐ Frequent ☐ Occasional ☐ Intermittent

ARM PAIN: ☐ Right ☐ Left ☐ Both ☐ Forearm ☐ Upper Arms

PAIN SCALE ☐ 0 ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ 7 ☐ 8 ☐ 9 ☐ 10

☐ Mild ☐ Mild to Moderate ☐ Moderate ☐ Moderate to Severe ☐ Severe

☐ Constant ☐ Frequent ☐ Occasional ☐ Intermittent

ARM NUMBNESS: **Hand** ☐ Right ☐ Left ☐ Both **Arm** ☐ Right ☐ Left ☐ Both

DEGREE SCALE ☐ 0 ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ 7 ☐ 8 ☐ 9 ☐ 10

☐ Mild ☐ Mild to Moderate ☐ Moderate ☐ Moderate to Severe ☐ Severe

☐ Constant ☐ Frequent ☐ Occasional ☐ Intermittent

ARM PINS/NEEDLES:

Hand ☐ Right ☐ Left ☐ Both **Arm** ☐ Right ☐ Left ☐ Both

DEGREE SCALE ☐ 0 ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ 7 ☐ 8 ☐ 9 ☐ 10

☐ Mild ☐ Mild to Moderate ☐ Moderate ☐ Moderate to Severe ☐ Severe

☐ Constant ☐ Frequent ☐ Occasional ☐ Intermittent

ARM W**EAKNESS:**

Hand ☐ Right ☐ Left ☐ Both **Arm** ☐ Right ☐ Left ☐ Both

DEGREE SCALE ☐ 0 ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ 7 ☐ 8 ☐ 9 ☐ 10

☐ Mild ☐ Mild to Moderate ☐ Moderate ☐ Moderate to Severe ☐ Severe

☐ Constant ☐ Frequent ☐ Occasional ☐ Intermittent

ELBOW ☐ Right ☐ Left ☐ Both

PAIN SCALE ☐ 0 ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ 7 ☐ 8 ☐ 9 ☐ 10

☐ Mild ☐ Mild to Moderate ☐ Moderate ☐ Moderate to Severe ☐ Severe

☐ Constant ☐ Frequent ☐ Occasional ☐ Intermittent

WRIST ☐ Right ☐ Left ☐ Both

PAIN SCALE ☐ 0 ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ 7 ☐ 8 ☐ 9 ☐ 10

☐ Mild ☐ Mild to Moderate ☐ Moderate ☐ Moderate to Severe ☐ Severe

☐ Constant ☐ Frequent ☐ Occasional ☐ Intermittent

HAND PAIN: ☐ Right ☐ Left ☐ Both

PAIN SCALE ☐ 0 ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ 7 ☐ 8 ☐ 9 ☐ 10

☐ Mild ☐ Mild to Moderate ☐ Moderate ☐ Moderate to Severe ☐ Severe

☐ Constant ☐ Frequent ☐ Occasional ☐ Intermittent

HAND PINS/NEEDLES:

Hand ☐ Right ☐ Left ☐ Both **Arm** ☐ Right ☐ Left ☐ Both

DEGREE SCALE ☐ 0 ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ 7 ☐ 8 ☐ 9 ☐ 10

☐ Mild ☐ Mild to Moderate ☐ Moderate ☐ Moderate to Severe ☐ Severe

☐ Constant ☐ Frequent ☐ Occasional ☐ Intermittent

HAND NUMBNESS:

Hand ☐ Right ☐ Left ☐ Both **Arm** ☐ Right ☐ Left ☐ Both

DEGREE SCALE ☐ 0 ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ 7 ☐ 8 ☐ 9 ☐ 10

☐ Mild ☐ Mild to Moderate ☐ Moderate ☐ Moderate to Severe ☐ Severe

☐ Constant ☐ Frequent ☐ Occasional ☐ Intermittent

HAND W**EAKNESS:**

Hand ☐ Right ☐ Left ☐ Both **Arm** ☐ Right ☐ Left ☐ Both

DEGREE SCALE ☐ 0 ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ 7 ☐ 8 ☐ 9 ☐ 10

☐ Mild ☐ Mild to Moderate ☐ Moderate ☐ Moderate to Severe ☐ Severe

☐ Constant ☐ Frequent ☐ Occasional ☐ Intermittent

UPPER BACK PAIN: ☐ Right ☐ Left ☐ Both

SPASM ☐ Right ☐ Left ☐ Both

PAIN SCALE ☐ 0 ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ 7 ☐ 8 ☐ 9 ☐ 10

☐ Mild ☐ Mild to Moderate ☐ Moderate ☐ Moderate to Severe ☐ Severe

☐ Constant ☐ Frequent ☐ Occasional ☐ Intermittent

LOWER BACK PAIN: ☐ Right ☐ Left ☐ Both

SPASM ☐ Right ☐ Left ☐ Both

PAIN SCALE ☐ 0 ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ 7 ☐ 8 ☐ 9 ☐ 10

☐ Mild ☐ Mild to Moderate ☐ Moderate ☐ Moderate to Severe ☐ Severe

☐ Constant ☐ Frequent ☐ Occasional ☐ Intermittent

SACRO-ILIAC: ☐ Right ☐ Left ☐ Both

PAIN SCALE ☐ 0 ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ 7 ☐ 8 ☐ 9 ☐ 10

☐ Mild ☐ Mild to Moderate ☐ Moderate ☐ Moderate to Severe ☐ Severe

☐ Constant ☐ Frequent ☐ Occasional ☐ Intermittent

HIP PAIN: ☐ Right ☐ Left ☐ Both

PAIN SCALE ☐ 0 ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ 7 ☐ 8 ☐ 9 ☐ 10

☐ Mild ☐ Mild to Moderate ☐ Moderate ☐ Moderate to Severe ☐ Severe

☐ Constant ☐ Frequent ☐ Occasional ☐ Intermittent

BUTTOCK PAIN ☐ Right ☐ Left ☐ Both

PAIN SCALE ☐ 0 ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ 7 ☐ 8 ☐ 9 ☐ 10

☐ Mild ☐ Mild to Moderate ☐ Moderate ☐ Moderate to Severe ☐ Severe

☐ Constant ☐ Frequent ☐ Occasional ☐ Intermittent

LEG PAIN ☐ Right ☐ Left ☐ Both

RADIATING TO THE ☐ Knee ☐ Calf ☐ Foot

DOWN THE ☐ Front ☐ Back ☐ Side

PAIN SCALE ☐ 0 ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ 7 ☐ 8 ☐ 9 ☐ 10

☐ Mild ☐ Mild to Moderate ☐ Moderate ☐ Moderate to Severe ☐ Severe

☐ Constant ☐ Frequent ☐ Occasional ☐ Intermittent

LEG NUMBNESS ☐ Right ☐ Left ☐ Both

DEGREE SCALE ☐ 0 ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ 7 ☐ 8 ☐ 9 ☐ 10

☐ Mild ☐ Mild to Moderate ☐ Moderate ☐ Moderate to Severe ☐ Severe

☐ Constant ☐ Frequent ☐ Occasional ☐ Intermittent

LEG PINS & NEEDLES ☐ Right ☐ Left ☐ Both

DEGREE SCALE ☐ 0 ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ 7 ☐ 8 ☐ 9 ☐ 10

☐ Mild ☐ Mild to Moderate ☐ Moderate ☐ Moderate to Severe ☐ Severe

☐ Constant ☐ Frequent ☐ Occasional ☐ Intermittent

LEG WEAKNESS ☐ Right ☐ Left ☐ Both **in the** ☐ Thigh ☐ Calf

DEGREE SCALE ☐ 0 ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ 7 ☐ 8 ☐ 9 ☐ 10

☐ Mild ☐ Mild to Moderate ☐ Moderate ☐ Moderate to Severe ☐ Severe

☐ Constant ☐ Frequent ☐ Occasional ☐ Intermittent

KNEE PAIN ☐ Right ☐ Left ☐ Both

PAIN SCALE ☐ 0 ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ 7 ☐ 8 ☐ 9 ☐ 10

☐ Mild ☐ Mild to Moderate ☐ Moderate ☐ Moderate to Severe ☐ Severe

☐ Constant ☐ Frequent ☐ Occasional ☐ Intermittent

ANKLE PAIN ☐ Right ☐ Left ☐ Both

PAIN SCALE ☐ 0 ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ 7 ☐ 8 ☐ 9 ☐ 10

☐ Mild ☐ Mild to Moderate ☐ Moderate ☐ Moderate to Severe ☐ Severe

☐ Constant ☐ Frequent ☐ Occasional ☐ Intermittent

FOOT PAIN ☐ Right ☐ Left ☐ Both

PAIN SCALE ☐ 0 ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ 7 ☐ 8 ☐ 9 ☐ 10

☐ Mild ☐ Mild to Moderate ☐ Moderate ☐ Moderate to Severe ☐ Severe

☐ Constant ☐ Frequent ☐ Occasional ☐ Intermittent

FOOT PINS & NEEDLES ☐ Right ☐ Left ☐ Both

DEGREE SCALE ☐ 0 ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ 7 ☐ 8 ☐ 9 ☐ 10

☐ Mild ☐ Mild to Moderate ☐ Moderate ☐ Moderate to Severe ☐ Severe

☐ Constant ☐ Frequent ☐ Occasional ☐ Intermittent

FOOT WEAKNESS ☐ Right ☐ Left ☐ Both **in the** ☐ Thigh ☐ Calf

DEGREE SCALE ☐ 0 ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ 7 ☐ 8 ☐ 9 ☐ 10

☐ Mild ☐ Mild to Moderate ☐ Moderate ☐ Moderate to Severe ☐ Severe

☐ Constant ☐ Frequent ☐ Occasional ☐ Intermittent

I understand the above information and guarantee this form was completed correctly to the best of my knowledge and understand it is my responsibility to inform this office of any changes in my medical status.

Name (Print) _____ Date / / Signature _____