Advantage Chiropractic & Wellness

Dr. Chantel L. Moran, DC
5797 State Route 31 Ste #1 ~ Cicero, NY 13039
Phone: (315) 699-4533 ~ Fax: (315) 699-4534
www.mychiroadvantage.com

Patient Information

Today's Date / /

Patient Title: *(check one)* ❑ Mr. ❑ Mrs. ❑ Ms. ❑ Miss ❑ Dr. ❑ Prof. ❑ Rev.

First Name_____ **Nick Name**_____

Last Name _____ **Middle Name** _____ **Suffix** _____

Address 2 _____

City_____ **State**_____ **Zip Code** _____

Primary Phone _____ **Secondary Phone** _____

Mobile Phone _____

Home email _____ **Work Email** _____

Which email address would you like us to use to communicate with you? *(check one)* ❑ Home ❑ Work

Whom may we thank for referring you? _____

***BEST* Contact Method** *(check one)*

❑ Primary Phone ❑ Secondary Phone ❑ Mobile Phone ❑ Home Email ❑ Work Email

Date of Birth / / **Age**_____ **Gender** *(check one)* ❑ Male ❑ Female ❑Unspecified

Marital Status *(check one)* ❑ Single ❑ Married ❑ Other **SSN** _____

Employment Status *(check one)*

❑ Employed ❑ FT Student ❑ PT Student ❑ Other ❑ Retired ❑ Self Employed

Employer:_____

Race *(check all that apply)*

❑ White ❑ Black/African American ❑ Hispanic ❑ American Indian/Alaskan Native
❑ Asian ❑ Asian Indian ❑ Chinese ❑ Filipino
❑ Japanese ❑ Korean ❑ Vietnamese ❑ Native Hawaiian or other Pacific Island
❑Samoan ❑ Guamanian or Chamorro ❑Other_____ ❑ I choose not to specify

Ethnicity *(check one)* ❑ Hispanic or Latino ❑ Not Hispanic or Latino ❑ I choose not to specify

Preferred Language *(check one)*

❑ English ❑ Spanish ❑ American Sign Language ❑ Chinese ❑ French ❑ German
❑ Tagalog ❑ Vietnamese ❑ Italian ❑ Korean ❑ Russian ❑ Polish
❑ Arabic ❑ Portuguese ❑ Japanese ❑ French Creole ❑ Greek ❑ Hindi
❑ Persian ❑ Urdu ❑ Gujarati ❑ Armenian ❑ I choose not to specify

Accident Information

Is your condition due to an accident? ❑ *Yes: Date: _____ ❑ No

Type of Accident: ❑ Auto ❑ Work ❑ Home ❑ Other

To whom have you made a report of your accident?
❑ Auto Insurance ❑ Employer ❑ Worker's Compensation Insurance ❑ Other

Attorney Name (if applicable) _____
**Please bring the accident claim information so we may make a copy for your files*

Insurance Information

Do you have Health Insurance Coverage? ❑ Yes ❑ *No *If yes, please present your health insurance ID card when you arrive at our office for your first visit. We will make a photocopy for our files.*

Company: _____ **ID Number:** _____

Who is responsible for this account? _____ **Relationship to Patient:** _____

D.O.B.: _____ **SS #:** _____

Are you enrolled in: ❑ Medicare? If you have a Medicare Supplemental insurance, please present BOTH health insurance ID cards when you arrive at our office for your first visit. We will make a photocopy for our files.

*If you do not have health insurance coverage, Advantage Chiropractic & Wellness offers affordable payment options that will fit most budgets.

ASSIGNMENT AND RELEASE

I, the undersigned certify that I (or my dependent) have insurance coverage with _____ and assign directly to DR. CHANTEL L. MORAN, DC all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I hereby authorize the doctor to release all information necessary to secure payment of benefits. I authorize the use of this signature on all insurance submissions.

X _____

Responsible Party

_____ _____

Relationship Date

Emergency Contact Information

Name: _____ **Relationship:** _____

Home Phone: _____ **Work:** _____

Verification Question *(choose only one question by checking the question, then give the answer to that question)*

❑ What is the name of your favorite pet? ❑ In what city were you born? ❑ What high school did you attend?
❑ What is your favorite movie? ❑ What is your mother's maiden name? ❑ On what street did you grow up?
❑ What was the make of your first car? ❑ When is your anniversary? ❑ What is your favorite color?

Verification Answer to the Chosen question: _____

I authorize release of any information concerning my (or my minor child's) healthcare, advice and treatment provided for the purpose of evaluating and administering claims for insurance benefits. I also hereby authorize payment of insurance benefits otherwise payable to me directly to doctor.

_____ _____

Signature Date

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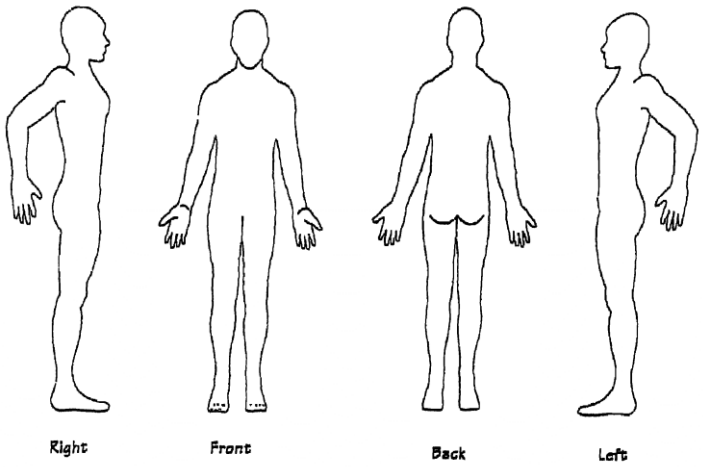
Patient Health Questionnaire

Patient Name: _____

Chief Complaint (include location and mark diagram) _____

_____

Using the letter(s) below, mark areas of your complaint(s): A = Aches B = Burning P = Pins/Needles S = Stabbing O = Other	

How often do you experience your symptoms?

☐ Intermittently (0 – 25% of the day) ☐ Occasionally (26 – 50% if the day)

☐ Frequently (51-75% of the day) ☐ Constantly (76 – 100% of the day)

What describes the nature of your Symptoms?

☐ Sharp ☐ Shooting ☐ Dull Ache ☐ Burning ☐ Numb ☐ Tingling ☐ Other _____

How are your symptoms changing?

☐ Getting Better ☐ Not Changing ☐ Getting Worse

Rate Intensity

(0 = No Pain/Symptoms, 10 = Worst Pain/Symptoms)

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

Secondary Complaint(s), if any (Briefly Explain) _____

_____

During the past 4 weeks how much has pain interfered with your normal work?

☐ Not at all ☐ A little bit ☐ Moderately ☐ Quite a bit ☐ Extremely

During the past 4 weeks how much has pain interfered with your social activities?

☐ Not at all ☐ A little bit ☐ Moderately ☐ Quite a bit ☐ Extremely

Who have you seen for your symptoms? Describe treatment (if any) _____

_____

Have you had these symptoms in the past? ☐ Yes ☐ No If Yes, When? _____

Have you ever received Chiropractic Care? ☐ Yes ☐ No If Yes, When? _____

What type of regular exercise do you perform? ☐None ☐ Light ☐Moderate ☐Strenuous

Patient Signature _____ **Date** _____

Patient Name _____ **Date** _____

What is your height and weight? Height _____ft____inches Weight_____lbs

For each of the conditions below, place a check in the "Past" or "Present" column if appropriate:

Past	Present	
❑	❑	Headaches
❑	❑	Neck Pain
❑	❑	Upper Back Pain
❑	❑	Mid Back Pain
❑	❑	Low Back Pain
❑	❑	Shoulder Pain
❑	❑	Up. Arm/Elbow Pain
❑	❑	Carpal Tunnel Synd.
❑	❑	Knee/Low. Leg Pain
❑	❑	Ankle/Foot Pain
❑	❑	Jaw Pain
❑	❑	Tinnatus/ringing ears
❑	❑	Joint Swelling
❑	❑	Osteoarthritis
❑	❑	Rheumatiod Arthritis
❑	❑	Osetopenia
❑	❑	Osteoporosis
❑	❑	General Fatigue
❑	❑	Muscular Incoordination
❑	❑	Visual Disturbances
❑	❑	Dizziness
❑	❑	Vertigo
❑	❑	High Blood Pressure
❑	❑	Heart Attack
❑	❑	Chest Pain
❑	❑	Stroke
❑	❑	Angina

Past	Present	
❑	❑	Kidney Stones
❑	❑	Kidney Disorders
❑	❑	Bladder Infection
❑	❑	Painful Urination
❑	❑	Loss Bladder Control
❑	❑	Abnorm. weight gain
❑	❑	Abnorm. weight loss
❑	❑	Loss of Appetite
❑	❑	Abdominal Pain
❑	❑	Ulcer
❑	❑	Thyroid Disease
❑	❑	Hepatitis
❑	❑	Liver Disease
❑	❑	Gall Bladder Disease
❑	❑	Cancer/Tumor
❑	❑	Asthma
❑	❑	Chronic Sinusitis
❑	❑	Allergies
❑	❑	Fibromyalgia
❑	❑	Systemic Lupus
❑	❑	Epilepsy
❑	❑	Dermatitis/Rash
❑	❑	Eczema/Psoriasis
❑	❑	HIV/AIDS
❑	❑	Depression
❑	❑	Drug Addiction
❑	❑	Alcoholism
❑	❑	STD

Past	Present	
❑	❑	Excessive Thirst
❑	❑	Frequent Urination
❑	❑	Diabetes
	❑	Type 1
	❑	Type 2

If yes to Diabetes, was your blood lab-work test for hemoglobin A1c > 9.0%?
❑ Yes ❑ No ❑ Not Sure

Past	Present	
		Men Only
❑	❑	Prostatitis
❑	❑	Prostate Cancer
❑	❑	Infertility
❑	❑	Erectile Dysfunction
		Females Only
❑	❑	Birth Control Pills
❑	❑	PMS/PMDD
❑	❑	Fibroids/Cysts
❑	❑	Horm. Replacement
❑	❑	Breast Cancer
❑	❑	Infertility
❑	❑	Menopause
❑	❑	Pregnancy

If yes : # of pregnancies: ____
# of Children: _____
# of C-Sections: _____

Do you currently smoke tobacco of any kind? ❑ Yes ❑ Former smoker ❑ Never been a smoker

If yes, how often do you smoke: ❑ Current every day smoker ❑ Current sometimes smoker

If yes, what is your level of interest in quitting smoking?

❑ 0 ❑ 1 ❑ 2 ❑ 3 ❑ 4 ❑ 5 ❑ 6 ❑ 7 ❑ 8 ❑ 9 ❑ 10

No interest *Very Interested*

Indicate if an immediate family member has had any of the following:

❑ Rheumatoid Arthritis ❑ Heart Problems ❑ Diabetes ❑ Cancer ❑ Lupus ❑ Other: _____

List all prescription/over-the-counter medications & nutritional/herbal supplements you are taking:

_____

List all surgical procedures/hospitalizations and dates:

_____

Patient Signature _____ **Date** _____

NECK INDEX

Name:_____Date:_____

This questionnaire has been designed to give the doctor information as to how your neck pain has affected your ability to manage in everyday life. Please answer every section and mark in each section only the ONE box which applies to you. We realize you may consider that two of the statements in any one section relate to you, but please just mark the box which most closely describes your problem.

Pain Intensity

- ❑ I have no pain at the moment.
- ❑ The pain is very mild at the moment.
- ❑ The pain is moderate at the moment.
- ❑ The pain is fairly severe at the moment.
- ❑ The pain is very severe at the moment.
- ❑ The pain is the worst imaginable at the moment.

Personal Care (Washing, Dressing, etc.)

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

Lifting

- ❑ I can lift heavy weights without extra pain.
- ❑ I can lift heavy weights but it gives extra pain.
- ❑ Pain prevents me from lifting heavy weights off the floor, but I can manage if they are conveniently positioned, for example on a table.
- ❑ Pain prevents me from lifting heavy weights, but I can manage light to medium weights if they are conveniently positioned.
- ❑ I can lift very light weights.
- ❑ I cannot lift or carry anything at all.

Reading

- ❑ I can read as much as I want to with no pain in my neck.
- ❑ I can read as much as I want to with slight pain in my neck.
- ❑ I can read as much as I want with moderate pain in my neck.
- ❑ I cannot read as much as I want because of moderate pain in my neck.
- ❑ I can hardly read at all because of severe pain in my neck.
- ❑ I cannot read at all.

Recreation

- ❑ I am able to engage in all recreation activities with no neck pain at all.
- ❑ I am able to engage in all recreation activities, with some neck pain.
- ❑ I am able to engage in most, but not all, of my usual recreation activities because of pain in my neck.
- ❑ I am able to engage in a few of my usual recreation activities because of pain in my neck.
- ❑ I can hardly do any recreation activities because of pain in my neck.
- ❑ I cannot do any recreation activities at all.

Concentration

- □ I can concentrate fully when I want to with no difficulty.
- ❑ I can concentrate fully when I want to with slight difficulty.
- ❑ I have a fair degree of difficulty in concentrating when I want to.
- ❑ I have a lot of difficulty in concentrating when I want to.
- ❑ I have a great deal of difficulty in concentrating when I want to.
- ❑ I cannot concentrate at all.

Work

- ❑ I can do as much work as I want to.
- ❑ I can do my usual work, but no more.
- ❑ I can do most of my usual work, but no more.
- ❑ I cannot do my usual work.
- ❑ I can hardly do any work at all.
- ❑ I cannot do any work at all.

Driving

- ❑ I can drive my car without any neck pain.
- ❑ I can drive my car as long as I want with slight pain in my neck.
- ❑ I can drive my car as long as I want with moderate pain in my neck.
- ❑ I cannot drive long as I want because of moderate pain in my neck.
- ❑ I can hardly drive at all because of severe pain in my neck.
- ❑ I cannot drive my car at all.

Sleeping

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

Headaches

- ❑ I have no headaches at all.
- ❑ I have slight headaches that come infrequently.
- ❑ I have moderate headaches which come infrequently.
- ❑ I have moderate headaches which come frequently.
- ❑ I have severe headaches which come frequently.
- ❑ I have headaches almost all the time.

Neck Score

BACK INDEX

Name:_____Date:_____

This questionnaire has been designed to give the doctor information as to how your back pain has affected your ability to manage in everyday life. Please answer every section and mark in each section only the ONE box which applies to you. We realize you may consider that two of the statements in any one section relate to you, but please just mark the box which most closely describes your problem.

Pain Intensity

- ❑ I have no pain at the moment.
- ❑ The pain is very mild at the moment.
- ❑ The pain is moderate at the moment.
- ❑ The pain is fairly severe at the moment.
- ❑ The pain is very severe at the moment.
- ❑ The pain is the worst imaginable at the moment.

Personal Care (washing, dressing, etc.)

- ❑ I can look after myself normally but it is very painful.
- ❑ I can look after myself normally but it is very painful.
- ❑ It is painful to look after myself and I am slow and careful.
- ❑ I need some help but manage most of my personal care.
- ❑ I need help every day in most aspects of my personal care.
- ❑ I need help every day in most aspects of self-care.
- ❑ I do not get dressed, wash with difficulty, and stay in bed.

Sleeping

- ❑ My sleep is never disturbed by pain.
- ❑ My sleep is occasionally disturbed by pain
- ❑ Because of pain, I have less than 6 hours sleep.
- ❑ Because of pain, I have less than 4 hours sleep.
- ❑ Because of pain, I have less than 2 hours sleep.
- ❑ Pain prevents me from sleeping at all.

Walking

- ❑ Pain does not prevent me walking any distance.
- ❑ Pain prevents me walking more than 1mile.
- ❑ Pain prevents me walking more than ¼ of a mile.
- ❑ Pain prevents me walking more than 100 yards.
- ❑ I can only walk using a stick or crutches.
- ❑ I am in bed most of the time and have to crawl to the toilet.

Sitting

- ❑ I can sit in any chair as long as I like.
- ❑ I can sit in my favorite chair as long as I like.
- ❑ Pain prevents me from sitting for more than 1 hour.
- ❑ Pain prevents me from sitting for more than ½ hour.
- ❑ Pain prevents me from sitting for more than 10 mins.
- ❑ Pain prevents me from sitting at all.

Standing

- ❑ I can stand as long as I want without extra pain.
- ❑ I can stand as long as I want but it gives me extra pain.
- ❑ Pain prevents me from standing more than 1 hour.
- ❑ Pain prevents me from standing for more than ½ an hour.
- ❑ Pain prevents me from standing for more than 10 minutes.
- ❑ Pain prevents me from standing at all.

Lifting

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

Changing degree of pain

- ❑ My pain is rapidly getting better.
- ❑ My pain fluctuates but overall is definitely getting better.
- ❑ My pain seems to be better but improvement is slow.
- ❑ My pain is neither getting better or worse.
- ❑ My pain is gradually worsening.
- ❑ My pain is rapidly worsening.

Social Life

- ❑ My social life is normal and causes me no extra pain.
- ❑ My social life is normal but increases the degree of pain.
- ❑ Pain has no significant effect on my social life apart from limiting my more energetic interests, i.e. sports.
- ❑ Pain has restricted my social life and I do not go out as often.
- ❑ Pain has restricted social life to my home.
- ❑ I have no social life because of pain.

Traveling

- ❑ I can travel anywhere without pain.
- ❑ I can travel anywhere but it gives extra pain.
- ❑ Pain is bad but I manage journeys of over two hours.
- ❑ Pain restricts me to short necessary journeys under 30 minutes.
- ❑ Pain prevents me from traveling except to receive treatment.
- ❑ Pain prevents me from all traveling.

Back Score

Acknowledgements

Chiropractic Care: ☐ I instruct the chiropractor to deliver the care, in her professional judgment, can best help me in the restoration of my health. I also understand that the chiropractic care offered in this practice is based on the best available evidence and designed to reduce or correct vertebral subluxation. Chiropractic is a separate and distinct healing art from medicine and does not proclaim to cure any named disease or entity.

Privacy Verification: ☐ I may request a copy of the Privacy Policy and understand it describes how my personal health information is protected and released on my behalf for seeking reimbursement from any involved third parties, grant permission to be called to confirm or reschedule an appointment and to be sent occasional cards, letter, emails or health information to me as an extension of my care in this office.

Permission to contact: ☐ I grant permission to be called to confirm or reschedule an appointment and to be sent occasional cares, letters, emails or health information to me as an extension of my care in this office.

Payment Verification: ☐ I acknowledge that any insurance I may have is an agreement between the carrier and me and that I am responsible for the payment of any covered or non-covered services I receive.

Cancellation Policy: ☐ I understand that if I am unable to make my scheduled appointment, I am required to call within 24 hours to reschedule. If I no call/no show, I will be responsible for a fee of $25 that is not covered by my insurance.

General Verification: ☐ To the best of my ability, the information I have supplied is complete and truthful. I have not misrepresented the presence, severity or cause of my health concern.

Signature:_____Date:_____