MUNROE CHIROPRACTIC

6035 Main Street | Williamsville, NY 14221
P: 716-632-4476 | F: 716-632-4503

Today's date:

Office use Only
☐ Cash ☐ NF
☐ WC ☐ Med.

HEALTH QUESTIONNAIRE

In order to save time, and better serve you, please complete all questions.

Name: *(First)* ______________________ *(M)* ____________________ *(Last)* ____________________

Date of Birth:______________ Gender: ________________ Sex at birth: ☐ M ☐ F *Preferred name*:______________

Address:_________________________________ City:____________________ State:_____ Zip:__________

Home#:_________________ Cell#:__________________ Work #:__________________ Preferred #: H C W

Email Address: ____________________________________ **Relationship Status:** ____________________

Employment Status: ☐ Part Time ☐ Full Time ☐ Disabled ☐ Retired ☐ Not Employed

Occupation:______________________ Employer:____

Employers Address____

Student Status: ☐ Part Time ☐ Full Time School:____

Do you have Medicare as your primary insurance? Yes No If yes, what is your Medicare ID number: ________________

Primary Care Physician *(Name, Address, and telephone number)*:____________________________________

____

Whom may we thank for referring you to our office?____

Who can we contact in case of an emergency?________________________________ Phone#:____________

Main Complaint: Why are you here today? Be specific with location:______________________________

____

Are today's complaints the result of (Please check 'Yes' or 'No'): A. Worker's Compensation Injury? [ ] Yes [No

B. Auto (No Fault) Accident? [ ] Yes [ ] No C. Home Injury? [ ] Yes [ ] No

Date complaints started:__________________ 2. Did it begin gradually or suddenly?____________________

How did it start? Explain:____

Rate the severity of your pain: (0 = No Pain to 10 = Excruciating) (Please Circle) 1 2 3 4 5 6 7 8 9 10

Frequency of symptoms: [ ]Constant (75-100%) [ ] Frequent (50-75%) [ ] Occasional (25-50%) [ ] Intermittent (10-25%) [ ]Rare

Describe your pain: [ ]Aching [ ]Gripping [ ]Pressure [ ] Sharp [ ]Shooting [ ] Soreness [ ]Stiffness Other:____________

Does it radiate to any other part of your body? Yes No Where?_________________________________

If yes, are you experiencing: [ ] Numbness [ ] Tingling [ ] Weakness

What makes your symptoms better?____

What makes your symptoms worse?____

Time of day symptoms are worst: [ ] Morning [ ] Afternoon [ ]Evening [ ]After work [ ] Middle of night Other:____________

Doctor's Initials:____________

Name:______________________________ Date:______________

Does your condition interfere with: [ ] Work [ ] Sleep [ ] Daily Routine [ ] Recreation [ ] Chores [ ] Child/Pet care

Activities hindered: [ ] Bending [ ]Driving [ ]Laying down [ ]Lifting [ ] Typing [ ] Walking

Have you tried home remedies? Yes No What?______________________________

What doctors have you seen and what tests have been done for your condition?______________________________

Have you had anything like this before? Yes No Details:______________________________

Has your problem been getting BETTER, WORSE, or STAYING about the SAME?______________________________

Have you been unable to work as a result of your current problem? [ ] Yes [ ] No

Do you have any other problems that you would like the doctors to evaluate?______________________________

Past History:

Have you had any of the following childhood diseases: [ ] Measles [ ] Rubella [ ] Chickenpox [ ] Mumps

[ ] Scarlet Fever [ ] Rheumatic Fever [ ] Tuberculosis [ ] Other?:______________________________

Any fever, unexplained weight loss/gain or changes in bowel or bladder functions: [ ] Yes [ ] No

Have you been diagnosed with any other conditions? Yes No Explain:______________________________

Are you under a doctor's care presently for any type of health problem?______________________________

Have you had any broken bones? Yes No Which ones?______________________________

Have you ever had any whiplash, auto accidents, work injuries, home injuries or falls?[ ]Yes [ ] No When?______________

Have you undergone any type of surgery? Yes No What and when?______________________________

Do you eat regular meals? Yes No How many meals per day? ______________ Snacks per day?______________

How often do you exercise?______________________________

Do you take vitamins or nutritional supplements?______________________________

How many hours per night do you usually sleep? _________ How do you sleep? On your: [ ] Back [ ] Side [ ] Stomach

Do you wear: [ ] Heel Lifts [ ] Shoe Lifts [ ] Arch Supports [ ] Orthotics

Do you drink alcohol, caffeine or use recreational drugs?______________________________

Do any diseases run in your blood relatives?______________ Any relatives suffer a stroke?:______________

Do you have any allergies?______________________________

Are you taking any medication? Yes No If yes please list with Dose amount and response to medication

____

Do you currently smoke? [ ]Yes [ ] No Have you smoked in the past? [ ]Yes [ ] No

Have you had any of these following symptoms for even a short or temporary duration?

Sudden collapse without loss of consciousness [ ] YES [ ] NO

Diminished or partial loss of vision in 1 or both eyes [ ] YES [ ] NO

Numbness of loss of sensation in the face, arms, hands, fingers, and/or legs [ ] YES [ ] NO

Weakness, clumsiness, or strength loss in the face, arms, hands, fingers, and/or legs [ ] YES [ ] NO

Any other abnormal or loss in any other part of your body [ ] YES [ ] NO

Loss of consciousness, even momentary blackouts [ ] YES [ ] NO

Doctor's Initials:______________

Name:______________________________ Date:______________

Symptoms

General:

- ☐ Bruise easily
- ☐ Dental problems
- ☐ Depression
- ☐ Difficulty sleeping
- ☐ Dizziness
- ☐ Fainting
- ☐ Fever
- ☐ Forgetfulness
- ☐ Headache
- ☐ Lack of Understanding
- ☐ Loss of sleep
- ☐ Nervousness
- ☐ Numbness
- ☐ Sweats
- ☐ Tiredness
- ☐ Heart or blood vessel disease
- ☐ Bone spurs on neck
- ☐ Hardening of the arteries
- ☐ Slurred speech or other speech problems

Gastrointestinal:

- ☐ Poor appetite
- ☐ Bloating
- ☐ Bowel/Bladder changes
- ☐ Constipation
- ☐ Diarrhea
- ☐ Excessive hunger
- ☐ Excessive thirst
- ☐ Gas
- ☐ Hemorrhoids
- ☐ Indigestion
- ☐ Nausea
- ☐ Rectal bleeding
- ☐ Stomach pain
- ☐ Vomiting
- ☐ Vomiting Blood

Cardiovascular:

- ☐ Chest pain
- ☐ High blood pressure
- ☐ Irregular heartbeat
- ☐ Low blood pressure
- ☐ Poor circulation
- ☐ Rapid heartbeat
- ☐ Swelling of ankles
- ☐ Varicose veins

Eye, Ear, Nose, Throat:

- ☐ Bleeding gums
- ☐ Blurred vision
- ☐ Crossed eyes
- ☐ Difficulty swallowing
- ☐ Double vision
- ☐ Ear ache
- ☐ Ear discharge
- ☐ Hay fever
- ☐ Hoarseness
- ☐ Loss of hearing
- ☐ Nosebleeds
- ☐ Persistent cough
- ☐ Ringing in ears
- ☐ Sinus Problems
- ☐ Vision- Flashes
- ☐ Vision- Halos

Men:

- ☐ Breast lump
- ☐ Erection difficulties
- ☐ Lump in testicles
- ☐ Penis discharge
- ☐ Sore on penis
- ☐ Difficulty with urination
- ☐ Excessive Urination
- ☐ Other: ______________

Date of last prostate exam:__________

Women:

- ☐ Abnormal pap smear
- ☐ Bleeding between periods
- ☐ Breast lump
- ☐ Extreme menstrual pain
- ☐ Hot flashes
- ☐ Nipple discharge
- ☐ Painful intercourse
- ☐ Vaginal discharge
- ☐ Other:______________

Date of last menstrual period:__________

Date of last pap smear: __________

Have you had a mammogram? __________

Do you take birth control pills?__________

If yes, for how long?__________

Are you pregnant?__________

Number of children:__________

Attention: Payment is to be made at the time of the visit unless prior arrangements have been made with this office. By signing below, you grant consent to any procedures or treatments necessary for treatment of any condition as deemed reasonable by the attending doctor.

Patient Signature: ______________________________ Date:______________

Office use only:

Acct# __________ *XR#* __________ *XR views* ____________________

CA who entered pt in CT: __________ *Video shown by:* __________ *One on given by:* __________

Doctors initials:__________

Patients Name: ______________________________ **Munroe Chiropractic PC/**Cervical Conditions

We are dedicated to more than just decreasing your pain and want to help you reach a goal that will help you live YOUR best life. Below you will find a list of daily activities, please select the ones that apply to you and your condition. This will help our Doctors better understand your specific needs and customize your treatment plan.

Section 1- Pain Intensity	**Section 6- Recreation**
A. The pain is mild and comes and goes B. The pain is mild and does not vary C. The pain is moderate and comes and goes D. The pain is moderate and does not vary E. The pain is severe and comes and goes F. The pain is severe and does not vary	A. I am able to engage in all of my recreational activities with no pain B. I am able to engage in recreational activities with mild pain C. I am able to engage in recreational activities with moderate pain D. Unable to engage in most recreational activities due to severe pain E. I cannot partake in recreational activities at all
Section 2- Personal Care (washing, dressing)	**Section 7- Work**
A. I am able to wash/dress with no difficulty B. I am able to wash/dress with mild difficulty C. I am able to wash/dress with moderate difficulty D. Unable to wash/dress without severe difficulty E. Because of pain, I am unable to wash/dress without help	A. I am able to work as much as I want B. I am able to do light amounts of work C. I am able to do moderate amounts of work D. Unable to perform work duties without to severe pain E. Unable to work at all due to pain
Section 3- Lifting	**Section 8- Driving**
A. I can lift very light weights B. I can lift light weights C. I can lift medium weights D. I can lift heavy weights E. I can lift no weight at all	A. I can drive my car without pain B. I can drive my car with mild pain C. I can drive my car with moderate pain D. Unable to drive my car without severe pain E. Unable to drive my car at all due to pain
Section 4- Reading	**Section 9- Sleeping**
A. I can read as much as I want without pain B. I can read as much as I want with mild pain C. I can read as much as I want with moderate pain D. I cannot read as much as I want due to severe pain E. I cannot read/concentrate at all due to pain	A. I have no trouble sleeping B. My sleep is slightly disturbed (less than 1 hr) C. My sleep is mildly disturbed (1-2 hrs sleepless) D. My sleep is moderately disturbed (2-3 hrs sleepless) E. My sleep is greatly disturbed (3-5 hrs sleepless)
Section 5- Headaches	**Additional Neck Difficulties not listed above:**
A. I have no headaches at all B. I have slight headaches which come infrequently C. I have slight headaches which come frequently D. I have moderate headaches which come infrequently E. I have moderate headaches which come frequently F. I have severe headaches which come infrequently G. I have severe headaches which come frequently H. I have constant headaches	______________________________ ______________________________ ______________________________

Patient ***Signature***: ______________________________ Date: ______________

Patients Name: ______________________________

Munroe Chiropractic PC/Lumbar Conditions

We are dedicated to more than just decreasing your pain and want to help you reach a goal that will help you live YOUR best life. Below you will find a list of daily activities, please select the ones that apply to you and your condition. This will help our Doctors better understand your specific needs and customize your treatment plan.

Section 1- Pain Intensity

A. The pain is mild and comes and goes
B. The pain is mild and does not vary
C. The pain is moderate and comes and goes
D. The pain is moderate and does not vary
E. The pain is severe and comes and goes
F. The pain is severe and does not vary

Section 2- Personal care

A. I am able to wash/dress with no difficulty
B. I am able to wash/dress with mild difficulty
C. I am able to wash/dress with moderate difficulty
D. Unable to wash/dress without severe difficulty
E. Because of pain, I am unable to wash/dress without help

Section 3- Lifting

A. I can lift very light weights
B. I can lift light weights
C. I can lift medium weights
D. I can lift heavy weights
E. I can lift no weight at all

Section 4- Walking

A. Pain does not prevent me from walking any distance
B. Pain prevents me from walking more than a mile
C. Pain prevents me from walking a ½ mile
D. Pain prevents me from walking a ¼ mile
E. I can only walk using a walking device

Section 5- Sitting

A. I can sit in a chair with no difficulty
B. I can sit in a chair with mild difficulty
C. I can sit in a chair with moderate difficulty
D. I can sit in a chair with severe difficulty
E. I cannot sit in a chair at all

Section 6- Standing

A. I can stand for more than 1-2 hours
B. I can stand for 30-60 minutes
C. I can stand for 15-30 minutes
D. I can stand for less than 15 minutes
E. I cannot stand at all

Section 7- Sleeping

A. I have no trouble sleeping
B. My sleep is slightly disturbed (less than 1 hr)
C. My sleep is mildly disturbed (1-2 hrs sleepless)
D. My sleep is moderately disturbed (2-3 hrs sleepless)
E. My sleep is greatly disturbed (3-5 hrs sleepless)

Section 8- Social Life

A. My pain does not affect my social life
B. My pain mildly affects my social life
C. My pain moderately affects my social life
D. My pain severely affects my social life
E. I have no social life due to my pain

Section 9- Traveling

A. I get no pain while traveling
B. I get mild pain while traveling
C. I get moderate pain while traveling
D. I get severe pain while traveling
E. I cannot travel due to my pain

Section 10- Work

A. I am able to work as much as I want
B. I am able to do light amounts of work
C. I am able to do moderate amounts of work
D. Unable to perform some and/or most work duties due to severe pain
E. Unable to work at all due to pain

Additional Low Back Difficulties not listed above:______________________________

Patient ***Signature***: ______________________________ Date:______________

MUNROE CHIROPRACTIC PATIENT PRIVACY NOTICE

This notice describes how medical information about you may be used and disclosed and how you can get access to that information. Please review this notice carefully.

Munroe Chiropractic is committed to maintaining the privacy of your protected health information ("PHI"), which includes information about your health condition and the care and treatment you receive from our office. The creation of a record detailing the care and services you receive helps this office to provide you with quality health care. This Notice details how your PHI may be used and disclosed to third parties. This Notice also details your rights regarding your PHI.

MUNROE CHIROPRACTIC MAY USE AND/OR DISCLOSE YOUR PHI FOR THE FOLLOWING REASONS:

- **Treatment**: In order to provide you with the healthcare you require our office will provide your PHI to those health care professionals, whether on our staff or not, directly involved in your care so that they may understand your health condition and needs.
- **Payment:** In order to get paid for services provided to you we will provide your PHI, directly or through a billing service, to appropriate third party payers, pursuant to their billing and payment requirements.
- **Health Care Operations:** In order for our office to operate in accordance with applicable law and insurance requirements and in order for the office to continue to provide quality and efficient care, it may be necessary for us to compile, use and/or disclose your PHI.

Munroe Chiropractic may also use and /or disclose your PHI without your specific authorization in the following additional instances:
De-Identified Information Business Associate / Personal Representative Emergency Situations / Public Health Activities Abuse, Neglect or Domestic Violence / Health Oversight Activities Judicial and Administrative Proceedings / Law Enforcement Purposes / Coroner or Medical Examiners / Sign-In Sheet Referral Board / Avert a Threat to Health or Safety / Specialized Government Functions / Workers' Compensation National Security and Intelligence Activities / Military and Veterans Family Member or any other person identified by you

Munroe Chiropractic's additional uses of your information:
New Patient Letter Telephone Messages / Personal Acknowledgement Cards / Appointment Reminder Cards

Uses and/or disclosures, other than those listed above will be made only with your written authorization.

YOUR RIGHTS: You have the right to...

- Revoke any authorization in writing, at any time.
- The right to request restrictions on the use and disclosure of your Protected Health Information.
- The right to receive confidential communications concerning your medical condition and treatment.
- The right to inspect and copy your Protected Health Information
- The right to amend or submit corrections to your protected health information.
- The right to receive and accounting of how and to whom your Protected Health Information has been disclosed.
- The right to receive a printed copy of this notice.
- Complain to Munroe Chiropractic or the Secretary of the Department of Health and Human Services if you believe your privacy rights have been violated.
- To obtain more information on or have your questions about your rights answered, you may contact Marianne Millidge at 632-4476 or via e-mail at marianne @munroechiropractic.com

MUNROE CHIROPRACTIC'S REQUIREMENTS:

- We are required by Federal Law to maintain the privacy of your PHI and to provide you with this privacy notice.
- We are required by New York State Law to maintain a higher level of confidentiality with respect to certain portions of your medical information than is provided under Federal Law. The particular state statutes are posted in our reception area.
- We are required to abide by the requirements of this privacy notice.
- We reserve the right to change the terms of this privacy notice and to make the new privacy notice provisions effective for all of your PHI that it maintains.
- We will distribute any revised privacy notice to you prior to implementation.
- We will not retaliate against you for filing a complaint.

THIS NOTICE IS IN EFFECT AS OF APRIL 14, 2003.

Munroe Chiropractic, PC
6035 Main Street
Williamsville, NY, 14221
Phone 716-632-4476 Fax 716-632-4503

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

By signing below, I certify that I have received and reviewed this notice and all of my questions have been answered to my satisfaction in language I can understand.

____
Name of Individual

____
Signature of Individual

____
Signature of Legal Representative

____
Relationship
(e.g, Attorny-In-Fact, Gurdian, Parent if a minor)

Date signed:______________________

Witness:______________________