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:__________

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Workers Compensation Accident information

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

Patient Name:____ Today's Date:____________________

Current work status: [ ] Working with no restrictions or limitations [ ] Working with restrictions or limitations

[ ] Unable to work [ ] Retired [ ] Disabled When was the last time you worked?____________________

Have you **missed work** because of the injury: [ ] Yes [ ] No , if yes **date(s)** you first missed work ____________

Does your employer have **light duties** or other jobs you can perform? [ ] Yes [ ] No [ ] I'm unsure

Do any other **Doctors have you off of work**? [ ] Yes [ ] No If yes, Who:____________________

Was your injury classified in Worker's Compensation court as a **Permanent Partial Disability (PPD)**? [ ] Yes [ ] NO

Address where ***the accident*** occurred: ____

** If other than employer's address**

Explain in detail how the injury occurred:____

____

____

List ALL parts of the body injured:____

Please indicate the **symptoms that are a result of this accident**:

[ ] Dizziness	[ ] Difficulty Sleeping	[ ] Jaw Problems	[ ] Nausea
[ ] Memory Loss	[ ] Irritability	[ ] Arm/Shoulder pain	[ ] Back Pain
[ ] Headache(s)	[ ] Fatigue	[ ] Numb hands/fingers	[ ] Low Back Pain
[ ] Blurred Vision	[ ] Tension	[ ] Chest Pain	[ ] Back Stiffness
[ ] Buzzing in Ear	[ ] Neck Pain	[ ] Shortness in Breath	[ ] Leg Pain
[ ] Ears Ringing	[ ] Neck Stiffness	[ ] Stomach Upset	[ ] Numb Feet/Toes

Where you **hospitalized** for this injury? [ ] Yes [ ] No How did you get there? [ ] Ambulance [ ] Private transportation

When did you go? [ ] Right after the accident [ ] The next day [ ] 2 or more days later

Provide name of hospital and /or attending doctor/treatment:____________________________

Were X-rays taken? [ ]Yes [ ] No If yes, what part of your body?____________________

Have you received **Surgery** for this injury? [ ] Yes [ ] No if yes, was it effectiveness

Have you received **any medical or chiropractic care related to this injury** before today's visit? [ ]Yes [ ] No

If yes, from where?______________________ When?______________________

With Whom?______________________ Are you still under care? [ ] Yes [ ] No

Have you had **any previous Workers Compensation or Auto No-Fault injuries?**[ ] Yes [ ] No

If yes, when and where were you treated for this injuries:______________________

Have you had ***any prior injury or treatment to the affected body parts***: [ ] Yes [ ] No

If yes, when and where were you treated for this injuries:______________________

Please indicate your **daily job duties** and any activities which you are occasionally asked to perform.

[ ] Bending	[ ] Driving	[ ] Pulling	[ ] Stooping
[ ] Carrying	[ ] Lifting	[ ] Repetitive motions	[ ] Typing
[ ] Computer use	[ ] Operate equipment	[ ] Sitting	[ ] Twisting
[ ] Crawling	[ ] Pushing	[ ] Standing	[ ] Walking

Other:______________________

Indicate your ***degree of comfort*** while performing the following activities:

Self Care	[ ] Comfortable	[ ] Uncomfortable	[ ] Painful
Lifting/Carrying	[ ] Comfortable	[ ] Uncomfortable	[ ] Painful
Walking	[ ] Comfortable	[ ] Uncomfortable	[ ] Painful
Strenuous Activity	[ ] Comfortable	[ ] Uncomfortable	[ ] Painful
Walking up stairs	[ ] Comfortable	[ ] Uncomfortable	[ ] Painful
Sitting tolerance	[ ] Comfortable	[ ] Uncomfortable	[ ] Painful
Standing	[ ] Comfortable	[ ] Uncomfortable	[ ] Painful
Using hands at chest level	[ ] Comfortable	[ ] Uncomfortable	[ ] Painful
Reaching over head	[ ] Comfortable	[ ] Uncomfortable	[ ] Painful
Pushing/pulling	[ ] Comfortable	[ ] Uncomfortable	[ ] Painful
Gripping/grasping/manipulating	[ ] Comfortable	[ ] Uncomfortable	[ ] Painful
Repetitive hand motions	[ ] Comfortable	[ ] Uncomfortable	[ ] Painful
Forceful activities	[ ] Comfortable	[ ] Uncomfortable	[ ] Painful
Kneeling, bending or squatting	[ ] Comfortable	[ ] Uncomfortable	[ ] Painful
Sleeping	[ ] Comfortable	[ ] Uncomfortable	[ ] Painful
Movement	[ ] Comfortable	[ ] Uncomfortable	[ ] Painful
Sexual Intercourse	[ ] Comfortable	[ ] Uncomfortable	[ ] Painful
Travel/Social/recreational activity	[ ] Comfortable	[ ] Uncomfortable	[ ] Painful

Have you retained an attorney for this case? [ ] Yes [ ] No

If yes, please provide us name &phone number:______________________

YOU CANNOT TREAT WITH A MESSAGE THERAPIST, ACUPUNCTURIST OR PHYSICAL THERAPIST ON THE SAME DAY AS YOUR CHIROPRACTIC TREATMENT-even if it's for different body parts. Your insurance company will not pay for both, so please keep this in mind when scheduling your appointments

PATIENT SIGNATURE:______________________

DATE:______________________ DOCTOR REVIEWED/INITIALS:______________________

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.

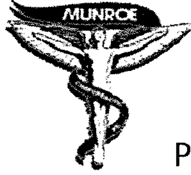
YOUR RIGHTS: You have the right to...

- 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, Attorney-In-Fact, Guardian, Parent if a minor)

Date signed:______________________

Witness:______________________

NOTICE THAT YOU MAY BE RESPONSIBLE FOR MEDICAL COSTS IN THE EVENT OF FAILURE TO PROSECUTE, OR IF COMPENSATION CLAIM IS DISALLOWED, OR IF AGREEMENT PURSUANT TO WCL §32 IS APPROVED

WCB CASE NO. (If Known)	CARRIER CASE NO. (If Known)	DATE OF INJURY	NATURE OF INJURY OR ILLNESS	INJURED PERSON'S SOC. SEC. NO.

CLAIMANT	NAME	ADDRESS APT. NO.
EMPLOYER		
INSURANCE CARRIER		

You may become responsible for the medical costs of treatment for your illness or condition with the provider listed below if (1) you fail to prosecute the claim for workers' compensation or (2) it is determined by the Workers' Compensation Board that the illness or condition which required treatment was not a result of a compensable workplace accident or occupational disease or (3) if an agreement is executed by you and approved pursuant to Workers' Compensation Law §32 in which you waive your right to medical benefits from the workers' compensation carrier/self-insured employer for treatment/services performed after the date the agreement is approved. If any of the above events occurs, the provider may bill you directly instead of the employer or insurance carrier, and you will be responsible for the provider's fees for services rendered.

I hereby acknowledge that I have read the above and understand the circumstances under which I may become responsible for payment.

Claimant's Signature____________________ Date __________

Provider's Name and Address Munroe Chiropractic, 6035 Main St. Williamsville, NY 14221

TO THE CLAIMANT

Workers' Compensation Board Regulation 325-1.23 permits your doctor or therapist to request that you sign this A-9 notice. By signing this notice, you acknowledge your obligation to pay the provider's fees for the services you receive if it turns out that such fees are not legally required to be paid by your employer or its workers' compensation insurance carrier and if such fees are not covered by other insurance. The employer or carrier may not be required to pay the doctor's fees if, for example, you fail to file a claim for workers' compensation, or fail to notify your employer of your injury or illness, or fail to attend a Board hearing if your employer challenges your right to benefits. Even if you make all required efforts to prosecute your claim, the Workers' Compensation Board may still find that you are not entitled to benefits. In such cases, this notice advises your health provider that you acknowledge your personal liability for payment of his/her bills.

Workers' Compensation Law Section 32

The A-9 notice also covers instances in which a claimant with an existing valid workers' compensation case comes to an agreement with his/her employer or its insurance carrier settling his/her case in accordance with Section 32 of the Workers' Compensation Law. A Section 32 agreement may include a provision which relieves the employer or carrier of the liability to pay future medical bills associated with the case. Your health care provider may ask you to sign this A-9 notice to insure that you acknowledge your personal liability for payment of his/her bills if you have waived your right to future medical benefits under a Section 32 agreement.

If you have any questions, contact your attorney or licensed hearing representative, if you have one. You may also contact your local district office of the Workers' Compensation Board.

TO THE HEALTH CARE PROVIDER

This notice is meant to advise the workers' compensation claimant that he/she may be responsible for payment. Failure of the claimant to sign this form does not relieve the provider of the obligation to treat the claimant, nor does it negate the claimant's responsibility for payment.

Keep the original of this form for your records and give a copy to the claimant. **Do not file with the Workers' Compensation Board.** You will receive Notices of Decisions in which the compensability of a claim, authorization of treatment, or payment of medical bills is included. You will also be notified if the claimant submits a Section 32 Agreement with the Board for approval. Do not bill the claimant unless and until you receive a Board decision finding that 1) claimant failed to prosecute the claim, or 2) the claim is denied, or 3) the treatment is not causally related to the work injury, or 4) a Section 32 agreement relieving the carrier of liability for medical treatment is approved.