



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 you currently smoke? Yes No Have you smoked in the past? Yes No

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

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 or 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: _____

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.



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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: _____