WELCOME to PORTOLESE FAMILY CHIROPRACTIC

Office: 215-361-6130 Fax: 215-361-7860
www.chirogal.com

Patient Information

Date: _____ Pt#_____ Doctor:_____
Patient: _____
Address: _____
City: _____ State: _____ Zip: _____
Sex: ☐ M ☐F Age: _____ Birth date: _____
☐Single ☐Married ☐Widowed ☐Separated ☐Divorced
Patient SS#: _____
Occupation: _____
Employer: _____
Employer Address: _____
_____
Employer Phone: _____
Children's Names & Ages: _____
_____
Spouse's Name: _____
Whom may we thank for referring you?
_____

Contact Information

Home: _____
Work: _____
Cell: _____
Email Address: _____
Best time & place to reach you: _____

In Case of Emergency, Contact:

Name: _____
Relationship: _____
Home Phone: _____
Work Phone: _____ Ext.: _____
Cell Phone: _____

Insurance

Subscriber's Name: _____
Relationship to Patient: _____
Subscriber's Birth date: _____
Subscriber's SS#: _____
Insurance Company: _____
ID#: _____
Is patient covered by additional insurance?: ☐Yes ☐ No
Subscriber's Name (Secondary Ins.): _____
Relationship to Patient: _____
Secondary Insurance Co.: _____
Secondary Ins. ID#: _____

Assignment & Release

I, the undersigned, certify that I (or my dependent) have insurance coverage with (insurance company) _____ and assign directly to *Portolese Family Chiropractic* 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(s) to release all information necessary to secure payment of benefits. I authorize the use of this signature on all insurance submissions.

_____
(Patient or Guardian's Signature) Date

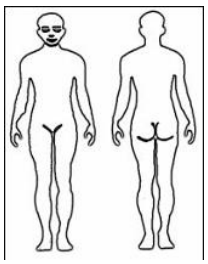
Accident Information

Is your condition due to an accident? ☐Yes ☐No
If so, when did the accident happen? (Date) _____
Type of Accident: ☐ Auto ☐ Work ☐ Home ☐ Other
Have you reported your accident? ☐Yes ☐No
If so, to whom?:
☐Auto Insurance ☐Employer ☐Worker's Comp. ☐Other
Is there an attorney involved? ☐Yes ☐No
Attorney's Name (if applicable): _____

The patient understands and agrees to allow this chiropractic office to use his/her Patient Health Information for the purpose of treatment, payment, healthcare operations and coordination of care. We want you to know how your Patient Health Information is going to be used in this office and your rights concerning those records. If you would like to have a more detailed account of our policies and procedures concerning the privacy of your Patient Health information, we encourage you to read the HIPAA NOTICE that is available to you at the front desk before signing this consent. If there is anyone you do not want to receive your medical records, please inform our office. P.F.C. has my consent to use my name for the purpose of referral boards, testimonials, kids' photo boards, birthdays, etc. My name and/or photos will be used strictly for special acknowledgments.

Patient or Guardian's Signature: _____ Date: _____

Patient Condition



Reason for visit: _____
When did your symptoms appear?: _____ How did it happen? _____
Describe the location of pain (**mark on diagram**): _____
Describe the pain: ☐ sharp ☐ spasms ☐ burning ☐ shooting ☐ throbbing ☐ dull ☐ stiffness
☐ ache ☐ cramping ☐ tingling ☐ numbness ☐ swelling ☐ other: _____
Rate Severity (1-10, 10 is the worst) _____ Is the pain getting worse? ☐Yes ☐No
How long does the pain last? ☐ seconds ☐ minutes ☐ hours ☐ all day
How often does the pain occur? ☐ daily ☐ several times / week ☐ a.m. only ☐ p.m. only
Is the pain constant or does it come and go? (circle one) Constant Comes & Goes
What activities make the pain worse? ☐ sitting ☐ standing ☐ bending ☐ twisting ☐ lying down ☐ pushing ☐ pulling
☐ driving ☐ getting out of a chair ☐ any movement ☐ walking ☐ other _____
What makes the pain feel better? ☐ rest ☐ activity ☐ ice ☐ heat ☐ massage ☐ stretching ☐ other: _____
Does the pain interfere with your… ☐ work ☐ sleep ☐ daily routine ☐ recreation ☐ other: _____

Patient Name: _____ **Pt#** _____ **Date:** _____

Health History

Family Medical Doctor: _____ Phone Number: _____

What treatments have you already received for this condition?: ☐ Medications ☐ Surgery ☐ Physical Therapy ☐ Chiropractic Services ☐ None ☐ Other: _____

Name & Address of other doctor(s) who have treated you for this condition: _____

Date of Last: Physical Exam _____ Spinal X-ray _____ Blood Test _____ Spinal Exam _____ Mammogram _____
Chest X-ray _____ Urine Test _____ Dental X-ray _____ MRI / CT / Bone / Dexa Scan _____

Are you pregnant? ☐ No ☐ Yes Due Date _____

Do you have (or have you ever had) the following?:

AIDS/HIV	☐ Yes ☐ No	Diabetes	☐ Yes ☐ No	Measles	☐ Yes ☐ No	Rheumatoid Arthritis	☐ Yes ☐ No
Alcoholism	☐ Yes ☐ No	Emphysema	☐ Yes ☐ No	Migraines	☐ Yes ☐ No	Rheumatic Fever	☐ Yes ☐ No
Allergy Shots	☐ Yes ☐ No	Epilepsy	☐ Yes ☐ No	Miscarriage	☐ Yes ☐ No	Scarlet Fever	☐ Yes ☐ No
Anemia	☐ Yes ☐ No	Fractures	☐ Yes ☐ No	Mononucleosis	☐ Yes ☐ No	Stroke	☐ Yes ☐ No
Anorexia	☐ Yes ☐ No	Glaucoma	☐ Yes ☐ No	Multiple Sclerosis	☐ Yes ☐ No	Suicide Attempt	☐ Yes ☐ No
Appendicitis	☐ Yes ☐ No	Goiter	☐ Yes ☐ No	Mumps	☐ Yes ☐ No	Thyroid Problems	☐ Yes ☐ No
Arthritis	☐ Yes ☐ No	Gonorrhea	☐ Yes ☐ No	Osteoporosis	☐ Yes ☐ No	Tonsillitis	☐ Yes ☐ No
Bleeding Disorders	☐ Yes ☐ No	Gout	☐ Yes ☐ No	Pacemaker	☐ Yes ☐ No	Tuberculosis	☐ Yes ☐ No
Breast Lump	☐ Yes ☐ No	Heart Disease	☐ Yes ☐ No	Parkinson's Disease	☐ Yes ☐ No	Tumors / Growths	☐ Yes ☐ No
Bronchitis	☐ Yes ☐ No	Hepatitis	☐ Yes ☐ No	Pinched Nerve	☐ Yes ☐ No	Typhoid Fever	☐ Yes ☐ No
Bulimia	☐ Yes ☐ No	Hernia	☐ Yes ☐ No	Pneumonia	☐ Yes ☐ No	Ulcers	☐ Yes ☐ No
Cancer	☐ Yes ☐ No	Herniated Disc	☐ Yes ☐ No	Polio	☐ Yes ☐ No	Vaginal Infections	☐ Yes ☐ No
Cataracts	☐ Yes ☐ No	Herpes	☐ Yes ☐ No	Prostate Problem	☐ Yes ☐ No	Venereal Disease	☐ Yes ☐ No
Chemical Dependency	☐ Yes ☐ No	High Blood Pressure	☐ Yes ☐ No	Prosthesis	☐ Yes ☐ No	Whooping Cough	☐ Yes ☐ No
Chicken Pox	☐ Yes ☐ No	High Cholesterol	☐ Yes ☐ No	Psychiatric Care	☐ Yes ☐ No		
		Kidney Disease	☐ Yes ☐ No				
		Liver Disease	☐ Yes ☐ No				

Other Illnesses?: _____

Family Medical History: Mother: _____ Father: _____

Siblings: _____ Grandparents: _____ Other: _____

Complicated Factors: _____

Exercise:

How many times a week? _____

Type: _____

Work Activity:

Hours / week: _____

☐ Sitting ☐ Light Labor

☐ Standing ☐ Heavy Labor

Habits:

☐ Smoking: Packs per Day _____ ☐ Coffee/Caffeine: Cups per Day _____

☐ Alcohol: Drinks per Week _____ ☐ High Stress Level: Reason _____

☐ Sleep Position _____ How old is your mattress? _____

Injuries / Surgeries you have had: *Description* *Date*

Car Accidents 1. _____ _____

Falls (down stairs, on ice, etc.) _____ _____

Head Injuries / Concussions _____ _____

Broken Bones _____ _____

Dislocations _____ _____

Surgeries / Hospitalizations: _____ _____

Medications	**Allergies**	**Vitamins / Herbs / Minerals**
_____	_____	_____
_____	_____	_____

Patient Goals: _____

Doctor's Signature: _____ Date: _____

Oswestry Disability Index

Section 1 – Pain Intensity

- ❑ I have no pain at the moment. (0)
- ❑ The pain is very mild at the moment. (1)
- ❑ The pain is moderate at the moment. (2)
- ❑ The pain is fairly severe at the moment. (3)
- ❑ The pain is very severe at the moment. (4)
- ❑ The pain is the worst imaginable at the moment. (5)

Section 2 – Personal Care (washing, dressing, etc.)

- ❑ I can look after myself normally without causing extra pain. (0)
- ❑ I can look after myself normally but it is very painful. (1)
- ❑ It is painful to look after myself and I am slow and careful. (2)
- ❑ I need some help but manage most of my personal care. (3)
- ❑ I need help every day in most aspects of my personal care. (4)
- ❑ I do not get dressed, wash with difficulty, and stay in bed. (5)

Section 3 - Lifting

- ❑ I can lift heavy weights without extra pain. (0)
- ❑ I can lift heavy weights but it gives extra pain.(1)
- ❑ Pain prevents me from lifting heavy weights off the floor, but I can manage if they are conveniently positioned (i.e. on a table). (2)
- ❑ Pain prevents me from lifting heavy weights, but I can manage light to medium weights if they are conveniently positioned. (3)
- ❑ I can lift only very light weights. (4)
- ❑ I cannot lift or carry anything at all. (5)

Section 4 – Walking

- ❑ Pain does not prevent me walking any distance. (0)
- ❑ Pain prevents me walking more than 1mile. (1)
- ❑ Pain prevents me walking more than ¼ of a mile. (2)
- ❑ Pain prevents me walking more than 100 yards. (3)
- ❑ I can only walk using a stick or crutches. (4)
- ❑ I am in bed most of the time and have to crawl to the toilet. (5)

Section 5 – Sitting

- ❑ I can sit in any chair as long as I like. (0)
- ❑ I can sit in my favorite chair as long as I like. (1)
- ❑ Pain prevents me from sitting for more than 1 hour. (2)
- ❑ Pain prevents me from sitting for more than ½ hour. (3)
- ❑ Pain prevents me from sitting for more than 10 minutes. (4)
- ❑ Pain prevents me from sitting at all. (5)

Patient Name: _____

Patient ID: _____Score: _____

Section 6 – Standing

- ❑ I can stand as long as I want without extra pain. (0)
- ❑ 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.

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Section 7 – Sleeping

- ❑ My sleep is never disturbed by pain. (0)
- ❑ My sleep is occasionally disturbed by pain. (1)
- ❑ Because of pain, I have less than 6 hours sleep. (2)
- ❑ Because of pain, I have less than 4 hours sleep. (3)
- ❑ Because of pain, I have less than 2 hours sleep. (4)
- ❑ Pain prevents me from sleeping at all. (5)

Section 8 – Sex life (if applicable)

- ❑ My sex life is normal and causes no extra pain. (0)
- ❑ My sex life is normal but causes some extra pain. (1)
- ❑ My sex life is nearly normal but is very painful. (2)
- ❑ My sex life is severely restricted by pain. (3)
- ❑ My sex life is nearly absent because of pain. (5)
- ❑ Pain prevents any sex life at all. (5)

Section 9 – Social Life

- ❑ My social life is normal and cause me no extra pain. (0)
- ❑ My social life is normal but increases the degree of pain. (1)
- ❑ Pain has no significant effect on my social life apart from limiting my more energetic interests, i.e. sports. (2)
- ❑ Pain has restricted my social life and I do not go out as often. (3)
- ❑ Pain has restricted social life to my home. (4)
- ❑ I have no social life because of pain. (5)

Section 10 – Traveling

- ❑ I can travel anywhere without pain. (0)
- ❑ I can travel anywhere but it gives extra pain. (1)
- ❑ Pain is bad but I manage journeys of over two hours. (2)
- ❑ Pain restricts me to short necessary journeys under 30 minutes. (3)
- ❑ Pain prevents me from traveling except to receive treatment. (4)

Section 11 - Previous Treatment

Over the past three months have you received treatment, tablets or medicines of any kind for your back or leg pain? Please check the appropriate box.

- ❑ No
- ❑ Yes (if yes, please state the type of treatment you have received)

Date: _____

Portolese Family Chiropractic
490 Pennbrook Parkway
Lansdale, PA 19446
#215-361-6130

Neck Disability Index

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.

Section 1 – Pain Intensity

- ❑ I have no pain at the moment. (0)
- ❑ The pain is very mild at the moment. (1)
- ❑ The pain is moderate at the moment. (2)
- ❑ The pain is fairly severe at the moment. (3)
- ❑ The pain is very severe at the moment. (4)
- ❑ The pain is the worst imaginable at the moment. (5)

Section 2 – Personal Care (Washing, Dressing, etc.)

- ❑ I can look after myself normally without causing extra pain. (0)
- ❑ I can look after myself normally but it causes extra pain. (1)
- ❑ It is painful to look after myself and I am slow and careful. (2)
- ❑ I need some help but manage most of my personal care. (3)
- ❑ I need help every day in most aspects of self care. (4)
- ❑ I do not get dressed, I wash with difficulty and stay in bed. (5)

Section 3 – Lifting

- ❑ I can lift heavy weights without extra pain. (0)
- ❑ I can lift heavy weights but it gives extra pain. (1)
- ❑ Pain prevents me from lifting heavy weights off the floor, but I can manage if they are conveniently positioned, for example on a table. (2)
- ❑ Pain prevents me from lifting heavy weights, but I can manage light to medium weights if they are conveniently positioned. (3)
- ❑ I can lift very light weights. (4)
- ❑ I cannot lift or carry anything at all. (5)

Section 4 – Reading

- ❑ I can read as much as I want to with no pain in my neck. (0)
- ❑ I can read as much as I want to with slight pain in my neck. (1)
- ❑ I can read as much as I want with moderate pain in my neck. (2)
- ❑ I cannot read as much as I want because of moderate pain in my neck. (3)
- ❑ I can hardly read at all because of severe pain in my neck. (4)
- ❑ I cannot read at all. (5)

Section 5 – Headaches

- ❑ I have no headaches at all. (0)
- ❑ I have slight headaches that come infrequently. (1)
- ❑ I have moderate headaches which come infrequently. (2)
- ❑ I have moderate headaches which come frequently. (3)
- ❑ I have severe headaches which come frequently. (4)
- ❑ I have headaches almost all the time. (5)

Section 6 – Concentration

- ❑ I can concentrate fully when I want to with no difficulty. (0)
- ❑ I can concentrate fully when I want to with slight difficulty. (1)
- ❑ I have a fair degree of difficulty in concentrating when I want to. (2)
- ❑ I have a lot of difficulty in concentrating when I want to. (3)
- ❑ I have a great deal of difficulty in concentrating when I want to. (4)
- ❑ I cannot concentrate at all. (5)

Section 7 – Work

- ❑ I can do as much work as I want to. (0)
- ❑ I can do my usual work, but no more. (1)
- ❑ I can do most of my usual work, but no more. (2)
- ❑ I cannot do my usual work. (3)
- ❑ I can hardly do any work at all. (4)
- ❑ I cannot do any work at all. (5)

Section 8 – Driving

- ❑ I can drive my car without any neck pain. (0)
- ❑ I can drive my car as long as I want with slight pain in my neck. (1)
- ❑ I can drive my car as long as I want with moderate pain in my neck. (2)
- ❑ I cannot drive my car as long as I want because of moderate pain in my neck. (3)
- ❑ I can hardly drive at all because of severe pain in my neck. (4)
- ❑ I cannot drive my car at all. (5)

Section 9 – Sleeping

- ❑ I have no trouble sleeping. (0)
- ❑ My sleep is slightly disturbed (less than 1 hour sleepless). (1)
- ❑ My sleep is mildly disturbed (1-2 hours sleepless). (2)
- ❑ My sleep is moderately disturbed (2-3 hours sleepless). (3)
- ❑ My sleep is greatly disturbed (3-5 hours sleepless). (4)
- ❑ My sleep is completely disturbed (5-7 hours sleepless). (5)

Section 10 – Recreation

- ❑ I am able to engage in all my recreation activities with no neck pain at all. (0)
- ❑ I am able to engage in all my recreation activities, with some pain in my neck. (1)
- ❑ I am able to engage in most, but not all, of my usual recreation activities because of pain in my neck. (2)
- ❑ I am able to engage in a few of my usual recreation activities because of pain in my neck. (3)
- ❑ I can hardly do any recreation activities because of pain in my neck. (4)
- ❑ I cannot do any recreation activities at all. (5)

Patient Name: _____ ***Date:*** _____

Patient ID: _____ ***Score:*** _____

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