DR. MICHAEL A. STIRPE
Certified Chiropractic Sports Physician

1628 W. Genesee St.
Syracuse, NY 13204
(315)472-7128
(315)472-9844 - Fax

Recent changes have been made concerning New York State Health Laws which provide patients with a Right To Privacy Act. Due to these changes, we are in compliance as long as you understand our Office Policies and Procedures.

- We have patients openly sign in daily to know who has visited our office and if the insurance company wants proof, we have your signature on that specific sign-in sheet.
- The adjustment area is an open room where individuals and families receive their adjustment.
- Examination room is private where we perform confidential examinations, consultations and, at patient's request, may get adjusted in that room.
- 95% of all patients that visit our office come as referrals of current patients. As a thank you, we like to acknowledge those patients on a board that states "Thank you for referring _____" or "Welcome to our Office".
- Any requests for information from attorneys or doctors concerning your health care for a number of visits, we will not send this information without having a signed consent.
- We believe that regular care is important to your general health. We will periodically remind you of scheduled appointments and/or inform you that it is time for an appointment. We will either call and/or send out a reminder unless you state otherwise.

Your healing experience is one of trust between you and me. I look at your health and your health concerns in the highest regard. Your personal privacy will never be violated.

If you agree to how we practice in this office, please sign and date this form below and we will keep it in our file for authorities, if requested.

_____ _____

Your Signature & Print Name **Today's Date**

PATIENT INTAKE INFORMATION

Date: _____

_____

(Legal) First Name (Legal) M.I. (Legal) Last Name DOB Age

Street _____ Apt. # _____

City _____ State _____ Zip Code _____

Social Security # _____ Marital Status [ ] S [ ] M [ ] W [ ] D Spouse _____

Language: English _____ Spanish _____ Indian _____ Japanese _____ Chinese_____ Korean _____ French _____ German _____

Russian _____ Other _____

Race/Ethnicity: White _____ American Indian or Alaska Native _____ Asian _____ Native Hawaiian/Other Pacific Islander _____

Black or African American _____ Hispanic or Latino _____ Decline to Answer _____

Contact Information: Home Phone _____ Work Phone _____ Cell Phone _____

Cell Carrier _____ Email Home _____

Email Work _____ Primary Care Physician: _____

Contact Preference: Home Ph _____ Work Ph _____ Cell Ph _____ Email Hm _____ Email Wk _____ Postal Mail _____

Emergency Contact _____ Phone _____

Who referred you to our office? _____ Phone _____

Occupation: _____ Employer _____

Employer Address _____

Street City State Zip

Insurance Information: *A copy of your insurance card(s) will be made. In addition, please complete the information requested below.*

Are you the policy holder? [ ] Y [ ] N If No, who is? Spouse _____ Parent _____ Employer _____ Other _____

_____

Policy Holder's First Name M.I. Last Name DOB

Policy Holder's Social Security # _____

Policy Holder's Employer _____

Do you have secondary insurance? [ ] Y [ ] N If yes, please complete the following:

_____

Policy Holder's First Name M.I. Last Name DOB

Policy Holder's Social Security# _____

Policy Holder's Employer _____

This Exam is for your:

Neck Mid-Back Low Back Other _____(circle all that apply)

Did anything happen to cause this problem? Y N
If yes, describe: _____

Have there been any injuries: Y N

Is your Condition: Improving Worse No Change

Please circle the Quality of the complaint/pain: dull aching sharp shooting burning throbbing
deep nagging other _____

Does this complaint/pain radiate or travel (shoot) to any areas of your body? Where? _____

Do you have any numbness or tingling in your body? Where? _____

Grade Intensity/Severity (No complaint/pain) 0 1 2 3 4 5 6 7 8 9 10 (Worst possible pain/complaint imaginable)

How often does pain last: ( ) Constant ( ) Frequent ( ) Intermittent ( ) Occasional

Does anything aggravate the complaint? _____

Does anything make the complaint better? _____

Do you have spasms? Yes No Side: R L Both

Previous interventions, treatments, medications, surgery, or care you have sought for your complaint:

_____
_____
_____

Medications

What medications are you currently taking? Please include all non-prescription and over the counter vitamins, herbs, minerals, etc. List date started, brand name, strength, dosage, frequency, duration, quantity, refills available, prescribed by.
Please be as specific as possible.

_____
_____
_____
_____

Do you have allergies? [ ] Food [ ] Environmental [ ] Medication
List Type of Allergy and Reaction(s)

_____
_____
_____
_____

I have read the above information and certify it to be true and correct to the best of my knowledge, and hereby authorize this Office of Chiropractic to provide me with chiropractic care in accordance with this state's statutes.

Patient Signature: _____ Date: _____

Doctor's Signature: _____ Date: _____

DR. MICHAEL A. STIRPE
Certified Chiropractic Sports Physician
DR. TIMOTHY M. WHITING

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MEDICAL HISTORY FORM

AS PART OF YOUR MEDICAL HISTORY, HAVE YOU EVER BEEN TREATED FOR, OR DO YOU HAVE ANY OF THE FOLLOWING:

YES	NO	
___	___	ALCOHOL/DRUG ABUSE
___	___	ARTHRITIS
___	___	CANCER
___	___	CHRONIC PAIN
___	___	DIABETES
___	___	DO YOU DRINK ALCOHOL? What _____ How Much _____ (Beer/Wine/Liquor)
___	___	DO YOU SMOKE? How Long _____ How much_____Cigs/Cigar/Pipe
___	___	EPILEPSY
___	___	FAMILY HISTORY OF BACK/NECK PAIN
___	___	HEADACHES
___	___	HEAD INJURIES
___	___	HEARING PROBLEMS
___	___	HEART DISEASE
___	___	HIGH BLOOD PRESSURE
___	___	INTESTINAL PROBLEMS
___	___	KIDNEY/BLADDER PROBLEMS
___	___	KNEE INJURIES
___	___	LIVER DISEASE
___	___	LOSS OF TOES, FINGERS, ETC.
___	___	MILITARY INJURIES
___	___	OTHER? _____
___	___	PERMANENT DEFORMITIES/SCARS
___	___	PSYCHIATRIC DISORDERS (Depression, anxiety, etc.)
___	___	RHEUMATIC FEVER
___	___	SEIZURES
___	___	SERIOUS INFECTIONS
___	___	SKIN DISEASE
___	___	SPINAL INJURIES (BACK OR NECK)
___	___	STOMACH PROBLEMS
___	___	SURGERIES _____
___	___	VISION PROBLEMS

DAILY HABITS

What type of exercise do you perform on a daily basis? □ None □ Moderate □ Heavy
What do your daily work habits include? (Ex: sitting, standing, light labor, heavy labor, computer work)

_____
What vitamins do you currently take? _____
What kind of other nutritional supplements do you take, if any? _____
How much coffee or caffeinated beverages do you consume on a daily basis? _____

_____ _____
Signature of Patient, Parent, Guardian or Personal Representative Date

_____ _____
Please print name of Patient, Parent, Guardian or Personal Rep. Relationship to Patient

For re-ordering information, contact:
ACTIVATOR METHODS, INC., P.O. Box 80317, Phoenix, AZ 85060-0317
Phone: (602) 224-0220; Facsimile (602) 224-0230

NECK PAIN DISABILITY INDEX QUESTIONNAIRE

NAME (Please Print): _____ DATE: _____

AGE: _____ DATE OF BIRTH: _____ OCCUPATION: _____

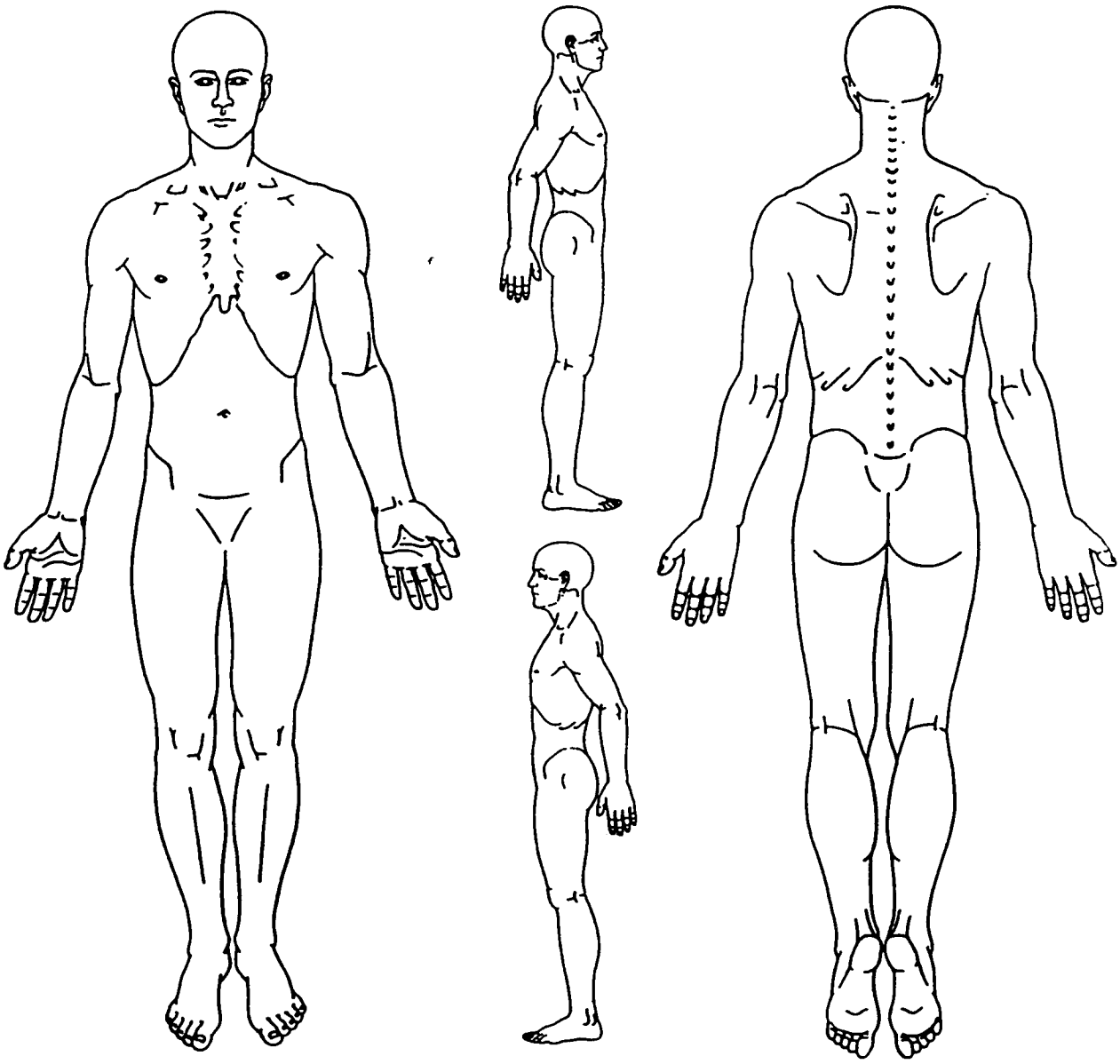
HOW LONG HAVE YOU HAD NECK PAIN? ___YEARS ___MONTHS ___WEEKS

IS THIS YOUR FIRST EPISODE OF NECK PAIN? ___YES ___NO

USE THE LETTERS BELOW TO INDICATE THE TYPE AND LOCATION OF YOUR SENSATIONS RIGHT NOW

(Please remember to complete both sides of this form.)

KEY: **A**=ACHE **B**=BURNING **N**=NUMBNESS
P=PINS & NEEDLES **S**=STABBING **O**=OTHER



OVER PLEASE

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NECK PAIN DISABILITY INDEX QUESTIONNAIRE

Please Read: This questionnaire is designed to enable us to understand how much your neck pain has affected your ability to manage your everyday activities. Please answer each Section by circling the **ONE CHOICE** that most applies to you. We realize that you may feel that more than one statement may relate to you, but **PLEASE, JUST CIRCLE THE ONE CHOICE WHICH MOST CLOSELY DESCRIBES YOUR PROBLEM RIGHT NOW.**

Section 1 — Pain Intensity

A I have no pain at the moment.
B The pain is very mild at the moment.
C The pain is moderate at the moment.
D The pain is fairly severe at the moment.
E The pain is very severe at the moment.
F The pain is the worst imaginable at the moment.

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

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

Section 3 — Lifting

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

Section 4 — Reading

A I can read as much as I want to with no pain in my neck.
B I can read as much as I want to with slight pain in my neck.
C I can read as much as I want with moderate pain in my neck.
D I cannot read as much as I want because of moderate pain in my neck.
E I cannot read at all.

Section 5 — Headaches

A I have no headaches at all.
B I have slight headaches which come infrequently.
C I have moderate headaches which come infrequently.
D I have moderate headaches which come frequently.
E I have severe headaches which come frequently.
F I have headaches almost all the time.

After Vernon & Mior, 1991
Reprinted by permission of the Journal of Manipulative and Physiological Therapeutics

Section 6 — Concentration

A I can concentrate fully when I want to with no difficulty.
B I can concentrate fully when I want to with slight difficulty.
C I have a fair degree of difficulty in concentrating when I want to.
D I have a lot of difficulty in concentrating when I want to.
E I have a great deal of difficulty in concentrating when I want to.
F I cannot concentrate at all.

Section 7 — Work

A I can do as much as I want to.
B I can only do my usual work, but no more.
C I can do most of my usual work, but no more.
D I cannot do my usual work.
E I can hardly do any work at all.
F I cannot do any work at all.

Section 8 — Driving

A I can drive my car without any neck pain.
B I can drive my car as long as I want with slight pain in my neck.
C I can drive my car as long as I want with moderate pain in my neck.
D I cannot drive my car as long as I want because of moderate pain in my neck.
E I can hardly drive at all because of severe pain in my neck.
F I cannot drive my car at all.

Section 9 — Sleeping

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

Section 10 — Recreation

A I am able to engage in all of my recreational activities, with no neck pain at all.
B I am able to engage in all of my recreational activities, with some pain in my neck.
C I am able to engage in most, but not all of my usual recreational activities because of pain in my neck.
D I am able to engage in a few of my usual recreational activities because of pain in my neck.
E I can hardly do any recreational activities because of pain in my neck.
F I cannot do any recreational activities at all.

REVISED March 11, 1993

Comments: _____

_____

Patient Signature: _____ Date: _____

ACTIVATOR METHODS, INC., P.O. Box 80317, Phoenix, AZ 85060-0317
(602) 224-0220 Fax: (602) 224-0230

REVISED OSWESTRY CHRONIC LOW BACK PAIN DISABILITY QUESTIONNAIRE

NAME (Please Print): _____ DATE: _____

AGE: _____ DATE OF BIRTH: _____ OCCUPATION: _____

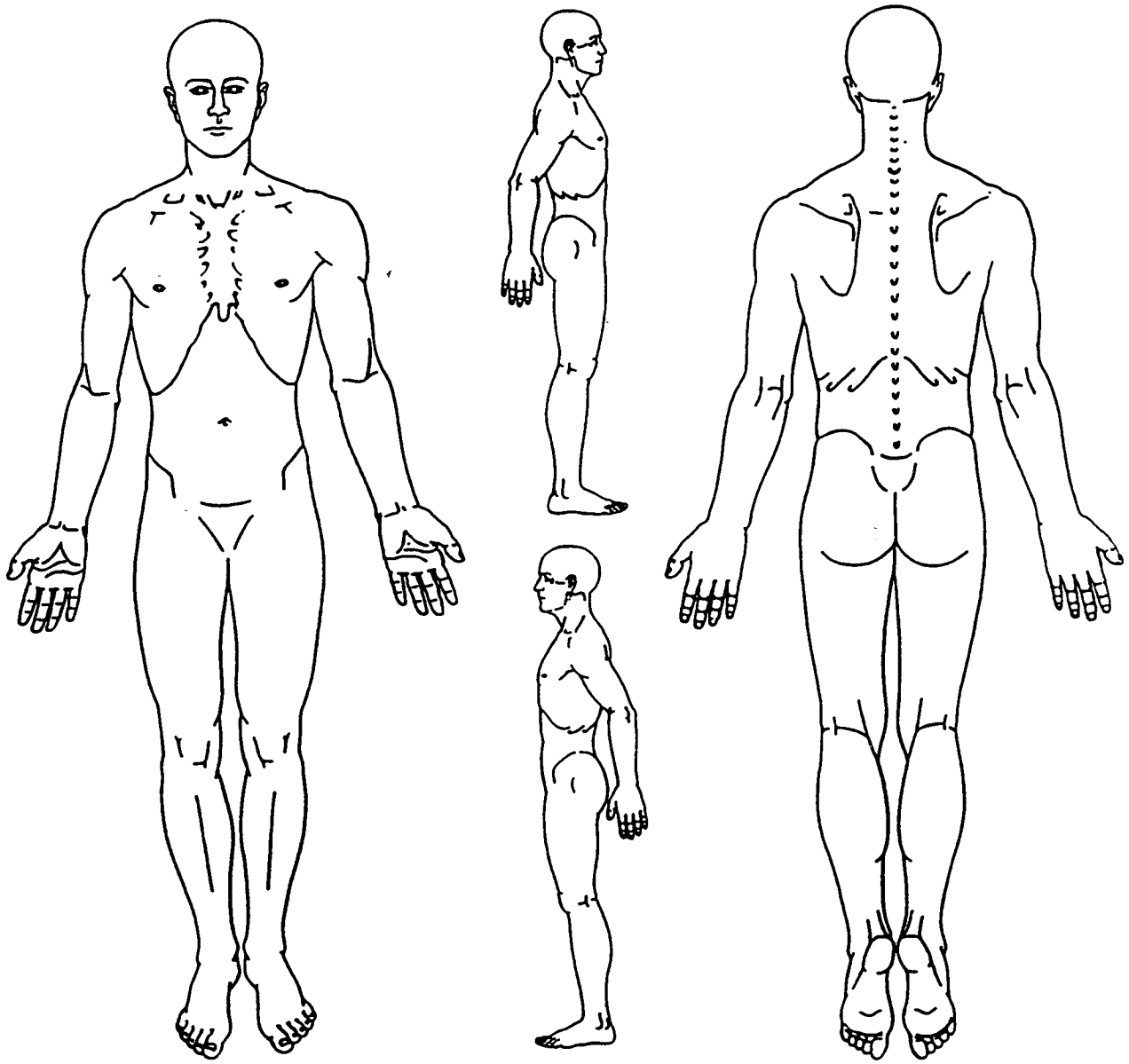
HOW LONG HAVE YOU HAD LOW BACK PAIN? ___YEARS ___MONTHS ___WEEKS

IS THIS YOUR FIRST EPISODE OF LOW BACK PAIN? ___YES ___NO

USE THE LETTERS BELOW TO INDICATE THE TYPE AND LOCATION OF YOUR SENSATIONS RIGHT NOW

(Please remember to complete both sides of this form.)

KEY: **A**=ACHE **B**=BURNING **N**=NUMBNESS
P=PINS & NEEDLES **S**=STABBING **O**=OTHER



OVER PLEASE

REVISED OSWESTRY CHRONIC LOW BACK PAIN DISABILITY QUESTIONNAIRE

Please Read: This questionnaire is designed to enable us to understand how much your low back pain has affected your ability to manage your everyday activities. Please answer each section by circling the **ONE CHOICE** that most applies to you. We realize that you may feel that more than one statement may relate to you, but **PLEASE JUST CIRCLE THE ONE CHOICE WHICH MOST CLOSELY DESCRIBES YOUR PROBLEM RIGHT NOW.**

SECTION 1 -- Pain Intensity

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

SECTION 2 -- Personal Care

A I would not have to change my way of washing or dressing in order to avoid pain.
B I do not normally change my way of washing or dressing even though it causes some pain.
C Washing and dressing increases the pain, but I manage not to change my way of doing it.
D Washing and dressing increases the pain and I find it necessary to change my way of doing it.
E Because of the pain, I am unable to do some washing and dressing without help.
F Because of the pain, I am unable to do any washing or dressing without help.

SECTION 3 -- Lifting

A I can lift heavy weights without extra pain.
B I can lift heavy weights, but it causes extra pain.
C Pain prevents me from lifting heavy weights off the floor.
D Pain prevents me from lifting heavy weights off the floor, but I can manage if they are conveniently positioned, e.g., on a table.
E Pain prevents me from lifting heavy weights, but I can manage light to medium weights if they are conveniently positioned.
F I can only lift very light weights, at the most.

SECTION 4 -- Walking

A Pain does not prevent me from walking any distance.
B Pain prevents me from walking more than one mile.
C Pain prevents me from walking more than 1/2 mile.
D Pain prevents me from walking more than 1/4 mile.
E I can only walk while using a cane or on crutches.
F I am in bed most of the time and have to crawl to the toilet.

SECTION 5 -- Sitting

A I can sit in any chair as long as I like without pain.
B I can only sit in my favorite chair as long as I like.
C Pain prevents me from sitting more than one hour.
D Pain prevents me from sitting more than 1/2 hour.
E Pain prevents me from sitting more than ten minutes.
F Pain prevents me from sitting at all.

From: N. Hudson, K. Tome-Nicholson, A. Breen; 1989

REVISED 9/11/92

SECTION 6 -- Standing

A I can stand as long as I want without pain.
B I have some pain while standing, but it does not increase with time.
C I cannot stand for longer than one hour without increasing pain.
D I cannot stand for longer than 1/2 hour without increasing pain.
E I cannot stand for longer than ten minutes without increasing pain.
F I avoid standing, because it increases the pain straight away.

SECTION 7 -- Sleeping

A I get no pain in bed.
B I get pain in bed, but it does not prevent me from sleeping well.
C Because of pain, my normal night's sleep is reduced by less than one-quarter.
D Because of pain, my normal night's sleep is reduced by less than one-half.
E Because of pain, my normal night's sleep is reduced by less than three-quarters.
F Pain prevents me from sleeping at all.

SECTION 8 -- Social Life

A My social life is normal and gives me no pain.
B My social life is normal, but increases the degree of my pain.
C Pain has no significant effect on my social life apart from limiting my more energetic interests, e.g., dancing, etc.
D Pain has restricted my social life and I do not go out very often.
E Pain has restricted my social life to my home.
F I have hardly any social life because of the pain.

SECTION 9 -- Traveling

A I get no pain while traveling.
B I get some pain while traveling, but none of my usual forms of travel make it any worse.
C I get extra pain while traveling, but it does not compel me to seek alternative forms of travel.
D I get extra pain while traveling which compels me to seek alternative forms of travel.
E Pain restricts all forms of travel.
F Pain prevents all forms of travel except that done lying down.

SECTION 10 -- Changing Degree of Pain

A My pain is rapidly getting better.
B My pain fluctuates, but overall is definitely getting better.
C My pain seems to be getting better, but improvement is slow at present.
D My pain is neither getting better nor worse.
E My pain is gradually worsening.
F My pain is rapidly worsening.

Comments: _____

Patient Signature: _____ Date: _____