



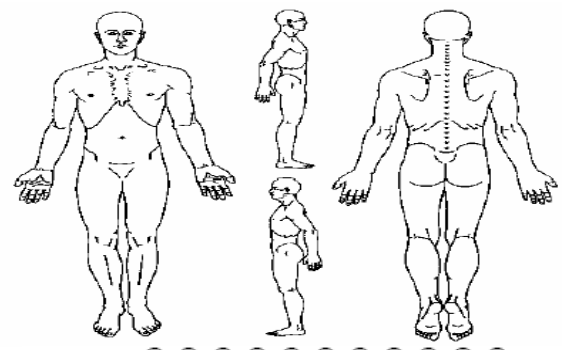
810 CENTER ROAD, WEST SENECA, NY 14224 (716) 674-4254 FAX: (716) 674-4392  
WWW.WNYCHIROPRACTIC.COM

Name: \_\_\_\_\_ Sex: \_\_\_\_\_  
First Last Middle Initial  
 Home Address \_\_\_\_\_ Home Phone: \_\_\_\_\_  
City State Zip Code  
 Birth date: \_\_\_\_/\_\_\_\_/\_\_\_\_ Age: \_\_\_\_ SS#: \_\_\_\_\_ Cell Phone: \_\_\_\_\_  
 Preferred method of communication: (circle) Home Cell email other: \_\_\_\_\_  
 E-Mail Address: \_\_\_\_\_ Marital Status: S M D W Spouse; \_\_\_\_\_  
 Employer \_\_\_\_\_ Occupation \_\_\_\_\_

Will this case be covered by any insurance company? Y N (circle) BC/BS / Univera / W. Comp / N. Fault / IHA / Other  
 Insurance Card ID #: \_\_\_\_\_ Group #: (BC/BS Only) \_\_\_\_\_  
 How did you hear about WNY Chiropractic? (circle) Staff Ph. Bk. Screen/Health Fair Web Location Ad OR  
 Referred By: \_\_\_\_\_  
Patient Name and Relationship

Your Chief Complaint: \_\_\_\_\_ Other complaints: \_\_\_\_\_  
 How & when did this occur: (must be specific) \_\_\_\_\_  
 Have you been treated by anyone else for this condition? Y N If yes, by whom? \_\_\_\_\_  
 Is this condition interfering with \_\_\_\_ Work \_\_\_\_ Sleep \_\_\_\_ Daily living routine  
 Treatment Objective: (circle) Relief Correction Strength/Rehab Prevention Maintenance of Health/Wellness

- A = ACHE
- B = BURNING
- N = NUMBNESS
- P = PINS & NEEDLES
- S = STABBING
- O = OTHER \_\_\_\_\_



On the diagram, please indicate where, and what type of symptoms that you are experiencing, right now. Write the appropriate abbreviations (See next to diagram) over the area of the body where those symptoms are occurring.

My Pain Level right now: No Pain ① ② ③ ④ ⑤ ⑥ ⑦ ⑧ ⑨ ⑩ Worst Possible

**\*\*All chiropractic treatment MUST BE PRE-AUTHORIZED for BC/BS or Univera patients and must satisfy the requirements set fort by the carrier which are subject to review. Only "Acute and Medically Necessary" treatment is covered for a specific condition. Maintenance care, Wellness care, treatment for a Chronic condition or for non Spine related conditions are NOT COVERED. I understand that I am responsible for these services, or those services that have been denied by the carrier.**

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

For Doctor's Use Only		C2	C3	C4	C5	L2	L4	T2	P1
C	TH L Right	Left	Wt. _____	Ht. _____	BP _____				
Does Patient Smoke?	Yes No	Discussed smoking cessation:		Yes No					
		Will Attempt?		Yes No					

**If you are having problems with you neck or shoulder please fill out this form**

**NECK 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 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 related to you, but ***PLEASE JUST CIRCLE THE ONE CHOICE THAT MOST CLOSELY DESCRIBES YOUR PROBLEM RIGHT NOW.***

<b>SECTION 1--Pain Intensity</b> A. I have no pain at the moment B. The pain is mild at the moment. C. The pain comes and goes and is moderate. D. The pain is moderate and does not vary much. E. The pain is severe but comes and goes. F. The pain is severe and does not vary much.	<b>SECTION 6 -- Concentration</b> 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.
<b>SECTION 2--Personal Care (Washing, Dressing, etc.)</b> A. I can look after myself 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.	<b>SECTION 7--Work</b> A. I can do as much work 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.
<b>SECTION 3--Lifting</b> 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 but I can 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.	<b>SECTION 8--Driving</b> A. I can drive my car without 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 my car at all because of severe pain in my neck. F. I cannot drive my car at all.
<b>SECTION 4 --Reading</b> 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 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 as much as I want because of severe pain in my neck. F. I cannot read at all.	<b>SECTION 9--Sleeping</b> 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).
<b>SECTION 5--Headache</b> 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.	<b>SECTION 10--Recreation</b> A. I am able engage in all recreational activities with no pain in my neck at all. B. I am able engage in all recreational activities with some pain in my neck. C. I am able engage in most, but not all recreational activities because of pain in my neck. D. I am able 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 all.

**SIGNATURE:** \_\_\_\_\_

**DATE:** \_\_\_\_\_

**DISABILITY INDEX SCORE:** \_\_\_\_\_

# **If you are having problems with you back/legs please fill out this form**

## **OSWESTRY DISABILITY INDEX**

Name: \_\_\_\_\_ Age: \_\_\_\_\_ Date: \_\_\_\_\_ Raw Score: \_\_\_\_\_

Please complete this questionnaire by circling **one** answer in each section. It is designed to give us information as to how your back (or leg) trouble has affected your ability to manage in everyday life.

<p><b>SECTION 1 – Pain Intensity</b></p> <p>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.</p>	<p><b>SECTION 6 –Standing</b></p> <p>A. I can stand as long as I want without extra pain.            B. I can stand as long as I want but it gives me extra pain.            C. Pain prevents me from standing for more than one hour.            D. Pain prevents me from standing for more than half an hour.            E. Pain prevents me from standing for more than ten minutes.            F. Pain prevents me from standing at all.</p>
<p><b>SECTION 2 – Personal Care</b></p> <p>A. I can look after myself normally without causing extra pain.            B. I can look after myself normally but it is painful.            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, wash with difficulty and stay in bed.</p>	<p><b>SECTION 7 – Sleeping</b></p> <p>A. My sleep is never disturbed by pain.            B. My sleep is occasionally disturbed by pain.            C. Because of pain I have less than 6 hours sleep.            D. Because of pain I have less than 4 hours sleep.            E. Because of pain I have less than 2 hours sleep.            F. Pain prevents me from sleeping at all.</p>
<p><b>SECTION 3 – Lifting</b></p> <p>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, e.g., 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 only very light weights.            F. I cannot lift or carry anything at all.</p>	<p><b>SECTION 8 – Social Life</b></p> <p>A. My social life is normal and gives me no extra pain.            B. My social life is normal but increases the degree of 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 as often.            E. Pain has restricted social life to my home.            F. I have no social life because of pain.</p>
<p><b>SECTION 4 –Walking</b></p> <p>A. Pain does not prevent me walking any distance.            B. Pain prevents me walking more than one mile.            C. Pain prevents me walking more than a quarter of a mile.            D. Pain prevents me from walking more than 100 yards.            E. I can only walk using a stick or crutches.            F. I am in bed most of the time and have to crawl to the toilet.</p>	<p><b>SECTION 9 – Traveling</b></p> <p>A. I can travel anywhere without pain.            B. I can travel anywhere but it gives extra pain.            C. Pain is bad but I manage journeys over two hours.            D. Pain restricts me to journeys of less than one hour.            E. Pain restricts me to journeys of less than 30 minutes.            F. Pain prevents me from traveling except to receive treatment.</p>
<p><b>SECTION 5 –Sitting</b></p> <p>A. I can sit in any chair as long as I like.            B. I can sit in my favorite chair as long as I like.            C. Pain prevents me from sitting for more than one hour.            D. Pain prevents me from sitting for more than half an hour.            E. Pain prevents me from sitting for more than ten minutes.            F. Pain prevents me from sitting at all.</p>	<p><b>SECTION 10 – Changing Degree of Pain</b></p> <p>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.</p>

Patient Signature \_\_\_\_\_ Date \_\_\_\_\_



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PLEASE COMPLETELY FILL IN THE ONE CIRCLE THAT BEST DESCRIBES YOUR ANSWER. (Example: ● )

Last Name	<input type="text"/>	First Name	<input type="text"/>
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1. In general, would you say your health is

Excellent	Very good	Good	Fair	Poor
<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

The following questions are about activities you might do during a typical day.  
Does your health now limit you in these activities? If so, how much?

2. Moderate activities, such as moving a table, pushing a vacuum cleaner, bowling, or playing golf

Yes, limited a lot	Yes, limited a little	No, not limited at all
<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

3. Climbing several flights of stairs

<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
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During the past week, how much of the time have you had any of the following problems with your work or other regular daily activities as a result of your physical health?

4. Accomplished less than you would like

All of the time	Most of the time	Some of the time	A little of the time	None of the time
<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

5. Were limited in the kind of work or other activities

<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
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During the past week, how much of the time have you had any of the following problems with your work or other regular daily activities as a result of any emotional problems (such as feeling depressed or anxious)?

6. Accomplished less than you would like

All of the time	Most of the time	Some of the time	A little of the time	None of the time
<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

7. Did work or other activities less carefully than usual

<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
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8. During the past week, how much did pain interfere with your normal work (including work outside the home and housework)?

Not at all	A little bit	Moderately	Quite a bit	Extremely
<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

These questions are about how you feel and how things have been with you during the past week.  
For each question, please give the one answer that comes closest to the way you have been feeling.

How much of the time during the past week...

9. Have you felt calm and peaceful?

All of the time	Most of the time	Some of the time	A little of the time	None of the time
<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

10. Did you have a lot of energy?

<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
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11. Have you felt downhearted and depressed?

<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
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12. During the past week, how much of the time has your physical health or emotional problems interfered with your social activities (like visiting friends, relatives, etc.)?

All of the time	Most of the time	Some of the time	A little of the time	None of the time
<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

How would you rate the severity of your main problem on a scale from 0 (not severe) to 10 (worst imaginable)?

	Not severe	0	1	2	3	4	5	6	7	8	9	10	Worst imaginable
13. Right now		<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	
14. On average		<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	
15. At its best		<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	
16. At its worst		<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	

Service Date:  /  /

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Last name	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	First name	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
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PLEASE COMPLETELY FILL IN THE ONE CIRCLE THAT BEST DESCRIBES YOUR ANSWER. (Example: ● )

1. Why are you here today? If there are many reasons, please choose only the most important or most severe one.

- |  |                                |                             |                                |
|--|--------------------------------|-----------------------------|--------------------------------|
| <input type="radio"/> Neck               | <input type="radio"/> Shoulder | <input type="radio"/> Hip   | <input type="radio"/> Headache |
| <input type="radio"/> Upper/<br>mid back | <input type="radio"/> Elbow    | <input type="radio"/> Knee  | <input type="radio"/> Other    |
| <input type="radio"/> Lower back         | <input type="radio"/> Wrist    | <input type="radio"/> Ankle |                                |
|  | <input type="radio"/> Hand     | <input type="radio"/> Foot  |                                |

2. When did this problem first begin?

- Less than 1 month ago    1-3 months ago    4-6 months ago    7-12 months ago    More than 1 year ago

<b>Has this problem...</b>	<b>No</b>	<b>Yes</b>
----------------------------	-----------	------------

- |  |                       |                       |
|--|-----------------------|-----------------------|
| 3. ... resulted from a work injury (i.e. workers' compensation insurance claim)? | <input type="radio"/> | <input type="radio"/> |
| 4. ... resulted from a motor vehicle accident (i.e. no fault insurance claim)?   | <input type="radio"/> | <input type="radio"/> |
| 5. ... recently been evaluated by a medical doctor?                              | <input type="radio"/> | <input type="radio"/> |

<b>Since this problem began, have you noticed...</b>	<b>No</b>	<b>Yes</b>
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- |   |                       |                       |
|---|-----------------------|-----------------------|
| 6. ... so much weakness in both your arms that you are unable to lift them?                 | <input type="radio"/> | <input type="radio"/> |
| 7. ... so much weakness in both your legs that you are unable to walk without help?         | <input type="radio"/> | <input type="radio"/> |
| 8. ... difficulty controlling your bowel or bladder, or have you been unable to urinate?    | <input type="radio"/> | <input type="radio"/> |
| 9. ... pain in your chest, shortness of breath, or coughing up blood?                       | <input type="radio"/> | <input type="radio"/> |
| 10. ... that one leg felt more warm, more swollen, more red, or more tender than the other? | <input type="radio"/> | <input type="radio"/> |

<b>Have you recently...</b>	<b>No</b>	<b>Yes</b>
-----------------------------	-----------	------------

- |   |                       |                       |
|---|-----------------------|-----------------------|
| 11. ... had blurred vision, double vision, dizziness, or fainting?                    | <input type="radio"/> | <input type="radio"/> |
| 12. ... had any type of infection, fever, or chills?                                  | <input type="radio"/> | <input type="radio"/> |
| 13. ... had any type of surgery, surgical procedure, or medical procedure?            | <input type="radio"/> | <input type="radio"/> |
| 14. ... lost a lot of weight without really trying to (i.e. without being on a diet)? | <input type="radio"/> | <input type="radio"/> |
| 15. ... had any type of accident, fall, or trauma?                                    | <input type="radio"/> | <input type="radio"/> |

<b>Have you ever...</b>	<b>No</b>	<b>Yes</b>
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- |   |                       |                       |
|---|-----------------------|-----------------------|
| 16. ... been diagnosed with cancer?   | <input type="radio"/> | <input type="radio"/> |
| 17. ... been diagnosed with osteoporosis (i.e. weak, soft, or brittle bones)? | <input type="radio"/> | <input type="radio"/> |
| 18. ... been diagnosed with a weakened immune system?                         | <input type="radio"/> | <input type="radio"/> |
| 19. ... used any injected drugs (i.e. non-prescription drugs)?                | <input type="radio"/> | <input type="radio"/> |
| 20. ... used steroids such as prednisone for more than 4 weeks?               | <input type="radio"/> | <input type="radio"/> |

<b>Is this problem something that ...</b>	<b>No</b>	<b>Yes</b>
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- |   |                       |                       |
|---|-----------------------|-----------------------|
| 21. ... you've had before?  | <input type="radio"/> | <input type="radio"/> |
| 22. ... generally gets worse (i.e. more severe or frequent) with movement, activity, or exercise? | <input type="radio"/> | <input type="radio"/> |
| 23. ... generally gets better (i.e. less severe or frequent) with rest?                           | <input type="radio"/> | <input type="radio"/> |
| 24. ... was recently examined with diagnostic imaging tests such as x-rays, MRI scan, or CT scan? | <input type="radio"/> | <input type="radio"/> |
| 25. ... is also being treated by a health professional other than a chiropractor?                 | <input type="radio"/> | <input type="radio"/> |

Service Date:  /  /

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