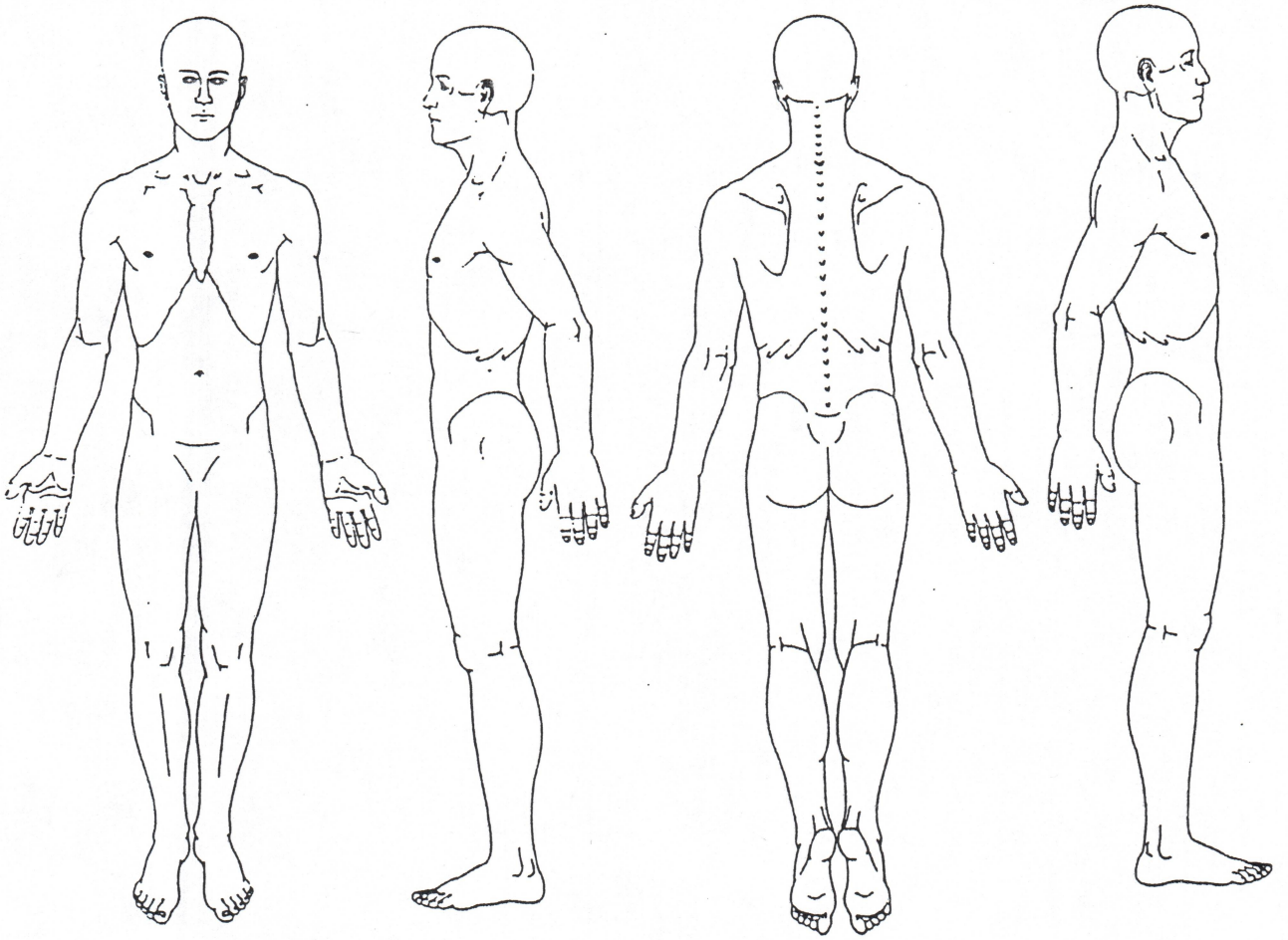
PAIN DRAWING

DATE_____ NAME_____

Using the following descriptive symbols, draw the location of your pain on body outlines below. In addition, mark the level of your pain on the pain line at the bottom of the page.

Ache	Burning	Numbness	Pins & Needles	Stabbing	Other
ΛΛΛ	====	0000	.....	//////////	XXXX
ΛΛ	===	00	.....	//////	XXX



No Pain _____ Worst Possible Pain

Please make a slash through this line as to the level of your pain.

_____

Patient Signature

Christos Vasakiris, D.C.,D.A.C.A.N.
350 West Montauk Highway
Lindenhurst, N.Y , 11757

PLEASE PRINT

Patient Name _____ SS# _____

Address _____ City _____

State _____ Zip Code _____ Birth Date ____/____/_____ Age _____

Circle one: Marital Status: S/M/D/W/P
How Did you find us?_____
Your Occupation _____ Years at this job _____

Your Employer's Name &
Address_____

Cell Phone (____) _____ Work Phone (____) _____
Home Phone # (____) _____

E-Mail Address:_____

MEDICAL PHYSICIAN'S NAME _____
ADDRESS _____

EMERGENCY CONTACT
NAME:_____PHONE_____

If the patient is a minor, permission is hereby given to the doctors in this office to perform an examination and treatments. I am his/her legal guardian.

Parent Signature _____

INSURANCE INFORMATION: (choose one)

Medical Insurance company name: _____
Policy #: _____ Group #: _____
Insured person's name _____ SS#: _____

No-Fault Insurance Company: _____
Policy Number (Insurance Card) _____ Phone #: _____
Mailing Address _____

Worker's Compensation Carrier Name/Phone#_____
Claim # _____ Policy # _____ Date injured _____

Please answer all the following questions to the best of your ability.

WHAT IS YOUR MAJOR COMPLAINT? _____

_____

HOW LONG HAVE YOU HAD THIS PROBLEM? _____

PLEASE DESCRIBE WHAT YOU FEEL IS THE CAUSE OF THIS COMPLAINT:

_____

_____

If Your Current Problem is from an AUTO ACCIDENT OR WORK Injury PLEASE SPECIFY:

WORK RELATED **AUTO RELATED**

This Box For Auto & Work injury Only

Please specify the date and time of your injury: Date: _____ Time: _____ Location: _____

If this was a car accident, were you (circle one): DRIVER / PASSENGER in the: FRONT/ BACK of the car or A PEDESTRIAN

How long have you been working at your current job? _____ (circle one): FULL TIME or PART TME

Are you currently working? YES or NO Last Day worked: ____/____/____

TO WHOM WAS THE ACCIDENT REPORTED IF IT OCCURRED AT WORK? (ex. Supervisor) _____

Did you report this accident to your insurance company? YES or NO

Please specify exactly what tasks your job involves: _____

_____

If you have been treated or seen by another Doctor or Hospital for this problem, please give us their name and address as well as what the doctor did for you and what they told you.

NAME OF DOCTOR: _____ SPECIALTY: _____

TREATMENT GIVEN: _____

SPECIAL TESTS (x-rays, etc.): _____

WHAT DID THEY SAY? _____

IS YOUR CONDITION GETTING: (circle one) WORSE BETTER SAME

WHAT HAVE YOU BEEN DOING FOR THIS INJURY AT HOME? _____

PRIOR TO THIS INJURY, HAVE YOU HAD A SIMILAR COMPLAINT? YES or NO

_____

_____

DO YOU NOTICE ANY ACTIVITY RESTRICTIONS TO YOUR DAILY ROUTINE SINCE THE INJURY?

_____

HOW HAS THE PAIN AFFECTED YOUR SLEEP HABITS? _____

_____

WHAT MAKES YOUR PAIN WORSE? _____

WHAT MAKES YOUR PAIN BETTER? _____

_____

IS THERE ANY OTHER AREA OF YOUR BODY THAT CAUSES YOU PAIN? (circle one) YES or NO

If yes, where? _____

_____

HAVE YOU EVER HAD A PREVIOUS MOTOR VEHICLE ACCIDENT OR JOB INJURY IN YOUR LIFE? (circle one) YES or NO If yes, when and how? _____

_____

PREVIOUS MEDICAL HISTORY

Smoker? Yes/No Packs/Day _____ Alcohol intake weekly yes/no (circle one)
Recreational Drugs (ever) Yes/No Allergies_____

Describe all surgeries

_____
_____

Describe all fractures _____

Describe all Medical Problems (Diabetes, High Blood Pressure,Heart, Kidney, etc.)

_____
_____

Describe all Hospitalizations:

_____
_____

List all Medications or Pills You Currently are Taking:

- _____
- _____
- _____
- _____

Have you ever had any of the following tests performed? & Why!

- MRI
- CAT SCAN
- X-RAYS
- EMG/NCV
- MYELOGRAM
- PAIN INJECTIONS

HAVE YOU EVER BEEN DIAGNOSED OR SUSPECTED OF HAVING CANCER?
_____

HAVE YOU EVER HAD A MOTOR VEHICLE ACCIDENT? WHEN?
_____

HAVE YOU EVER BEEN INJURED ON THE JOB BEFORE? WHEN?
_____

CHECK OFF ALL CONDITIONS THAT YOU MAY HAVE CURRENTLY OR HAVE HAD IN THE PAST

□ ATHRITIS	□ THYROID PROBLEMS	□ ULCERS
□ ARTERIOSCLEROSIS	□ HIGH BLOOD PRESSURE	□ PAIN UPON URINATION
□ ANEMIA	□ EPILEPSY	□ BLOOD IN STOOLS
□ ASTHMA	□ GALL BLADDER	□ DIFFICULTY SLEEPING
□ ALCOHOLISM	□ LIVER	□ VENEREAL DISEASE
□ WEAKNESS OF MUSCLES	□ INTESTINAL PROBLEMS	□ FEVER
□ HEAD TRAUMA	□ DEPRESSION	□ HEART ATTACK
□ SWELLING FEET	□ HEADACHES	□ FAINTING
□ BLOOD PROBLEMS	□ NECK PAIN	□ WEIGHT LOSS
□ DIABETES	□ NUMBNESS arms/legs	□ STROKE
DO YOU HAVE A PACEMAKER? (CIRCLE ONE)		YES or NO

AUTHORIZATION TO RELEASE INFORMATION

You are authorized to release any information you deem necessary concerning my physical condition to any insurance company, attorney, or adjuster in order to process any claim for reimbursement of charges incurred by me as a result of professional services rendered by you, and I hereby release you of any consequence thereof. I have received the Notice of Privacy Practices (HIPPA) and I have been offered a copy of such.

ACKNOWLEDGEMENT & UNDERSTANDING

I hereby acknowledge that I am receiving (or about to receive) health care services at **Dr. Christos Vasakiris, D.C., P.C.'s office** and that I have been advised that the doctor providing the services is willing to wait for payment for these services, provided that there continues to be a reasonable chance that payment will be made by insurance proceeds or out of the settlement of a liability claim. I understand that if it is determined that either:

(a) There is no insurance company obligated to pay for the services, or if the insurance company involved refuses to acknowledge an assignment to the doctor of make other provisions for the protection of the interest of the doctor, or

(b) If the liability claim exists and my attorney refuses to agree to protect the doctor, or I have not engaged the services of an attorney:

then payment for the services rendered by the doctor at **350 West Montauk Highway Lindenhurst** will be made on a current and timely basis by myself and paid in full. I agree to take full responsibility for the outstanding balance.

I hearby give consent to Dr. Christos Vasakiris to administer any/all chiropractic services allowed under the scope of practice in New York State which he deems necessary in the treatment and diagnosis of my condition.

PATIENT'S SIGNATURE _____ **DATE** _____

Christos Vasakiris, D.C.,P.C.
350 West Montauk Highway
Lindenhurst, N.Y. 11757

Consent to Allow Treatment

I have been informed verbally about my condition and proposed chiropractic treatment program as well as alternative courses of care, the benefits, the risks and the side effects of the treatment and the consequences of not having the proposed treatment.

I do not expect the doctor to be able to be able to anticipate or explain all risks and complications. I wish to rely on the doctor to exercise his judgment during the course of the treatments which he feels at the time, based upon the facts then known, will be in my best interest.

I understand and am informed that, as in all health care, in the practice of chiropractic there are some risks to treatment, including but not limited to, muscle strains and joint sprains, bruising, fractures, dislocations, disc derangements and vascular injuries.

My doctor has responded to all of my questions/requests for information about the proposed treatment. I have read, or have had read to me, the above consent. I have also had the opportunity to ask questions about its content. By signing below, I consent to treatment.

_____ Date_____
Patient Signature/
Parent or Guardian

_____ Date_____
Doctors Signature

PATIENT CONSENT
FOR USE AND/OR DISCLOSURE OF PROTECTED HEALTH INFORMATION TO CARRY OUT TREATMENT, PAYMENT AND HEALTHCARE OPERATIONS

_____ hereby states that by signing this consent, I acknowledge and agree as follows.
PATIENT NAME

1. The Practice's Privacy Notice has been provided to me prior to my signing this Consent. The Privacy Notice includes a complete description of the uses and/or disclosure of my protected health information ("PHI") necessary for the Practice to provide treatment to me, and also necessary for the Practice to obtain payment for that treatment and to carry out it's health care operations. The Practice has further explained to me that the Privacy Notice will be available to me in the future upon my request. The Practice has further explained to my right to obtain a copy of the Privacy Notice prior to signing this Consent, and has encouraged me to read the Privacy Notice carefully prior to my signing the Consent.
2. The Practice reserves the right to change it's privacy practices that are described in it's Privacy Notices, in accordance with applicable law.
3. I understand that, and consent to, the following appointment reminders that will be used by the practice a) a postcard mailed to me at the address provided by me; and b) telephoning my home, cellular device or place of employment, and leaving a message on my answering machines or with the individual answering the phone.
4. The Practice may use and/or disclose my PHI (which includes information about my health or condition and treatment provided to me) in order for the practice to treat me and obtain payment for that treatment, and as necessary for the Practice to conduct it's specific healthcare operations.
5. I understand that I have a right to request that the Practice restrict how my PHI is used and/or disclosed to carry out treatment, payment and/or health care operations. However, the practice is not required to agree to any restrictions that I have requested. If the practice agrees to a requested restriction, then the restriction is binding on the Practice.
6. I understand that this Consent is valid for seven (7) years. I further understand that I have the right to revoke consent, in writing, at anytime for *all future* transaction, with the understanding that such revocation shall not apply to the extend that the practice has already taken action in reliance on this consent.
7. I understand that <u>if I revoke consent</u> at any time, <u>the Practice has the right to refuse to treat me.</u>
8. I understand that if I do not sign this consent evidencing my consent to the uses and disclosures described to me above and contained in the Privacy Notice, then the Practice will have the option not to treat me.

I have read and understand the forgoing notice, and all of my questions have been answered to my full satisfaction in a way that I can understand.

_____ _____
Name of Individual (Printed) **Signature of Individual** **Date**

_____ _____
Signature of Legal Representative **Relationship**

OSWESTRY LOW BACK DISABILITY QUESTIONNAIRE

Instructions: this questionnaire has been designed to give us information as to how your back pain has affected your ability to manage everyday life. Please answer every section and mark in each section only the ONE box which applies to you at this time. We realize you may consider 2 of the statements in any section may relate to you, but please mark the box which most closely describes your current condition.

1. PAIN INTENSITY

- ☐ I can tolerate the pain I have without having to use pain killers
- ☐ The pain is bad but I manage without taking pain killers
- ☐ Pain killers give complete relief from pain
- ☐ Pain killers give moderate relief from pain
- ☐ Pain killers give very little relief from pain
- ☐ Pain killers have no effect on the pain and I do not use them

2. PERSONAL CARE (e.g. Washing, Dressing)

- ☐ I can look after myself normally without causing extra pain
- ☐ I can look after myself normally but it causes extra pain
- ☐ It is painful to look after myself and I am slow and careful
- ☐ I need some help but manage most of my personal care
- ☐ I need help every day in most aspects of self care
- ☐ I don't get dressed, I was with difficulty and stay in bed

3. LIFTING

- ☐ I can lift heavy weights without extra pain
- ☐ I can lift heavy weights but it gives extra pain
- ☐ Pain prevents me from lifting heavy weights off the floor, but I can manage if they are conveniently positioned, i.e. on a table
- ☐ Pain prevents me from lifting heavy weights, but I can manage light to medium weights if they are conveniently positioned
- ☐ I can lift very light weights
- ☐ I cannot lift or carry anything at all

4. WALKING

- ☐ Pain does not prevent me walking any distance
- ☐ Pain prevents me walking more than one mile
- ☐ Pain prevents me walking more than ½ mile

Pain prevents me walking more than ¼ mile
can only walk using a stick or crutches

- ☐ I am in bed most of the time and have to crawl to the toilet

5. SITTING

- ☐ I can sit in any chair as long as I like
- ☐ I can only sit in my favorite chair as long as I like
- ☐ Pain prevents me from sitting more than one hour
- ☐ Pain prevents me from sitting more than ½ hour
- ☐ Pain prevents me from sitting more than 10 minutes
- ☐ Pain prevents me from sitting at all

6. STANDING

- ☐ I can stand as long as I want without extra pain
- ☐ I can stand as long as I want but it gives me extra pain
- ☐ Pain prevents me from standing for more than one hour
- ☐ Pain prevents me from standing for more than 30 minutes
- ☐ Pain prevents me from standing for more than 10 minutes
- ☐ Pain prevents me from standing at all

7. SLEEPING

- ☐ Pain does not prevent me from sleeping well
- ☐ I can sleep well only by using medication
- ☐ Even when I take medication, I have less than 6 hrs sleep
- ☐ Even when I take medication, I have less than 4 hrs sleep
- ☐ Even when I take medication, I have less than 2 hrs sleep
- ☐ Pain prevents me from sleeping at all

8. SOCIAL LIFE

- ☐ My social life is normal and gives me no extra pain
- ☐ My social life is normal but increases the degree of pain
- ☐ Pain has no significant effect on my social life apart from limiting my more energetic interests, i.e. dancing, etc.
- ☐ Pain has restricted my social life and I do not go out as often
- ☐ Pain has restricted my social life to my home
- ☐ I have no social life because of pain

9. TRAVELLING

- ☐ I can travel anywhere without extra pain
- ☐ I can travel anywhere but it gives me extra pain
- ☐ Pain is bad, but I manage journeys over 2 hours
- ☐ Pain restricts me to journeys of less than 1 hour
- ☐ Pain restricts me to short necessary journeys under 30 minutes
- ☐ Pain prevents me from traveling except to the doctor or hospital

10. EMPLOYMENT/ HOMEMAKING

- ☐ My normal homemaking/ job activities do not cause pain.
- ☐ My normal homemaking/ job activities increase my pain, but I can still perform all that is required of me.
- ☐ I can perform most of my homemaking/ job duties, but pain prevents me from performing more physically stressful activities (e.g. lifting, vacuuming)
- ☐ Pain prevents me from doing anything but light duties.
- ☐ Pain prevents me from doing even light duties.
- ☐ Pain prevents me from performing any job or homemaking chores.

Neck Disability Index

This questionnaire is designed to help us better understand how your neck pain affects your ability to manage everyday -life activities. Please mark in each section the **one box** that applies to you. Although you may consider that two of the statements in any one section relate to you, please mark the box that **most closely** describes your present -day situation.

Section 1 - Pain Intensity

- ❑ I have no pain at the moment.
- ❑ The pain is very mild at the moment.
- ❑ The pain is moderate at the moment.
- ❑ The pain is fairly severe at the moment.
- ❑ The pain is very severe at the moment.
- ❑ The pain is the worst imaginable at the moment.

Section 2 - Personal Care

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

Section 3 – Lifting

- ❑ I can lift heavy weights without causing extra pain.
- ❑ I can lift heavy weights, but it gives me extra pain.
- ❑ Pain prevents me from lifting heavy weights off the floor but I can manage if items are conveniently positioned, ie. on a table.
- ❑ Pain prevents me from lifting heavy weights, but I can manage light weights if they are conveniently positioned.
- ❑ I can lift only very light weights.
- ❑ I cannot lift or carry anything at all.

Section 4 – Work

- ❑ I can do as much work as I want.
- ❑ I can only do my usual work, but no more.
- ❑ I can do most of my usual work, but no more.
- ❑ I can't do my usual work.
- ❑ I can hardly do any work at all.
- ❑ I can't do any work at all.

Section 5 – Headaches

- ❑ I have no headaches at all.
- ❑ I have slight headaches that come infrequently.
- ❑ I have moderate headaches that come infrequently.
- ❑ I have moderate headaches that come frequently.
- ❑ I have severe headaches that come frequently.
- ❑ I have headaches almost all the time.

Section 6 – Concentration

- ❑ I can concentrate fully without difficulty.
- ❑ I can concentrate fully with slight difficulty.
- ❑ I have a fair degree of difficulty concentrating.
- ❑ I have a lot of difficulty concentrating.
- ❑ I have a great deal of difficulty concentrating.
- ❑ I can't concentrate at all.

Section 7 – Sleeping

- ❑ I have no trouble sleeping.
- ❑ My sleep is slightly disturbed for less than 1 hour.
- ❑ My sleep is mildly disturbed for up to 1-2 hours.
- ❑ My sleep is moderately disturbed for up to 2-3 hours.
- ❑ My sleep is greatly disturbed for up to 3-5 hours.
- ❑ My sleep is completely disturbed for up to 5-7 hours.

Section 8 – Driving

- ❑ I can drive my car without neck pain.
- ❑ I can drive as long as I want with slight neck pain.
- ❑ I can drive as long as I want with moderate neck pain.
- ❑ I can't drive as long as I want because of moderate neck pain.
- ❑ I can hardly drive at all because of severe neck pain.
- ❑ I can't drive my care at all because of neck pain.

Section 9 – Reading

- ❑ I can read as much as I want with no neck pain.
- ❑ I can read as much as I want with slight neck pain.
- ❑ I can read as much as I want with moderate neck pain.
- ❑ I can't read as much as I want because of moderate neck pain.
- ❑ I can't read as much as I want because of severe neck pain.
- ❑ I can't read at all.

Section 10 – Recreation

- ❑ I have no neck pain during all recreational activities.
- ❑ I have some neck pain with all recreational activities.
- ❑ I have some neck pain with a few recreational activities.
- ❑ I have neck pain with most recreational activities.
- ❑ I can hardly do recreational activities due to neck pain.
- ❑ I can't do any recreational activities due to neck pain.

Patient Name _____ Date _____

Score _____ [50] Benchmark -5 = _____