MIDDLETOWN
CHIROPRACTIC CENTER
AT THE CENTER OF A HEALTHY LIFE

Patient Application

First Name: _____ M.I.: _____ Last Name: _____ Date: _____ / _____ / _____
Address: _____
City: _____ State: _____ Zip: _____
Gender: M / F Age: _____ DOB: ___ / ___ / ___ SS#: _____-_____-_____
Email Address: _____
Home #: _____ Cell # _____ Work# _____

Occupation: _____
Employer Name: _____

Marital Status: _____ Spouse's Name: _____
Spouse's Occupation/Employer: _____ Cell#: _____
How Many Children Do You Have? _____ Children's Ages: _____
Emergency Contact Name: _____ Phone #: _____

How Did You Hear About This Office?

☐ Existing Patient: _____ ☐ Insurance Company Website: _____
☐ Facebook / Google: _____ ☐ Walk-In/Drive-By _____
☐ CrossFit: _____ ☐ Community Event: _____
☐ Other: _____

What Medications Are You Currently Taking? _____
What Supplements Are You Currently Taking? _____

Do You Exercise? ☐ Yes ☐ No What Activities? How Often? _____
Do You Smoke? ☐ Yes ☐ No How Much? / How Often? _____
Do You Drink Alcohol? ☐ Yes ☐ No How Much? / How Often? _____
Do You Drink Coffee? ☐ Yes ☐ No How Much? / How Often? _____
Do You Have Any Allergies? (specify) _____
Are You Pregnant? ☐ Yes ☐ No Date of Last Menstrual Period? ____ / ____ / ____

I Have: ☐ Never Received Treatment For This Problem ☐ Been Seen By Another Chiropractor ☐ Been Seen By Another Doctor ☐ Been Hospitalized
Have You Ever Received Chiropractic Care? ☐ Yes ☐ No Purpose of Visit(s): _____
Last Visit? _____ Chiropractor's/Office Name: _____
How Long Did You Receive Treatment? _____
Did They Take "Before" and "After" X-Rays? ☐ Yes ☐ No
Did You Perform Rehabilitation Exercises at Home? ☐ Yes ☐ No
What Surgeries Have You Had? _____
List Any Recent Accidents or Falls: _____

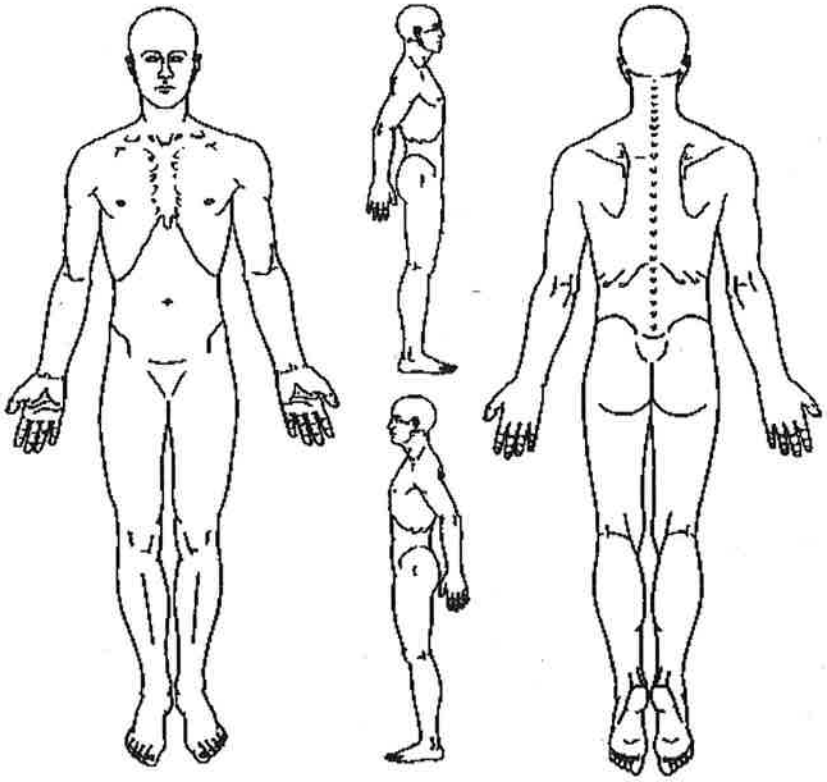
Are you satisfied with your current energy levels?	No / Yes
Do you experience Mental sluggishness (a.k.a. Brain Fog)?	No / Yes
Do you suffer with any hormonal issues?	No / Yes
Do you feel worse/cranky when you skip meals?	No / Yes
Do you feel better/energized when you eat?	No / Yes
Are your levels of stress moderate to severe on a consistent basis?	No / Yes

Would you like Dr. Kolenda to discuss treatment options for these issues? Yes / No

Purpose for This Visit? _____
How Long Have You Been Suffering from this Problem? _____
On A Scale of 1 to 10, How Severe is it at its Worst? 1 2 3 4 5 6 7 8 9 10
What Makes It Feel Worse? _____
What Makes It Feel Better? _____
When Do You Notice It Most? (circle) Morning Afternoon Evening
What % of the Day Do You Experience It? 0 10 20 30 40 50 60 70 80 90 100

On the diagram below, please label <u>ALL</u> areas you are experiencing symptoms as it relates to the purpose of your visit today using the appropriate letter from the box below.

A=Aching	**C=Cramping**	**R=Throbbing Pain**	**N=Numbness**	**O=Other**
B=Burning	**D=Dull Pain**	**S=Stiffness**	**T=Tingling**	



Health Conditions

Mark with an "X" Current Symptoms and "O" Past Symptoms

___ Neck Pain
___ Pain in Shoulders/Arms/ Hands
___ Numbness/Tingling in Hands
___ Coldness in Hands
___ Weakness of Grip
___ Headaches/ Migraines
___ Fatigue/ Low Energy
___ Thyroid Problems
___ Allergies/ Sinus
___ TMJ Pain
___ Visual Disturbances
___ Hearing Disturbances
___ Dizziness/ Loss of Balance
___ Ear Infections
___ Fainting
___ Epilepsy
___ ADD/ADHD

___ Depression
___ Upper/Mid Back Pain
___ Pain in Ribs/Chest
___ Heartburn/Indigestion
___ Nausea
___ Reflux
___ Ulcers/Gastritis
___ Shortness of Breath
___ Asthma/Wheezing
___ High/Low Blood Pressure
___ Heart Palpitations
___ Heart Murmurs
___ Tachycardia
___ Pacemaker
___ Heart Attack
___ Stroke
___ Diabetes
___ Cancer
___ Hypoglycemia

___ Hyperglycemia
___ Pain with Cough/Sneeze
___ Low Back Pain
___ Pain in Hips/Legs/Feet
___ Numbness/Tingling in Legs / Feet
___ Coldness in Feet
___ Weakness in Legs
___ Frequent/Difficulty Urinating
___ Diarrhea/Constipation
___ Kidney Problems
___ Prostate Problems
___ Sexual Dysfunction
___ Menstrual Irregularities
___ Menopausal Problems
___ Trouble Sleeping
___ Trouble Concentrating
___ Traumas/Car Accidents (Please List):

The Neck Disability Index

Patient name: _____ File#_____ Date:_____

Please read instructions:

This questionnaire has been designed to give the doctor information as to how your neck pain has affected your ability to manage everyday life. Please answer every section and mark in each section only the ONE box that applies to you. We realize that you may consider that two of the statements in any one section relate to you, but please just mark the box that most closely describes your problem.

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 (Washing, Dressing, etc.)

- ☐ 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 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, for example, on a table.
- ☐ Pain prevents me from lifting heavy weights off the floor, 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.

SECTION 4-READING

- ☐ I can read as much as I want to, with no pain in my neck.
- ☐ I can read as much as I want to, with slight pain in my neck.
- ☐ I can read as much as I want to, with moderate pain in my neck.
- ☐ I can't read as much as I want, because of moderate pain in my neck.
- ☐ I can hardly read at all, because of severe pain in my neck.
- ☐ I cannot read 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 when I want to, with no difficulty.
- ☐ I can concentrate fully when I want to, with slight difficulty.
- ☐ I have a fair degree of difficulty in concentrating when I want to.
- ☐ I have a lot of difficulty in concentrating when I want to.
- ☐ I have a great deal of difficulty in concentrating when I want to.
- ☐ I cannot concentrate at all.

SECTION 7-WORK

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

SECTION 8-DRIVING

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

SECTION 9-SLEEPING

- ☐ I have no trouble sleeping.
- ☐ My sleep is slightly disturbed (less than 1 hr sleepless).
- ☐ My sleep is mildly disturbed (1-2 hrs sleepless).
- ☐ My sleep is moderately disturbed (2-3 hrs sleepless).
- ☐ My sleep is greatly disturbed (3-5 hrs sleepless).
- ☐ My sleep is completely disturbed (5-7 hrs sleepless).

SECTION 10-RECREATION

- ☐ I am able to engage in all my recreation activities, with no neck pain at all.
- ☐ I am able to engage in all my recreation activities, with some neck pain at all.
- ☐ I am able to engage in most, but not all, of my usual recreation activities, because of pain in my neck.
- ☐ I am able to engage in few of my recreation activities, because of pain in my neck.
- ☐ I can hardly do any recreation activities, because of pain in my neck.
- ☐ I can't do any recreation activities at all.

Instructions:

1. The NDI is scored in the same way as the Oswestry Disability Index.

2. Using this system, a score of 10-28% (i.e., 5-14 points) is considered by the authors to constitute mild disability; 30-48% is moderate; 50-68% is severe; 72% or more is complete.

REVISED OSWESTRY 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 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 minute without increasing pain.** **F I avoid standing, because it increases the pain straight away.**
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 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 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 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, eg. 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 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, My 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 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 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 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.**	***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: _____

_____

_____

NAME: _____ **DATE:** _____ **SCORE:** _____

Rand 36 Health Survey Questionnaire

1. In general, would you say your health is:

Excellent	Very Good	Good	Fair	Poor
(1)	(2)	(3)	(4)	(5)

2. **Compared to one year ago**, how would you rate your health in general **now**?

Much better now than one year ago	Somewhat better now than 1 year ago	About the same	Somewhat worse now than one year ago	Much worse now than 1 year ago
(1)	(2)	(3)	(4)	(5)

The following items are about activities you might do during a typical day. Does **your health now limit you** in these activities? If so, how much? (Circle one number on each line.)

	Yes, Limited **a Lot**	Yes, Limited **a Little**	**No**, Not Limited at All
3. **Vigorous activities**, such as running, lifting heaving objects, participating in strenuous sports	(1)	(2)	(3)
4. **Moderate activities**, such as moving a table, pushing a vacuum cleaner, bowling, or playing golf	(1)	(2)	(3)
5. Lifting or carrying groceries	(1)	(2)	(3)
6. Climbing **several** flights of stairs	(1)	(2)	(3)
7. Climbing **one** flight of stairs	(1)	(2)	(3)
8. Bending, kneeling, or stooping	(1)	(2)	(3)
9. Walking **more than a mile**	(1)	(2)	(3)
10. Walking **several** blocks	(1)	(2)	(3)
11. Walking **one** block	(1)	(2)	(3)
12. Bathing or dressing yourself	(1)	(2)	(3)

During **the past 4 weeks**, have you had any of the following problems with your work or other regular daily activities **as a result of your physical health**? (Circle one number on each line.)

	Yes	No
13. Cut down **the amount of time** you spent on work or other activities	(1)	(2)
14. **Accomplished less** than you would like	(1)	(2)
15. Were limited in the **kind of work** or other activities	(1)	(2)
16. Had **difficulty performing the work** or other activities (for example, it took extra effort)	(1)	(2)

During **the past 4 weeks**, 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)? (Circle 1 number on each line.)

	Yes	No
17. Cut down **the amount of time** you spent on work or other activities	(1)	(2)
18. **Accomplished less** than you would like	(1)	(2)
19. Didn't do work or other activities as **carefully** as usual	(1)	(2)

20. During the **past 4 weeks**, to what extent has your physical health or emotional problems interfered with your **normal social activities** with family, friends, neighbors or groups? (Circle)

Not at all	Slightly	Moderately	Quite a bit	Extremely
(1)	(2)	(3)	(4)	(5)

21. How much **bodily** pain have you had during the **past 4 weeks**? (Circle one.)

None	Very Mild	Mild	Moderate	Severe	Very Severe
(1)	(2)	(3)	(4)	(5)	(6)

22. During **the past 4 weeks**, how much did **pain** interfere with your normal work (including both work outside the home and housework)? (Circle one.)

Not at all	Slightly	Moderately	Quite a bit	Extremely
(1)	(2)	(3)	(4)	(5)

The Questions below are about how you feel and how things have been with you **during the past 4 weeks**. For each question, please give one answer that comes closest to the way you have been feeling.

How much of the time during **the past 4 weeks**.... (Circle one number on each line.)

	All of the Time	Most of the Time	A Good Bit of the Time	Some of the Time	A Little of the Time	None of the Time
23. Did you feel full of pep?	(1)	(2)	(3)	(4)	(5)	(6)
24. Have you been a very nervous person?	(1)	(2)	(3)	(4)	(5)	(6)
25. Have you felt so down in the dumps that nothing could cheer you up?	(1)	(2)	(3)	(4)	(5)	(6)
26. Have you felt calm and peaceful?	(1)	(2)	(3)	(4)	(5)	(6)
27. Did you have a lot of energy?	(1)	(2)	(3)	(4)	(5)	(6)
28. Have you felt downhearted and blue?	(1)	(2)	(3)	(4)	(5)	(6)
29. Did you feel worn out?	(1)	(2)	(3)	(4)	(5)	(6)
30. Have you been a happy person?	(1)	(2)	(3)	(4)	(5)	(6)
31. Did you feel tired?	(1)	(2)	(3)	(4)	(5)	(6)

32. During **the past 4 weeks,** how much of the time has **your physical health or emotional problems** interfered with your social activities (like visiting friends, relatives, etc.)? (Circle one number.)

All of the Time	Most of the Time	Some of the Time	A Little of the Time	None of the Time
(1)	(2)	(3)	(4)	(5)

How **TRUE** or **FALSE** is each of the following statements for you? (Circle one number on each line.)

	Definitely True	Mostly True	Don't Know	Mostly False	Definitely False
33. I seem to get sick a little easier than other people	(1)	(2)	(3)	(4)	(5)
34. I am as healthy as anybody I know	(1)	(2)	(3)	(4)	(5)
35. I expect my health to get worse	(1)	(2)	(3)	(4)	(5)
36. My health is excellent	(1)	(2)	(3)	(4)	(5)

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OFFICE POLICIES

1. It is our office policy that any patient and /or insurance company that pays up-front or in advance is entitled to an administrative discount.

2. If you have any out of pocket responsibility what will be your method of payment?
☐Cash ☐Check ☐Credit Card/Debit Card ☐Attorney /Letter of Protection

3. If you miss your appointment & do not call to reschedule 30 minutes prior to the office closing, you will be considered a "no-show". There is a missed appointment fee of $25.00 which will be auto-debited from your credit card/bank account on file.

I understand and agree that health and accident insurance policies are an agreement between the insurance carrier and myself. Furthermore, I understand Middletown Chiropractic Center will prepare any necessary reports, and forms to assist in making collections from my insurance company and that any amount authorized to be paid directly to Middletown Chiropractic Center will be credited to my account upon receipt. *However*, I clearly understand and agree that all services rendered to me, are charged directly to me and that I am personally responsible for payment.

I also understand that if I suspend or terminate my care at this office, any outstanding charges for professional services rendered to me will be immediately due and payable. I agree that I will be responsible for all attorney and legal fees if legal action becomes necessary to collect this amount.

Print Patient Name: _____ Date: ___ /___ /___

Patient Signature *(or Guardian authorizing care)*: _____
Date: ___ /___ /___

In case of emergency notify: _____ Relationship:_____

Address: _____
City: _____ State: _____ Zip Code: _____
Phone Number: _____

MIDDLETOWN
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Privacy Notice

THIS NOTICE DESCRIBES HOW CHIROPRACTIC AND MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

In the course of your care as a patient at Middletown Chiropractic Center we may use or disclose personal and health related information about you in the following ways:

- Your personal health information, including your clinical records, may be disclosed to another healthcare provider or hospital if it is necessary to refer you for further diagnosis, assessment or treatment.
- Your healthcare records as well as your billing records may be disclosed to another party, such as an insurance carrier, an HMO, a PPO, or your employer, if they are or may be responsible for the payment of your services.
- Your name, address, phone number, and healthcare records may be used to contact you regarding appointment reminders, information about alternative to your present care, or other health related information that may be of interest to you.

If you are not at home to receive an appointment reminder, a message may be left on your answering machine. Furthermore, you have the right to inspect or obtain a copy of the information we will use for these purposes. You also have the right to refuse to provide authorization for this office to contact you regarding these matters. If you do not provide us with this authorization it will not affect the care provided to you or the reimbursement avenues associated with your care.

Under federal law, we are also permitted or required to use or disclose your health information without your consent or authorization in the following circumstances:

- If we are providing healthcare to you based on the orders of another healthcare provider.
- If we provide healthcare services to you in an emergency.
- If we are required by law to provide care to you and we are unable to obtain our consent after attempting to do so.
- If there are substantial barriers to communicating with you, but in our professional judgment we believe that you intend for us to provide care.
- If we are ordered by the courts or another appropriate agency.

Any use or discloser of your protected health information, other than as outlined above, will only be made upon your written authorization.

We normally provide information about your health to you in person at the time you receive chiropractic care from us. We may also mail information to you regarding your healthcare or about the status of your account. If you would like to receive this information at an address other than your home or, if you would like the information in a different form please advise us in writing as to your preferences.

You have the right to inspect and/or copy your health information for seven years from the date that the record was created or as long as the information remains in our files. In addition you have the

right to request an amendment to your health information. Requests to inspect, copy or amend our health related information should be provided to us in writing.

We are required by state and federal law to maintain the privacy of your patient file and the protected health information therein. We are also required to provide you with this notice of our privacy practices with respect to your health information.

We are further required by law to abide by the terms of this notice while it is in effect. We reserve the right to alter or amend the terms of this privacy notice. If changes are made to our privacy notice we will notify you in writing as soon as possible following the changes. Any change in our privacy notice will apply to all of your information in our files.

Information that we use or disclose based on this privacy notice may be subject to re-discloser by the person to whom we provide the information and may no longer be protected by the federal privacy rules.

If you have a complaint regarding our privacy notice, our privacy practices or any aspect of our privacy activities you should direct your complaint to: Jason L. Kolenda, DC

If you would like further information about our privacy policies and practices please contact: Jason L. Kolenda, DC.

This notice is effective as of August 1, 2016. This notice, and any alterations or amendments made hereto will expire seven (7) years after the date upon which the record was created. My signature acknowledges that I have received a copy of this notice.

Name (Print)	Signature	Date

If you are a minor, or if you are being represented by another party:

Representative Name (Print)	Representative Signature	Date

Description of the authority to act on behalf of the patient.