

PLEASE PRINT

PATIENT INFORMATION:

FULL NAME _____ DATE OF BIRTH ___/___/___ AGE _____ MALE FEMALE

ADDRESS _____ APT# _____ SSN _____

CITY _____ STATE _____ ZIP CODE _____ PHONE _____

ALTERNATE PHONE (CELL) (_____) _____ EMAIL ADDRESS _____

EMPLOYER'S NAME _____ OCCUPATION _____

WORK ADDRESS _____ CITY _____ STATE _____ ZIP _____

WORK PH. # (_____) _____ EXT _____ HOW DID YOU HEAR ABOUT US? _____

MARITAL STATUS: SINGLE MARRIED WIDOWED

EMERGENCY CONTACT _____ PHONE _____

PHYSICIAN INFORMATION:

PRIMARY CARE PHYSICIAN _____ NUMBER _____

ORTHOPEDIST _____ NUMBER _____

CLAIM INFORMATION:

IS YOUR CONDITION DUE TO AN AUTO ACCIDENT A PERSONAL INJURY WORK INJURY OTHER

TYPE OF CLAIM CASH GROUP HEALTH INS PERSONAL INJURY WORKER'S COMP

MEDICARE

I WILL BE PAYING TODAY BY CASH CHECK MASTER CARD AMEX DISCOVER

OTHER

INSURANCE INFORMATION:

RELATIONSHIP TO INSURED? SELF SPOUSE CHILD SPOUSE: _____

INSURED'S EMPLOYER SAME AS ABOVE

INSURED'S SSN SAME AS ABOVE SSN: _____ INSURED DOB SAME AS ABOVE

PRIMARY INSURANCE CO _____ ADDRESS _____

CITY _____ STATE _____ ZIP CODE _____ PHONE # (_____) _____

POLICY NUMBER _____

SECONDARY INSURANCE CO _____ ADDRESS _____

CITY _____ STATE _____ ZIP CODE _____ PHONE # (_____) _____

POLICY NUMBER _____ GROUP NUMBER _____

AUTHORIZATIONS:

A. I hereby authorize release of any medical information necessary to process this claim and request payment of insurance benefits either to myself or to the party who accepts assignment.

B. I authorize payment of any medical benefit from third-parties for benefits submitted for my claim to be paid directly to this office. I authorize the direct payment to this office of any sum I now or hereafter owe this office by my attorney, out of proceeds of any settlement of my case and by any insurance company contractually obligated to make payment to me or you based upon the charges submitted for products and services rendered.

C. I understand and agree that health and accident policies are an arrangement between an insurance carrier and myself. Furthermore, I understand that this office will prepare any necessary reports and forms to assist me in making collection from the insurance company and that any amount authorized to be paid directly to this office 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 and treatment, any fees for products or professional services rendered will be immediately due and payable.

Patient's Signature _____ Date: _____

Guardian Signature: _____ Date: _____

Emp In: _____

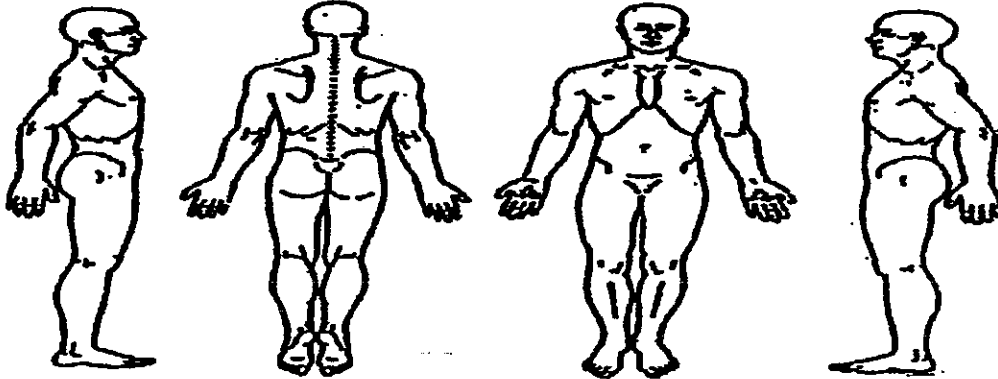
Emp In: _____

PATIENT INTAKE FORM

Patient Name: _____ Date: _____

1. Is today's problem caused by: Auto Accident Workman's Compensation Major Medical Case

2. Indicate on the drawings below where you have pain/symptoms



3. How often do you experience your symptoms?

- Constantly (76-100% of the time) Occasionally (26-50% of the time)
 Frequently (51-75% of the time) Intermittently (1-25% of the time)

4. How would you describe the type of pain?

- Sharp Numb
 Dull Tingly
 Diffuse Sharp with motion
 Achy Shooting with motion
 Burning Stabbing with motion
 Shooting Electric like with motion
 Stiff Other: _____

5. How are your symptoms changing with time?

- Getting Worse Staying the Same Getting Better

6. Using a scale from 0-10 (10 being the worst), how would you rate your problem?

0 1 2 3 4 5 6 7 8 9 10 (Please circle)

7. How much has the problem interfered with your work?

- Not at all A little bit Moderately Quite a bit Extremely

8. How much has the problem interfered with your social activities?

- Not at all A little bit Moderately Quite a bit Extremely

9. Who else have you seen for your problem?

- Chiropractor Neurologist Primary Care Physician
 ER physician Orthopedist Other: _____
 Massage Therapist Physical Therapist No one

10. How long have you had this problem? _____

11. How do you think your problem began?

12. Do you consider this problem to be severe?

- Yes Yes, at times No

13. What aggravates your problem?

13a. What alleviates your problem?

14. What concerns you the most about your problem?

Emp In: _____

Patients Name (Print): _____

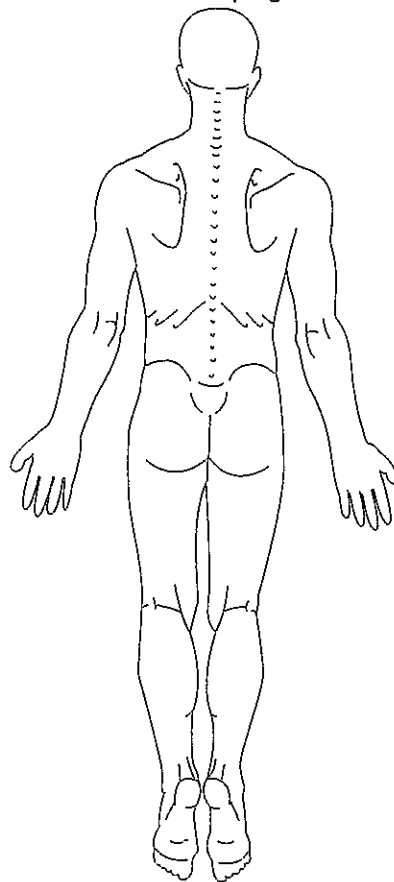
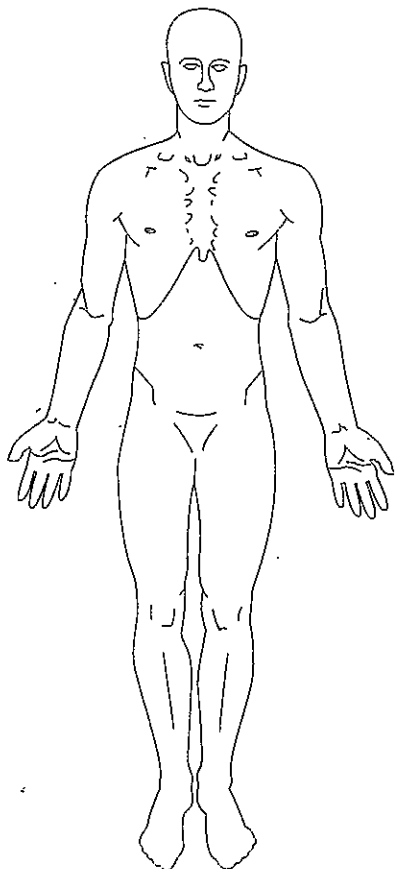
Date: _____

Patient ID#: _____

Please draw the location of your pain or discomfort on the images below. Use the symbols shown to represent the type(s) of pain:

- D – Dull
- B – Burning
- N – Numb

- S – Stabbing/Cutting
- T – Tingling (Pins&Needles)
- C – Cramping



On the scales below, please draw a vertical line representing your pain or discomfort:

Rate the pain you have right **now**:

Rate your pain at its **best** in the past week:

No Pain

Unbearable Pain

No Pain

Unbearable Pain



Rate your **average** pain in the past week:

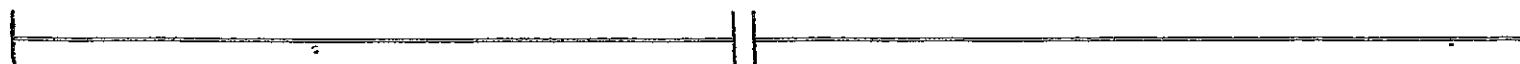
Rate your **worst** pain in the past week:

No Pain

Unbearable Pain

No Pain

Unbearable Pain



Emp In: _____

Name: _____ Date: _____

OVERALL FUNCTIONAL HEALTH ASSESSMENT

What is your function health?

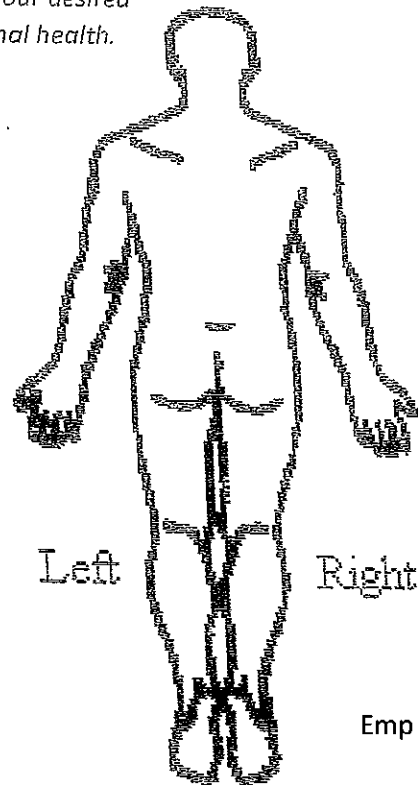
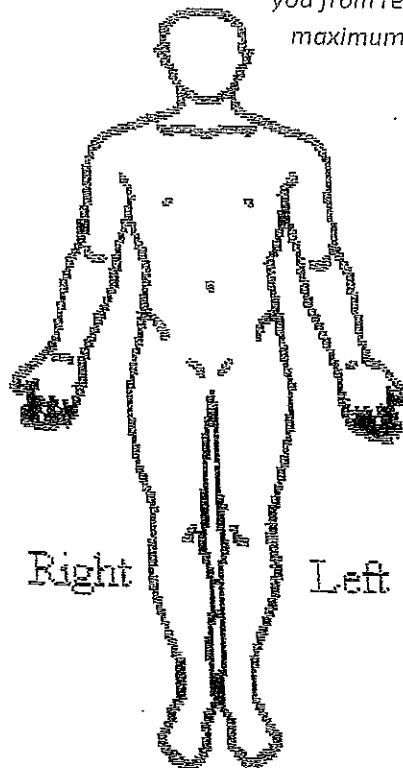
At Physical Synergy, we are dedicated to helping each and every patient obtain their maximum level of functional health. Functional health is your ability to perform your day to day tasks and activities, as well as, your leisure and recreational activities without discomfort and to the best of your ability.

For example, do you find yourself walking down the stairs on an angle because your knees bother you, or avoid getting down on the floor to play with your kids because your back hurts when you try and get up?

Take a moment and think about how your current level of pain/discomfort affects your ability to live your life each day. Now, think back one, and even five years ago to your ability to get the most out of each day, and compare that to today.

Average Functional Health this Week		Average Functional Health 1 year ago	
Poor	Optimal	Poor	Optimal
Functional Health Today		Functional Health Today	
Poor	Optimal	Poor	Optimal

Indicate on the figure below the area(s) you feel are preventing you from reaching your desired maximum functional health.



Emp In: _____

REVISED OSWESTRY BACK PAIN DISABILITY QUESTIONNAIRE

Name _____

Date _____

Please read carefully:

This questionnaire has been designed to enable us to understand how your back pain has affected your ability to manage everyday life. Please answer every section, and mark in each section only ONE CHOICE which 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 one box 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 gives me 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 4 - Walking

- A. Pain does not prevent me from walking any distance.
B. Pain prevents me from walking more than 1 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 using a stick or 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 sitting more than 1 hour.
D. Pain prevents me sitting more than 1/2 hour.
E. Pain prevents me sitting more than 10 minutes.
F. Pain prevents me from sitting at all.

OTHER COMMENTS:

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 1 hour without increasing pain.
D. I cannot stand for longer than 1/2 hour without increasing pain.
E. I cannot stand for longer than 10 minutes without increasing pain.
F. Pain prevents me from standing at all.

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, eg, 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.

Examiner _____

With Permission from: Hudson-Cook N, Tomes-Nicholson K, Breen AC. A Revised Oswestry Back Disability Questionnaire. Manchester Univ Press, 1989.

Emp In: _____

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 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.
- 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, 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 with moderate pain.
- 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 which come infrequently.
- I have slight headaches which come frequently.
- I have moderate headaches which come infrequently.
- I have severe headaches which come frequently.
- I have headaches almost all the time.

Scoring: Questions are scored on a vertical scale of 0-5. Total scores and multiply by 2. Divide by number of sections answered multiplied by 10. A score of 22% or more is considered a significant activities of daily living disability.

(Score x 2) / (Sections x 10) = %ADL

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 only 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 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 my car 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 moderately disturbed (1-2 hrs. sleepless).
- My sleep is moderately disturbed (2-3 hrs. sleepless).
- My sleep is greatly disturbed (3-4 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 pain in my neck.
- 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 a few of my usual 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.

Comments _____ %ADL

Reference: Vemon, Mior. JMPT 1991; 14(7): 409-

FORM 501

Emp In: _____

Your name: _____

Who can we thank for referring you to our office?

____ Family: _____

____ Friend: _____

____ Website: _____

____ Other (please specify): _____

____ Yellow Pages

Would you like to receive text messages confirming your appointments?

We will send you a text message the night before your appointment instead of calling you letting you know the date and time of your appointment. If you would like to sign up for this please provide the information below:

Cell phone number: _____

Cell phone carrier: _____

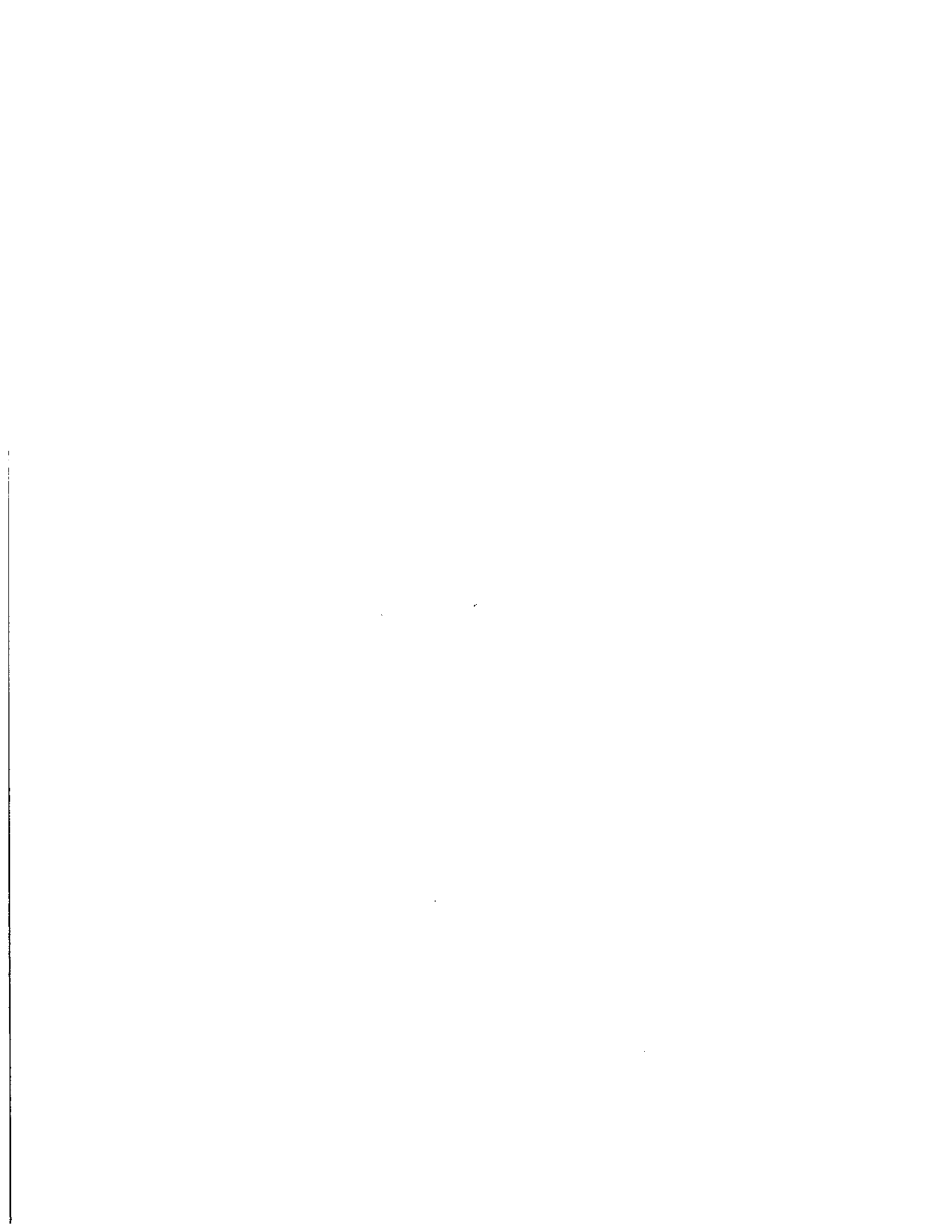
Signature: _____ date: _____

Manual Therapy Appointment Cancellation Policy

If you need to cancel your manual therapy appointment please give us 24 hour notice. We do charge \$50 for no shows or appointments that were not cancelled within the 24 hour time line.

Patient Signature: _____ date: _____

Emp In: _____



Consent for Purposes of Treatment, Payment & Healthcare Operations

In this document. "I" and "my" refer to the patient and "Chiropractor" refers to Physical Synergy

I consent to the use or disclosure of my protected health information by Chiropractor for the purpose of analyzing, diagnosing or providing treatment to me, obtaining payment for my health care bills or to conduct health care operations of Chiropractor. I understand that analysis diagnosis or treatment of me by Chiropractor may be conditioned upon my consent as evidenced by my signature below.

I understand I have the right to request a restriction as to how my protected health information is used or disclosed to carry out treatment, payment or healthcare operations of the practice. Chiropractor is not required to agree to the restrictions that I may request. However, if I have the right to revoke this consent, in writing, at any time, except to the extent that Chiropractor has taken action in reliance on this Consent.

My "protected health information" means health information, including my demographic information, collected from me and created or received by my physician, another health care provider, a health plan, my employer or health care clearinghouse. This protected health information relates to my past, present or future physical or mental health or condition and identifies me, or there is a reasonable basis to believe the information may identify me.

I have been provided with a copy of the Notice of Privacy Practices of Chiropractor and understand that I have a right that Notice's Notice of Privacy Practices prior to signing this document. The Notice of Privacy Practices describes the types of uses and disclosures of my protected health information what will occur in my treatment, payment of my bills or in the performance of health care operations of Chiropractor. The Notice of Privacy Practices for Chiropractor is also posted in the waiting room at Physical Synergy. This Notice of Privacy Practices also describes my rights and duties of the Chiropractor with respect to my protected health information. Chiropractor reserves the right to change the privacy practices that are described in The Notice of Privacy Practices. I may obtain a revised notice of privacy practices by calling the office of the Chiropractor and requesting a revised copy be sent in the mail or asking for one at the time of my next appointment.

Signature of Patient/Personal Representative

Printed Patient Name

Date of Signing

Description of Personal Representative's Authority

Emp In: _____

Office Policy and Insurance

This agreement is between PHYSICAL SYNERGY and _____
(patient name)

I _____ (patient name), do hereby authorize and agree to pay for services rendered to me by DR. MICHAEL TROKNYA during my course of treatment as agreed upon. I also hereby authorize and agree to pay in full any outstanding balance due on my account if requested at the time of my release from care.

I instruct an insurance carrier that may be liable to pay my physician directly for any outstanding medical bills.

I understand that if I have a personal injury protection policy (PIP) that it is the contractual obligation of my insurer to pay any and all medical bills, which are the result of an automobile accident, unless my benefits have been exhausted. I instruct any insurance company that may be liable to pay to pay my doctor within 30 days of the date of receipt of my claims, as required by the Connecticut Department of Insurance, by way of issuance of a separate draft make payable to PHYSICAL SYNERGY.

In the event I so choose to have any attorney represent me in this case, I do hereby instruct said attorney to pay in full any outstanding monies due my physician at the time of settlement with any liability claim that may result from this case. My attorney shall not withhold any portion of the amount due to my physician under this agreement to offset attorney's fees. I also instruct my attorney to pay my doctor immediately upon settlement, by way of issuance of a separate draft made payable to PHYSICAL SYNERGY.

I understand and acknowledge that all charges incurred by me are my responsibility regardless of any settlement made by any insurance companies. I am instructing and agreeing to the above conditions as a safeguard to the physician's right to collect payment.

I understand that PHYSICAL SYNERGY has the right to expect good faith payments on my account and that full payment is being deferred only until such time as any insurance company makes payment on my account. If a settlement does not occur within a reasonable amount of time, I agree to make other arrangements to pay my account in full.

I understand that PHYSICAL SYNERGY does not render any services on the assumption that their charges will be paid by any insurance company. Patients who carry health insurance should remember that professional services are rendered and charged to the patient if not paid in full by the insurance company. This excludes patients with an accepted workers' compensation injury. Insured patients are expected to take care of their fees and/or patient portion as services are rendered. Even though an insurance claim is filed, you will receive a statement if your account has a balance due.

Methods of payment

(Accepted workers' compensation patients are excluded)

- A. Payment at the time of service is expected unless prior arrangements are made in advance. Cash, checks and credit cards are accepted.
- B. If participating in the WellCare Program, which allows the patient to pay in advance for the recommended adjustments, and thereby receive subsequent savings, or other cash payment agreement, the patient's insurance company will not be billed. However, if the patient suffers an injury or illness, which merits injury/illness care, the patient's insurance may be utilized.

Patients Signature Date

Patient's Parent or Guardian Signature Date

Acknowledgement and Agreement of Receipt

As the insurance adjuster or attorney on this claim, I acknowledge that I have received notice of the patient's agreement above and will abide by it as agreed upon and instructed from _____ (patient's name).

Adjuster or Attorney Signature Date

Emp In: _____