WESTERN NEW YORK
PAIN RELIEF
& INTEGRATIVE WELLNESS
CENTER

INITIAL INTAKE & EVALUATION FORM

Name _____ Nickname _____

Address_____

City_____ State_____ ZIP/Postal_____

Phone_____ Email_____

Date of Birth_____ Social Security_____

Spouse's Name_____ Phone Number_____

Your Occupation_____ Retired? YES / NO 07/31/19

Conditions & Symptoms

Please check all the apply

___Neck Pain	___Arthritis (Hands)	___Spinal Stenosis	___Cancer/ Chemotherapy	___Pinched Nerve
___Low Back Pain	___Arthritis (Feet)	___Degenerative Disc	___Diabetes	___Poor Circulation
___Foot Pain	___Sciatica	___Vascular Dysfunction	___High Cholesterol	___Joint Replacement
___Hand Pain	___Surgically Implanted Medical Device/Cord	___Leg Pain	___Poor Wound Healing	___Traumatic Brain Injury
___Foot Numbness	___ Herniated Disc	___Plantar Fascitis	___High Blood Pressure	___Excessive Thirst or Urination
___Hand Numbness	___Bulging Disc	___Morton's Neuroma	___Stroke/ Blood Clots	___Serious Eye Conditions
___Surgery of: HAND / FOOT / NECK / UPPER BACK / LOW BACK			___Decreased Mobility/Balance	

___Other_____

Personal Health Goals

Please list the conditions you are looking to have treated with us:

1)_____
2)_____
3)_____
4)_____

How long have you had symptoms for each condition?

1)_____
2)_____
3)_____
4)_____

How much is your daily average water intake?

_____

We offer programs on Nutritional Education and Weight Loss. Are you interested in learning more?

Yes /No

On a scale from 1 to 10, with one being no pain and 10 being the worst, how would you rate your pain in the last week? _____

On a scale from 1 to 10, with one being no pain and 10 being the worst, If you had to accept some pain after the completion of a whole treatment plan, what would be acceptable? _____

Relevant Medical Information:

Primary Physician:

Name_____ Address_____ Phone_____

Date of Last Appointment_____

Specialists:
Have you visited any Specialists(Podiatrist, Neurologist, Surgeon, etc.) in regards to your conditions?
Name Specialty Phone Number

_____ _____ _____
_____ _____ _____
_____ _____ _____
_____ _____ _____

Known Allergies:
Items you have a reaction to: Reaction:

_____ _____
_____ _____
_____ _____
_____ _____
_____ _____

Medications (prescription and non prescription) and Supplements (Vitamins, Herbs, Etc.):
You may also attach a list
Name Dosage Times Per Day

_____ _____ _____
_____ _____ _____
_____ _____ _____
_____ _____ _____
_____ _____ _____
_____ _____ _____
_____ _____ _____
_____ _____ _____
_____ _____ _____
_____ _____ _____
_____ _____ _____
_____ _____ _____

Is there any time of day your symptoms improve?

_____

Is there any time of day your symptoms worsen?

_____

Is there any activities that improve your symptoms?

_____

Is there any activities that worsen your symptoms?

_____

Please list any treatment from your Primary Physician or Specialist that has eased your symptoms:
1)_____
2)_____
3)_____
4)_____

Please list any treatment from your Primary Physician or Specialist that has worsened or has not affected your symptoms:
1)_____
2)_____
3)_____
4)_____

Are your conditions interfering with any of the following Activities of Daily Life?

___Walking	___Standing	___Hygiene	___Cooking/Eating
___Recreation	___Work	___Sleep	___Shopping
___Dressing	___Housework	___Driving	___Sitting

In relationship to the area of your condition, have you felt any of the following symptoms?

___Numbness	___Cramping	___Aching Pain	___Pins & Needles Pain
___Tingling	___Swelling	___Stabbing Pain	___Tiredness
___Cold Hands/Feet	___Burning	___Sharp Pain	___Dead Feeling
___Hot Sensation	___Shocking	___Throbbing Pain	___Heaviness

Medical History

Do you smoke? Yes / No **How many cigarettes a day?____ How long?____**
Did you smoke? Yes / No **How long did you smoke?____ How long ago did you stop?____**
Do you drink? Yes / No **How many drinks per week?____ Is your drinking mostly social?** Yes / No
Do you exercise regularly? Yes / No **How often?**_____

Modified MICHIGAN NEUROPATHY SCREENING INSTRUMENT

A. Please take a few minutes to answer the following questions about your the feelings in your legs/and or feet, or the feelings in your hands and/or arms.

1) Is the area affected primarily your hands or your feet?	Hands / Feet
2) Are your hands or feet numb ?	Yes / No
3) Do you have any burning pain in your hands or feet?	Yes / No
4) Are your hands of feet too sensitive to touch?	Yes / No
5) Do you get muscle cramps in your hands or feet?	Yes / No
6) Do you ever have any prickling feelings in your hands or feet?	Yes / No
7) Does it hurt when the bed covers touch your skin?	Yes / No
8) When you get into the tub or shower, are you able to tell the hot water from the cold?	Yes / No
9) Have you ever had an open sore on your hands or feet?	Yes / No
10) Has your doctor ever told you that you have diabetic neuropathy?	Yes / No
11) Do you feel weak all over most of the time?	Yes / No
12) Are you symptoms worse at night?	Yes / No
13) Do your legs hurt when you walk?	Yes / No
14) Do your hands hurt when gripping?	Yes / No
15) Are you able to sense your feet when you walk?	Yes / No
16) Are you able to sense your palms/ fingers when touching objects?	Yes / No
17) Is the skin on your feet or hands so dry that it cracks open?	Yes / No
18) Have you ever had an amputation?	Yes / No

Total:_____

Low Back Questionnaire

Section 1 – Pain Intensity ___I can tolerate the pain I have without having to use pain medication. ___The pain is bad but I manage without having to take pain medication. ___Pain medication provides me complete relief from pain. ___Pain medication provides me moderate relief from pain. ___Pain medication provides me little relief from pain. ___Pain medication has no effect on the pain	**Section 6 – Standing** ___I can stand as long as I want without increased pain. ___I can stand as long as I want but increases my pain. ___Pain prevents me from standing for more than 1 hour. ___Pain prevents me from standing for more than ½ hour. ___Pain prevents me from standing for more than 10 mins. ___Pain prevents me from standing at all.
Section 2 – Personal Care (Washing, Dressing, etc.) ___I can take care of myself normally without causing increased pain. ___I can take care of myself normally but it increases my pain. ___It is painful to take care of myself and I am slow and careful. ___I need help but I am able to manage most of my personal care. ___I need help every day in most aspects of my care. ___I do not get dressed, wash with difficulty and stay in bed.	**Section 7 – Sleeping** ___Pain does not prevent me from sleeping well. ___I can sleep well only by using pain medication. ___Even when I take pain medication, I sleep less than 6 hours. ___Even when I take pain medication, I sleep less than 4 hours. ___Even when I take pain medication, I sleep less than 2 hours. ___Pain prevents me from sleeping at all
Section 3 – Lifting ___I can lift heavy weights without increased pain. ___I can lift heavy weights but it causes increased pain. ___Pain prevents me from lifting heavy weights off the floor, but I can manage if weights are conveniently positioned, e.g. 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 only very light weights. ___I cannot lift or carry anything at all.	**Section 8 – Social Life** ___My social life is normal and does not increase my pain. ___My social life is normal, but it increases my level of pain. ___Pain prevents me from participating in more energetic activities (ex sports, dancing, etc. ___Pain prevents me from going out very often. ___Pain has restricted my social life to my home. ___I have hardly any social life because of my pain.
Section 4 - Walking ___Pain does not prevent me walking any distance. ___Pain prevents me walking more than 1 mile. ___Pain prevents me walking more than ½ mile ___Pain prevents me walking more than ¼ mile ___I can only walk using crutches or a cane.	**Section 9 – Traveling** ___I can travel anywhere without increased pain. ___I can travel anywhere but it increases my pain. ___Pain restricts travel over 2 hours. ___Pain restricts travel over 1 hour. ___Pain restricts my travel to short necessary journeys under ½ hour. ___Pain prevents all travel except for visits to the doctor/therapist or hospital.
Section 5 - Sitting ___I can it in any chair as long as I like. ___I can only sit in my favorite chair as long as I like. ___Pain prevents me sitting more than 1 hour. ___Pain prevents me from sitting more than ½ hour. ___Pain prevents me from sitting more than 10 mins. ___Pain prevents me from sitting at all.	**Section 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 (ex. 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/homemaking chores.

For Office Use Only:

Score:____/100

Neck Pain Questionnaire

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 increased pain.
___I can lift heavy weights but it causes increased pain.
___Pain prevents me from lifting heavy weights off the floor, but I can manage if weights are conveniently positioned, e.g. on a table.
___Pain prevents me from lifting heavy weights but I can manage light to medium weights if they're conveniently positioned.
___I can lift only 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 in my neck.
___ I cannot 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 which come infrequently.
___ I have moderate headaches which come frequently.
___ I have severe headaches which 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 cannot 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 cannot 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 cannot drive my car at all.

Section 9 – Sleeping

___ I have no trouble sleeping.
___ My sleep is slightly disturbed (less than 1 hour sleepless).
___ My sleep is mildly disturbed (1-2 hours sleepless).
___ My sleep is moderately disturbed (2-3 hours sleepless).
___ My sleep is greatly disturbed (3-5 hours sleepless).
___ My sleep is completely disturbed (5-7 hours 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 cannot do any recreation activities at all.

For Office Use Only:

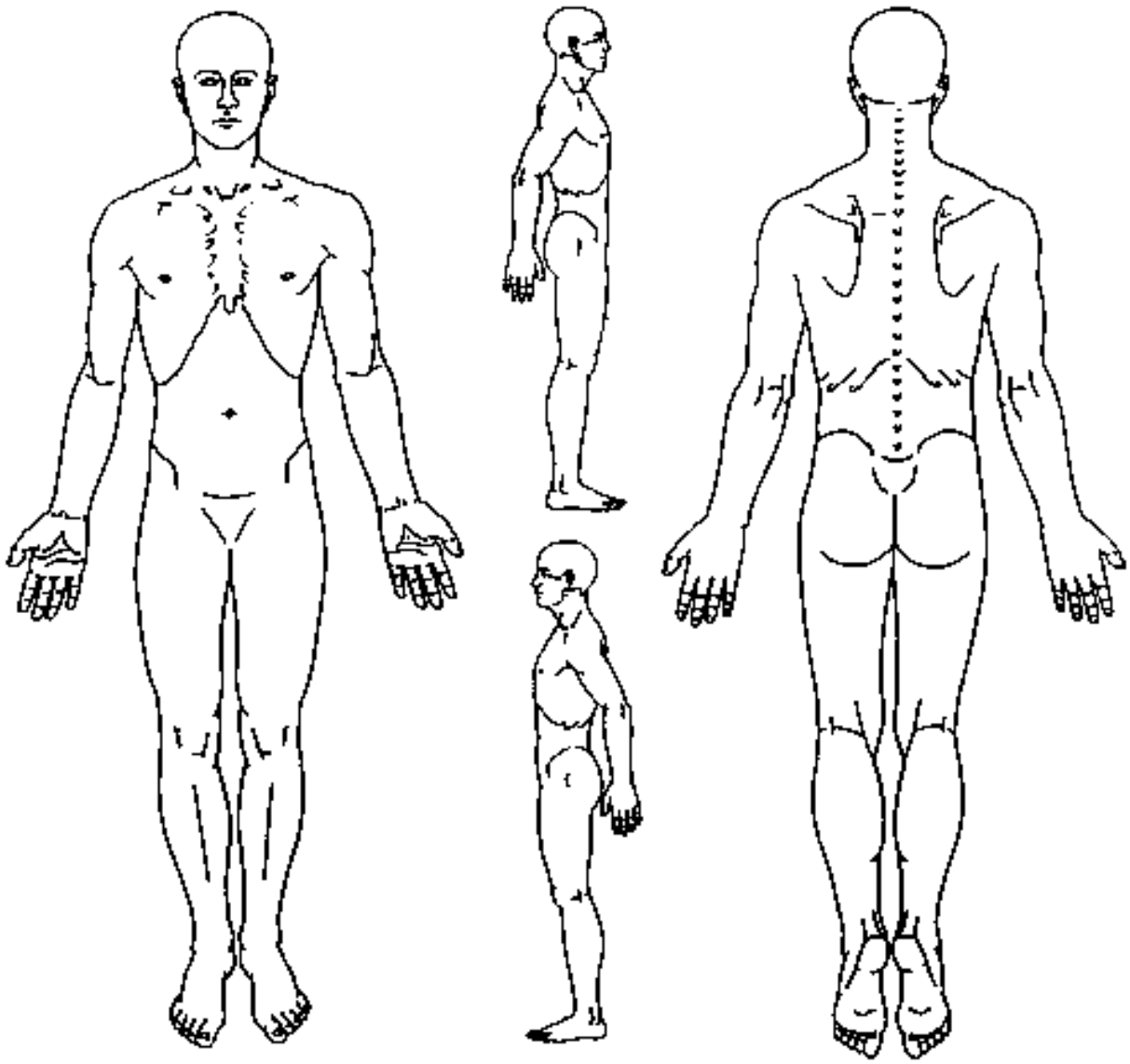
Score:____/100

Name: _____ **Date:** _____ **7**

Signature: _____

Using the diagram below draw the areas afflicted by your condition using the table below:

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



Cheektowaga Chiropractic P.L.L.C.

AUTHORIZATION AND ASSIGNMENT

To: Christian Milioto D.C. & Kevin Nightingale D.C., Cheektowaga Chiropractic P.L.L.C.
4415 Union Rd, Cheektowaga, NY 14225 (716)-650-7246

In consideration of your undertaking to treat me, I agree to the following:

Authorization to Release Information

You are authorized to release any medical information you deem appropriate 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 there of.

Authorization to Pay Directly to Doctor

I authorize the direct payment to you of any sum I now or hereafter owe you by my attorney out of the proceeds of any settlement of my case, and/or by any insurance company obligated to reimburse me for the charges for your services or otherwise obligated to reimburse me for the charges for your services or otherwise obligated to make payment to me or you based in whole or in part upon the charges made for your services. If my current policy prohibits direct payment to the doctor, I hereby also instruct and direct the insurance company to make out the payment and mail it to Cheektowaga Chiropractic P.L.L.C. 4415 Union Road, Cheektowaga, NY 14225.

Assignment of Cause of Action

In the event any insurance company is obligated by contractual agreement to make payment to me or to you for the demand by you, I hereby assign and transfer to you the cause of action that exists in my favor against any such company (the name(s) of which is/are believed to be correctly set forth under pertinent data below) and authorize you to prosecute said action either in my name or your name as you see fit and further authorize you to compromise, settlement or otherwise resolve said claim in my name or your name as you see fit. However, it is understood that until all reasonable efforts have been made to collect the sums due from the insurance company (or companies) contractually obligated, you will refrain from attempts and efforts to collect the amounts owed directly from me. I understand that whatever amounts you do not collect from insurance proceeds (whether it be all or part of what is due), I personally owe you, and agree to pay in current manner.

Acknowledgment and Understanding

I hereby acknowledge that I am receiving (or about to receive) health care services from Cheektowaga Chiropractic and that I have been advised that the doctor(s) providing the services is/are willing to wait for payment for these services, provided that there continues to be a reasonable chance that payment will be made either by insurance proceeds or out of the settlement of a liability claim. I hereby give permission for the provider of these services to collect this interest from the settlement on my case. Further, because of the continuing changes in the health care industry and the variety of reimbursement procedures and policy restrictions or limitations it is my understanding that the doctor at Chiropractic will be basing his treatment decisions upon his clinical experience and education and not upon any third party, insurance companies reimbursement policies.

I understand that if it is determined either:
That 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 or make other provisions for the protection of the interest of the doctor(s);or
If a liability claim exists, and my attorney refuses to agree to protect the interest of the doctor(s), or if I have not engaged the services of an attorney; or,
If I refuse an offer of settlement, then payment for services rendered by doctor(s) at Cheektowaga Chiropractic P.L.L.C. will *be made on a current basis and my bill paid in full within 30 days from my last treatment or as soon as my liability claim is settled, whichever occurs first.*
A photocopy of this Authorization and Assignment shall be considered as effective and valid as the original.

_____

Patient's Name Print **Patient's Signature** **Date**

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

_____

Personal Rep. Name Print **Personal Rep. Signature** **Date**

_____

Witness Name Print **Witness Signature** **Date**

Cheektowaga Chiropractic P.L.L.C.

To: Christian Milioto D.C. & Kevin Nightingale D.C., Cheektowaga Chiropractic P.L.L.C.
4415 Union Rd, Cheektowaga, NY 14225 (716)-650-7246

Notice of Privacy Practices for Protected Health Information

Consent for Purposes of Treatment, Payment & Healthcare Operations (3/03)

In this document, "I" and "my" refer to the patient,

and "Chiropractor" refers to Cheektowaga Chiropractic

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 Chiropractor agrees to a restriction that I request, the restriction is binding on Chiropractor.

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 a 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. You agree to allow Cheektowaga Chiropractic P.L.L.C. to use my name on testimonials upon your consent.

I have been provided with a copy of the Notice of Privacy Practices of Chiropractor and understand that I have a right to review the 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 that will occur in my treatment, payment of my bills or in the performance of health care operations of Chiropractor. 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 Chiropractor and requesting a revised copy be sent electronically, in the mail or asking for one at the time of my next appointment.

This notice will expire seven years after the date upon which the record was created. By signing below, I acknowledge that I have read and/or received a copy of this notice.

_____

Patient's Name Print **Patient's Signature** **Date**

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

_____

Personal Rep. Name Print **Personal Rep. Signature** **Date**

_____

Witness Name Print **Witness Signature** **Date**

Cheektowaga Chiropractic P.L.L.C.

To: Christian Milioto D.C. & Kevin Nightingale D.C., Cheektowaga Chiropractic P.L.L.C.
4415 Union Rd, Cheektowaga, NY 14225 (716)-650-7246

INFORMED CONSENT TO CHIROPRACTIC TREATMENT

TO THE PATIENT: *You have a right as a patient to be informed about your condition and the recommended chiropractic adjustments and other chiropractic procedures to be used so that you may make the decision whether or not to undergo the procedure after knowing the potential risks and hazards involved. This disclosure is not meant to scare or alarm you; it is simply an effort to make you better informed so you may give or withhold your consent to the procedure.*

I hereby request and consent to the performance of chiropractic adjustments and any other chiropractic procedures, including examination tests and physical therapy techniques, on me (or on the patient named below for which I am legally responsible) which are recommended by the doctor of chiropractic named below and/or other licensed doctors of chiropractic who now or in the future render treatment to me while employed by, working for or associated with, or serving as back-up for the doctor of chiropractic named below.

I have had an opportunity to discuss with the doctor named below and/or with office personnel the nature, purpose and risks of chiropractic adjustments and other recommended procedures and have had my questions answered to my satisfaction. I understand that the results are not guaranteed.

I understand that, as with any health care procedure, there are certain complications, which may arise during a chiropractic adjustment. Those complications include but are not limited to: fractures, disc injuries, dislocations, muscle strains, ligamentous sprains, Horner's syndrome, diaphragmatic paralysis, cervical myelopathy, separations and some stiffness or soreness following the first few days of treatment. Ancillary procedures (S.A.S.T.M., Electric Stimulation, Spinal Decompression, Therapeutic Laser, Heat, Ice, Sauna, WBV, etc…) could produce skin irritation, burns, bruising, or other minor complications however, the probability of adverse reaction due to ancillary procedures is considered "rare". Some types of manipulation of the neck have been associated with injuries to the arteries in the neck leading to or contributing to serious complications including stroke. The risk of cerebrovascular injury or stroke has been estimated at one in every three million and can be even further reduced by screening procedures. I do not expect the doctor to be able to anticipate all risks and complications and I wish to rely on the doctor to exercise judgment during the course of the procedure(s) which the doctor feels at the time, based upon the facts then known, is in my best interest. I further acknowledge that no guarantees or assurances have been made concerning the results intended from the treatment.

Other treatment options that could be considered may include: Over the counter analgesics: the risk of these medications include irritation to the stomach, liver, and kidneys and other side effects on a significant number of cases. Medical care: typically anti-inflammatory drugs, tranquilizers and analgesics. Risks of these drugs include a multitude of undesirable side effects and patient dependence on a significant number of cases. Hospitalization: in conjunction with medical care adds risk of exposure to virulent communicable disease in a significant number of cases. Surgery: in conjunction with medical care adds to the risks of adverse reaction to anesthesia as well as an extended convalescent period in a significant number of cases.

Chiropractic treatment, including spinal adjustment/manipulation, has been the subject of government reports and multidisciplinary studies conducted over many years and have been demonstrated to be highly effective treatment for spinal pain, headaches and other similar symptoms. Chiropractic care contributes to your overall health. The risk of injuries or complications from chiropractic treatment is substantially lower than that association with many medical or other treatments, medications, and procedures given the same symptoms.

I have read or have had read to me the above explanation of the chiropractic adjustment and related treatment. I have also had an opportunity to ask questions about its content, and by signing below I state that I have weighed the risks involved in undergoing treatment and I have myself decided that it is in my best interest to undergo the chiropractic treatment recommended. Having been informed of the risks, benefits, and alternatives, I hereby give my consent to that treatment. I intend this consent form to cover the entire course of treatment for my present condition and for any future conditions(s) for which I seek treatment.

Patient's Name Print	**Patient's Signature**	**Date**

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

Personal Rep. Name Print	**Personal Rep. Signature**	**Date**

Witness Name Print	**Witness Signature**	**Date**