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 _____

Emergency Contact _____ Phone Number _____

Your Occupation (Current or Prior to retirement) _____ Retired? YES / NO

02/01/22

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 Fasciitis	___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.) regarding your conditions?

Name	Specialty	Phone Number

Known Allergies:

Items you have a reaction to:	Reaction:

Medications (prescription and nonprescription) 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?
Morning / Afternoon / Night / None
Is there any time of day your symptoms worsen?
Morning / Afternoon / Night / None

Are there any activities that improve your symptoms?

_____

Are 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)_____

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? _____**

Oxford Claudication Score

Please select the one (1) most relevant choice relating to your back and leg conditions in the past month:

Section 1 – Pain frequency **On the average, how often have you experienced pain in your back, buttock, or down the legs.** ___Not at all ___Less than once a week ___At least once a week ___Every day for at least a few minutes ___Every day for most of the day ___Every minute of the day	**Section 6 – Leg weakness** **On the average, how would you describe the strength in your legs ankles or feet in the past month?** ___Very strong ___Strong ___Moderate ___Less the usual ___Weak ___No strength
Section 2 – Total Pain Severity **On the average, how would you describe the worst pain you have had in the last month?** ___None ___Mild ___Moderate ___Severe ___Very Severe ___Intolerable	**Section 7 – Balance** **On the average, which statement best describes your steadiness when standing or walking in the past month?** ___I have no problems with my balance ___I sometimes feel my balance is off, but can walk without an aid ___I often feel my balance if off, but can walk without an aid ___I am able to walk with an aid ___I have difficulty walking despite use of an aid ___I cannot stand up
Section 3 – Back Pain Severity **On the average, how would you describe the pain or discomfort in your back or buttocks in the last month** ___None ___Mild ___Moderate ___Severe ___Very Severe ___Intolerable	**Section 8 – Walking distance** **On the average in the past month, when you go for a walk, how far are you able to walk before your back or leg troubles you?** ___More than 2 miles or no limit ___More than a ¼ mile, but less than 2 miles ___More than 100 yards but less than ¼ mile ___More than 50 feet, but less than 100 yards. ___Less than 50 feet ___Not at all
Section 4 – Leg Pain Severity **On the average, how would you describe the pain or discomfort in your legs or feet in the past month?** ___None ___Mild ___Moderate ___Severe ___Very Severe ___Intolerable	**Section 9 – Walk ability** **On the average, which statement describes your walking ability over the past month?** ___There is no limit to my walking ability ___I can walk far enough to do everything I want to do ___I can walk comfortably from home to the stops of my transport. ___I can walk comfortably around the house ___I can walk only from the bedroom to the bathroom or kitchen ___I am not able to walk at all
Section 5 – Nerve Symptom Severity **On the average, how would you describe the numbness, tinging, burning, or dead weight feeling in your legs or feet in the last month?** ___None ___Mild ___Moderate ___Severe ___Very Severe ___Intolerable	**Section 10 – Walking Speed** **On the average, which statement best describes your walking over the last month** ___I can walk at normal speed ___I walk slowly standing upright ___I walk slowly bent forward ___I must stop and stand still when I walk ___I must stop and sit down when I walk ___I cannot walk at all.

For Office Use Only:

Score: ____/100

Low Back Questionnaire

Please select the one (1) most relevant choice in each of the Sections below:

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. ___I am in bed most of the time.	**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 for as long as I like. ___I can only sit in my favorite chair for 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

Please select the one (1) most relevant choice in each of the Sections below:

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:

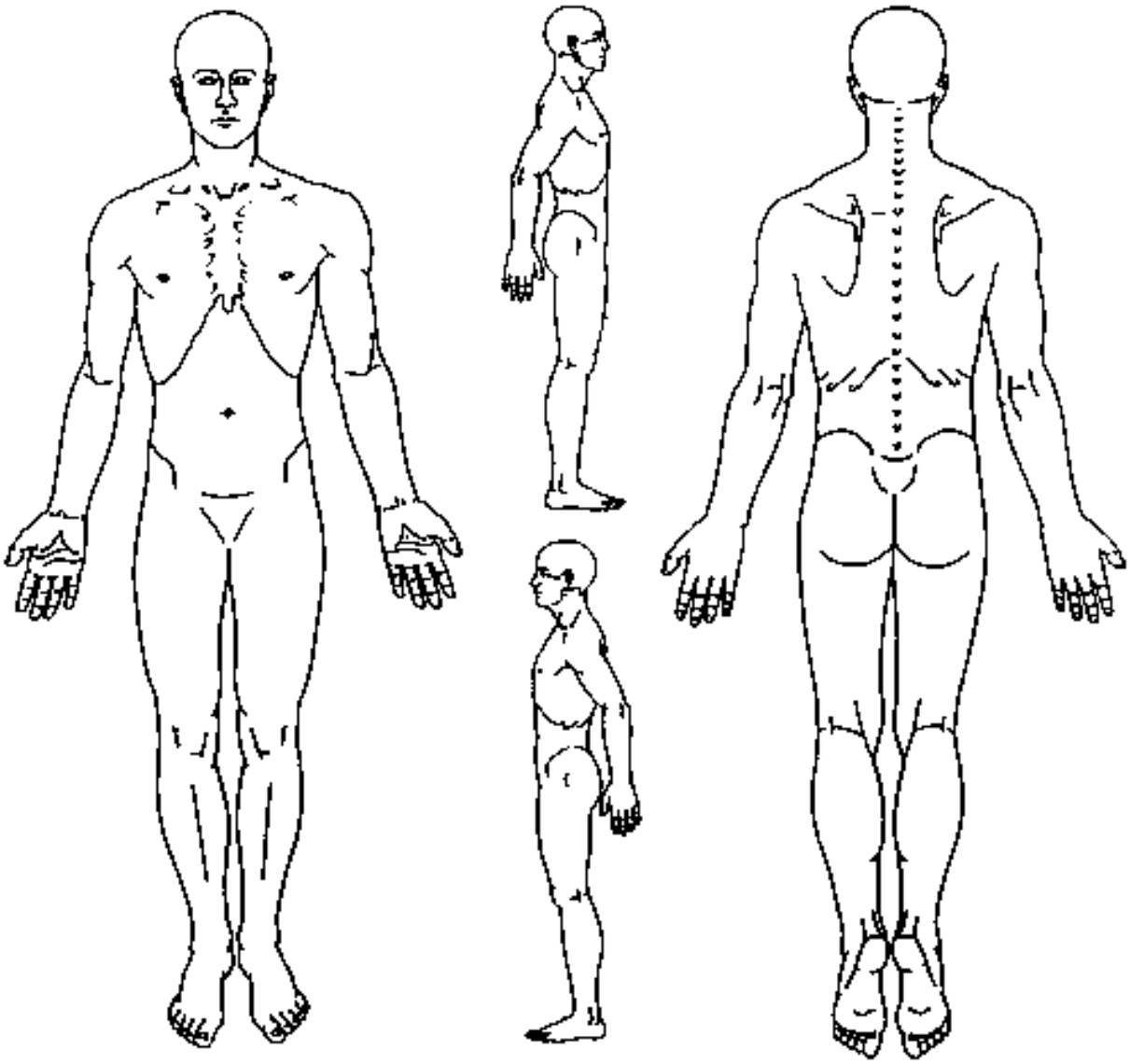
Score: ____/100

Name: _____ **Date: _____**

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 to process any claim for reimbursement of charges incurred by me because of professional services rendered by you, and I hereby release you of any consequence thereof.

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, if 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 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**