**MILLENNIUM CHIROPRACTIC** **NEW PATIENT INTAKE FORM**

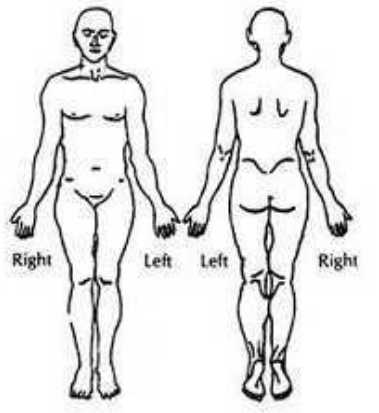
Please allow our staff to photocopy your **driver's license & insurance details**. All information you supply is confidential. We comply with all federal privacy standards. Please print clearly.

Consultation Notes- Dr. only

**Name: _____ Date of Birth: _____**
**Address: _____City_____Zip Code_____**
**Phone # Home: _____Work: _____ Cell: _____**
**E-mail address: _____**
**Occupation: _____ Employer: _____**
**Insurance: ☐ Yes ☐ No If Yes,** *Please let us copy your insurance card.* Preferred Language: _____
Do you need interpreter: Yes No

**Marital status** ☐ S ☐M ☐W ☐D ☐SEP **Gender** ☐ male ☐ female

1. **The symptoms that prompted you to seek care today are**:
   ☐Headache ☐Neck Pain ☐Mid-Back Pain ☐Low Back Pain ☐ Other:_____
2. **Your symptoms are the result of** :
   ☐ An Accident ☐ Work ☐ Auto ☐ Other_____ Date of Accident_____
   ☐ A worsening long term condition
   ☐ An interest in ☐ Wellness ☐ Other_____
3. **Onset:** (when did you 1st notice your current symptoms?) **Date:**_____
4. **Intensity** (how extreme are your current symptoms?) *Absent* **0** 1 2 3 4 **5** 6 7 8 9 **10** *Agonizing*
5. **Duration & Timing** (How often do you feel it?)
   ☐Comes & Goes 0-25% ☐ 26-50%
   ☐ 51-75% ☐76-100% Constant
6. **Location**: (Where does it hurt?) Please mark on picture.




7. **Quality of Symptoms** (What does it feel like?):
   ☐ Numbness ☐ Throbbing ☐ Nagging
   ☐ Dull ☐ Sharp ☐ Stiffness ☐ Tingling
   ☐ Stabbing ☐ Aching ☐ Burning ☐ Shooting
8. **Does The pain Radiate to other parts of your body?** _____
9. **What makes your condition worse**? ☐Sitting ☐ Standing or walking ☐Coughing or straining ☐Extending your back
   **What makes your condition better**? ☐ Lying with knees flexed ☐ Sitting ☐ Nothing relieves my pain
10. **In the past week, how much has your pain interfered with your daily activities** (e.g., work, household chores, social activities)? No interference **0** 1 2 3 4 **5** 6 7 8 9 **10** unable to carry any activities
11. **Prior Interventions:** What have you done to relieve the pain?
    □ Medications □ Surgery □ Physical Therapy □ Chiropractic □Massage □ Ice □ Heat
12. **Past health history:**

| Have you... | Yes | No | If yes, explain briefly |
|---|---|---|---|
| ... been hospitalized in the last 5 year? | □ | □ | _____ |
| ... had any surgeries? If yes, when & what? | □ | □ | _____ |
| ... had any broken bones? | □ | □ | _____ |
| ... had any strains or sprains? | □ | □ | _____ |
| …had Prior Auto Accidents? | □ | □ | If yes, when? _____ |

Type of accident _____
Injuries suffered & treatment received_____
_____

Do you take minerals, herbs or vitamins? □ □ _____
How is most of your day spent? ☐ standing, ☐sitting, ☐other: _____
How much sleep do you average per night? _____ Hours.
What is your preferred sleeping position? _____ How old is your mattress? _____

Dr. Initials

Patient Name
_____
Consult. Notes

Date Of Last:
**Physical Exam** _____ **Spinal X-rays**_____
**Spinal Exam** _____ **MRI, CT-Scan,** _____
**Blood Test** _____ **Urine Test** _____ **Bone Scan**_____

**13. In general would you say your overall health right now is:**
☐ Excellent ☐ Very Good ☐ Good ☐ Fair ☐ Poor

**14.** Have you had any previous problems in your current problem areas? ☐**Yes** ☐ **No If Yes, Explain**_____
_____

**15. Reviews of Systems: Please mark any of the following conditions/symptoms that apply to you.**

| | | |
|---|---|---|
| ☐ Headache | ☐ Pain in Hands or Arms | ☐ Chest Pains |
| ☐ Neck Pain | ☐ Numbness in Hands or Arms | ☐ Heart Attack (date)_____ |
| ☐ Neck Stiffness | ☐ Pain in Legs or Feet | ☐ High Blood Pressure |
| ☐ Low Back Pain | ☐ Numbness in Legs or Feet | ☐ Stroke(date)_____ |
| ☐ Numbness in Groin/Buttocks | ☐ Marked morning pain/stiffness | ☐ Epilepsy/Seizures |
| ☐ Nervousness | ☐ Fatigue | ☐ Cancer/Tumor (explain)_____ |
| ☐ Tension | ☐ Depression | ☐ Painful Urination |
| ☐ Irritability | ☐ Visual Disturbances | ☐ Diabetes |
| ☐ Dizziness/Fainting | ☐ Loss of Memory | ☐ Diarrhea |
| ☐ Pain between Shoulders | ☐ Shoulder Pain | ☐ Constipation |
| ☐Sleeping Problems | ☐ Sinus | ☐ Stomach Upset |
| ☐ Shortness of Breath | ☐ Heartburn/Reflux | ☐Weight Gain ( Unexplainable) |
| ☐ Recent Fever | ☐ Asthma | ☐ Weight Loss (Unexplainable) |
| ☐ Loss of Balance | ☐ Allergies | ☐ Loss of Smell or Taste |
| ☐ Ringing in Ears | ☐ Cold Hands/Feet | ☐Menstrual Problems |
| ☐ Jaw/TMJ Problems | ☐ Osteoporosis | ☐ Menopause |

**16. FAMILY HISTORY: Is there a family History of:**

| | Heart Problems | Arthritis | Cancer | High Blood Pressure | Diabetes | Stroke |
|---|---|---|---|---|---|---|
| **Father's side** | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ |
| **Mother's side** | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ |

**17. Please list all medications you are currently taking:**
1._____ 2._____ 3._____
4._____ 5._____ 6._____

**18. Exercise:** ☐None ☐ Moderate ☐ Daily ☐ Heavy Type:_____
**19. Habits:** ☐ Smoking _____packs/day, ☐ Alcohol _____Drinks/Week
☐Caffeine Drinks _____Cups/Day ☐High Stress **Reason:**_____
**20. Women Only: Are You pregnant? ☐ Yes ☐ No, If yes, due date**_____

**21. Acknowledgements:**

Initials_____ I instruct the chiropractor to deliver the care that, in her professional judgement, can best help me in the restoration of my health. I also understand that the chiropractic care offered in this practice is based on the best available evidence and designed to reduce or correct vertebral subluxation. Chiropractic is a separate and distinct healing art from medicine and does not proclaim to cure any named disease or entity.

Initials_____ I may request a copy of the HIPAA Privacy Policy & understand it describes how my personal health information is protected and released on my behalf for referrals to specialists, as needed, to assist in proper diagnosis & for seeking reimbursement from any involved third parties.

Initials_____ I grant permission to be **called, emailed or texted** to confirm or reschedule an appointment & to be sent occasional newsletter emails as an extension of my care in this office.

Initials_____ I acknowledge that any insurance I may have is an agreement between the carrier and me and that **I am responsible for payment of any covered or non-covered services I receive.**

Initials_____ To the best of my ability, the information I have supplied is complete and truthful. I have not misrepresented the presence, severity or cause of my health concern.

If the patient is a child, print child's full name: _____

**Signature**_____ **Date**_____

Dr. Signature

**MILLENNIUM CHIROPRACTIC**

**INFORMED CONSENT:**

I hereby request and consent to the performance of chiropractic adjustments and other chiropractic procedures, including various modes of physical therapy, massage therapy on me (or on the patient named below, for whom I am legally responsible) By Dr. Meral Elgendy, D.C. I have had an opportunity to discuss with Dr. Meral Elgendy, D.C., the nature and purpose of chiropractic adjustments and other procedures. I understand that results are not guaranteed.

I understand and am informed that, as in the practice of medicine, in the practice of chiropractic there are some risks to treatment, including but not limited to fractures, disc injuries, strokes, dislocations and sprains. I do not expect the doctor to be able to anticipate and explain all risks and complications, and I wish to rely upon the doctor to exercise judgment during the course of the procedure which the doctor feels at the time, based upon the facts then known to him or her, is in my best interest.

I have read, or have had read to me, the above consent. I have also had an opportunity to ask questions about its content, and by signing below I agree to the above-named procedures. I intend this consent form to cover the entire course of treatment for my present condition and for any future condition(s) for which I seek treatment.

**Patient Signature_____ Date _____**

**FINANCIAL RESPONSIBILITY, AUTHORIZATON & ASSIGNMENT :**

I authorize Meral Elgendy, D.C. to release any information deemed 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.

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 by any insurance company obligated to make payment to me or you based in whole or in part upon the charges made for your services. I understand that whatever amounts you do not collect from insurance proceeds (whether it is all or part of what is due) I personally owe you.

I, the undersigned do hereby appoint Meral Elgendy, D.C. authority necessary to endorse and cash my checks, drafts or money orders which are made payable to the undersigned or as co-payee with this clinic when said payments are due to services rendered on behalf of the undersigned by the clinic.

I understand and agree that health and accident insurance policies are an agreement between an insurance carrier and me. I clearly understand and agree that all services rendered 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 professional services rendered me will be immediately due and payable. I will be responsible for any costs of collection, attorney's fee or court costs required to collect my bill.

**Patient Signature_____ Date _____**

**PATIENT BILLING ACKNOWLEDGEMENT FORM OF NON-COVERED SERVICES/PRODUCTS:**

Under your health plan, you are financially responsible for co-payments, co-insurance and deductibles for covered services, as well as those services that exceed benefit limits. You are also financially responsible for all non-covered services as defined by your health plan contract.

The services/ products listed below usually are not covered by most health plans. Your acknowledgement below indicates that you have been adviced of this information and that you agree to pay for the listed services or products, if that is the case with your specific health plan. Some of the services/products that might not be covered under your specific health plan are as follows: **These fees reflect a discount from our regular fee schedule, and it is only for payment made at the time of service & for those who don't have sufficient or any chiropractic coverage, and will also apply to Auto Accident cases where Patient pays out of pocket at the time of service**. (Not Valid w/attorney liens & Med-pay.)

- Massage/Therapy: **$20.00/15 minutes (ASHN Members-Massage therapy - $11.25/15 min.)**
- Maintenance/Supportive Care: **$75.00 Initial Visit &$45.00/follow –up CMT**.
- Custom Made Orthotics : **$200-$425.00** depending on your choice of FootLevelers product line

I, _____, acknowledge that I have been told in advance by my provider that the services/products listed above are not covered by my Health Plan. I agree to pay for these non-covered services.

**CANCELLATION POLICY:** Please....out of respect for our other patients as well as for our Doctor & therapists, call if there is a change in your schedule. You will be billed the **full amount for a missed or no show appointment**.
There is a **$25.00** charge for cancellations under 24 hrs.

**Patient Signature_____ Date _____**

PLEASE FILL ONLY IF YOU HAVE NECK PAIN, OTHERWISE PLEASE SKIP

# Neck Index

ACN Group, Inc. Form NI-100

ACN Group, Inc. Use Only rev 3/27/2003

**Patient Name** _____ **Date** _____

*This questionnaire will give your provider information about how your neck condition affects your everyday life. Please answer every section by marking the one statement that applies to you. If two or more statements in one section apply, please mark the one statement that most closely describes your problem.*

## Pain Intensity

⓪ I have no pain at the moment.
① The pain is very mild at the moment.
② The pain comes and goes and is moderate.
③ The pain is fairly severe at the moment.
④ The pain is very severe at the moment.
⑤ The pain is the worst imaginable at the moment.

## Personal Care

⓪ I can look after myself normally without causing extra pain.
① I can look after myself normally but it causes extra pain.
② It is painful to look after myself and I am slow and careful.
③ I need some help but I manage most of my personal care.
④ I need help every day in most aspects of self care.
⑤ I do not get dressed, I wash with difficulty and stay in bed.

## Sleeping

⓪ I have no trouble sleeping.
① My sleep is slightly disturbed (less than 1 hour sleepless).
② My sleep is mildly disturbed (1-2 hours sleepless).
③ My sleep is moderately disturbed (2-3 hours sleepless).
④ My sleep is greatly disturbed (3-5 hours sleepless).
⑤ My sleep is completely disturbed (5-7 hours sleepless).

## Lifting

⓪ I can lift heavy weights without extra pain.
① I can lift heavy weights but it causes extra pain.
② Pain prevents me from lifting heavy weights off the floor, but I can manage if they are conveniently positioned (e.g., on a table).
③ Pain prevents me from lifting heavy weights off the floor, but I can manage light to medium weights if they are conveniently positioned.
④ I can only lift very light weights.
⑤ I cannot lift or carry anything at all.

## Reading

⓪ I can read as much as I want with no neck pain.
① I can read as much as I want with slight neck pain.
② I can read as much as I want with moderate neck pain.
③ I cannot read as much as I want because of moderate neck pain.
④ I can hardly read at all because of severe neck pain.
⑤ I cannot read at all because of neck pain.

## Driving

⓪ I can drive my car without any neck pain.
① I can drive my car as long as I want with slight neck pain.
② I can drive my car as long as I want with moderate neck pain.
③ I cannot drive my car as long as I want because of moderate neck pain.
④ I can hardly drive at all because of severe neck pain.
⑤ I cannot drive my car at all because of neck pain.

## Concentration

⓪ I can concentrate fully when I want with no difficulty.
① I can concentrate fully when I want with slight difficulty.
② I have a fair degree of difficulty concentrating when I want.
③ I have a lot of difficulty concentrating when I want.
④ I have a great deal of difficulty concentrating when I want.
⑤ I cannot concentrate at all.

## Recreation

⓪ I am able to engage in all my recreation activities without neck pain.
① I am able to engage in all my usual recreation activities with some neck pain.
② I am able to engage in most but not all my usual recreation activities because of neck pain.
③ I am only able to engage in a few of my usual recreation activities because of neck pain.
④ I can hardly do any recreation activities because of neck pain.
⑤ I cannot do any recreation activities at all.

## Work

⓪ I can do as much work as I want.
① I can only do my usual work but no more.
② I can only do most of my usual work but no more.
③ I cannot do my usual work.
④ I can hardly do any work at all.
⑤ I cannot do any work at all.

## Headaches

⓪ I have no headaches at all.
① I have slight headaches which come infrequently.
② I have moderate headaches which come infrequently.
③ I have moderate headaches which come frequently.
④ I have severe headaches which come frequently.
⑤ I have headaches almost all the time.

Index Score = [Sum of all statements selected / (# of sections with a statement selected x 5)] x 100

*Neck Index Score* _____

PLEASE FILL ONLY IF YOU HAVE BACK PAIN, OTHERWISE PLEASE SKIP

# Back Index

Form BI-100

rev 3/27/2003

***Patient Name*** _____ ***Date*** _____

*This questionnaire will give your provider information about how your back condition affects your everyday life. Please answer every section by marking the one statement that applies to you. If two or more statements in one section apply, please mark the one statement that most closely describes your problem.*

## *Pain Intensity*

⓪ The pain comes and goes and is very mild.
① The pain is mild and does not vary much.
② The pain comes and goes and is moderate.
③ The pain is moderate and does not vary much.
④ The pain comes and goes and is very severe.
⑤ The pain is very severe and does not vary much.

## *Sleeping*

⓪ I get no pain in bed.
① I get pain in bed but it does not prevent me from sleeping well.
② Because of pain my normal sleep is reduced by less than 25%.
③ Because of pain my normal sleep is reduced by less than 50%.
④ Because of pain my normal sleep is reduced by less than 75%.
⑤ Pain prevents me from sleeping at all.

## *Sitting*

⓪ I can sit in any chair as long as I like.
① I can only sit in my favorite chair as long as I like.
② Pain prevents me from sitting more than 1 hour.
③ Pain prevents me from sitting more than 1/2 hour.
④ Pain prevents me from sitting more than 10 minutes.
⑤ I avoid sitting because it increases pain immediately.

## *Standing*

⓪ I can stand as long as I want without pain.
① I have some pain while standing but it does not increase with time.
② I cannot stand for longer than 1 hour without increasing pain.
③ I cannot stand for longer than 1/2 hour without increasing pain.
④ I cannot stand for longer than 10 minutes without increasing pain.
⑤ I avoid standing because it increases pain immediately.

## *Walking*

⓪ I have no pain while walking.
① I have some pain while walking but it doesn't increase with distance.
② I cannot walk more than 1 mile without increasing pain.
③ I cannot walk more than 1/2 mile without increasing pain.
④ I cannot walk more than 1/4 mile without increasing pain.
⑤ I cannot walk at all without increasing pain.

## *Personal Care*

⓪ I do not have to change my way of washing or dressing in order to avoid pain.
① I do not normally change my way of washing or dressing even though it causes some pain.
② Washing and dressing increases the pain but I manage not to change my way of doing it.
③ Washing and dressing increases the pain and I find it necessary to change my way of doing it.
④ Because of the pain I am unable to do some washing and dressing without help.
⑤ Because of the pain I am unable to do any washing and dressing without help.

## *Lifting*

⓪ I can lift heavy weights without extra pain.
① I can lift heavy weights but it causes extra pain.
② Pain prevents me from lifting heavy weights off the floor.
③ Pain prevents me from lifting heavy weights off the floor, but I can manage if they are conveniently positioned (e.g., on a table).
④ Pain prevents me from lifting heavy weights off the floor, but I can manage light to medium weights if they are conveniently positioned.
⑤ I can only lift very light weights.

## *Traveling*

⓪ I get no pain while traveling.
① I get some pain while traveling but none of my usual forms of travel make it worse.
② I get extra pain while traveling but it does not cause me to seek alternate forms of travel.
③ I get extra pain while traveling which causes me to seek alternate forms of travel.
④ Pain restricts all forms of travel except that done while lying down.
⑤ Pain restricts all forms of travel.

## *Social Life*

⓪ My social life is normal and gives me no extra pain.
① My social life is normal but increases the degree of pain.
② Pain has no significant affect on my social life apart from limiting my more energetic interests (e.g., dancing, etc).
③ Pain has restricted my social life and I do not go out very often.
④ Pain has restricted my social life to my home.
⑤ I have hardly any social life because of the pain.

## *Changing degree of pain*

⓪ My pain is rapidly getting better.
① My pain fluctuates but overall is definitely getting better.
② My pain seems to be getting better but improvement is slow.
③ My pain is neither getting better or worse.
④ My pain is gradually worsening.
⑤ My pain is rapidly worsening.

Index Score = [Sum of all statements selected / (# of sections with a statement selected x 5)] x 100

*Back Index Score*