# Welcome To Matteo Chiropractic

Last Name: ______________________ First Name: ______________________ Middle Initial: __________

Home Phone: _____________ Cell _____________ Work Phone: ______________________

Street Address and Number: ______________________________________________

City, State, and Zip Code: ______________________________________________

Email Address: ______________________________________________

Age: __________ Date of Birth: __________ Social Security #: ______________________

Sex: Male Female # of Children ________ **Circle One:** Married Single Widowed Divorced

Occupation: ______________________ Employer: ______________________

Spouse's Name: ______________________ Spouse's Occupation: ______________________

Driver's License # __________ State ________ How were you referred to our office? ______________

In case of emergency, please contact (include phone): ______________________________

Please describe your condition(s) beginning with the most severe.

1. ______________ 3. ______________ 5. ______________

2. ______________ 4. ______________ 6. ______________

When did this/these conditions begin? __________ Is the condition getting (circle) better worse same

What is the cause of your condition(s)? ______________________________

What makes the condition feel better or worse? ______________________________

Have you seen any other Physician for this condition? (Please list name and dates.) ______________

______________________________________________

Have you ever been treated by another chiropractor? (If yes, who/when/same condition?) ______________

______________________________________________

Have you ever had similar symptoms to present condition? ______________________________

Are you currently treating with any other physician? (If yes, please explain.) ______________

______________________________________________

Please list your family Physician, location, (city and state), & Medications you are currently taking: ______________

______________________________________________

**FINANCIAL RESPONSIBILIBY AND ASSIGNMENT OF BENEFITS**

I agree to pay all charges for medical and health services not covered by my insurance company. I authorize my Insurance Company to pay directly to Matteo Chiropractic, 129-10 23 Ave, College Point, NY 11356 such sum as may be due and owing this office for services rendered to me.

**I CERTIFY THAT I HAVE READ AND UNDERSTAND THESE STATEMENTS** and the above statements are true to the best of my knowledge.

______________________________________________

Patient Signature or legally authorized representative Date

# 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* ______

# Back Index

ACN Group, Inc.  Form BI-100

ACN Group, Inc. Use Only 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

# Matteo Chiropractic

## 129-10 23rd Avenue
## College Point, NY 11356

## INFORMED CONSENT

I HEREBY REQUEST AND CONSENT TO THE PERFORMANCE OF CHIROPRACTIC ADJUSTMENTS AND OTHER CHIROPRACTIC/ PHYSICAL THERAPY/MEDICAL PROCEDURES, INCLUDING VARIOUS MODES OF PHYSIOTHERAPY AND DIAGNOSTIC X-RAYS BY Matteo Chiropractic . THIS CONSENT IS EXTENDED TO OTHER LICENSED CHIROPRACTORS, PHYSICAL THERAPISTS, CHIROPRACTIC ASSISTANTS, LICENSED PROFESSIONALS, OR STAFF, WHO NOW OR IN THE FUTURE, ARE EMPLOYED BY, WORKING WITH OR ASSOCIATED WITH THIS OFFICE.

I CERTIFY THAT I HAVE HAD THE OPPORTUNITY TO DISCUSS, WITH THE DOCTOR OF CHIROPRACTIC AND/OR OTHER OFFICE PERSONAL, THE NATURE AND PURPOSE OF THE CARE THAT IS BEING PROVIDED. I UNDERSTAND THAT THE RESULTS ARE NOT GUARANTEED. FURTHER, I HAVE BEEN INFORMED AND I UNDERSTAND THAT, AS IN THE PRACTICE OF ANY OF THE HEALING ARTS, IN THE PRACTICE OF CHIROPRACTIC, THERE ARE SOME RISKS TO TREATMENT INCLUDING, BUT NOT LIMITED TO, FRACTURES, DISC INJURIES, STROKES, DISLOCATIONS AND SPRAINS. I ALSO UNDERSTAND THAT THE DOCTOR WHO HAS EXPLAINED ALL OF THESE THINGS TO ME, IS NOT EXPECTED TO BE ABLE TO ANTICIPATE AND EXPLAIN ALL RISKS AND COMPLICATIONS. I WILL RELY ON THE DOCTOR TO EXERCISE APPROPRIATE JUDGMENT DURING THE COURSE OF CARE, BASED ON THE FACTS KNOWN AT THIS TIME, AND IN MY BEST INTEREST.

MY SIGNATURE BELOW CERTIFIES THAT I HAVE READ, OR HAVE HAD READ TO ME THE ABOVE CONSENT. I ALSO CERTIFY THAT I HAVE HAD THE OPPORTUNITY TO ASK QUESTIONS AND OPTIONS TO CARE HAVE BEEN EXPLAINED. BY SIGNING THIS CONSENT FORM, I AGREE TO THE CARE BEING PROVIDED TO ME FOR THE ENTIRE COURSE OF TREATMENT FOR MY PRESENT CONDITION(S) AND FOR ANY FUTURE CONDITION(S) FOR WHICH I SEEK TREATMENT.

PATIENT'S NAME ______________________________ SIGNATURE X______________________________

WITNESS'S NAME ______________________________ SIGNATURE ______________________________

DATE______________________________

*Consent for use or disclosure of Health Information. Our Privacy Pledge*

*Appointment Reminders & Healthcare Information Authorization*

This office utilizes a daily sign-in sheet. Every patient is required to sign-in and this sheet is visible to all who enter this office.

The Office may need to contact you for various reasons. We will be using your name, address, phone number and clinical records for this information. Signing this page gives us authorization to contact you and is valid for 7 years. You have the right to give us this authorization and if denied will not affect the treatment we provide to you or the methods we use to obtain reimbursement for your care. You may revoke your authorization at any time in writing. Information may have already been released before we receive your request to revoke. If you would like to place any restrictions on the use of your information please let us know in writing. We are not required to agree, however if we do, the restriction is binding. Information we use or disclose based on this authorization may be subject to re-disclosure by anyone who has access to the information and may no longer be protected by the federal privacy rules. If you were required to give your authorization as a condition of obtaining insurance, the insurance company may have a right to your health information if they decide to contest any of your claims.

We are concerned with protecting your privacy. While the law requires us to give you this disclosure, please understand that we always have respected your privacy. We may have to disclose your health information to another health care provider if it is necessary to refer you to them. We may have to disclose your information and billing records to another party if they are potentially responsible for the payment of your services. We may need your information within our practice for operational purposes.

______________________________ ____________________________________

Print Name | Signature | date

Authorized Provider Representative

9/09