

## Welcome to Stone Chiropractic, LLC

We are pleased to welcome you to our practice. Please take a few minutes to fill out this form.

If you have any questions, we would be glad to help you.

We look forward to working with you and maintaining your health!

Date: \_\_\_\_\_

Name: (Last, First, M) \_\_\_\_\_ DOB: \_\_\_\_\_

Street Name: \_\_\_\_\_ City, State, Zip: \_\_\_\_\_

Home Phone: \_\_\_\_\_ Cell Phone: \_\_\_\_\_ Work Phone: \_\_\_\_\_

Email: \_\_\_\_\_ Perf. Comm: Home, Cell, Work Phone, Email, None

Do you give your consent to Email and Text you for appointment reminders and office information Yes No

Gender: Male Female Social Security #: \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_

Employer: \_\_\_\_\_ Occupation: \_\_\_\_\_

Are you married? Yes No Spouse Name: \_\_\_\_\_

Race: African American/Black, American Indian/Alaska Native, Asian, Native Hawaiian/Other Pacific Islander, Caucasian/White, Other \_\_\_\_\_, Decline to Specify

Spanish/Hispanic/Latino decent? Yes No

### **List Medications and dosages you are currently taking**

1. \_\_\_\_\_
2. \_\_\_\_\_
3. \_\_\_\_\_
4. \_\_\_\_\_

### **List supplements and dosages you are currently taking**

1. \_\_\_\_\_
2. \_\_\_\_\_
3. \_\_\_\_\_
4. \_\_\_\_\_

Have you ever sustained a work injury for which you received treatment? Yes No

If yes, please explain \_\_\_\_\_

Is your current condition related to a work injury? Yes No

Have you ever been in an automobile accident? Yes No

When? \_\_\_\_\_

## Welcome to Stone Chiropractic, LLC

In order of importance, list your Primary Medical Issues (include date of onset).

1. \_\_\_\_\_
2. \_\_\_\_\_
3. \_\_\_\_\_
4. \_\_\_\_\_

Main reason for consulting our office today? Circle all that apply.

Become pain free, explanation of my condition, learn how to care for my condition, reduce symptoms, resume normal activity, other \_\_\_\_\_

To help us better understand the nature and origin of your complaints, we ask that you carefully complete this drawing. Use the symbols listed below to detail where you hurt and how it hurts on the figures.

**/// = dull ache/throb**

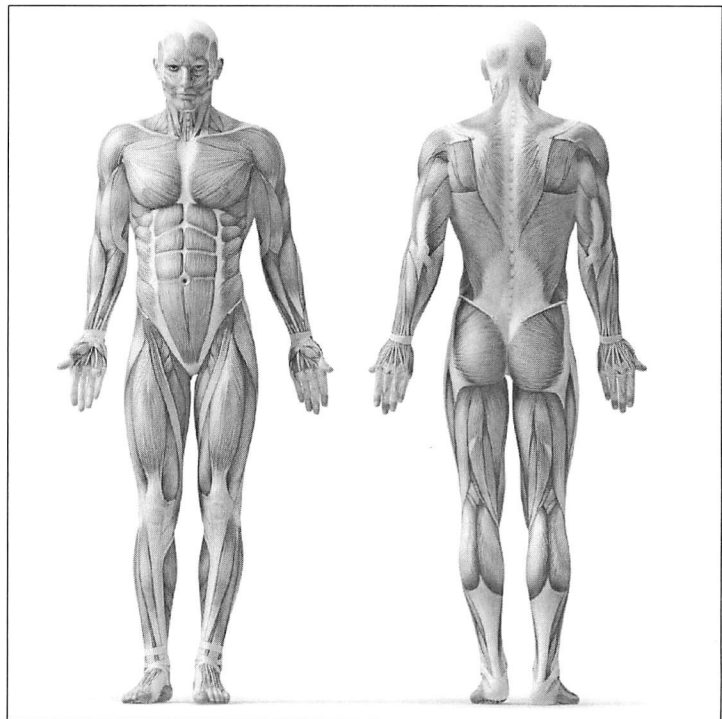
**xxx = sharp/stabbing**

**bbb = burning**

**ooo = numbness**

**ttt = tingling**

**ccc = cramping**



On a pain scale of 0-10 (10 being severe pain) rate your pain,

- |                       |                                  |
|-----------------------|----------------------------------|
| 1. Area of pain _____ | Pain number 1 2 3 4 5 6 7 8 9 10 |
| 2. Area of pain _____ | Pain number 1 2 3 4 5 6 7 8 9 10 |
| 3. Area of pain _____ | Pain number 1 2 3 4 5 6 7 8 9 10 |
| 4. Area of pain _____ | Pain number 1 2 3 4 5 6 7 8 9 10 |

Does any of your pain travel? Yes No If yes, please explain \_\_\_\_\_

What makes your pain better? \_\_\_\_\_

Is your pain worse at any particular part of the day? \_\_\_\_\_

## Welcome to Stone Chiropractic, LLC

List, in order of importance, other Medical Issues you may be seeing other providers for.

Please list issue and provider.

1. \_\_\_\_\_
2. \_\_\_\_\_
3. \_\_\_\_\_
4. \_\_\_\_\_

List any past surgeries you have had.

1. \_\_\_\_\_
2. \_\_\_\_\_
3. \_\_\_\_\_
4. \_\_\_\_\_

Have you ever had x-rays? ☐ Yes ☐ No

If yes, date of last x-ray and reason: \_\_\_\_\_

Have you ever had an MRI/CT? ☐ Yes ☐ No

If yes, date of last MRI/CT and reason: \_\_\_\_\_

Have you ever had other test/studies? ☐ Yes ☐ No If yes, list below.

- |                |                   |                  |
|----------------|-------------------|------------------|
| 1. Date: _____ | Study/Test: _____ | Treatment: _____ |
| 2. Date: _____ | Study/Test: _____ | Treatment: _____ |
| 3. Date: _____ | Study/Test: _____ | Treatment: _____ |

Have you seen any other providers for your present complaint(s) today? ☐ Yes ☐ No

If yes, list their names and specialty: \_\_\_\_\_

What treatments have you received for your current complaint?

\_\_\_\_\_

**How do you sleep?** ☐ well ☐ trouble falling asleep ☐ trouble staying asleep ☐ insomnia

**Do you wake tired?** ☐ Yes ☐ No If yes how long has this been happening? \_\_\_\_\_

**How is your diet?** ☐ Balanced ☐ Not Balanced **Do you Exercise?** Yes No How Often? \_\_\_\_\_

**Do you smoke?** Yes No How Often? \_\_\_\_\_ **Do you Drink Alcohol?** How Much? \_\_\_\_\_

**How often do you exercise?** ☐ Never ☐ Rarely ☐ Sometimes ☐ Regularly ☐ Competitively

**How do you like work?** ☐ Above average ☐ Average ☐ Below average ☐ N/A

**My family stress is:** ☐ Severe ☐ Moderate ☐ Minimal ☐ None

**My job stress is:** ☐ Severe ☐ Moderate ☐ Minimal ☐ None

**How would you rate your stress level?** 1 2 3 4 5 6 7 8 9 10 (1 = poor, 10 = extreme)

## Welcome to Stone Chiropractic, LLC

Please check the following conditions that you have or have had:

<input type="checkbox"/> AIDS	<input type="checkbox"/> Heart attack	<input type="checkbox"/> Rheumatic fever
<input type="checkbox"/> Abdomen aneurysm	<input type="checkbox"/> Cardiac pacemaker	<input type="checkbox"/> Carotid artery disease
<input type="checkbox"/> Brain aneurysm clips	<input type="checkbox"/> Heart valve replacement	<input type="checkbox"/> Shrapnel
<input type="checkbox"/> Acid Reflux	<input type="checkbox"/> High blood pressure	<input type="checkbox"/> Sheet metal occupation
<input type="checkbox"/> Anemia	<input type="checkbox"/> Shunt	<input type="checkbox"/> Stroke
<input type="checkbox"/> Arthritis	<input type="checkbox"/> Irritable bowel syndrome	<input type="checkbox"/> Tuberculosis
<input type="checkbox"/> Cancer	<input type="checkbox"/> Low blood pressure	<input type="checkbox"/> Venereal disease
<input type="checkbox"/> Crohn's disease	<input type="checkbox"/> Multiple sclerosis	<input type="checkbox"/> Yeast infection
<input type="checkbox"/> Dentures	<input type="checkbox"/> Parkinson's disease	<input type="checkbox"/> Harrington rod
<input type="checkbox"/> Diabetes	<input type="checkbox"/> Penile prosthesis	<input type="checkbox"/> Prosthesis
<input type="checkbox"/> Diabetic insulin pump	<input type="checkbox"/> Polio	<input type="checkbox"/> Wire Structures
<input type="checkbox"/> Epilepsy	<input type="checkbox"/> Eye prosthesis	<input type="checkbox"/> Joint replacement
<input type="checkbox"/> Hearing aid	<input type="checkbox"/> Permanent eye makeup	<input type="checkbox"/> IUD
<input type="checkbox"/> Hardening of the arteries	<input type="checkbox"/> Past/present metallic in eye	<input type="checkbox"/> Hyperthyroidism
<input type="checkbox"/> Electrodes	<input type="checkbox"/> Ulcerative Colitis	<input type="checkbox"/> Hashimoto's disease
<input type="checkbox"/> Bypass surgery	<input type="checkbox"/> Autoimmune disease	<input type="checkbox"/> Other _____
		<input type="checkbox"/> <b>Check here if none apply</b>

Thank you for completing this form. The information you have provided will assist us in attending to your healthcare needs. I have read and completed all answers to the above questions to the best of my knowledge. I understand that this information will be used by Dr. Stone to help determine appropriate and healthful chiropractic treatment. If there are any changes in my medical status, I will inform Dr. Stone.

**Patient Signature:** \_\_\_\_\_ **Date:** \_\_\_\_\_

**Parent's Signature:** \_\_\_\_\_ **Date:** \_\_\_\_\_

### Consent for Treatment

I, undersigned, hereby authorize Mark P. Stone, D.C., C.C.S.P. and whomever he designates, his assistants to perform diagnostic test, and to administer therapies as is necessary. I also certify that no guarantee or assurance has been made to the results that may be obtained.

**Patient Signature:** \_\_\_\_\_ **Date:** \_\_\_\_\_

*If patient is a minor please indicate relation to the child* \_\_\_\_\_.

**Patient Name:** \_\_\_\_\_ **Legal Guardians signature:** \_\_\_\_\_

I understand that the treatment I am about to receive by Mark P. Stone D.C., C.C.S.P., at Stone Chiropractic, LLC is *NOT* regarding a Personal Injury or Workman's Compensation case.

\_\_\_\_\_  
**Print Name**

\_\_\_\_\_  
**Signature**

\_\_\_\_\_  
**Date**

\_\_\_\_\_  
**Office Witness: Print Name**

\_\_\_\_\_  
**Signature**

\_\_\_\_\_  
**Date**

## Informed Consent

Every type of health care is associated with some risks of potential problems. This includes chiropractic health care. We want you to be informed about potential problems associated with chiropractic health care before consenting to treatment. This is a legal requirement in Connecticut.

Chiropractic adjustments are the moving of bones with the doctor's hands or with the use of a mechanical device or machine (drop table). Frequently adjustments create a “pop” or “click” sound/sensation in the area being treated.

In this office we use trained staff personnel to assist the doctor with portions of your consultation, examination, sEMG, physical therapy application, aqua-massage therapy, PEMF, exercise instruction, Wave vibration, cold low level laser, Energy Balance foot bath etc.

**Neck Artery Dissection and Stroke:** Dissection is when the lining of a neck artery breaks down. This might happen spontaneously or from an injury or from a trivial movement (hair shampooing, checking traffic, looking up, etc.). Dissections tend to cause neck pain and/or headache. Dissections may form a clot that can dislodge and interfere with brain blood flow. If that happens, it is called a stroke. Stroke means that a portion of the brain or spinal cord does not receive enough oxygen from the blood stream. The results can be temporary or permanent dysfunction of the brain, with a very rare complication of death. The literature is mixed or uncertain as to whether chiropractic adjustments are associated with stroke or not. Recent evidence suggests that it is not (2008, 2015, 2016, 2019), although the same evidence often suggests that the patient may be entering the chiropractic office for neck pain/headaches or other symptoms that may in fact be a spontaneous dissection of a neck artery. There are no in-the-office tests to diagnose a spontaneous neck artery dissection (2020), but they might be detectable with advanced imaging (CT/MRI, etc.). If we think you may be suffering from a spontaneous neck artery dissection and/or associated stroke, you will be immediately referred to emergency services.

Anecdotal cases suggest that chiropractic adjustments may be associated with dissection and/or stroke that arise from the vertebral artery; this is because the vertebral artery is located inside the neck vertebrae. The adjustment that is suggested to increase the strain on the vertebral artery is called the “extension-rotation-thrust atlas adjustment.” We do not do this type adjustment on patients. Other types of neck adjustments may also potentially be related to vertebral artery strokes, but no one is certain. It is estimated that the incidence of this type of complication ranges between 1 per every 400,000-10,000,000 neck adjustments (2004). A large 10-year study estimated an incidence of 1 per 5.85 million neck adjustments, equivalent to 1,430 years of clinical practice (2001). If you experience any of the “5 Ds And 3 Ns” (on a following separate page) before, during or after an adjustment, tell us immediately, and if we can’t be reached, go to the emergency department immediately. Also, please read, fill out, and sign **Stroke Risk Factors**.

Three other potential problems that are not quantifiable because they are extremely rare and may have no association with chiropractic adjusting are carotid artery injury, spinal dural leak of cerebral spinal fluid, and bleeding in the coverings around the spinal column (dural hematoma).

**Disc Herniations:** Both neck and back disc herniations may create pressure on the spinal nerve or on the spinal cord. They are frequently successfully treated by chiropractors and chiropractic adjustments, traction, etc. Occasionally chiropractic treatment (adjustments, traction, etc.) may aggravate a disc/nerve problem and rarely surgery may become necessary for correction.

**Cauda Equina Syndrome:** Cauda Equina Syndrome occurs when a low back disc problem puts pressure on the nerves that control bowel, bladder, and sexual function. Representative symptoms include leaky bladder, or leaky bowels, or loss of sensation (numbness) around the pelvic sexual organs (the saddle area), or the inability to start/stop urination or to start/stop a bowel movement. Cauda Equina Syndrome is a medical emergency because

## Welcome to Stone Chiropractic, LLC

the nerves that control these functions can permanently die, and those functions may be lost or compromised forever. The standard approach is to surgically decompress the nerves, and the window to do so may be as short as 12-72 hours, depending. If you have any of these symptoms, tell us immediately, and if we can't be reached, go to the emergency department immediately.

**Soft Tissue Injury:** Soft tissues primarily refer to muscles and ligaments. Rarely, chiropractic care may overstretch some muscle or ligament fibers. The result is a temporary increase in pain and necessary treatments for resolution, but there are no long-term effects for the patient.

**Rib and other Fractures:** Rarely a chiropractic adjustment may crack a rib bone, and this is referred to as a fracture. We adjust all patients very carefully, and especially those who have known osteoporosis. Other fracture locations are extremely rare but possible, especially in those aged over 65 years and/or on steroid drugs.

**Physical Therapy Burns:** Some of the machines we use generate heat. We also use both heat and cold pack and recommend them for home care on occasion. Everyone's skin has different sensitivity to these modalities, and rarely, both heat or ice can burn or irritate the skin. The result is a temporary increase in pain, and there may even be some blistering of the skin. Never put an ice pack directly on the skin, always have an insulating towel between. We use cold (low-level) laser therapy which produces no heat and cannot result in burn.

**Acupuncture:** The risk of acupuncture are low. Common side effects include soreness and minor bleeding or bruising where the needles were inserted. Single use, disposable needles are now the practice standard, so the risk of infection is low. Please inform the Doctor if you have a bleeding disorder, have a pacemaker or if you are pregnant.

**Soreness:** It is common for chiropractic care to result in a temporary increase in soreness in the region being treated. This is nearly always a temporary symptom that occurs while your body is undergoing therapeutic change. It is not dangerous, but please do tell your doctor about it.

**Other Problems:** There may be other problems or complications that might arise from chiropractic treatment other than those noted above. These other problems or complications occur so rarely that it is not possible to anticipate and/or explain them all in advance of treatment.

Chiropractic is a system of health care delivery, and, therefore, as with any health care delivery system, we cannot promise a cure for any symptom, disease, or condition as a result of treatment in this clinic. We will always give you our best care, and if results are not acceptable, we will refer you for additional diagnostics or to another provider whom we feel will assist your situation.

Alternatives to chiropractic care include: do nothing, drugs, surgery, acupuncture, massage, etc. Risks from these procedures should be discussed with that particular provider.

If you have any questions on the above, please ask your doctor. When you have a full understanding, please sign and date below.

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**Patient's Name Printed**

---

**Today's Date**

---

**Patient's Signature**

---

**Parent or Guardian Signature For Minor**

---

**Doctor's Signature Verifying Discussion**

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**Date**

**Non-Chiropractic (Adjustment/Manipulation) Factors and Vascular Events**

**High Blood Pressure (Hypertension)**

The higher one's blood pressure the higher the internal pressure in the vascular system. Please let your chiropractor know if you have high blood pressure (hypertension).

What is typical blood pressure for you? \_\_\_\_\_

Are you currently taking blood pressure medication? \_\_\_\_\_

**Genetic Collagen Disease**

Genetic collagen diseases weaken the strength of blood vessels, increasing vascular event occurrences. A partial list of these diseases includes:

- Ehlers-Danlos syndrome
- Loeys-Dietz Syndrome
- Osteogenesis Imperfecta
- Fibromuscular Dysplasia
- Marfan syndrome
- Polycystic Kidney Disease

Do you have any of these collagen diseases? Yes\_\_\_\_ No\_\_\_\_

Do you have any other collagen disease? Yes\_\_\_\_ No\_\_\_\_

If so, please list: \_\_\_\_\_

**Birth Control Pills**

Are you presently taking birth control pills? Yes\_\_\_\_ No\_\_\_\_

If yes, how long have you been taking birth control pills? \_\_\_\_\_

Have you taken birth control pills in the past? Yes\_\_\_\_ No\_\_\_\_

- If yes, how long did you take birth control pills? \_\_\_\_\_
- When did you stop taking birth control pills? \_\_\_\_\_

**Smoking: Tobacco and/or Marijuana**

Do you currently smoke tobacco? Yes\_\_\_\_ No\_\_\_\_

- If YES, how much do you smoke in a typical *day*? \_\_\_\_\_

Have you smoked tobacco in the past? Yes\_\_\_\_ No\_\_\_\_

- If YES, when did you stop smoking tobacco? \_\_\_\_\_

Do you currently smoke marijuana? Yes\_\_\_\_ No\_\_\_\_

## Welcome to Stone Chiropractic, LLC

### Alcohol

Alcohol consumption increases the risk of vascular events (heart attacks and strokes) in a linear manner (the more the consumption the higher the risk).

Please estimate your weekly drinks of alcohol: \_\_\_\_\_

### Fluoroquinolone Antibiotics

Fluoroquinolone Antibiotics are very commonly prescribed and are known to weaken the strength of the vascular (blood vessel) wall, increasing the incidence of vascular events.

Fluoroquinolone Antibiotics include but are not limited to:

- Ciprofloxacin (Cipro, Proquin XR)
- Levofloxacin (Levaquin and Quixin)
- Delafloxacin (Baxdela)
- Moxifloxacin (Avelox)
- Gatifloxacin (Tequin)
- Norfloxacin (Noroxin)
- Gemifloxacin (Factive)
- Ofloxacin (Floxin, Ocuflox, Floxacin)

Are you currently taking any of these antibiotics? Yes\_\_\_\_ No\_\_\_\_

Have you recently taken any of these antibiotics? Yes\_\_\_\_ No\_\_\_\_ If Yes date you stopped taking them\_\_\_\_\_

### Homocysteine

Homocysteine is an amino acid that is *not* involved in protein synthesis. Elevated levels of homocysteine are strongly associated with an increased risk of vascular events (heart attacks and strokes). Homocysteine levels are measured in blood. Studies support:

- Total homocysteine levels <6μmol/L, is optimal.
- Total homocysteine levels between 6μmol/L - 9μmol/L is acceptable.
- Total homocysteine levels above 10μmol/L are too high.
  - >10.2μmol/L are associated with doubling of vascular risks.
  - >20μmol/L are associated with an 8-9 -fold increase in vascular risks.
- For every 5μmol/L rises in homocysteine levels, there is a 32% increased risk of ischemic heart disease and a 59% increased risk of stroke.

Homocysteine levels are controlled (reduced) by vitamins B2 (riboflavin), B6 (pyridoxine), B9 (folate), and B12 (cobalamin).

Have you had your homocysteine levels tested? Yes\_\_\_\_ No\_\_\_\_ If yes please provide the value \_\_\_\_\_

- If NO, please have your PCP measure your homocysteine and provide us results.

Do you take B vitamins or a multivitamin supplement? Yes\_\_\_\_ No\_\_\_\_

### Methylenetetrahydrofolate Reductase (MTHFR) Gene

A known mutation in the MTHFR gene increases homocysteine levels and hence the risks of vascular events (heart attacks and strokes).

Do you have the MTHFR mutation? Yes\_\_\_\_ No\_\_\_\_ Unknown\_\_\_\_

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**Patient's Signature**

---

**Today's Date**



## Welcome to Stone Chiropractic, LLC

### Agreement for Payment of Services

I understand and agree that health and accident insurance 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 collections from the insurance company and the any amount authorized to be paid directly to this office will be credited to my account. However, 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 also agree to pay all costs of collection including but not limited to attorney fees.

Please note that while we may participate with your insurance company, coverage of service is dependent on whether the care is considered "Medically Necessary" by your insurance company's standards of care and that your treatment yields a significant improvement in your clinical findings and function.

Clinically Appropriate Care; which enhances life, relieves symptoms, wellness care, supportive care and maintenance care are important to your health and wellbeing but are not deemed Medically Necessary and therefore not a covered service, and I understand I am financially responsible for this care.

**Patient Signature:** \_\_\_\_\_ **Date:** \_\_\_\_\_

**Parent's Signature:** \_\_\_\_\_ **Date:** \_\_\_\_\_

### **Surface Electromyography (sEMG), Laser Therapy, Acupuncture, Supplements and Supports Waiver**

Please be aware that the electromyography examination (sEMG), laser therapy, acupuncture, supplements and supports will not be covered by most health care plans, and therefore the patient is financially responsible whether we participate with your plan or not.

Please sign below verifying that you understand your monetary responsibility for service and this fee will be due at the time of service.

**Patient Signature:** \_\_\_\_\_ **Date:** \_\_\_\_\_

**Parent's Signature:** \_\_\_\_\_ **Date:** \_\_\_\_\_

**The Primary Signs and Symptoms of Vertebral Artery Blood Flow Abnormality(stroke)  
are the 5 Ds And 3 Ns:**

<b>Dizziness/vertigo/giddiness/light headedness</b>	<b>Nausea (with possible vomiting)</b>
<b>Drop attacks/loss of consciousness</b>	<b>Numbness on one side of the face and/or body</b>
<b>Diplopia (or other visual problems/ amaurosis fugax [a painless temporary loss of vision in one or both eyes]</b>	<b>Nystagmus (rapid jerky movements of the eyes)</b>
<b>Dysarthria (speech difficulties)</b>	<b>Ataxia of gait (walking difficulties / incoordination / falling to one side</b>
<b>Dysphagia [discomfort or difficulty in swallowing]</b>	

**Ehlers-Danlos Syndrome** affects connective tissue, primarily the skin, joints, and blood vessel walls. Symptoms include overly flexible joints that can dislocate, and skin that's translucent, elastic, and bruises easily. In some cases, there may be dilation and even rupture of major blood vessels. Treatment helps manage symptoms and monitor for complications. Options include drugs, physical therapy, and sometimes surgery.

**Loeys-Dietz Syndrome** is characterized by enlargement of the aorta, which is the large blood vessel that distributes blood from the heart to the rest of the body. The aorta can weaken and stretch, causing a bulge in the blood vessel wall (an aneurysm). Stretching of the aorta may also lead to a sudden tearing of the layers in the aorta wall (aortic dissection). People with Loeys-Dietz syndrome can also have aneurysms or dissections in arteries throughout the body and have arteries with abnormal twists and turns (arterial tortuosity).

**Osteogenesis imperfecta (OI)** is an inherited (genetic) bone disorder that is present at birth. It is also known as brittle bone disease. A child born with OI may have soft bones that break (fracture) easily, bones that are not formed normally, and other problems. Signs and symptoms may range from mild to severe.

**Fibromuscular Dysplasia** is a condition that causes the medium-sized arteries in the body to narrow and grow larger. Narrowed arteries can reduce blood flow and affect how body organs work. Fibromuscular dysplasia is most often seen in the arteries leading to the kidneys and brain. But it also can affect arteries in the legs, heart, belly area and, rarely, the arms. More than one artery can be involved.

**Marfan Syndrome** is a genetic disorder that changes the proteins that help make healthy connective tissue. This leads to problems with the development of connective tissue, which supports the bones, muscles, organs, and tissues in your body. Mutations (changes) to a specific gene cause Marfan syndrome, and most people inherit the disorder from their parents.

**Polycystic Kidney Disease (also called PKD)** causes numerous cysts to grow in the kidneys. These cysts are filled with fluid. If too many cysts grow or if they get too big, the kidneys can become damaged. PKD cysts can slowly replace much of the kidneys, reducing kidney function and leading to kidney failure.

**Stone Chiropractic, LLC, Mark P. Stone, D.C, C.C.S.P.,  
51 Deport Street Suite 504, Watertown, CT 06795  
Phone: 860-274-5484 Fax: 860-274-4923**

Stone Chiropractic, LLC  
51 Depot Street, Suite 504  
Watertown, CT 06795  
P: 860-274-5484 F: 860-274-4923

**Notice of Privacy Practices Acknowledgement**

I understand that under the Health Insurance Portability and Accountability Act (Hipa), I have certain rights to privacy regarding my protected health information. I acknowledge that I have received or have been given the opportunity to receive a copy of your Notice of Privacy Practices. I also understand that this practice has the right to change it Notice of Privacy Practices and that I may contact the practice at any time to obtain a current copy of the Notice of Privacy Practices.

\_\_\_\_\_  
Patient name

\_\_\_\_\_  
Signature patient/legal guardian

\_\_\_\_\_  
Date

**For Office Use Only**

We attempted to obtain written Acknowledgment of receipt of our Notice of Privacy Practices, but Acknowledgment could not be obtained because:

- ☐ Individual refused to sign
- ☐ Communications barriers prohibited obtaining the Acknowledgment
- ☐ An emergency situation prevented us from obtaining Acknowledgment
- ☐ Other (Please Specify) \_\_\_\_\_  
\_\_\_\_\_

\_\_\_\_\_  
Staff signature

\_\_\_\_\_  
Date

# QUADRUPLE ANALOGUE SCALE

Emp \_\_\_\_\_

Patient Name: (Legibly) \_\_\_\_\_ Date \_\_\_\_\_, 2025

Initial Visit: ☐


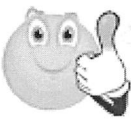


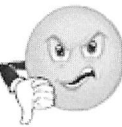


Has there been any change in your Condition since your last visit? Accident, Trauma, Fall etc Yes/No

Has there been any changes in your medication? Yes/No \_\_\_\_\_


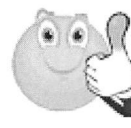
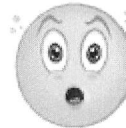

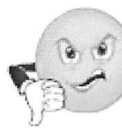


Please Circle area of Pain. Head, Neck, Mid-Back, Lower Back, Sacrum, Shoulder, Rib, Hip, Thigh, Leg, Knee, Hand, Elbow, Ankle, Foot Other \_\_\_\_\_

Instructions: Please circle the **number** that best describes your current complaint.


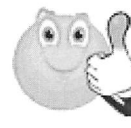
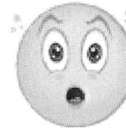

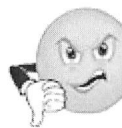


## 1. WHAT IS YOUR PAIN *RIGHT NOW*?

						
No Pain 0	Minimal/Mild 1-2	Mild/Mod 3-4	Moderate 5-6	Moderate/Severe 7-8	Severe 9-10	

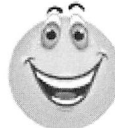
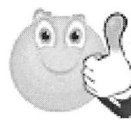
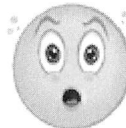

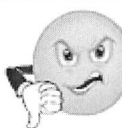


## 2. WHAT IS YOUR *TYPICAL OR AVERAGE* PAIN?

						
No Pain 0	Minimal/Mild 1-2	Mild/Mod 3-4	Moderate 5-6	Moderate/Severe 7-8	Severe 9-10	


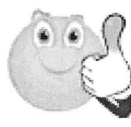


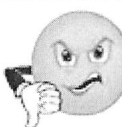


## 3. WHAT IS YOUR PAIN LEVEL AT ITS *BEST*?

						
No Pain 0	Minimal/Mild 1-2	Mild/Mod 3-4	Moderate 5-6	Moderate/Severe 7-8	Severe 9-10	

## 4. WHAT IS YOUR PAIN LEVEL AT ITS *WORST*?

						
No Pain 0	Minimal/Mild 1-2	Mild/Mod 3-4	Moderate 5-6	Moderate/Severe 7-8	Severe 9-10	

## 5. WHAT IS YOUR PAIN LEVEL **AFTER** TREATMENT? **MUST ANSWER AFTER TREATMENT**

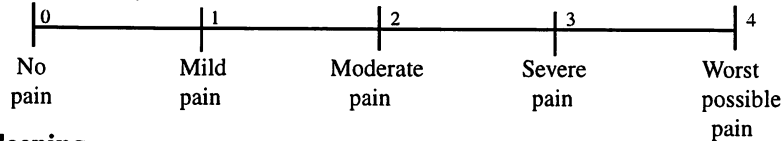
						
No Pain 0	Minimal/Mild 1-2	Mild/Mod 3-4	Moderate 5-6	Moderate/Severe 7-8	Severe 9-10	

# Functional Rating Index

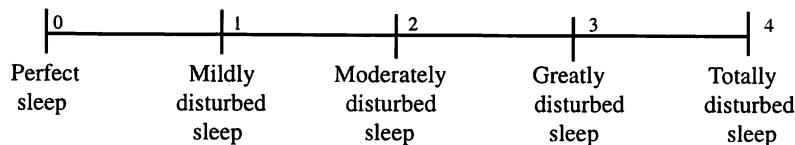
For use with Neck and/or Back Problems only.

In order to properly assess your condition, we must understand how much your neck and/or back problems have affected your ability to manage everyday activities. For each item below, **please circle the number which most closely describes your condition right now.**

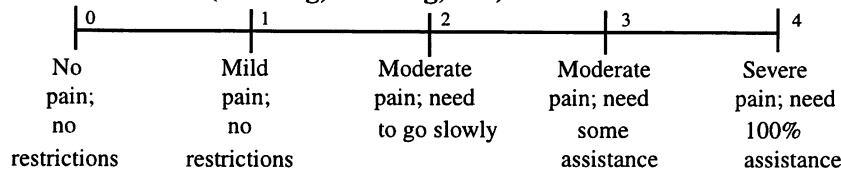
## 1. Pain Intensity



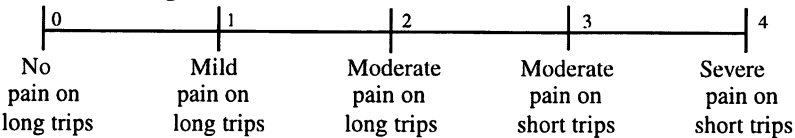
## 2. Sleeping



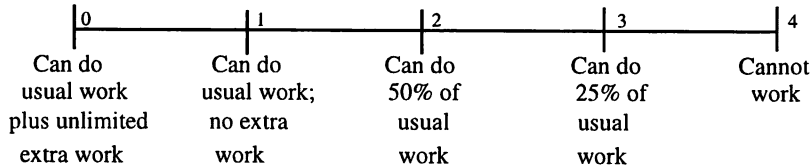
## 3. Personal Care (washing, dressing, etc.)



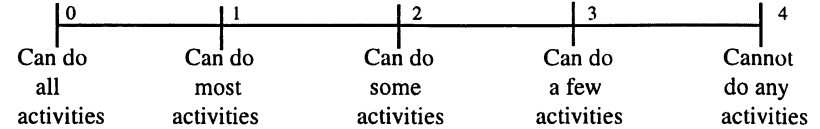
## 4. Travel (driving, etc.)



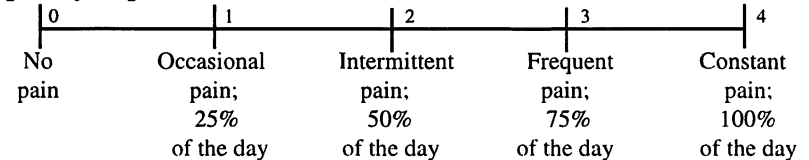
## 5. Work



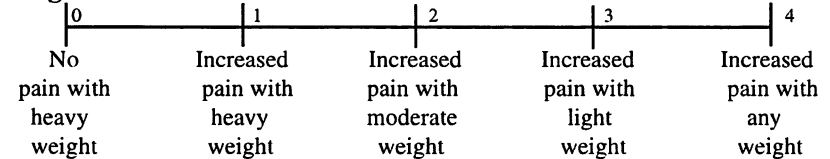
## 6. Recreation



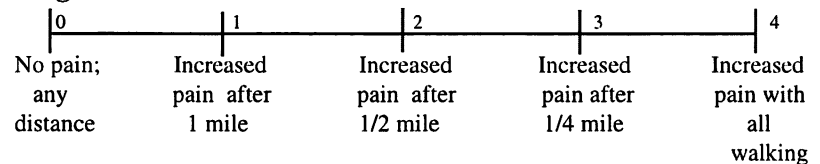
## 7. Frequency of pain



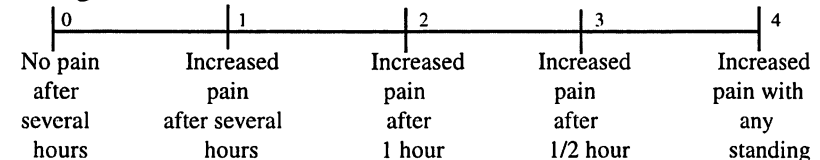
## 8. Lifting



## 9. Walking



## 10. Standing



Name \_\_\_\_\_  
PRINTED

Signature

Total Score \_\_\_\_\_

Date