

Movement Rx Pain Relief

Powered by RochesterSpine+SportsChiropractic, PLLC
135 Sully's Trail, Suite 5, Pittsford, NY 14534 | 585-626-4500 (Office) | 585-348-9102 (Fax)

Please take a few minutes to complete this questionnaire. We want you to know that it is our sincere desire to help in any way we can, and your answers will assist this process. Thank you.

PERSONAL INFORMATION:

Date:

First Name: Initial: Last Name:

How would you like to be addressed by our staff?

Male Female Age: Birth Date: Are you interested in receiving our newsletter? Yes No

Home Phone: Cell Phone: Email:

Address:

City: State: Zip Code:

Married Single Widowed Separated Divorced

Spouse's Name: Number of Children:

Emergency Contact: Relationship: Home Phone:

Referred By (Friend, Family, Physician, etc.):

WORK INFORMATION:

Occupation: Employer: Work Phone:

HEALTH INFORMATION:

Family Physician: May our office inform your physician of our exam findings, diagnosis, and treatment plan? Yes No

Address:

City: State: Zip Code:

Please provide health insurance card to the front desk for copying **OR** complete the following information

Do You Have Health Insurance? Yes No Insurance Company Name:

ID #: Group #: Subscriber's DOB:

Previous Chiropractic Care? Yes No If Yes, when and for what problem?

Is Today's Visit Due to A Work-Related Injury: Yes No Is Today's Visit Due to A Personal Injury/Auto Accident: Yes No

If yes to either question, please check with receptionist, additional information may be needed.

What is your goal from treatment?

What are your top 3 health concerns?

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CHIEF COMPLAINT:

Patient Full Name:

Chief complaint or why are you seeking care?

Date of Onset:

Was the Onset: Gradual Sudden

Since onset, has it gotten: Worse Better

Have you experienced this problem before?

Yes No

If Yes, When?

Describe what caused the pain:

PLEASE ANSWER THE FOLLOWING QUESTIONS TO HELP EXPLAIN YOUR CHIEF COMPLAINT:

Describe the quality of the complaint/pain:

- sharp
- dull/ache
- throbbing
- tingling/numbness
- other:

Does any of the following make the pain worse:

- lifting/bending/pushing/pulling
- cough/sneeze/bowel movement
- driving/riding/sitting
- walking/running/standing
- other:

Describe if pain is in a single spot or does it spread out:

- radiating dull, deep ache
- pin point
- burning, sharp stabbing, tingling, numb
- other:

Does any of the following make it better:

- rest/layingdown
- sitting
- walking/exercise
- other:

How often are you aware of the pain:

- intermittent (less than 25% of time when awake)
- occasional (25-50% of time when awake)
- frequent (50-75% of time when awake)
- constant (75-100% of time when awake)

Does it interfere with your daily activities:

- minimal (annoyance, no impairment)
- slight (tolerated, some impairment)
- moderate (marked impairment)
- marked (preclude any activity)

Have you detected any possible relationship of your current chief complaint with any of the following:

- Muscle Weakness Bowel/Bladder Problems Digestion Cardiac/Respiratory Other:

Does your pain ever awaken you from a sound sleep? Yes No

Have you tried any self-treatment? Yes No

If Yes, explain:

Results:

Have you lost consciousness or had double vision recently? Yes No

Are you currently pregnant? Yes No

Have you had any loss of bladder or bowel control? Yes No

Are you losing weight now, without trying? Yes No

Are you currently taking anti-coagulant/blood thinning medication? Yes No

Do you currently smoke Yes No or have you ever smoked? If Yes, how long and amount?

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HEALTH HISTORY:

Patient Full Name:

Have you **ever** had a **stroke** or issue with **blood clotting**? Yes No If yes, when:

Have you recently experienced **dizziness**, unexplained **fatigue**, **weight loss**, or **blood loss**? Yes No If yes, explain:

Have you ever had any major illnesses, injuries, broken bones, hospitalizations, accidents, surgeries, x-rays, MRI's or CT scans? Yes No

Date	Injury/Fracture/Illness/Surgeries/X-ray	Physician Seen / Treatment	Response to Treatment

Are you presently taking any prescription drugs, over-the-counter drugs, vitamins, or supplements? Yes No

Product/Drug	Reason	Dosage	Frequency

FAMILY HISTORY:

Please list any diseases, disorders, or major illnesses of your family members.

Father:

Mother:

Brother(s):

Sister(s):

Children:

Other:

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PLEASE WRITE IN A NUMBER: (1) PRESENTLY HAVE OR (2) PREVIOUSLY HAD

GENERAL HISTORY	EYES, EARS, NOSE, THROAT	MUSCULOSKELETAL	CARDIOVASCULAR
Cancer	Asthma	Arthritis	Hardening of arteries
Stroke	Colds	Bursitis	High blood pressure
Osteoporosis	Sore throat	Foot Trouble	Low blood pressure
Allergies	Deafness	Hernia (where)	Pain over heart
Convulsions	Dental decay	Low back pain	Poor circulation
Dizziness	Ear ache/noises	Neck pain/stiffness	Rapid heart beat
Fatigue	Ear discharge	Shoulder blade pain	Slow heart beat
Fever	Sinus infection	Pain or numbness in:	Swelling of ankles
HIV	Enlarged glands	Shoulders	GASTROINTESTINAL
Headache	Enlarged thyroid	Arms	Excessive belching or gas
Nervousness/depression	Nose bleeds	Elbows	Colitis
Multiple Sclerosis	Gum trouble	Hands	Colon trouble
Neuralgia	Difficulty swallowing/speaking	Hips	Constipation
Numbness	Nasal obstruction	Legs	Diarrhea
Sweats	URINARY	Knees	Difficult digestion
Tremors	Bed-wetting	Feet	Abdominal distention
Liver trouble	Blood in urine	Painful tailbone	Excessive hunger
Jaundice	Frequent urination	Poor posture	Gall bladder trouble
RESPIRATORY	Kidney infection or stones	Sciatica	Hemorrhoids
Chest pain	Painful urination	Spinal curvature/Scoliosis	Intestinal worms
Chronic cough	Pus in urine	GENITO	Nausea
Difficult breathing		Prostate trouble	Pain over stomach
TB (Tuberculosis)		Painful menstruation	Poor appetite
Spitting up blood		Hot flashes	Vomiting
Spitting up phlegm		Irregular cycle	Vomiting blood
Wheezing		Lumps in breasts	

LIFESTYLE:

I understand "servings" and portion sizes for Carbohydrates, Protein, Fat with each meal? Yes No

I eat five fruits and vegetables every day? Yes No I exercise 20-45 minutes every day? Yes No

My favorite fruit or vegetable is: My favorite activity or sport is:

Do you have a workout partner or personal trainer? Yes No

How many hours of sleep do you get per night?

Do you experience night sweats? Yes No

Do you awake refreshed? Yes No

Place a mark indicating your current health: **Poor Health** **Optimal Health**

Do you take time for yourself every day to focus on Gratitude, Love, and Personal expansion? Yes No

I am stressed at work? Yes No I am stressed at home? Yes No

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Place a mark indicating your current level: **No Stress** **Worst Possible Stress**

What type of treatment are you interested in? Pain Relief Optimizing Health Functional improvement All three

Are you interested in other services which may help your condition or improve your health?

Nutritional Support Rehabilitation Orthotics Exercise Weight Loss

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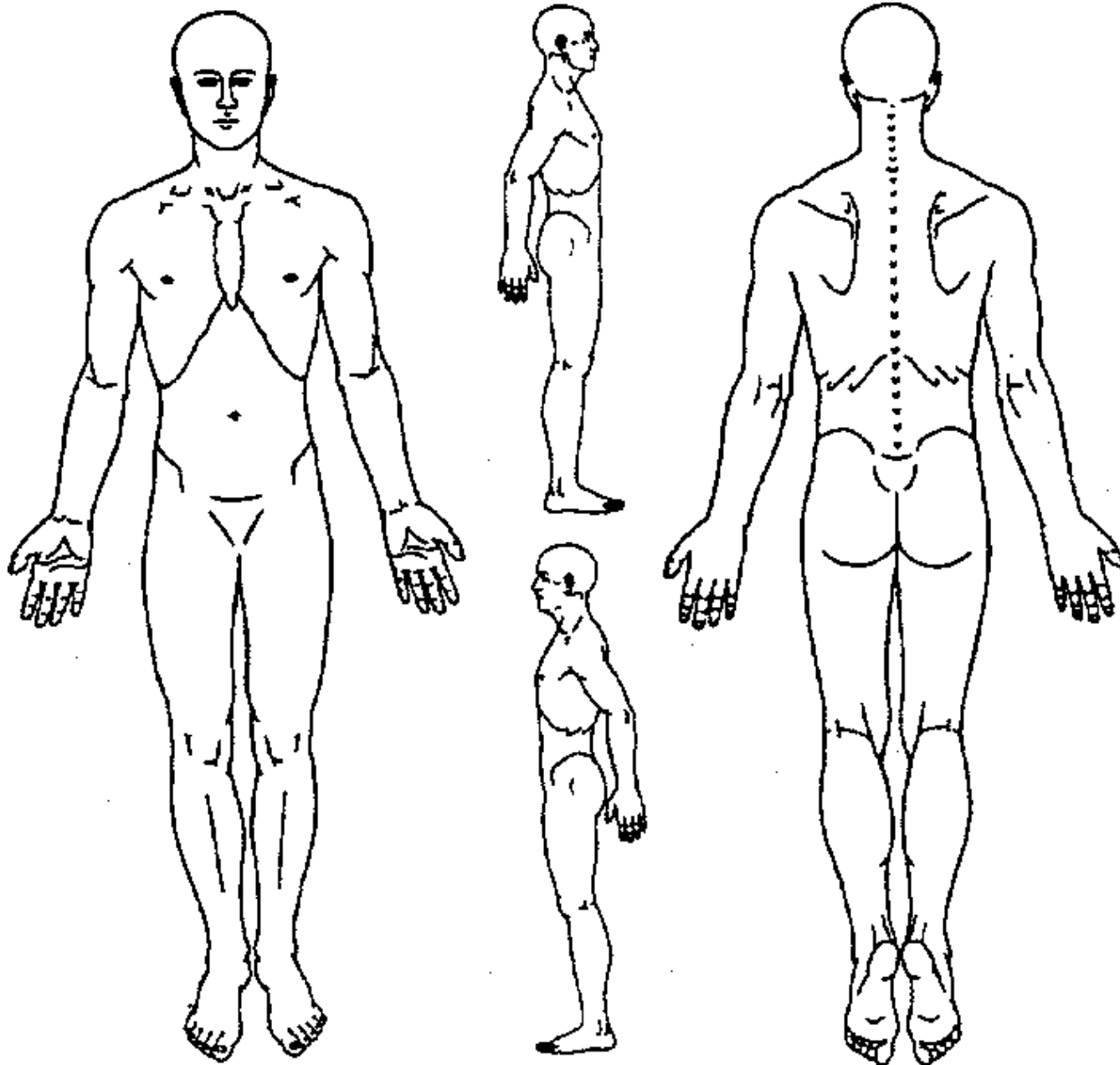
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PAIN DIAGRAM: _____

Patient Full Name:

After printing form, please indicate any location where you are experiencing pain using the descriptive key below.



Use the following letters to indicate the type and location of discomfort:

- A - Aching
- B - Burning
- N - Numbness/Tingling
- P - Pins and Needles
- S - Stabbing/Sharp
- T - Throbbing
- O - Other



PAIN SCALE

Place a mark indicating your current pain on the above scale

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OFFICE POLICY:

Patient Full Name:

The definitions of our office policies are stated below. Please take the time to read and sign where appropriate.

Insurance Verification: Verification is not a guarantee of payment and is only a quote of patient benefits. Insurance companies review charges individually and make payment accordingly. Charges which are not covered by insurance are the patient's responsibility and due within 30 days of billing.

Payment Policy: It is our policy to collect all fees at the time of service. Deductible, Co-payments, and Co-insurances are the patient's responsibility and will be collected at the time of service. Forms of payment accepted are cash, personal check, credit card. It is our policy to collect \$35.00 for checks that are returned to cover any fees which are incurred from the transaction.

If the patient has an outstanding balance from services not covered by the insurance company, patients will receive a bill outlining charges. Upon receipt, payment is due within 30 days. After 30 days, it is the clinic's policy to turn unpaid accounts over to a collection agency.

Appointment Policy: As a courtesy to our staff and other patients, please be on time for your scheduled appointment dressed in appropriate clothing for treatment. You may cancel or reschedule an appointment for any reason with more than 24 hours' notice. An appointment is considered missed if any of the following applies: not showing up, canceling within 24 hours, rescheduling within 24 hours, arriving five (5) or more minutes late, and/or being unprepared five (5) or more minutes late (e.g., not dressed in appropriate clothing for treatment).

A missed appointment is charged the full visit fee (\$75/15-minute treatment, \$130/30-minute exam). The missed appointment fee is waived for the first occurrence. You are responsible for paying missed appointment fee(s) prior to receiving further treatment; this fee is not covered by your insurance. You may or may not be seen the same day as the originally scheduled appointment.

By signing below, the patient acknowledges that he/she has received the HIPPA Privacy Policy and that he/she understands and will comply with Movement Rx Powered by RSSC office policies listed above.

Patient Signature

Date

I _____, hereby give my consent to the providers at Movement Rx Pain Relief/ Rochester Spine + Sports Chiropractic, to treat me by means of the following procedure(s):

Chiropractic procedures, Manual Therapy and Rehabilitation

I understand that, as in the practice of medicine, in the practice of chiropractic there are some risks to treatment. I do not expect my treatment provider to anticipate or explain all risks and complications, and I wish to rely on my treatment provider's judgment during the course of treatment.

The nature and purpose of the procedure, and possible alternative methods of treatment, have been fully explained to me. No guarantee or assurance has been given by anyone as to the results that may be obtained.

I HAVE PROVIDED TRUTHFUL AND ACCURATE INFORMATION AND WILL UPDATE THE OFFICE IF ANYTHING IN MY HEALTH HISTORY CHANGES. I HAVE READ OR HAD READ TO ME THIS CONSENT AND ITS CONTENTS HAVE BEEN FULLY EXPLAINED TO ME. ANY QUESTIONS I HAVE HAD REGARDING THESE PROCEDURES HAVE BEEN ANSWERED TO MY SATISFACTION. I CERTIFY THAT I UNDERSTAND THE CONTENTS OF THIS CONSENT AND THAT I AM SIGNING IT VOLUNTARILY AND FREELY AS MY OWN ACT AND DEED.

Patient Signature

Date

Witness

Date

Signature of Parent or Guardian (if a minor)

Date