

Falanga Family Chiropractic
4 Butternut Drive
Oswego, NY 13126
315 343-2961
315 343-4001 fax

PATIENT INFORMATION

Please PRINT

Patient's Name (Last, First M.I.) _____

Address: _____

City - State - Zip: _____

Phone Number (Home) _____ (Work) _____ (Cell) _____

Social Security #: _____ Date of Birth: _____

Marital Status: Single Married Divorced Widowed Other

Gender: Male Female

Emergency Contact Person: _____ Relationship to You: _____

Emergency Contact Phone #: _____

Current Employer: _____

Employer's Address: _____

City - State - Zip: _____

Job Description/Title: _____ Supervisor: _____

Current Work Status: Full Duty Modified Duty Not Working Unemployed

1) Did your injuries result from your employment? Yes No Date: _____

2) Did your injuries result from a motor vehicle accident? Yes No Date: _____

3) Did your injuries result from a "slip or fall"? Yes No Date: _____

4) Are your injuries the result of a medical condition? Yes No

If you answered "YES" to question #1, #2 OR #3 - Please provide the date your accident occurred: _____

Primary Health Insurance

Name of Carrier: _____ Subscriber: _____

Address: _____ Subscriber's ID#: _____

Subscriber's Group #: _____

City - State - Zip: _____ Subscriber's Date of Birth: _____

Phone Number: _____ Subscriber's Soc Sec #: _____

Secondary Health Insurance (if applicable)

Name of Carrier: _____ Subscriber: _____

Address: _____ Subscriber's ID#: _____

Subscriber's Group #: _____

City - State - Zip: _____ Subscriber's Date of Birth: _____

Phone Number: _____ Subscriber's Soc Sec #: _____

(Your) Motor Vehicle Insurance (if applicable)

Name of Carrier: _____ Insured: _____

Address: _____ City - State - Zip: _____

Policy #: _____ Claim #: _____

Phone Number: _____ Adjuster's Name: _____

Worker's Compensation Insurance (if applicable)

Name of Carrier: _____ Insured: _____

Address: _____ City - State - Zip: _____

Policy #: _____ Claim #: _____

Phone Number: _____ Adjuster's Name: _____

If Applicable, Please Complete Your Attorney Information

Name of Attorney: _____

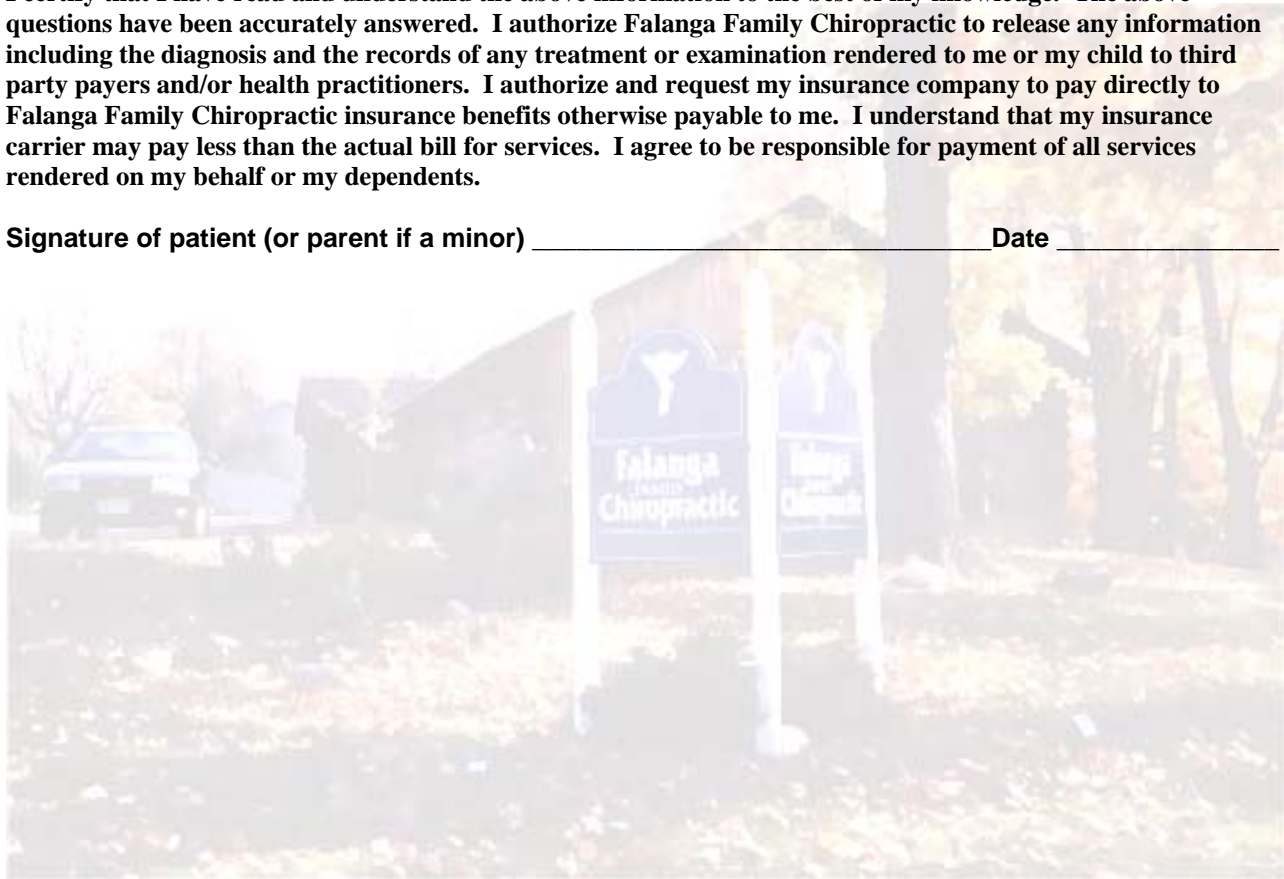
Attorney's Address: _____

City - State - Zip: _____

Attorney's Phone #: _____ Attorney's Fax #: _____

I certify that I have read and understand the above information to the best of my knowledge. The above questions have been accurately answered. I authorize Falanga Family Chiropractic to release any information including the diagnosis and the records of any treatment or examination rendered to me or my child to third party payers and/or health practitioners. I authorize and request my insurance company to pay directly to Falanga Family Chiropractic insurance benefits otherwise payable to me. I understand that my insurance carrier may pay less than the actual bill for services. I agree to be responsible for payment of all services rendered on my behalf or my dependents.

Signature of patient (or parent if a minor) _____ Date _____





Falanga Family Chiropractic

Patient History

Please fill out all the questions to the best of your knowledge. This information will become part of your medical record and will allow us to provide thorough medical care. It is very important to us and will be kept confidential. (**Please Print**)

Name _____ Date _____

Address _____

Home Phone _____ Work Phone _____ Cell Phone _____

Date of Birth ____ / ____ / ____ Gender _____ SS # _____

Primary Care Physician _____ Phone # _____

HISTORY

What is the **complaint, pain, or injury** that caused you to schedule an appointment at Falanga Family Chiropractic?

PHYSICIANS (Please list physicians who have treated you):

Referring _____ Primary Care _____
Surgeon _____ Plastic/Reconstruction _____
Medical Oncologist _____ Radiation Oncologist _____
OB-Gyn _____ Other _____
Chiropractors/Osteopaths _____

Do you have a preferred chiropractic technique for treatment (Hands on, activator, etc.)? _____

MEDICAL HISTORY

Do you have or have you had any of the following?

	Y	N		Y	N		Y	N
High Blood Pressure	<input type="checkbox"/>	<input type="checkbox"/>	Aids or HIV	<input type="checkbox"/>	<input type="checkbox"/>	Osteoarthritis	<input type="checkbox"/>	<input type="checkbox"/>
Heart Attack	<input type="checkbox"/>	<input type="checkbox"/>	Hepatitis	<input type="checkbox"/>	<input type="checkbox"/>	Joint Replacement	<input type="checkbox"/>	<input type="checkbox"/>
Low Blood Pressure	<input type="checkbox"/>	<input type="checkbox"/>	Heart Disease	<input type="checkbox"/>	<input type="checkbox"/>	Stomach Disorder/Ulcer	<input type="checkbox"/>	<input type="checkbox"/>
Rheumatic Fever	<input type="checkbox"/>	<input type="checkbox"/>	Cardiac Pacemaker	<input type="checkbox"/>	<input type="checkbox"/>	Thyroid Problem	<input type="checkbox"/>	<input type="checkbox"/>
Swollen Ankles	<input type="checkbox"/>	<input type="checkbox"/>	Heart Murmur	<input type="checkbox"/>	<input type="checkbox"/>	Stroke	<input type="checkbox"/>	<input type="checkbox"/>
Fractures	<input type="checkbox"/>	<input type="checkbox"/>	Chest Pain	<input type="checkbox"/>	<input type="checkbox"/>	Tuberculosis	<input type="checkbox"/>	<input type="checkbox"/>
Asthma	<input type="checkbox"/>	<input type="checkbox"/>	Anemia	<input type="checkbox"/>	<input type="checkbox"/>	Liver Disease	<input type="checkbox"/>	<input type="checkbox"/>
Epilepsy/Seizures	<input type="checkbox"/>	<input type="checkbox"/>	Osteoporosis	<input type="checkbox"/>	<input type="checkbox"/>	Diabetes	<input type="checkbox"/>	<input type="checkbox"/>
Leukemia	<input type="checkbox"/>	<input type="checkbox"/>	Emphysema	<input type="checkbox"/>	<input type="checkbox"/>	Other:	<input type="checkbox"/>	<input type="checkbox"/>
Incontinence	<input type="checkbox"/>	<input type="checkbox"/>	Cancer	<input type="checkbox"/>	<input type="checkbox"/>	Please Specify: _____		
Kidney Diseases	<input type="checkbox"/>	<input type="checkbox"/>	Rheumatoid Arthritis	<input type="checkbox"/>	<input type="checkbox"/>	_____		

WOMEN: Are you pregnant or think you may be pregnant? Yes No
 Are you postmenopausal? Yes No

PERSONAL and SOCIAL HISTORY

Do you drink alcoholic beverages? Yes No
 If yes, how much per week? _____
 Do you smoke? Yes No
 If yes, how many packs per week? _____ How long? _____
 Age and health of spouse _____
 Any person, family, or job problems that might pertain to your situation/recovery?

REVIEW OF SYSTEMS – Check all that apply

GENERAL HEALTH

- Good Fair Bad

Recent:

- Weight loss Weight gain Sweats Chills
 Fever Chronic fatigue Trouble Sleeping

SKIN

- Rashes Acne Scars Psoriasis

Other _____

EYE

- Glasses Contacts Cataracts Glaucoma

Blurred vision Other _____

EAR, NOSE and THROAT

- Dentures/partial plates Braces Caps Loose teeth
 Taste problems Smelling problems Recent sore throat or sinus infection
 Ringing in ears Dizziness Neck Lumps/masses

GLANDULAR PROBLEMS

- Thyroid Goiter Ovaries Testicles

ENDOCRINE PROBLEMS

- Excessive Thirst Urination Growth of hair

ALLERGY

- Hay fever Asthma Hives Metal

Other _____

HEART/VASCULAR

- Chest pain Shortness of breath Heart attack
 Congestive heart failure Dyspnea Rheumatic fever
 Heart murmur High blood pressure Hardening of the arteries
 Stroke Anemia Dropsy
 Ankle swelling Racing heart beat Palpitation
 Irregular beat

LUNG

Current or recent:

- Cold
- Cough
- Sore throat or infection

History of:

- Asthma
- Pneumonia
- Tuberculosis
- Pleurisy
- Cough
- Coughing up blood
- Bronchitis
- Sputum
- Wheezing
- Smoking
- COPD
- Emphysema

GASTRO-INTESTINAL

- Hepatitis
- Jaundice
- Mouth problems
- Tonsillitis
- Esophagitis
- Hernia
- Gallbladder
- Change of bowel habits
- Typhoid fever
- Hemorrhoids
- Piles
- Nausea
- Vomiting
- Diarrhea
- Constipation
- Recent bleeding
- Tarry (black) stools
- Appendicitis
- Laxatives
- Food allergies or intolerance
- Heartburn
- Use of antacids
- Irregularity
- Pain before or after meals

KIDNEY/BLADDER

- Kidney/bladder infections
- Bleeding
- Pain or burning on urination
- Frequent voiding
- Bladder trouble (list below)
- Stones
- Syphilis
- Gonorrhea
- Hydrocele
- Nephritis
- Discharge
- Strictures
- Incontinence
- Obstruction

Urinating at night, number of times per night _____

GYNECOLOGICAL

Could you be pregnant now? Yes No Date of last period _____

Number of pregnancies _____ Live births _____

Menstrual history: Age at onset _____ Frequency _____ Duration _____

Menopause (change of life) Yes No Age _____

Any bleeding or spotting since menopause? _____

BONE MARROW

- Anemia
- Bleeding/bruising tendencies
- Radiation
- Benzene or other exposure? _____

NEUROMUSCULAR (provide details below)

- Headaches
- Visual disturbances
- Dizziness
- Blackouts
- Paralysis
- Stroke
- Forgetfulness
- Head Injury
- Numbness
- Convulsions
- Epilepsy
- Back pain
- Sciatica
- Neck pain or injury
- Arthritis
- Ruptured muscles
- Torn ligaments
- Severe/recurrent sprains
- Trick knees
- Rheumatism
- Gout
- Phlebitis
- Partial or complete amputations
- Pain or cramps when walking

PSYCHIATRIC PROBLEMS

- Nervous breakdown
- Severe anxiety
- Depression
- Suicidal
- Other _____

COMMENTS/EXPLANATIONS:

Patient Health Questionnaire

Patient Name _____ Date _____

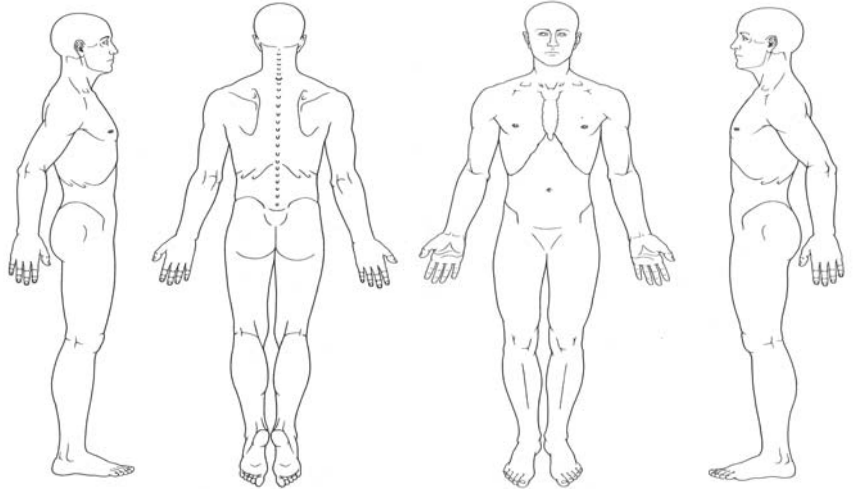
1. Describe your symptoms

a. When did your symptoms start? _____

b. How did your symptoms begin? _____

2. How often do you experience your symptoms? Indicate where you have pain or other symptoms

- ① Constantly (76-100% of the day)
- ② Frequently (51-75% of the day)
- ③ Occasionally (26-50% of the day)
- ④ Intermittently (0-25% of the day)



3. What describes the nature of your symptoms?

- ① Sharp
- ② Dull ache
- ③ Numb
- ④ Shooting
- ⑤ Burning
- ⑥ Tingling

4. How are your symptoms changing?

- ① Getting Better
- ② Not Changing
- ③ Getting Worse

5. During the past 4 weeks:

a. Indicate the average intensity of your symptoms

None ① ② ③ ④ ⑤ ⑥ ⑦ ⑧ ⑨ ⑩ Unbearable

b. How much has pain interfered with your normal work (including both work outside the home, and housework)

① ② A little bit ③ Moderately ④ Quite a bit ⑤ Extremely

6. During the past 4 weeks how much of the time has your condition interfered with your social activities?

(like visiting with friends, relatives, etc)

① ② Most of the time ③ Some of the time ④ A little of the time ⑤ None of the time

7. In general would you say your overall health right now is...

① Excellent ② Very Good ③ Good ④ Fair ⑤ Poor

8. Who have you seen for your symptoms?

- ① No One
- ② Other Chiropractor
- ③ Medical Doctor
- ④ Physical Therapist
- ⑤ Other

a. What treatment did you receive and when? _____

b. What tests have you had for your symptoms and when were they performed?

- ① Xrays date: _____
- ② MRI date: _____
- ③ CT Scan date: _____
- ④ Other date: _____

9. Have you had similar symptoms in the past?

- ① Yes
- ② No

a. If you have received treatment in the past for the same or similar symptoms, who did you see?

- ① This Office
- ② Other Chiropractor
- ③ Medical Doctor
- ④ Physical Therapist
- ⑤ Other

10. What is your occupation?

- ① Professional/Executive
- ② White Collar/Secretarial
- ③ Tradesperson
- ④ Laborer
- ⑤ Homemaker
- ⑥ FT Student
- ⑦ Retired
- ⑧ Other

a. If you are not retired, a homemaker, or a student, what is your current work status?

- ① Full-time
- ② Part-time
- ③ Self-employed
- ④ Unemployed
- ⑤ Off work
- ⑥ Other

Patient Signature _____ Date _____

Back Index

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.

**Back
Index
Score**

Neck Index

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.

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).

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.

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.

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.

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.

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.

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.

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.

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.

Neck
Index
Score