Tina Shores, D.C.
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190 Perrin Drive
Rochester, New York 14622
Phone (585) 544-1540
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Welcome to our office.

Patient Information

Date___________

Patient Name____

Address____

____
City State Zip

Email Address: ____

Sex M F Age______Date of Birth_____/______/______

Single Married Widowed Separated Divorced

Occupation____

Spouse's Name____

Spouse's Employer______________________________________

Whom may we thank for referring you?___________________

____

Family (Parents, Siblings) Health History_______________

____

____

____

____

Contact Numbers

Home (____)____________ Cell (____)_________________

IN CASE OF EMERGENCY, CONTACT:

Name_________________ Relationship_________________

Home #_______________ Work #______________________

Insurance Information

Insurance Co.____

Policy Number: ____

Policy Holders Name:___________________________________

Policy Holders Date of Birth: ___________________________

How are you related to Policy Holder: Self / Spouse / Child

Lifestyle

Glasses of water per day_________________________

Kind of Shoes you wear most often__________________

Do you wear orthotics? ___________________________

How old is your mattress? _________________________

Sleep Position: (back) (side L / R) (stomach) (couch)

Accident Information

Is condition due to the accident? Yes No Date_________

Type of accident Auto Work Home Other

To whom have you made a report of your accident?

Auto Insurance Employer Work Comp. Other

Attorney Name (if applicable)_____________________________

Patient Condition

Reason for your Visit?____

When did it begin?_______________What do you think was the cause?___________Make's it better?___________ Worse?____________

Rate the severity of the pain on a scale of 0 (no pain) to 10 (excruciating pain) 0 1 2 3 4 5 6 7 8 9 10

Type of pain: Sharp Dull Throbbing Numbness Aching Shooting Burning Tingling Cramping Stiffness Swelling Other

____

How often do you have this pain?___________________________ Is it constant or does it come and go?_______________________

Does the pain interfere with your Work Sleep Daily Routine Hobby/Recreation

Previous history of primary complaint?____

Health History

Name: **Date:**

Primary Care Physician?___________________________Office Phone( )_______________ Address:_______________________________

Are you being seen by other specialists?______________________ Who is your OB/GYN Physician?(Female Only________________

What treatment have you already received for your condition? Medications (list)____

Have you seen a Chiropractor in the past? Who ____________________Date of last adjustment_______________ None

Date of Last: Physical Exam________________ Blood Test____________________ Urine Test____________________________

Spinal Exam________________ Spinal X-ray____________________ Chest X-ray____________________________

MRI, CT, Scan________________ DEXA (Bone density______________ Prostate Exam__________________________

AIDS/HIV	Y N	Emphysema	Y N	Parkinson's Disease	Y N
Allergy	Y N	Epilepsy	Y N	Pneumonia	Y N
Anemia	Y N	Fainting	Y N	Polio	Y N
Appendicitis	Y N	Fractures	Y N	Prostate Issues	Y N
Arthritis	Y N	Glaucoma	Y N	Psychiatric Care	Y N
Asthma	Y N	Gout	Y N	Rheumatoid Arthritis	Y N
Bleeding disorder	Y N	Hernia	Y N	Scarlet Fever	Y N
Breast Lump	Y N	Herniated Disc	Y N	Stroke	Y N
Bronchitis	Y N	High/Low Blood Pressure	Y N	Thyroid Problem	Y N
Cancer	Y N	High Cholesterol	Y N	Tuberculosis	Y N
Cataracts	Y N	Kidney Disease	Y N	Tumor/Growth	Y N
Chemical Dependency	Y N	Liver Disease	Y N	Ulcer/Colitis	Y N
Chicken Pox	Y N	Migraine Headaches	Y N	Whopping Cough	Y N
Diabetes	Y N	Multiple Sclerosis	Y N	Heart Attack	Y N
Depression	Y N	Osteoporosis	Y N		
Difficulty breathing	Y N	Pacemaker	Y N		

Other:________________
____
____
____

Exercise
Never
Seldom
Frequent
Daily

Work Activity
Sitting (desk)
Computer
Standing
Light Labor
Heavy Labor

Habits
Smoking Packs/Day_______For_____Yrs.
Alcohol Drinks/Week_____________
Caffeine Cups/Day_______________
High Stress Reason________________

Women Only
Are you pregnant? Y N
Number of pregnancies?______.
How many deliveries?________.
Vaginal C-section
Birth Control Pills? Y N

Injuries/Surgeries you have had: Please indicate actual dates or year.

Motor Vehicle Accidents____

Broken Bones/Fractures____

Spinal Injuries (Neck, Back, Low Back, Pelvis)_____________________________________

Head Injuries/Concussions____

Surgeries (include all, i.e. Tonsillectomy)____

Medications
Anti-inflammatory____

Muscle Relaxants____

Pain Killer/Analgesic______________________________________

Heart Medication________________ Coumadin_____________

Other____

Vitamin/Herb/Mineral
Multivitamin_____________________________

Multimineral_____________________________

Herbs__________________________________

Other__________________________________

____

CHIROPRACTIC ASSOCIATES OF ROCHESTER

Patient Name ______________________________ Date______________________________

☐ Regular ☐ Worker's Comp ☐ No Fault

On the diagram, please indicate the location of pain and the symbol that best describes what you are currently experiencing:

SHARP/STABBING	+++
DULL/ACHY	VVVV
PINS/NEEDLES	0000
NUMBNESS	////
OTHER	XXXX

Type of discomfort: ____ Sharp _____ Dull _____ Aching ______ Burning ______Numbness
(choose all that apply) _____ Tightness ______ Throbbing _____ Diffuse ______Shooting ______Tingling
_____ Other

Frequency of Pain: _______ Constant (100%-75%) _______Frequent (75%-50%) _______Intermittent (50%-25%) _______Occasional (25%-0%)

Discomfort increases with: ______Movement _______Applying Pressure _____ Sitting ______Coughing

Discomfort decrease with: ______Rest _______ Movement ________ Medication _______ Ice _______Heat
______ Chiropractic Care

Region	At WORST	At BEST	TODAY
NECK	0 1 2 3 4 5 6 7 8 9 10	0 1 2 3 4 5 6 7 8 9 10	0 1 2 3 4 5 6 7 8 9 10
MID/UPPER BACK	0 1 2 3 4 5 6 7 8 9 10	0 1 2 3 4 5 6 7 8 9 10	0 1 2 3 4 5 6 7 8 9 10
LOW BACK	0 1 2 3 4 5 6 7 8 9 10	0 1 2 3 4 5 6 7 8 9 10	0 1 2 3 4 5 6 7 8 9 10
Other_______________	0 1 2 3 4 5 6 7 8 9 10	0 1 2 3 4 5 6 7 8 9 10	0 1 2 3 4 5 6 7 8 9 10

Scale: 0=no pain or discomfort 10=most intense pain

-For office use only-

Notes:

____

____

____

____

	Cervical ROM	Lumbar ROM
Flexion	(90)	(90)
Ext	(70)	(35)
LLF	(40)	(25)
RLF	(40)	(25)
Lrot	(70)	(30)
Rrot	(70)	(30)

Patient's Name____ Date ____________

OVERALL HEALTH HISTORY

Do you have vertigo (dizziness)?	YES__________	NO_________
Do you pass out easily (faint, loss of consciousness)?	YES__________	NO_________
Do you have double vision or have you lost sight in one eye?	YES__________	NO_________
Do you have any slurred speech or difficulty in arranging words properly?	YES__________	NO_________
Have you had any difficulty walking, with coordination or falling to one side?	YES__________	NO_________
Do you have any nausea or vomiting?	YES__________	NO_________
Do you have numbness on one side of you face or body?	YES__________	NO_________
Do you have any visual disturbances or rapid eye movement?	YES__________	NO_________
Do you have a headache or head pain that is unlike any you have had before?	YES__________	NO_________
Do you have headaches for hours or days?	YES__________	NO_________
Do you have history of stroke in the family?	YES__________	NO_________
Do you have chest pain?	YES__________	NO_________
Do you have any change in bowel or bladder habits?	YES__________	NO_________
Do you have a sore that does not heal?	YES__________	NO_________
Do you have any unusual bleeding or discharge?	YES__________	NO_________
Do you have any thickening in your breasts or elsewhere?	YES__________	NO_________
Do you have indigestion or difficulty swallowing?	YES__________	NO_________
Do you have a change in any wart or mole?	YES__________	NO_________
Do you have a nagging cough or hoarseness?	YES__________	NO_________
Do you have night sweats?	YES__________	NO_________
Do you have pain in the neck, jaw or face?	YES__________	NO_________
Do you have a drooping eyelid or changes in your pupils?	YES__________	NO_________
Do you have any ringing in your ears?	YES__________	NO_________
Do you take birth control pills?	YES__________	NO_________

PROBLEM SPECIFIC

Head:	headaches y / n location_____________________________
Neck:	difficulty with: turning L—R—forward—backward—tilt right—tilt left
Midback:	pain with cough, sneeze of bowel movement
Low Back:	pain down the buttock—legs pain with cough sneeze or bowel movement

Shoulder:____

Elbow:____

Wrist:____

Hand/Fingers:____

Hip:____

Knee:____

Ankle:____

Foot/Toes:____

Bournemouth Questionnaire
Back Pain (BQ-back)

Name: **Date:**

*Please circle **ONE** number for each of the following statements that best describes your neck pain and how it is affecting you **NOW**. Please read each question carefully before answering:*

Question	Scale
1. Over the past few days, on average, how would you rate your back pain?	**No Pain** … **Worst Possible Pain** 0 1 2 3 4 5 6 7 8 9 10
2. Over the past few days, on average, how has your back pain interfered with your daily activities (housework, washing, dressing, lifting, reading, driving, sleeping)?	**No Interference** … **Unable to carry-on with normal day-to-day activities** 0 1 2 3 4 5 6 7 8 9 10
3. Over the past few days, on average, how has your back pain interfered with your normal social routine including recreational, social, and family activities?	**No Interference** … **Unable to participate in any social and recreational activities** 0 1 2 3 4 5 6 7 8 9 10
4. Over the past few days, on average, how anxious (uptight, tense, irritable, difficulty in relaxing/concentrating) have you been feeling?	**Not Anxious At All** … **Extremely Anxious** 0 1 2 3 4 5 6 7 8 9 10
5. Over the past few days, on average, how depressed (down-in-the-dumps, sad, in low spirits, pessimistic, lethargic) have you been feeling?	**Not Depressed At All** … **Extremely Depressed** 0 1 2 3 4 5 6 7 8 9 10
6. Over the past few days, how do you think your work (both inside the home and/or employed work) has affected your back pain?	**Makes It No Worse** … **Makes It Very Much Worse** 0 1 2 3 4 5 6 7 8 9 10
7. Over the past few days, on average, how much have you been able to control (help/reduce) and cope with your back pain on your own?	**I Can Control My Pain Completely** … **I Have No Control Whatsoever** 0 1 2 3 4 5 6 7 8 9 10

THANK YOU VERY MUCH FOR YOUR TIME IN COMPLETING THIS QUESTIONNAIRE

Source: Bolton JE, Breen AC. The Bournemouth Questionnaire: a short-form comprehensive outcome measure. I. Psychometric properties in back pain patients. J Manipulative Physiol Ther 1999;22(8):503-10.

Chiropractic Associates of Rochester
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The Keele STarT Back Screening Tool

Patient name: ______________________________ Date: ____________

Thinking about the **last 2 weeks** pick your response to the following questions:

		Disagree 0	Agree 1
1	My back pain has **spread down my leg(s)** at some time in the last 2 weeks	☐	☐
2	I have had pain in the **shoulder** or **neck** at some time in the last 2 weeks	☐	☐
3	I have only **walked short distances** because of my back pain	☐	☐
4	In the last 2 weeks, I have **dressed more slowly** than usual because of back pain	☐	☐
5	It's not really safe for a person with a condition like mine to be physically active	☐	☐
6	**Worrying thoughts** have been going through my mind a lot of the time	☐	☐
7	I feel that **my back pain is terrible** and **it's never going to get any better**	☐	☐
8	In general I have **not enjoyed** all the things I used to enjoy	☐	☐

9. Overall, how **bothersome** has your back pain been in the **last 2 weeks**?

Not at all	Slightly	Moderately	Very much	Extremely
☐	☐	☐	☐	☐
0	0	0	1	1

Total score (all 9): ________________ Sub Score (Q5-9):____________

CARE PLAN GOALS:
1. Pain Reduction by ______________________________
2. TX Duration______________________________
3. Improve ROM______________________________
4. Resume ADL______________________________
5. Resume Work______________________________
6. Other GOALS______________________________

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INFORMED CONSENT TO CHIROPRACTIC TREATMENT

Chiropractic care, spinal adjustments, has been the subject of government reports and multidisciplinary studies conducted over many years that have been demonstrated to be a highly effective treatment for spinal pain, headaches and other symptoms. Maintaining spinal alignment through chiropractic care contributes to your overall well-being. The risk of injuries or complications from chiropractic treatment is substantially lower than that associated with many medical treatment, medications and procedures given for the same condition.

I acknowledge that I have received information regarding my condition and proposed chiropractic treatment as well as alternative courses of care, the benefits, the risks, the side effects of treatment and the consequences of not having the proposed treatment.

I understand and am informed that, as in all health care, in the practice of chiropractic there are some risks to treatment, including but not limited to: muscle strains & sprains, fractures, dislocations, disc injuries and strokes. I wish to rely on the doctor to exercise judgment during the course of the treatment that he feels at the time based upon the facts then known, is in my best interests.

My doctor has responded to all of my requests for information about the proposed treatment. I have read, or have had read to me, the above consent. I have also had the opportunity to ask questions about its content. I intend this consent to apply to all my present and future chiropractic care in this office.

Patient Signature____Date____________

Witness____Date____________

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PATIENT ACKNOWLEDGEMENT & CONSENT FORM

I understand that under the Health Insurance Portability & Accountability Act of 1996 ("HIPAA"), I have certain rights to privacy regarding my protected health information. I understand that this information can and will be used to:

- Conduct, plan and direct my treatment and follow-up among the multiple healthcare providers whom may be involved in that treatment directly and indirectly.
- Obtain payment from third party payers.
- Conduct normal healthcare operations such as quality assessments and physician certifications.

I have read and understand the Notice of Privacy Practices containing a more complete description of the uses and disclosures of my health information. I have been given the right to review such Notice of Privacy Practices prior to signing this consent. I understand that this practice has the right to change the Notice of Privacy Practices from time to time and that I may contact this practice at any time at the address above to obtain a current copy of the Notice of Privacy Practices.

I understand that I may request in writing that you restrict how my private information is used or disclosed to carry out treatment, payment or healthcare options. I also understand the practice is not required to agree to my requested restrictions, but if the practice does agree then it is bound to abide by such restrictions.

This notice is in effect as of the date signed below. By signing below, I certify that I have received this notice and all of my questions have been answered to my satisfaction with language that I can understand.

Patient Name ______________________________

Relationship to Patient ______________________________

Signature: ______________________________

Date: ______________________________

OFFICE USE ONLY

I attempted to obtain the patient's signature in acknowledgement and consent on this Notice of Privacy Practices Acknowledgement/Consent Form, but was unable to do so as documented below:

Date	Initials	Reason

190 Perrin Drive
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OFFICE FINANCIAL AGREEMENT-2022

It is your responsibility to know what your insurance policy covers. Insurance covers acute, medically necessary care. If your insurance denies payment for our services at any time, you agree to take full financial responsibility. Some insurance companies will not allow multiple family members to be treated on the same day in the same office.

Please sign and initial designated insurance line.

_____**Excellus BC/BS, Aetna and United**
Deduct- Referral may be needed. Until your annual deductible is met the office fee will be procedure dependent. Fee is due at time of service. Once the deductible is met, you will be responsible for co-insurance policy dependent. Supplements, orthotics, supports, etc. are not covered.
Co-Pay- Referral may be needed. Your co-pay is due at the time of service and will range from $10-$60 depending upon your contract. Supplements, orthotics, cushion are not covered and are the patient's responsi Blues cover **acute care** and not maintenance care.

_____ **Medicare Advantage Plans: Aetna/BCBS/MVP Gold/United**
PCP referral is required. Primary care physician sets number of visits allowed. Should your carrier or PCP fail to supply authorization, you will be responsible for the usual and customary fee (ABN).

____**Medicare:** No referral needed. Until your annual estimated Deductible of $233.00 is met the office fee is $40.00 - $90.00. You will be responsible for any usual and customary fee (ABN)

_____**MVP/CIGNA/OTHER***:* The doctors in this office are out of network providers. Initial consultation fee, history and examination is $80.00. Subsequent visits thereafter are $40.00. Depending on your contract you may have out of **network coverage**. We will supply you with a claim form so that you can submit to your insurance company.

____**Usual & Customary Office Fees:** First visit for consultation, history and examination is $80.00. Subsequent visits thereafter are $40.00. Initial Spinal scan fee included in $80.00 charge.

Rock Tape (Kinesio Tape):
__ Option 1: Free application with purchase of roll (for life of roll)
__ Option 2: $5.00 charge per region application

_____ **Worker's Compensation:** If you require treatment for an injury that occurred while performing your normal employment, you may be eligible for 100% coverage by your employer's worker's compensation insurance. In such cases, to ensure your coverage, it is your responsibility to report your injury to your employer in writing and fill out the appropriate reports. Failure to do so will jeopardize your coverage. Should your case be denied you would become liable for services rendered. **Mileage sheets will be available for $20.**

____**Auto Accidents/No Fault Insurance**: If you are seeking treatment because of an auto accident, you may be eligible for 100% coverage by your No-Fault Insurance. Some companies have a deductible that must be met first. It is your responsibility to contact your insurance company and fill out the appropriate reports. Should your insurance decline to pay for your case, you would become liable for all services rendered. **Mileage sheets will be available for $20.00**

_____ **Maintenance Care**: Elective healthcare defined as patient has achieved and maintained pre-complaint status, plateaued in improvement, and/or chronic symptoms show no progression in reduction or remain stable. Treatment intervals are at regular intervals (example: 1 time a week, every 2 weeks, every 4 weeks, etc.) Benefits of maintenance care include enhanced quality of life, improved health, prevention of future injury. This is a service not covered by the insurance company and you will be responsible for the office fee of $40. If you sustain a future incident or injury, your chiropractic care would again meet the criteria for acute care and would be covered by your health plan until that condition has achieved pre complaint status or plateaued in improvement.

There may be additional services/products needed to supplement your care.

I, the undersigned certify that I (or my dependent) have insurance coverage with ____________________ and assign directly to Chiropractic Associates of Rochester all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether paid by insurance. I hereby authorize the doctor to release all information necessary to secure the payment of benefits. I authorize the use of this signature on all insurance submissions.

- **Please note that our office does not allow a personal balance over $100 (unless other financial arrangements have been made in writing). Should your account become 60 days delinquent a $10 charge per month will be assessed to the outstanding balance.**
- **Payment is due at the time of service. Payment in the form of cash, check, HSA, Credit Card is accepted.**
- **Returned Checks will have a $25 service charge.**

____

Responsible Party Signature **Date**

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AUTHORIZATION FOR RELEASE OF INFORMATION:

TO: ______________________________________

____

____

SPECIFIC DESCRIPTION OF INFORMATION TO BE DISCLOSED:

______ Medical Records regarding ____

______ X-Rays and / or report of findings, CT Scans, MRI's

______ Consult reports from specialists

______ Test Results

______ Billing Records

______ Other ____

I understand the information disclosed pursuant to this authorization may be subject to redisclosure by the recipient and no longer protected by Federal privacy regulations.

Initials __________

I understand that this authorization is voluntary and that I may revoke it at anytime by submitting my revocation in writing to the entity providing the information. The revocation will only be effective from the date the written revocation is provided and will not apply retroactively.

Initials __________

I understand that this authorization will expire one (1) year from the date of the original signature indicated below.

Initials __________

Patient Name: ____

Date of Birth: ____________________

Signature of Patient ____Date: __________________

If under age 18 Signature of Guardian: ______________________________Date: __________________

Relationship to Patient: ____