NOTARO CHIROPRACTIC

Text: (716)534-8885

Fax: (866)907-6157

Grand Island:
2283 Grand Island Blvd
Grand Island, NY. 14072
(716) 773-2222

North Tonawanda:
603 Division St.
North Tonawanda, NY. 14120
(716) 693-0556

Niagara Falls:
10158 Niagara Falls Blvd
Niagara Falls, NY. 14304
(716) 298-0368

East Amherst:
4754 North French Rd.
East Amherst, NY. 14051
(716) 688-8815

Please use the back of this page to provide any additional relevant information.

Name: _____ Date of Birth: _____Sex: M F

Address:

_____

(Street) (City) (State) (Zip)

Marital Status: _____ Weight: _____ Height: _____

Social Security Number: _____-____-_____ Email: _____

Home Phone: _____ Cell Phone: _____ Accepts Text Messages? YES NO (Please circle which phone number to call for appointment reminders)

How did you hear about us? (Please explain; we have a referral program!)_____

Insurance Health Insurance Company Name: _____

Group #: _____ ID #: _____ Family Doctor Name:

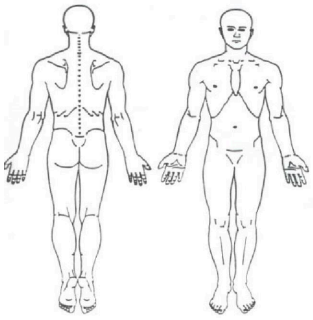
_____ Phone: _____ Name of Person on insurance: _____

Symptoms

Describe presenting complaint(s) in detail. Please indicate the current complaints you are experiencing by marking the areas on the image: _____

Approximate date your symptoms began: _____

Description of how your symptoms began: _____ _____



Are you currently working: YES NO

*If no, reason for unemployment: _____

Occupation & name of employer: _____

Address of employer: _____

Were you hurt at work: YES NO

Were you hurt in an automobile accident: YES NO

Would your employer be interested in complimentary safety lectures by our doctors? YES NO

Would you be interested in a nutritional program & supplements? YES NO

Have you ever seen a Chiropractor? YES & doctor's name is/was _____ NO

Have you had X-rays, MRI, CT-Scan, Bone Scan or Blood Work (please circle)

Where: _____ When: _____

Have you ever been treated for or suspected of having cancer in the past or present? YES NO Please list all medications, vitamins, minerals, and herbs you take: _____

_____

Please list all allergies/reactions to drugs, foods or other substances you have:

_____

Have you been in or had ANY accidents or injuries: NO YES When: _____ Please describe: _____

_____

Have you had any surgeries or fractures: NO YES List with dates: _____

Please list any family history of illnesses or diseases and the family member associated: _____

_____

Emergency Contact – Name: _____ Phone: _____

Signature:_____ Date:_____

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Patient Name: _____

AUTHORIZATION FOR RELEASE OF RECORDS:

To _____, I hereby authorize you to release to GRAND ISLAND CHIROPRACTIC any information including the diagnosis and records of any treatment or examination rendered to me during my period of treatment.

Date: _____ Signature: _____ Date: _____ Witness: _____

AUTHORIZATION FOR ASSIGNMENT OF BENEFITS:

I authorize payment of any medical benefits to be paid directly to GRAND ISLAND CHIROPRACTIC for any services rendered to me.

Date: _____ Signature: _____ Date: _____ Witness: _____

NOTICE OF PATIENT PRIVACY

By signing the below, I certify that I have received and reviewed this notice and all of my questions have been answered to my satisfaction in language that I can understand.

Name (Printed): _____ Signature: _____ Date: _____ Witness: ____

_____ _____

Signature of Legal Representative Relationship: (ex: Attorney-In-Fact, Guardian, Parent if a minor)

CONSENT TO TREAT

I have received information about my condition and proposed chiropractic treatment program as well as alternative courses of benefits, the risks and the side effects of the treatment and consequences of not having the proposed treatment. I understand that, as in all health care, in the practice of chiropractic there are some risks to treatment, including but not limited to muscle strains and sprains, fractures, dislocations, disc injuries and strokes. I do not expect the doctor to be able to anticipate or explain all the risks. I wish to rely on the doctor to exercise judgment during the course of the treatments which they feel at the time, based upon what is known, is in my best interest. My doctor has responded to all of my requests for information about the proposed treatment. I have, or have had read to me, the above consent. I have also had the opportunity to ask questions about its consent. By signing below, I authorize treatment.

Date: _____ Signature: _____ Date: _____ Witness: _____

ACKNOWLEDGEMENT OF FINANCIAL LIABILITY

I understand that I may be financially responsible for any charges incurred at this office, including co-payments, deductibles, all collection and/or legal fees on any unpaid account referred for collection, and charge denied or not covered by my insurance company. I realize my care may be subject to pre-authorization by the insurance company, and I accept any responsibility for charges, which may not be approved. The insurance company will review any/all documentation submitted by Grand Island Chiropractic for review for medical necessity and base their insurance, deductibles, referrals etc. I understand that this office agrees to notify me if a service is not covered and will notify me if the insurance company does not approve my care as soon as possible. If a treatment plan is approved, this office will make me aware of the number of office visits allowed. Initial visits may be denied and this may be beyond the office's ability to notify the patient prior to rendering acute care. While waiting for the insurance coverage approval. These charges will be the patient's responsibility if denied by the insurance company.

This office may seek payment from you for any services your health insurance plan determines to be not medically necessary. I have read and understand my obligations for payment for care in the absence of insurance coverage.

Date: _____ Signature: _____ Date: _____ Witness: _____

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NOTIFICATION CONSENT:

Notaro Chiropractic will now be sending reminder texts and calls for your convenience on upcoming appointments as friendly reminders.

Notaro Chiropractic will also be sending emails monthly for our new monthly promotions on supplies

*By signing this form, you agree to receive text messages, phone call and emails regarding appointments and promotions from Notaro Chiropractic, its management company Chiropractic Office Solutions, agents, contractors and assignees.

Audio and visual recordings may be used at the front desk for quality assurance. The recordings are kept secure and are destroyed pursuant to a routine deletion policy.

Thank you!

Signature: _____

Date: _____

Notaro Chiropractic & Massage Therapy Cancellation Policy

We require 24 hours notice for all canceled appointments so that other patients can be seen during those times.

If you cancel or no show with less than 24 hours notice, there were be the following fees:

Chiropractic $35

Massage $50

Thank you!

Signature: _____

Date: _____

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WORKERS COMPENSATION FORM

Name:_____ Date of accident:_____

Approximate time:_____ Location of accident (city):_____

WCB#_____ Carrier Case # _____

Place of employment at time of accident:_____

Address:_____ Phone #_____

Was this injury reported? Yes or No To Whom:_____

Was an accident report filled out? Yes or No

Please explain HOW you were injured and WHAT PART of your body was injured:

_____
_____
_____

Have you been on compensation for THIS condition before? Yes or No

If yes, please explain:_____

For this condition, were you taken to the hospital? Yes or No

If yes, please give name of hospital_____

Name all tests & x-rays performed and where for this injury:

_____
_____
_____

Please list all doctors treating you for this condition:

_____

_____

Are you presently working? Yes or No

Have you lost time from work due to this injury? Yes or No

If yes, please list dates:_____

Workers' Compensation Covers Chiropractic Care Completely. This sheet is for your protection in the event a hearing is necessary. In the event I fail to prosecute the claim for Workers' Compensation for this condition, or it is determined that there is no case, I _____

Agree to pay the treating doctors of Grand Island Chiropractic and/or Notaro Chiropractic her/her usual and customary fees and any collection fees plus a 10% surcharge for services to the above claimant in the identified case

Signature:_____ Date:_____

Termination of Care Waiver:

I hereby acknowledge and understand that if I do not keep appointment as recommend to me by my attending Doctor at this Chiropractic office, he/she has full and complete right to suspend my personal injury case with my third party carrier and relinquish and disability granted me within a reasonable period of time.

Signature:_____Date:_____

**If during the course of your case, your insurance company requires you to have an examination from any other doctor, you must notify us immediately.

OFFICE USE: Verified _____

NEW YORK STATE OF OPPORTUNITY. Workers' Compensation Board

Employee Claim

State of New York - Workers' Compensation Board

C-3

Fill out this form to apply for workers' compensation benefits because of a work injury or work-related illness. Type or print neatly. This form may also be filled out on-line at www.wcb.ny.gov.

WCB Case Number (if you know it): _____

A. YOUR INFORMATION (Employee)

1. Name: _____ (First / MI / Last) 2. Date of Birth: ____/____/____

3. Mailing address: _____ (Number and Street/PO Box/Apartment No. / City / State / Zip Code)

4. Social Security Number: ___-___-____ 5. Phone Number: (____) _____ 6. Gender: ☐ M ☐ F ☐ X

7. Will you need a translator if you have to attend a Board hearing? ☐ Yes ☐ No If yes, for what language? _____

B. YOUR EMPLOYER(S)

1. Employer when injured: _____ 2. Phone Number: (____) _____

3. Your work address: _____ (Number and Street / City / State / Zip Code)

4. Date you were hired: ____/____/____ 5. Your supervisor's name: _____

6. List names/addresses of any other employer(s) at the time of your injury/illness: _____

7. Did you lose time from work at the other employment(s) as a result of your injury/illness? ☐ Yes ☐ No

C. YOUR JOB on the date of the injury or illness

1. What was your job title or description? _____

2. What types of activities did you normally perform at work? _____

3. Was your job? (check one) ☐ Full Time ☐ Part Time ☐ Seasonal ☐ Volunteer ☐ Other: _____

4. What was your gross pay (before taxes) per pay period? _____ 5. How often were you paid? _____

6. Did you receive lodging or tips in addition to your pay? ☐ Yes ☐ No If yes, describe: _____

D. YOUR INJURY OR ILLNESS

1. Date of injury or date of onset of illness: ____/____/____ 2. Time of injury: _____ ☐ AM ☐ PM

3. Where did the injury/illness happen? (e.g., 1 Main Street, Pottersville, at the front door) _____

4. Was this your usual work location? ☐ Yes ☐ No If no, why were you at this location? _____

5. What were you doing when you were injured or became ill? (e.g., unloading a truck, typing a report) _____

6. How did the injury/illness happen? (e.g., I tripped over a pipe and fell on the floor) _____

7. Explain fully the nature of your injury/illness; list body parts affected (e.g., twisted left ankle and cut to forehead): _____

YOUR NAME: First M Last DATE OF INJURY/ILLNESS: ____/____/____

D. YOUR INJURY OR ILLNESS *continued*

8. Was an object (e.g., forklift, hammer, acid) involved in the injury/illness? ☐ Yes ☐ No If yes, what? _____

9. Was the injury the result of the use or operation of a licensed motor vehicle? ☐ Yes ☐ No
   If yes, ☐ your vehicle ☐ employer's vehicle ☐ other vehicle License plate number (if known): _____
   If your vehicle was involved, give name and address of your motor vehicle insurance carrier: _____

10. Have you given your employer (or supervisor) notice of injury/illness? ☐ Yes ☐ No
    If yes, notice was given to: _____ ☐ orally ☐ in writing Date notice given: ____/____/____

11. Did anyone see your injury happen? ☐ Yes ☐ No ☐ Unknown If yes, list names: _____

E. RETURN TO WORK

1. Did you stop work because of your injury/illness? ☐ Yes, on what date? ____/____/____ ☐ No, skip to Section F.
2. Have you returned to work? ☐ Yes ☐ No If yes, on what date? ____/____/____ ☐ regular duty ☐ limited duty
3. If you have returned to work, who are you working for now? ☐ Same employer ☐ New employer ☐ Self employed
4. What is your gross pay (before taxes) per pay period? _____ How often are you paid? _____

F. MEDICAL TREATMENT FOR THIS INJURY OR ILLNESS

1. What was the date of your first treatment? ____/____/____ ☐ None received (skip to question F-5)
2. Were you treated on site? ☐ Yes ☐ No
3. Where did you receive your first off site medical treatment for your injury/illness? ☐ none received ☐ Emergency Room
   ☐ Doctor's office ☐ Clinic/Hospital/Urgent Care ☐ Hospital Stay over 24 hours
   Name and address where you were first treated: _____
   _____ Phone Number: (____) _____
4. Are you still being treated for this injury/illness? ☐ Yes ☐ No
   Give the name and address of the doctor(s) treating you for this injury/illness: _____
   _____ Phone Number: (____) _____
5. Have you had another injury to the same body part, or a similar illness? ☐ Yes ☐ No
   If yes, were you treated by a doctor? ☐ Yes ☐ No If yes, provide the names and addresses of the doctor(s) who treated you and **COMPLETE AND FILE FORM C-3.3 TOGETHER WITH THIS FORM:**
   _____
   _____
   _____
6. Was the previous injury/illness work related? ☐ Yes ☐ No
   If yes, were you working for the same employer that you work for now? ☐ Yes ☐ No

I am hereby making a claim for benefits under the Workers' Compensation Law. My signature affirms that the information I am providing is true and accurate to the best of my knowledge and belief.

Any person who knowingly and with INTENT TO DEFRAUD presents, causes to be presented, or prepares with knowledge or belief that it will be presented to, or by an insurer, or self-insurer, any information containing any FALSE MATERIAL STATEMENT or conceals any material fact, SHALL BE GUILTY OF A CRIME and subject to substantial FINES AND IMPRISONMENT.

Employee's Signature: _____ Print Name: _____ Date: ____/____/____

On behalf of Employee: _____ Print Name: _____ Date: ____/____/____

An individual may sign on behalf of the employee only if they are legally authorized to do so and the employee is a minor, mentally incompetent or incapacitated.

I certify to the best of my knowledge, information and belief, formed after an inquiry reasonable under the circumstances, that the allegations and other factual matters asserted above have evidentiary support, or are likely to have evidentiary support after a reasonable opportunity for further investigations or discovery.

Signature of Attorney/Representative (if any): _____ Date: ____/____/____

Print Name: _____ Title: _____

ID No., if any: R _____ If Licensed Representative, License No.: _____ Expiration Date: ____/____/____

NEW YORK STATE | Workers' Compensation Board

Limited Release of Health Information (HIPAA)

State of New York - Workers' Compensation Board

C-3.3

WCB Case No. *(if you know it)*:

To Claimant: If you received treatment for a *previous* injury to the same body part or for an illness similar to the one described in your current Claim, fill out this form. This form allows the health care providers you list below to release health care information about your previous injury/illness to your employer's workers' compensation insurer. The federal HIPAA law (Health Insurance Portability and Accountability Act of 1996) says you have a right to get a copy of this form. If you do not understand this form, talk to your legal representative. If you do not have a legal representative, the Advocate for Injured Workers at the Workers' Compensation Board can help you. Call: 800-580-6665.

To Health Care Provider: A **copy** of this HIPAA-compliant release allows you to disclose health information. If you send records to the employer's workers' compensation insurer in response to this release, also mail copies to the Claimant's legal representative. (If no legal representative is listed below, send copies to the Claimant.) Health care providers who release records must follow New York state law and HIPAA.

This release is:

- **Voluntary.** Your health care provider(s) must give you the same care, payment terms, and benefits, whether you sign this form or not.
- **Limited.** It gives your health care provider(s) permission to release only those health records that are related to the previous illness/condition you describe below.
- **Temporary.** It ends when your current claim for compensation is established or disallowed and all appeals are exhausted.
- **Revocable.** You can cancel this release at any time. To cancel, send a letter to the health care provider(s) listed on this form. Also, send a copy of your letter to your employer's workers' compensation insurer and the Workers' Compensation Board. *Note: You may not cancel this release with respect to medical records already provided.*
- **For records only.** It gives your health care provider(s) listed on this form permission to send copies of your health care records to your employer's workers' compensation insurer.

This form does NOT allow your health care provider(s) to release the following types of information:

- **HIV-related information**
- **Psychotherapy notes**
- **Alcohol/Drug treatment**
- **Mental Health treatment** (unless you check below)
- **Verbal information** (your health care providers may not discuss your health care information with anyone)

Any medical records released will become part of your workers' compensation file and are confidential under the Workers' Compensation Law.

A. YOUR INFORMATION (Claimant)

1. Name: 2. Social Security Number: - -
3. Mailing Address:
4. Date of Birth: / / 5. Date of the current injury/illness: / /
6. Current injury/illness, including all body parts injured:
7. Your legal representative's name and address (if any):

☐ *Check here if you allow your health care provider(s) to release* ***mental health care*** *information.*

B. YOUR HEALTH CARE PROVIDER(S)

(List all health care providers who treated you for a *previous* injury to the same body part or similar illness. If more than 2 providers attach their contact information to this form.)

1. Provider: 2. Phone Number: ( )
3. Mailing Address:
4. Other provider (if any): 5. Phone Number: ( )
6. Mailing Address:

C. READ AND SIGN BELOW.

I hereby request that the health care provider(s) listed above give my employer's workers' compensation insurer copies of all health records related to any previous injury/illness, to all body parts, described above.

Claimant's signature (ink only -- use blue ballpoint pen, if possible.) Date

If the claimant is unable to sign, the person signing on the claimant's behalf must fill out and sign below:

Your name Relationship to Claimant Signature (ink only – use blue ballpoint pen, if possible.) Date

NOTICE THAT YOU MAY BE RESPONSIBLE FOR MEDICAL COSTS IN THE EVENT OF FAILURE TO PROSECUTE, OR IF COMPENSATION CLAIM IS DISALLOWED, OR IF AGREEMENT PURSUANT TO WCL §32 IS APPROVED

WCB CASE NO. (If Known)	CLAIM ADMIN CLAIM NUMBER (If Known)	DATE OF INJURY	NATURE OF INJURY OR ILLNESS	CLAIMANT'S SOC. SEC. NO.

CLAIMANT	NAME	ADDRESS	APT. NO.
EMPLOYER			
INSURANCE CARRIER			

You may become responsible for the medical costs of treatment for your illness or condition with the health care provider listed below if (1) you fail to prosecute the claim for workers' compensation or (2) it is determined by the Workers' Compensation Board that the illness or condition which required treatment was not a result of a compensable workplace accident or occupational disease or (3) if an agreement is executed by you and approved pursuant to Workers' Compensation Law §32 in which you waive your right to medical benefits from the workers' compensation insurer/self-insured employer for treatment/services performed after the date the agreement is approved. If any of the above events occurs, the provider may bill you directly instead of the employer or insurance carrier, and you will be responsible for the provider's fees for services rendered.

I hereby acknowledge that I have read the above and understand the circumstances under which I may become responsible for payment.

Claimant's Signature_____ Date _____

Provider's Name and Address _____

TO THE CLAIMANT

Workers' Compensation Board Regulation 325-1.23 permits your health care provider to request that you sign this A-9 notice. By signing this notice, you acknowledge your obligation to pay the provider's fees for the services you receive if it turns out that such fees are not legally required to be paid by your employer or its workers' compensation insurance carrier and if such fees are not covered by other insurance. The employer or insurer may not be required to pay the provider's fees if, for example, you fail to file a claim for workers' compensation, or fail to notify your employer of your injury or illness, or fail to attend a Board hearing if your employer challenges your right to benefits. Even if you make all required efforts to prosecute your claim, the Workers' Compensation Board may still find that you are not entitled to benefits. In such cases, this notice advises your health provider that you acknowledge your personal liability for payment of their bills.

Workers' Compensation Law Section 32

The A-9 notice also covers instances in which a claimant with an existing valid workers' compensation case comes to an agreement with their employer or its insurance carrier settling their case in accordance with Section 32 of the Workers' Compensation Law. A Section 32 agreement may include a provision which relieves the employer or insurer of the liability to pay future medical bills associated with the case. Your health care provider may ask you to sign this A-9 notice to insure that you acknowledge your personal liability for payment of their bills if you have waived your right to future medical benefits under a Section 32 agreement.

If you have any questions, contact your attorney or licensed hearing representative, if you have one. You may also contact your local district office of the Workers' Compensation Board.

TO THE HEALTH CARE PROVIDER

This notice is meant to advise the workers' compensation claimant that they may be responsible for payment. Failure of the claimant to sign this form does not relieve the provider of the obligation to treat the claimant, nor does it negate the claimant's responsibility for payment.

Keep the original of this form for your records and give a copy to the claimant. **Do not file with the Workers' Compensation Board.** You will receive Notices of Decisions in which the compensability of a claim, authorization of treatment, or payment of medical bills is included. You will also be notified if the claimant submits a Section 32 Agreement with the Board for approval. Do not bill the claimant unless and until you receive a Board decision finding that 1) claimant failed to prosecute the claim, or 2) the claim is denied, or 3) the treatment is not causally related to the work injury, or 4) a Section 32 agreement relieving the insurer of liability for medical treatment is approved.

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950 Maple Road
Williamsville, NY. 14221
(716)580-3044

Notaro Chiropractic
603 Division St.
North Tonawanda, NY. 14120
(716)693-0556

Thomas J. Notaro, D.C.
Michael C. Baase, D.C.
Curtis Gordon, D.C.
Megan Lafave, D.C.
Warren Marranca, D.C.
Scott Arends, D.C.
Emily Patrick, D.C.
April Williams, D.C.
Jake Eberth, D.C.
Michael Buziak, D.C
Joseph Schwartzott, D.C

INFORMATION REGARDING WORKERS' COMPENSATION & NO-FAULT INSURANCE:

This office has established a Workers' Compensation/No-Fault case for you. You MUST maintain the prescribed schedule of visits in order for us to keep your case active. If you miss an appointment, it is required that you call and reschedule your appointment. MISSED APPOINTMENTS- more than three without notice will result in thee suspension of your case

IT IS VERY IMPORTANT TO NOTIFY THE FRONT DESK OF THE FOLLOWING:

1. When you return or are taken off work. After you return to work, you <u>are still covered</u> under Workers' Compensation/No-Fault and should continue to schedule appointments.

2. When you receive notification to see an Independent Examiner or any other correspondence from the insurance carrier.

3. When you receive notice that the insurance carrier will no longer pay for your treatment.

4. When you receive an assigned Workers' Compensation number from the Workers' Compensation Board.

PLEASE NOTE:

Under Workers' Compensation and No-Fault you are entitled to mileage reimbursement. YOU MUST KEEP TRACK OF YOUR OFFICE VISITS and mail them to your insurance carrier. Our office will gladly furnish you with a mileage form or make copies of your file if you need them. WE WILL NOT FURNISH THE VISIT DATES FOR YOU FOR ANY REASON. PLEASE KEEP TRACK OF THEM TO RECEIVE YOUR REIMBURSEMENT.

Please initial here that you understand these terms _____ Patient

_____Witness

WORKERS' COMPENSATION PAYMENT POLICY

In the event that workers' compensation does not grant visits, you will be responsible for payment of all visits treated for.

By signing this, you agree to pay any visits denied for treatment.

Signature:_____

Date:_____

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

0	1	2	3	4
No pain	Mild pain	Moderate pain	Severe pain	Worst possible pain

2. Sleeping

0	1	2	3	4
Perfect sleep	Mildly disturbed sleep	Moderately disturbed sleep	Greatly disturbed sleep	Totally disturbed sleep

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

0	1	2	3	4
No pain; no restrictions	Mild pain; no restrictions	Moderate pain; need to go slowly	Moderate pain; need some assistance	Severe pain; need 100% assistance

4. Travel (driving, etc.)

0	1	2	3	4
No pain on long trips	Mild pain on long trips	Moderate pain on long trips	Moderate pain on short trips	Severe pain on short trips

5. Work

0	1	2	3	4
Can do usual work plus unlimited extra work	Can do usual work; no extra work	Can do 50% of usual work	Can do 25% of usual work	Cannot work

6. Recreation

0	1	2	3	4
Can do all activities	Can do most activities	Can do some activities	Can do a few activities	Cannot do any activities

7. Frequency of pain

0	1	2	3	4
No pain	Occasional pain; 25% of the day	Intermittent pain; 50% of the day	Frequent pain; 75% of the day	Constant pain; 100% of the day

8. Lifting

0	1	2	3	4
No pain with heavy weight	Increased pain with heavy weight	Increased pain with moderate weight	Increased pain with light weight	Increased pain with any weight

9. Walking

0	1	2	3	4
No pain; any distance	Increased pain after 1 mile	Increased pain after 1/2 mile	Increased pain after 1/4 mile	Increased pain with all walking

10. Standing

0	1	2	3	4
No pain after several hours	Increased pain after several hours	Increased pain after 1 hour	Increased pain after 1/2 hour	Increased pain with any standing

Name _____
PRINTED

_____
Signature

_____
Date

Total Score _____

PAIN DIAGRAM AND VISUAL ANALOG SCALE

Patient Name:_____ Age:_____

Dear Patient,

New York State Workers' Compensation Board and No-Fault Medical Treatment Guidelines require us to document a positive patient response to treatment. Positive results are defined primary as functional gains which can be objectivity measured.

Objective functional gains include, but are not limited to, positional tolerances, range of motion, strength, endurance, activates of daily living, cognition, psychological behavior and efficiency/velocity measure which can be qualified.

On the diagram below, please indicate where and what type of symptoms that you are experiencing right now. Write appropriate abbreviations (see key below) over the area of the body where those symptoms are occurring.

A= ACHE

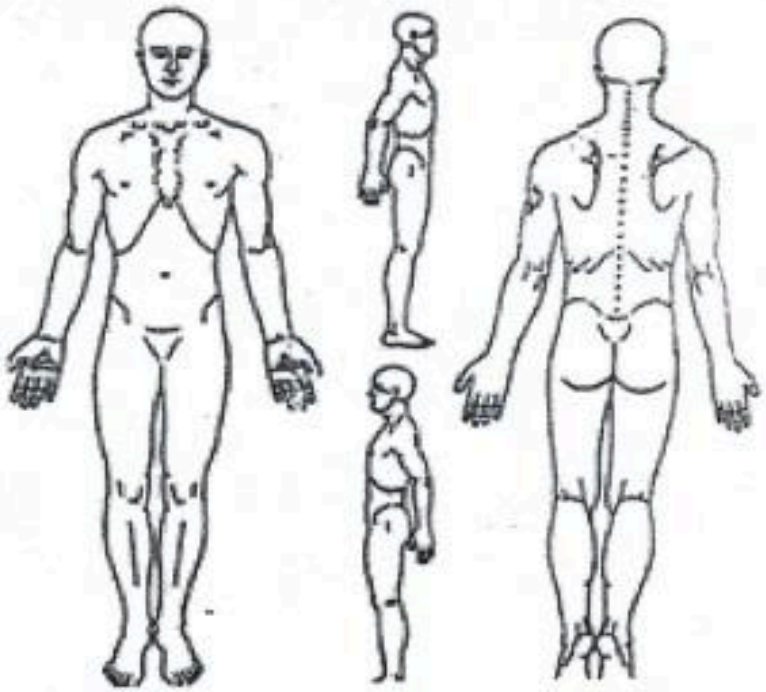
B= BURNING

N= NUMBNESS

P= PINS & NEEDLES

S= STABBING

O= OTHER_____



Instructions: Please ***circle*** that number that corresponds to the pain level that you are expecting.

Note: If you have more than one complaint, please indicate your pain levels for each complaint. Please indicate your pain level for

1. Your pain at its worst
2. Your pain right now
3. Your average pain level

Example:
No pain 0 1 2 3 4 5 6 7 8 9 10 Worst possible

1. My pain when it is at its worst is:

No pain 0 1 2 3 4 5 6 7 8 9 10 Worst possible

2. My pain right now is:

No pain 0 1 2 3 4 5 6 7 8 9 10 Worst possible

3. My average pain level is:

No pain 0 1 2 3 4 5 6 7 8 9 10 Worst possible

NAME_____ DATE OF EXAM _____
COMPLAINT_____
WEIGHT_____ HEIGHT _____ BLOOD PRESSURE _____R RESPIRATIONS _____ TEMP _____ PULSE _____ _____L

PRESENTING COMPLAINT(S) _____

HOW CHIEF COMPLAINT BEGAN AND DATE _____

PAST MVA OR SERIOUS ACCIDENTS OR TRAUMA'S _____

PAST SURGERY _____

DISABILITY PERCENTAGE: _____%

PAST NEURO/MUSCULO/SKELETAL CONDITIONS _____

SIGNIFICANT SOFT TISSUE FINDINGS _____

CERVICAL ROM: WNL___

Flexion(65) _____
Extension (50) _____
R. Lat Flex (55)_____
L. Lat Flex (55)_____
R. Rotation (80) _____
L. Rotation (80) _____

LUMBAR ROM: WNL _____

Flexion (90) _____
Extension (30 _____
R. Lat Flex (35)_____
L. Lat Flex (35)_____
R. Rotation (30) _____
L. Rotation (30) _____

ORTHO:

Compression	R_____	L_____	SLR	R_____	L_____	Yeomans Test	R_____	L_____
Shoulder Depr.	R_____	L_____	Well Leg R_____		L_____	Bil. Leg Raise	R_____	L_____
Soto Hall	R_____	L_____	Braggards Test	R_____	L_____	Becterews Test	R_____	L_____
Distraction	R_____	L_____	Kemps Test	R_____	L_____	Fabre Test	R_____	L_____
Valsalva	R_____	L_____	Valsalva	R_____	L_____			

NEURO:

Biceps	R_____	L_____	Patellar	R_____	L_____	Toe Walk	R_____	L_____
Brach Rad.	R_____	L_____	Achilles	R_____	L_____	Heel Walk	R_____	L_____
Triceps	R_____	L_____	Ext. Hallicus	R_____	L_____			
Myotomes	R_____	L_____	Dermatomes	R_____	L_____			
Dermatomes	R_____	L_____						

*CHIROPRACTIC FINDING: PALPATION

INSPECTION/POSTURAL_____

COMMENTS/FINDINGS/PRECAUTIONS/RECOMMENDATIONS: _____

BILLING REGIONS: 1-2, 3-4, +extremity

Examined By:_ _____ _____ _____ _____ _____

Dr Thomas Notaro | Dr Michael Baase | Dr Curtis Gordon | Dr. Megan Lafave | Dr. April Williams

_____ _____ _____ _____ _____ _____

Dr. Jake Eberth | Dr. Warren Marranca | Dr. Scott Arends | Dr. Brittany Gaston | Dr. Emily Patrick | Dr. Michael Buziak