A. Bastecki Health May Be As Easy As ... ABC

A. Bastecki Chiropractic

PATIENT APPLICATION FORM

WELCOME TO OUR OFFICE. We specialize in assisting our patients to achieve their ***Highest level of Health*** through our Spinal and Postural Rehabilitation programs, as well as other Natural health systems and solutions. Our approach is very Unique, Different and Advanced from other rehabilitation programs. This allows our patients to achieve far Superior results compared to most other systems.

Please fill out the following information **thoroughly** so the doctor can understand your Health history, profile and current conditions. This will best help him determine if he feels he can help, the course of evaluation needed and ultimately if he can accept your case which then will include his **BEST** recommendations to resolve/correct your condition.

Please feel free to ask any questions if you need assistance.

We look forward to serving you.

Patient Signature:_____

Date:_____

PATIENT APPLICATION SURVEY

Name: _____ (Age) _____ Gender: M☐ F☐

Home Address: _____ Home Phone: ( ) _____

City, State, Zip: _____ Work Phone: ( ) _____

Email Address: _____ Cell Phone: ( ) _____

Birth Date: _____/_____/_____ Social Security #: _____ - _____ - _____ Marital Status: S☐ M☐ D☐ W☐

Names of Children: _____ Ages: _____

Occupation: _____ Employer Name: _____

Spouse's Name: _____ Work Phone: ( ) _____ Cell Phone: ( ) _____

Spouse's Employer: _____ Occupation: _____

How were you referred to this office? _____

PURPOSE OF THIS VISIT

Reason for this visit: _____

Is this purpose related to an auto accident / work injury? ○Yes ○No If so, when: _____

Describe: _____

Please describe the pain & its location: _____

When did this condition begin? _____/_____/_____ When did you first notice it? _____

Is this condition getting worse? ○Yes ○No Is this condition: ○ Constant ○ Comes & goes ○ Activity related

Does complaint(s) interfere with: ☐Work ☐ Sleep ☐Hobbies ☐Daily Routine Explain: _____

What activities aggravate your symptoms? _____

Is there anything, which has relieved your symptoms? ☐Yes ☐No Describe: _____

Have you experienced this condition before? ☐Yes ☐No If so, please explain: _____

Who have you seen for this? _____ What did they do? _____

How did you respond? _____

EXPERIENCE WITH CHIROPRACTIC

Have you seen a Chiropractor before? ☐Yes ☐No Who? _____ When? _____

Reason for visits: _____

How did you respond? _____

Did your previous chiropractor take before and after x-rays? ☐Yes ☐No

Did you know posture determines your health? ☐Yes ☐No

Are you aware of any of your poor posture habits? ☐Yes ☐No

Explain: _____

Are you aware of any poor posture habits in your spouse or children? ☐Yes ☐No

Explain: _____

The most common postural weakness is Forward Head Syndrome (head and neck starting to bend forward and progressively moving downward weakening your whole body). Even less severe forms of this posture can cause many adverse affects on your overall health. Have you ever been told or fell like you carry your head forward, noticed a rounding of your shoulders or a developing "hump" at the base of your neck? Yes☐No☐

Date: _____

HEALTH LIFESTYLE

Do you exercise? ☐Yes ☐No How often? 1X ☐ 2X ☐ 3X ☐ 4X ☐ 5X ☐ per week other: _____

What activities? Running Jogging Weight Training Cycling Yoga Pilates Swimming _____

Do you smoke? Yes No How much? _____

Do you drink alcohol? Yes No How much / week? _____

Do you drink coffee? Yes No How many cups / day? _____

Do you take any supplements (i.e. vitamins, minerals, herbs)? _____

HEALTH CONDITIONS

Abnormal postural habits or distortions are the result of trauma or stress to the body that have misaligned the vertebrae in your spine. When these vertebrae are twisted from their normal position, they will cause stress to the spinal cord and the delicate nerves that pass between the vertebrae. These misalignments are called subluxations (sub-lux-a-shuns). It has been extensively documented that subluxations, causing stress to your nerves, will weaken and distort the overall structure of your spine. This results in a weakened and distorted POSTURE. Postural distortions have many serious and adverse affects on your overall health. The most common and detrimental postural distortion is called Forward Head Syndrome (a "hunched forward" posture starting in the neck and progressively moving down your spine weakening the entire body). Please check any health condition you may be experiencing, now or in the past.

CERVICAL SPINE (NECK):

Postural distortions from subluxations, (causing Forward Head Syndrome), in your neck will weaken the nerves into your arms, hands and head affecting these parts of your body. Do you experience…?

- ○ Neck Pain
- ○ Pain into your shoulders/arms/hands
- ○ Numbness/tingling in arms/hands
- ○ Hearing Disturbances
- ○ Weakness In Grip
- ○ Headaches
- ○ Dizziness
- ○ Visual Disturbances
- ○ Coldness In Hands
- ○ Thyroid Conditions
- ○ Sinusitis
- ○ Allergies/Hay fever
- ○ Recurrent Colds/Flu
- ○ Low Energy/Fatigue
- ○ TMJ/Pain/Clicking

Explain: _____

THORACIC SPINE (UPPER BACK):

Postural distortions from subluxations (resulting from Forward Head Syndrome) in the upper back will weaken the nerves to the heart and lungs and affect these parts of your body. Do you experience…?

- ○ Heart Palpitations
- ○ Heart Murmurs
- ○ Tachycardia
- ○ Heart Attacks/Angina
- ○ Recurrent Lung Infections/Bronchitis
- ○ Asthma/Wheezing
- ○ Shortness Of Breath
- ○ Pain On Deep Inspiration/Expiration

THOPRACIC SPINE (MID BACK):

Postural distortions from subluxations (resulting from Forward Head Syndrome) in the mid back will weaken the nerves into your ribs/chest and upper digestive tract, and affect these parts of your body. Do you experience…?

- ○ Mid Back Pain
- ○ Pain Into Your Ribs/Chest
- ○ Indigestion/Heartburn
- ○ Reflux
- ○ Nausea
- ○ Ulcers/Gastritis
- ○ Hypoglycemia
- ○ Tired/Irritable after eating or when you haven't eaten for a while

LUMBAR SPINE (LOW BACK):

Postural distortions from subluxations in the low back (resulting from Forward Head Syndrome) will weaken the nerves into your legs/feet and pelvic organs and affect these parts of your body. Do you experience…?

- ○ Pain into your hips/legs/feet
- ○ Numbness/tingling in your legs/feet
- ○ Coldness in your legs/feet
- ○ Muscle cramps in your legs/feet
- ○ Constipation / Diarrhea
- ○ Weakness/injuries in your hips/knees/ankles
- ○ Recurrent Bladder Infections
- ○ Frequent/Difficulty Urinating
- ○ Menstrual Irregularities/Cramping (females)
- ○ Sexual Dysfunction
- ○ Low Back Pain

Please list any health conditions not mentioned: _____

Please list any medications / surgeries: _____

FAMILY HEALTH HISTORY

Have you or any of your family members ever been diagnosed with the following:

- ☐ Diabetes
- ☐ Rheumatic Fever
- ☐ High Blood Pressure
- ☐ Kidney Disease
- ☐ Liver Disease
- ☐ Broken Bones/Fractures
- ☐ Pneumonia
- ☐ Whooping Cough
- ☐ Thyroid
- ☐
- ☐ Varicose Veins
- ☐ Circulatory Problems
- ☐ Heart Disease
- ☐ Epilepsy/Seizures
- ☐ Metal Implants
- ☐ Appendectomy
- ☐ Polio
- ☐ Chicken Pox
- ☐ Small Pox
- ☐
- ☐ Neurological Problems
- ☐ Stroke
- ☐ Cancer
- ☐ Migraine Headaches
- ☐ Infectious Disease
- ☐ Rheumatoid Arthritis
- ☐ Tuberculosis
- ☐ Mumps
- ☐ Influenza
- ☐ Lumbago
- ☐ Lung Disease
- ☐ Heart Murmur
- ☐ Osteoporosis
- ☐ Arthritis
- ☐ Gall Bladder
- ☐ Hernia
- ☐ Anemia
- ☐ Multiple Sclerosis
- ☐ Sexually Transmitted Disease
- ☐ Eczema

☐ Other: _____

When a patient seeks chiropractic health care and we accept a patient for such care, it is essential for both to be working towards the same objective.

Chiropractic has only one goal: to eliminate misalignments within the spine column which interfere with the expression of the body's innate healing ability. It is important that each patient understand both the objective and the method that will be used to attain our goal. This will prevent any confusion or disappointment.

Adjustment: The specific application of forces to faciliate the body's correction of vertebral subluxation. Our chiropractic method of correction is specific adjustments of the spine.

Health: A state of optimal physical, mental and social well-being, not merely the absence of disease, pain, or infirmity.

Vertebral Subluxation: A misalignment of one or more of the 24 vertebrae in the spinal column which causes alteration of nerve function and interference to the transmission of mental impulse, resulting in the lessening of the body's ability to express its maximum health potential.

We do not offer to diagnose or treat any disease or condition other than vertebral subluxation. However, if during the course of chiropractic spinal examination we encounter non-chiropractic or unusual findings, we will recommend that you seek the services of a health care provider who specializes in that area.

Regardless of what the disease is called, we do not offer to treat it. Nor do we offer advice regarding treatment prescribed by others. OUR ONLY PRACTICE OBJECTIVE is to eliminate major interference to the expression of the body's innate healing wisdom. Our only method is specific adjusting to correct vertebral subluxations.

I, _____ have read and fully understand the above statements.

All questions regarding doctors objectives pertaining to my care in this office have been answered to my complete satisfaction.

I, therefore, accept chiropractic care on this basis.

Signature _____ Date _____

Consent to evaluate and adjust a minor child

I, _____ being the parent or guardian of

_____ have read and fully understand the above terms of Acceptance and hereby grant permission for my child to receive chiropractic care.

HEALTHCARE AUTHORIZATION FORM

THE FOLLOWING AUTHORIZES A. BASTECKI CHIROPRACTIC TO USE AND/OR DISCLOSE PROTECTED HEALTH CARE INFORMATION IN ACCORDANCE WITH THE FOLLOWING SPECIFIC AUTHORIZATIONS:

I give permission to A. Bastecki Chiropractic to use my name, address, phone numbers and clinical records to contact me with birthday cards, holiday related cards, health related e-mails messages and information about treatment alternatives or other health related information as well as any advertisements, newsletters or patient of the week/month postings.

I give permission to A. Bastecki Chiropractic to treat me in an open room where other patients are also being treated. I am aware that other persons in the office may overhear some of my protective health care information during the course of my treatment. Should I need to speak with a doctor or physical therapist in private, the doctor or therapist will provide a private room for these conversations.

By signing the following you are giving A. Bastecki Chiropractic permission to use and disclose your protected health information in accordance with the directives listed above

ACKNOWLEDGEMENT OF RECIEPT & NOTICE OF PRIVACY PRACTICES

I _____ understand and have been provided with a notice of information practices that provides me a more complete description of information uses and disclosures, I understand that I have the following rights and privileges:

* The right to review the notice prior to signing this consent
* The right to object to the use of my health care information for directory purpose
* The right to request restrictions as to how my health care information may be used or disclosed in this office to carry out treatment, payment, or health care operations

RADIOGRAPH CONSENT

I _____ do hereby give my consent to allow A. Bastecki Chiropractic and it's representatives, as deemed by the examining physician to take radiographs of my spine and/or extremities.

I also hereby declare that to my knowledge that I am not pregnant _____ (Initial)

Signature of Patient/or Guardian of said Minor _____ Date _____

INSURANCE INFORMATION

I clearly understand that all insurance coverage, whether accident, work related, or general coverage is an arrangement between my insurance carrier and myself. A. Bastecki Chiropracticwill bill any services to my insurance carrier that they are performing these services are strictly as a convenience to me. A. Bastecki Chiropractic will provide any necessary reports or required information to aid in insurance reimbursement of services, but I understand that insurance carriers may deny my claims and that I am ultimately responsible for any unpaid balances.

I understand there could be some services that my insurance company does not cover, if this is the case are you willing to pay for these services ☐YES ☐NO

Patients Signature_____ Date_____

Guardian or Spouse's Signature Authorizing Care_____ Date_____

I hereby authorize A. Bastecki Chiropractic to administer care as deemed necessary to my child, a minor under the age of 18 years old.

Name of Insurance Co. _____ Policy#_____

Address_____ Phone # _____

Insured's Name_____ Insured's SS# _____

Relationship to Insured _____ Birthdate _____/_____/_____

Employer_____

Who should receive charges on your account?

☐ Patient ☐ Spouse ☐ Parent/Guardian ☐ Workers Comp ☐ Auto Insurance

☐ Medicare ☐ Personal Health Insurance

Spinal Rehabilitation Consent and Waiver

Part of the treatment at A. Bastecki Chiropractic involves specific spinal and physical exercise that may cause injury if used improperly. I, on behalf of myself, understand that there is an inherent risk of injury when choosing to participate in any physical rehabilitative activities. Use of the spinal and postural correction equipment is an integral part of my health and postural restoration process and will be instructed to me before I can start such activities. I, on behalf of myself, assume all risks of injury and illness that may result from such use. This includes use of the wobble chairs, traction equipment, treadmill, therapy ball chairs, vibratory platforms or any other equipment located in A.Bastecki Chiropractic.

I on behalf of myself, do hereby fully release and discharge the A.Bastecki Chiropractic and their employees from any and all liability, claims and causes of action from injuries or illness, damages or loss which I, on behalf of myself, may have or which may accrue to me on account of participation in all activities utilizing the facility.

Signature of Patient _____ Date _____

Neck Pain and Disability Index

Name: _____ Chart #: _____ Date: _____

Please Read Instructions:

This questionnaire has been designed to give the doctor information as to how your neck pain has affected your ability to manage in everyday life. In each section, please fill in ONE circle only which most closely describes your problem.

Section 1 - Pain Intensity

- ○ A. I have no pain at the moment.
- ○ B. The pain is very mild at the moment.
- ○ C. The pain is moderate at the moment.
- ○ D. The pain is fairly severe at the moment.
- ○ E. The pain is very severe at the moment.
- ○ F. The pain is the worst imaginable at the moment.

Section 2 - Personal Care

- ○ A. I can look after myself normally without causing extra pain.
- ○ B. I can look after myself normally but it causes extra pain.
- ○ C. It is painful to look after myself and I am slow and careful.
- ○ D. I need some help but manage most of my personal care.
- ○ E. I need help every day in most aspects of self care.
- ○ F. I do not get dressed, I wash with difficulty and stay in bed.

Section 3 - Lifting

- ○ A. I can lift heavy weight without extra pain.
- ○ B. I can lift heavy weight but it gives extra pain.
- ○ C. Pain prevents me from lifting heavy weights off the floor, but I can manage if they are conveniently positioned.
- ○ D. Pain prevents me from lifting heavy weights, but I can manage light-medium weights if they are conveniently positioned.
- ○ E. I can lift very light weights.
- ○ F. I cannot lift or carry anything at all.

Section 4 - Reading

- ○ A. I can read as much as I want with no pain in my neck.
- ○ B. I can read as much as I want with slight pain in my neck.
- ○ C. I can read as much as I want with moderate pain in my neck.
- ○ D. I can't read as much as I want because of moderate pain in my neck.
- ○ E. I can hardly read at all because of severe pain in my neck.
- ○ F. I cannot read at all.

Section 5 - Headaches

- ○ A. I have no headaches at all.
- ○ B. I have slight headaches which come infrequently.
- ○ C. I have moderate headaches which come infrequently.
- ○ D. I have moderate headaches which come frequently.
- ○ E. I have severe headaches which come frequently.
- ○ F. I have headaches almost all the time.

Section 6 - Concentration

- ○ A. I can concentrate fully when I want with no difficulty
- ○ B. I can concentrate fully when I want with slight difficulty.
- ○ C. I have a fair degree of difficulty in concentrating when I want.
- ○ D. I have a lot of difficulty in concentrating when I want.
- ○ E. I have a great degree of difficulty in concentrating when I want.
- ○ F. I cannot concentrate at all.

Section 7 - Work

- ○ A. I can do as much work as I want.
- ○ B. I can only do my usual work, but no more.
- ○ C. I can do most of my usual work, but no more.
- ○ D. I can hardly do any work at all.
- ○ E. I cannot do my usual work.
- ○ F. I can't do any work at all.

Section 8 - Driving

- ○ A. I can drive my car without any neck pain.
- ○ B. I can drive my car as long as I want with slight pain in my neck.
- ○ C. I can drive my car as long as I want with moderate pain.
- ○ D. I can't drive my car as long as I want because of moderate pain.
- ○ E. I can hardly drive at all because of severe pain in my neck.
- ○ F. I can't drive my car at all.

Section 9 - Sleeping

- ○ A. I have no trouble sleeping.
- ○ B. My sleep is slightly disturbed (less than 1 hr. sleepless).
- ○ C. My sleep is mildly disturbed (1-2 hrs. sleepless).
- ○ D. My sleep is moderately disturbed (2-3 hrs. sleepless).
- ○ E. My sleep is greatly disturbed (3-5 hrs. sleepless).
- ○ F. My sleep is completely disturbed (5-7 hrs. sleepless).

Section 10 - Recreation

- ○ A. I am able to engage in all recreational activities with no neck pain.
- ○ B. I am able to engage in all my recreational activities, with some pain in my neck.
- ○ C. I am able to engage in most, but not all of my usual recreational activities because of pain in my neck.
- ○ D. I am able to engage in a few of my usual recreational activities because of pain in my neck.
- ○ E. I can hardly do any recreational activities because of pain.
- ○ F. I can't do any recreational activities at all.

Office Use Only

Score: _____

I understand that the information I have provided above is current and complete to the best of my knowledge.

Signature: _____

Revised Oswestry Low Back Pain and Disability

Name: _____ **Chart #:** _____ **Date:** _____

Please Read Instructions:

This questionnaire has been designed to give the doctor information as to how your low back pain has affected your ability to manage in everyday life. In each section, please fill in ONE circle which most closely describes your problem.

Section 1 - Pain Intensity

- ○ A. The pain comes and goes and is very mild.
- ○ B. The pain is mild and does not vary much.
- ○ C. The pain comes and goes and is moderate.
- ○ D. The pain is moderate and does not vary much.
- ○ E. The pain comes and goes and is very severe.
- ○ F. The pain is severe and doesn't vary much.

Section 2 - Personal Care

- ○ A. I can look after myself normally without causing extra pain.
- ○ B. I can look after myself normally but it causes extra pain.
- ○ C. It is painful to look after myself and I am slow and careful.
- ○ D. I need some help but can manage most of my personal care.
- ○ E. I need help every day in most aspects of self care.
- ○ F. I do not get dressed, I wash with difficulty and stay in bed.

Section 3 - Lifting

- ○ A. I can lift heavy weight without extra pain.
- ○ B. I can lift heavy weight but it gives extra pain.
- ○ C. Pain prevents me from lifting heavy weights off the floor.
- ○ D. Pain prevents me from lifting heavy weights, but I can manage if they are conveniently positioned.
- ○ E. Pain prevents me from lifting heavy weights, but I can manage light-medium weights if they are conveniently positioned.
- ○ F. I can only lift very light weights at the most.

Section 4 - Walking

- ○ A. I have no pain walking.
- ○ B. I cannot walk more than one mile without increasing pain.
- ○ C. I cannot walk more than 1/2 mile without increasing pain.
- ○ D. I cannot walk more than 1/4 mile without increasing pain.
- ○ E. I can walk with crutches.
- ○ F. I cannot walk at all without increasing pain.

Section 5 - Sitting

- ○ A. I can sit in any chair as long as I like.
- ○ B. I can only sit in my favorite chair as long as I like.
- ○ C. Pain prevents me from sitting more than one hour.
- ○ D. Pain prevents me from sitting more than a half hour.
- ○ E. Pain prevents me from sitting more than 10 minutes.
- ○ F. I avoid sitting because it increases pain straight away.

Section 6 - Standing

- ○ A. I can stand as long as I want without pain.
- ○ B. I have some pain on standing but it does not increase with time.
- ○ C. I cannot stand for longer than one hour without increasing pain.
- ○ D. I cannot stand for longer thanf 1/2 hour without increasing pain.
- ○ E. I can't stand for longer than 10 minutes without increasing pain.
- ○ F. I avoid standing because it increases the pain straight away.

Section 7 - Sleeping

- ○ A. I get no pain in bed.
- ○ B. I get pain in bed but it doesn't prevent me from sleeping well.
- ○ C. Because of pain my normal night's sleep is reduced by < 1/4.
- ○ D. Because of pain my normal night's sleep is reduced by < 1/2.
- ○ E. Because of pain my normal night's sleep is reduced by < 3/4.
- ○ F. Pain prevents me from sleeping at all.

Section 8 - Traveling

- ○ A. I get no pain while traveling.
- ○ B. I get some pain while traveling but none of my usual forms of travel make it any worse.
- ○ C. I get extra pain while traveling but it does not compel me to seek alternative forms of travel.
- ○ D. I get extra pain while traveling which compels me to seek alternative forms of travel.
- ○ E. Pain restricts all forms of travel.
- ○ F. Pain prevents all forms of travel except that done lying down.

Section 9 - Social Life

- ○ A. My social life is normal and gives me no pain.
- ○ B. My social life is normal but increases the degree of pain.
- ○ C. Pain limits my more energetic interests, e.g. dancing, etc.
- ○ D. Pain has restricted my social life and I do not go out very often.
- ○ E. Pain has restricted my social life to my home.
- ○ F. I have hardly any social life because of the pain.

Section 10 - Changing Degree of Pain

- ○ A. My pain is rapidly getting better.
- ○ B. My pain fluctuates but overall is definitely getting better.
- ○ C. My pain seems to be getting better but improvement is slow.
- ○ D. My pain is neither getting better nor worse.
- ○ E. My pain is gradually worsening.
- ○ F. My pain is rapidly worsening.

Office Use Only

Score: _____

I understand that the information I have provided above is current and complete to the best of my knowledge.

Signature: _____

QUADRUPLE VISUAL ANALOGUE SCALE

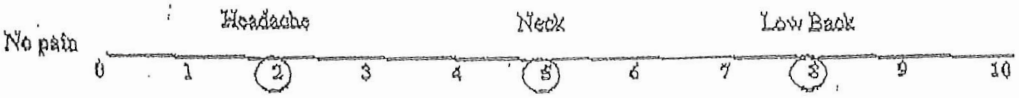
Patient Name _____ Date _____

Please read carefully:

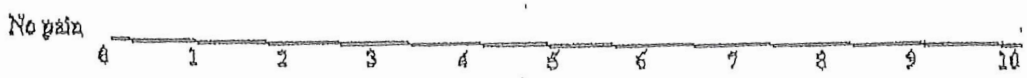
Instructions: Please circle the number that best describes the question being asked.

Note: If you have more than one complaint, please answer each question for each individual complaint and indicate the score for each complaint. Please indicate your pain level right now, average pain, and pain at its best and worst.

Example:

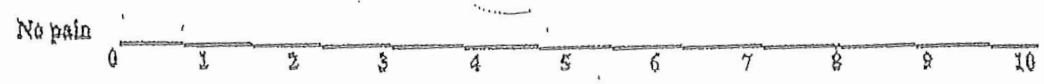


1 – What is your pain RIGHT NOW?



2 – What is your TYPICAL or AVERAGE pain?

3 – What is your pain level AT ITS BEST (How close to "0" does your pain get at its best)?



4 – What is your pain level AT ITS WORST (How close to "10" does your pain get at its worst)?

OTHER COMMENTS:

_____

_____

_____
Examiner

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