

CHIROPRACTIC *Naturally*  
337 Belgrade Ave  
Roslindale, MA 02131  
Tel: (857) 273-4162 Fax: (857) 273-3946

## New Patient Registration Form

**Date:** \_\_\_\_\_ ( ) Insurance ( ) Wellness/Maintenance ( ) Auto Accident ( ) Worker's Comp ( ) Slip and Fall

**Patient name:** \_\_\_\_\_ **Patient SSN:** \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_ **DOB:** \_\_\_\_/\_\_\_\_/\_\_\_\_

**Address:** \_\_\_\_\_ **City:** \_\_\_\_\_ **State:** \_\_\_\_\_ **Zip code:** \_\_\_\_\_

**Email:** \_\_\_\_\_ **(Cell)** \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_ **(Home)** \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_ **(Work)** \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_

**Date of Accident/Injury** \_\_\_\_\_ **Date of first Symptoms** \_\_\_\_\_ **Emergency Contact (Name/#):** \_\_\_\_\_

**Occupation:** \_\_\_\_\_ **Sex:** ( ) Male ( ) Female **Marital Status:** ( ) Single ( ) Married ( ) Divorced ( ) Widowed ( ) Minor

**Patient Employer/School:** \_\_\_\_\_ **Spouse's name/DOB:** \_\_\_\_\_

**MAY WE SEND YOUR PHYSICIAN INFORMATION ABOUT YOUR CONDITION?** ( ) YES ( ) NO

**Primary Care Physician Name:** \_\_\_\_\_ **Office Telephone:** \_\_\_\_\_

### INSURANCE INFORMATION

**Insurance Company:** \_\_\_\_\_ **Group#:** \_\_\_\_\_ **Member#** \_\_\_\_\_

**Subscriber name and DOB (if different from patient):** \_\_\_\_\_ **Relationship to patient:** \_\_\_\_\_

**Do you have secondary insurance? (Provide information listed above):** \_\_\_\_\_

### ASSIGNMENT AND RELEASE

I certify that I, and/or my dependent (s), have insurance coverage with \_\_\_\_\_ and assigned directly to Dr. Imonti or Dr. Robin all insurance benefits, if any, otherwise payable to me services rendered. I understand that I am financial responsible for all charges whether or not paid by insurance. I authorize the use of my signature on all insurance submissions. The above named Chiropractor may use my healthcare information and may disclose such information to the above named insurance company (ies) and their agents for the purpose of obtaining payment for services and determining insurance benefits or the benefits payable for related services. This consent will end when my current treatment plan is completed or 1 year from the date signed below.

**Patient/Representative Signature:** \_\_\_\_\_ **Date:** \_\_\_\_\_

**Print Patient/Representative Name:** \_\_\_\_\_ **Relationship to Patient:** \_\_\_\_\_

### HIPAA PATIENT CONSENT FORM

Our Notice of Privacy Practices provides information about how we may use and disclose protected health information about you. The Notice contains a Patient's Rights section describing your rights under the law. You have the right to review our Notice before signing this Consent. The terms of our Notice may change. If we change our Notice, you may obtain a revised copy by contacting our office. You have the right to request that we restrict how protected health information about you is used or disclosed for treatment, payment, or health care operations. We are not required to agree to this restriction, but if we do, we shall honor that agreement. By signing this form, you consent to our use and disclosure of protected health information about you for treatment, payment, and health care options. You have the right to revoke this Consent, in writing, signed by you. However, such a revocation shall not affect any disclosures we have already made based on your prior Consent. The Practice provides this form to comply with the Health Insurance Portability and Accountability Act of 1996 (HIPAA).

The Patient Understands that: • Protected health information may be disclosed or used for treatment, payment, or health care operations. • The Practice has a Notice of Privacy Practices and the patient has the opportunity to review this Notice. • The Practice reserves the right to change the Notice of Privacy Practices. • The patient has the right to restrict the use of their information but the Practice does not have to agree to those restrictions. • The patient may revoke this consent in writing at any time and all future disclosures will then cease. • The Practice may condition receipt of treatment upon the execution of this Consent.

This consent was signed by Printed Name: \_\_\_\_\_

**Patient or Representative Signature** \_\_\_\_\_ **Date** \_\_\_\_\_

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## Informed Consent

**Chiropractic:** It is important to acknowledge the difference between the health care specialties of Chiropractic, Osteopathy and Medicine. Chiropractic healthcare seeks to restore through natural means with the use of medicine or surgery. This gives the body maximum opportunity to utilize its inherent recuperative powers. The success of the chiropractic doctor's procedures often depend on environment, underlying causes, physical and spinal conditions. It is important to understand what to expect from chiropractic health care services.

**Analysis:** A doctor of chiropractic conducts a clinical analysis for the express purpose of determining whether there is evidence of Vertebral Subluxation Syndrome (VS) or Vertebral Subluxation Complexes (VSC). When such VSS or VSC complexes are found, chiropractic adjustments and ancillary procedures may be given in an attempt to restore spinal integrity. It is the chiropractic premise that spinal alignment allows nerve transmission throughout the body and gives the body an opportunity to use its inherent recuperative powers.

**Diagnosis:** Although doctors of chiropractic are experts in chiropractic diagnosis, the VSS and VSC, they are not internal medical specialists. Every chiropractic patient should be mindful of his/her own symptoms and should secure other opinions if he/she has any concern as to the nature of his/her total condition. Your doctor of chiropractic may express an opinion as to whether or not you should take this step, but you are responsible for the final decision.

**Informed consent for chiropractic care:** A patient, coming to the doctor of chiropractic, gives the doctor permission and authority to care for the patient in accordance with the chiropractic tests, diagnosis and analysis. The chiropractic adjustment or other clinical procedures are usually beneficial and seldom cause any problems. In rare cases, increased pain, muscle spasms, or rib injury underlying physical defects, deformities or pathologies may render the patient susceptible to injury. The doctor of course, will not give a chiropractic adjustment, or health care, if he/she is aware that such care may be contraindicated. Again, it is the responsibility of the patient to make it known or to learn through health care procedures whatever he/she is suffering from: latent pathological defects, illnesses, or deformities which would otherwise not come to the attention of the doctor of chiropractic. The patient is provided a specialized, non-duplicating health service. The doctor of chiropractic is licensed in a special practice and is available to work with other types of providers in your health regime.

**Results:** The purpose of chiropractic services is to promote natural health through the reduction of VSS and/or VSC. Since there are so many variables, it is difficult to predict the time schedule or efficacy of the chiropractic procedures. Sometimes the response is phenomenal. In most cases there is a more gradual, but quite satisfactory response. Occasionally, the results are less than expected. Two or more similar conditions may respond differently to the same chiropractic care. May medical failures find quick relief through chiropractic. In turn, we must admit that conditions which do not respond to chiropractic care may come under the control or be helped through medical science. The fact is that the science of chiropractic and medicine may never be so exact as to provide definite answers to all problems. Both have made great strides in alleviating pain and controlling disease.

**Acknowledgement and Understanding:** It is further understood that I, the undersigned, agree to pay the full amount of the charges should my condition be such that it is not covered by my policy, or if, for any reason, the insurance company and/or my attorney refused to pay my balance at this office. I understand that I am responsible for whatever fees my insurance company does not pay on my claim. (Typically, this includes deductibles and/or co-payments). \_\_\_\_\_

**To the Patient:** Please discuss any questions or problems with the doctor before signing this state of policy. I have read and understand the foregoing.

\_\_\_\_\_  
Patient Name (Print)

\_\_\_\_\_  
Patient Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Patient name (If patient is under 18 yrs. old)

\_\_\_\_\_  
Parent or Legal Guardian

\_\_\_\_\_  
Relationship to Patient

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**MEDICAL RECORDS REQUEST**

I, \_\_\_\_\_, do hereby authorize \_\_\_\_\_  
Patients name Hospital Name

to furnish all my records concerning examination, diagnosis, x-rays, treatments, prognosis, etc. to:

**Chiropractic *Naturally***  
337 Belgrade Avenue  
Roslindale, MA 02131

Date of Accident \_\_\_\_/\_\_\_\_/\_\_\_\_  
Visit of \_\_\_\_/\_\_\_\_/\_\_\_\_  
Date of Request \_\_\_\_/\_\_\_\_/\_\_\_\_

Records of \_\_\_\_\_  
Date of Birth \_\_\_\_\_  
Social Security # \_\_\_\_\_

\_\_\_\_\_  
Patient Signature

\_\_\_\_\_  
Date

*A copy of this authorization shall have the same force and effect as the original.*  
**Please enclose any tests along with the medical records.**  
***If the patient is a minor (under age 18), parent of legal guardian must sign below:***

\_\_\_\_\_  
Parent/legal guardian signature

\_\_\_\_\_  
Relation to patient

\_\_\_\_\_  
Date

## NECK DISABILITY INDEX QUESTIONNAIRE

Patient Name \_\_\_\_\_ Date \_\_\_\_\_

Please read carefully:

*This questionnaire has been designed to enable us to understand how your neck pain has affected your ability to manage everyday life. Please answer every section, and mark in each section only **ONE CHOICE** which applies to you. We realize you may consider that two of the statements in any one section relate to you but please just mark the one box, which most closely describes your problem right now.*

### 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 (washing, dressing, etc.)

- A. I can look after myself 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, wash with difficulty and stay in bed.

### SECTION 3 – Lifting

- A. I can lift heavy weights without extra pain.
- B. I can lift heavy weights but it gives extra pain.
- C. Pain prevents me from lifting heavy objects off the floor, but I can manage if they are conveniently positioned, e.g. on a table.
- D. Pain prevents me from lifting heavy weights but I can manage light to 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 cannot 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 to with no difficulty.
- B. I can concentrate fully when I want to with slight difficulty.
- C. I have a fair degree of difficulty in concentrating when I want to.
- D. I have a lot of difficulty in concentrating when I want to.
- E. I cannot concentrate at all.

### SECTION 7 – Work

- A. I can do as much work as I want to.
- 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 cannot do my usual work.
- E. I can hardly do any work at all.
- F. I cannot do any work at all.

### SECTION 8 – Driving

- A. I can drive without any neck pain.
- B. I can drive as long as I want with slight pain in my neck.
- C. I can drive as long as I want with moderate pain in my neck.
- D. I cannot drive as long as I want because of moderate pain in my neck.
- E. I can hardly drive at all because of severe pain in my neck.
- F. I cannot 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 (2-5 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 my recreation activities with no neck pain at all.
- B. I am able to engage in all my recreation activities with some pain in my neck.
- C. I am able to engage in most, but not all of my usual recreation activities because of pain in my neck.
- D. I am able to engage in a few of my usual recreation activities because of pain in my neck.
- E. I can hardly do any recreation activities because of pain in my neck.
- F. I cannot do any recreation activities at all.

### OTHER COMMENTS:

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Examiner \_\_\_\_\_

SCORE: \_\_\_\_\_

## REVISED OSWESTRY LOW BACK PAIN DISABILITY QUESTIONNAIRE

**PLEASE READ:** This questionnaire is designed to enable us to understand how much your low back pain has affected your ability to manage your everyday activities. Please answer each section by circling the **ONE CHOICE** that most applies to you. We realize that you may feel that more than one statement may relate to you, but **PLEASE JUST CIRCLE ONE CHOICE WHICH MOST CLOSELY DESCRIBES YOUR PROBLEM RIGHT NOW.**

<b>SECTION 1 – Pain Intensity</b> 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 severe. F. The pain is severe and does not vary much.	<b>SECTION 6 – Standing</b> A. I can stand as long as I want without pain. B. I have some pain while 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 than ½ hour without increasing pain. E. I cannot stand for longer than ten minute without increasing pain. F. I avoid standing, because it increases the pain straight away.
<b>SECTION 2 – Personal Care</b> A. I would not have to change my way of washing or dressing in order to avoid pain. B. I do not normally change my way of washing or dressing even though it causes some pain. C. Washing and dressing increases the pain, but I manage not to change my way of doing it. D. Washing and dressing increases the pain and I find it necessary to change my way of doing it. E. Because of the pain, I am unable to do some washing and dressing without help. F. Because of the pain, I am unable to do any washing or dressing without help.	<b>SECTION 7 – Sleeping</b> A. I get no pain in bed. B. I get pain in bed, but it does not prevent me from sleeping well. C. Because of pain, my normal night's sleep is reduced by less than one quarter. D. Because of pain, my normal night's sleep is reduced by less than one-half. E. Because of pain, my normal night's sleep is reduced by less than three-quarters. F. Pain prevents me from sleeping at all.
<b>SECTION 3 – Lifting</b> A. I can lift heavy weights without extra pain. B. I can lift heavy weights, but it causes extra pain. C. Pain prevents me from lifting heavy weight off the floor. D. Pain prevents me from lifting heavy weights off the floor, but I can manage if they are conveniently positioned, eg. on a table. E. Pain prevents me from lifting heavy weights, but I can manage light to medium weights if they are conveniently positioned. F. I can only lift very light weights, at the most.	<b>SECTION 8 – Social Life</b> A. My social life is normal and give me no pain. B. My social life is normal, but increases the degree of my pain. C. Pain has no significant effect on my social life apart from limiting my more energetic interests, My 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.
<b>SECTION 4 – Walking</b> A. Pain does not prevent me from walking any distance. B. Pain prevents me from walking more than one mile. C. Pain prevents me from walking more than ½ mile. D. Pain prevents me from walking more than ¼ mile. E. I can only walk while using a cane or on crutches. F. I am in bed most of the time and have to crawl to the toilet.	<b>SECTION 9 – Traveling</b> 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.
<b>SECTION 5 – Sitting</b> A. I can sit in any chair as long as I like without pain. 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 ½ hour. E. Pain prevents me from sitting more than ten minutes. F. Pain prevents me from sitting at all.	<b>SECTION 10 – Changing Degree of Pain</b> 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 at present. D. My pain is neither getting better nor worse. E. My pain is gradually worsening. F. My pain is rapidly worsening.

**COMMENTS:** \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

**PATIENT NAME:** \_\_\_\_\_ **DATE:** \_\_\_\_\_ **SCORE:** \_\_\_\_\_

Patient Name: \_\_\_\_\_

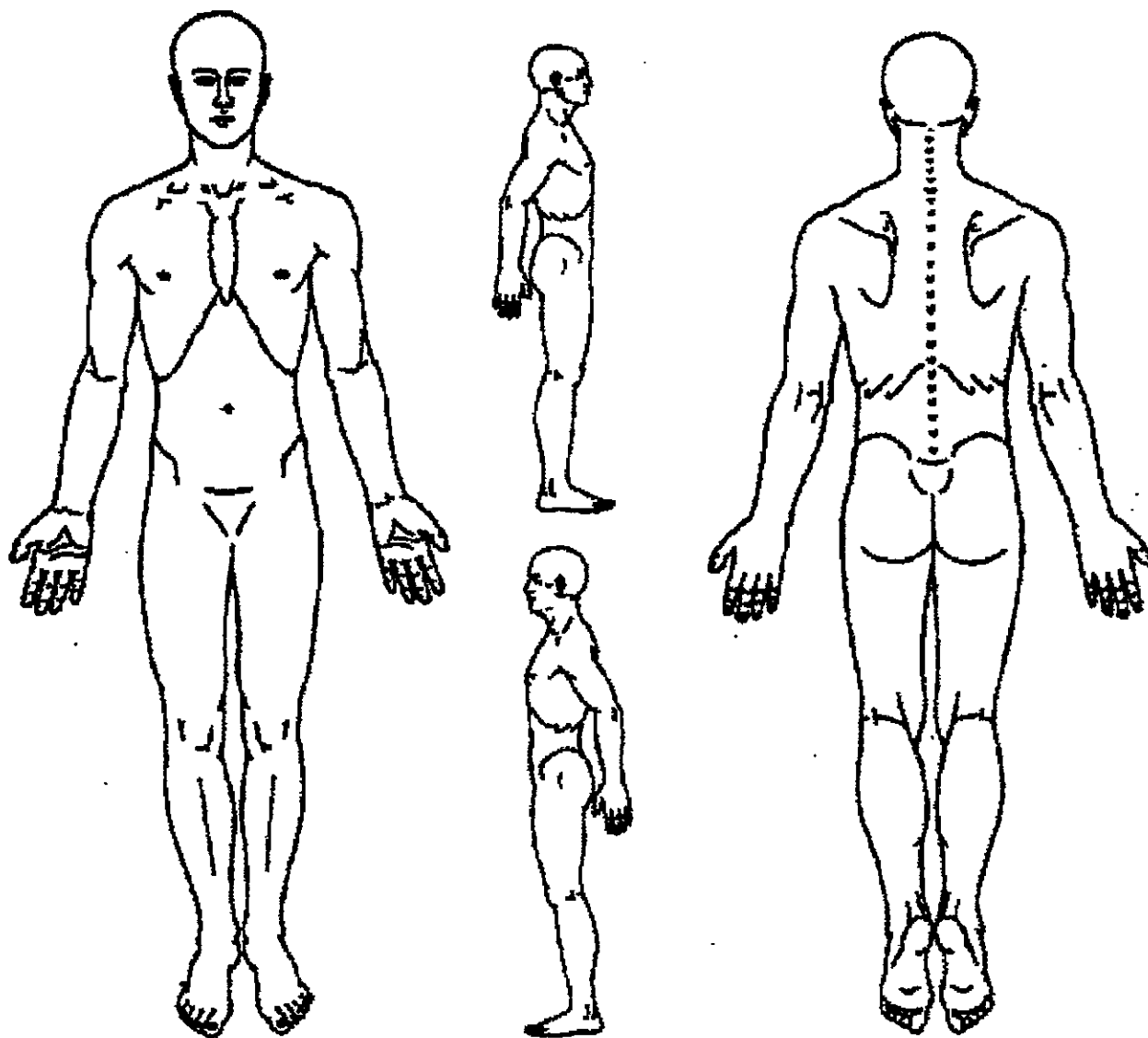
Date: \_\_\_\_\_

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### PAIN DIAGRAM

On the diagrams below mark where you are experiencing pain, right now. Use the letters below to indicate the type and location of your sensations.

Key: A -ACHE B -BURNING N -NUMBNESS  
P -PINS & NEEDLES S -STABBING O -OTHER



### PAIN SCALE

Rate the severity of your pain by checking one box on the following scale:

No Pain

Worst Possible  
Pain

0	1	2	3	4	5	6	7	8	9	10
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