

CONFIDENTIAL REGISTRATION

Date: _____

Last Name: _____ First Name: _____

Address: _____

City: _____ State: _____ Zip Code: _____

Home Phone: _____ Work Phone: _____

Cell Phone: _____ E-mail Address: _____

Emergency Contact: _____ Emergency Phone: _____

Employer Name : _____

Address: _____

Date of Birth: _____ S.S.#: _____

Gender: M F Marital Status: _____ Referred By: _____

Is condition related to: Illness Employment Auto Other _____ N/A

Date of Accident (if applicable): _____

Insurance Company Name: _____

Address: _____

Phone #: _____ Group#: _____ I.D.#: _____

Name of Insured: _____ Relationship to Insured: _____

Does your insurance company require a referral from your primary physician? _____

Name and phone number of primary care physician: _____

Do you have secondary insurance coverage? _____ Name of Company: _____

Spouse's Name: _____ Birthdate: _____

PATIENT AGREEMENT

I, the undersigned have insurance coverage, with _____, and assigned directly to Dr. Coyne all medical benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I hereby authorize the doctor to release all information necessary to secure the payment of benefits. I realize that insurance assignment is a courtesy extended by the doctors and that I am ultimately responsible for payment of all services rendered if the insurance company denies payment to the office.

Signature: _____ Date: _____

DR. ELLEN COYNE, Chiropractor 164 West 79 Street, New York, NY 10024 (212) 875 - 9780

B
DC

Please answer each Section by circling the **ONE CHOICE** that most applies to you. You may feel that more than one statement relates to you, but only **circle the one choice that closely describes your problem *right now***.

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 is severe but comes and goes.
- F. The pain is severe and does not vary much.

SECTION 2--Personal Care

- 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 increase the pain, but I manage not to change my way of doing it.
- D. Washing and dressing increase the pain and I find it necessary to change my way of doing it.
- E. Because of the pain, I am occasionally unable to do any washing and dressing without help.
- F. Because of the pain, I am always unable to do any washing or dressing without help.

SECTION 3--Lifting

- 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 weights off the floor.
- D. Pain prevents me from lifting heavy weights off the floor, but I can manage if they are conveniently positioned, e.g. on the 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.

SECTION 4 --Walking

- A. Pain does not prevent me from walking any distance.
- B. Pain prevents me from walking more than a one mile.
- C. Pain prevents me from walking more than a 1/2 mile.
- D. Pain prevents me from walking more than 1/4 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.

SECTION 5--Sitting

- 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 despite pain.
- C. Pain prevents me from sitting more than one hour.
- D. Pain prevents me from sitting more than 1/2 hour.
- E. Pain prevents me from sitting more than ten minutes.
- F. Pain prevents me from sitting at all.

SECTION 6 -- Standing

- 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 1/2 hour without increasing pain.
- E. I can't stand for more than 10 minutes without increasing pain.
- F. I avoid standing because it increases pain right away.

SECTION 7--Sleeping

- A. I get no pain in bed.
- B. I get pain in bed, but it does not prevent me from sleeping.
- 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.

SECTION 8--Social Life

- A. My social life is normal and gives 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, 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. Pain prevents me from any social activity at all.

SECTION 9--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 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 at present.
- D. My pain is neither getting better nor worse.
- E. My pain is gradually worsening.
- F. My pain is rapidly worsening.

SECTION 11--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 cannot do my usual work.
- E. I can hardly do work at all.
- F. I cannot do any work at all.

SECTION 12--Reading

- A. I can read as much as I want with no pain.
- B. I can read as much as I want with slight pain.
- C. I can read as much as I want with moderate pain.
- D. I cannot read as much as I want because of moderate pain.
- E. I cannot read as much as I want because of severe pain.
- F. I cannot read at all due to pain.

Patient Name _____ Patient/Other Signature _____

Date ___/___/___ Relationship to Patient _____

C
DC

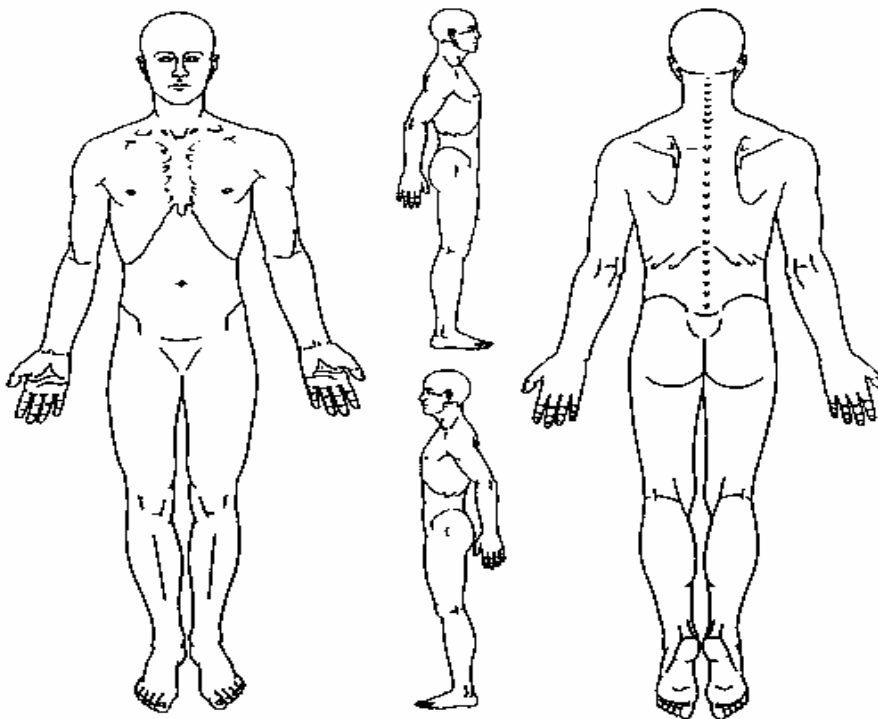
Patient Name _____

Date ____/____/____

How long have you had your symptoms? ____ days ____ weeks ____ months ____ years

On the diagram below, please indicate where, and what type of symptoms that you are experiencing, right now. Write the appropriate abbreviations (see the 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 fill in the bubble that corresponds to the pain level that you are experiencing.

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 at its least and ③ your average pain level.

Example:

No Pain ① ② ③ ④ ● ⑥ ⑦ ⑧ ⑨ ⑩ Worst Possible

① My pain when it is at its worst is:

No Pain ① ② ③ ④ ⑤ ⑥ ⑦ ⑧ ⑨ ⑩ Worst Possible

② My pain when it is at its least is:

No Pain ① ② ③ ④ ⑤ ⑥ ⑦ ⑧ ⑨ ⑩ Worst Possible

③ My average pain level is:

No Pain ① ② ③ ④ ⑤ ⑥ ⑦ ⑧ ⑨ ⑩ Worst Possible

Patient/Other Signature _____ Relationship to Patient _____

Provider Signature _____ Date _____

Patient Health Questionnaire- page 2

Patient Name _____

What type of regular exercise do you perform? (1) None (2) Light (3) Moderate (4) Strenuous

What is your height and weight? Height ____ft____inches Weight ____lbs.

For each of the condition listed below, place a check in the Past column if you have had the condition in the past. If you presently have a condition listed below, place a check in the Present column.

Past	Present		Past	Present		Past	Present	
<input type="radio"/>	<input type="radio"/>	HEADACHE	<input type="radio"/>	<input type="radio"/>	HIGH BLOOD PRESSURE	<input type="radio"/>	<input type="radio"/>	DIABETES
<input type="radio"/>	<input type="radio"/>	NECK PAIN	<input type="radio"/>	<input type="radio"/>	HEART ATTACK	<input type="radio"/>	<input type="radio"/>	EXCESSIVE THIRST
<input type="radio"/>	<input type="radio"/>	UPPER BACK PAIN	<input type="radio"/>	<input type="radio"/>	CHEST PAINS	<input type="radio"/>	<input type="radio"/>	FREQUENT URINATION
<input type="radio"/>	<input type="radio"/>	MID BACK PAIN	<input type="radio"/>	<input type="radio"/>	STROKE			
<input type="radio"/>	<input type="radio"/>	LOW BACK PAIN	<input type="radio"/>	<input type="radio"/>	ANGINA	<input type="radio"/>	<input type="radio"/>	SMOKING
			<input type="radio"/>	<input type="radio"/>	KIDNEY DISORDER	<input type="radio"/>	<input type="radio"/>	DRUG/ALCOHOL
<input type="radio"/>	<input type="radio"/>	SHOULDER PAIN	<input type="radio"/>	<input type="radio"/>	BLADDER INFECTION			DEPENDENCE
<input type="radio"/>	<input type="radio"/>	ELBOW/UPPER ARM PAIN	<input type="radio"/>	<input type="radio"/>	PAINFUL URINATION	<input type="radio"/>	<input type="radio"/>	ALLERGIES
<input type="radio"/>	<input type="radio"/>	WRIST PAIN	<input type="radio"/>	<input type="radio"/>	LOSS OF BLADDER CONTROL	<input type="radio"/>	<input type="radio"/>	DEPRESSION
<input type="radio"/>	<input type="radio"/>	HAND PAIN	<input type="radio"/>	<input type="radio"/>	PROSTATE PROBLEMS	<input type="radio"/>	<input type="radio"/>	SYSTEMIC LUPUS
						<input type="radio"/>	<input type="radio"/>	EPILEPSY
<input type="radio"/>	<input type="radio"/>	HIP/UPPER LEG PAIN	<input type="radio"/>	<input type="radio"/>	ABNORMAL WEIGHT GAIN/LOSS	<input type="radio"/>	<input type="radio"/>	DERMATITIS/
<input type="radio"/>	<input type="radio"/>	KNEE/LOWER LEG PAIN	<input type="radio"/>	<input type="radio"/>	LOSS OF APPETITE			ECZEMA/RASH
<input type="radio"/>	<input type="radio"/>	ANKLE/FOOT PAIN	<input type="radio"/>	<input type="radio"/>	ABDOMINAL PAIN	<input type="radio"/>	<input type="radio"/>	HIV/AIDS
<input type="radio"/>	<input type="radio"/>	JAW PAIN	<input type="radio"/>	<input type="radio"/>	LOSS OF APPETITE			
			<input type="radio"/>	<input type="radio"/>	ABDOMINAL PAIN			FEMALES ONLY
<input type="radio"/>	<input type="radio"/>	JOINT SWELLING/STIFFNESS	<input type="radio"/>	<input type="radio"/>	HEPITITIS	<input type="radio"/>	<input type="radio"/>	BIRTH CONTROL PILLS
<input type="radio"/>	<input type="radio"/>	ARTHRITIS	<input type="radio"/>	<input type="radio"/>	LIVER/GALL BLADDER DISORDER	<input type="radio"/>	<input type="radio"/>	HORMONAL
<input type="radio"/>	<input type="radio"/>	RHEUMATOID ARTHRITIS	<input type="radio"/>	<input type="radio"/>	CANCER			REPLACEMENT
			<input type="radio"/>	<input type="radio"/>	TUMOR	<input type="radio"/>	<input type="radio"/>	PREGNANCY
<input type="radio"/>	<input type="radio"/>	GENERAL FATIGUE	<input type="radio"/>	<input type="radio"/>	ASTHMA			OTHER HEALTH ISSUES:
<input type="radio"/>	<input type="radio"/>	MUSCULAR INCOORDINATION	<input type="radio"/>	<input type="radio"/>	CHRONIC SINUSITIS	<input type="radio"/>	<input type="radio"/>	
<input type="radio"/>	<input type="radio"/>	VISUAL DISTURBANCES				<input type="radio"/>	<input type="radio"/>	
<input type="radio"/>	<input type="radio"/>	DIZZINESS				<input type="radio"/>	<input type="radio"/>	

INDICATE IF AN IMMEDIATE FAMILY MEMBER HAS HAD ANY OF THE FOLLOWING:

Rheumatoid Arthritis Heart Problem Diabetes Cancer Lupus _____

List all prescription and over-the-counter medications, and nutritional/herbal supplements you are taking:

List all the surgical procedures you have had and times you have been hospitalized:

Patient Signature _____ Date _____

Provider's Additional Comments

Doctor's Signature _____ Date _____