

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

Patient Health Questionnaire - PHQ

ACN Group, Inc. Form PHQ-202

ACN Group, Inc. Use Only rev 3/27/2003

Patient Name _____ Date _____

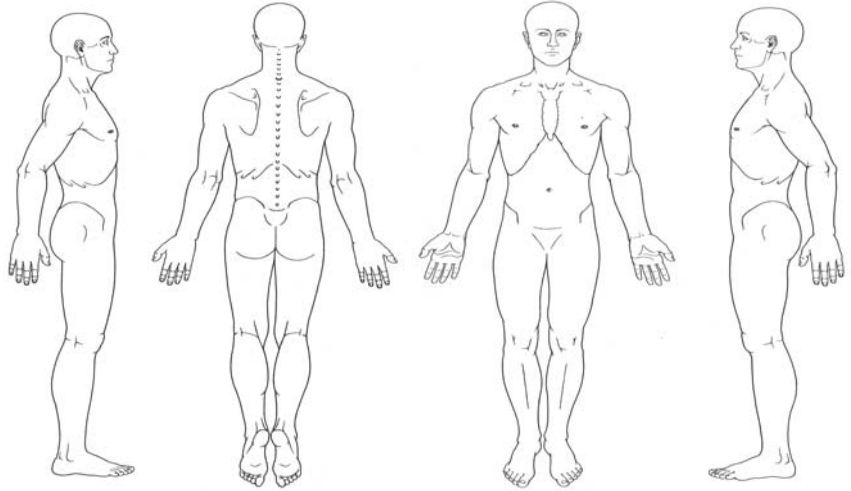
1. Describe your symptoms

a. When did your symptoms start?

b. How did your symptoms begin?

2. How often do you experience your symptoms? Indicate where you have pain or other symptoms

- ① Constantly (76-100% of the day)
- ② Frequently (51-75% of the day)
- ③ Occasionally (26-50% of the day)
- ④ Intermittently (0-25% of the day)



3. What describes the nature of your symptoms?

- ① Sharp
- ② Dull ache
- ③ Numb
- ④ Shooting
- ⑤ Burning
- ⑥ Tingling

4. How are your symptoms changing?

- ① Getting Better
- ② Not Changing
- ③ Getting Worse

5. During the past 4 weeks:

a. Indicate the average intensity of your symptoms

None ① ② ③ ④ ⑤ ⑥ ⑦ ⑧ ⑨ ⑩ Unbearable

b. How much has pain interfered with your normal work (including both work outside the home, and housework)

① Not at all ② A little bit ③ Moderately ④ Quite a bit ⑤ Extremely

6. During the past 4 weeks how much of the time has your condition interfered with your social activities?

(like visiting with friends, relatives, etc)

① All of the time ② Most of the time ③ Some of the time ④ A little of the time ⑤ None of the time

7. In general would you say your overall health right now is...

① Excellent ② Very Good ③ Good ④ Fair ⑤ Poor

8. Who have you seen for your symptoms?

- ① No One
- ② Other Chiropractor
- ③ Medical Doctor
- ④ Physical Therapist
- ⑤ Other

a. What treatment did you receive and when?

b. What tests have you had for your symptoms and when were they performed?

- ① Xrays date: _____
- ② MRI date: _____
- ③ CT Scan date: _____
- ④ Other date: _____

9. Have you had similar symptoms in the past?

- ① Yes
- ② No

a. If you have received treatment in the past for the same or similar symptoms, who did you see?

- ① This Office
- ② Other Chiropractor
- ③ Medical Doctor
- ④ Physical Therapist
- ⑤ Other

10. What is your occupation?

- ① Professional/Executive
- ② White Collar/Secretarial
- ③ Tradesperson
- ④ Laborer
- ⑤ Homemaker
- ⑥ FT Student
- ⑦ Retired
- ⑧ Other

a. If you are not retired, a homemaker, or a student, what is your current work status?

- ① Full-time
- ② Part-time
- ③ Self-employed
- ④ Unemployed
- ⑤ Off work
- ⑥ Other

Patient Signature _____ Date _____

Back Index

ACN Group, Inc. Form BI-100

ACN Group, Inc. Use Only rev 3/27/2003

Patient Name _____ **Date** _____

This questionnaire will give your provider information about how your back condition affects your everyday life. Please answer every section by marking the one statement that applies to you. If two or more statements in one section apply, please mark the one statement that most closely describes your problem.

Pain Intensity

- ① The pain comes and goes and is very mild.
- ② The pain is mild and does not vary much.
- ③ The pain comes and goes and is moderate.
- ④ The pain is moderate and does not vary much.
- ⑤ The pain comes and goes and is very severe.
- ⑥ The pain is very severe and does not vary much.

Sleeping

- ① I get no pain in bed.
- ② I get pain in bed but it does not prevent me from sleeping well.
- ③ Because of pain my normal sleep is reduced by less than 25%.
- ④ Because of pain my normal sleep is reduced by less than 50%.
- ⑤ Because of pain my normal sleep is reduced by less than 75%.
- ⑥ Pain prevents me from sleeping at all.

Sitting

- ① I can sit in any chair as long as I like.
- ② I can only sit in my favorite chair as long as I like.
- ③ Pain prevents me from sitting more than 1 hour.
- ④ Pain prevents me from sitting more than 1/2 hour.
- ⑤ Pain prevents me from sitting more than 10 minutes.
- ⑥ I avoid sitting because it increases pain immediately.

Standing

- ① I can stand as long as I want without pain.
- ② I have some pain while standing but it does not increase with time.
- ③ I cannot stand for longer than 1 hour without increasing pain.
- ④ I cannot stand for longer than 1/2 hour without increasing pain.
- ⑤ I cannot stand for longer than 10 minutes without increasing pain.
- ⑥ I avoid standing because it increases pain immediately.

Walking

- ① I have no pain while walking.
- ② I have some pain while walking but it doesn't increase with distance.
- ③ I cannot walk more than 1 mile without increasing pain.
- ④ I cannot walk more than 1/2 mile without increasing pain.
- ⑤ I cannot walk more than 1/4 mile without increasing pain.
- ⑥ I cannot walk at all without increasing pain.

Personal Care

- ① I do not have to change my way of washing or dressing in order to avoid pain.
- ② I do not normally change my way of washing or dressing even though it causes some pain.
- ③ Washing and dressing increases the pain but I manage not to change my way of doing it.
- ④ Washing and dressing increases the pain and I find it necessary to change my way of doing it.
- ⑤ Because of the pain I am unable to do some washing and dressing without help.
- ⑥ Because of the pain I am unable to do any washing and dressing without help.

Lifting

- ① I can lift heavy weights without extra pain.
- ② I can lift heavy weights but it causes extra pain.
- ③ Pain prevents me from lifting heavy weights off the floor.
- ④ Pain prevents me from lifting heavy weights off the floor, but I can manage if they are conveniently positioned (e.g., on a table).
- ⑤ Pain prevents me from lifting heavy weights off the floor, but I can manage light to medium weights if they are conveniently positioned.
- ⑥ I can only lift very light weights.

Traveling

- ① I get no pain while traveling.
- ② I get some pain while traveling but none of my usual forms of travel make it worse.
- ③ I get extra pain while traveling but it does not cause me to seek alternate forms of travel.
- ④ I get extra pain while traveling which causes me to seek alternate forms of travel.
- ⑤ Pain restricts all forms of travel except that done while lying down.
- ⑥ Pain restricts all forms of travel.

Social Life

- ① My social life is normal and gives me no extra pain.
- ② My social life is normal but increases the degree of pain.
- ③ Pain has no significant affect on my social life apart from limiting my more energetic interests (e.g., dancing, etc).
- ④ Pain has restricted my social life and I do not go out very often.
- ⑤ Pain has restricted my social life to my home.
- ⑥ I have hardly any social life because of the pain.

Changing degree of pain

- ① My pain is rapidly getting better.
- ② My pain fluctuates but overall is definitely getting better.
- ③ My pain seems to be getting better but improvement is slow.
- ④ My pain is neither getting better or worse.
- ⑤ My pain is gradually worsening.
- ⑥ My pain is rapidly worsening.

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Score**

Neck Index

ACN Group, Inc. Form NI-100

ACN Group, Inc. Use Only rev 3/27/2003

Patient Name _____ **Date** _____

This questionnaire will give your provider information about how your neck condition affects your everyday life. Please answer every section by marking the one statement that applies to you. If two or more statements in one section apply, please mark the one statement that most closely describes your problem.

Pain Intensity

- ⓪ I have no pain at the moment.
- ① The pain is very mild at the moment.
- ② The pain comes and goes and is moderate.
- ③ The pain is fairly severe at the moment.
- ④ The pain is very severe at the moment.
- ⑤ The pain is the worst imaginable at the moment.

Sleeping

- ⓪ I have no trouble sleeping.
- ① My sleep is slightly disturbed (less than 1 hour sleepless).
- ② My sleep is mildly disturbed (1-2 hours sleepless).
- ③ My sleep is moderately disturbed (2-3 hours sleepless).
- ④ My sleep is greatly disturbed (3-5 hours sleepless).
- ⑤ My sleep is completely disturbed (5-7 hours sleepless).

Reading

- ⓪ I can read as much as I want with no neck pain.
- ① I can read as much as I want with slight neck pain.
- ② I can read as much as I want with moderate neck pain.
- ③ I cannot read as much as I want because of moderate neck pain.
- ④ I can hardly read at all because of severe neck pain.
- ⑤ I cannot read at all because of neck pain.

Concentration

- ⓪ I can concentrate fully when I want with no difficulty.
- ① I can concentrate fully when I want with slight difficulty.
- ② I have a fair degree of difficulty concentrating when I want.
- ③ I have a lot of difficulty concentrating when I want.
- ④ I have a great deal of difficulty concentrating when I want.
- ⑤ I cannot concentrate at all.

Work

- ⓪ I can do as much work as I want.
- ① I can only do my usual work but no more.
- ② I can only do most of my usual work but no more.
- ③ I cannot do my usual work.
- ④ I can hardly do any work at all.
- ⑤ I cannot do any work at all.

Personal Care

- ⓪ I can look after myself normally without causing extra pain.
- ① I can look after myself normally but it causes extra pain.
- ② It is painful to look after myself and I am slow and careful.
- ③ I need some help but I manage most of my personal care.
- ④ I need help every day in most aspects of self care.
- ⑤ I do not get dressed, I wash with difficulty and stay in bed.

Lifting

- ⓪ I can lift heavy weights without extra pain.
- ① I can lift heavy weights but it causes extra pain.
- ② Pain prevents me from lifting heavy weights off the floor, but I can manage if they are conveniently positioned (e.g., on a table).
- ③ Pain prevents me from lifting heavy weights off the floor, but I can manage light to medium weights if they are conveniently positioned.
- ④ I can only lift very light weights.
- ⑤ I cannot lift or carry anything at all.

Driving

- ⓪ I can drive my car without any neck pain.
- ① I can drive my car as long as I want with slight neck pain.
- ② I can drive my car as long as I want with moderate neck pain.
- ③ I cannot drive my car as long as I want because of moderate neck pain.
- ④ I can hardly drive at all because of severe neck pain.
- ⑤ I cannot drive my car at all because of neck pain.

Recreation

- ⓪ I am able to engage in all my recreation activities without neck pain.
- ① I am able to engage in all my usual recreation activities with some neck pain.
- ② I am able to engage in most but not all my usual recreation activities because of neck pain.
- ③ I am only able to engage in a few of my usual recreation activities because of neck pain.
- ④ I can hardly do any recreation activities because of neck pain.
- ⑤ I cannot do any recreation activities at all.

Headaches

- ⓪ I have no headaches at all.
- ① I have slight headaches which come infrequently.
- ② I have moderate headaches which come infrequently.
- ③ I have moderate headaches which come frequently.
- ④ I have severe headaches which come frequently.
- ⑤ I have headaches almost all the time.

Neck
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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 THRIST
<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 _____