Welcome To

Venti Chiropractic
& Sports Health

Patient Information

Name: _____ Today's Date: _____

Address: _____ City: _____ State: _____ Zip: _____

Home Phone: _____ Cell: _____ Email: _____

Sex: ❑ Male ❑ Female Date of Birth: _____ ❑ Married ❑ Single ❑ Divorced ❑ Separated ❑ Minor

Occupation: _____ Employer/School: _____

Spouse/Parent's Name: _____ Children's Names/Age: _____

Person to contact in case of emergency: _____ Phone: _____

Whom may we thank for referring you to our office? _____

Responsible Party

Person responsible for this account: _____ Relationship to patient: _____

Address: _____ City: _____ State: _____ Zip: _____

Insurance Information

Name of Insured: _____ Relationship to patient: _____

Insured's DOB: _____ Insured's Social Security #: _____

Name of Employer: _____ Address: _____

City: _____ State: _____ Zip: _____

Insurance Co: _____ Phone: _____ Group #: _____ ID#: _____

Insurance Co. Address: _____ City: _____ State: _____ Zip: _____

Symptoms

Reason(s) for visit: _____

When did you first notice your symptoms: _____

Is it getting worse? _____

What **aggravates your pain**? ❑ Sitting ❑ Standing ❑ Walking ❑ Bending ❑ Lying down
❑ Lifting Objects ❑ Sleeping ❑ Working out ❑ Other _____

What, if anything, **relieves your pain**? ❑ Sitting ❑ Standing ❑ Walking ❑ Bending ❑ Lying down
❑ Lifting Objects ❑ Sleeping ❑ Stretching ❑ Ice ❑ Heat ❑ Other _____

	DULL	ACHING	SHARP	NUMB	BURNING	SHOOTING	TINGLING	CRAMPING	THROBBING	STIFF	RADIATING	
EXAMPLE: LOW BACK			X			X						1 2 3 4 5 6 7 8 9 10
												1 2 3 4 5 6 7 8 9 10
												1 2 3 4 5 6 7 8 9 10
												1 2 3 4 5 6 7 8 9 10
												1 2 3 4 5 6 7 8 9 10
												1 2 3 4 5 6 7 8 9 10
												1 2 3 4 5 6 7 8 9 10
												1 2 3 4 5 6 7 8 9 10

Circle Severity of Pain
1 = Barely, 10= Severe

Is/Are the pain(s) constant or does it come and go? _____

Has this problem been treated before? _____ If yes, how has it been treated and by whom? _____.

Personal (Circle all that apply to YOU)

AIDS/HIV	Allergy Shots	Anemia	Anorexia	Appendicitis	Arthritis	Depression	Heart Disease
Breast Lump	Bronchitis	Bulimia	Cancer	Fibromyalgia	Chicken Pox	Gout	Measles
Emphysema	Epilepsy	Fractures	Glaucoma	Cataracts	Gonorrhea	Liver Disease	Parkinson's
Hepatitis	Hernia	Herniated Disc	Herpes	Goiter	Kidney Disease	Pacemaker	Thyroid
Headaches	Miscarriage	Mono	M.S.	High Chol	Osteoporosis	Stroke	Diabetes
Migraines	Polio	Prostate	Prosthesis	Mumps	Rheumatoid	Pneumonia	Tuberculosis
Tumors	Implants	V.D.	Bleeding	Chronic Fatigue	Tonsillitis	HBP	Ulcers
Asthma	Other_____						

Family (Circle all that apply to your FAMILY MEMBERS)

AIDS/HIV	Allergy Shots	Anemia	Anorexia	Appendicitis	Arthritis	Depression	Heart Disease
Breast Lump	Bronchitis	Bulimia	Cancer	Fibromyalgia	Chicken Pox	Gout	Measles
Emphysema	Epilepsy	Fractures	Glaucoma	Cataracts	Gonorrhea	Liver Disease	Parkinson's
Hepatitis	Hernia	Herniated Disc	Herpes	Goiter	Kidney Disease	Pacemaker	Thyroid
Headaches	Miscarriage	Mono	M.S.	High Chol	Osteoporosis	Stroke	Diabetes
Migraines	Polio	Prostate	Prosthesis	Mumps	Rheumatoid	Pneumonia	Tuberculosis
Tumors	Implants	V.D.	Bleeding	Chronic Fatigue	Tonsillitis	HBP	Ulcers
Asthma	Other_____						

Dates of Last Exams: _____

List any types of surgeries which you have had and the dates in which they occurred: _____

_____.

Please list all medications/vitamin, prescribed or over-the-counter, you are currently taking: _____

_____.

(Women) Are you pregnant? ❑ Yes ❑ No Taking birth control? ❑ Yes ❑ No

Daily Habits

What type of exercise do you perform on a daily basis? ❑ None ❑ Moderate ❑ Heavy

What do your daily work habits include? _____.

Do you smoke? ❑ Yes ❑ No How much per day? _____.

How much alcohol do you consume weekly? _____ Caffeinated beverages? _____.

Certification and Assignment

To the best of my knowledge, the above information is complete and correct. I understand that it is my responsibility to inform my doctor if I or my minor child has a change in health.

I certify that I, and/or my dependent(s), have insurance coverage with _____ and assign directly to Venti Chiropractic & Sports Health all insurance 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 authorize the use of my signature on all insurance submissions.

Dr. Ventimiglia or Dr. Tamburro may use my health care information and disclose such information to the above named insurance company and their agents for the purpose of obtaining payment for services and determining insurance benefits or the benefits payable for related services.

_____ _____

Signature of Patient, Parent, Guardian, or Personal Representative Date

_____ _____

Please Print Name of Patient, Guardian, or Personal Representative Relationship to Patient

NOTICE OF PRIVACY PRACTICE

I have been offered and have read and understand the ***Notice of Privacy Practices*** and the ***Office Policies***

Signature: _____ Date: _____

TERMS OF ACCEPTANCE

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

Chiropractic has only one goal. It is most important that each patient understands both the objective and the method that will be used to attain it. This will prevent any confusion or disappointment.

Adjustment: An adjustment is the specific application of forces to facilitate the body's correction of vertebral subluxation. Our chiropractic method of correction is by specific adjustment of the spine.

Health: A state of optimal physical, mental, and social well-being, not merely the absence of disease 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 impulses, resulting in a lessening of the body's innate ability to express its maximum human potential.

We do not offer to diagnose or treat any disease or condition other than vertebral subluxations. However, if during the course of a chiropractic spinal examination, we encounter non-chiropractic or unusual findings, we advise 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 a major interference to the expression of the body's innate wisdom. Our only method is specific adjusting to correct vertebral subluxations.

_____ _____ _____

(Print Name) (Signature) (Date)

Consent to evaluate and adjust a minor child:

I, _____ being the parent or legal guardian of _____, have read and fully understand the above Informed Consent and hereby grant permission for my child to receive chiropractic care.

Pregnancy Release: This is to certify that to the best of my knowledge, I am not pregnant and the above doctor and his/her associates have my permission to perform an x-ray evaluation. I have been advised that x-ray can be hazardous to an unborn child.

Date of last menstrual cycle: _____.

_____ _____

(Signature) (Date)

AUTOMOBILE ACCIDENT QUESTIONNAIRE

Patient's Name:_____ Today's Date:_____

Date of Accident:_____ Have you retained an attorney? Y N

In your own words, describe the accident. _____

_____

THE FOLLOWING QUESTIONS PERTAIN TO YOU AND THE VEHICLE YOU WERE IN:

Vehicle type:

- ❑Car ❑Pickup
- ❑Van ❑Truck
- ❑Station Wagon ❑Bus
- ❑Other_____

Vehicle size:

- ❑Subcompact ❑Full-size
- ❑Compact ❑Mini
- ❑Mid-size ❑Light
- ❑Heavy ❑Other_____

Your position in the vehicle:

- ❑Driver
- ❑Passenger ——— Location——— ❑Left ❑Middle ❑Right
- ❑Other _____ ❑Front Passenger ❑Rear Passenger ❑Third Seat (rear)

Speed of your vehicle:

- ❑Stopped ❑Moving Moderately
- ❑Parked ❑Moving Fast
- ❑Slowing ❑Moving at apprx ____MPH
- ❑Moving Slowly

Why Vehicle was slowed or stopped:

- ❑Traffic Signal ❑Parking
- ❑Pedestrian ❑Traffic
- ❑Stop Sign ❑Busy Intersection

Collision Type:

- ❑Driver Side Impact ❑Head On Collision
- ❑Passenger Side Impact ❑Rear Impact
- ❑Front Impact ❑Pedestrian Incident

THE FOLLOWING QUESTIONS CONCERN THE OTHER VEHICLE INVOLVED IN THE ACCIDENT:

Vehicle type:

- ❑Car ❑Pickup
- ❑Van ❑Truck
- ❑Station Wagon ❑Bus
- ❑Other_____

Vehicle size:

- ❑Subcompact ❑Full-size
- ❑Compact ❑Mini
- ❑Mid-size ❑Light
- ❑Heavy ❑Other_____

CONDITIONS AT THE TIME OF THE ACCIDENT:

Time of day:

- ❑Full daylight
- ❑Dawn
- ❑Dusk
- ❑Night

Road Conditions:

- ❑Dry
- ❑Damp
- ❑Wet
- ❑Snow covered
- ❑Ice covered
- ❑Patchy Ice/Snow

Visibility:

- ❑Excellent
- ❑Good
- ❑Fair
- ❑Poor

Visibility comprimised by:

- ❑Brightness
- ❑Darkness
- ❑Rain
- ❑Snow
- ❑Fog
- ❑Traffic

THE FOLLOWING QUESTIONS CONCERN THE MOMENT OF IMPACT OF THE ACCIDENT:

Were you...

- ❑Totally unaware that the accident was impending
- ❑Aware that the accident was impending
- ❑Aware that the accident was impending and braced for it

Restraints: (check all that apply)

- ❑Seat belt
- ❑Shoulder harness
- ❑No restraints

If you were the driver of the vehicle, was your foot on the brake pedal? ❑Yes ❑No ❑Knocked off by impact

Was the air bag deployed?

- ❑Car not equipped with air bag
- ❑Air bag deployed
- ❑Air bag not deployed

Position of YOUR head at time of impact?

- ❑Facing straight ahead
- ❑Tilted forward
- ❑Rotated to the left
- ❑Rotated to the right

Position of Your body at time of impact?

- ❑Straight
- ❑Leaning forward
- ❑Rotated to the left
- ❑Rotated to the right

What position was YOUR headrest in?

- ❑High position
- ❑Middle position
- ❑Low position

Was your head thrown...?

- ❑Backward and then forward
- ❑Forward then backward
- ❑To the left ❑To the left then the right
- ❑To the right ❑To the right, then the left

Was your body thrown...?

- ❑Backward and then forward
- ❑Forward then backward
- ❑To the left ❑To the left, then the right
- ❑To the right ❑To the right then the left
- ❑Across the vehicle
- ❑Outside the vehicle
- ❑Under the vehicle

Damage to vehicle YOU were in:

- ❑Incurred minimal damage
- ❑Incurred moderate damage
- ❑Incurred severe damage
- ❑Was totalled
- ❑Not known

Citations:

- ❑None issued
- ❑Yourself
- ❑Driver of vehicle patient was a passenger of
- ❑Driver of other vehicle
- ❑Not sure

AS A RESULT OF THE FORCE OF THE COLLISION, WHICH OBJECTS IN THE VEHICLE DID YOUR BODY STRIKE?

Head

- ❑Steering wheel
- ❑Dashboard
- ❑Windshield
- ❑Armrest
- ❑Headrest
- ❑Rear view mirror
- ❑Left door
- ❑Right door
- ❑Left window
- ❑Right window
- ❑Console
- ❑Gear shift
- ❑Front seat
- ❑Backseat

Left Arm

- ❑Steering wheel
- ❑Dashboard
- ❑Windshield
- ❑Armrest
- ❑Headrest
- ❑Rear view mirror
- ❑Left door
- ❑Right door
- ❑Left window
- ❑Right window
- ❑Console
- ❑Gear shift
- ❑Front seat
- ❑Backseat

Right Arm

- ❑Steering wheel
- ❑Dashboard
- ❑Windshield
- ❑Armrest
- ❑Headrest
- ❑Rear view mirror
- ❑Left door
- ❑Right door
- ❑Left window
- ❑Right window
- ❑Console
- ❑Gear shift
- ❑Front seat
- ❑Backseat

Torso

- ❑Steering wheel
- ❑Dashboard
- ❑Windshield
- ❑Armrest
- ❑Headrest
- ❑Rear view mirror
- ❑Left door
- ❑Right door
- ❑Left window
- ❑Right window
- ❑Console
- ❑Gear shift
- ❑Front seat
- ❑Backseat

Left Leg

- ❑Steering wheel
- ❑Dashboard
- ❑Windshield
- ❑Armrest
- ❑Headrest
- ❑Rear view mirror
- ❑Left door
- ❑Right door
- ❑Left window
- ❑Right window
- ❑Console
- ❑Gear shift
- ❑Front seat
- ❑Backseat

Right Leg

- ❑Steering wheel
- ❑Dashboard
- ❑Windshield
- ❑Armrest
- ❑Headrest
- ❑Rear view mirror
- ❑Left door
- ❑Right door
- ❑Left window
- ❑Right window
- ❑Console
- ❑Gear shift
- ❑Front seat
- ❑Backseat

THE FOLLOWING QUESTIONS CONCERN THE TIME PERIOD IMMEDIATELY FOLLOWING THE ACCIDENT:

Did you lose conciousness?

- ❑Yes
- ❑No

Immediately following the accident, did you feel...?

- ❑Dizzy
- ❑Dazed
- ❑Disoriented
- ❑Weak
- ❑Nervous
- ❑Nauseated

Were you able to walk unaided?

- ❑Yes
- ❑No

Where did you go...?

- ❑Drove home
- ❑Was driven home
- ❑Drove to hospital
- ❑Was driven to hospital
- ❑Taken to hospital via ambulance
- ❑Drove to work
- ❑Was driven to work
- ❑Drove to school
- ❑Was driven to school

Next day discomfort...?

❑increased ❑decreased ❑same

Did your major complaints exist before the accident?

❑Yes ❑ No

In what areas did you IMMEDIATELY feel pain?

❑Head	Shoulder	❑Left	❑Right	Hip	❑Left	❑Right
❑Neck	Arm	❑Left	❑Right	Thigh	❑Left	❑Right
❑Upper back	Elbow	❑Left	❑Right	Knee	❑Left	❑Right
❑Mid back	Wrist	❑Left	❑Right	Calf	❑Left	❑Right
❑Ribs	Hand	❑Left	❑Right	Ankle	❑Left	❑Right
❑Chest	Fingers	❑Left	❑Right	Foot	❑Left	❑Right
❑Abdomen	Buttock	❑Left	❑Right	Toes	❑Left	❑Right
❑Low Back ❑Pelvis						

In what areas did you experience lacerations (cuts)?

❑Head	Shoulder	❑Left	❑Right	Hip	❑Left	❑Right
❑Neck	Arm	❑Left	❑Right	Thigh	❑Left	❑Right
❑Upper back	Elbow	❑Left	❑Right	Knee	❑Left	❑Right
❑Mid back	Wrist	❑Left	❑Right	Calf	❑Left	❑Right
❑Ribs	Hand	❑Left	❑Right	Ankle	❑Left	❑Right
❑Chest	Fingers	❑Left	❑Right	Foot	❑Left	❑Right
❑Abdomen	Buttock	❑Left	❑Right	Toes	❑Left	❑Right
❑Low Back ❑Pelvis						

At the hospital, what areas were x-rayed?

❑Head	Shoulder	❑Left	❑Right	Hip	❑Left	❑Right
❑Neck	Arm	❑Left	❑Right	Thigh	❑Left	❑Right
❑Upper back	Elbow	❑Left	❑Right	Knee	❑Left	❑Right
❑Mid back	Wrist	❑Left	❑Right	Calf	❑Left	❑Right
❑Ribs	Hand	❑Left	❑Right	Ankle	❑Left	❑Right
❑Chest	Fingers	❑Left	❑Right	Foot	❑Left	❑Right
❑Abdomen	Buttock	❑Left	❑Right	Toes	❑Left	❑Right
❑Low Back ❑Pelvis						

Where did you experience pain on the day FOLLOWING the accident?

❑Head	Shoulder	❑Left	❑Right	Hip	❑Left	❑Right
❑Neck	Arm	❑Left	❑Right	Thigh	❑Left	❑Right
❑Upper back	Elbow	❑Left	❑Right	Knee	❑Left	❑Right
❑Mid back	Wrist	❑Left	❑Right	Calf	❑Left	❑Right
❑Ribs	Hand	❑Left	❑Right	Ankle	❑Left	❑Right
❑Chest	Fingers	❑Left	❑Right	Foot	❑Left	❑Right
❑Abdomen	Buttock	❑Left	❑Right	Toes	❑Left	❑Right

❑ Low back ❑ Pelvis

Neck Index

Form N1-100

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.

~~Index Score = [Sum of all statements selected / (# of sections with a statement selected x 5)] x 100~~

Neck Index Score

Back Index

Form BI100

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

⓪ The pain comes and goes and is very mild.
① The pain is mild and does not vary much.
② The pain comes and goes and is moderate.
③ The pain is moderate and does not vary much.
④ The pain comes and goes and is very severe.
⑤ The pain is very severe and does not vary much.

Personal Care

⓪ I do not have to change my way of washing or dressing in order to avoid pain.
① I do not normally change my way of washing or dressing even though it causes some pain.
② Washing and dressing increases the pain but I manage not to change my way of doing it.
③ Washing and dressing increases the pain and I find it necessary to change my way of doing it.
④ Because of the pain I am unable to do some washing and dressing without help.
⑤ Because of the pain I am unable to do any washing and dressing without help.

Sleeping

⓪ I get no pain in bed.
① I get pain in bed but it does not prevent me from sleeping well.
② Because of pain my normal sleep is reduced by less than 25%.
③ Because of pain my normal sleep is reduced by less than 50%.
④ Because of pain my normal sleep is reduced by less than 75%.
⑤ Pain prevents me from sleeping at all.

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.
③ Pain prevents me from lifting heavy weights off the floor, but I can manage if they are conveniently positioned (e.g., on a table).
④ Pain prevents me from lifting heavy weights off the floor, but I can manage light to medium weights if they are conveniently positioned.
⑤ I can only lift very light weights.

Sitting

⓪ I can sit in any chair as long as I like.
① I can only sit in my favorite chair as long as I like.
② Pain prevents me from sitting more than 1 hour.
③ Pain prevents me from sitting more than 1/2 hour.
④ Pain prevents me from sitting more than 10 minutes.
⑤ I avoid sitting because it increases pain immediately.

Traveling

⓪ I get no pain while traveling.
① I get some pain while traveling but none of my usual forms of travel make it worse.
② I get extra pain while traveling but it does not cause me to seek alternate forms of travel.
③ I get extra pain while traveling which causes me to seek alternate forms of travel.
④ Pain restricts all forms of travel except that done while lying down.
⑤ Pain restricts all forms of travel.

Standing

⓪ I can stand as long as I want without pain.
① I have some pain while standing but it does not increase with time.
② I cannot stand for longer than 1 hour without increasing pain.
③ I cannot stand for longer than 1/2 hour without increasing pain.
④ I cannot stand for longer than 10 minutes without increasing pain.
⑤ I avoid standing because it increases pain immediately.

Social Life

⓪ My social life is normal and gives me no extra pain.
① My social life is normal but increases the degree of pain.
② Pain has no significant affect on my social life apart from limiting my more energetic interests (e.g., dancing, etc).
③ Pain has restricted my social life and I do not go out very often.
④ Pain has restricted my social life to my home.
⑤ I have hardly any social life because of the pain.

Walking

⓪ I have no pain while walking.
① I have some pain while walking but it doesn't increase with distance.
② I cannot walk more than 1 mile without increasing pain.
③ I cannot walk more than 1/2 mile without increasing pain.
④ I cannot walk more than 1/4 mile without increasing pain.
⑤ I cannot walk at all without increasing pain.

Changing degree of pain

⓪ My pain is rapidly getting better.
① My pain fluctuates but overall is definitely getting better.
② My pain seems to be getting better but improvement is slow.
③ My pain is neither getting better or worse.
④ My pain is gradually worsening.
⑤ My pain is rapidly worsening.

Index Score = [Sum of all statements selected / (# of sections with a statement selected x 5)] x 100

Back Index Score _____