



Tel: (845) 342-5506
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18 Golf Links Road
Middletown, NY 10940

Middletown Chiropractic
Dr. James E. Romano, D.C.

NEW PATIENT INFORMATION FORM

TODAY'S DATE: _____
PATIENT'S NAME: _____ SOCIAL SECURITY NO: _____
STREET ADDRESS: _____
CITY: _____ STATE: _____ ZIP CODE: _____
HOME PHONE #: _____ WORK PHONE #: _____
DATE OF BIRTH: _____ CELL PHONE #: _____
MARITAL STATUS: SINGLE MARRIED WIDOWED DIVORCED OTHER
EMPLOYMENT STATUS: EMPLOYED (full-time) EMPLOYED (part-time)
 FULL-TIME STUDENT PART-TIME STUDENT
EMPLOYER/SCHOOL/UNIVERSITY: _____
ADDRESS: _____ CITY/STATE/ZIP: _____
OCCUPATION: _____ EMPLOYER'S PHONE#: _____

INSURANCE INFORMATION OF POLICY HOLDER

INSURANCE COMPANY: _____ ADDRESS: _____
POLICY HOLDER'S EMPLOYER: _____
PERSON RESPONSIBLE FOR THIS BILL: _____ POLICY HOLDER: _____
POLICY HOLDER'S DOB: _____ POLICY HOLDER'S SOC. SEC. NO.: _____
POLICY NO.: _____ GROUP NO.: _____ REL. TO PATIENT: _____

TYPE OF INJURY: _____ WORK RELATED _____ AUTO ACCIDENT _____ NEITHER _____ SCHOOL REL.
INSURANCE CARRIER: _____ CLAIM NO.: _____
CONTACT PERSON: _____ PHONE NO.: _____
CARRIER'S ADDRESS: _____ CITY/STATE/ZIP: _____
DATE OF INJURY: _____
WHO IS YOUR MEDICAL DOCTOR????? _____

PLEASE GIVE YOUR INSURANCE CARD TO THE RECEPTIONIST TO PHOTOCOPY!!!!

PATIENT'S SIGNATURE: _____

Middletown Chiropractic
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18 Golf Links Road
Middletown, NY 10940

FINANCIAL POLICY

I understand that I am responsible for all co-payments and referrals, if required by my insurance company at the time of the visit. If my insurance company requires that I meet a deductible, I will be responsible for that amount until such time that my deductible is met.

If payment is denied because I did not obtain a referral, I will be responsible for my bill.

If Middletown Chiropractic does not participate with my insurance company, charges for all office visits will be payable at the time of the visit. Additionally, I will be responsible for any balance not paid by my insurance company.

Signature

Date

Middletown Chiropractic
Dr. James E. Romano, D.C.
18 Golf Links Road, Middletown, NY 10940

THIS NOTICE DESCRIBES HOW CHIROPRACTIC AND MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

In this course of your care as a patient at Middletown Chiropractic, we may use or disclose personal and health related information about you in the following ways:

*Your personal health information, including all of your clinical records, may be disclosed to another health care provider or hospital if it is necessary to refer you for further diagnosis, assessment or treatment.

*Your health care records as well as your billing records may be disclosed to another party, such as an insurance carrier, an HMO, a PPO, or your employer, if they are or may be responsible for the payment of your services.

*Your name, address, phone number, and your health care records may be used to contact you regarding appointment reminders, birthday cards, Newsletters, information about alternatives to your present care, or other health related information that may be of interest to you.

If you are not at home to receive an appointment reminder, a message may be left on your answering machine. Further, you have the right to inspect or obtain a copy of the information we will use for these purposes. You also have the right to refuse to provide authorization for this office to contact you regarding these matters. If you do not provide us with this authorization it will not affect the care provided to you or the reimbursement avenues associated with your care.

Under federal law, we are also permitted or required to use or disclose your health information without your consent or authorization in these following circumstances:

*If we are providing health care services to you based on the orders of another health care provider.

*If we provide health care services to you in an emergency.

*If we are required by law to provide care to you and we are unable to obtain your consent after attempting to do so.

*If there are substantial barriers to communicating with you, but in our professional judgment we believe that you intend for us to provide care.

*If we are ordered by the courts or another appropriate agency.

Any use or disclosure of your protected health information, other than as outlined above, will only be made upon your written authorization.

We normally provide information about your health to you in person at the time you receive chiropractic care from us. We may also mail information to you regarding your health care or about the status of your account. If you would like to receive this information at an address other than your home, or if you would like the information in a different form please advise us in writing as to your preferences.

You have the right to inspect and/or copy your health information for six years from the date that the record was created or as long as the information remains in our files. In addition you have the right to request an amendment to your health information. Requests to inspect, copy or amend your health related information should be provided to us in writing.

We are required by state and federal law to maintain the privacy of your patient file and the health protected health information therein. We are also required to provide you with this notice of our privacy practices with respect to your health information.

We are further required by law to abide by the terms of this notice while it is in effect. We reserve the right to alter or amend the terms of this privacy notice. If changes are made,

to our privacy notice we will notify you in writing as soon as possible following the changes. Any change in our privacy notice will apply for all of your health information in our files.

Information that we use or disclose based on this privacy notice may be subject to re-disclosure by the person to whom we provide the information and may no longer be protected by the federal privacy rules.

If you have a complaint regarding our privacy notice, our privacy practices or any aspect of our privacy activities you should direct your complaint to:
The Secretary of Health and Human Service

If you would like further information about our privacy policies and practices please contact: **Dr. James Romano** at the above address.

This notice is effective as of January 1, 2006. This notice, and any alterations or amendments made hereto will expire six years after the date upon which the record was created. My signature acknowledges that I have read and received a copy of this notice.

Name (please print) Signature Date

If you are a minor, or if you are being represented by another party

Personal Representative (printed) Personal Representative Signature Date

Description of the authority to act on behalf of the patient.

Patient Health Questionnaire - PHQ

ACN Group, Inc. - Form PHQ-202

ACN Group, Inc. Use Only rev 7/18/05

Patient Name _____ Date _____

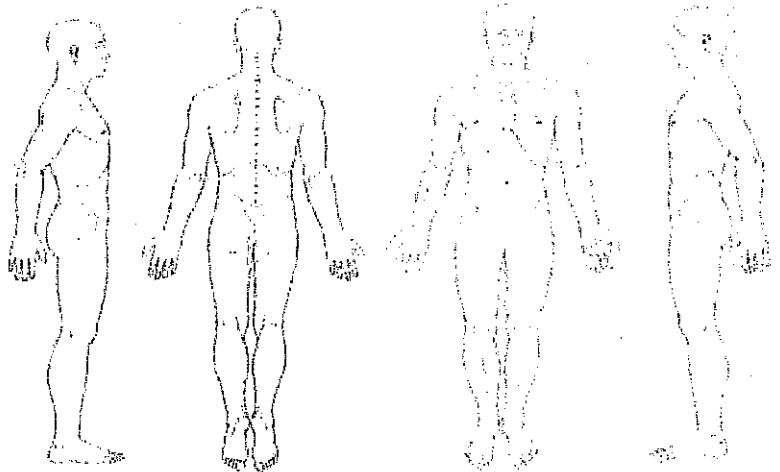
1. Describe your symptoms

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 Unbearable ⑩

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 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 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 _____

Patient Health Questionnaire - page 2

Patient Name _____ Date _____

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

What is your height and weight? Height Weight lbs.
Feet Inches

For each of the conditions 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.

- | <table border="0" style="width: 100%;"> <tr> <th style="text-align: left;">Past</th> <th style="text-align: left;">Present</th> </tr> <tr> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> </tr> </table> <ul style="list-style-type: none"> <input type="checkbox"/> Headaches <input type="checkbox"/> Neck Pain <input type="checkbox"/> Upper Back Pain <input type="checkbox"/> Mid Back Pain <input type="checkbox"/> Low Back Pain <input type="checkbox"/> Shoulder Pain <input type="checkbox"/> Elbow/Upper Arm Pain <input type="checkbox"/> Wrist Pain <input type="checkbox"/> Hand Pain <input type="checkbox"/> Hip/Upper Leg Pain <input type="checkbox"/> Knee/Lower Leg Pain <input type="checkbox"/> Ankle/Foot Pain <input type="checkbox"/> Jaw Pain <input type="checkbox"/> Joint Swelling/Stiffness <input type="checkbox"/> Arthritis <input type="checkbox"/> Rheumatoid Arthritis <input type="checkbox"/> General Fatigue <input type="checkbox"/> Muscular Incoordination <input type="checkbox"/> Visual Disturbances <input type="checkbox"/> Dizziness | Past | Present | <input type="checkbox"/> | <input type="checkbox"/> | <table border="0" style="width: 100%;"> <tr> <th style="text-align: left;">Past</th> <th style="text-align: left;">Present</th> </tr> <tr> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> </tr> </table> <ul style="list-style-type: none"> <input type="checkbox"/> High Blood Pressure <input type="checkbox"/> Heart Attack <input type="checkbox"/> Chest Pains <input type="checkbox"/> Stroke <input type="checkbox"/> Angina <input type="checkbox"/> Kidney Stones <input type="checkbox"/> Kidney Disorders <input type="checkbox"/> Bladder Infection <input type="checkbox"/> Painful Urination <input type="checkbox"/> Loss of Bladder Control <input type="checkbox"/> Prostate Problems <input type="checkbox"/> Abnormal Weight Gain/Loss <input type="checkbox"/> Loss of Appetite <input type="checkbox"/> Abdominal Pain <input type="checkbox"/> Ulcer <input type="checkbox"/> Hepatitis <input type="checkbox"/> Liver/Gall Bladder Disorder <input type="checkbox"/> Cancer <input type="checkbox"/> Tumor <input type="checkbox"/> Asthma <input type="checkbox"/> Chronic Sinusitis | Past | Present | <input type="checkbox"/> | <input type="checkbox"/> | <table border="0" style="width: 100%;"> <tr> <th style="text-align: left;">Past</th> <th style="text-align: left;">Present</th> </tr> <tr> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> </tr> </table> <ul style="list-style-type: none"> <input type="checkbox"/> Diabetes <input type="checkbox"/> Excessive Thirst <input type="checkbox"/> Frequent Urination <input type="checkbox"/> Smoking/Use Tobacco Products <input type="checkbox"/> Drug/Alcohol Dependence <input type="checkbox"/> Allergies <input type="checkbox"/> Depression <input type="checkbox"/> Systemic Lupus <input type="checkbox"/> Epilepsy <input type="checkbox"/> Dermatitis/Eczema/Rash <input type="checkbox"/> HIV/AIDS <p>Females Only</p> <ul style="list-style-type: none"> <input type="checkbox"/> Birth Control Pills <input type="checkbox"/> Hormonal Replacement <input type="checkbox"/> Pregnancy <input type="checkbox"/> <p>Other Health Problems/Issues</p> <ul style="list-style-type: none"> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> | Past | Present | <input type="checkbox"/> | <input type="checkbox"/> |
|--|--------------------------|---------|--------------------------|--------------------------|--|------|---------|--------------------------|--------------------------|--|------|---------|--------------------------|--------------------------|
| Past | Present | | | | | | | | | | | | | |
| <input type="checkbox"/> | <input type="checkbox"/> | | | | | | | | | | | | | |
| Past | Present | | | | | | | | | | | | | |
| <input type="checkbox"/> | <input type="checkbox"/> | | | | | | | | | | | | | |
| Past | Present | | | | | | | | | | | | | |
| <input type="checkbox"/> | <input type="checkbox"/> | | | | | | | | | | | | | |

Indicate if an immediate family member has had any of the following:
 Rheumatoid Arthritis Heart Problems 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

Doctors Signature _____ Date _____

Back Index

ACN Group, Inc. - Form BI-100

ACN Group, Inc. Use Only rev 11/13/02

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.

Back
Index
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

- ① I have no pain at the moment.
- ② The pain is very mild at the moment.
- ③ The pain comes and goes and is moderate.
- ④ The pain is fairly severe at the moment.
- ⑤ The pain is very severe at the moment.
- ⑥ The pain is the worst imaginable at the moment.

Sleeping

- ① I have no trouble sleeping.
- ② My sleep is slightly disturbed (less than 1 hour sleepless).
- ③ My sleep is mildly disturbed (1-2 hours sleepless).
- ④ My sleep is moderately disturbed (2-3 hours sleepless).
- ⑤ My sleep is greatly disturbed (3-5 hours sleepless).
- ⑥ My sleep is completely disturbed (5-7 hours sleepless).

Reading

- ① I can read as much as I want with no neck pain.
- ② I can read as much as I want with slight neck pain.
- ③ I can read as much as I want with moderate neck pain.
- ④ I cannot read as much as I want because of moderate neck pain.
- ⑤ I can hardly read at all because of severe neck pain.
- ⑥ I cannot read at all because of neck pain.

Concentration

- ① I can concentrate fully when I want with no difficulty.
- ② I can concentrate fully when I want with slight difficulty.
- ③ I have a fair degree of difficulty concentrating when I want.
- ④ I have a lot of difficulty concentrating when I want.
- ⑤ I have a great deal of difficulty concentrating when I want.
- ⑥ I cannot concentrate at all.

Work

- ① I can do as much work as I want.
- ② I can only do my usual work but no more.
- ③ I can only do most of my usual work but no more.
- ④ I cannot do my usual work.
- ⑤ I can hardly do any work at all.
- ⑥ I cannot do any work at all.

Personal Care

- ① I can look after myself normally without causing extra pain.
- ② I can look after myself normally but it causes extra pain.
- ③ It is painful to look after myself and I am slow and careful.
- ④ I need some help but I manage most of my personal care.
- ⑤ I need help every day in most aspects of self care.
- ⑥ I do not get dressed, I wash with difficulty and stay in bed.

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, 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.
- ⑥ I cannot lift or carry anything at all.

Driving

- ① I can drive my car without any neck pain.
- ② I can drive my car as long as I want with slight neck pain.
- ③ I can drive my car as long as I want with moderate neck pain.
- ④ I cannot drive my car as long as I want because of moderate neck pain.
- ⑤ I can hardly drive at all because of severe neck pain.
- ⑥ I cannot drive my car at all because of neck pain.

Recreation

- ① I am able to engage in all my recreation activities without neck pain.
- ② I am able to engage in all my usual recreation activities with some neck pain.
- ③ I am able to engage in most but not all my usual recreation activities because of neck pain.
- ④ I am only able to engage in a few of my usual recreation activities because of neck pain.
- ⑤ I can hardly do any recreation activities because of neck pain.
- ⑥ I cannot do any recreation activities at all.

Headaches

- ① I have no headaches at all.
- ② I have slight headaches which come infrequently.
- ③ I have moderate headaches which come infrequently.
- ④ I have moderate headaches which come frequently.
- ⑤ I have severe headaches which come frequently.
- ⑥ I have headaches almost all the time.

Neck
Index
Score

Middletown Chiropractic

18 Golf Links Road
Middletown, NY 10940

Phone: (845) 342-5506

Dear Patient:

In an effort to provide you with flexible payment arrangements, we have expanded our payment policy.

PAYMENT ARRANGEMENTS ARE REQUESTED AT THE TIME OF YOUR VISIT
We now offer the following payment options:

- Payment by cash
- Payment by check
- Payment by credit card
- Automatic monthly billing to your Visa or MasterCard
- Guarantee any amount not covered by insurance with Visa or MasterCard.

Please make your choice, sign below and return to office manager before treatment.

Our office is a fully approved and accredited user of the *Visa and MasterCard Health Care Program* which will enable you to use your Visa and MasterCard to automatically cover amounts not paid by your insurance. You may also choose a comfortable amount to be automatically billed to your Visa or MasterCard on a monthly basis.

If none of the above apply, please see the office manager. Thank you.

Print your name here and sign below

x _____
Date: _____

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