WISNIEWSKI CHIROPRACTIC
10483 Frankstown Road
Pittsburgh, PA 15235
(412) 242-1600

First Name______________________ M.I._____ Last Name_______________________

Phone (H)___________________ (W)__________________ (C)____________________

Street____Apt______________

City___________________________________State_____Zip_____________

Age________ Sex______ Birthdate_________________ Number of Children_________

Marital Status(S M W D Other) Spouse's Name________________________________

Social Security_______________________Occupation___________________________

Employer___________________________Work Address_________________________

Referred by____________________ Person Responsible for this Account_____________

E-Mail Address____

Are you covered on any other health insurance plan, such as your spouses? Yes No
Are you here for a free exam? Yes No

1. What is your major complaint?____
2. Is this condition due to an: A) Auto Accident B) Work Injury C) Other Accident
   D) Unknown cause E) Illness

***** IF YOU ANSWERED A,B,C TO THE ABOVE QUESTION, STOP AND SEE FRONT DESK*****

3. Are the symptoms: A) Improving B) Getting Worse C) About the Same D) Intermittent
   Date symptoms appeared ________________________
4. Circle any activities which aggravate your condition: A) Standing B) Walking
   C) Sitting D) Lying E) Bending F) Lifting G) Twisting H) Coughing
5. Have you had these symptoms before? Yes if so when?______________ No
6. Have you seen another doctor for this condition?________
7. If so what kind of Doctor did you see (specialty of doctor) ____________________________

Drs. Name____Date Consulted____/_____/______

Diagnosis____

I understand and agree that health &accident insurance policies are an arrangement between an insurance carrier and myself. I authorize and direct payment from my insurance carrier directly to this office with the understanding that all moneys will be credited to my account upon receipt. However, I clearly understand and agree that all services rendered me are charged directly to me and that I am personally responsible for payment. I also understand that if I suspend or terminate my chiropractic care all fees for professional services rendered to me will be immediately due and payable. I authorize release of all my medical records to the doctors of Wisniewski Chiropractic.

Signature____Date_____/____/_____

WORK/ COMP QUESTIONNAIRE

Name____ Approved By__________________________________(Office Use Only)

1) Date of Accident _____/_____/_____ 2) Time of Accident _____:_____(AM/PM)

3) Name of Employer at time of Accident____

4) Employer Address____

5) City_____________________________________ State____________ Zip____________ Phone # ( )__________________

6) Occupation____

7) In terms of an 8 hour workday I: (Circle number of hours for each activity)

Sit (1 2 3 4 5 6 7 8) hours

Stand (1 2 3 4 5 6 7 8) hours

Walk (1 2 3 4 5 6 7 8) hours

8) On the job, I perform the following activities: (Circle as many as apply)

A) Bend/Stoop B) Squat C) Crawl D) Climb E) Reach above shoulders F) Crouch G) Kneel H) Push/Pull I) Maintain awkward posture

9) On the job, I regularly lift between:

A) 1-10 lbs. B) 11-24 lbs. C) 25-34 lbs. D) 35-50 lbs. E) 51-74 lbs. F) 75-100 lbs.

10) Are you required to bend over while lifting? (Y / N)

11) Do you use your hands for repetitive movements such as: (Circle as many as apply)

A) Simple Grasping (left hand) B) Firm Grasping (left hand) C) Fine Manipulating (left hand)
D) Simple Grasping (right hand) E) Firm Grasping (right hand) F) Fine Manipulating (right hand)

Prior to this accident were you experiencing any similar physical complaints? (Y / N) If "Yes" please explain:____________________

____

____

In your own words, please describe accident:____

____

____

____

____

____

____

____

____

Important:: This form may he used in the determination of your Workers Compensation eligibility
and the amount of compensation you are entitled.

To protect *your* rights please fill out this form correctly and completely!

EXAM FORM

NAME ______________________________ DATE ______________________________

HEIGHT ______________________________ WEIGHT ____________________

12. **GENERAL SYMPTOMS**:
A) Nervousness B) Irritability C) Fatigue D) Depression
E) Loss of Sleep F) Tension G) PMS H) Jaw Pain

13. **HEAD**:
A) Headache 1) Mild 2) Moderate 3) Severe
How often? (1 2 3 4 5 6) per (Day/Week/Month)
Are they? 1) Sharp 2) Dull
Are they? 1) Constant 2) Intermittent
Where are they located? 1) Back of head 2) Forehead
3) Temples 4) Right side
5) Left side 6) Behind eyes
B) Lightheaded C) Memory loss D) Fainting
E) Blurred vision F) Double vision G) Sensitivity to light
H) Loss of balance I) Hearing loss J) Ringing in ears

14. **NECK**:
A) Pain 1) Letf 2) Right 3) Both
Pain level 1) Mild 2) Moderate 3) Severe
Pain increased *by* 1) Forward movement
2) Backward movement
3) Rotate head left 4) Rotate head right
4) Bend neck letf 6) Bend neck right
B) Stiffness C) Muscle spasm D) Grinding/grating sound

15. **SHOULDER**:
A) Pain in joint 1) Left 2) Right 3) Both
B) Pain across shoulder 1) Left 2) Right 3) Both
C) Limitation of movement'1) Left 2) Right 3) Both
D) Tension 1) Left 2) Right 3) Both

18. ARMS:
A) Pain in upper arm 1) Letf 2) Right 3) Both
B) Pain in elbow 1) Letf 2) Right 3) Both
C) Pain in forearm 1) Letf 2) Right 3) Both
D) Pins & needles (Arm) 1) Left 2) Right 3) Both
E) Pins & needles (Forearm) 1) Left 2) Right 3) Both
F) Numbness in arm 1) Left 2) Right 3) Both
G) Numbness in forearm 1) Left 2) Right 3) Both

17. **HANDS:**
A) Pain in wrist 1) Letf 2) Right 3) Both
B) Pain in hand 1) Left 2) Right 3) Both
C) Pins & needles 1) Left 2) Right 3) Both
D) Numbness 1) Left 2) Right 3) Both

18. MIDBACK:
A) Pain 1) Letf 2) Right 3) Both
Pain level 1) Mild 2) Moderate 3) Severe
Pain type 1) Sharp/stabbing 2) Dull ache
B) Muscle spasm 1) Left 2) Right 3) Both

19. **CHEST**:
A) Deep chest pain 1) Left 2) Right 3) Both
Pain level 1) Mild 2) Moderate 3) Severe
B) Pain around ribs 1) Letf 2) Right 3) Both
C) Shortness of breath
D) Irregular heartbeat

19. **ABDOMINAL COMPLAINTS**:
A) Pain 1) Mild 2) Moderate 3) Severe
B) Nervous stomach C) Nausea D) Gas
E) Constipation F) Diarrhea G) Heartburn
H) Indigestion I) Loss of appetite

20. LOW BACK:
A) Upper lumbar pain 1) Letf 2) Right 3) Both
B) Lower lumbar pain 1) Left 2) Right 3) Both
C) Sacro-iliac pain 1) Left 2) Right 3) Both
Low back pain 1) Mild 2) Moderate 3) Severe
0) Muscle spasm 1) Letf 2) Right 3) Both

21. **HIPS AND LEGS**:
A) Pain in buttocks 1) Left 2) Right 3) Both
Pain level 1) Mild 2) Moderate 3) Severe
B) Pain in hip joint 1) Letf 2) Right 3) Both
Pain level 1) Mild 2) Moderate 3) Severe
C) Pain down leg 1) Left 2) Right 3) Both
Pain revel 1) Mild 2) Moderate 3) Severe
Pain radiates to 1) Knee 2) Calf 3) Foot
D) Numbness down leg 1) Left 2) Right 3) Both
Location 1) Front 2) Back 3) Side
E) Pins & needles (Legs) 1) Left 2) Right 3) Both
Location 1) Front 2) Back 3) Side
F) Knee pain 1) Left 2) Right 3) Both
G) Leg cramps 1) Left 2) Right 3) Both

22. **FEET**
A) Ankle pain 1) Left 2) Right 3) Both
B) Swollen ankle 1) Letf 2) Right 3) Both
C) Foot pain 1) Left 2) Right 3) Both
D) Numbness of feet 1) Letf 2) Right 3) Both
E) Swollen feet 1) Letf 2) Right 3) Both
F) Cramps 1) Letf 2) Right 3) Both

Date of most recent X-Rays taken: ____________ Type: Cerv ________ Lumb ________ Thor ________

REVIEW OF SYSTEMS

PATIENT NAME ______________________________ **DATE** __________

Please mark all that apply to your health condition:

General
____ Fever
____ Unexplained Weight Loss
____ Fatigue
____ Lightheaded
____ Fainting
____ Memory Loss
____ Loss of Balance
____ Loss of Sleep
____ Headaches
____ Jaw Pain
____ Skin Lesions
____ Other __________________

Eyes
____ Blurred Vision
____ Double Vision
____ Cloudy Vision
____ Flashes of Light
____ Sensitivity to Light
____ Other __________________

Ears
____ Hearing Loss
____ Ringing in Ears
____ Other __________________

Nose
____ Loss of Smell
____ Runny Nose
____ Other __________________

Throat
____ Sore Throat
____ Other __________________

Mouth
____ Dry Mouth
____ Ulcers
____ Cold Sores
____ Other _________________

Cardiovascular
____ Cold Hands
____ Cold Feet
____ Chest Pains
____ Blue Lips
____ Blue Nails
____ Irregular Heartbeat
____ Other _________________

Respiratory
____ Chest Congestion
____ Shortness of Breath
____ Difficulty Breathing
____ Other __________________

Gastrointestinal
____ Abdominal Pain
____ Nervous Stomach
____ Nausea
____ Gas
____ Constipation
____ Diarrhea
____ Heartburn
____ Indigestion
____ Loss of Appetite
____ Other __________________

Genitourinary
____ PMS
____ Irregular Periods
____ Impotence
____ Painful Urination
____ Inability to Urinate
____ Other __________________

Musculoskeletal
Aches or Pains in the:
____ Neck
____ Upper Back
____ Lower Back
____ Arms
____ Legs
____ Hands
____ Feet
____ Other __________________

Psychological
____ Nervousness
____ Irritability
____ Depression
____ Tension
____ Other __________________

Other
____
____
____
____
____

EXAM

Patient Name ______________________________ Date ______________________

1) Has anyone recommended/prescribed medication or surgery for this condition? Yes No

2) Are you currently taking ANY medications? Yes No
   Please List ALL Medications:

3) What have you done for your condition yourself and did it help?

____
____
____

4) Have you ever had surgery or been hospitalized?
   Yes No (What was the surgeries & when)

5) Have you ever had any previous auto or work related accidents? Yes No (Date / Describe)

6) List all doctors/hospitals or testing facilities that you've sought care at for this condition:

Name	Address & Phone #
a)______________________	__________________________
b)______________________	__________________________
c)______________________	__________________________

7) Patient *MUST* Sign A Records Release Form!

DR. RAYMOND C. WISNIEWSKI * 10483 FRANKSTOWN RD. * PITTSBURGH, PA 15235

NOTICE OF PRIVACY PRACTICES

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

1. OUR PLEDGE REGARDING MEDICAL INFORMATION

The privacy of your medical information is important to us. We understand that your medical information is personal and we are committed to protecting it. We create a record of the care and services you receive at our office. We need this record to provide you with quality care and to comply with certain legal requirements. This notice will tell you about the ways we may use and share medical information about you. We also describe your rights and certain duties we have regarding the use and disclosure of medical information.

2. OUR LEGAL DUTY

Law requires us to:

- Keep your medical information private.
- Give you this notice describing our legal duties, privacy practices, and your rights regarding your medical information.
- Follow the terms of the notice that is now in effect.

We have the right to:

- Change our privacy practices and the terms of this notice at any time, provided that the changes are permitted by law.
- Make the changes in our privacy practices and the new terms of our notice effective for all medical information that we keep, including information previously created or received before the changes.

Notice of change to privacy practices:

- Before we make an important change in our privacy practices, we will change this notice and make the new notice available upon request.

3. USE AND DISCLOSURE OF YOUR MEDICAL INFORMATION.

The following section describes different ways that we use and disclose medical information. Not every use or disclosure will be listed. However, we have listed all of the different ways we are permitted to use and disclose medical information. We will not use or disclose Your medical information for any purpose not listed below, without your specific written authorization. Any specific written authorization you provide may be revoked at any time by writing to us.

FOR TREATMENT: We may use medical information about you to provide you with medical treatment or services. We may disclose medical information about you to doctors, nurses, technicians, medical students, or other people who are taking care of you. We may also share medical information about you to your other health care providers to assist them in treating you. We utilize sign in sheets, which may be seen, by other patients and call patients by name. If this is unacceptable please inform the office personnel, and other arrangements for you will be made.

FOR PAYMENT: We may use and disclose your medical information for payment purposes.

FOR HEALTH CARE OPERATIONS: We may use and disclose your medical information for your health care operations. This may include measuring and improving quality, evaluating the performance of employees, conducting training programs and getting the accreditation, certificates, licenses and credentials we need to serve you.

For more information or to file a complaint:

The US. Department of Health & Human Services
Office of Civil Rights 200 Independence Avenue,
S.W. Washington, D.C. 20201
Toll Free: 1-877-696-6775

I (print) ______________________ have received a copy of this office's Notice of Privacy Practices.

(signature) ______________________ (date) ____________

Terms of Acceptance

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

Chiropractic has only one goal. It is important that each patient understand 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 specific adjustments 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 health potential.

We do not offer to diagnose or treat any disease or condition other than vertebral subluxation. However, if during the course of a chiropractic spinal examination, we encounter non-chiropractic or unusual findings, we will advise you. If you desire advice, diagnosis, or treatment for those findings, we will recommend that you seek the services of another health care provider.

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 major interference to the expression of the body's innate wisdom. Our only method is specific adjusting to correct vertebral subluxations.

I, ______________________________, have read and fully understand the above statements.

All questions regarding the doctor's objectives pertaining to my care in this office have been answered to my complete satisfaction. I, therefore, accept chiropractic care on this basis.

________________________________ ____________________

(Signature of patient) (Date)

Consent to evaluate and adjust a minor child.

I, _______________________________, being the parent or legal guardian of _______________________________ have read and fully understand the above terms of acceptance 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-rays can be hazardous to an unborn child. Date of last menstrual period ____________.

___________________________________ ________________

Signature Date