

MARVIN FAMILY CHIROPRACTIC, PC
Kenneth R. Marvin DC,CCSP
37 East Central Avenue
Pearl River, New York 10965
845-735-4755
845-735-1055 fax
www.MARVINCHIRO.com
drmarvin@marvinchiro.com

Welcome to Marvin Family Chiropractic, PC!

In order to make your visit as efficient as possible please fill out the attached forms completely and legibly.

TIPS TO FILLING OUT OUR OFFICE PAPERWORK

Page 1 tips:

- 1- Please include your email, cell phone # and cell carrier. We DO NOT share your personal information with anyone. This information will allow us to communicate with you more efficiently.
- 2- Please fill in height and weight.
- 3- If you have a primary care doctor please list their name and if you would like us to contact them/send a report to them.
- 4- If you have a list of medications there is no need to write them all down. Please bring them to the office and one of our staff will make a copy of it.
- 5- List all medications you are allergic to.
- 6- VERY IMPORTANT: ARE YOU TAKING ANY BLOOD THINNING MEDICATION? IF YES WHICH ONE(S).

Page 2 tips:

- 1- On page 2 please do not forget to mark where your pain is on the pain diagram.
- 2- Please sign privacy agreement and release of medical records agreement.

Page 3 tips:

- 1- Fill in insurance information and bring your insurance card to the office. We will make a copy of it and verify the benefits at the office.
- 2- Fill in credit card information. Your card will never be charged without notifying you first.
- 3- If a minor is being treated, please fill out the "Consent to treat minor" portion.

Page 4 tips:

- 1- Only circle the areas where your complaint is located. If you only have neck pain, fill in the CERVICAL pain region. If you have neck and upper back pain, fill in the CERVICAL and THORACIC pain. If you have lower back pain please circle the LUMBAR pain area etc.

Finally: Please fill out the Neck index and/or Back index or both if needed.

THIS IS REQUIRED!

Thank you in advance for filling out the forms completely. We look forward to seeing you in the office. Please do not forget to bring your paperwork and insurance card(if you have insurance) to the office. If the patient is under 17 years old a guardian must be present during the office visit.

Sincerely,

Dr. Marvin and Staff

WELCOME TO MARVIN FAMILY CHIROPRACTIC, PC

Date: _____
Name: _____
Address: _____
City: _____ State: _____
Zip: _____ DOB: _____
Home phone: _____
Employer phone: _____
Cell: _____ Cell Carrier: _____
EMAIL : _____
Social Security #: _____
How did you hear of our office: _____

YOUR employer: _____
Address: _____
Occupation: _____
MARRIED DIVORCED SINGLE WIDOWED
Spouse's name: _____
SPOUSE'S employer: _____
Emergency contact info:
Name _____
Phone: _____
Relation: _____

Is it work related? Y or N Is it related to a Motor Vehicle Accident? Y or N

HEIGHT: ' " **WEIGHT:** lb **Primary Care Physician:** _____ **Last seen:** _____
Would you like us to send a copy of your visit to your Primary Care Physician? YES or NO your initials: _____

ALLERGIES TO MEDICATIONS?: YES OR NO. IF YES: _____
PLEASE LIST ALL MEDICATIONS NONE _____

If you have a list of your medications please give it to our office staff.

Do you drink alcohol? NO social 1-2x wk 3-4x wk >5xwk Do you smoke? never current former quit:(when _____)

Do you exercise?: cardio weights yoga _____ 1-2x wk 3-4x wk daily

Surgical hx:(date/type of surgery) _____

Hospitalizations:(where and yr) _____

Major illness: _____

History of motor vehicle accident: Y or N _____

History of work related injury: Y or N _____

Do you take supplements: Y or N _____

DO YOU TAKE BLOOD THINNING MEDICATION(IE COUMADIN, PRADAXA ETC): YES OR NO

Health history: circle those that apply

PACEMAKER YES OR NO
DEFIBULATOR YES OR NO

Sleep affected YES or NO

head pain old new
neck pain: old new
upper back pain: old new
mid back pain: old new
lower back pain old new
buttock pain old new
upper extremity pain old new
lower extremity pain old new
high blood pressure old new
high cholesterol old new

Type 1 Diabetes old new
Type 2 Diabetes old new
facial pain old new
heart problems old new
lung problems old new
bowel problems old new
bladder problems old new
prostate problems old new
GI problems old new
pregnancy old new
LMP(last cycle) : _____
fevers/chill/sweats old new
thyroid problem (hypO or hypEr)

cancer: _____ old new

stroke _____ old new

anxiety old new

depression old new

Family history: NONE

high blood pressure mom dad

Type 1 2 diabetes mom dad

other family history:

Was there any head trauma? Y or N Have you had this before? Y or N when? _____

Are you having any(circle all that apply): fevers-chills-sweats-unexplained weight loss-bowel problems-bladder problems? NONE

1st Complaint: _____ start date? _____

Why did your problem start: _____ Onset type: RAPID OR GRADUAL

Your condition: getting worse getting better staying the same Scale of 0 to 10 (0 no pain 10 worst) worst: ___/10 today: ___/10 best: ___/10

type of pain: sharp dull achy throbbing stiff tight sore numbness tingling burning pulling tension _____

2nd Complaint: _____ start date? _____ Onset type: RAPID OR GRADUAL

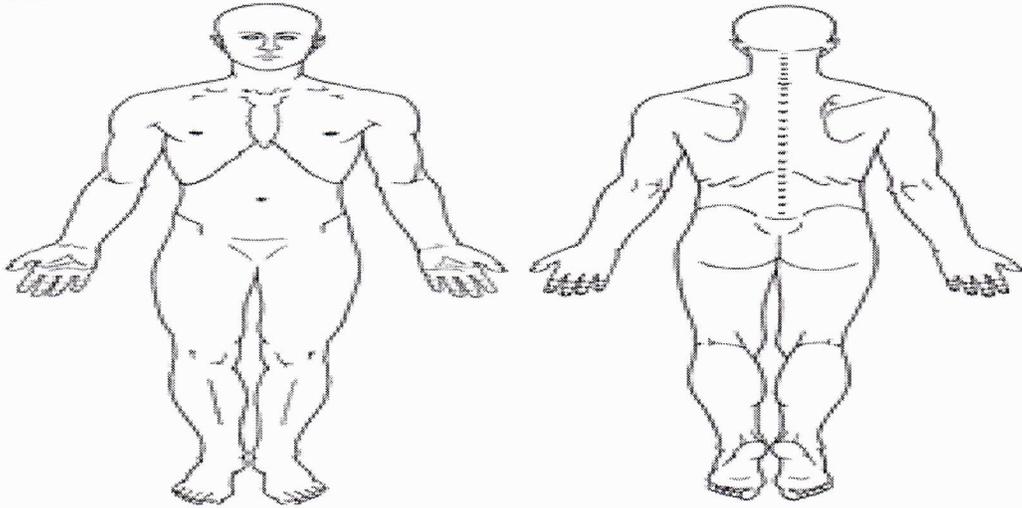
Why did your problem start: _____

Your condition: getting worse getting better staying the same

Scale of 0 to 10 (0 no pain 10 worst) worst: ___/10 today: ___/10 best: ___/10

type of pain: sharp dull achy throbbing stiff tight sore numbness tingling burning pulling tension _____

*******PLEASE MARK WHERE IT HURTS*******



Notice of Privacy For: Patient's Protect Health Information

This notice describes how health care information about you may be used and disclosed and how can get access to this information. Please review it carefully.

This office abides by the terms described in this policy.

This office uses and discloses your protected health care information for the following reasons:

- To share with other treating health care providers regarding your health care.
- To submit to insurance companies or Workers' Compensation Claim to verify that treatment has been rendered.
- To determine patient's benefits in a health care plan.
- Releasing information required by State or Federal Public Health Law.
- To assist in overcoming a language barrier when caring for a patient.
- Business associates providing written assurances for your privacy have been attained.
- Emergency situations.
- Abuse, neglect or domestic violence.
- Appointment reminder to household members or answering machines.
- Sign-in logs may be disclosed to verify office visits.

Any other uses or disclosures will only be made with your specific written prior authorization.

You have the right to:

- Revoke authorization, in writing at any time by specifying what you want restricted and to whom.
- Speak to our privacy officer who is Dr. Kenneth R. Marvin and can be reached at 845-735-4755 regarding privacy issues.
- Inspect, copy and amend your protected health information and amend it as allowed by law.
- Obtain an accounting of disclosures of your protected health information.
- To render a complaint to our privacy office or Secretary of Health and Human Services.

This office reserves the right to change the terms of this notice and to make new notice provisions for all protected health information that it maintains. Patients may also get an updated copy upon request at any time by asking the staff.

I acknowledge that I have received and reviewed this notice with full understanding.

Name of Patient (PRINT) Signature of Patient/Legal Representative Date

RELEASE OF MEDICAL RECORDS:

I, hereby give authorization for the release my medical records to Marvin Family Chiropractic, PC.

Name of Patient (PRINT) Signature of Patient/Legal Representative Date

AREA BELOW IS FOR OFFICE USE ONLY

blood pressure: left right / mm/hg pulse:left right b/m

INSURANCE INFORMATION

Name of Ins. Company: _____ Policy #: _____

Group #: _____ Name of the Insured: _____ Insured Date of Birth: _____

Name of Insured Employer: _____ City: _____ State: _____

***** **FINANCIAL AGREEMENT*******

I understand it is my responsibility to provide Marvin Family Chiropractic PC with valid and current insurance/referral information. I understand that my carrier may have timely filing limitations and failure to provide valid and current insurance information may result in no coverage and you being responsible for any charges incurred.

I hereby request that my insurance company send payment directly to Marvin Family Chiropractic, PC.

I understand and agree that my insurance policy is an agreement between my insurance carrier and myself.

I understand that Marvin Family Chiropractic, PC will prepare any necessary forms to assist me in making collection from the insurance company and that any amounts paid to this office will be credited to my account upon receipt.

Our office does not accept payment from secondary insurance, however we will fill out necessary paperwork to make it easier for you to be reimbursed. I understand that I am responsible for all non covered services.

I clearly understand and agree that all services rendered to me are charged directly to me and that I am personally responsible for payment.

I also understand that should I terminate my treatment that any fees outstanding would become *IMMEDIATELY DUE AND PAYABLE*.

I further understand that any fees not paid within a 30 day period will be assessed a \$10 billing fee and 1.5 % monthly interest charge. Should it become necessary for this office to utilize a collection company for payment of services, my account would be subject to a \$50.00 collection fee. Failure to pay any balances more than 30 days old will result in your credit card being charged.

YOUR CARD WILL NOT BE CHARGED WITHOUT INFORMING YOU FIRST

CREDIT CARD INFORMATION

Card #: _____ Expiration date: _____

Name on card: _____ Name of bank: _____

PATIENT NAME: _____

Patient/Guardian Signature:

Date: _____

Consent to treat minor:

I, _____ hereby allow Dr. Kenneth Marvin to evaluate and treat _____ (minor's name) Date: _____

PATIENT NAME: _____

Patient name: _____

Cervical/neck pain is worse:

same all day
in the AM

in the afternoon
in the evening

varies through out the day

Cervical/neck pain increased pain with:

looking up
looking down
tilting left
tilting right
looking left

looking right
sleeping
driving
reading
concentrating

coughing
swallowing
bending
lifting
personal

ADLs(bathing,
cooking)

Cervical/neck pain is less with:

heat
ice
stretching
chiropractic care
rest

laying down
medications
Biofreeze
TENS
NSAIDs

muscles relaxers
pain medication
massage

Thoracic/upper/mid back pain is worse:

same all day
in the AM
in the afternoon

in the evening
varies through out the day

Thoracic/upper/mid back pain increased pain with:

bending
lifting

breathing
coughing
twisting
walking

running
tilting
reaching
carrying

laying down
sitting
using the computer
sleeping

Thoracic/upper/mid back pain decreased with:

heat
ice
chiropractic care

medication
stretching
NSAIDs

muscle relaxers
pain medication
rest

laying down rest
movement
sleeping

Lumbar/lower back/buttock pain is worse:

same all day
in the AM

in the afternoon
in the evening

varies through out the day

Lumbar/lower back/buttock pain increases with:

bending
bowel movt
carrying
changing position in
bed
sleeping
squatting

coughing/sneezing
driving
getting out of bed
getting out of car
laying down
standing
twisting

lifting
personal activities
running
seated to standing
sitting
working
walking

sporting activities

Lumbar/lower back/buttock pain is decreased with :

heat
ice
medications

chiropractic care
massage
stretching
rest
sleep

laying down
movement
walking
TENS
NSAIDSs

Tylenol
muscle relaxer
pain medication

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.

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.

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.

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.

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.

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.

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.

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.

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.

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]

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[Statement selected x 5] x 100

Back
Index
Score

NECK DISABILITY INDEX QUESTIONNAIRE

NAME _____ AGE _____ DATE _____ SCORE _____

PLEASE READ: This questionnaire is designed to enable us to understand how much your neck pain has affected your ability to manage your everyday activities. Please answer each section by circling the ONE CHOICE that most applies to you. We realize that you may feel that more than one statement may relate to you, but **PLEASE JUST CIRCLE THE ONE CHOICE THAT MOST CLOSELY DESCRIBES YOUR PROBLEM RIGHT NOW.**

<p><i>SECTION 1 - Pain Intensity</i></p> <p>A. I have no pain at the moment. B. The pain is very mild at the moment. C. The pain is moderate at the moment. D. The pain is fairly severe at the moment. E. The pain is very severe at the moment. F. The pain is the worst imaginable at the moment.</p>	<p><i>SECTION 6 - Concentration/</i></p> <p>A. I can concentrate fully when I want to with no difficulty. B. I can concentrate fully when I want to with slight difficulty. C. I have a fair degree of difficulty in concentrating when I want to. D. I have a lot of difficulty in concentrating when I want to. E. I have a great deal of difficulty in concentrating when I want to. F. I cannot concentrate at all.</p>
<p><i>SECTION 2 - Personal Care (Washing, Dressing, etc.)</i></p> <p>A. I can look after myself normally without causing extra pain. B. I can look after myself normally, but it causes extra pain. C. It is painful to look after myself and I am slow and careful. D. I need some help, but manage most of my personal care. E. I need help every day in most aspects of self care. F. I do not get dressed, I wash with difficulty and stay in bed.</p>	<p><i>SECTION 7 - Work</i></p> <p>A. I can do as much work as I want to. 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 any work at all. F. I cannot do any work at all.</p>
<p><i>SECTION 3 - Lifting</i></p> <p>A. I can lift heavy weights without extra pain. B. I can lift heavy weights, but it gives extra pain. C. Pain prevents me from lifting heavy weights off the floor, but I can manage if they are conveniently positioned, for example, on a table. D. Pain prevents me from lifting heavy weights, but I can manage light to medium weights if they are conveniently positioned. E. I can lift very light weights. F. I cannot lift or carry anything at all.</p>	<p><i>SECTION 8 - Driving</i></p> <p>A. I can drive my car without any neck pain. B. I can drive my car as long as I want with slight pain in my neck. C. I can drive my car as long as I want with moderate pain in my neck. D. I cannot drive my car as long as I want because of moderate pain in my neck. E. I can hardly drive at all because of severe pain in my neck. F. I cannot drive my car at all.</p>
<p><i>SECTION 4 - Reading</i></p> <p>A. I can read as much as I want to with no pain in my neck. B. I can read as much as I want to with slight pain in my neck. C. I can read as much as I want to with moderate pain in my neck. D. I cannot read as much as I want because of moderate pain in my neck. E. I cannot read as much as I want because of severe pain in my neck. F. I cannot read at all.</p>	<p><i>SECTION 9 - Sleeping</i></p> <p>A. I have no trouble sleeping. B. My sleep is slightly disturbed (less than 1 hour sleepless). C. My sleep is mildly disturbed (1-2 hours sleepless). D. My sleep is moderately disturbed (2-3 hours sleepless). E. My sleep is greatly disturbed (3-5 hours sleepless). F. My sleep is completely disturbed (5-7 hours)</p>
<p><i>SECTION 5 - Headaches</i></p> <p>A. I have no headaches at all. B. I have slight headaches which come infrequently. C. I have moderate headaches which come infrequently. D. I have moderate headaches which come frequently. E. I have severe headaches which come frequently. F. I have headaches almost all the time.</p>	<p><i>SECTION 10 - Recreation</i></p> <p>A. I am able to engage in all of my recreational activities with no neck pain at all. B. I am able to engage in all of my recreational activities with some pain in my neck. C. I am able to engage in most, but not all of my recreational activities because of pain in my neck. D. I am able to engage in a few of my recreational activities because of pain in my neck. E. I can hardly do any recreational activities because of pain in my neck. F. I cannot do any recreational activities at all.</p>

COMMENTS: _____
