

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 _____

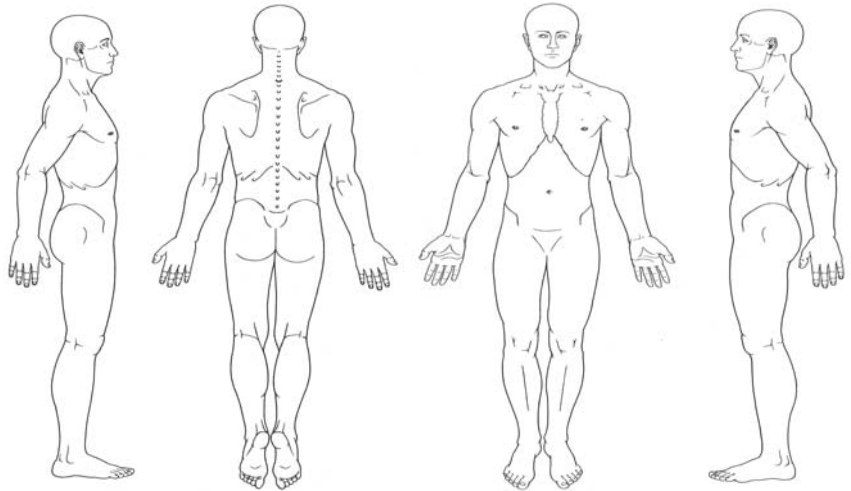
1. Describe your symptoms

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 _____

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 _____

AUTOMOBILE ACCIDENT QUESTIONNAIRE

Dr. Ellen Coyne, Family Chiropractor

PATIENT'S NAME: _____ Today's Date: _____
Date of Accident: _____

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

<u>Vehicle type:</u>		<u>Vehicle Size</u>	
<input type="checkbox"/> Car	<input type="checkbox"/> Pickup	<input type="checkbox"/> Subcompact	<input type="checkbox"/> Full-size
<input type="checkbox"/> Van	<input type="checkbox"/> Truck	<input type="checkbox"/> Compact	<input type="checkbox"/> Mini
<input type="checkbox"/> SUV	<input type="checkbox"/> Bus	<input type="checkbox"/> Mid-size	<input type="checkbox"/> Light
<input type="checkbox"/> Other _____		<input type="checkbox"/> Heavy	<input type="checkbox"/> Other _____

Your position in the vehicle:

Driver
 Passenger ---- Location ---- Front Passenger Rear Passenger - Left Middle Right
 Third Seat (rear)

Speed of your vehicle:

Stopped Moving Moderately
 Parked Moving Fast
 Slowing Moving approx. _____ 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:

<u>Vehicle type:</u>		<u>Vehicle Size</u>	
<input type="checkbox"/> Car	<input type="checkbox"/> Pickup	<input type="checkbox"/> Subcompact	<input type="checkbox"/> Full-size
<input type="checkbox"/> Van	<input type="checkbox"/> Truck	<input type="checkbox"/> Compact	<input type="checkbox"/> Mini
<input type="checkbox"/> SUV	<input type="checkbox"/> Bus	<input type="checkbox"/> Mid-size	<input type="checkbox"/> Light
<input type="checkbox"/> Other _____		<input type="checkbox"/> Heavy	<input type="checkbox"/> Other _____

CONDITIONS AT THE TIME OF THE ACCIDENT:

<u>Time of day:</u>	<u>Road Conditions:</u>	<u>Visibility:</u>	<u>Visibility compromised by:</u>
<input type="checkbox"/> Full daylight	<input type="checkbox"/> Dry	<input type="checkbox"/> Excellent	<input type="checkbox"/> Brightness
<input type="checkbox"/> Dusk	<input type="checkbox"/> Damp	<input type="checkbox"/> Good	<input type="checkbox"/> Darkness
<input type="checkbox"/> Night	<input type="checkbox"/> Wet	<input type="checkbox"/> Fair	<input type="checkbox"/> Rain
	<input type="checkbox"/> Snow covered	<input type="checkbox"/> Poor	<input type="checkbox"/> Snow
	<input type="checkbox"/> Ice covered		<input type="checkbox"/> Fog
	<input type="checkbox"/> Patchy Ice/ Snow		<input type="checkbox"/> Traffic

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

<u>Were you</u>	<u>Restraints: (check all that apply)</u>
<input type="checkbox"/> Totally unaware that the accident was impending	<input type="checkbox"/> Seat Belt
<input type="checkbox"/> Aware that the accident was impending	<input type="checkbox"/> Shoulder Harness
<input type="checkbox"/> Aware that the accident was impending and braced for it	<input type="checkbox"/> 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 w/ air bag
 Air bag deployed
 Air bag not deployed

What position was YOUR headrest in?

High position
 Middle position
 Low position

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
- Tilted forward
- Rotated to the left
- Rotated to the right

Damage to vehicle YOU were in:

- Incurred minimal damage
- Incurred moderate damage
- Incurred severe damage
- Was totaled
- Not Known

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 you 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

Citations:

- None issued
- Yourself
- Driver of vehicle patient was passenger of
- Driver of other vehicle
- Not Sure

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

Head

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

Left Arm

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

Right Arm

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

Torso

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

Left Leg

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

Right Leg

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

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

Did you lose consciousness?

- YES
 NO

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

- Dizzy Weak Disoriented
 Dazed Nervous Nauseated

Were you able to walk unaided

- YES
 NO

Where did you go...?

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

Next day discomfort...?

- Increased Decreased Same

Did your major complaints exist before the accident?

- YES NO

In what areas did you IMMEDIATELY feel pain?

- | | | | | | | |
|-------------------------------------|---------------------------------|-------------------------------|--------------------------------|-------|-------------------------------|--------------------------------|
| <input type="checkbox"/> Head | Shoulder | <input type="checkbox"/> Left | <input type="checkbox"/> Right | Hip | <input type="checkbox"/> Left | <input type="checkbox"/> Right |
| <input type="checkbox"/> Neck | Arm | <input type="checkbox"/> Left | <input type="checkbox"/> Right | Thigh | <input type="checkbox"/> Left | <input type="checkbox"/> Right |
| <input type="checkbox"/> Upper Back | Elbow | <input type="checkbox"/> Left | <input type="checkbox"/> Right | Knee | <input type="checkbox"/> Left | <input type="checkbox"/> Right |
| <input type="checkbox"/> Mid Back | Wrist | <input type="checkbox"/> Left | <input type="checkbox"/> Right | Calf | <input type="checkbox"/> Left | <input type="checkbox"/> Right |
| <input type="checkbox"/> Ribs | Hand | <input type="checkbox"/> Left | <input type="checkbox"/> Right | Ankle | <input type="checkbox"/> Left | <input type="checkbox"/> Right |
| <input type="checkbox"/> Chest | Finger | <input type="checkbox"/> Left | <input type="checkbox"/> Right | Foot | <input type="checkbox"/> Left | <input type="checkbox"/> Right |
| <input type="checkbox"/> Abdomen | Buttock | <input type="checkbox"/> Left | <input type="checkbox"/> Right | Toes | <input type="checkbox"/> Left | <input type="checkbox"/> Right |
| <input type="checkbox"/> Low Back | <input type="checkbox"/> Pelvis | | | | | |

In what areas did you experience lacerations (cuts)?

- | | | | | | | |
|-------------------------------------|---------------------------------|-------------------------------|--------------------------------|-------|-------------------------------|--------------------------------|
| <input type="checkbox"/> Head | Shoulder | <input type="checkbox"/> Left | <input type="checkbox"/> Right | Hip | <input type="checkbox"/> Left | <input type="checkbox"/> Right |
| <input type="checkbox"/> Neck | Arm | <input type="checkbox"/> Left | <input type="checkbox"/> Right | Thigh | <input type="checkbox"/> Left | <input type="checkbox"/> Right |
| <input type="checkbox"/> Upper Back | Elbow | <input type="checkbox"/> Left | <input type="checkbox"/> Right | Knee | <input type="checkbox"/> Left | <input type="checkbox"/> Right |
| <input type="checkbox"/> Mid Back | Wrist | <input type="checkbox"/> Left | <input type="checkbox"/> Right | Calf | <input type="checkbox"/> Left | <input type="checkbox"/> Right |
| <input type="checkbox"/> Ribs | Hand | <input type="checkbox"/> Left | <input type="checkbox"/> Right | Ankle | <input type="checkbox"/> Left | <input type="checkbox"/> Right |
| <input type="checkbox"/> Chest | Finger | <input type="checkbox"/> Left | <input type="checkbox"/> Right | Foot | <input type="checkbox"/> Left | <input type="checkbox"/> Right |
| <input type="checkbox"/> Abdomen | Buttock | <input type="checkbox"/> Left | <input type="checkbox"/> Right | Toes | <input type="checkbox"/> Left | <input type="checkbox"/> Right |
| <input type="checkbox"/> Low Back | <input type="checkbox"/> Pelvis | | | | | |

At the hospital, what areas were x-rayed?

- | | | | | | | |
|-------------------------------------|---------------------------------|-------------------------------|--------------------------------|-------|-------------------------------|--------------------------------|
| <input type="checkbox"/> Head | Shoulder | <input type="checkbox"/> Left | <input type="checkbox"/> Right | Hip | <input type="checkbox"/> Left | <input type="checkbox"/> Right |
| <input type="checkbox"/> Neck | Arm | <input type="checkbox"/> Left | <input type="checkbox"/> Right | Thigh | <input type="checkbox"/> Left | <input type="checkbox"/> Right |
| <input type="checkbox"/> Upper Back | Elbow | <input type="checkbox"/> Left | <input type="checkbox"/> Right | Knee | <input type="checkbox"/> Left | <input type="checkbox"/> Right |
| <input type="checkbox"/> Mid Back | Wrist | <input type="checkbox"/> Left | <input type="checkbox"/> Right | Calf | <input type="checkbox"/> Left | <input type="checkbox"/> Right |
| <input type="checkbox"/> Ribs | Hand | <input type="checkbox"/> Left | <input type="checkbox"/> Right | Ankle | <input type="checkbox"/> Left | <input type="checkbox"/> Right |
| <input type="checkbox"/> Chest | Finger | <input type="checkbox"/> Left | <input type="checkbox"/> Right | Foot | <input type="checkbox"/> Left | <input type="checkbox"/> Right |
| <input type="checkbox"/> Abdomen | Buttock | <input type="checkbox"/> Left | <input type="checkbox"/> Right | Toes | <input type="checkbox"/> Left | <input type="checkbox"/> Right |
| <input type="checkbox"/> Low Back | <input type="checkbox"/> Pelvis | | | | | |

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

- | | | | | | | |
|-------------------------------------|---------------------------------|-------------------------------|--------------------------------|-------|-------------------------------|--------------------------------|
| <input type="checkbox"/> Head | Shoulder | <input type="checkbox"/> Left | <input type="checkbox"/> Right | Hip | <input type="checkbox"/> Left | <input type="checkbox"/> Right |
| <input type="checkbox"/> Neck | Arm | <input type="checkbox"/> Left | <input type="checkbox"/> Right | Thigh | <input type="checkbox"/> Left | <input type="checkbox"/> Right |
| <input type="checkbox"/> Upper Back | Elbow | <input type="checkbox"/> Left | <input type="checkbox"/> Right | Knee | <input type="checkbox"/> Left | <input type="checkbox"/> Right |
| <input type="checkbox"/> Mid Back | Wrist | <input type="checkbox"/> Left | <input type="checkbox"/> Right | Calf | <input type="checkbox"/> Left | <input type="checkbox"/> Right |
| <input type="checkbox"/> Ribs | Hand | <input type="checkbox"/> Left | <input type="checkbox"/> Right | Ankle | <input type="checkbox"/> Left | <input type="checkbox"/> Right |
| <input type="checkbox"/> Chest | Finger | <input type="checkbox"/> Left | <input type="checkbox"/> Right | Foot | <input type="checkbox"/> Left | <input type="checkbox"/> Right |
| <input type="checkbox"/> Abdomen | Buttock | <input type="checkbox"/> Left | <input type="checkbox"/> Right | Toes | <input type="checkbox"/> Left | <input type="checkbox"/> Right |
| <input type="checkbox"/> Low Back | <input type="checkbox"/> Pelvis | | | | | |

PATIENT'S SIGNATURE: _____ DATE: _____

No-Fault Initial Consultation

Patient Name: _____

Date: _____

Age: _____

Date of Accident: _____

No-Fault Insurance Carrier (please present auto insurance card so we may obtain a copy):

Have you retained an attorney: Yes / No If yes, your attorney's name and address/ telephone #:

Were you taken or treated in the hospital? YES / NO

If Yes, What Hospital: _____

Date of Discharge: _____

Test Performed: _____

Was any other doctor consulted after your accident? YES / NO

If Yes, Please list name and type of treatment given:

Have you lost time at work due to accident? YES / NO

First date out of work: _____

Date returned to work _____ Partial or Full Duty

Past medical/ surgical history: _____

List medications you are currently taking: _____

Please explain in detail how your accident happened: (Do not leave blank)
