Chiropractic Partners
RESTORING HEALTH AND WELLNESS

Michael Krasnov, D.C., C.C.S.P.
3319 Durham Chapel Hill Blvd.
Durham, NC 27707
(P)919-383-9890

NEW PATIENT INTAKE

First Name _____ MI _____ Last Name _____

Address _____

City _____ State _____ Zip Code _____

Home Phone _____ Cell Phone _____

Work Phone _____ Email _____

Date of Birth ____/____/____ Age _____ SSN# _____-____-_____

Marital Status ❑Single ❑Married ❑Other **Gender** ❑Male ❑Female

Employment Status ❑Employed ❑Unemployed ❑Student ❑Retired ❑Other

Employer Name _____ Job Description _____

Address _____ City _____ State _____ Zip _____

Race (check one)

❑White	❑Black/African American	❑Hispanic	❑American Indian/Alaskan
❑Asian	❑Asian Indian	❑Chinese	❑Filipino
❑Japanese	❑Korean	❑Vietnamese	❑Native Hawaiian/Pacific Island
❑Samoan	❑Guamanian or Chamorro	❑Other	❑I choose not to specify

Ethnicity (check one) ❑Hispanic or Latino ❑Not Hispanic/Latino ❑I choose not to specify

Preferred Language (check one)

❑English	❑Spanish	❑American Sign Language	❑Chinese	❑French	❑German	
❑Tagalog	❑Vietnamese	❑Italian	❑ Korean	❑Russian	❑Polish	❑ Arabic
❑Portuguese	❑Japanese	❑French Creole	❑Greek	❑Hindi	❑Persian	❑Urdu
❑Gujarati	❑Armenian	❑I choose not to specify				

Verification Question (choose only one question and give answer to that question)

❑What is the name of your favorite pet? ❑In what city were you born? ❑When is your anniversary?
❑What high school did you attend? ❑What is your favorite movie? ❑What is your favorite color?
❑What is your mother's maiden name? ❑What was the make of your first car?

Verification Answer to Chosen question: _____
****HAS TO BE LONGER THAN 6 CHARACTERS*****

Emergency Contact Name _____ Relationship _____

Phone Number _____

Current medications, including frequency and dosage if known.

If there are no current medications, check here: ☐

Name of Medication	Start Date	Name of Medication	Start Date
1)_____	/_____	5)_____	/_____
2)_____	/_____	6)_____	/_____
3)_____	/_____	7)_____	/_____
4)_____	/_____	8)_____	/_____

List any known allergies you have had to any medications.

If no allergies are known, check here: ☐

1)_____

2)_____

3)_____

4)_____

Do you currently smoke tobacco of any kind? ☐Yes ☐Former Smoker ☐Never been a smoker

If yes, how often do you smoke: ☐Current every day smoker ☐Current sometimes smoker

If yes, what is your level of interest in quitting smoking?

No interest ☐0 ☐1 ☐2 ☐3 ☐4 ☐5 ☐6 ☐7 ☐8 ☐9 ☐10 *Very interested*

Has any doctor diagnosed you with Diabetes presently? ☐Yes ☐No

If yes, what kind? ☐Type 1 ☐Type 2

If yes to Diabetes, was your blood lab-work test for hemoglobin A1c > 9.0%? ☐Yes ☐No ☐Not sure

If yes, other comments regarding Diabetes: _____

Patient Signature: _____ Date: _____

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 _____

_____

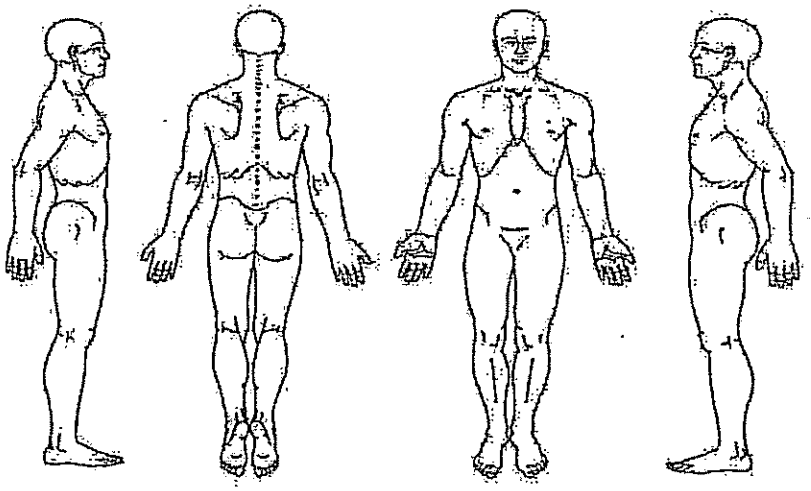
a. When did your symptoms start? _____

b. How did your symptoms begin? _____

2. How often do you experience your symptoms?

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)

Indicate where you have pain or other symptoms



3. What describes the nature of your symptoms?

① Sharp ④ Shooting
② Dull ache ⑤ Burning
③ Numb ⑥ Tingling

4. How are your symptoms changing?

① Getting Better
② Not Changing
③ Getting Worse

5. During the <u>past 4 weeks:</u>

a. Indicate the average intensity of your symptoms

None ⓪ 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 <u>past 4 weeks</u> 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:* _____ ③ CT Scan *date:* _____
② MRI *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* _____

Back Index

ACN Group, Inc. Form BI-100

ACN Group, Inc. Use Only 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 / (# of sections with a statement selected x 5)] x 100

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

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 _____

PATIENT NAME: _____ DATE: _____

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

DIRECTIONS: Below, please check all that apply to you.

MEDICAL CONDITIONS

- ☐ Arthritis
- ☐ Cancer
- ☐ Heart Disease
- ☐ Neck Surgery
- ☐ Stroke
- ☐ Asthma
- ☐ Diabetes
- ☐ Hypertension
- ☐ Psychiatric Illness
- ☐ Ataxia
- ☐ Epilepsy
- ☐ Hypothyroidism
- ☐ Skin Disorder
- ☐ Back surgery
- ☐ Gallbladdder
- ☐ MS
- ☐ Sleep Apnea

SURGERIES

- ☐ Abdominal
- ☐ Cardiovascular Procedures
- ☐ Foot
- ☐ Hernia
- ☐ Laminectomies
- ☐ Shoulder
- ☐ Brain
- ☐ Appendectomy
- ☐ Capal Tunnel
- ☐ Gall Bladder
- ☐ Hysterectomy
- ☐ Lumbar Spine
- ☐ Tonsillectomy
- ☐ Inguinal Hernia
- ☐ Back
- ☐ Cervical Spine
- ☐ Gastrointestinal
- ☐ Joint Replacement
- ☐ Neck
- ☐ Transurethral Prostate Surgery
- ☐ C-Section
- ☐ Cervical Disc Procedure
- ☐ Hand
- ☐ Knee
- ☐ Radical Prostatectomy
- ☐ Urogenital

ALLERGIES

- ☐ Codeine
- ☐ Peanut
- ☐ Watermelon
- ☐ Eggs
- ☐ Penicillin
- ☐ Wheat/Gluten
- ☐ Fish and Shellfish
- ☐ Soy
- ☐ Milk and Lactose
- ☐ Sulfites

SOCIAL HISTORY

- ☐ caffeine used occasionally
- ☐ drink alcohol occasionally
- ☐ exercise often
- ☐ smoke more than 1 pack a day
- ☐ caffeine used often
- ☐ drink alcohol often
- ☐ experience stress occasionlly
- ☐ wear seatbelts always
- ☐ chew tobacco occasionally
- ☐ exercise not at all
- ☐ experience stress often
- ☐ wear seatbelts never
- ☐ chew tobacco often
- ☐ exercise occasionally
- ☐ smoke 1 pack or less per day
- ☐ wear seatbelts usually

FAMILY HISTORY

- ☐ arthritis (parent)
- ☐ cholesterol (parent)
- ☐ heart problems (parent)
- ☐ psychiatric (parent)
- ☐ thyroid (parent)
- ☐ arthritis (sibling)
- ☐ cholesterol (sibling)
- ☐ heart problems (sibling)
- ☐ psychiatric (sibling)
- ☐ thyroid (sibling)
- ☐ cancer (parent)
- ☐ diabetes (parent)
- ☐ high blood pressure (parent)
- ☐ stroke (parent)
- ☐ cancer (sibling)
- ☐ diabetes (sibling)
- ☐ high blood pressure (sibling)
- ☐ stroke (sibling)

SUBSTANCE USE

- ☐ Alcohol (past)
- ☐ Barbituates (past)
- ☐ Crystal Meth
- ☐ Marijuana (present)
- ☐ Alcohol (present)
- ☐ Barbituates (present)
- ☐ Heroin (past
- ☐ Amphetamines (past)
- ☐ Cocaine (past)
- ☐ Heroin (present)
- ☐ Amphetamines (present)
- ☐ Cocaine (present)
- ☐ Marijuana (past)

MALE CHILDREN

- ☐ Under 6 years
- ☐ Under 10 years
- ☐ Under 19 years

FEMALE CHILDREN

- ☐ Under 6 years
- ☐ Under 10 years
- ☐ Under 19 years

OCCUPATIONAL ACTIVITES

- ☐ Administration
- ☐ Construction
- ☐ Healthcare
- ☐ Household
- ☐ Military
- ☐ Teacher
- ☐ Business Owner
- ☐ Daycare/Childcare
- ☐ Heavy Equipment Operator
- ☐ Light Manual Labor
- ☐ Police/Fire
- ☐ Truck Driver
- ☐ Clerical/Secretarial
- ☐ Executive/Legal
- ☐ Heavy Manual Labor
- ☐ Manufacturing
- ☐ Professional Service
- ☐ Computer User
- ☐ Food Service Industry
- ☐ Home Services
- ☐ Medium Manual Labor
- ☐ Retail Worker

RECREATIONAL ACTIVITIES

- ☐ Backpacking
- ☐ Golf
- ☐ Soccer
- ☐ Weight Lifting
- ☐ Biking
- ☐ Racquetball
- ☐ Swimming
- ☐ Boating
- ☐ Running
- ☐ Tennis
- ☐ Football
- ☐ Skiing
- ☐ Walking

PATIENT NAME: _____ DATE: _____

REVIEW OF SYSTEMS (Check box if you have had trouble with any of the following. Circle NO if none.)

CARDIOVASCULAR			NO
	Present	Past	
Poor Circulation			
High Blood Pressure			
Aortic Aneurism			
Heart Disease			
Vascular Disease			
Chest Pain			
High Cholesterol			
Pacemaker			
Jaw Pain			
Irregular Heartbeat			
Swelling of Legs			
GENITOURINARY			NO
	Present	Past	
Kidney Disease			
Lower Side Pain			
Burning Urination			
Frequent Urination			
Blood in Urine			
Kidney Stone			
HEMATOLOGIC/LYMPHATIC			NO
	Present	Past	
Hepatitis			
Blood Clots			
Cancer			
Easy Bruising			
Easy Bleeding			
Fevers/Chills/Sweats			

RESPIRATORY			NO
	Present	Past	
Asthma			
Tuberculosis			
Shortness of Breath			
Emphysema			
Cold/Flu			
Cough/Wheezing			
EARS/NOSE/THROAT			NO
	Present	Past	
Dizziness			
Hearing Loss			
Sinus Infection			
Nosebleed			
Sore Throat			
Difficulty Swallowing			
Bleeding Gums			
EYES			NO
	Present	Past	
Glaucoma			
Double Vision			
Blurred Vision			
Cataracts			
INTEGUMENTARY			NO
	Present	Past	
Skin Lesions			
Skin Ulcers			
Skin Disease			
Eczema			
Psoriasis			
Rashes			

ALLERGIC/IMMUNOLOGIC			NO
	Present	Past	
Hives			
Immune Disorder			
HIV/AIDS			
Allergy Shots			
Cortisone Use			
GASTROINTESTINAL			NO
	Present	Past	
Gallbladder Problems			
Bowel Problems			
Constipation			
Liver Problems			
Ulcers			
Diarrhea			
Nausea/Vomiting			
Bloody Stools			
Poor Appetite			
MUSCULOSKELETAL			NO
	Present	Past	
Gout			
Arthritis			
Joint Stiffness			
Muscle Weakness			
Osteoporosis			
Broken Bones			
Joints Replaced			
ENDOCRINE			NO
	Present	Past	
Thyroid Disease			
Diabetes			
Hair Loss			
Menopausal			
Menstrual Problems			

PSYCHIATRIC			NO
	Present	Past	
Depression			
Anxiety Disorder			
Unusual Stress			
Constitutional			NO
	Present	Past	
Weight Loss/Gain			
Energy Loss/Problem			
Difficulty Sleeping			
NEUROLOGICAL			NO
	Present	Past	
Babinski			
Stroke			
Seizures			
Head Injury			
Brain Aneurysm			
Numbness			
Severe Headaches			
Pinched Nerves			
Parkinson's Disease			
Carpal Tunnel			
Spinning/Balance			

Patient Name: _____ Date: _____

PAYMENT/INSURANCE INFORMATION

Which of the following will you be using to assist in the payment of your charges?

❑ Self-pay ❑ Health Insurance ❑ Medicare ❑ Auto Insurance ❑Worker's Comp

❑ Other: _____

WORKER'S COMPENSATION INJURY / AUTO ACCIDENT / PERSONAL INJURY

If this is a work injury, have you filed an injury report with your employer? ❑ Yes ❑ No

Date: ____/____/____ Time: ____ am/pm To Whom Reported: _____

If this is an auto accident, did you obtain a police report? ❑ Yes ❑ No

For purposes of coordinating care, we recommend that we send records to the referring physician, if applicable, as well as to your primary physician if he/she is not the referring physician.

❑ **I do not want my records sent to my physicians.**

❑ **I hereby give permission to release records of treatment from Dr. Krasnov to the following physicians:**

Primary Care Physician: _____ Facility: _____

Referring Physician: _____ Facility: _____
(If different from primary)

Other: _____ Facility: _____

PATIENT SIGNATURE: X_____ Date: _____

WORKER'S COMPENSATION FORM

NOTICE: If you were injured on the job, you must **REPORT THE INJURY** to your employer. Failure to do so will result in denial of any payment. In the event that your worker's compensation insurance will not cover, you are responsible for your bill. Thank you.

NAME:_____ DATE OF BIRTH_____

ADDRESS:_____ CITY_____ STATE_____ ZIP_____
Must have street address if P.O. Box

SOCIAL SECURITY #_____ Home Phone_____ Work Phone_____

EMPLOYER:_____ ADDRESS:_____

Name of person you reported the injury to: _____

Is this person your supervisor? Yes / No If no, supervisor's name: _____

Who referred you to our office?_____

Please explain how the accident happened:_____

_____

_____

_____

Date of present injury:_____ Time:_____

Did you feel pain immediately at the time of the injury? YES / NO *(If no, please state when you began to have pain and where.)*_____

_____

Did you return to work following the injury? YES / NO

When you reported the injury to your supervisor, were you instructed to see a particular Dr.? YES / NO

How much time have you lost from work as a result of this injury? _____

AGREEMENT TO PAY IN THE EVENT COMPENSATION IS DENIED:

In the event that I fail to prosecute the claim for worker's compensation for this illness or condition or it is determined that the illness or condition is not a result of a compensable worker's compensation case, I hereby agree to pay this office's usual and customary fees for services rendered to me.

Date_____ Signature_____

PLEASE DO NOT WRITE BELOW THIS LINE

(Verifications will be indicated on call-in sheet if patient not a walk-in.)

This injury was verified by _____ on _____. Time of Call: _____

Name of supervisor or employer who verified the injury:_____

Claims mailing address:_____ Employer recognizes claim:

_____ YES / NO