Welcome to Dr. Lynn C. Friedman

Performance Health and Wellness

978 Route 45•Suite 109A•Pomona, NY 10970 (845)786-2022 www.drlfriedman.com

Please allow our staff to photocopy your driver's license and insurance details.
All information you supply is confidential. We comply with all federal privacy standards.

PATIENT INFORMATION

Thank you for choosing our office for your chiropractic needs. Please complete this form as completely and accurately as possible. If you have any questions or concerns, do not hesitate to ask for assistance. We will be happy to help.

(Please Print)

Name_____ Date_____ Referred by _____

☐ **Male** ☐ **Female Date of Birth** ___/___ / ___ **AGE** _____ **Height** _____ **Weight** _____ S.S.#_____-_____-_____

Address_____ City _____ State_____ Zip_____

Cell # (_____)_____ Cell Phone Carrier_____ Home/Work # (_____)_____

Email _____ (for appt reminders/our newsletter subscription)

Employer_____ Your Occupation_____

Employer/School Address_____

Marital Status ☐ S ☐ M ☐ D ☐ W Spouse/Partner's/Legal Guardian: _____

How many children do you have? ____ Names & Ages of children _____

Emergency Contact _____ Phone # (____)_____ Relation _____

INSURANCE INFORMATION

Insurance Company_____ Provider Number (____)_____

Policy # _____ Group # _____ Claim# _____

If you are not the principal insurance card holder for this account please provide the following info

Name of Policy Holder: _____ Relationship to Patient:_____
Policy Holder's DOB: _____/_____/_____ Policy Holder's SSN: ____-____-_____ Phone# (____) _____
Address_____ City _____ State_____ Zip _____

Name of Employer _____ Work # (_____)_____

Is patient covered by another insurance? ♦ Yes ♦ No
Secondary Insurance Carrier :_____ Policy #:_____

ASSIGNMENT/AUTHORIZATION/RELEASE: I certify that I, and/or my dependents, have insurance with the above named insurance company(s) and assign directly to Dr. Lynn C Friedman all insurance benefits, if any, otherwise payable to me for services rendered. I authorize the use of my signature on all insurance submissions. I understand that for all "co-pays" and referrals, if required by my insurance company are due at the time of each 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 didn't obtain a referral, I will be responsible for my bill. If Dr. Lynn C Friedman does not participate with my insurance company, charges for all office visits will be payable at the time of the visit. Additionally, I am financially responsible for all charges whether or not paid by insurance. The above named provider's office may use my health care information and may disclose such information to the above named insurance company(s) and their agents for the purpose of obtaining payment for services and determining benefits payable for related services.

☐ Private Pay/Cash: By checking this box, I acknowledge that I do not have insurance and understand that I am financially responsible for all services at the time they are rendered.

X_____ DATE: _____
Signature of Patient, Parent or Legal Guardian (if minor)
Relationship to Patient _____Phone # (_____)_____

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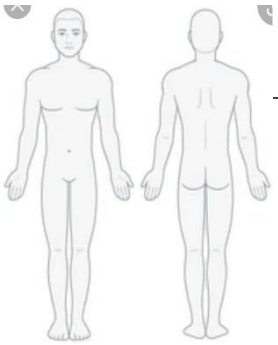
REASON FOR SEEKING CORRECTIVE CHIROPRACTIC CARE

Reason for the Visit - Main Complaint - _____RT/LT
Secondary Complaint - _____RT/LT
Add'l Complaint - _____RT/LT

Mark location of your pain on diagram below



Is this purpose related to an auto accident/work injury? ☐Y ☐N If so, when _____
When did this problem start? ___/___/___ Did it begin: ☐Sudden ☐Gradual _____
How did this symptom begin? (be specific) _____
_____
Have you ever had this problem before? ☐Y ☐ N If yes, when _____
Pain(s) present what % of the time? ☐ 100% ☐ 75% ☐ 50% ☐ 25% ☐ less than 25%

Quality of the pain: ☐*achy* ☐*burning* ☐*cramping* ☐*dull* ☐*grabbing* ☐*numb* ☐*sharp* ☐*shooting* ☐*sore* ☐*stabbing* ☐*stiff* ☐*tender* ☐*throbbing* ☐*other* _____

Is this condition **getting worse**? ☐Y ☐N; Pain worse on the left right both sides center?
Does this pain radiates/travels to your ☐arm ☐leg? ☐does not radiates ☐Y if yes, please indicate to where on diagram**
Please indicate the severity of the pain on a scale from 1-10 (1 minor pain, 10 major pain)

1----2----3----4----5----6----7----8----9----10

What makes this pain or condition **better**? _____ Worse? _____
Does complaint(s) interfere with: ☐work ☐sleep ☐hobbies ☐daily routine; Explain: _____
What time of the day is it worst? _____Have you missed days from work? ☐ ☐, Dates_____
Have you consulted other healthcare practitioner for this complaint? ☐ Y ☐N
Poor Posture and **Stress** can cause spinal damage. Rate your **Stress level in the last 90 days**: (1 minor pain, 10 major pain)

1----2----3----4----5----6----7----8----9----10

What is the **major stressor in your life**? ☐none ☐home/family ☐friends ☐work☐other_____

EXPERIENCE WITH CHIROPRACTIC

Have you ever received Chiropractic Care? ☐Y ☐N Dr's Name _____ When?_____
Why did you go? _____ Was it a positive experience? Y ☐ N☐If no explain: _____
Did your previous chiropractor take before and after x-rays? Did you know posture determines your health? ☐Y ☐N
Are you aware of any **poor posture habits** that affects? ☐You ☐your Spouse ☐your Kids ☐Y ☐N; If no explain: _____

FAMILY HISTORY

Are Both Your Parents Alive Y N … and in Good Health? Y N…if no explain _____

Family History: If any immediate blood relative has any please check ☑ and indicate if it's your Father(F) Mother(M) Other Relative(O)

☐**Arthritis** F M O	☐**Diabetes** F M O	☐**Heart** F M O	☐**Lung disease** F M O	☐**Scoliosis** F M O
☐**Cancer** F M O	☐**High BP** F M O	☐**High Cholesterol** F M O	☐**Stroke** F M O	☐**Other** F M O

SURGERY/HOSPITAL/ACCIDENT/HISTORY

Please list all past surgeries and dates: _____
_____
_____
Please list past hospitalizations and dates:_____
Please list all previous accidents, falls traumas and dates: _____
Please list Any Medications currently taking and their purpose: _____
_____
Any Allergies: _____
Name of your Primary Care Physician? _____ Last Physical Exam: _____

Doctor's Initals _____

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Please check all that apply to your Health History:

- ☐ Aids/HIV
- ☐ Alcoholism
- ☐ Allergy Shots
- ☐ Anemia
- ☐ Anorexia
- ☐ Appendicitis
- ☐ Arthritis
- ☐ Bleeding Disorders
- ☐ Bronchitis
- ☐ Broken Rib
- ☐ Bulimia
- ☐ Bursitis
- ☐ Cancer
- ☐ Cataracts
- ☐ Chicken Pox
- ☐ Chemical Dependency
- ☐ Colitis
- ☐ Concussion
- ☐ Cracked Rib(s)
- ☐ Diabetes
- ☐ Depression
- ☐ Drug Poisoning
- ☐ Eczema
- ☐ Emphysema
- ☐ Epilepsy
- ☐ Fainting
- ☐ Food Poisoning
- ☐ Fractures
- ☐ Gastritis
- ☐ Glaucoma
- ☐ Goiter
- ☐ Gonorrhea
- ☐ Gout
- ☐ Hay Fever
- ☐ Head Injury
- ☐ Hepatitis
- ☐ Hernia
- ☐ Herniated Disc
- ☐ Herpes
- ☐ High Blood Pressure
- ☐ High Cholesterol
- ☐ Irritable Bowel Syndrome
- ☐ Jaundice
- ☐ Kidney Disease
- ☐ Liver Disease
- ☐ Low Blood Pressure
- ☐ Lumbago
- ☐ Measles
- ☐ Meningitis
- ☐ Migraines
- ☐ Mononucleosis
- ☐ Multiple Sclerosis
- ☐ Mumps
- ☐ Neuralgia
- ☐ Neuritis
- ☐ Osteoarthritis
- ☐ Osteoporosis
- ☐ Pacemaker
- ☐ Parkinson's Disease
- ☐ Pneumonia
- ☐ Pleurisy
- ☐ Psychiatrist Care
- ☐ Prostate Problems
- ☐ Polio
- ☐ Pinched Nerve
- ☐ Rheumatic Fever
- ☐ Rheumatoid Arthritis
- ☐ Recurrent Dislocation
- ☐ Scarlet Fever
- ☐ Sciatica
- ☐ Shingles
- ☐ Stones
- ☐ Stroke
- ☐ Suicide Attempt
- ☐ Tonsillitis
- ☐ Typhoid Fever
- ☐ Ulcers
- ☐ Vaginal Infections
- ☐ Venereal Disease
- ☐ Whiplash When? _____
- ☐ Whooping Cough
- ☐ Worms

Type of Drug_____ Age (at time of incident)_____

Brief Explanation_____

_____

_____

Females Only: Currently pregnant? ☐Yes ☐ No **Are you currently nursing**? ☐Yes ☐ No **Painful/Abnormal Menstrual Cycle?** ☐Yes ☐ No **Menopause?** ☐Yes ☐ No **Miscarriage?** ☐Yes ☐ No **Do you have children?** ☐Yes ☐ No

If "Yes", Pregnancies and outcomes: (please include delivery dates if applicable)

_____ _____

_____ _____

HEALTH LIFESTYLE & COMPLICATING FACTORS

Do you exercise? ☐No ☐Yes How often? _____ per wk **What activities**? run walk weights other _____

Do you smoke? ☐No ☐Yes How much?

_____

Do you drink alcohol? ☐No ☐Yes How much/week?

_____

Do you drink coffee? ☐No ☐Yes How much cups/day?

_____

Do you take supplements? ☐No ☐Yes Please list supplements

_____

Have you had the COVID-19 Vaccine? ☐No ☐Yes Have you had COVID-19 and any complications from the vaccine or virus?

_____

Doctor's Initals _____

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QUALITY OF LIFE & ACTIVITIES OF DAILY LIVING

How does your condition currently interfere with your life and ability to function?

	No Effect	Mild Effect	Moderate Effect	Severe Effect
Sitting	☐	☐	☐	☐
Rising out of Chair	☐	☐	☐	☐
Standing	☐	☐	☐	☐
Walking	☐	☐	☐	☐
Lying Down	☐	☐	☐	☐
Bending over	☐	☐	☐	☐
Climbing stairs	☐	☐	☐	☐
Using a Computer	☐	☐	☐	☐
Getting in/out of car	☐	☐	☐	☐
Driving a car	☐	☐	☐	☐
Looking over shoulder	☐	☐	☐	☐
Caring for family	☐	☐	☐	☐

	No Effect	Mild Effect	Moderate Effect	Severe Effect
Grocery shopping	☐	☐	☐	☐
Household Chores	☐	☐	☐	☐
Lifting Objects	☐	☐	☐	☐
Reaching overhead	☐	☐	☐	☐
Showering or bathing	☐	☐	☐	☐
Dressing myself	☐	☐	☐	☐
Love life	☐	☐	☐	☐
Getting to Sleep	☐	☐	☐	☐
Staying asleep	☐	☐	☐	☐
Concentrating	☐	☐	☐	☐
Exercising	☐	☐	☐	☐
Yard Work	☐	☐	☐	☐

APPOINTMENT CANCELLATION POLICY

We understand that there are times when you must miss and appointment due to emergencies or obligations for work or family. However, when you do not call to cancel an appointment, you may be preventing another patient from getting much needed treatment. Conversely, the situation may arise where another patient fails to cancel and we are unable to schedule you for a visit, due to a seemingly "full" appointment schedule.

If an appointment is not cancelled at least 24 hours in advance you will be charged a fifty dollar ($50) fee; this will not be covered by your insurance company.

For your convenience a print out of all appointments is available upon request at checkout.
I have read the above information and understand the above mentioned fees.

Acknowledgement of Receipt of Notice or Privacy Practices

I certify that I have received a copy of Notice of Privacy Practices. The Notice of Privacy Practices describes the types of uses and disclosures of my protected health information that might occur in my treatment, payment of my bills or in the performance of Performance Health & Wellness health care operations. The Notice of Privacy Practices also describes my rights and Performance Health & Wellness duties with respect to my protected health information. The Notice of Privacy Practices is posted in the office.

Performance Health & Wellness reserves the right to change the privacy practices that are described in the Notice of Privacy Practices. I may obtain a revised Notice of Privacy Practices by calling the office and requesting a revised copy to be sent in the mail, or asking for one at the time of my next appointment.

_____ _____
Signature of Patient or Personal Representative **Name of Patient or Personal Representative**

_____ _____
Date **Description of Personal Representative's Authority**

Doctor's Initals _____

Copy is available upon request.

Performance Health and Wellness

Dr. Lynn C Friedman

Neck Index

Patient Name_____ Date_____

This questionaire 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 once 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 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 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 was 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.
(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 with come infrequently.
(3) I have moderate headaches with come frequently.
(4) I have severe headaches which come frequently.
(5) I have headaches almost all of the time.

Performance Health and Wellness
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Back Index

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.