

**Bialecki Family Chiropractic**  
**3140 Sheridan Drive Suite 140 Amherst New York 14226**  
**716-240-9365**

**No-Fault Questionnaire**

Date: \_\_\_\_\_

Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_ SS#: \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_

Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Employer's Name: \_\_\_\_\_ Employer's Phone # ( ) \_\_\_\_\_ - \_\_\_\_\_

Employer's Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Auto Insurance Company for the Vehicle **YOU** were in: \_\_\_\_\_

Auto Insurance Policy #: \_\_\_\_\_ Agent: \_\_\_\_\_

Auto Insurance Company address: \_\_\_\_\_ Phone: ( ) \_\_\_\_\_ - \_\_\_\_\_

Date of Accident: \_\_\_\_\_ Claim#: \_\_\_\_\_ Time of Day: \_\_\_\_\_

Have you retained an Attorney: \_\_\_\_\_ If yes, Attorney's Name: \_\_\_\_\_

Attorney's Address: \_\_\_\_\_ Phone number: ( ) \_\_\_\_\_ - \_\_\_\_\_

**Nature of Accident:**

Where were you seated in the vehicle? \_\_\_\_\_ How many people were in the Car? \_\_\_\_\_

Which direction were you headed? (North) (South) (East) (West). Where did the accident occur? \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Were you Struck from: (Behind) (Front) (Left Side) (Right side). Were the police notified? \_\_\_\_\_

Do you have a police report? \_\_\_\_\_ Were you seated belted? \_\_\_\_\_

Any injuries prior to this motor vehicle accident? \_\_\_\_\_ If, yes please explain: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

In your own words, please describe the accident: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Name: \_\_\_\_\_

Date of Accident: \_\_\_\_\_

Where were you taken after the accident? \_\_\_\_\_

Have you been treated by another doctor since the accident? \_\_\_\_\_ If yes, please list names and addresses: \_\_\_\_\_

Since your injury occurred, are your symptoms: (Improved) (Worse) (The Same)  
Do you have any activity restrictions as a result of this injury? \_\_\_\_\_ If yes, please describe in detail: \_\_\_\_\_

Circle any of the following symptoms you have noticed since the accident:

- |                     |                  |                       |                      |
|---------------------|------------------|-----------------------|----------------------|
| (Headache)          | (Fainting)       | (Irritability)        | (Light bothers eyes) |
| (Face Flushed)      | (Pins & Needles) | (Feet Cold)           | (Nervousness)        |
| (Chest Pain)        | (Cold Sweat)     | (Shortness of Breath) | (Loss of taste)      |
| (Hands Cold)        | (Loss of Memory) | (Neck Stiffness)      | (Dizziness)          |
| (Fatigue)           | (Tension)        | (Loss of balance)     | (Depression)         |
| (Sleeping Problems) | (Diarrhea)       | (Constipation)        | (Back Pain)          |
| (Ears Ringing)      | (Fever)          | (Numbness in fingers) |                      |
| (Loss of smell)     | (Stomach upset)  | Other: _____          |                      |

Have you lost any time from work as a result of this accident? \_\_\_\_\_ If yes, what was your last day that you worked? \_\_\_\_\_

**TERMINATION OF CARE WAIVER**

I hereby acknowledge and understand that if I do not keep scheduled appointments as recommended to me by my attending doctor at this chiropractic office, Dr. John M. Bialecki has full and complete right to terminate my case that I am under his care for. Also, that any outstanding amount on my account are my responsibility. I, the undersigned also state that all information provided to Dr. John M. Bialecki is true to my knowledge.

\_\_\_\_\_  
Patient Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Parent and/or Guardian Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Provider/Staff Signature

\_\_\_\_\_  
Date

**NEW YORK MOTOR VEHICLE NO-FAULT INSURANCE LAW  
ASSIGNMENT OF BENEFITS FORM**

(FOR ACCIDENTS OCCURRING ON AND AFTER 3/1/02)

I, \_\_\_\_\_, ("Assignor") hereby assign to Dr. Bialecki, ("Assignee")  
(Print patient's name) (Print hospital or health care provider name)

all rights, privileges and remedies to payment for health care services provided by assignee to which I am entitled under Article 51 (the No-Fault statute) of the insurance Law.

The Assignee hereby certifies that they have not received any payment from or on behalf of the Assignor and shall not pursue payment directly from Assignor for services provided by said Assignee for injuries sustained due to the motor vehicle accident which occurred on \_\_\_\_\_, not withstanding any other agreement to the contrary.  
(Print accident date)

This agreement may be revoked by the assignee when benefits are not payable based upon the assignor's lack of coverage and/or violation of a policy condition due to the actions or conduct of the assignor.

ANY PERSON WHO KNOWINGLY AND WITH INTENT TO DEFRAUD ANY INSURANCE COMPANY OR OTHER PERSON FILES AN APPLICATION FOR INSURANCE OR STATEMENT OF CLAIM CONTAINING ANY MATERIALLY FALSE INFORMATION, OR CONCEALS FOR THE PURPOSE OF MISLEADING, INFORMATION CONCERNING ANY FACT MATERIAL THERETO, COMMITS A FRADUDLENT INSURANCE ACT, WHICH IS A CRIME, AND SHALL ALSO BE SUBJECT TO A CIVIL PENALTY NOT TO EXCEED FIVE THOUSAND DOLLARS AND THE STATED VALUE OF THE CLAIM FOR EACH SUCH VIOLATION.

\_\_\_\_\_  
(Print name of Patient) (Signature of Patient)  
\_\_\_\_\_  
(Date of Signature)

\_\_\_\_\_  
\_\_\_\_\_  
(Address)

Dr. John M. Bialecki  
(Print name of Provider) (Signature of Provider)  
\_\_\_\_\_  
(Date of Signature)

3140 Sheridan Drive Suite 140  
Amherst, New York 14226  
(Address)



**Medical Records Authorization**

Hospital or  
Urgent Care  
After  
Accident

**I HEREBY AUTHORIZE:** \_\_\_\_\_

to disclose the following protected health information: (Specially describe the information to be released.): ALL RECORDS REGARDING TREATMENT FOR D.O.I.

**RELEASE RECORDS TO:**

**Name:** John M. Bialecki D.C.  
3140 Sheridan Drive, Suite 140  
Amherst, New York 14226

**Address:** \_\_\_\_\_

**Fax #:** 716-240-9368

Disclosure of information is authorized for the following purposes: EVALUATION AND TREATMENT

**I UNDERSTAND** that I may refuse to sign this authorization. My refusal does not affect my treatment. I may revoke this authorization at any time, in writing, and that if I choose to do so, my request to revoke will not affect any actions taken by the Bialecki Family Chiropractic before receiving my revocation.

**I UNDERSTAND** that there is a potential for information use or disclosed pursuant to this authorization to be subject to redisclosure by the recipient and no longer be protected by federal or state law.

**THE EXPIRATION DATE** cannot be greater than 90 days from the date of the request.

I fully understand and accept the terms of this authorization.

**Patient's Name:** \_\_\_\_\_

(Please print- If name was different due to marital status, please include previous name as well)

**Patient's Full Address:** \_\_\_\_\_

**Telephone No:** \_\_\_\_\_

**Relationship:** \_\_\_\_\_

**Patient's Birthdate:** \_\_\_\_/\_\_\_\_/\_\_\_\_

**Signed:** \_\_\_\_\_

**Date:** \_\_\_\_/\_\_\_\_/\_\_\_\_

Please Complete All Highlighted Sections  
**CHIROPRACTIC REGISTRATION & HISTORY**

**Patient Information**

Date: \_\_\_\_\_  
 SS/HIC/Patient ID #: \_\_\_\_\_  
 Patient First Name: \_\_\_\_\_  
 Patient Middle Initial: \_\_\_\_\_  
 Patient Last Name: \_\_\_\_\_  
 Address: \_\_\_\_\_  
 City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_  
 Email: \_\_\_\_\_  
 Sex:  Male  Female Age: \_\_\_\_\_  
 Birthdate: \_\_\_\_\_  
**MARITAL STATUS**  Married  Widowed  Single  Minor  
 Separated  Divorced  Partnered for \_\_\_\_\_ Years  
 Occupation: \_\_\_\_\_  
 Patient Employer/School: \_\_\_\_\_  
 Employer/School Address: \_\_\_\_\_  
 Employer/School Phone: \_\_\_\_\_  
 Spouse's Name: \_\_\_\_\_  
 Birthdate: \_\_\_\_\_ SS# \_\_\_\_\_  
 Spouse's Employer: \_\_\_\_\_  
 Whom may we thank for referring you? \_\_\_\_\_

**Insurance**

Who is responsible for this account? \_\_\_\_\_  
 Relationship to Patient: \_\_\_\_\_  
 Insurance Co.: \_\_\_\_\_  
 FD# \_\_\_\_\_  
 Is patient covered by additional insurance?  Yes  No  
 Subscriber's Name: \_\_\_\_\_  
 Birthdate: \_\_\_\_\_ SS# \_\_\_\_\_  
 Relationship to Patient: \_\_\_\_\_  
 Insurance Co.: \_\_\_\_\_  
 Group # \_\_\_\_\_

**ASSIGNMENT AND RELEASE**

I certify that I, and/or my dependent(s), have insurance coverage with \_\_\_\_\_ (Name of Insurance Company(ies)) and assign directly to Dr. Bicdecki all insurance 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 authorize the use of my signature on all insurance submissions.

The above-named doctor may use my health care information and may disclose such information to the above-named Insurance Company(ies) and their agents for the purpose of obtaining payment for services and determining insurance benefits or the benefits payable for related services. This consent will end when my current treatment plan is completed or one year from the date signed below.

Signature of Patient, Parent, Guardian or Personal Representative

Please print name of Patient, Parent, Guardian or Personal Representative

Date Relationship to Patient

**Phone Numbers**

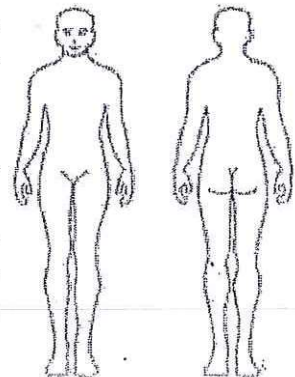
Home Phone: \_\_\_\_\_ Cell Phone: \_\_\_\_\_  
 Best time and place to reach you: \_\_\_\_\_  
**IN CASE OF EMERGENCY, CONTACT**  
 Name: \_\_\_\_\_ Relationship: \_\_\_\_\_  
 Home Phone: \_\_\_\_\_ Work Phone: \_\_\_\_\_

**Accident Information**

Is condition due to an accident?  Yes  No Date: \_\_\_\_\_  
 Type of accident:  Auto  Work  Home  Other: \_\_\_\_\_  
 To whom have you made a report of your accident?  Auto Insurance  
 Employer  Worker Comp.  Other: \_\_\_\_\_  
 Attorney Name (if applicable): \_\_\_\_\_

**Patient Condition**

Reason for Visit: \_\_\_\_\_  
 When did your symptoms appear? \_\_\_\_\_  
 Is this condition getting progressively worse?  Yes  No  Unknown  
 Mark an X on the picture where you continue to have pain, numbness, or tingling.  
 Rate the severity of your pain on a scale from 1 (least pain) to 10 (severe pain)  
**Type of pain:**  Sharp  Dull  Throbbing  Numbness  Aching  Shooting  
 Burning  Tingling  Cramps  Stiffness  Swelling  Other: \_\_\_\_\_  
 How often do you have this pain? \_\_\_\_\_  
 Is it constant or does it come and go? \_\_\_\_\_  
 Does it interfere with your  Work  Sleep  Daily Routine  Recreation  
 Activities or movements that are painful to perform:  Sitting  Standing  Walking  Bending  Lying Down





**Health History**

What treatment have you already received for your condition?  Medications  Surgery  Physical Therapy  Chiropractic Services  None

Other: \_\_\_\_\_

Name and address of other doctor(s) who have treated you for your condition: \_\_\_\_\_

Date of Last: Physical Exam: \_\_\_\_\_ Spinal X-Ray: \_\_\_\_\_ Blood Test: \_\_\_\_\_

Spinal Exam: \_\_\_\_\_ Chest X-Ray: \_\_\_\_\_ Urine Test: \_\_\_\_\_

Dental X-Ray: \_\_\_\_\_ MRI, CT-Scan, Bone Scan: \_\_\_\_\_

Place a mark on Yes" or "No" to indicate if you have had any of the following:

	Y	N		Y	N		Y	N		Y	N
AIDS/HIV	<input type="radio"/>	<input type="radio"/>	Diabetes	<input type="radio"/>	<input type="radio"/>	Liver Disease	<input type="radio"/>	<input type="radio"/>	Rheumatoid Arthritis	<input type="radio"/>	<input type="radio"/>
Alcoholism	<input type="radio"/>	<input type="radio"/>	Emphysema	<input type="radio"/>	<input type="radio"/>	Measles	<input type="radio"/>	<input type="radio"/>	Rheumatic Fever	<input type="radio"/>	<input type="radio"/>
Allergy Shots	<input type="radio"/>	<input type="radio"/>	Epilepsy	<input type="radio"/>	<input type="radio"/>	Migraine Headaches	<input type="radio"/>	<input type="radio"/>	Scarlet Fever	<input type="radio"/>	<input type="radio"/>
Anemia	<input type="radio"/>	<input type="radio"/>	Fractures	<input type="radio"/>	<input type="radio"/>	Miscarriage	<input type="radio"/>	<input type="radio"/>	Sexually Transmitted Disease	<input type="radio"/>	<input type="radio"/>
Anorexia	<input type="radio"/>	<input type="radio"/>	Glaucoma	<input type="radio"/>	<input type="radio"/>	Mononucleosis	<input type="radio"/>	<input type="radio"/>	Stroke	<input type="radio"/>	<input type="radio"/>
Appendicitis	<input type="radio"/>	<input type="radio"/>	Goiter	<input type="radio"/>	<input type="radio"/>	Multiple Sclerosis	<input type="radio"/>	<input type="radio"/>	Suicide Attempt	<input type="radio"/>	<input type="radio"/>
Arthritis	<input type="radio"/>	<input type="radio"/>	Gonorrhea	<input type="radio"/>	<input type="radio"/>	Mumps	<input type="radio"/>	<input type="radio"/>	Thyroid Problems	<input type="radio"/>	<input type="radio"/>
Asthma	<input type="radio"/>	<input type="radio"/>	Gout	<input type="radio"/>	<input type="radio"/>	Osteoporosis	<input type="radio"/>	<input type="radio"/>	Tonsillitis	<input type="radio"/>	<input type="radio"/>
Bleeding Disorders	<input type="radio"/>	<input type="radio"/>	Heart Disease	<input type="radio"/>	<input type="radio"/>	Pacemaker	<input type="radio"/>	<input type="radio"/>	Tuberculosis	<input type="radio"/>	<input type="radio"/>
Breast Lump	<input type="radio"/>	<input type="radio"/>	Hepatitis	<input type="radio"/>	<input type="radio"/>	Parkinson's Disease	<input type="radio"/>	<input type="radio"/>	Tumors, Growths	<input type="radio"/>	<input type="radio"/>
Bronchitis	<input type="radio"/>	<input type="radio"/>	Hernia	<input type="radio"/>	<input type="radio"/>	Pinched Nerve	<input type="radio"/>	<input type="radio"/>	Typhoid Fever	<input type="radio"/>	<input type="radio"/>
Bulimia	<input type="radio"/>	<input type="radio"/>	Herniated Disk	<input type="radio"/>	<input type="radio"/>	Pneumonia	<input type="radio"/>	<input type="radio"/>	Ulcers	<input type="radio"/>	<input type="radio"/>
Cancer	<input type="radio"/>	<input type="radio"/>	Herpes	<input type="radio"/>	<input type="radio"/>	Polio	<input type="radio"/>	<input type="radio"/>	Vaginal Infections	<input type="radio"/>	<input type="radio"/>
Cataracts	<input type="radio"/>	<input type="radio"/>	High Blood Pressure	<input type="radio"/>	<input type="radio"/>	Prostate Problem	<input type="radio"/>	<input type="radio"/>	Whooping Cough	<input type="radio"/>	<input type="radio"/>
Chemical Dependency	<input type="radio"/>	<input type="radio"/>	High Cholesterol	<input type="radio"/>	<input type="radio"/>	Prosthesis	<input type="radio"/>	<input type="radio"/>	Other: _____	<input type="radio"/>	<input type="radio"/>
Chicken Pox	<input type="radio"/>	<input type="radio"/>	Kidney Disease	<input type="radio"/>	<input type="radio"/>	Psychiatric Care	<input type="radio"/>	<input type="radio"/>	Other: _____	<input type="radio"/>	<input type="radio"/>

**EXERCISE**

- None
- Moderate
- Daily
- Heavy

**WORK ACTIVITY**

- Sitting
- Standing
- Light Labor
- Heavy Labor

**HABITS**

- Smoking Packs/Day: \_\_\_\_\_
- Alcohol Drinks/Week: \_\_\_\_\_
- Coffee/Caffeine Drinks Cups/Day: \_\_\_\_\_
- High Stress Level Reason: \_\_\_\_\_

Are you pregnant?  Yes  No

Injuries/Surgeries you have had	Description	Date
<input type="checkbox"/> Falls	_____	_____
<input type="checkbox"/> Head Injuries	_____	_____
<input type="checkbox"/> Broken Bones	_____	_____
<input type="checkbox"/> Dislocations	_____	_____
<input type="checkbox"/> Surgeries	_____	_____

**Medications**

**Allergies**

**Vitamins/Herbs/Minerals**

Pharmacy Name: \_\_\_\_\_

Pharmacy Phone: \_\_\_\_\_



# Informed Consent to Care

You are the decision maker for your health care. Part of our role is to provide you with information to assist you in making informed choices. This process is often referred to as "informed consent" and involves your understanding and agreement regarding the care we recommend, the benefits and risks associated with the care, alternatives, and the potential effect on your health if you choose not to receive the care.

We may conduct some diagnostic or examination procedures if indicated. Any examinations or tests conducted will be carefully performed but may be uncomfortable.

Chiropractic care centrally involves what is known as a chiropractic adjustment. There may be additional supportive procedures or recommendations as well. When providing an adjustment, we use our hands or an instrument to reposition anatomical structures, such as vertebrae. Potential benefits of an adjustment include restoring normal joint motion, reducing swelling and inflammation in a joint, reducing pain in the joint, and improving neurological functioning and overall well-being.

It is important that you understand, as with all health care approaches, results are not guaranteed, and there is no promise to cure. As with all types of health care interventions, there are some risks to care, including, but not limited to: muscle spasms, aggravating and/or temporary increase in symptoms, lack of improvement of symptoms, burns and/or scarring from electrical stimulation and from hot or cold therapies, including but not limited to hot packs and ice, fractures (broken bones), disc injuries, strokes, dislocations, strains, and sprains. With respect to strokes, there is a rare but serious condition known as an "arterial dissection" that typically is caused by a tear in the inner layer of the artery that may cause the development of a thrombus (clot) with the potential to lead to a stroke. The best available scientific evidence supports the understanding that chiropractic adjustment does not cause a dissection in a normal, healthy artery. Disease processes, genetic disorders, medications, and vessel abnormalities may cause an artery to be more susceptible to dissection. Strokes caused by arterial dissections have been associated with over 72 everyday activities such as sneezing, driving, and playing tennis.

Arterial dissections occur in 3-4 of every 100,000 people whether they are receiving health care or not. Patients who experience this condition often, but not always, present to their medical doctor or chiropractor with neck pain and headache. Unfortunately a percentage of these patients will experience a stroke.

The reported association between chiropractic visits and stroke is exceedingly rare and is estimated to be related in one in one million to one in two million cervical adjustments. For comparison, the incidence of hospital admission attributed to aspirin use from major GI events of the entire (upper and lower) GI tract was 1219 events/ per one million persons/year and risk of death has been estimated as 104 per one million users.

It is also important that you understand there are treatment options available for your condition other than chiropractic procedures. Likely, you have tried many of these approaches already. These options may include, but are not limited to: self-administered care, over-the-counter pain relievers, physical measures and rest, medical care with prescription drugs, physical therapy, bracing, injections, and surgery. Lastly, you have the right to a second opinion and to secure other opinions about your circumstances and health care as you see fit.

I have read, or have had read to me, the above consent. I appreciate that it is not possible to consider every possible complication to care. I have also had an opportunity to ask questions about its content, and by signing below, I agree with the current or future recommendation to receive chiropractic care as is deemed appropriate for my circumstance. I intend this consent to cover the entire course of care from all providers in this office for my present condition and for any future condition(s) for which I seek chiropractic care from this office.

Patient Name: \_\_\_\_\_ Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Parent or Guardian: \_\_\_\_\_ Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Witness Name: \_\_\_\_\_ Signature: \_\_\_\_\_ Date: \_\_\_\_\_



**STATEMENT OF ACKNOWLEDGEMENT OF FINANCIAL RESPONSIBILITY  
DISCLAIMER, RELEASE OF MEDICAL INFORMATION FORM AND  
DECLARATION**

I understand that I may be financially responsible for any charges incurred at this office, including co pays, deductibles, and charges denied or not covered by my insurance company.

I realize my care may be subject to pre-authorization by the insurance company, and I accept any responsibility for charges which may not be approved. The insurance company will review any/all documentation submitted by Dr. John M. Bialecki., for review for medical necessity and base their approval/denial upon this documentation.

I understand that this office agrees to notify me as soon as possible if a service is not covered and will notify me if my care is not approved by the insurance company. If a treatment plan is approved, this office will make me aware of the number of office visits allowed and the time frame of the authorization. Initial visits may be denied and this may be beyond the office's ability to notify the patient prior to rendering acute care, while waiting for insurance coverage approval. These charges will be the patient's responsibility if denied by the insurance company.

This office may seek payment from you for any services your health insurance plan determines to be not medically necessary.

I have read and understood my obligations for payment for care in the absence of insurance coverage.

\_\_\_\_\_  
(Print Patient's Name)

\_\_\_\_\_  
Date

\_\_\_\_\_  
Signature (Patient, Parent or Guardian)

\* I authorize Dr. John M. Bialecki. to release any medical information pertinent to my treatment plan to my insurance company or an authorized representative for review. This authorization for release of information shall remain valid for the term of my coverage under my current policy/policies. I certify that all insurance information given to this office is correct and complete. I also know that I am entitled to receive a copy of this authorization form.

\*I declare under penalty of perjury (under the laws of United States of America) that the foregoing is true and correct: I am not attempting to investigate Bialecki Chiropractic as a representative of any agent or entity, or any insurance company or other organizational entity or person.

\_\_\_\_\_  
(Printed Name)

\_\_\_\_\_  
Date

\_\_\_\_\_  
(Signature)

\_\_\_\_\_  
Witness signature

## BIALECKI CHIROPRACTIC

### NO SHOW POLICY/ FINANCIAL POLICY : AS OF 1/1/2023

Our goal is to provide quality care in a timely manner for our patients. We understand unplanned issues can occur. We schedule our appointments with the doctors to ensure the proper amount of time is spent with each patient. It is important that you are on time for the appointment you are given with Dr Bialecki.

If your schedule changes, please contact the office and we can arrange a different time for you. We request you give at least **24 hour** notice to cancel or reschedule your appointment. A **"No Show" fee of \$35-\$70** will be applied and charged directly to you depending on the type of appointment it is. The fee at any point can increase without prior notice. The "No Show" fee is not reimbursable by your insurance company. If you are more than 15 minutes late to an appointment, you may be asked to reschedule (which a fee may be applied) or you may have to wait for the next available time that day or another day.

Our office may decide to terminate its relationship with you if there is consecutive (less than 24 hr notice) cancels and/or no shows.

### NO FAULT & WORKERS COMPENSATION PLANS:

You are responsible for providing Bialecki Chiropractic with the information related to your case so we can properly submit for charges. The fees mandated by New York State No fault and Workers Comp will be changed to reflect our contracted fees and you will be responsible for payment. If you have private insurance, it may be possible to charge depending on coverage of chiropractic care plan with your insurance.

### NO SHOW POLICY AGREEMENT- EFFECTIVE 1/1/2023

Bialecki Chiropractic has implemented an updated policy. Recent changes in health markets and payment processes have altered insurance coverages to shift the cost of care to our patients. Credit card information can be collected by front office and kept confidential. If no card on file we may request you pay over the phone any balance before scheduling your next appointment. Bialecki Chiropractic may be authorized to charge the account for any appointments missed without the 24 hour notice of cancellation or rescheduling. We want to do our best to service our patients the best way we can.

Print Name: \_\_\_\_\_ Date: \_\_\_\_\_

Signature: \_\_\_\_\_



# NECK BOURNEMOUTH QUESTIONNAIRE

Patient Name \_\_\_\_\_ Date \_\_\_\_\_

**Instructions:** The following scales have been designed to find out about your neck pain and how it is affecting you. Please answer ALL the scales, and mark the ONE number on EACH scale that best describes how you feel.

1. Over the past week, on average, how would you rate your neck pain?

No pain

Worst pain possible

0 1 2 3 4 5 6 7 8 9 10

2. Over the past week, how much has your neck pain interfered with your daily activities (housework, washing, dressing, lifting, reading, driving)?

No interference

Unable to carry out activity

0 1 2 3 4 5 6 7 8 9 10

3. Over the past week, how much has your neck pain interfered with your ability to take part in recreational, social, and family activities?

No interference

Unable to carry out activity

0 1 2 3 4 5 6 7 8 9 10

4. Over the past week, how anxious (tense, uptight, irritable, difficulty in concentrating/relaxing) have you been feeling?

Not at all anxious

Extremely anxious

0 1 2 3 4 5 6 7 8 9 10

5. Over the past week, how depressed (down-in-the-dumps, sad, in low spirits, pessimistic, unhappy) have you been feeling?

Not at all depressed

Extremely depressed

0 1 2 3 4 5 6 7 8 9 10

6. Over the past week, how have you felt your work (both inside and outside the home) has affected (or would affect) your neck pain?

Have made it no worse

Have made it much worse

0 1 2 3 4 5 6 7 8 9 10

7. Over the past week, how much have you been able to control (reduce/help) your neck pain on your own?

Completely control it

No control whatsoever

0 1 2 3 4 5 6 7 8 9 10

\_\_\_\_\_  
Examiner

OTHER COMMENTS: \_\_\_\_\_



# Headache Disability Index

Patient Name \_\_\_\_\_

Date \_\_\_\_\_

Please check the correct response about your headaches:

1. I have a headache:  once per month  more than once but less than four times per month  more than once per week
2. My headache is:  mild  moderate  severe

Please read carefully: The purpose of this scale is to identify difficulties you may be experiencing because of your headaches. Please check Yes, Sometimes or No for each item. Answer each question only as it pertains to your headache.

		Yes	Sometimes	No
1	Do you feel disabled because of your headache?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
2	Do you feel restricted in performing your routine daily activities?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
3	Do you feel no one understands the effect your headaches have on your life?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
4	Do you restrict your recreational activities (for example, sports, hobbies) because of your headaches?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
5	Do your headaches make you angry?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
6	Do you feel that you are going to lose control because of your headaches?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
7	Are you less likely to socialize because of your headaches?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
8	Do you feel like your spouse (or significant other), family and friends have no idea what you are going through because of your headaches?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
9	Do you feel your headaches are so bad that you will go insane?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
10	Is your outlook on the world affected by your headaches?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
11	Are you afraid to go outside when you feel a headache is starting?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
12	Do you feel desperate because of your headaches?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
13	Are you concerned that you are paying penalties at work or at home because of headaches?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
14	Do your headaches place stress on your relationships with family or friends?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
15	Do you avoid being around people when you have a headache?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
16	Do you believe your headaches are making it difficult for you to achieve your goals in life?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
17	Are you unable to think clearly because of your headaches?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
18	Do you get tense (for example, muscle tension) because of your headaches?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
19	Do you not enjoy social gatherings because of your headaches?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
20	Do you feel irritable because of your headaches?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
21	Do you avoid traveling because of your headaches?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
22	Do your headaches make you feel confused?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
23	Do your headaches make you feel frustrated?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
24	Do you find it difficult to read because of your headaches?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
25	Do you find it difficult to focus your attention away from your headaches and on other things?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

**SCORING INSTRUCTIONS:** Yes = 4 points, Sometimes = 2, No = 0.

Using this system, a total score of 10-28 is considered to indicate mild disability; 30-48 is moderate disability; 50-68 is severe disability; 72 or more is complete disability.



## BACK BOURNEMOUTH QUESTIONNAIRE

Patient Name \_\_\_\_\_ Date \_\_\_\_\_

**Instructions:** The following scales have been designed to find out about your back pain and how it is affecting you. Please answer ALL the scales, and mark the ONE number on EACH scale that best describes how you feel.

1. Over the past week, on average, how would you rate your back pain?

No pain

Worst pain possible

0 1 2 3 4 5 6 7 8 9 10

2. Over the past week, how much has your back pain interfered with your daily activities (housework, washing, dressing, walking, climbing stairs, getting in/out of bed/chair)?

No interference

Unable to carry out activity

0 1 2 3 4 5 6 7 8 9 10

3. Over the past week, how much has your back pain interfered with your ability to take part in recreational, social, and family activities?

No interference

Unable to carry out activity

0 1 2 3 4 5 6 7 8 9 10

4. Over the past week, how anxious (tense, uptight, irritable, difficulty in concentrating/relaxing) have you been feeling?

Not at all anxious

Extremely anxious

0 1 2 3 4 5 6 7 8 9 10

5. Over the past week, how depressed (down-in-the-dumps, sad, in low spirits, pessimistic, unhappy) have you been feeling?

Not at all depressed

Extremely depressed

0 1 2 3 4 5 6 7 8 9 10

6. Over the past week, how have you felt your work (both inside and outside the home) has affected (or would affect) your back pain?

Have made it no worse

Have made it much worse

0 1 2 3 4 5 6 7 8 9 10

7. Over the past week, how much have you been able to control (reduce/help) your back pain on your own?

Completely control it

No control whatsoever

0 1 2 3 4 5 6 7 8 9 10

OTHER COMMENTS: \_\_\_\_\_ Examiner \_\_\_\_\_