WELCOME

MARK WOLFF DC, LLC

Dr. Preston Aronson, D.C.

Name: _____ Today's Date: _____

☐ Male ☐ Female Date of Birth __/__/__ Age ____ Height _____ Weight____ SS# _____

Marital Status: ☐ Single ☐ Married ☐ Divorced ☐ Widowed ☐ Separated Number of children: _____

Home Address: _____
Street Address/P.O. Box City State Zip Code

Email address: _____ How did you hear about us? _____

Employed: ☐ Fulltime ☐ Part Time

Home Phone #: _____ Work Phone #: _____ Job Description: _____

Employer Business Name: _____ Occupation: _____ Years Employed: ____

Employer's Address: _____
Street City State Zip Code

Emergency Contact Person: _____

Phone #: _____ Relationship: _____

INSURANCE INFORMATION:

Subscriber's Name: _____ Relationship: _____ Subscriber's Date of Birth: __/__/__

Please provide your insurance card and a photo ID to the receptionist.

List surgical operations and the year you had them: _____

Have you been in a motor vehicle accident in the past year? _____ Past 5 years? _____ Over 5 years ago? _____

Have you had any mental or emotional disorders? _____

Circle any of the following conditions you have had:

Alcoholism	Colitis	Heart disease	Prostate problems
Allergies	Diabetes	Hernia	Rheumatic fever
Anemia	Emphysema	High blood pressure	Scarlet fever
Arteriosclerosis	Epilepsy	H.I.V./A.I.D.S.	S.T.D.
Arthritis	Gout	Liver disease	Stroke
Asthma	Gynecologic problems	Multiple sclerosis	Tuberculosis
Bursitis	Hearing problems	Pleurisy	Ulcers
Cancer	Hepatitis	Pneumonia	Urinary tract problems

General Consent Form: The undersigned hereby consents to evaluation and treatment rendered according to the applicable standards of care. It is understood that options exist for treatment and all treatments are choices between risks and benefits. If the risks and benefits of proposed treatment are not clear to me, I understand that further information may he requested from Dr. Mark Wolff. I understand that I have a responsibility to communicate honestly with Dr. Wolff and to notify him of any cbanges in my health status.

Financial Awareness and Consent: I understand I am financially responsible, WHETHER OR NOT MY INSURANCE COMPANY PAYS, for all charges incurred by me. I hereby assign my major medical insurance benefits, including Medicare, private insurance and other health plans to Dr. Mark Wolff. Any overpayment will be promptly refunded. I also authorize release of protected health information required to secure payment.

Patient's Signature: _____ Date: __/__/__

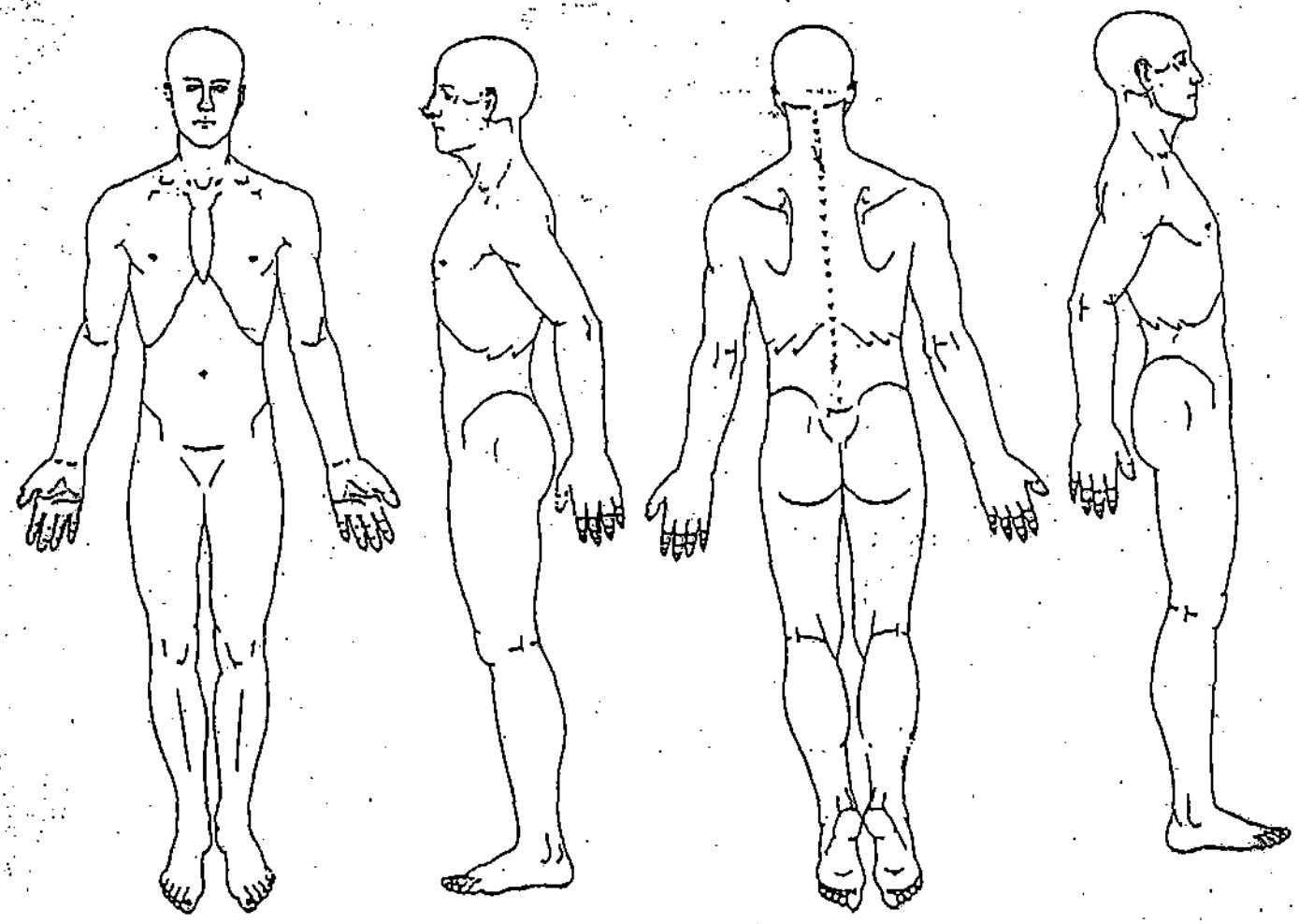
Responsible Party's Signature (if patient is a minor): _____ Date: __/__/__

PAIN DRAWING

DATE_____ NAME_____

Using the following descriptive symbols, draw the location of your pain on body outlines below. In addition, mark the level of your pain on the pain line at the bottom of the page.

Ache	Burning	Numbness	Pins & Needles	Stabbing	Other
ʌʌʌ	====	0000	.....	/////////	XXXX
ʌʌ	===	00	.....	//////	XXX



No Pain _____ Worst Possible Pain

Please make a slash through this line as to the level of your pain.

_____

Patient Signature

This questionnaire is designed to enable the doctor to understand how much your neck and/or back pain has affected your ability to manage your everyday activities.

Shade bubbles like this → ●

Functional Assessment

Please Fax to
(1)-303-778-0378

A	B	C	D	E	F	G	H	I	J	K	L	M
N	O	P	Q	R	S	T	U	V	W	X	Y	Z

Print with capital letters within the boxes

PLEASE darken the circle next to THE ONE CHOICE which most closely describes your *CURRENT* condition.

1. Personal Care and Hygeine
- O Take care of self, without causing pain.
- O Take care of self, but this causes pain.
- O Can do slowly and carefully, with pain.
- O Need some help, manage most personal care.
- O Need help every day for personal care.
- O Do not get dressed, stay in bed.

2. Lifting
- O Can lift up to 50 pounds or more, without pain.
- O Can lift 50 pounds or more, but it causes pain.
- O Pain prevents lifting 50 pounds or more off floor.
- O Can manage lifting 10-30 pounds.
- O Can lift 10 pounds or less.
- O Cannot lift or carry anything at all.

3. Work
- O Can do as much work as I want.
- O Can only do my usual work.
- O Can do most of my usual work.
- O Cannot do my usual work.
- O Can hardly do any work.
- O Cannot do any work at all.

4. Concentration (Thinking)
- O Can concentrate without problems.
- O Can concentrate with slight difficulty.
- O Mild degree of difficulty.
- O Moderate difficulty concentrating.
- O Severe difficulty concentrating.
- O Cannot concentrate at all.

5. Walking (Ambulation)
- O Pain does not prevent walking.
- O Pain prevents walking more than one mile.
- O Pain prevents walking more than ½ mile.
- O Pain prevents walking more than ¼ mile.
- O Can walk only with assistance.
- O Stay in bed most of the time.

6. Standing
- O Stand without pain.
- O Have some pain while standing.
- O Cannot stand for longer than one hour.
- O Cannot stand for longer than ½ hour.
- O Cannot stand for longer than ten minutes.
- O Avoid standing when possible.

7. Sitting
- O Sit in any chair without pain.
- O Sit only in my favorite chair without pain.
- O Pain prevents sitting more than one hour.
- O Pain prevents sitting more than ½ hour.
- O Pain prevents sitting more than 15 minutes.
- O Pain prevents sitting at all.

Staff use only

DISCHARGE

O **Final treatment for this episode**

Total $ charges this episode.

8. Sleeping
- O No trouble sleeping, feel rested.
- O Sleep is slightly disturbed.
- O Sleep is mildly disturbed.
- O Sleep is moderately disturbed.
- O Sleep is greatly disturbed.
- O Sleep completely disturbed, tired.

9. Pain Intensity and Severity
- O Have no pain.
- O Pain is very mild.
- O Pain is moderate.
- O Pain is fairly severe.
- O Pain is very severe.
- O Pain is the worst imaginable.

10. Driving (Traveling)
- O Can drive without pain.
- O Can drive with slight pain.
- O Can drive with moderate pain.
- O Cannot drive due to moderate pain.
- O Can hardly drive due to severe pain.
- O Cannot drive at all.

WOLFF — Doctor Name
DC — Designation

01607 — Doctor ID
CO — State

45607

First Name — Last Name

Patient Signature

Last 4 digits of SSN

Date

PATIENT ACKNOWLEDGEMENT

By subscribing my name below, I acknowledge receipt of a copy of this 6 page Notice of Privacy Practices, and my understanding and my agreement to its terms.

_____
Patient Name (Print)

_____
Signature
Date:_____