PIETRANTONE HEALTH

121 Elm Street • East Aurora, NY 14052 • (716) 655-1421 • email: office@drspietrantone.com • www.drspietrantone.com
Dr. Luke Pietrantone • Dr. Michelle Pietrantone • Rebecca Greiner, LMSW

PERSONAL INFORMATION

Full Name:		Name you wish to be called:	
Parent Name (for children):			
Street Address:			
City:		State:	Zip:
Phone: | Home:	Work:	E-Mail:	
Date of Birth:	Gender: M / F		
Occupation:	Employer:		
Who were you referred by?			
Person to contact in case of emergency:		Phone:	

PRIMARY CONCERN

What brings you to my office?				
Date of original condition:			Date of most recent occurrence:	
Was there an event that created the condition?				
When this condition started, did you have any other health issues at that time?				
Where there significant life changes or stressors such as loss of a loved one, divorce, moving, travel, job related, new baby, etc at the time the condition started?				
What makes it better?				
What makes it worse?				
Is the condition getting worse?			Is the condition constant?	
Is it worse at a certain time of day?				
Is this condition interfering with:	Work?	Sleep?	Activity?	Other?
Please list your goals for treatment, (immediate and future), and if you are also concerned with optimizing your overall health and well-being:				

HEALTH HISTORY

List other current health issues & problems:

List other practitioners seen, treatments, self-care activities, and results:

Blood work results: ***(please bring copies with you to your appointment)***

List all surgeries you have had, with dates and results:

Have you ever been in an accident or seriously injured? (if so, please describe):

Do you have any dental or TMJ problems? **Y N** (if so, please describe):

Have you had your wisdom teeth or other teeth removed? **Y N** (if yes note which teeth?):

Have you ever had a root canal? **Y N** (if yes note which teeth?):

List all medications, vitamins, herbs and other supplements you are now taking, the dose, and reason for taking:
(please bring actual bottles w/pills in with you to your appointment)

List all medications and other substances (i.e.: foods) to which you are allergic:

FAMILY HISTORY

Please list age(s) and health problems (if any). If deceased, please list age at death and cause of death.
Father:
Mother:
Children:
Grandparents:
Brothers:
Sisters:

GENERAL

Describe your present exercise habits including frequency per week, duration, and heart rate:	
Type of sport(s) /activity / exercise routine you participate in:	
Hours you train/exercise average per week:	Do you train by yourself or with others?
Do you use a heart rate monitor? **Y N**	What type of shoes do you wear? (Name / Style)
Describe your job activities (stress levels) and hours of work per week:	
Is there traveling associated with your job?	
Is your job physical or are you sitting at a computer?	

DEVELOPMENTAL INFORMATION

Are you aware of any prenatal/birth events or injuries such as maternal stress, accident, drug exposure, difficult labor, forceps delivery, breech birth, induced labor, pitocin, anesthesia, anoxia, premature/late delivery or post birth problems? Other? Please describe.

Were you separated from a caregiver within the first 5 years of development? If so, what were the circumstances?

Problems with growth/development such as severe or recurrent illnesses or infections, allergies, emotional difficulties, behavioral problems, appetite/digestion, language/speech, coordination? Walking/talking early or late? History of ear infections? Please describe.

History of physical trauma, injury, head injury, TBI, coma, accidents, high fever, serious illness, surgery, CNS infection, poisoning, anoxia, stroke or heart attack? Broken nose?

EDUCATIONAL INFORMATION

Do you currently or have you ever received any assistance in school/have an IEP/504 plan? Please describe.

Do you receive any interventions such as PT/OT/speech, etc.?

Have you had developmental/psychiatric testing? **Y N**
If yes, what were the results of that testing?

Are any of the following symptoms present? Check all that apply.

- ☐ Inattention
- ☐ Daydreaming
- ☐ Poor concentration
- ☐ Lack of motivation
- ☐ Hyperactivity after sugar
- ☐ Hyperactivity after sedatives
- ☐ Overwhelmed by stimuli
- ☐ Disorganized
- ☐ Hard to make decisions (executive functions)
- ☐ Impulsivity
- ☐ Distractibility
- ☐ Stimulus seeking
- ☐ Thrill seeking
- ☐ Competing thoughts; too many thoughts

PSYCHOLOGICAL INFORMATION

Are you currently in mental health counseling? **Y N**

Have you ever been in mental health counseling? Please note the time frame & reason.

Are any of the following symptoms present? Check all that apply.

- ☐ Anxiety (worry)
- ☐ Depression (blue, low, hopeless)
- ☐ Irritability
- ☐ Feelings easily hurt
- ☐ Perfectionist
- ☐ Remorseful after tantrums
- ☐ Cries easily (Feelings hurt)
- ☐ Rumination
- ☐ Guilt
- ☐ Withdraws when stressed
- ☐ Passive
- ☐ Wishes was dead
- ☐ Grumpy
- ☐ Thinks little of self
- ☐ Performance anxiety
- ☐ Shy
- ☐ Seasonal affective disorder
- ☐ Fidgets
- ☐ Whining
- ☐ Tired, listless
- ☐ Obsessive thoughts
- ☐ Binge eating
- ☐ Anorexia
- ☐ Bulimia
- ☐ Panic attacks
- ☐ Encopresis (soiling)
- ☐ Irritable bowl syndrome
- ☐ Rages
- ☐ Anxiety (fear)
- ☐ Depression (agitation)
- ☐ Agitation
- ☐ Mania
- ☐ Paranoia
- ☐ Suidical thoughts or actions
- ☐ Shame
- ☐ Compulsive behavior
- ☐ Involuntary movements or tics
- ☐ Impatient
- ☐ Aggressive; initiates conflict
- ☐ Jealous, envious
- ☐ Angry
- ☐ Lacks remorse
- ☐ Hates self
- ☐ Dissociative
- ☐ Exhausted
- ☐ Lacks empathy
- ☐ Lacks cause and effect thinking
- ☐ Manipulative, controlling
- ☐ Holds a grudge
- ☐ Poor comprehension and expression of emotions
- ☐ Lacks body awareness (Pain, discomfort, appetite)
- ☐ High pain threshold
- ☐ Loud, unmodulated voice
- ☐ Poor eye contact
- ☐ Poor social awareness

Do you identify any history of trauma? History of physical/sexual/emotional abuse?

In a few words, describe your relationship with your mother.

In a few words, describe your relationship with your father.

Do you feel as though you have a support system? This can include family, friends, faith based organizations.

PAIN QUESTIONAIRE

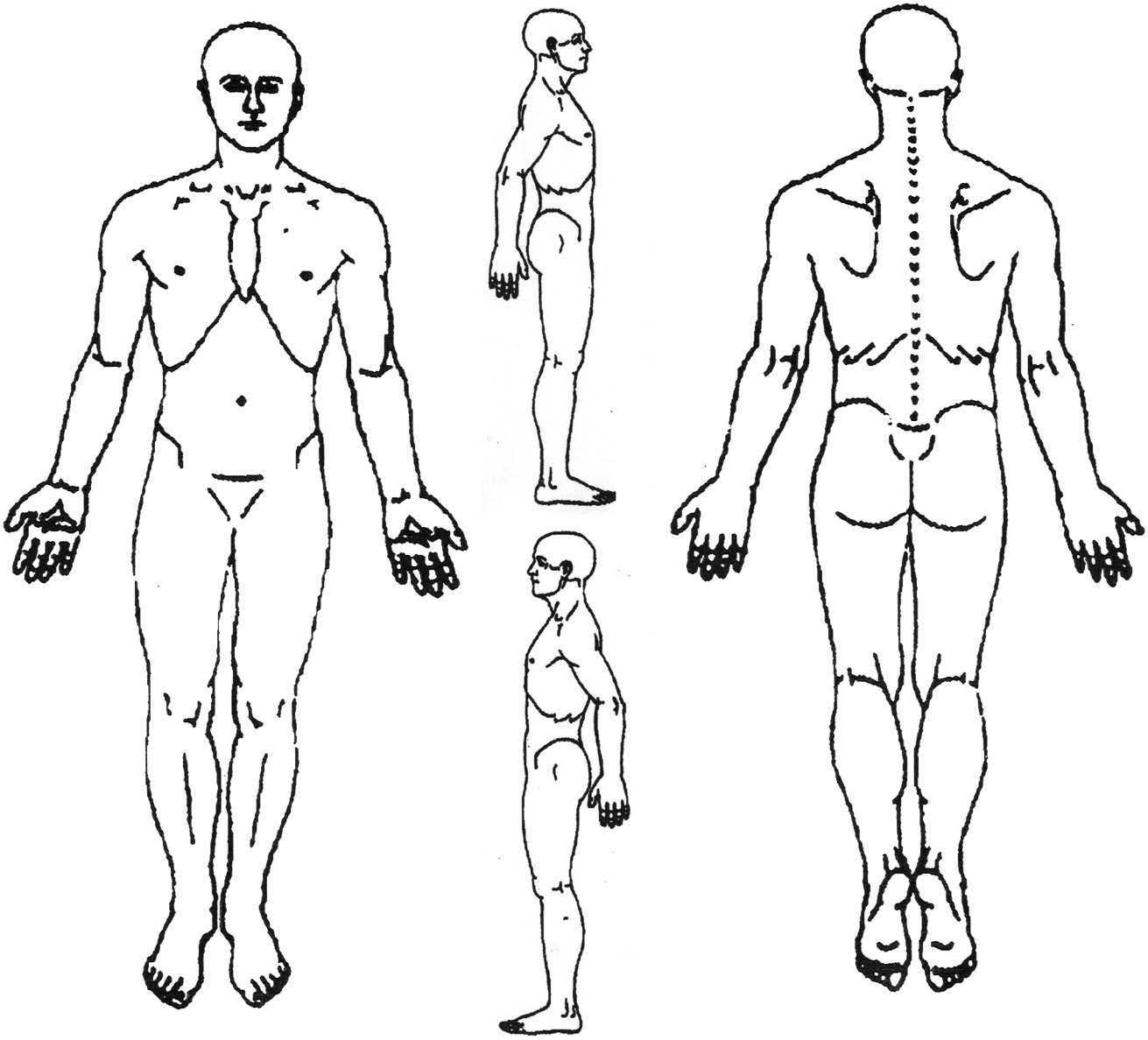
Skip to the next section if you are not currently experiencing pain.

Please place a single vertical line through the scale below at the point that best describes your pain.
(0 is no pain, 10 is the worst pain imaginable)

0.....|.....|.....|.....|.....|.....|.....|.....|.....|.....10

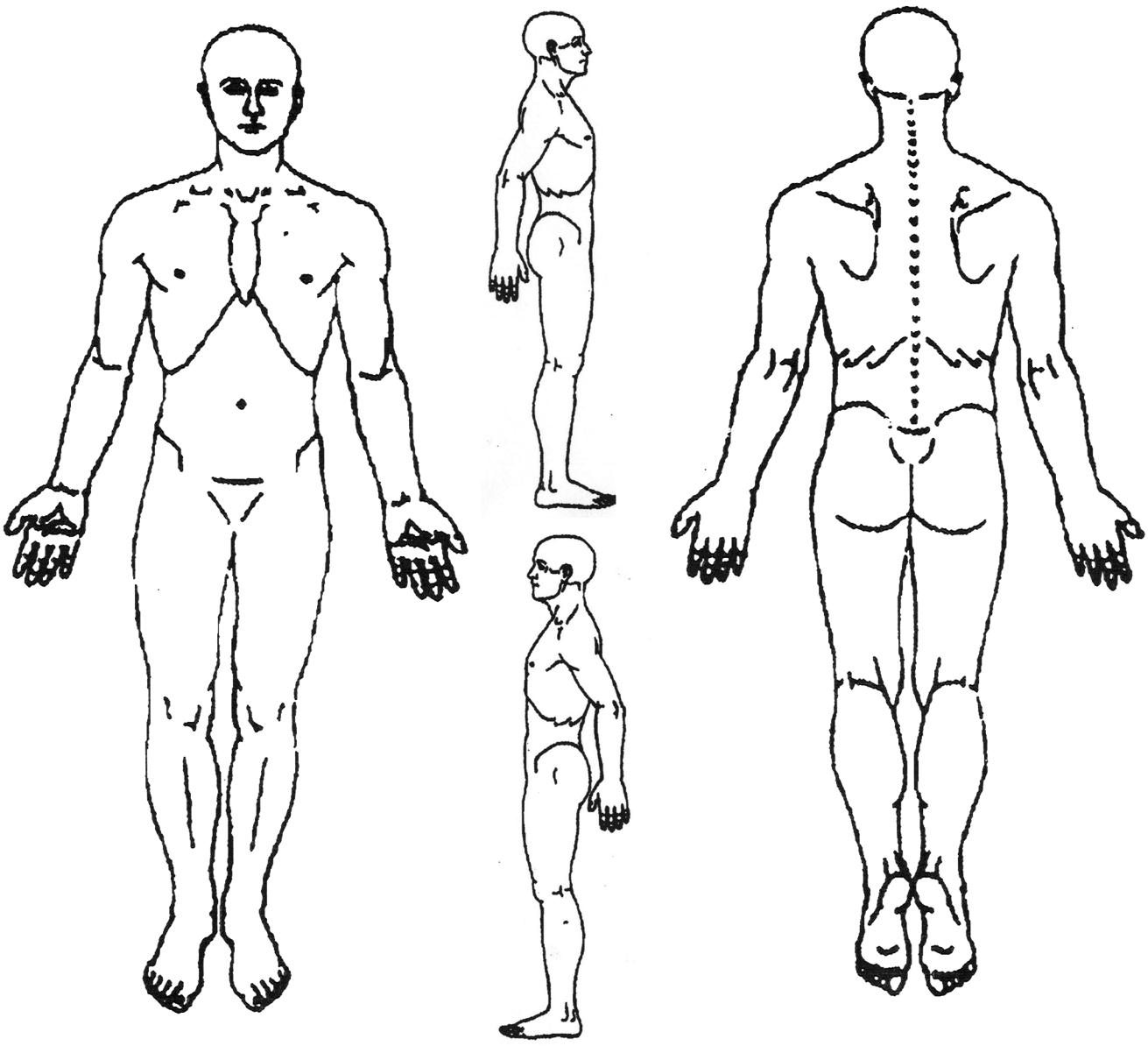
Place the letters listed below on the diagrams to indicate the type and location of your current sensations.

A = Ache B = Burning N = Numbness O = Other P = Pins & Needles S = Stabbing T = Throbbing



HISTORY OF INJURY

Please mark with an "X" **all the places on your body which have ever been injured** (sprains, strains, broken bones, scars from surgeries or accidents, severe bruises, falls, etc.). Please also include any tattoos and piercings, other than ear.



SYMPTOM SURVEY

Please circle the appropriate number on all questions below. **0 as the least/never to 3 as the most/always.**
Underline the symptom if it is now not a problem, but was sometime in the past, (over 3 months ago).

CATEGORY I – COLON

Feeling that bowels do not empty completely	0 1 2 3
Lower abdominal pain relieved by passing stool or gas	0 1 2 3
Alternating constipation and diarrhea	0 1 2 3
Diarrhea	0 1 2 3
Constipation	0 1 2 3
Hard, dry, or small stool	0 1 2 3
Coated tongue or "fuzzy" debris on tongue	0 1 2 3
Pass large amount of foul-smelling gas	0 1 2 3
More than 3 bowel movements daily	0 1 2 3
Use laxatives frequently	0 1 2 3

CATEGORY II – INTESTINAL BARRIER

Increasing frequency of food reactions	0 1 2 3
Unpredictable food reactions	0 1 2 3
Aches, pains, and swelling throughout the body	0 1 2 3
Unpredictable abdominal swelling	0 1 2 3
Frequent bloating and distention after eating	0 1 2 3
Abdominal intolerance to sugars and starches	0 1 2 3

CATEGORY III – CHEMICAL TOLERANCE

Intolerance to smells	0 1 2 3
Intolerance to jewelry	0 1 2 3
Intolerance to shampoo, lotion, detergents, etc	0 1 2 3
Multiple smell and chemical sensitivities	0 1 2 3
Constant skin outbreaks	0 1 2 3

CATEGORY IV – STOMACH

Excessive belching, burping, or bloating	0 1 2 3
Gas immediately following a meal	0 1 2 3
Offensive breath	0 1 2 3
Difficult bowel movements	0 1 2 3
Sense of fullness during and after meals	0 1 2 3
Difficulty digesting fruits and vegetables; undigested food found in stools	0 1 2 3

CATEGORY V – HYPERACIDITY

Stomach pain, burning, or aching 1-4 hours after eating	0 1 2 3
Use of antacids	0 1 2 3
Feel hungry an hour or two after eating	0 1 2 3
Heartburn when lying down or bending forward	0 1 2 3
Temporary relief by using antacids, food, milk, or carbonated beverages	0 1 2 3
Digestive problems subside with rest and relaxation	0 1 2 3
Heartburn due to spicy foods, chocolate, citrus, peppers, alcohol, and caffeine	0 1 2 3

CATEGORY VI – SMALL INTESTINES

Roughage and fiber cause constipation	0 1 2 3
Indigestion and fullness last 2-4 hours after eating	0 1 2 3
Pain, tenderness, soreness on left side under rib cage	0 1 2 3
Excessive passage of gas	0 1 2 3
Nausea and/or vomiting	0 1 2 3
Stool undigested, foul smelling, mucus like, greasy, or poorly formed	0 1 2 3

CATEGORY VI (CONT.) – URINARY

Increased thirst and appetite	0 1 2 3
Frequent urination	0 1 2 3
Blood in urine	0 1 2 3
Incontinence	0 1 2 3
Painful urination	0 1 2 3
Urinate more than once at night	0 1 2 3

CATEGORY VII – SMALL INTESTINES

Abdominal distention after consumption of fiber, starches, and sugar	0 1 2 3
Abdominal distention after certain probiotic or natural supplements	0 1 2 3
Lowered gastrointestinal motility, constipation	0 1 2 3
Raised gastrointestinal motility, diarrhea	0 1 2 3
Alternating constipation and diarrhea	0 1 2 3
Suspicion of nutritional malabsorption	0 1 2 3
Frequent use of antacid medication	0 1 2 3
Have you been diagnosed with Celiac Disease, Irritable Bowel Syndrome, Diverticulosis/ Diverticulitis, or Leaky Gut Syndrome? *circle all that apply*	Yes No

CATEGORY VIII – LIVER/GALL BLADDER

Greasy or high-fat foods cause distress	0 1 2 3
Lower bowel gas and/or bloating several hours after eating	0 1 2 3
Bitter metallic taste in mouth, especially in the morning	0 1 2 3
Burpy, fishy taste after consuming fish oils	0 1 2 3
Difficulty losing weight	0 1 2 3
Unexplained itchy skin	0 1 2 3
Yellowish cast to eyes	0 1 2 3
Stool color alternates from clay colored to normal brown	0 1 2 3
Reddened skin, especially palms	0 1 2 3
Dry or flaky skin and/or hair	0 1 2 3
History of gallbladder attacks or stones	0 1 2 3
Have you had your gallbladder removed?	Yes No

CATEGORY IX – DETOXIFICATION

Acne and unhealthy skin	0 1 2 3
Excessive hair loss	0 1 2 3
Overall sense of bloating	0 1 2 3
Bodily swelling for no reason	0 1 2 3
Hormone imbalances	0 1 2 3
Weight gain	0 1 2 3
Poor bowel function	0 1 2 3
Excessively foul-smelling sweat	0 1 2 3

CATEGORY X – BLOOD SUGAR

Crave sweets during the day	0 1 2 3
Irritable if meals are missed	0 1 2 3
Depend on coffee to keep going/get started	0 1 2 3
Get light-headed if meals are missed	0 1 2 3
Eating relieves fatigue	0 1 2 3

SYMPTOM SURVEY (cont.)

CATEGORY X (CONT.)

Feel shaky, jittery, or have tremors	0 1 2 3
Agitated, easily upset, nervous	0 1 2 3
Poor memory/forgetful	0 1 2 3
Blurred vision	0 1 2 3

CATEGORY XI – INSULIN RESISTANCE

Fatigue after meals	0 1 2 3
Crave sweets during the day	0 1 2 3
Eating sweets does not relieve cravings for sugar	0 1 2 3
Must have sweets after meals	0 1 2 3
Waist girth is equal or larger than hip girth	0 1 2 3
Frequent urination	0 1 2 3
Increased thirst and appetite	0 1 2 3
Difficulty losing weight	0 1 2 3

CATEGORY XII – ADRENAL HYPO

Cannot stay asleep	0 1 2 3
Crave salt	0 1 2 3
Slow starter in the morning	0 1 2 3
Afternoon fatigue	0 1 2 3
Dizziness when standing up quickly	0 1 2 3
Afternoon headaches	0 1 2 3
Headaches with exertion or stress	0 1 2 3
Weak nails	0 1 2 3

CATEGORY XIII – ADRENAL HYPER

Cannot fall asleep	0 1 2 3
Perspire easily	0 1 2 3
Under a high amount of stress	0 1 2 3
Weight gain when under stress	0 1 2 3
Wake up tired even after 6 or more hours of sleep	0 1 2 3
Excessive perspiration or perspiration with little or no activity	0 1 2 3

CATEGORY XIV – ELECTROLYTE + PH BALANCE

Edema and swelling in ankles and wrists	0 1 2 3
Muscle cramping	0 1 2 3
Poor muscle endurance	0 1 2 3
Frequent urination	0 1 2 3
Frequent thirst	0 1 2 3
Crave salt	0 1 2 3
Abnormal sweating from minimal activity	0 1 2 3
Alteration in bowel regularity	0 1 2 3
Inability to hold breath for long periods	0 1 2 3
Shallow, rapid breathing	0 1 2 3

CATEGORY XV – THYROID HYPO

Tired/sluggish	0 1 2 3
Feel cold—hands, feet, all over	0 1 2 3
Require excessive amounts of sleep to function properly	0 1 2 3
Increase in weight even with low-calorie diet	0 1 2 3
Gain weight easily	0 1 2 3
Difficult, infrequent bowel movements	0 1 2 3
Depression/lack of motivation	0 1 2 3
Morning headaches that wear off as the day progresses	0 1 2 3
Outer third of eyebrow thins	0 1 2 3
Thinning of hair on scalp, face, or genitals, or excessive hair loss	0 1 2 3
Dryness of skin and/or scalp	0 1 2 3
Mental sluggishness	0 1 2 3

CATEGORY XVI – THYROID HYPER

Heart palpitations	0 1 2 3
Inward trembling	0 1 2 3
Increased pulse even at rest	0 1 2 3
Nervous and emotional	0 1 2 3
Insomnia	0 1 2 3
Night sweats	0 1 2 3
Difficulty gaining weight	0 1 2 3
Low energy-fatigue	0 1 2 3
Weakness	0 1 2 3
Fever-Chills	0 1 2 3
Headaches	0 1 2 3
Lack of Sleep	0 1 2 3
Reduced Mental Acuity	0 1 2 3
Brain Fog	0 1 2 3

SYMPTOM SURVEY (cont.)

***** MALES ONLY**

Urination difficulty or dribbling	0 1 2 3
Frequent urination	0 1 2 3
Pain inside of legs or heels	0 1 2 3
Feeling of incomplete bowel emptying	0 1 2 3
Leg twitching at night	0 1 2 3
Decreased libido	0 1 2 3
Decreased number of spontaneous morning erections	0 1 2 3
Decreased fullness of erections	0 1 2 3
Difficulty maintaining morning erections	0 1 2 3
Spells of mental fatigue	0 1 2 3
Inability to concentrate	0 1 2 3
Episodes of depression	0 1 2 3
Muscle soreness	0 1 2 3
Decreased physical stamina	0 1 2 3
Unexplained weight gain	0 1 2 3
Increase in fat distribution around chest and hips	0 1 2 3
Sweating attacks	0 1 2 3
More emotional than in the past	0 1 2 3
Prostate problems	0 1 2 3
Hernia	0 1 2 3
Discharge	0 1 2 3
Premature ejaculation	0 1 2 3
Sexually transmitted disease	Yes No
Testicular lump/pain	Yes No
Vasectomy	Yes No

***** MENOPAUSAL FEMALES ONLY**

How many years have you been menopausal? _____

Since menopause, do you ever have uterine bleeding?	Yes No
Sores	Yes No
Yeast Infections	Yes No
Sexually Transmitted Disease	Yes No
Hot flashes	0 1 2 3
Mental fogginess	0 1 2 3
Disinterest in sex	0 1 2 3
Mood swings	0 1 2 3
Depression	0 1 2 3
Painful intercourse	0 1 2 3
Shrinking breasts	0 1 2 3
Facial hair growth	0 1 2 3
Acne	0 1 2 3
Increased vaginal pain, dryness, or itching	0 1 2 3
Decreased Sexual Interest	0 1 2 3
Discharge	0 1 2 3
Itching	0 1 2 3

***** MENSTRUATING FEMALES ONLY**

Perimenopausal	Yes No
Alternating menstrual cycle lengths	Yes No
Extended menstrual cycle (greater than 32 days)	Yes No
Shortened menstrual cycle (less than 24 days)	Yes No
Bleeding between Periods	Yes No
Sores	Yes No
Yeast Infections	Yes No
Sexually Transmitted Disease	Yes No
Pain and cramping during periods	0 1 2 3
Scanty blood flow	0 1 2 3
Heavy blood flow	0 1 2 3
Breast pain and swelling during menses	0 1 2 3
Pelvic pain during menses	0 1 2 3
Back pain during menses	0 1 2 3
Tired/Fatigue	0 1 2 3
Over-Emotional	0 1 2 3
Irritable and depressed during menses	0 1 2 3
Pain with Intercourse	0 1 2 3
Acne	0 1 2 3
Facial hair growth	0 1 2 3
Hair loss/thinning	0 1 2 3
Decreased Sexual Interest	0 1 2 3
Discharge	0 1 2 3
Itching	0 1 2 3

Age at First Period _____

Number of Days in Cycle _____

Usual Length of Period _____

Start of Last Period Date _____

Number of Pregnancies _____

Number of Deliveries _____

Complications with Pregnancies _____

Birth Control Method _____

DIET HISTORY

How much do you drink each day (8oz):			
Water:	Juice:	Diet Soda:	Regular Soda:
Regular Coffee:	Decaf Coffee:	Regular Tea:	Sweet Tea:
Energy Drinks/Other:		Alcohol:	

List oils or fats that you use in cooking:

Do you frequently skip meals? **Y N**

Are you on any special diet or nutrition program? **Y N**
Describe:

Are you allergic or sensitive to any foods? **Y N** / If yes, name the foods and describe the problem.

What foods do you dislike?

What is/are your favorite food(s)?

Circle the foods you crave:
Meats Fats Sweets Salty Foods Vegetables Fruits Breads Fatty Foods Spicy foods Sour Foods Cereals Dairy
Other individual:

Circle: Do you use?... butter margarine shortening coconut oil

Do you eat organic foods? **Y N**

Do you know what partially hydrogenated fats are? **Y N** / If yes, do you eat them? **Y N**

Do you eat from fast food restaurants? **Y N** / If yes, how often?

What do you usually eat for breakfast?

What do you usually eat for lunch?

What do you usually eat for dinner?

What do you usually eat for snacks (in between meals and/or before bed)?

What foods do you eat a lot of (at least once a day, every day)?

How many bowel movements do you have per day?

Are your bowel movements hard, firm or loose?

Dr. Luke Pietrantone and Dr. Michelle Pietrantone are Chiropractors, and not medical or osteopathic physicians. As a result, this practice and the care provided is limited to that which is permitted by State Law. We do not provide the type of care or treat conditions that fall within the scope of practice of Medical Doctors, and do not treat or offer cures for diseases or illnesses, only supportive advice and therapies.

Psychotherapy and Neurofeedback Services

Rebecca Greiner, LMSW, provides psychotherapy and neurofeedback services within the parameters of New York State regulations. Please note that we do not provide any diagnostic services or mental health diagnoses. These services are intended to support your mental and emotional well-being but are not covered or reimbursable by insurance. Clients seeking these services should understand that payments will be required out-of-pocket. Please inquire about the current rates for psychotherapy and neurofeedback services when scheduling.

Financial

This practice does not participate (not in-network) with any insurance. We will provide you with a receipt with the appropriate diagnosis codes and procedure codes upon request to the front desk for chiropractic visits only. We are unable to fill out any paperwork for approvals, authorizations, etc. Patients may opt to submit this to their insurance on their own. However, any reimbursement depends solely on your insurance plan's coverage and limits.

All payments for appointments are due at the time of the visit. We accept all major credit cards, FSA cards, HSA cards, cash and checks.

All supplements and additional supplies are the patient's responsibility and payment is due at the time of the visit.

Please give our office at least 24 hours advance notice for any cancellation. If 24 hours notice is not given, 50% of the appointment fee will be billed to you. You will not be able to schedule subsequent appointments if you have an outstanding no-show balance.

Emergencies

If you have a medical emergency and are unable to contact us through the office phone, 716-655-1421, please go to the Emergency Room or dial 911.

For mental health emergencies, please contact **Crisis Services in Buffalo** at 716-834-3131. This service is available 24/7 and can provide immediate assistance in cases of mental health crises, suicidal thoughts, or other urgent emotional distress. For further support, you may also call the National Suicide Prevention Lifeline at **988**.

Confidentiality

We will never sell your information such as emails or phone numbers. Any requests for documentation by doctors, family, and insurance companies will require your written consent.

By signing below you understand and agree to the above office policies including the 24-hour cancelation fee. Bring this form to your first appointment. We cannot begin treatment without it.

_____

Name (printed)

_____

Name (signed)

_____

Date