CHIROPRACTIC
SPINE & SPORT
Physical Therapy
Acupuncture
Massage Therapy

Patient Information

Patient Name:_____Date of Birth: _____/_____/

Street Address: _____

City:_____State:_____Zip: _____

SS# _____ Sex:_____ Marital Status: S M D W Student: Y or N

Home Phone:_____-_____-_____ Cell Phone _____

Email:_____

Employer:_____Work Phone _____

Emergency Contact Name: _____

Relationship:_____Emergency Contact Number _____

Referring Doctor: _____

Primary Care Doctor: _____

Condition/Body Part: _____

I hereby agree and give my consent to medical treatment in treating my physical condition. I authorize release of any medical information needed to process my claim. I understand that I am responsible for any charges that are not covered by my insurance carrier. Furthermore, I understand that I am responsible to inform the office of any changes that occur. I authorize release of payment directly to Community Chiropractic Spine & Sport Physical Therapy regardless of participation in or out-of-network. Should I default on my financial responsibility and collection action is necessary, I will be responsible for collection costs that are incurred.

Patient/Parent/Guardian Signature:_____Date: _____

Primary Insurance

Insurance Company: _____

Group Number:_____ID Number/Claim Number: _____

Answer if Policy Holder is different from Patient:

Policy Holder Name:_____

Policy Holder's Date of Birth:_____/_____/_____and SSN _____

Sex: _____ Relation to Patient: _____

Street Address: _____

City:_____State:_____Zip:_____

If Auto or Worker's Comp:

Adjuster/Caseworker's Name:_____Phone Number_____

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Cancelled Appointments

At Community Chiropractic Spine & Sport Physical Therapy we believe it is important for our patients to keep all of their scheduled appointments, in order to be successful in reaching their treatment goals. With that in mind, we have developed the following cancellation policy.

It is our policy that any appointment that needs to be cancelled must be cancelled with 24 hours' notice. If appropriate notice is not given there will be a charge of $25 for a broken appointment. Broken appointment charges are not billable to medical insurance plans and will be the patient's responsibility.

Please remember that our objective is to help you meet your physical therapy and functional goals. It is essential to keep your scheduled appointments for a positive outcome.

By my signature below, I acknowledge that I have read and will abide by this Cancellation Policy.

_____

Patient or Guardian Signature Date

Designated Individuals Authorization Form

I hereby authorize on or all of the designated parties below to request and receive the release of any protected health information regarding my treatment, payment or administrative operations related to treatment and payment. I understand that the identity of designated parties must be verified before the release of any information.

Authorized Designees:

_____

Emergency Contact Name Relationship

_____

Name Relationship

_____

Name Relationship

_____

Patient Name Signature

Notice of Privacy Policy

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

Uses and Disclosures of Health Information

Community Chiropractic Spine & Sport Physical Therapy is required by law to protect the privacy of your personal health information, provide this notice about our information practices and follow the information practices that are described herein. Community Chiropractic Spine & Sport Physical Therapy uses your personal health information primarily for treatment; obtaining payment for treatment; conducting internal administrative activities and evaluating the quality of care that we provide. Community Chiropractic Spine & Sport Physical Therapy may also use or disclose your personal health information without prior authorization for public health purposes, for auditing purposes, for research studies and for emergencies. We also provide information when required by law in any other situation. Community Chiropractic Spine & Sport Physical Therapy's policy is to obtain your written authorization before disclosing your personal health information. If you provide us with a written authorization to release your information for any reason, you may later revoke that authorization to stop future disclosures at any time. Community Chiropractic Spine & Sport Physical Therapy may change its policy at any time. When changes are made, a new Notice of Information Practices will be posted in the waiting room and patient exam areas and will be provided to you on your next visit. You may also request an updated copy of our Notice of Information Practices at any time.

Patient's Individual Rights

You have the right to review or obtain a copy of your personal health information at any time. If you request photocopies of your personal health information, we may charge you $0.25 per page for these copies. You have the right to request a list of instances where we have disclosed your personal health information for reasons other than treatment, payment or other related administrative purposes. You may request in writing that we do not disclose your personal health information for treatment, payment and administrative purposes except when specifically authorized by you, when required by law or in emergency circumstances. Community Chiropractic Spine & Sport Physical Therapy will consider all such requests on a case by case basis, but the practice is not legally required to accept them.

Concerns and Complaints

If you are concerned that Community Chiropractic Spine & Sport Physical Therapy may have violated your privacy policy rights or if you disagree with any decision we have made regarding access or disclosure of your personal health information, please contact our practice manager at the address listed. You may also send a written complaint to the U.S. Department of Health and Human Services. For further information on Community Chiropractic Spine & Sport Physical Therapy's health information practices or if you have a complaint, please contact the following:

Community Chiropractic Spine & Sport

Physical Therapy
Office Administrator

8 Essex Way • Suite 204 • Essex Junction,VT 05452

I acknowledge that I have seen the "Notice of Privacy Practices". I understand that I may ask questions about the "Notice of Privacy Practices" at any time.

Patient or Guardian Signature Date

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Medical Screening Questionnaire

Name:_____Date:_____/_____/_____
Height:_____ft._____in. Weight:_____lbs.
Are you latex sensitive? ☐ Yes ☐ No Do you have a pacemaker? ☐ Yes ☐ No
Do you smoke? ☐ Yes ☐ No Have you fallen recently? ☐ Yes ☐ No

FOR WOMEN: Are you currently pregnant or think you might be pregnant? ☐ Yes ☐No
ALLERGIES: List any medication(s) you are allergic to: _____

Have you RECENTLY noted any of the following (check all that apply)?

☐ Numbness or Tingling	☐ Fatigue	☐ Constipation
☐ Muscle Weakness	☐ Fever/Chills/Sweats	☐ Diarrhea
☐ Dizziness/Lightheadedness	☐ Nausea/Vomiting	☐ Falls
☐ Heartburn/Indigestion	☐ Weight Gain/Loss	☐ Fainting
☐ Difficulty with walking balance	☐ Difficulty Swallowing	☐ Cough
☐ Changes in bowel or bladder function	☐ Shortness of Breath	☐ Headaches

Have you EVER been diagnosed with any of the following conditions (check all that apply)?

☐ Depression	☐ Thyroid Problems	☐ Cancer
☐ Heart Problems	☐ Lung Problems	☐ Diabetes
☐ Chest Pain/Angina	☐ Tuberculosis	☐ Osteoporosis
☐ Chemical Dependency (ie. Alcoholism)	☐ High Blood Pressure	☐ Stroke
☐ Circulation Problems	☐ Rheumatoid Arthritis	☐ Epilepsy
☐ Blood Clots	☐ Other Arthritic Condition	☐ Asthma
☐ Multiple Sclerosis	☐ Bladder/Urinary Tract Infection	☐ Anemia
☐ Eye Problem/Infection	☐ Kidney Problem/Infection	☐ Ulcers
☐ Bone or Joint Infection	☐ Pneumonia	☐ Liver Problems
☐ Sexually Transmitted Disease/HIV	☐ Pelvic Inflammatory Disease	☐ Hepatitis

Has anyone in your immediate family (parents, brothers, sisters) EVER been diagnosed with any of the following conditions (check all that apply)?

☐ Cancer	☐ Diabetes	☐ Tuberculosis
☐ Heart Problems	☐ Thyroid Problems	☐ Stroke
☐ High Blood Pressure	☐ Depression	☐ Blood Clots

During the past month have you been:
Feeling down, depressed or hopeless? ☐ Yes ☐ No
Bothered by having little interest or pleasure in doing things? ☐ Yes ☐ No
If yes to either, is this something with which you would like help? ☐ Yes ☐ Yes, but NOT today ☐ No

Please list any medications you are currently taking (INCLUDING pills, injections, and/or skin patches):

_____

_____

Have you ever taken steroid medications for any medical conditions? ☐ Yes ☐ No
Have you ever taken blood thinning or anticoagulant medication for any medical condition? ☐ Yes ☐ No

Please list any surgeries or other conditions for which you have been hospitalized, including dates:

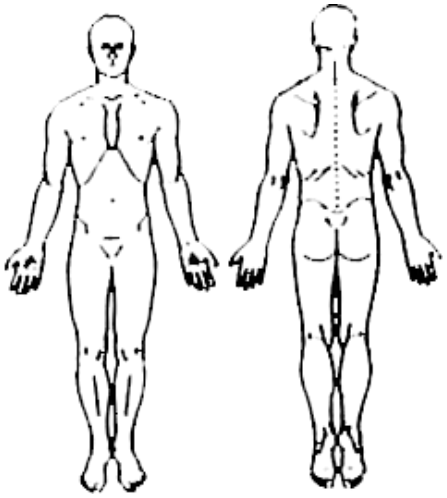
What date (roughly) did your present problems start? _____

My symptoms are currently: ☐ Getting Better ☐ Getting Worse ☐ Staying about the same

Treatment received so far for this problem (chiropractic, injections, surgery, etc.): _____

Please list special tests performed for this problem (x-ray, MRI, labs, etc.): _____

Body Chart:
Please mark the areas where you feel symptoms on the chart to the right with the following symbols to describe your symptoms:



↓: Shooting/Sharp Pain
○: Dull/Aching Pain
|||: Numbness
=: Tingling

My symptoms currently:
☐ Come and Go
☐ Are Constant
☐ Are constant, but change with activity

Using the 0 to 10 scale, with 0 being "no pain" and 10 being the "worst pain imaginable" please describe:

Your **current** level of pain while completing this survey:	0 1 2 3 4 5 6 7 8 9 10
The **best** your pain has been in the past 24 hours:	0 1 2 3 4 5 6 7 8 9 10
The **worst** your pain has been in the past 24 hours:	0 1 2 3 4 5 6 7 8 9 10

Easing Factors: Identify up to 3 important positions or activities that make your symptoms better:

Aggravating Factors: Identify up to 3 important activities that you have difficulty with due to injury:

How are you currently able to sleep at night due to your symptoms?
☐No problem sleeping ☐Difficulty falling asleep ☐Awakened by pain ☐Sleep only with medication

When are your symptoms worst? ☐ Morning ☐ Afternoon ☐ Evening ☐ Night ☐ After Activity
When are your symptoms the best? ☐ Morning ☐ Afternoon ☐ Evening ☐ Night ☐ After Activity

_____
Patient Signature