Chicopee Center Chiropractic
333 Front Street, Suite 2 | Chicopee, MA 01013 | 413-598-8550

Full Legal Name: _____ *Preferred Name:* _____

D.O.B: _____ *Age:* _____ *Sex:* _____ *Preferred Pronouns:* _____

Address: _____ *City/State/Zip:* _____

Phone: _____ ☐ *Mobile* ☐ *Land* *Email:* _____

Legal Sex: _____ *Occupation:* _____ ☐ *FT* ☐ *PT* ☐ *Student* ☐ *Unemployed*

☐ *Single* ☐ *Married* ☐ *Live-In Partner* ☐ *Divorced* ☐ *Widowed* *Number of Children:* _____

Name of Primary Care Physician: _____

Briefly describe any health concerns, including impact they've had on your life: _____

_____

_____

How long have you had these problems? _____

If you are experiencing pain, please describe the nature of the pain. Please check all that apply.

☐ *Sharp* ☐ *Dull* ☐ *Stabbing* ☐ *Throbbing* ☐ *Tingling* ☐ *Comes and goes* ☐ *Constant* ☐ *Travels*

Since the problem started, is it: ☐ *About the same* ☐ *Getting Better* ☐ *Getting Worse*

What factors aggravate your pain: _____

My pain interferes with: ☐ *Work* ☐ *Sleep* ☐ *Walking* ☐ *Sitting* ☐ *Hobbies* ☐ *Leisure Time*

Which, if any, other providers have you seen for this problem? Please list the provider's name and specialty.

_____

_____

Please list any medications you are currently taking (and reason for medication): _____

_____

If you are currently taking any vitamins and/or supplements, please list: _____

_____

Have you ever been treated by a chiropractor? ☐ Yes ☐ No *If yes, when and where?* _____

_____

Please check (✓) all symptoms you've ever had, even if they do not seem related to the current problem:

☐ *Headaches*	☐ *Pins/Needles in Arms*	☐ *Dizziness*	☐ *Numbness in Fingers*
☐ *Fatigue*	☐ *Pins/Needles in Legs*	☐ *Diarrhea*	☐ *Cold Sweats*
☐ *Mood Swings*	☐ *Sleeping Difficulties*	☐ *Bloating*	☐ *Cysts*
☐ *Depression*	☐ *Stiff Neck*	☐ *Constipation*	☐ *Light Sensitivity*
☐ *Menstrual Pain*	☐ *Fainting*	☐ *Back Pain*	☐ *Low Energy*
☐ *Decreased Libido*	☐ *Irritability*	☐ *Cold Hands*	☐ *Fever*
☐ *Joint Pain*	☐ *Problems with Urination*	☐ *Ulcers*	☐ *Stomach Upset*
☐ *Anxiety*	☐ *Menstrual Irregularity*	☐ *Loss of Balance*	☐ *Tension*
☐ *Cold Feet/Hands*	☐ *Hot Flashes*	☐ *Heartburn*	☐ *High Cholesterol*

Did/Do you smoke cigarettes? ☐ Yes ☐ No *If yes, how many per day and how long?* _____

Do you drink alcohol? ☐ Yes ☐ No *If yes, how many drinks per week?* _____

Have you been involved in any accidents? ☐ Yes ☐ No *If yes, type of accident and when?* _____

_____

Have you had any type of surgery? ☐ Yes ☐ No *If yes, what type(s) and when?* _____

_____

On a scale of 1 – 10 (10 being the most extreme stress) please rate your current stress level: _____

On a scale of 1 – 10 (1 being poor and 10 being excellent) please rate the following:

Diet: _____ *Exercise:* _____ *Sleep:* _____ *General Health:* _____

Is there anything else you'd like to share? _____

_____

The statements I have made on this form are accurate to the best of my recollection. I agree to allow this office to complete a comprehensive examination to further evaluate my concerns and guide my treatment.

Patient Printed Name: _____

Parent/Guardian Signature: _____ *Date Signed:* _____

Chicopee Center Chiropractic

Dr. Steven Przezdziecki
333 Front Street, Suite 2 | Chicopee, MA 01013 | 413-598-8550

CONSENT TO TREAT A MINOR

I hereby authorize Dr. Steven Przezdziecki of Chicopee Center Chiropractic and whomever he may designate as his assistant, to administer chiropractic care as they deem necessary to the following patient:

Name of Minor: _____ Minor Date of Birth: _____

I certify that I am the parent or legal guardian responsible for all medical decisions of the child whose name is listed above.

Parent/Guardian Printed Name: _____

Parent/Guardian Signature: _____ Date Signed: _____

FOR OFFICE USE ONLY

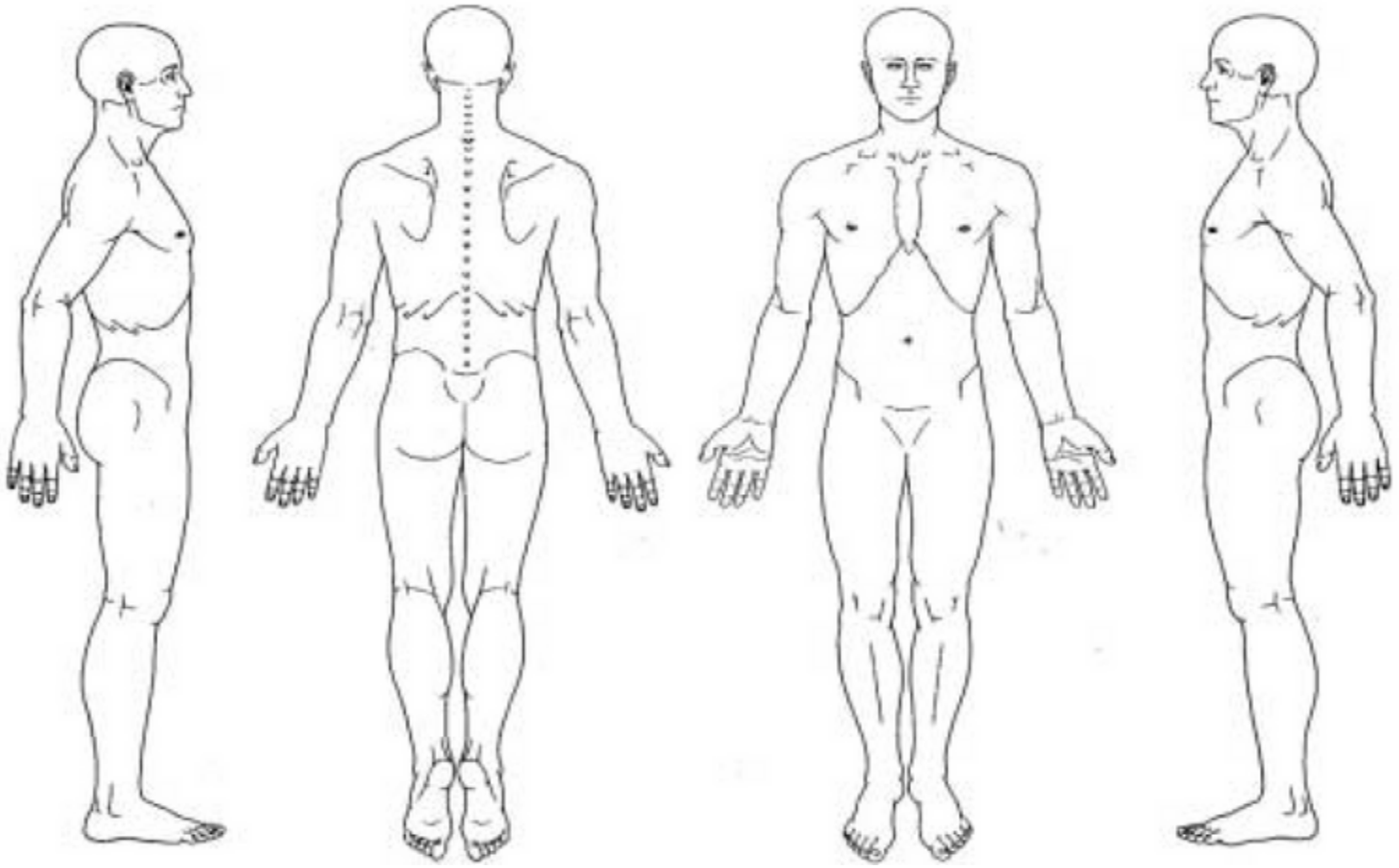
Witness Signature: *Date*:

Chicopee Center Chiropractic

PAIN DIAGRAM

Please mark the area of injury or discomfort on the chart below, using the appropriate symbols:

Numbness	**Pins and Needles**	**Burning**	**Aching**	**Stabbing**
--------	oooooooo	^^^^^	xxxxxx	⊗⊗⊗⊗⊗
--------	oooooooo	^^^^^	xxxxxx	⊗⊗⊗⊗⊗



Please make a slash in the line below to indicate the levels of your pain:

No Pain ——————————————————————— *Worst Possible Pain*

Patient Name: _____

Parent/Guardian Signature: _____ Date Signed: _____

Chicopee Center Chiropractic

Dr. Steven Przezdziecki
333 Front Street, Suite 2 | Chicopee, MA 01013 | 413-598-8550

INFORMED CONSENT

I hereby request and consent to the performance of chiropractic adjustments and other chiropractic procedures, including various modes of physical therapy, on me or the person named below (for whom I am legally responsible) by Dr. Steven Przezdziecki, including those working at the office listed above, whether signatories to this form or not.

I have had an opportunity to discuss with Dr. Steven Przezdziecki, or other office clinic personnel, the nature and purpose of chiropractic adjustments and procedures. I understand the results are not guaranteed.

I understand and am informed that, as in the practice of medicine, in the practice of chiropractic, there are some risks to treatment, including but not limited to, fractures, disk injuries, strokes, dislocations, and sprains. I do not expect the doctor to be able to anticipate and explain all risks and complications, and I wish to rely on the doctor to exercise judgment during the course of the procedure which the doctor feels at the time, based on the facts then known, and is in my best interest.

I have read, or have had read to me, the above consent. I have also had an opportunity to ask questions about this consent. By signing below, I have agreed to the above named procedures. I intend this consent form to cover the entire course of treatment for my present condition and for any future condition(s) for which I seek treatment in this office.

Patient Name: _____

Parent/Guardian Signature: _____ Date Signed: _____

Chicopee Center Chiropractic

333 Front Street, Suite 2 | Chicopee, MA 01013 | Ph. 413-598-8550 | Fx. 413-598-8556

AUTHORIZATION TO RELEASE HEALTH RECORDS

Patient Name: _____

Date of Birth: _____ Phone: _____

I understand that I may revoke this consent at any time except to the extent that action has been taken in reliance thereon.

By signing this form, I authorize Chicopee Center Chiropractic to obtain the medical records indicated in the box below.

Parent/Guardian Signature: _____ Date: _____

***For Office Use Only*:**

Permission is given to _____ to release the requested medical records to Dr. Steven Przezdziecki at Chicopee Center Chiropractic.

Records Requested: _____

Chicopee Center Chiropractic

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CANCELLATION AND NO-SHOW POLICY

This policy was designed to help the office run more efficiently, in addition to maximizing the number of patients we are able to accommodate. When a person does not make it to a scheduled appointment, this leaves open time in our schedule that could have allowed another patient to receive the care they need.

Late Cancellation. We ask that you please be courteous and contact our office promptly if you are unable to attend a scheduled appointment. We require at least a 24-hour notice so we have the opportunity to offer the appointment to another patient. Failure to cancel a scheduled appointment without 24-hour notice will be recorded as a late cancellation in your file and a fee of $40.00 may be charged.

No-Show. A no-show is when a patient misses an appointment without notice. We have a voicemail system which is able to receive messages 24-hours a day. No-shows cause an inconvenience to both patients that are in need of our services and the daily operations of our practice. Failure to present for your scheduled appointment without notice will be recorded as a no-show in your file and a fee of $50.00 may be charged.

Late Arrival. If you arrive late to your appointment, we will do our best to fit you into the schedule, however, if it is more than five minutes, we may need to reschedule your appointment to another time and the late cancellation fee may apply.

By signing below, I acknowledge my understanding of the terms of this policy. I further understand that these fees have nothing to do with my copayment or deductible and thus cannot be billed to my insurance company.

Patient Name: _____

Parent/Guardian Signature: _____ Date Signed: _____

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PRIVACY PRACTICES AND OFFICE POLICIES

(a) **Privacy Notice Acknowledgement.** We are very concerned with protecting your privacy, especially in matters that concern your personal health information. In accordance with the *Health Insurance Portability and Accountability Act* of 1996 (HIPAA), we are required to supply you with a copy of our privacy policies and procedures. We encourage you to read this document carefully, for it outlines the use and limitations of the disclosure of your health information and your rights as a patient. If you ever have any questions or concerns regarding the use or dissemination of your personal health information, we would be happy to address them.

(b) **Financial Policy and Responsibility.** You, as the patient, are ultimately responsible for all fees. We do accept insurance assignments and will file your insurance claim for you. You will be responsible for all co-payments or balances as required by your specific insurance plan. If your insurance plan requires a referral from your primary care physician, please be sure to obtain that referral prior to your visit to our office. All copayments, deductibles, and coinsurance are due at the time of service, or upon receipt of a bill. If for any reason your insurance plan denies payment for services rendered, the balance will become the responsibility of the patient.

(c) **Patient Non-Compliance Policy.** It is the goal of our office to provide the most comprehensive care possible. Each patient is given a treatment plan that addresses their individual health concerns and it is essential that patients adhere to their recommended plan of care. During the initial consultation and evaluation, Dr. Przezdziecki will discuss the importance of patient compliance. The office policies on non-compliance will be discussed and explained in full.

By signing below, I acknowledge that I (a) have read and agree to the Authorization for Services and that I have received a copy of Dr. Przezdziecki's Notice of Privacy Practices for Protected Health Information, (b) have read, understood and agree to the information regarding the financial policy and responsibility, and (c) I also agree to the policies regarding treatment non-compliance.

Patient Name: _____

Parent/Guardian Signature: _____ Date Signed: _____

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NOTICE OF PRIVACY PRACTICES FOR PROTECTED HEALTH INFORMATION

- ACKNOWLEDGEMENT FORM -

By signing below, I acknowledge that I have received, read, and agree to Chicopee Center Chiropractic / Dr. Steven Przezdziecki's Notice of Privacy Practices for Protected Health Information.

Patient Name: _____

Parent/Guardian Signature: _____ Date Signed: _____