CONFIDENTIAL PATIENT INFORMATION

NAME _____ [redacted] _____

STREET _____ APT# _____

CITY _____ STATE _____ ZIP _____

PHONE: Please circle preferred method of contact
(H) _____ (W) _____ (CELL) _____

DOB __/__/__ AGE _____ email _____

SEX _____ MARITAL _____ CHILDREN _____ REFERRED BY _____

OCCUPATION _____ EMPLOYER _____

EMERGENCY CONTACT PERSON _____ PHONE _____

PURPOSE OF THIS APPOINTMENT _____

PRIMARY CARE PHYSICIAN _____

OTHER PHYSICIANS SEEN FOR THIS CONDITION _____

PRIOR CHIROPRACTIC CARE OR PHYSICAL THERAPY THIS YEAR? _____

INSURANCE

INSURANCE CARRIER _____ ID# _____

SUBSCRIBER'S NAME _____

SECONDARY INSURANCE _____ ID# _____

ACCIDENT/INJURY: WORK _____ **AUTO** _____ **DATE** _____ **LOST TIME** _____

INSURANCE CARRIER _____

ADDRESS _____ PHONE _____

CLAIMS ADJUSTOR _____ CLAIM# _____

ATTORNEY _____ PHONE _____

Name _____ Date _____

1. Please Describe Your Complaint(s); If more than one, please number them according to severity: _____

_____

_____

_____

a. Description (What does it feel like?) Please Number according to complaints.

___ Sharp Pain	___ Shooting	___Numb	___Pulsing
___ Dull Pain	___ Gripping	___Throbbing	___Stiff
___ Ache	___ Burning	___Weak	___Tingling

b. Frequency (How often does it occur?):

___ Constant (76-100%) ___ Occasional (26-50%)
___ Frequent (51-75%) ___ Intermittent (25% or less)

c. Intensity: Circle the # that best describes your overall level of discomfort

No Pain (0) (1) (2) (4) (5) (6) (7) (8) (9) (10) Unbearable Pain

2. a. How long has your problem been present? __days __wks __mos __yrs. Has it __decreased __not changed __increased?

b. If it followed a specific incident, please date & describe: _____

_____

3. What doctors/providers have you seen for this episode? ___DC ___MD ___DO ___PT

a. Examinations included: (Dates) X-rays___/___/___ MRI___/___/___ CT___/___/___ ___Other___/___/___
Comments: _____

b. Treatment has included: ___Exercise___Heat___Cold___Medications___Support___Electrical Therapy
___Manipulation___Surgery___; Comments: _____

4. In the past have you been treated for the same or similar problem? ___Yes___No If yes, when? _____
Type of provider seen? ___DC___MD___DO___PT

5. What makes your problem better? ___Lying down ___Walking ___Standing ___Sitting ___Movement/Exercise ___Inactivity
Medication: Type _____

6. What makes your problem worse? ___Lying down ___Walking ___Standing ___Sitting ___Movement/Exercise ___Inactivity
Medication: Type _____

7. How would you rate your general stress level? ___ No Stress ___Minimal Stress ___Moderate Stress ___Greatly Stressed

8. Physical activity at work: ___Sitting more than 50% of workday ___Light physical work ___Manual Labor
___Heavy manual labor ___Repeated Motion-Describe (specific) _____

9. General Physical Activity: ___No regular exercise ___Light exercise program ___Moderate exercise program
___Strenuous exercise program -Describe (specific) _____

10. Does your complaint affect your ability to work or otherwise be active? (Check any that apply.) ___No effect

___Need limited assistance with common everyday tasks. ___Cannot perform work duties as of___/___/___ (date)

___Need assistance often. ___/___/___ (date) ___Unable to function without assistance. ___/___/___ (date)

If you have ever had a listed symptom in the past, please check that symptom in the Past Column. If you are presently troubled by a particular symptom, check that symptom in the Present column.

Past	Present	Condition
___	___	Neck Pain
___	___	Shoulder Pain (R___ L___)
___	___	Pain in Upper Arm or Elbow (R___L___)
___	___	Hand Pain (R___L___)
___	___	Wrist Pain (R___L___)
___	___	Upper Back Pain
___	___	Low Back Pain
___	___	Pain in Upper Leg or Hip (R___L___)
___	___	Pain in Lower Leg or Knee (R___L___)
___	___	Pain in Ankle or Foot (R___L___)
___	___	Jaw Pain
___	___	Swelling, Stiffness of Joint(s)
___	___	Fainting
___	___	Visual Disturbances
___	___	Convulsions
___	___	Dizziness
___	___	Headache
___	___	Muscular Un-coordination
___	___	Tinnitus (Ear Noises)
___	___	Rapid Heart Beat
___	___	Chest Pains
___	___	Loss of Appetite
___	___	Anorexia
___	___	Abnormal Weight
		___ Gain ___ Loss
___	___	Excessive Thirst
___	___	Chronic Cough
___	___	Chronic Sinusitis
___	___	General Fatigue
___	___	Irregular Menstral Flow
___	___	Profuse Menstral Flow
___	___	Breast ___Soreness ___Lumps
___	___	Endometriosis
___	___	PMS
___	___	Loss of Bladder Control
___	___	Painful Urination
___	___	Frequent Urination
___	___	Abdominal Pain
___	___	Constipation/irregular bowel habits
___	___	Difficulty in Swallowing
___	___	Heartburn/Indigestion
___	___	Dermatitis/Eczema/Rash

Past	Present	Condition
___	___	Depression
___	___	Aortic Aneurysm
___	___	High Blood Pressure
___	___	Angina
___	___	Heart Attack (date) _____
___	___	Stroke (date) _____
___	___	Asthma
___	___	Cancer, Explain _____
___	___	Tumor, Explain _____
___	___	Prostate Problems
___	___	Blood Disorder
___	___	Emphysema (chronic lung disorders)
___	___	Arthritis
___	___	Rheumatoid Arthritis
___	___	Diabetes
___	___	Epilepsy
___	___	Ulcer
___	___	Liver / Gallbladder problems
___	___	Kidney Stones
___	___	Hepatitis
___	___	Bladder Infection
___	___	Kidney Disorders (by condition)
___	___	Colitis
___	___	Irritable Colon
___	___	HIV/AIDS
___	___	Other

If a family member has had any of the following, please mark the appropriate box:

___ Cancer	___ Epilepsy
___ Rheumatoid Arthritis	___ Chronic Back Problems
___ Diabetes	___ Chronic Headaches
___ Heart Problems	___ Lupus
___ Lung Problems	___ Other _____
___ High Blood Pressure _____	

Yes	No	
___	___	Do you have a permanent disability?
		Location_____
___	___	Date rating received ___/___/___
___	___	Rating Percentage _____%

Present Weight _____ pounds Height _____feet _____inches

Please check any of the following that apply to you

Past	Present	Condition
___	___	Pregnancy, # of births _____
___	___	Birth Control Pills, type _____
___	___	Medications (list if not listed elsewhere)
		_____
		_____
___	___	Hospitalizations/Surgical Procedures (list if not described elsewhere) _____

Past	Present	Habits
___	___	Tobacco
___	___	Alcohol
___	___	Drug or Alcohol Dependence
___	___	Coffee/Tea/Caffinated Soft Drinks: cups/cans per day _____

Patient's Signature: _____ **Date Signed** ___/___/___

Doctor's Comments:

PAYMENT INFORMATION AND MEDICAL RELEASE

(A copy of this will be provided to you at your request)

Insurance Billing and Payment

Please provide us with all of the information needed to process your claim with your insurer.

Please be familiar with the authorization and referral requirements of your HMO/PPO. In many cases, your primary care or referring physician must call or send in a referral to the insurance company BEFORE we can obtain authorization.

We will do all we can to submit treatment plans or other information required for the start or continuation of treatment. The insurer may take a few days or weeks to process the request. You will be notified if your treatment has not been authorized. If the delay is unusually long, you may be given the option of continuing to schedule appointments with the understanding that you are responsible for services you receive that are not authorized. Your assistance in handling insurance or authorization problems may be needed and greatly appreciated.

Payment of deductibles, co-pays and coinsurance is expected at the time of service unless other arrangements have been made in advance. We accept cash or checks, **credit or debit cards**. If we need to bill you for any outstanding balance, please note there is no service charge for the first bill. Any additional reminders will carry a $2 service charge each time.

Assignment of Benefits

By signing this form, I hereby authorize insurance payments directly to DR. RICHARD A. SENNETT.

Finance Charges

A finance charge of one and one half (1.5%) per month with a maximum per annum charge not to exceed state and federal laws, will be charged on all past due accounts. In case suit shall be brought for collection hereof, or the same has to be collected upon demand of any attorney, or collection service, the guarantor agrees to pay all reasonable attorney fees or collection costs.

Cancellation and No-Show Policy

We require 24 hours notice for cancelled appointments. If you fail to show for your appointment or you have repeated cancellations, this may be grounds for discharge with notification to your physician and/or attorney. There will be a $40 charge for no-shows, or last minute cancellations.

Release of Medical Information

This authorization or photocopy thereof will authorize Dr. Richard A. Sennett to release any information regarding my condition including pertinent medical history, clinical findings and prognosis to my insurer and/or attorney in order to facilitate the processing of my claim for chiropractic services.

Patient's Signature _____ **Date** _____

PRIVACY ACT: Scheduling Appointments

By signing this form, I hereby authorize this office to contact me at home/work regarding future or missed appointments.

Patient's Signature _____ **Date** _____

CONSENT FOR USE OR DISCLOSURE OF HEALTH INFORMATION

DR. RICHARD SENNETT 555 DAY HILL ROAD, WINDSOR, CT. TEL(860)298-9898 Fax(860)683-1225

Our Privacy Pledge

We are very concerned with protecting your privacy. While the law requires us to give you this disclosure, please understand that we have, and always will, respect the privacy of your health information.

There are several circumstances in which we may have to use or disclose your health care information.

- We may have to disclose your health information to another health care provider or a hospital if it is necessary to refer you to them for the diagnosis, assessment, or treatment of your health condition.
- We may have to disclose your health information and billing records to another party if they are potentially responsible for the payment of your services.
- We may need to use your health information within our practice for quality control or other operational purposes.
- We may need to disclose your health information to the Connecticut Chiropractic Assoc. should we need their assistance to obtain reimbursement for services rendered.

We have a more complete notice that provides a detailed description of how your health information may be used or disclosed. You have the right to review that notice before you sign this consent form. We reserve the right to change our privacy practices as described in that notice. If we make a change to our privacy practices, we will notify you in writing when you come in for treatment or by mail. Please feel free to call us at any time for a copy of our privacy notices.

Your right to limit uses or disclosures

You have the right to request that we do not disclose your health information to specific individuals, companies, or organizations. If you would like to place any restrictions on the use or disclosure of your health information, please let us know in writing. We are not required to agree to your restrictions. However, if we agree with your restrictions, the restriction is binding on us.

Your right to revoke your authorization

You may revoke your consent to us at any time; however, your revocation must be in writing. We will not be able to honor your revocation request if we have already released your health information before we receive your request to revoke your authorization. If you were required to give your authorization as a condition of obtaining insurance, the insurance company may have a right to your health information if they decide to contest any of your claims.

I have read your consent policy and agree to it's terms. I am also acknowledging that I have received a copy of this notice.

_____ _____

Printed Name Authorized Provider Representative

_____ _____

Signature Date

_____

Date

Informed Consent to Chiropractic Treatment

The nature of chiropractic treatment: The doctor will use his/her hands or a mechanical device in order to move your joints. You may feel a "click" or "pop," such as the noise when a knuckle is "cracked," and you may feel movement of the joint. Various ancillary procedures such as hot or cold packs, electric muscle stimulation, therapeutic ultrasound or dry hydrotherapy may also be used.

Possible risks: As with any health care procedure, complications are possible following a chiropractic manipulation. Complications could include fractures of bone, muscular strain, ligamentous sprain, dislocation of joints, or injury to intervertebral discs, nerves or spinal cord. Cerebrovascular injury or stroke could occur upon severe injury to arteries of the neck. A minority of patients may notice stiffness or soreness after the first few days of treatment. The ancillary procedures could produce skin irritation, burns or minor complications.

Probability of risks occurring: The risks of complications due to chiropractic treatment have been described as "rare" about as often as complications are seen from the taking of a single aspirin tablet. The risk of cerebrovascular injury or stroke has been estimated at one in one million to one in ten million and can be even further reduced by screening procedures. The probability of adverse reaction due to ancillary procedures is also " rare".

Other treatment options, which could be considered, may include the following:

- *Over the counter analgesics*. The risk of these medications include irritation to stomach, liver and kidneys and other side effects in a significant number of cases.
- *Medical care*, typically anti-inflammatory drugs, tranquilizers and analgesics. Risks of these drugs include a multitude of undesirable side effects and patient dependence in a significant number of cases.
- *Surgery* in conjunction with medical care adds the risks of adverse reaction to anesthesia, as well as an extended convalescent period in a significant number of cases.

Risks of remaining untreated: Delay of treatment allows formation of adhesions, scar tissue and other degenerative changes. These changes further reduce skeletal mobility and induce chronic pain cycles. It is quite probable that delay of treatment will complicate the condition and make future rehabilitation more difficult.

Unusual risks: I have had the preceding unusual risks of my case explained to me.

I have read the explanation above of chiropractic treatment; I have had the opportunity to have any questions answered to my satisfaction. I have fully evaluated the risks and benefits of undergoing chiropractic treatment. I have freely decided to undergo the recommended treatment and hereby give my full consent to treatment.

Printed name	Signature	Date

Witness:

Printed name	Signature	Date

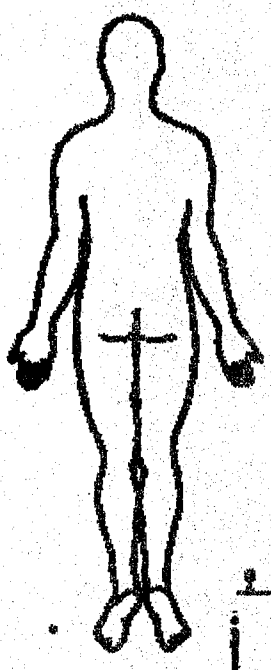
Verbal OK_____

Name:_____ Date:_____

Draw location of your pain on body outlines and mark how bad it is on pain line at bottom of page.

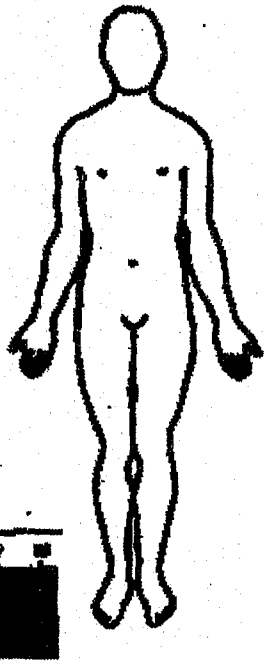
Ache	Burning	Numbness	Pins and Needles	Stabbing	Other
wwww	~ ~ ~ ~	0000	,,,,,,,,	!!!!!!	XXXXXX
ww	~ ~ ~ ~	0000	,,,,,	!!!!	XXXX

Back

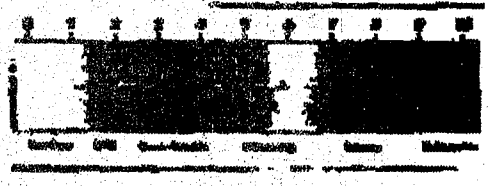


Left Right

Front



Right Left



VISUAL ANALOGUE SCALE

Please mark on the line the pain level that most accurately represents your pain:

NO PAIN: 0 1 2 3 4 5 6 7 8 9 10 UNBEARABLE PAIN

a) Right Now: _____

b) Average Pain _____

c) At Best _____

d) At Worst _____

VISUAL ANALOGUE SCALE

Please mark on the line the pain level that most accurately represents your pain:

NO PAIN: 0 1 2 3 4 5 6 7 8 9 10 UNBEARABLE PAIN

a) Right Now: _____

b) Average Pain _____

c) At Best _____

d) At Worst _____