

CONFIDENTIAL PATIENT INFORMATION

NAME _____

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.

- | | | | |
|-------------------------------------|-----------------------------------|------------------------------------|-----------------------------------|
| <input type="checkbox"/> Sharp Pain | <input type="checkbox"/> Shooting | <input type="checkbox"/> Numb | <input type="checkbox"/> Pulsing |
| <input type="checkbox"/> Dull Pain | <input type="checkbox"/> Gripping | <input type="checkbox"/> Throbbing | <input type="checkbox"/> Stiff |
| <input type="checkbox"/> Ache | <input type="checkbox"/> Burning | <input type="checkbox"/> Weak | <input type="checkbox"/> Tingling |

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

- | | |
|---|---|
| <input type="checkbox"/> Constant (76-100%) | <input type="checkbox"/> Occasional (26-50%) |
| <input type="checkbox"/> Frequent (51-75%) | <input type="checkbox"/> 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	Past	Present	Condition
___	___	Neck Pain	___	___	Depression
___	___	Shoulder Pain (R ___ L ___)	___	___	Aortic Aneurysm
___	___	Pain in Upper Arm or Elbow (R ___ L ___)	___	___	High Blood Pressure
___	___	Hand Pain (R ___ L ___)	___	___	Angina
___	___	Wrist Pain (R ___ L ___)	___	___	Heart Attack (date) _____
___	___	Upper Back Pain	___	___	Stroke (date) _____
___	___	Low Back Pain	___	___	Asthma
___	___	Pain in Upper Leg or Hip (R ___ L ___)	___	___	Cancer, Explain _____
___	___	Pain in Lower Leg or Knee (R ___ L ___)	___	___	Tumor, Explain _____
___	___	Pain in Ankle or Foot (R ___ L ___)	___	___	Prostate Problems
___	___	Jaw Pain	___	___	Blood Disorder
___	___	Swelling, Stiffness of Joint(s)	___	___	Emphysema (chronic lung disorders)
___	___	Fainting	___	___	Arthritis
___	___	Visual Disturbances	___	___	Rheumatoid Arthritis
___	___	Convulsions	___	___	Diabetes
___	___	Dizziness	___	___	Epilepsy
___	___	Headache	___	___	Ulcer
___	___	Muscular Un-coordination	___	___	Liver / Gallbladder problems
___	___	Tinnitus (Ear Noises)	___	___	Kidney Stones
___	___	Rapid Heart Beat	___	___	Hepatitis
___	___	Chest Pains	___	___	Bladder Infection
___	___	Loss of Appetite	___	___	Kidney Disorders (by condition)
___	___	Anorexia	___	___	Colitis
___	___	Abnormal Weight	___	___	Irritable Colon
___	___	___ Gain ___ Loss	___	___	HIV/AIDS
___	___	Excessive Thirst	___	___	Other
___	___	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	___	___	

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	Past	Present	Habits
___	___	Pregnancy, # of births _____	___	___	Tobacco
___	___	Birth Control Pills, type _____	___	___	Alcohol
___	___	Medications (list if not listed elsewhere)	___	___	Drug or Alcohol Dependence
___	___	_____	___	___	Coffee/Tea/Caffeinated Soft Drinks:
___	___	_____	___	___	cups/cans per day _____
___	___	Hospitalizations/Surgical Procedures (list if not described elsewhere)	___	___	_____

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
aching
ww

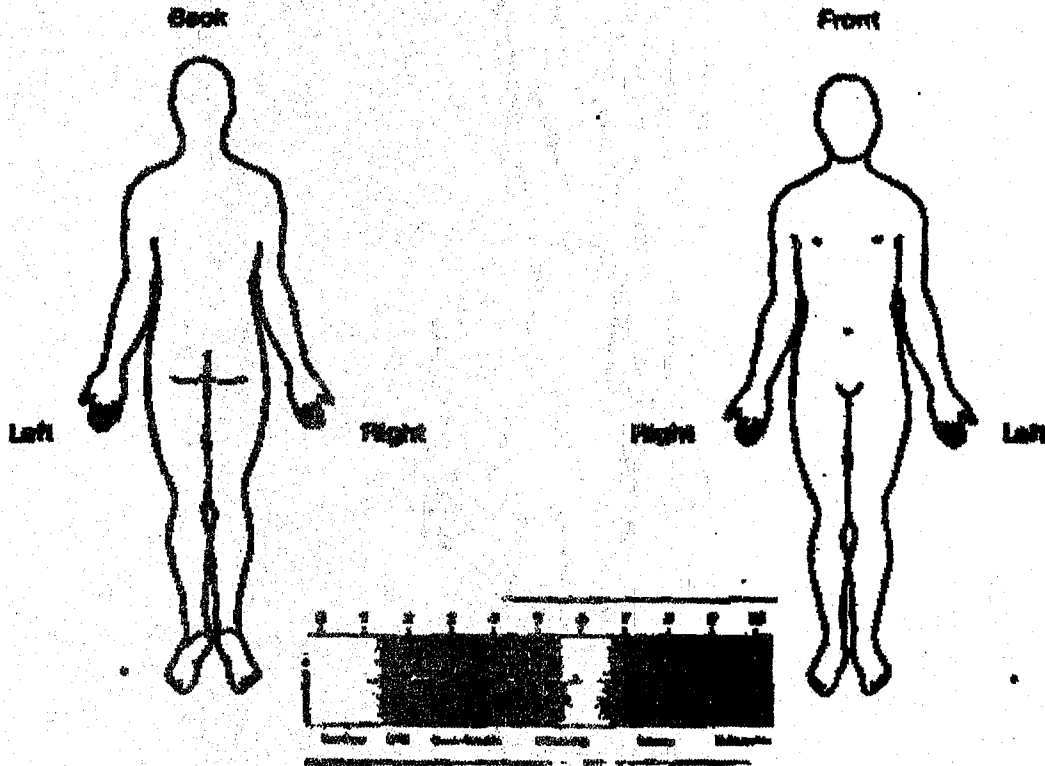
Burning
wwww
wwww

Stomping
OOOO
OOOO

Pins and Needles
.....
.....

Stabbing
|||||
|||||

Other
XXXXX
XXXXX



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:
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- d) At Worst
