CONFIDENTIAL PATIENT INFORMATION

NAME _____

STREET _____ **APT#** _____

CITY _____ **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 FOR 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 ADJUSTER _____**CLAIM#** _____

ATTORNEY _____**PHONE** _____

Name _____ Date_____

1. Please describe your complain(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:

   No Pain (0) (1) (2) (3) (4) (5) (6) (7) (8) (9) (10) Unbearable Pain

2. How long has your problem been present? __days__wks__mos__yrs. Has it __decreased__not changed__increased?
   a. 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 include: (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
_____	_____	Lower 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 Joints
_____	_____	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 Menstrual Flow
_____	_____	Profuse Menstrual Flow
_____	_____	Breast: Soreness____ Lumps____
_____	_____	Endometriosis
_____	_____	PMS
_____	_____	Loss of Bladder Control
_____	_____	Painful Urination
_____	_____	Frequent Urination
_____	_____	Abdominal Pain
_____	_____	Constipation/irregular Bowel Habits
_____	_____	Difficulty 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 disorder)
_____	_____	Arthritis
_____	_____	Rheumatoid Arthritis
_____	_____	Diabetes
_____	_____	Epilepsy
_____	_____	Ulcer
_____	_____	Liver/Gallbladder Problems
_____	_____	Kidney Stones
_____	_____	Hepatitis
_____	_____	Bladder Infection
_____	_____	Kidney Disorder (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)
		_____
		_____

Past	Present	Habits
_____	_____	Tobacco
_____	_____	Alcohol
_____	_____	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 _____/_____/_____

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 requirements of your HMO/PPO. In many cases, your primary care or referring provider 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 except cash or checks, credit or debit cards. If we need to bill you for any outstanding balance, please note that 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 annual charge not to exceed state and federal laws, will be charged on all past due accounts. In case suit shall be brought for a collection hereof, or the same has to be collected upon demand of any attorney, or collective service, the guarantor agrees to pay all reasonable attorney fees or collection costs.

Cancellation and No-Show Policy

We require 24 hours' notice for canceled 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 far am I hereby authorize this office to contact me at home Dash 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 healthcare information.

- We may have to disclose your health information to another healthcare provider or a hospital if it is necessary to refer you to them for 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 Association should we need their assistance to obtain reimbursement for services rendered.

We have a more complete notice that provides a detail description of how your health information may be used or disclosed. You have the right to review the 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 Use 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 or 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 the right to your health information if they decide to contest any of your claims.

I have read your consent policy and agree to its 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 healthcare 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 sever 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 risk 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 eliminated at one in one million to one and ten million and can be even further reduce 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 risk 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 reduced 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.

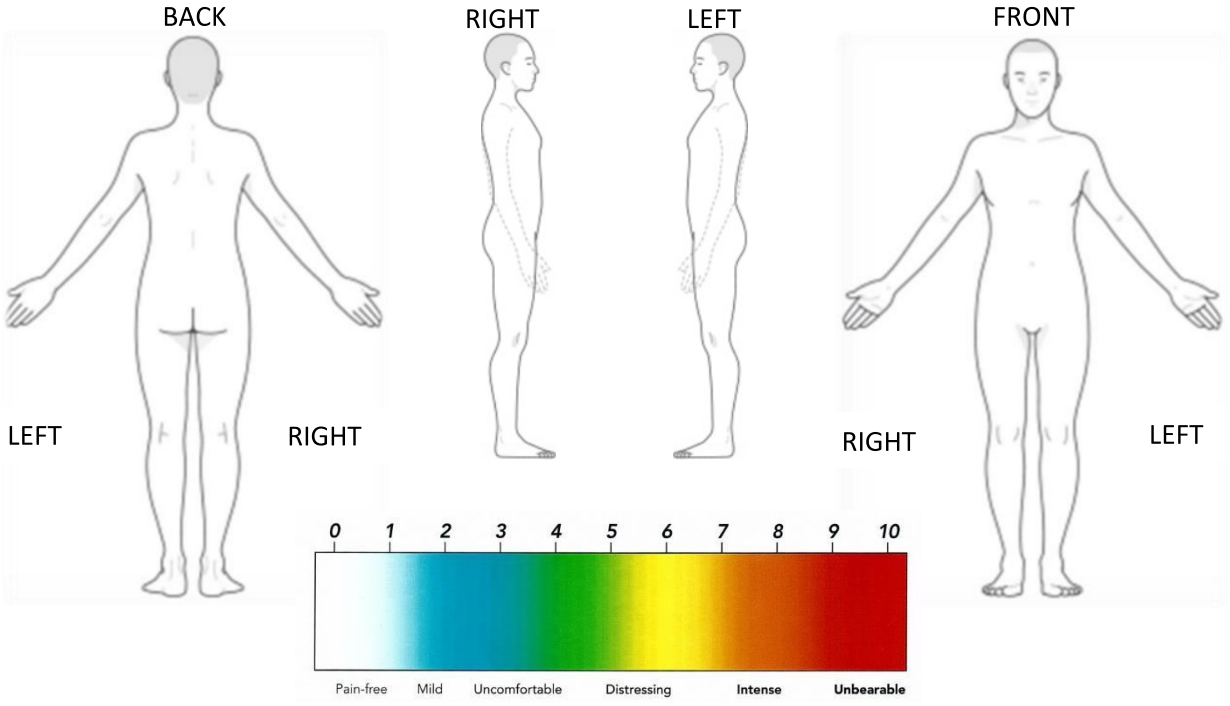
Printed name	Signature	Date
Witness:		
Printed name	Signature	Date

Verbal OK _____

Name _____ **Date**_____

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

Aches	**Throbbing**	**Weakness**	**Pins and Needles**	**Stabbing**	**Other**
w w w w w	“ “ “ “ “ “	0 0 0 0 0	* * * * *	/ / / / /	x x x x x



VISUAL ANALOUGE 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: _____
c) At Best: _____
d) At Worst: _____

VISUAL ANALOUGE SCALE

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

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