Onion River Chiropractic Registration and History

Patient Information

Date ______________________ _
Name: ______________________ _ __ _____ ___________ _
Address ____________________ _ __ _____ ___________ _
City ________________________ State _____ Zip, _______ _
SS/Patient ID# _______________ _ __ _____ ___________ _
Birthdate ____________________ _ __ _
Email ______________________ _ __ _____ ___________ _
Sex O M O F ____ Height ___________Weight

Married __ Widowed __ Single Minor
__ Separated __ Divorced __ Partnered for __ years

Patient Employer _____________________________________ _
Occupation ____ _
Employer Phone (_____________________________________
Spouse's Name _______________________________________ _
Whom may we thank for referring you? ___________________

Phone Numbers

Home Phone (_) Cell Phone(_) ___________ _
IN CASE OF EMERGENCY, CONTACT
Name: ________________________Relationship ___________ _

Cell Phone (__) ____________ Work Phone (_) ____________ _

Accident Information

Is condition due to an accident?:=' Yes [J No Date ___________ _
Type of Accident:::J Auto O Work O Home O Other
To whom have you made a report of your accident?
O Auto Insurance 0 Employer O Worker Comp O Other
Attorney Name (if applicable)

Insurance Information

Who is responsible for this account? ___________________________ _
Relationship to patient: ______________________________________ _

Insurance Co. __________________________ _________________ _
ID# ____________________________ Group# _________________ _
Is Patient covered by additional/secondary insurance? O Yes O No

Subscriber's Name ____________ __ _______________________ _
Birthdate _________________ 55# _ _______________________ _
Relationship to Patient _________ __ _______________________ _
2nd Insur. Co. _________________ __ ________________________ _
ID# __________________________ __Group# _________________ _

ASSIGNMENT AND RELEASE

I certify that I, and/or my dependent(s), have insurance coverage with

_ ____and assign directly to
(Name of Insurance Company(ies)

Dr. ____all insurance benefits,
if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I authorize the use of my signature on all insurance submissions.

The above-named doctor may use my health care information and may disclose such information to the above-named Insurance Company and their agents for the purpose of obtaining payment for services and determining insurance benefits or the benefits payable for related services. This consent will end when my current treatment plan is completed or one year from the date signed below.

Signature of Patient, Parent, Guardian or Personal Representative

Please print name of Patient, Parent, Guardian or Personal Representative

Date Relationship to Patient

Patient Condition

Reason for Visit ____ _
When did your symptoms appear? ________________________________ _
Is this condition getting progressively worse? O Yes O No O Unknown

Type of pain:
O Sharp O Dull O Throbbing O Numbness O Aching O Shooting
O Burning O TinglingO Cramps O Stiffness O Swelling O Other

How often do you have pain? ________________________Is it constant or does it comeandgo? ____ _

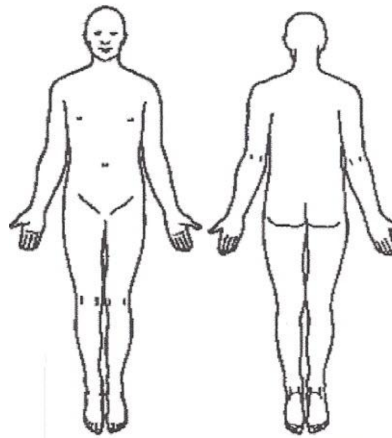
Does the pain interfere with your :O work O sleep O daily routine C recreation

Check the boxes listing activities or movements that are painful to perform:

o sitting OstandingOwalking 0 falling asleep 0 staying asleep 0 rising out of chair
o concentrating 0 computer use O reading O lying down O driving O housework
olifting/carrying groceries 0 housework Odressing/grooming 0 getting out of bed
C Using/lifting arms 0 head/neck movement

Circle your pain level 0 (no-pain) to 10 (worst-severe pain)
0 1 2 3 4 5 6 7 8 **9 10**

Mark an *'x'* on the picture where you have pain, numbness or tingling



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Have you ever seen a chiropractor before? __ Yes __ No Doctor:

What treatment have you already received for your condition? Medications Surgery Physical Therapy Other

Doctor name(s):

Imaging performed for this condition: _,_X-ray __ CT __ MRI __ Other

Circle "yes" or "no" to indicate if you have had any of the following:

AIDS/HIV	Yes No	Diabetes	Yes No	Liver Disease	Yes No	Rheumatic	Yes No
Alcoholism	Yes No	Emphysema	Yes No	Measles	Yes No	Scarlet Fever	Yes No
Allergy Shots	Yes No	Epilepsy	Yes No	Migraines	Yes No	STD's	Yes No
Anemia	Yes No	Fractures	Yes No	Miscarriage	Yes No	Stroke	Yes No
Anorexia	Yes No	Glaucoma	Yes No	Mononucleosis	Yes No	Suicide Attempt	Yes No
Appendicitis	Yes No	Goiter	Yes No	Multiple Sclerosis	Yes No	Thyroid Problems	Yes No
Arthritis	Yes No	Gonorrhea	Yes No	Mumps	Yes No	Tonsillitis	Yes No
Asthma	Yes No	Gout	Yes No	Osteoporosis	Yes No	Tuberculosis	Yes No
Bleeding Disorders	Yes No	Heart Disease	Yes No	Pacemaker	Yes No	Tumors, Growths	Yes No
Breast Lump	Yes No	Hepatitis	Yes No	Parkinson's Disease	Yes No	Typhoid Fever	Yes No
Bronchitis	Yes No	Hernia	Yes No	Pinched Nerve	Yes No	Ulcers	Yes No
Bulimia	Yes No	Herniated Disk	Yes No	Pneumonia	Yes No	Vaginal Infections	Yes No
Cancer	Yes No	Herpes	Yes No	Polio	Yes No	Whooping Cough	Yes No
Cataracts	Yes No	High Blood Pressure	Yes No	Prostate Problem	Yes No	Other	
Chemical Dependency	Yes No	High Cholesterol	Yes No	Prosthesis	Yes No		
Chicken Pox	Yes No	Kidney Disease	Yes No	Psychiatric Care	Yes No		

Exercise
- None
- Moderate
- Daily
- Heavy

W ty
- Sitting
- Standing
- Light Labor
- Heavy Labor

Habits
Smoking: __ Current, every day __ Current, some days __ Former Smoker __ Never Smoked
Alcohol: Drinks perweek ___________ _
Coffee/Caffeine Drinks: Cups per day ___________ _
High Stress Level: Reason, ___________________ ____ _

Preferred Language: English or other ________________________________ Ethnicity: Hispanic Non-Hispanic
Race: Caucasian Black/African American Asian American Indian/Alaskan Native Native American or Pacific Islander
More than one race Other

Are you pregnant? Yes No Due Date

Injuries/Surgeries you have had: Description Date

Falls/Head Injuries ____ _
Fractures/Dislocations ____ _
Surgeries, ____ _
X-rays/CT/MRItaken ____ _

Medications Presently Taking **Allergies to Medication** **Vitamins/Herbs/Minerals**

As part of your treatment here, soft tissue massage may be recommended to treat your condition. However, due to issues with some insurance companies this may not be a billable service.

In instances when the massage is not billable, there will be a $10.00 charge in addition to your copay. If you do not wish to have this service performed, please let us know before treatment.

Signature: ______________________________

Printed Name: _ _ _ _ _ _ _ _ _ _ _ _ _ _ _

Date:_____

ONION RIVER CHIROPRACTIC

440 MAIN STREET • WINOOSKI, VERMONT 05404 • **(802) 655-0354**

ONION RIVER CHIROPRACTIC OFFICE POLICY

* PAYMENT FOR INITIALL EXAMINATION IS DUE AT TIME OF TREATMENT UNLESS OTHER ARRANGEMENTS ARE MADE.

* ONION RIVER CHIROPRACTIC WILL DIRECT BILL SOME INSURANCE CARRIERS. PLEASE ASK IF YOURS APPLIES.

* PAYMENT OF INSURANCE DEDUCTffiLES AND/OR CO-PAYMENTS ARE DUE AT TIME OF TREATMENT UNLESS OTHER ARRANGEMENTS ARE MADE.

* IN ORDER FOR CHIROPRACTIC TREATMENT TO BE EFFECTIVE A FREQUENCY OF VISITS HAS BEEN DETERMINED FOR EACH PATIENT. PATIENTS ARE EXPECTED TO MAINTAIN THEIR PERSONAL TREATMENT PLAN.

* IN CONSIDERATION OF OTHER PATIENTS, ALL PATIENTS ARE EXPECTED TO ARRRIVE AT THIS OFFICE AT THEIR PRE-ARRANGED APPOINTMENT TIME. LATE PATIENTS OR WALK-INS WILL BE ATTENDED TO AS TIME PERMITS.

* 24 HOUR NOTICE MUST BE GIVEN TO CANCEL AN APPOINTMENT. IF NO NOTICE IS RECEIVED A $20.00 CHARGE WILL BE ASSESSED.

I have read and understand the above notice

Signaturej ____ _

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 (HIP AA), 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.

I acknowledge that I have received a copy of
Notice of Privacy Practices for Protected Health Information.

Patient Name Printed | Date

Patient Signature | Authorized Provider Rep.

Personal Representative Printed | Personal Rep. Signature

Description of Personal representatives authority to act for the patient.

ONION RIVER CHIROPRACTIC: INFORMED CONSENT

As with all health care professions, Chiropractic is associated with very rare potential risks in the delivery of treatment. While Chiropractic is extremely safe, it is our policy that all patients read and understand fully those possible risks involved with the chiropractic treatment prior to initiating treatment. Please understand that we are highly trained in patient examination and evaluation, allowing us to avoid many of the risks herein.

Stroke is the most serious known complication of Chiropractic treatment. It occurs in very rare circumstances after cervical manipulation and is due to an injury to the vertebral artery. Cervical treatment posts a very small risk. The most recent studies indicate that the incidence of stroke is approximately one in every three million cervical adjustment. Practitioners can lower this occurrence even further with proper orthopedic testing and history taking during their examination. Soreness may occur as a side effect after the adjustment and can last for 24-48 hours. This is a normal and accepted response to chiropractic care. If you do feel any abnormal amount of pain or if you are uncomfortable for a prolonged period of time following treatment, please inform us. Soft tissue injury may result from chiropractic care. On occasion discs, joints, ligaments and tendons can become irritated from an adjustment. Rib injury or fracture is a rare side effect of thoracic spine manipulation. Treatment is provided carefully to avoid such circumstances. Physical therapy modalities may cause rare minor burns to the skin and should be reported to the doctor or staff member if they occur. Other rare side effects may occur as a result of Chiropractic care and should be immediately reported to the doctors or staff of Onion River Chiropractic.

While we make it a goal to provide the best possible treatment for every one of our patients, it is important that patients understand that we cannot promise a cure for every symptom, condition or disease as a result of treatment in our office. Every attempt will be made to treat your condition to the best of our abilities and if we do not achieve the results we hope for, we will refer you to another provider who we feel can better assist you with your condition. If you have any questions or concerns with the above mentioned material or at any point during your course of care please feel free to ask questions. When you have full understanding of the above mentioned material and consent to receiving chiropractic care in our office, please print your name, sign and date below.

PRINT NAME: ______________________________

SIGNATURE: ______________________________ DATE: