SPRINGFIELD FAMILY CHIROPRACTIC LLC

Name: ____ Sex: M F D.O.B: ___/____/___
Last First MM/ DD/ YY

Address: ______________________________________ City: ______________________________
No. Street

State: _____ Zip:____________ Phone: __________________________
Phone Carrier (EX. Verizon) :_________

Email Address: ______________________ @ _______ Occupation/Employer: ______________

Social Security #: ______ - ____ - ________ Health Insurance Company: _________________

Contact Name/ Relation: ________________________ P: (Contact) (______)______-_________

Race (Circle One):

1) White (Caucasian)
2) Black or African American
3) American Indian or Alaskan Native
4) Native American or Pacific Islander
5) Decline to Answer

Ethnicity (Circle One):

1) Hispanic or Latino
2) Not Hispanic or Latino
3) Decline to Answer

Preferred Language: _____________________________
Primary Care Physician: _________________________ Clinic/Hospital: ____________________
Tell us how you found us: _______________________

Case History:
Reason for seeking treatment:

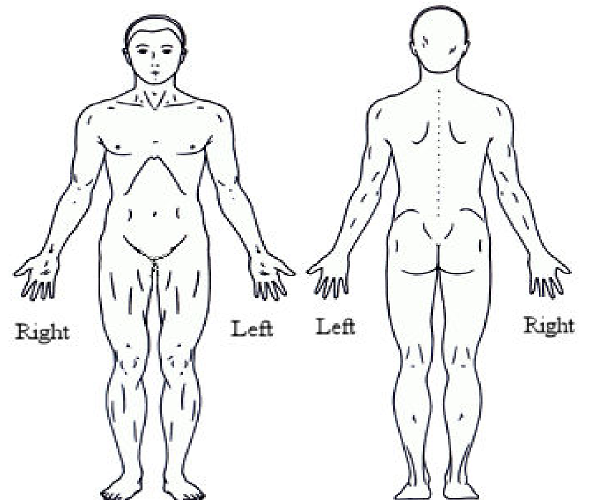
____

Rate your current pain 0-10, then use the following symbols from the key on the diagram(s) to describe your pain.

No Pain 0 1 2 3 4 5 6 7 8 9 10 Worse Pain

Dull Ache X X X X
Sharp/Stabbing / / / / /
Tightness # # # # #
Numbness o o o o o o
Burning ^ ^ ^ ^ ^ ^
Pins and needles + + + + + +
Other = = = = = =

Explain:___________________________
____
____



Please tell us more about **when** your symptoms started including **what activity** you were doing :
____
____
____

What makes the pain better? ____
What makes the pain worse? ____

Is there any part of the day when the pain is better or worse? Yes No
Explain: (ex: worse at night): ____

Have you had similar pains or injuries like this before? Yes No
Is the pain getting progressively worse? Yes No

Have you had bowel or bladder problems in the past or present? Yes No
Any vision, taste, smell, or hearing problems in the past or present? Yes No
Corrective lenses or glasses? Yes No
Does the pain interfere with your sleep? Yes No

Are you currently taking any medications? (Please include regularly used over the counter medications)

Medication Name	Dosage and Frequency (I, E, 5mg once a day, etc.)

Do you have any medication allergies?

Medication Name	Reaction	Onset Date	Additional Comments

Social History:

Do you take vitamins or any daily supplements? Yes No
If yes, list the brand and type: ____
How many bottles of water do you drink in a day? 1 2 3 4 5 6 7 8 9 10+
Caffeinated drinks per day? 1 2 3 4 5 6 7 8 9 10+

Smoking status (circle one):

Every day smoker, Occasional smoker, Former smoker, Never smoked
Smoking start date (optional): ____

Alcohol?	Daily	Socially	Infrequent	None
Illicit drugs?	Daily	Socially	Infrequent	None

How many times do you brush your teeth a day? _____ per day
Do you suffer from any allergies? Yes No

Family History:
Have you or your immediate family suffered from any of the following past or present?
*Please put numbers next to condition for yourself and/or family members
(If any relatives have deceased; please note cause of death and age.)

1) Major surgeries (back, neck, heart, lung, brain, abdomen)
Including (broken neck/face/skull)
2) Major Diseases or Disorders including Auto Immune
3) Stroke

4) High Blood Pressure	15) Dizziness	Self: ____________________
5) Low Blood Pressure	16) Nausea	__________________________
6) Heart Attack	17) Headache	
7) Heart Problems	18) Osteoporosis	Mother: __________________
8) Diabetes	19) Arthritis	__________________________
9) Abdominal Aortic Aneurysm	20) Kidney Problems (UTI)	
10) Poor Circulation	21) Clotting Issues	Father: __________________
11) Arteriosclerosis	22) Down Syndrome	__________________________
12) High Cholesterol	23) Congenital Disease	
13) Cancer		Siblings: ________________
14) Unexplained Weight Loss		__________________________

Were you in some sort of accident? Yes No

Please circle one if yes: Auto mobile/ Slip and fall/ Work accident/ Other

I choose to decline receipt of my clinical summary after every visit. (These summaries are often blank because of the nature and frequency of chiropractic care.)
I hereby certify that the statements and answers given on this form are accurate to the best of my knowledge and understand that it is my responsibility to inform Springfield Family Chiropractic LLC. of any changes in my health. I agree to allow this office to examine me for further evaluation.
Signature: ____Date: ____________________

Office Policies

PERMISSION TO COMMUNICATE

I authorize and give permission to Dr. Paul Dion and his staff to communicate with me by regular mail, email, phone calls to my home, work, wireless phone or answering machine(s). I understand that communication will be in regards to appointments, clinical issues and clerical issues. I understand that due diligence will be employed in being discrete about any clinical issues conveyed via any of the above modes of communication. I understand that I have the right to refuse certain types of communication by notifying Dr. Paul Dion or his staff in writing.

AUTHORIZATION TO RELEASE HEALTHCARE INFORMATION

I hereby authorize Dr. Paul Dion, or his assigned staff members, to release information contained in my medical records to any and all insurance carriers for whom I may be due benefits, to my primary care physician and other healthcare professionals associated with my treatment, to the state chiropractic board in the event of request, and to my attorney of record (if an attorney is involved).

ASSIGNMENT OF BENEFITS

I hereby instruct and direct that payments for my services to be sent directly to Dr. Paul Dion or Springfield Family Chiropractor LLC. P.O. Box 3091 Springfield, Ma. 01101. And not to my guardians, my estate, or my attorney, regardless of any assignments of benefits my attorney or others may present on my behalf, and regardless of the date of such other assignment or instruction may be signed by me or presented by others.

- I hereby instruct and direct that payments for health care provided me by Dr. Paul Dion as reflected in bills for such service that he may be present, as maybe due me under terms of a contract of insurance, or as a result of an action at court, settlement, structured settlement, judgment, verdict or arbitration award which I may receive or be due, be sent, be sent directly to Dr. Paul Dion. The instruction shall be considered irrevocable, and shall survive me, and my period of care under Dr. Dion forever and without exception.

COLLECTION POLICY AGREEMENT

- I hereby acknowledge that I am ultimately fully responsible for all the payment of all charges or fees for services provided me, regardless of any contract of insurance, any action at court, any settlement, structured settlement, verdict or arbitration award which I may receive or be due, or the course or outcome of any dispute regarding the same. I also understand that I may be charged a 1.5% monthly interest charge for any patient balances unpaid after 30 days.
- I agree to deliver to Dr. Dion any check, draft of funds that I may receive from any source intended as payment for services rendered me by Dr. Dion within 10 days of receipt by me and to be responisble for a 1.5% month interest accrued for failure to deliver money after 30 days.
- I agree to reimburse Dr. Dion for all reasonable collection costs he incurs that arise from collection actions he takes against me in the process of settling my account.

APPOINTMENT POLICY

We reserve the right to charge a $35.00 fee for appointments that are missed or appointments that are cancelled without notice of at least twenty-four (24) hours.

<u>The $35.00 fee is your bill.</u> (Not your insurance company's bill.)

Signature____ Date ___________________

CHIROPRACTIC INFORMED CONSENT TO TREAT

-I hereby request and consent to the performance of chiropractic procedures, including various modes of physiotherapy, diagnostic x-rays, and any supportive therapies on me (or on the patient named below, for whom I am legally responsible) by Dr. Paul J. Dion D.C. or other licensed doctors of chiropractic and support staff who now or in the future treat me while employed by, working or associated with or serving as back-up for the doctor of chiropractic named below, including those working at the clinic or office listed below or any other office or clinic, whether signatories to this form or not.

-I have had an opportunity to discuss with the Dr. Paul J. Dion D.C. and/or with other office or clinic personnel the nature and purpose of chiropractic adjustments and procedures.

-I understand and I am informed that, as is with all Healthcare treatments, results are not guaranteed and there is no promise to cure. I further understand and I am informed that, as is with all Healthcare treatments, in the practice of chiropractic there are some risks to treatment, including, but not limited to, muscle spasms for short periods of time, aggravating and/or temporary increase in symptoms, lack in improvement of symptoms, fractures, disc 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 upon the facts then known, is in my best interests.

-I further understand that Chiropractic adjustments and supportive treatment is designed to reduce and/or correct subluxations allowing the body to return to improved health. It can also alleviate certain symptoms through a conservative approach with hopes to avoid more invasive procedures. However, like all other health modalities, results are not guaranteed and there is no promise to cure. Accordingly, I understand that all payment(s) for treatment(s) are final and no refunds will be issued.

-I further understand that there are treatment options available for my condition other than chiropractic procedures. These treatment options include, **but not limited self-administered, over the counter analgesics and rest; medical care with prescription drugs such as anti-inflammatories, muscle relaxants and painkillers; physical therapy; steroid injections; bracing; and surgery**. I understand and have been informed that I have the right to a second opinion and secure other opinions if I have concerns as to the nature of my symptoms and treatment options.

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

Patients under 18 years of age
Name Printed of Guardian/Parental and Relationship to Patient: ____
Guardian/Parental Signature: ____

Signature of Patient: _______________________________________Date: __________________

Our office policy reserves the right to charge $35.00 for all appointments not cancelled or rescheduled prior to 24 hours of yours schedules appointment time. This fee is your responsibility and will be billed directly to you.

SIGNATURE: __________________________ DATE: ________