**Name**:_______________________________________ [ ] Male - [ ] Female **Today's Date**:__________
**Date of Birth**:____/____/____ **Age**:____ **Height**:_____ **Weight**:_____ **SS#**_____-_____-_____

**Marital Status**: [ ] Married - [ ] Single - [ ] Divorced - [ ] Widowed - [ ] Partner - **Number of Children:** _____
**Student Status**: [ ] Full Time - [ ] Part Time - [ ] Non-Student

**Home Address**:_______________________________________________________________
Street / P.O Box City State Zip Code
**E-Mail**:______________________________ **How did you hear about West Hartford Chiropractic**? [ ] Ad - [ ] Brochure - [ ] Internet - [ ] Provider - [ ] Other_____________________________________________

**Employment Status**: [ ] Full Time - [ ] Part Time **Employer:**________________________________
**Occupation(If retired, prior occupation):**______________________________________________
**WorkPhone**:________________________________ **Are you:** [ ] Working without restrictions - [ ] Working with restrictions - [ ] Not working/ off since ________

**Home Phone**:________________ **Cell Phone**:________________ **Primary Care Doctor**:________________
**Are you seeing us for an injury from** [ ] Auto - [ ] Work - [ ] Sports Injury - [ ] No Injury - [ ] Other _________
**Emergency Contact**: **Name:** ______________________ **Phone**:____________ **Relationship**:______________

**Insurance Information**: Please bill: [ ] Auto Insurance - [ ] Workman's Comp - [ ] Health Insurance - [ ] Self Pay
**Person Responsible for the Account**: _________________________ **Relationship**: _____________________
**Primary Insurance Name**: _________________________________ **Policy#:** __________________________
**Group#:** _______________________________ **Insured's Name:** ___________________________________
**Secondary Insurance Name**: ________________________________ **Policy#:** __________________________
**Group#:** _______________________________ **Insured's Name**___________________________________

**General Consent Form:**

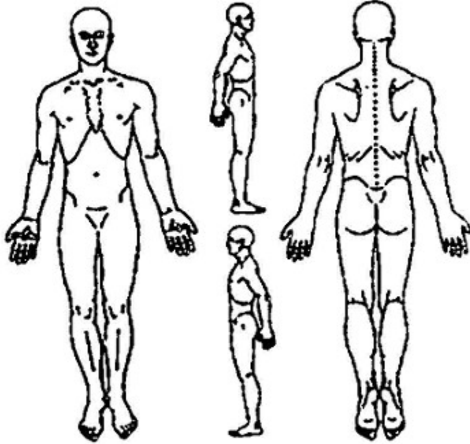
I authorize West Hartford Chiropractic, LLC to apply for benefits on my behalf for services rendered by West Hartford Chiropractic, LLC. I request payment from my insurance company be made directly to West Hartford Chiropractic, LLC. I certify that the information I have reported with regard to my personal information and my insurance coverage is correct and that the information in my chart is confidential. I understand that all requests for release of my records must be in writing. Protected health information will be released with written authorization, with minimal disclosure necessary as related to my care. I permit a copy of this authorization to be used in the place of the original. I may revoke this authorization at any time in writing. I understand that there is no guarantee that my insurance companies or pre-paid health plans will cover or pay for all of my charges. Notwithstanding denial, reduction of benefits or failure to pay for any reason, I understand that I am responsible for all remaining charges. I understand that nothing here, in this statement, relieves me of the primary responsibility and obligation to pay for medical services provided, within 30 days when a statement is rendered. In the event of any outstanding balance, this matter will be referred to collections, including attorney's fees and court costs. For Medicare and Medical Assistance: I authorize the release to the Social Security Administration and Health Care Financing Administration or its intermediaries any information needed for this or related claims.

**Patient Signature:** _______________________________________________ **Date** ____________

**Parent or Legal Guardian Signature:** ____________________________________ **Date**____________

What is your **major** complaint? ______________________________________________________________
**When** did your condition develop? ____________________________________________________________
**How** did your condition develop? _____________________________________________________________
Has your condition been getting better, worse or staying the same? ________________________________
What makes your condition better? ______________________________________________________________
What makes it worse? _________________________________________________________________________

Please mark on the diagram to explain and locate the areas of complaint.
**A**=ACHE **B**=BURNING **S**=STABBING **N**=NUMBNESS **P**=PINS & NEEDLES **O**=OTHER



**Do you currently have, or have you had in the past:**

| Complaint: | When & # of Episodes: |
| --- | --- |
| □ Back pain or stiffness | ______________ |
| □ Neck pain or stiffness | ______________ |
| □ Shoulder pain | ______________ |
| □ Hip pain | ______________ |
| □ Foot pain or trouble | ______________ |
| □ Swollen or painful joints | ______________ |
| □ Cold hands or feet | ______________ |
| □ Numbness or pain in the arms, hands or fingers | ______________ |
| □ Numbness or pain in the legs, feet, or toes | ______________ |

**Tests:** Please list the most recent date and location taken, if known.
**X-Ray of any area of the spine:** _________________ **EKG:** __________________ **MRI/CT:** __________________
Other tests pertaining to condition you are seeing us for:____________________________________________

| **Habits:** Do you… | **Yes** | **No** | If yes, please describe: |
| --- | --- | --- | --- |
| Smoke? | [ ] | [ ] | How many per day? Packs _________ Cigarettes _______ |
| Consume Alcohol? | [ ] | [ ] | How many drinks per day? ___________________________ |
| Consume coffee or tea? | [ ] | [ ] | How many cups per day? ____________________________ |
| Take street drugs? | [ ] | [ ] | ______________________________________________ |
| Exercise? | [ ] | [ ] | How often? (**D**aily, **W**eekly, **M**onthly) ______ Type: ______________________________________________ |

**Surgeries:** Please list all past surgeries: [ ] None
_____________________________________________________________________________________
_____________________________________________________________________________________

**Medicines:** Please list all currently used medicines. Include prescription and non prescription meds, vitamins and herbs. ___________________________________________________________________________
_____________________________________________________________________________________
_____________________________________________________________________________________

**Allergies:** Please list all known allergies, especially to medicines, latex _________________________________
_____________________________________________________________________________________

**Treatment** you are receiving or have received:
Medical Care:________________________________________________________________________
Chiropractic Care:____________________________________________________________________
Physical Therapy: ____________________________________________________________________
Massage Therapy:_____________________________________________________________________
Other: (Please Specify)_________________________________________________________________

**Males** ONLY: Do you have [ ] Changes in urine stream - [ ] Prostate trouble - [ ] Lump in testicles
**Females** ONLY: Do you have [ ] Menstrual problems - [ ] Breast lumps or pain - [ ] Tubal infections - [ ] Problems conceiving - [ ] History of miscarriages
**Are you currently or possibly pregnant?** ________ How many weeks? ____________ Due date ___________
Have you ever been on birth control pills? ________ Are you currently taking birth control pills? ___________
Are you seeing an OB-GYN regularly? [ ] Y [ ] N - Name_________________ Date of last exam? ___________
Number of Pregnancies __________ Abortions __________ Miscarriages __________ Children ___________

Do you currently or have you had (Please mark all that apply):

| **NEUROLOGICAL** | **Current** | **Past** |
|---|---|---|
| Headaches | [ ] | [ ] |
| Dizziness | [ ] | [ ] |
| Tremor | [ ] | [ ] |
| Stroke | [ ] | [ ] |
| Nausea | [ ] | [ ] |
| Speech problems | [ ] | [ ] |
| Trouble concentrating | [ ] | [ ] |
| Muscle weakness or paralysis | [ ] | [ ] |
| Memory Loss | [ ] | [ ] |
| Direct head trauma | [ ] | [ ] |
| Loss of consciousness | [ ] | [ ] |
| Poor coordination | [ ] | [ ] |
| Numbness in groin | [ ] | [ ] |
| Seizures | [ ] | [ ] |

| **MUSCULOSKELETAL** | **Current** | **Past** |
|---|---|---|
| Hernia | [ ] | [ ] |
| Arthritis or gout | [ ] | [ ] |
| Bursitis | [ ] | [ ] |
| Fractured bones | [ ] | [ ] |
| Pain fails to improve with rest | [ ] | [ ] |
| Pain greater than 4 weeks | [ ] | [ ] |
| Osteoporosis | [ ] | [ ] |
| Neck pain | [ ] | [ ] |
| Upper back pain | [ ] | [ ] |
| Mid back pain | [ ] | [ ] |
| Lower back pain | [ ] | [ ] |

| **CARDIOVASCULAR** | **Current** | **Past** |
|---|---|---|
| High blood pressure | [ ] | [ ] |
| Passing out | [ ] | [ ] |
| High cholesterol or triglycerides | [ ] | [ ] |
| Chest pain or angina | [ ] | [ ] |
| Heart disease | [ ] | [ ] |
| Murmur | [ ] | [ ] |
| Bleeding disorder | [ ] | [ ] |
| Pain near the heart | [ ] | [ ] |
| Hardening of the arteries | [ ] | [ ] |
| Varicose Veins | [ ] | [ ] |

| **CONSTITUTIONAL** | **Current** | **Past** |
|---|---|---|
| History of trauma | [ ] | [ ] |
| Infection | [ ] | [ ] |
| Unexplained weight loss | [ ] | [ ] |
| Unusual fatigue | [ ] | [ ] |
| Dizziness/Poor balance | [ ] | [ ] |
| Change in appetite | [ ] | [ ] |
| Fevers/Night Sweats | [ ] | [ ] |
| Cancer | [ ] | [ ] |
| Use of corticosteroids | [ ] | [ ] |
| Use of blood thinners | [ ] | [ ] |
| Intravenous drug use | [ ] | [ ] |
| HIV/AIDS | [ ] | [ ] |
| Hepatitis | [ ] | [ ] |
| Night pain | [ ] | [ ] |
| Tuberculosis | [ ] | [ ] |

| **RESPIRATORY** | **Current** | **Past** |
|---|---|---|
| Asthma | [ ] | [ ] |
| Shortness of breath | [ ] | [ ] |
| Chronic cough | [ ] | [ ] |
| Coughing up phlegm | [ ] | [ ] |
| Spitting up blood | [ ] | [ ] |
| Chest pain | [ ] | [ ] |
| Difficulty breathing | [ ] | [ ] |

| **URINARY** | **Current** | **Past** |
|---|---|---|
| Increased urination frequency | [ ] | [ ] |
| Pain or blood with urination | [ ] | [ ] |
| Kidney or bladder infection | [ ] | [ ] |
| Kidney Stones | [ ] | [ ] |
| Prostate problems | [ ] | [ ] |

| **EAR NOSE & THROAT** | **Current** | **Past** |
|---|---|---|
| Sinus problems | [ ] | [ ] |
| Difficulty swallowing | [ ] | [ ] |
| Blurred vision | [ ] | [ ] |
| Falling vision (one/both eyes) | [ ] | [ ] |
| Double vision | [ ] | [ ] |
| Eye pain | [ ] | [ ] |

| CARDIOVASCULAR (con.) | Current | Past |
|---|---|---|
| Swelling of ankles | [ ] | [ ] |
| Poor circulation | [ ] | [ ] |

| GENITO URINARY FOR WOMEN | YES | NO |
|---|---|---|
| Painful menstruation | [ ] | [ ] |
| Excessive flow | [ ] | [ ] |
| Hot flashes | [ ] | [ ] |
| Irregular cycle | [ ] | [ ] |
| Cramps or backache | [ ] | [ ] |
| Vaginal discharge | [ ] | [ ] |
| Swollen breasts | [ ] | [ ] |
| Lumps in breasts | [ ] | [ ] |
| Endocrine | [ ] | [ ] |

| GASTROINTESTINAL | Current | Past |
|---|---|---|
| Abdominal pain | [ ] | [ ] |
| Ulcer | [ ] | [ ] |
| Nausea | [ ] | [ ] |
| Heartburn/GERD | [ ] | [ ] |
| Recurring diarrhea/constipation | [ ] | [ ] |
| Hemorrhoid problems | [ ] | [ ] |
| Loss of bowel or bladder control | [ ] | [ ] |
| Vomited blood | [ ] | [ ] |
| Bloody or black stools | [ ] | [ ] |
| Jaundice | [ ] | [ ] |
| Liver problems | [ ] | [ ] |
| Gall bladder trouble | [ ] | [ ] |
| Intestinal worms | [ ] | [ ] |

| EAR NOSE & THROAT (con.) | Current | Past |
|---|---|---|
| Hearing impairment | [ ] | [ ] |
| Earache | [ ] | [ ] |
| Ringing/Buzzing noise in ears | [ ] | [ ] |
| Frequent colds | [ ] | [ ] |
| Enlarged glands | [ ] | [ ] |
| Difficulty swallowing | [ ] | [ ] |

| HEMATOLOGIC | Current | Past |
|---|---|---|
| Anemia | [ ] | [ ] |
| Bleeding or bruising tendency | [ ] | [ ] |
| Blood disease | [ ] | [ ] |

| ENDOCRINE | Current | Past |
|---|---|---|
| Diabetes | [ ] | [ ] |
| Thyroid trouble | [ ] | [ ] |

| INTEGUMENTARY/ALLERGIC | Current | Past |
|---|---|---|
| Skin conditions | [ ] | [ ] |
| Hay fever | [ ] | [ ] |

| PSYCHIATRIC/BEHAVIORAL | | | |
|---|---|---|---|
| Sleep problems | [ ] | [ ] | [ |
| Nervous tension | [ ] | [ ] | |
| Irritability | [ ] | [ ] | |
| Mood swings/Changes | [ ] | [ ] | |
| Medication | [ ] | [ ] | |

_______________________________________________

**Family History:** Do you or **any blood relative** have any of the following?
Please indicate who has the condition.

[ ] Cancer ____________________________________________________________________
[ ] Epilepsy ___________________________________________________________________
[ ] Multiple Sclerosis ____________________________________________________________
[ ] Diabetes ___________________________________________________________________
[ ] Heart Problems ______________________________________________________________
[ ] Arthritis ___________________________________________________________________
[ ] Headaches _________________________________________________________________
[ ] High blood pressure __________________________________________________________
[ ] Psychological Problems _______________________________________________________
[ ] Stroke _____________________________________________________________________
[ ] Spine or back disorder ________________________________________________________
[ ] Other______________________________________________________________________

**Please List: HOSPITALIZATIONS, OPERATIONS, AUTO ACCIDENTS OR WORK INJURIES, & TREATMENT/YEAR**

**How many** **Dates**

[ ] Motor Vehicle Accidents: ______________________________________________________
[ ] Hospitalizations: _____________________________________________________________
[ ] Work Injuries: _______________________________________________________________
[ ] Operations: _________________________________________________________________

**ANY OTHER SERIOUS ILLNESSES OR CONCERS NOT MENTIONED ABOVE:**

_____________________________________________________________________________
_____________________________________________________________________________
_____________________________________________________________________________

**West Hartford Chiropractic, LLC**

345 North Main Street, Suite 322, West Hartford, CT 06062

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**NOTICE OF PRIVACY PRACTICES**

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*This notice describes how medical information about you may be used and disclosed and how you can get access to this information. Please review it carefully and then sign the acknowledgement at the end.*

This Notice of Privacy Practice describes how we may use and disclose your protected health information to carry out treatment, payment or health care operations and for other purposes that are permitted or required by law. It also describes your rights to access and control your protected health information. "Protected health information" (PHI) is information about you, including demographic information, that may indentify you and that relates to your past, present, or future physical or mental health or condition and related health care services.

We are required to abide by the terms of this Notice of Privacy Practices. We may change the terms of our notice at any time. The new notice will be effective for all protected health information that we maintain at the time. Upon your request, we will provide you will any revised Notice of Privacy Practices by calling the office and requesting that a revised copy be sent to you in the mail or asking for one at the time of your next appointment.

## USES AND DISCLOSURE OF PROTECTED HEALTH INFORMATION

Your protected health information may be used and disclosed by your physician, our office staff, and others outside of our office that are involved in your care and treatment for the purpose of providing health care services to you. Your protected health information may also be used and disclosed to pay your health care bills and to support the operation of the physician's practice.

*The following are examples of the types of uses and disclosures of your protected health care information that the physician's office and the billing department are permitted to make.*

**TREATMENT**

We will use and disclose your protected health information (PHI) to provide, coordinate, or manage your health care and any related services. This includes the coordination or management of your health care with a third party that has already obtained your permission to have access to your PHI. For example, we would disclose your PHI as necessary, to a home health agency that provides care to you. We will also disclose PHI to other physician's who may be treating you when we have the necessary permission or authorization for you to disclose your protected health information. For example, your protected health information may be provided to a physician to whom you have been referred to ensure that the physician has the necessary information to diagnose or treat you. In addition, we may disclose your PHI time-to-time to another physician or health care provider who, at request of yourself or your physician, becomes involved in your care by providing assistance with your health care diagnosis or treatment to your physician.

**PAYMENT**

Your protected health information (PHI) will be used, as needed, to obtain payment for your health care services. This may include certain activities that your health insurance plan may undertake before it approves or pays for the services we recommend for you such as: making a determination of eligibility or coverage for insurance benefits reviewing services provided to you for medical necessity, and undertaking utilization review activities. (For example, obtaining approval for a hospital stay may require that your relevant protected health information be disclosed to the health plan to obtain approval for the hospital admission.)

**HEALTH CARE OPERATIONS**

We may use or disclose, as needed your protected health information (PHI) in order to support the business activities of your physician's practice. These activities include, but are not limited to quality assessment activities, employment review activities, training of medical students, licensing, and conduction or arranging for other business activities. We may disclose your protected health information to medical students that see patients in our office. We

may use a sign-in sheet at the registration desk where you will be asked to sign your name and the name of your physician. We may call you by name in the waiting room when your physician is ready to see you. We may use or disclose your PHI, as necessary, to contact you to remind you of your appointments. We will share your PHI with third party "business associates" that perform various activities (For example, billing and transcription services) for the practice. Whenever an arrangement between our office and a business associate involves the use of disclosure of your PHI, we will have a written contract that contains terms that will protect the privacy of your protected health information. We may use or disclose your PHI, as necessary, to provide you with information about treatment alternatives or other health-related benefits and services that may be of interest of you. We may also use and disclose your protected health information for other marketing activities. (For example: your name and address may be used to send you a newsletter about our practice and the services we offer.) We may also send you information about records or services that we believe may be beneficial to you. We may be required by law to disclose records that you have not authorized. (For example: if we receive a subpoena for the records or if we need to disclose your PHI to protect public health.) We will keep all disclosure of your medical records to the minimum necessary.

**OTHERS INVOLVED IN YOUR HEALTHCARE**

Unless you object, we may disclose your projected health information to a member of your family, a relative or to any other person that you identify. If you are unable to agree or object to such a disclosure, we may disclose such information as necessary if we determine that it is in your best interest based on our professional judgment. We may use or disclose your protected health information to an authorized public or private entity to assist or to coordinate your care. For example: the authorized entities may include, but are not limited to, research, death, organ donation, public health and safety, abuse or neglect, food and drug administration, criminal activity, and oversight agencies re: audits, investigations and inspections (which include government agencies, government benefit programs, and government regulatory programs and civil rights laws.) Also, we may use or disclose your protected health information when we are required to do so by law.

**PATIENT RIGHTS**

1. You have the right to inspect and copy your health information. (Prior notice required, fees may apply)
2. If you feel that the health information we have about you is incomplete or inaccurate, you have the right to request an amendment to your medical records. The request must be made in writing with the reason that supports your request. If we do not agree with your statement, you have a right to ask that your statement be placed in medical record.
3. You have the right to find out how your health information is used and to whom it is disclosed. You may request an accounting of your medical record disclosures made by us except for disclosures made for treatment, payment, and health care operations.
4. You have the right to receive a paper copy of this notice.
5. You may be asked to sign a specific authorization for the release of medical records for disclosure of your protected health information.
6. You have the right to request that we communicate with you in confidence about your PHI.
7. You have the right to request that we communicate with you about your PHI by different means or to different locations. Your request must be made in writing.

**COMPLAINTS**

We are required by law to maintain the privacy of your protected health information (PHI). You may complain to the Secretary of the U.S Department of Health and Human Services or you may complain to us if you believe that you privacy rights have been violated. You may reach our Privacy Contact: Sarah Laub at 860-232-5556. Or you can email at info@westhartfordchiropractic.com.

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**PRIVACY PRACTICES ACKNOWLEDGEMENT**

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I have received the Notice of Privacy Practices regarding my personal health information (PHI). I have been provided an opportunity to review it. I understand that this notice of privacy is to protect my personal health information (PHI).

**Patient Name: ____________________________________ Date of Birth: ____________________**
**Signature: ________________________________________ Date: __________________________**

# WEST HARTFORD CHIROPRACTIC, LLC

## INFORMED CONSENT/AUTHORIZATION FOR CHIROPRACTIC TREATMENT

*Medical doctors, Chiropractic doctors, Osteopaths, and Physical Therapists who perform manipulation are required by law to obtain your informed consent before starting treatment.*

I, the patient, do hereby give my consent to the performance of conservative noninvasive treatment to the joints and soft tissue. Physical therapy, ultra sound, hot or cold packs, infrared laser, electrical stimulation, and exercises may also be used.

Although spinal manipulation/adjustment is considered to be one of the safest, most effective forms of therapy for musculoskeletal problems, I am aware that there are possible risks and complications associated with these procedures as follows:

*Soreness:* I am aware that like exercise it is common to experience muscle soreness in the first few treatments.
*Dizziness:* Temporary symptoms like dizziness and nausea can occur but are relatively rare.
*Fractures/Joint Injury:* I further understand that in isolated cases underlying physical defects, deformities or pathologies like weak bones from osteoporosis may render the patient susceptible to injury. When osteoporosis, degenerative disk, or other abnormality is detected, this office will proceed with extra caution.
*Stroke:* Although strokes happen with some frequency in our world, strokes from chiropractic adjustments are extremely rare. I am aware that nerve or brain damage including stroke is reported to occur once in ten million treatments. Once in a million is about the same chance as getting hit by lightening, while one in a thousand is about the same chance as normal dose as aspirin or Tylenol causing death.
*Physical Therapy Burns:* Some of the therapies used in this office generate heat and may rarely cause a burn. Despite precautions, if a burn is obtained, there will be a temporary increase of pain and possible blistering. This should be reported to the doctor.

### Treatment Results

I also understand that there are beneficial effects associated with these treatment procedures including decreased pain, improved mobility and function, and reduced muscle spasm. However, I appreciate there is no certainty that I will achieve these benefits. I realize that the practice of medicine, including chiropractic, is not an exact science and I acknowledge that no guarantee has been made to me regarding the outcome of these procedures. I agree to the performance of these procedures by my doctor and such other person of the doctor's choosing.

### Alternative Treatments Available

There are reasonable alternatives to these procedures including rest, home applications of therapy, prescription or over-the-counter medications, exercises and possible surgery.
*Medications:* Medication can be used to reduce pain or inflammation. I am aware that the long-term use or overuse of medication is always a cause for concern. Drugs may mask pathology, produce inadequate or short-term relief, undesirable side-effects, physical or psychological dependence, and may have to be continued indefinitely.

*Rest/Exercise:* I understand that simple rest is not likely to reverse pathology, although it may temporarily reduce inflammation and pain. The same is true of ice, heat, or other home therapy. Prolonged bed rest contributes to weakened bones and joint stiffness. Exercises are of limited value but are not corrective of injured nerve and joint tissue.

*Surgery:* Surgery may be necessary for joint stability or serious disk rupture. Surgical risks may include unsuccessful outcome, complications, pain or reaction to anesthesia, and prolonged recovery.

*Non Treatment:* I understand the potential risks of refusing or neglecting care may include increased pain, scar/adhesion formation, restricted motion, possible nerve damage, increased inflammation, and worsening pathology. The aforementioned may complicate treatment making future recovery and rehabilitation more difficult and lengthy.

## Appointment Policy

Office visits are scheduled according to the severity of your condition and the program of chiropractic care that the Doctor feels is best for you. If your condition requires numerous appointments over the next few weeks or months, we have designed a Multiple Appointment Program for your convenience. This procedure would minimize your time in the office by incorporating your appointments into your daily routine.

**The frequency of your visitation schedule is of paramount importance to your results, so we ask that each patient assume responsibility of strict adherence to the appointment program as it is designed for optimum results.**

Regardless of how many appointments are scheduled for you each week, please note that it is the frequency of the visits that count, not on the days of which you receive the service. If, for any reason, you are unable to keep an appointment, we **require** that you telephone immediately to reschedule that visit. It is the patient's obligation to make up a missed appointment within 7 days of cancellation. If more than 2 visits are missed in a row, then this office reserves the right to charge a $35 fee for these missed appointments.

**I have read or have had read to me the above explanation of chiropractic treatment. I have made my decision voluntarily and freely. To attest to my consent to these procedures, I hereby affix my signature to this informed consent and authorization for treatment.**

**Signature of Patient or Guardian: ________________________________________ Date: ____________**

**Patient's Name Printed: ________________________________________________________________**