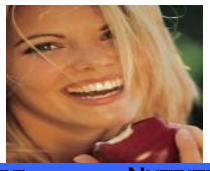
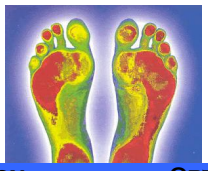
Chiropractic Health Care Center of Hamden, LLC

Dr. Bryan W. Barry

Chiropractic Physician
Board Certified
Acupuncture Practitioner
Clinical Nutritionist
Orthotic Specialist



Chiropractic Acupuncture Nutrition Orthotics

Part I - Personal Information- Patient

Patient Name_____
First Middle Last

Address_____
Street City State Zip Code

Home Ph ( )_____**Cell Ph( )**_____ **Date of Birth**___/___/___ **Age**_____

SSN#_____ **Marital Status**_____ **Number of Children**_____

E-Mail_____ **Name of Nearest Relative**_____
Whom may we thank for the referral?_____
How did you hear about us?_____

Part II - Employment Information

Occupation_____ **Employer (School)**_____

Work Address_____
Street City State Zip Code

Work Phone_____ **Fax**_____ **E-mail**_____

Part - III Primary Doctor Information

Doctor_____ **Specialty**_____

Clinic Name_____**Address**_____
Street City State Zip Code

Phone_____ **Fax**_____ **Email**_____

Patient's Signature_____ **Date**_____

Please continue on next page

2821 OLD Dixwell Avenue
Hamden, CT 06518
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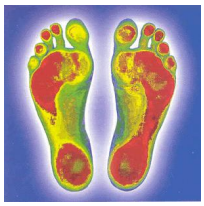

Part - IV Medical History Information

Primary Carrier_____ **Secondary Carrier**_____

Please present your insurance card to the front desk- Thank you

What is the purpose of this appointment?

_____

_____

List your health concerns in order of severity:

1._____

2._____

3._____

4._____

Date of your first symptom(s)?_____

Does anyone in your family have the same problem?_____

Have you ever had this condition before? Yes____**No**_____ **When**_____

Have you been treated for this condition? Yes____**No**_____**When**_____

Who treated you?_____ **Where were you treated?** _____

How was the outcome?_____

Additional Comments: _____

_____

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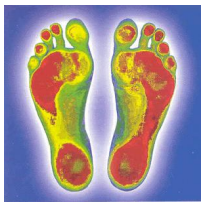

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1. Are you allergic to any of the following?

Allergies	Yes	No	List items that cause allergic reactions
Medicines			
Medical Dyes			
Plants/ Animals			
Foods			
Other			

2. List any and all medications you are taking

Current Medications	Dosage	For what health condition?

3. List any and all vitamins, supplements, and herbals you are taking

Current Supplements	Dosage	For what health condition?

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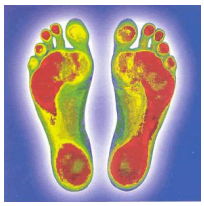

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4. Have you ever had any of the following?

Surgeries	Yes	List the type of surgeries and when
Tonsillectomy		
Appendectomy		
Cholecyctectomy (gall bladder removal)		
C-Section		
Other		

5. Have you ever been told you have any of the following major conditions?

Illness	Yes	No	Illness	Yes	No	Illness	Yes	No
Arthritis			Anemia			Asthma		
Neuritis			High Blood Pressure			Thyroid Condition		
Diabetes			Cancer	Specify Below		Prostate Condition		
Vascular Disease			Jaundice			Heart Disease		
Pneumonia			HIV/AIDS			Rheumatism		
Meningitis			Migraines			Bone /Joint Disease		
Digestive Disease			Tuberculosis			Epilepsy		
Poisoning			Pleurisy			Polio		
Aids/ HIV			Hepatitis			Other: list below		

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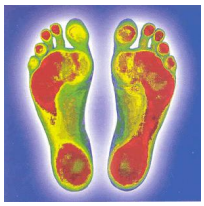

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6. Has anyone in your family suffered from the following illnesses?

Illnesses	Yes	No		Living	Deceased
Cancer			☐Dad ☐Mom ☐Brother ☐Sister ☐Other		
Stroke			☐Dad ☐Mom ☐Brother ☐Sister ☐Other		
Diabetes			☐Dad ☐Mom ☐Brother ☐Sister ☐Other		
Heart Conditions			☐Dad ☐Mom ☐Brother ☐Sister ☐Other		
Blood pressure			☐Dad ☐Mom ☐Brother ☐Sister ☐Other		

Part - V Personal Habits

1. Do you exercise regularly? ☐Yes ☐No
If "yes" do you exercise at ☐Home ☐Health Spa/ Gym
Do you ☐Use Machines ☐Calisthenics ☐Aerobics ☐Run ☐Jog ☐Walk ☐Swim ☐Other_____ How long (min)?_____How often?_____

2. Do you drink water? ☐Yes ☐No How many glasses per day?_____

3. Do you smoke or chew tobacco? ☐Yes ☐No ☐Quit
If "Yes" # of packs per pay? ____ and for how long? _____
If "Quit" How long ago_____ And how long did you smoke?_____

4. Have you ever been treated for alcoholism or substance abuse?
☐Yes ☐No If "Yes", When?_____ Where?_____

5. Do you drink ☐Coffee? ☐Tea? If "Yes" How many cups per day? _____

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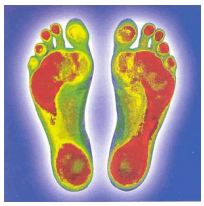


Your Input is Critical to our Success in Helping You

Your nervous system is the master system and controls and coordinates all systems, organs, tissues and cells of the human body. Health and wellness are therefore mediated through your nervous system. We utilize advanced diagnostic technology that is designed to detect nervous system disturbance that may affect vital organs as well as general health and wellness.

Please answer the following questions so we may better understand how to help you.

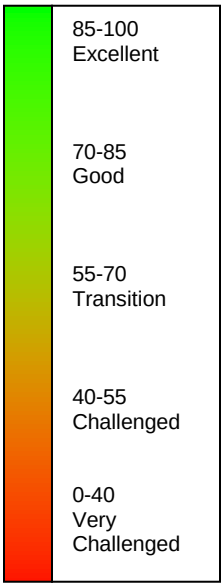
1. **On a scale of 1 to 10 (10 being most important) how important is your health to you? _____**
2. **On the graph to the right put an "X" to score where you think you are today.**
3. **Please circle where you would like to be (your goal).**
4. **How long do you think it might take to get where you circled? _____**
5. **What things might you need to change to help you reach your goal?**

   a._____

   b._____

   c._____

   d._____



6. **If we could make recommendations that would not only address your main health concerns, but could also help you with improving your overall health, would you like to hear them?**

   _____yes

   _____no

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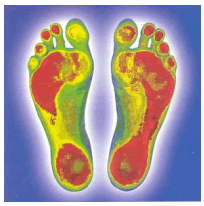

Please Read and sign our office and financial policies.

We would like to thank you for choosing Chiropractic Health Care Center of Hamden, LLC as your health care provider. As one of our patients we would like to keep you informed of our current office and financial policies. We require that you read and sign this document prior to any treatment.

Canceled Appointments: If you are unable to keep your scheduled appointment, please call our office 24 hours before your appointment to reschedule. This will allow us to provide that time slot to another patient.

No Insurance: Payment will be due at the time of service. If you are unable to pay your balance in full, you will need to make prior arrangements with our Office Manager, Roseann Ruocco.

Insurance: Please bring your insurance card with you at the time of your appointment. With insurance plans where we have agreed to participate in the network as a provider, your carrier requires that all co-pays be paid at the time of any services being rendered. The co-pay requirement can not be waived by our practice, as it is a requirement placed on you by your insurance carrier. If you do not have your co-pay at the time of your visit, you must provide payment at the time of your next visit. You are responsible for any co-insurance, deductibles or non-covered services not paid by your insurance within the state's required time limitation for paying health care claims. You will receive a statement from our office indicating what your insurance has paid. Any balance remaining is due upon receipt. If payment is not received with in 45 days after date of service, debt is collected by National Credit Systems, Inc.

You are responsible for any co-insurance, deductibles or non-covered services not paid by your insurance within the state's required time limitation for paying health care claims. You will receive a statement from our office indicating what your insurance has paid. Any balance remaining is due upon receipt.

HMO or POS: If your insurance carrier requires that you obtain a referral from your Primary Care Physician (PCP) before receiving services from another provider, please bring that referral with you prior to your next appointment.

Auto Accident Injury: If your injury is due to an automobile accident, we request that you provide us with any information that will assist us in getting your medical claims paid. This information may include a copy of the police report, a copy of your auto insurance, medical insurance, and names and information on other parties involved. Any unpaid services provided will be your responsibility.

Returned Checks: A $50.00 charge will be added to your account for any check returned by your bank for any reason.

Disability or Insurance Forms: There will be a charge of $35.00 for the completion of medical forms (charge is based upon number of pages and complexity of information requested). Payment is due at the time that you pick up the forms. Please allow 10 days for the completion of these forms. If you would like the forms mailed to you or the insurance, payment will be due prior to mailing.

Medical Records: We will provide you with a copy of your medical records upon request. You will need to sign a letter of release at the time of pick up. Please allow 7-10 days for us to copy your records. If you wish for your records to be mailed, there may be an associated fee to cover the mailing costs. You may be charged for additional copies of your medical records, rates charged within Connecticut state statutes.

X-Rays: Radiographs Medical imaging is provided by YNHH Temple Radiology located at 2560 Dixwell Avenue, Hamden, CT. If you have any questions or concerns, please contact our Office Manager, Roseann Ruocco at 203-288-2821.Thank you for allowing us to service you.

Patient Name:

Signature_____Date_____

E-mail: DrBryanBarry@aol.com
www.DrBryanBarry.com

(Office Copy)

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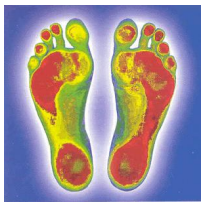

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Auto Accident Injury: If your injury is due to an automobile accident, we request that you provide us with any information that will assist us in getting your medical claims paid. This information may include a copy of the police report, a copy of your auto insurance, medical insurance, and names and information on other parties involved. Any unpaid services provided will be your responsibility.

Returned Checks: A $50.00 charge will be added to your account for any check returned by your bank for any reason.

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Thank you for choosing us for your healthcare needs. Dr. Bryan W. Barry **(**Patient Copy)

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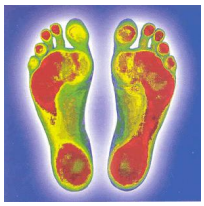


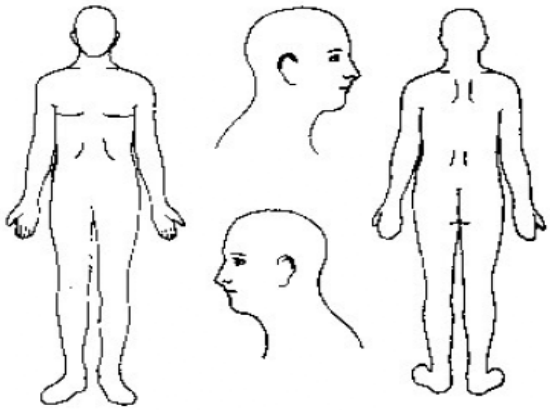
Date of Visit: ____/____/____ Patient: _____ Age: _____

What brought you here today? _____

_____

Place an "X" on the drawing below on areas causing you pain and a letter describing it

A = ACHE
B = BURNING
S = STABBING
N = NUMBNESS
P = PINS & NEEDLES



PAIN SCALE

Please circle the number that best describes your pain

0 1 2 3 4 5 6 7 8 9 10

NONE LITTLE MEDIUM SEVERE

Describe your past health history:

Prior Illness: _____

_____

Past Hospitalizations: _____

_____

Surgeries: _____

_____

Medications: _____

Patient Signature: X _____

(DO NOT WRITE BELOW THIS LINE)

EXAMINATION

Range of Motion

Cervical	Normal		Pain
Flexion	50		
Extension	60		
Left Lat Flex	45		
Right Lat Flex	45		
Left Rotation	80		
Right Rotation	80		
Lumbar	**Normal**		**Pain**
Flexion	60		
Extension	25		
Left Lat Flex	25		
Right Lat Flex	25		
Left Rotation	30		
Right Rotation	30		

Health HX Notes:

_____

_____

_____

_____

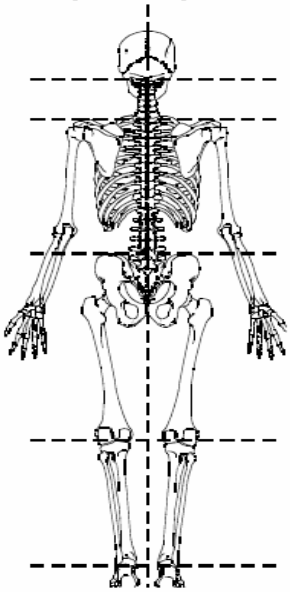
_____

_____

Asymmetry

C0
C1
C2
C3
C4
C5
C6
C7

L1
L2
L3
L4
L5
SAC
L-IL
R-IL

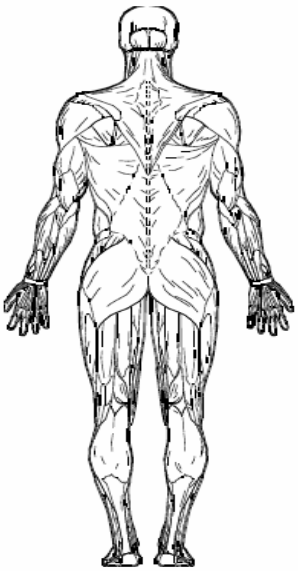


Using arrows (↑ ↓ → ←) mark the misaligned vertebrae

T1
T2
T3
T4
T5
T6
T7
T8
T9
T10
T11
T12

Using arrows (↑↓), mark postural asymmetry

Tissue



Mark tissue abnormalities
TP, LG, TN, SK, FS

TP=Trigger Points; LG=Ligaments (swollen or tender)
TN=Tendons; SK=Skin; FS=Fascial Restrictions

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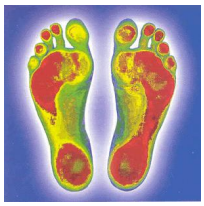

HISTORY OF PRESENT COMPLAINT

Complaint: _____

Qual & Chara: _____

On, Dur, Intens, Freq, Loc, Rad _____

_____

_____

Better or worse _____

_____

Prior TX, meds, other: _____

_____

EXAMINATION

Reflexes
(Wexler Scale)

Biceps _____
Triceps _____
Brac/rad_____
Patella _____
Achilles _____

B/P: ___/___ **PULSE:** _____ **RESP:** ____ **HT:** _____ **WT:** ____ **GRIP: (R)** ____ **(L)** ____

Sensory: C5: _____ C6: _____ C7: _____ C8: _____ T1: _____
L3: _____ L4: _____ L5: _____ S1: _____
D= Deficit **N= Normal** **(R) or (L)**

General Orth/Neuro Examination:
Spinous Percus: _____ Valsalva: _____
Dejerine Triad: _____ Rhomberg: _____ **(+) or (-), (R) or (L)**

Notes: _____

Test	(+)	(-)	R	L	Indication
Distraction					nerve root compression
Jackson					nerve root compression
Max Cerv Rot Comp					nerve root compression
Cerv Comp					nerve root compression
Soto Hall					(cerv) (thor) vertebral trauma
Spurlings					nerve root irritation
Shoulder Depress					nerve root compression

	(+)	(-)	R	L	Indication
Libman's					(low) (normal) (high) pain threshold
Burn's Bench					(hysteria) (malingering)
Hoover's					(hysterical paralysis) (malingering)

	(+)	(-)	R	L	Indication
Bechterew					sciatic disk compression
Beevor's					abdominal muscle weakness
Minors Sign					radicular disk pain
Ely					upper lumbar lesion
Fajersztajn					intervertabral disk syndrome
Nachlas					upper lumbar lesion
Gluteal punch					spinal lesion
Goldthwaite					lumbar differentiation
Heel walk					5th lumbar motor deficit
Kemps					intervertebral disk rupture
Lasague					(muscle) (disk) (nerve) irritation
Braggards					lumbar antalgic spasm
Supported Adam's					lumbosacral differentiation

MUSCLE TESTS

Level	Muscle	Muscle Grade	
C5	Deltoids	L:	R:
C6	Biceps	L:	R:
	Wrist extensors	L:	R:
C7	Triceps	L:	R:
	Wrist flexors	L:	R:
	Finger extensors	L:	R:
C8	Finger flexors	L:	R:
T1	Finger abductors	L:	R:
L2 -L3	Hip flexors	L:	R:
L4-L5	Hip extensors	L:	R:
L3-L4	Knee extensors	L:	R:
L5-S1	Knee flexors	L:	R:
L4-L5	Ankle extensors	L:	R:
S1-S2	Ankle flexors	L:	R:

TREATMENT PLAN

Initial TX on: ____/____/____

Level of Care: (include duration and frequency of visits)

_____

_____

_____

Specific Treatment Goals: _____

_____

Specific Objective Eval: _____

_____

_____

DIAGNOSIS: _____

_____

_____