Post Road Chiropractic

400 Post Road • Fairfield, CT 06430
Phone # (203) 255-3800 • Fax# (203) 256-5975

NEW PATIENT FORMS

Welcome to **Post Road Chiropractic**. We specialize in assisting our patients to achieve their highest level of health through our spinal and postural correction programs. Our approach is very different and more complete than other rehabilitative programs, which allows us to achieve superior correction as compared to other systems.

Please fill out the following information completely so the doctor can let you know if we can accept your case. Please feel free to ask any questions if you need assistance.

We look forward to serving you.

Dr. Matt & Staff

____
Patients Name

____
Patients Signature

____
Date

PATIENT REGISTRATION

Title: Mr./Mrs./Ms./Dr./Rev./Rank ____________ Date ___________________

Last Name ___________________________ First Name ___________________________ M.I _________

Nickname ____________

Address ____

City________________________ State __________ Zip_______________

Home Phone _______________ Cell Phone _______________ Work Phone _______________

Please use my: ❑ home ❑ cell ❑ work as my primary number *(check one)*

E-Mail ____

SSN # __________ - __________ - __________

Date of Birth ________________ Age ________ Gender: ❑ M ❑ F Marital Status: ❑ S ❑ M ❑ W ❑ D

Employer Name ________________________________ Occupation ________________________________

Spouse's Name ____ Phone __________________________

Spouse's Name _________________________________ Occupation ________________________________

Are you pregnant?: ❑ Yes ❑ No If so how many weeks? _________________________

Children (names, ages)

____

Most of our patients are referred by a family member or friend, what made you decide to visit our office?

Name ______________________________________ ❑ Friend ❑ Family Relationship: __________

❑ Other____

PURPOSE OF THIS VISIT

Reason for this visit/Main complaint ____

Was this due to an: ❑ auto accident? ❑ work injury? ❑ other _________________________________
When did this condition begin?____/____/____ Did it begin: ❑ Gradually ❑ Suddenly

What activities aggravate your symptoms? ____

Is there anything that has relieved your symptoms? ❑ Yes ❑ No
Please describe what helps _____________________________________

PURPOSE OF THIS VISIT (cont.)

Type of pain *(check all that apply)*:
❑ Sharp ❑ Dull ❑ Ache ❑ Burning ❑ Throbbing ❑ Spasm ❑ Numbness ❑ Tingling ❑ Shooting

Does the pain radiate into your arms or legs? ❑Yes ❑ No

Is the condition getting worse? ❑ Yes ❑ No

How often do you experience these symptoms throughout the day?
❑ 100% of the time ❑ 75% ❑ 50% ❑ 25% ❑ 10% ❑ Only with activity

Does your complaint interfere with: ❑Work ❑ Sleep ❑ Hobbies ❑ Daily Routine
Explain ____

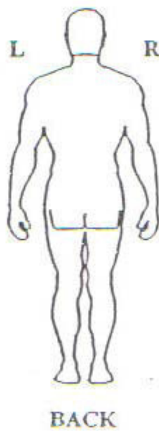
Have you experienced this condition before? ❑ Yes ❑ No
If yes, please explain____

Who have you seen for this condition?____
What did they do? ____
How did you respond? ____

Please list any other complaints:
1. ____
2. ____
3. ____
4. ____

AREA(S) OF COMPLAINT

Place "X's" on the area(s) where you have pain and draw lines to where it radiates:



____ ______________________
Patients Name Date

____
Patients Signature

HEALTH CONDITIONS

Posture distortions are the result of trauma or chronic poor posture. These distortions not only represent a change in the shape of the spine, but the stress it puts on the individual bones (vertebrae) causing them to be twisted from their normal position. This dysfunction, called a *subluxation*, puts stress on your spinal cord and the delicate nerves that pass between each of the vertebrae. The most common postural distortion is called *"Head Forward Syndrome"* which is a hunched forward posture that starts in the neck and has a domino effect on the rest of the spine weakening the entire spine and therefore body. Please mark any health condition you may be experiencing at present or in the past.

CERVICAL SPINE (NECK) - Subluxations in your neck weaken the nerves that go to your shoulders, arms, hands and head and can cause the following problems; are you suffering from any of these issues?

❑ Neck pain	❑ Pain into your shoulders/arms/hands	❑ Coldness in hands
❑ Headaches	❑ Numbness/tingling in arms/hands	❑ Thyroid condition
❑ Dizziness	❑ Hearing disturbances	❑ Recurrent colds/flu
❑ Sinusitis	❑ Weakness in grip	❑ Low energy/fatigue
❑ Allergies	❑ Visual disturbances	❑ TMJ pain/clicking

THORACIC SPINE (UPPER AND MID BACK) - Subluxations in your upper and mid back weaken the nerves that go to your lungs, heart, ribs/chest, and upper digestive tract; are you suffering from any of these issues?

❑ Heart palpitations	❑ Heart attacks/angina	❑ Recurrent lung infections/bronchitis
❑ Heart murmurs	❑ Asthma/wheezing	❑ Pain on deep inspiration/expiration
❑ Tachycardia	❑ Shortness of breath	❑ Hypoglycemia
❑ Mid back pain	❑ Reflux	❑ Indigestion/Heartburn
❑ Rib/chest pain	❑ Nausea	❑ Ulcers/Gastritis

LUMBAR SPINE (LOW BACK) - Subluxations in your low back weaken the nerves that go to your lower bowel, pelvic organs, legs and feet; are you suffering from any of these issues?

❑ Pain into your hips/legs/feet	❑ Weakness in your hips/knees/ankles	❑ Low back pain
❑ Muscle cramps in your legs/feet	❑ Constipation/diarrhea	❑ Numbness/tingling in your legs/feet
❑ Coldness in your legs/feet	❑ Frequent/difficulty urinating	❑ Cramps in your legs/feet
❑ Menstrual irregularities/cramping	❑ Sexual dysfunction	

Please list any health conditions not mentioned:
1. ____________________
2. ____________________
3. ____________________

Please list any medications you are currently taking and their purpose:
1. ____________________
2. ____________________
3. ____________________

Please list all past surgeries:
1. ____________________
2. ____________________
3. ____________________

Please list any previous accidents and injuries:
1. ____________________
2. ____________________
3. ____________________

HEALTH LIFESTYLE

Do you exercise?: ❑ Yes ❑ No How often?: ❑ 1x ❑ 2x ❑ 3x ❑ 4x ❑ 5x ❑ _____ per week

What activities?: ❑ Running ❑ Weights ❑ Cycling ❑ Yoga ❑ Pilates ❑ Swimming
❑ Other____

Do you smoke?: ❑ Yes ❑ No How many packs per day? ________

Do you drink alcohol?: ❑ Yes ❑ No What and how much?______________________________

Do you drink coffee?: ❑ Yes ❑ No How many cups per day?___________________________

Do you drink soda?: ❑ Yes ❑ No How many per 12 oz. servings per day?_______________

Do you drink water?: ❑ Yes ❑ No How much per day?_______________________________

Do you eat vegetables and fruits?: ❑ Yes ❑ No How many servings per day?________________________

Do you take any supplements (i.e. vitamins, minerals, herbs)? ____

EXPERIENCE WITH CHIROPRACTIC

Have you seen a chiropractor before?: ❑ Yes ❑ No
Who?____________________________________ When?____
Reason for visit(s)? ____
What treatments were given? ____
How did you respond?____
Did your previous chiropractor take before and after x-rays?: ❑ Yes ❑ No

Did you know your posture has a significant effect on your health?: ❑Yes ❑ No

Are you aware of any of your poor posture habits?: ❑Yes ❑ No
Explain ____

Are you aware of any poor posture habits in your spouse or children? ❑Yes ❑ No
Explain ____

TERMS OF ACCEPTANCE

When a person seeks chiropractic and rehabilitation health care and is accepted for such care, it is essential for both parties to be working towards the same objective. As a chiropractic and rehabilitation facility we have one main objective, to detect and correct/reduce the vertebral subluxation complex. It is important that each person understand both the objective and the method that will be used to attain this objective, thus preventing any confusion or disappointment.

Vertebral Subluxation: A misalignment of one or more of the 24 vertebra in the spinal column which causes alteration of nerve function and interference to the transmission of mental impulses, resulting in a lessening of the body's innate ability to express its maximum health potential.

Adjustment: A specific application of force to facilitate the body's correction of vertebral subluxation.
We do not offer to treat symptoms, but rather to determine if a patient has subluxations. If present, we will recommend a course of treatment including adjustments and rehabilitation procedures in an effort to achieve maximum correction of this dysfunction.

PROCEDURES

- No Charge Consultation- This is a brief meeting between you and the doctor to determine if you may benefit from the care we provide. There is no financial obligation in connection with this service.
- Exam - After your consultation, if the doctor believes you will likely benefit from the care we provide, a thorough orthopedic, neurologic, and chiropractic examination will be recommended.
- X-Rays- Based upon the exam findings, the doctor may recommend selected x-rays be taken.
- Report of Findings - Included in the cost of the examination is a report of findings. This is where the doctor presents his findings regarding your health to you. The doctor will explain what he feels to be the best and fastest approach to improved health for you, if any.
- Treatments- Include spinal and extra spinal adjustments, intersegmental traction, myofascial release, curve restoration traction, core muscle training, rehabilitation, posture correction exercises, nutritional recommendations and supplements.

PAYMENT POLICY

- Payment is expected at the time of service unless some other arrangement has been made between you and the doctor prior to treatment.
- Payment in full at the time of service entitles you to a discount.
- Health/Automobile Insurance
    - Your insurance coverage is a contract between you and your insurance company. We will gladly help you verify what your particular coverage is; however, we can not take responsibility for what your insurance does or does not cover. Ultimately, all services rendered to you are charged directly to you and you are responsible for payment.
    - We will file your insurance claim for you and do everything we can do to ensure you receive proper reimbursement.
    - If your policy has a deductible feature, it is due at the time of service.
    - We will do our very best to answer any questions you may have in regard to your insurance.
- There will be a $25 charge on any returned checks (plus the original amount of the check)

By my signature below, I acknowledge that I have read and agree to the above TERMS OF ACCEPTANCE.

____ ____________________

PATIENT SIGNATURE (or Parent/Guardian) DATE

INFORMED CONSENT

I hereby request and consent to the performance of chiropractic adjustments and other chiropractic procedures, including various modes of physiotherapy, examination, traction, and, if necessary, diagnostic x-rays, on me by the doctor of chiropractic and/or by other office or clinic personnel.

POSSIBLE RISKS
I understand and am informed that, as in all health care, in the practice of chiropractic, there are some risks to treatment. These include muscle strain, ligament sprain, fracture, disc injury, dislocation, paralysis, stroke, stiffness and soreness. The ancillary procedures could produce skin irritations, burns, or minor complications.

PROBABILITY OF RISKS OCCURING
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 estimated at one in one million to one in twenty million, and can be even further reduced by screening procedures. The probability of adverse reaction due to ancillary procedures is also considered rare.

OTHER TREATMENT OPTIONS THAT COULD BE CONSIDERED
- *Over-the-counter analgesics*. The risks 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.
- *Hospitalization* in conjunction with medical care adds risk of exposure to virulent communicable disease 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
Can further reduce ranges of motion, and induce chronic pain cycles. It is quite probable that delay of treatment will complicate the condition and delay of treatment allows formation of adhesions, scar tissue and other degenerative changes including arthritis. These changes make future rehabilitation more difficult.

CONSENT
I acknowledge I have discussed, or have had the opportunity to discuss, with my chiropractor the nature and purpose of chiropractic treatment in general and my treatment in particular (including spinal adjustment) as well as the contents of this Informed Consent. I consent to the chiropractic treatments offered or recommended to me by my chiropractor. I intend this consent to apply to all my present and future chiropractic care.

____ _______________________
PATIENT SIGNATURE (or Parent/Guardian) DATE

Pregnancy Release (Female Only)
This is to certify that to the best of my knowledge I am not pregnant and Corrective Chiropractic has my permission to perform an X-Ray evaluation. I understand the risks of taking an X-Ray to an unborn child.

Date of last menstrual period ______________________________ Initials_________________

NOTICE OF PRIVACY PRACTICES

We keep a record of the health care services provided to you. You may ask to see a copy of that record. We will not disclose your records to others unless you direct us to or unless the law authorizes or compels us to. You may see your record or get more information about it by contacting our office.

- We may share your health information to run our office, collect payment, treat you, thank you for referring others, discuss your case with your family, include you in health care classes, help you collect from your insurance company, inform you about other services, provide assistance with your diagnosis or treatment from another provider or radiologist.
- We may use your health information for health and safety reasons, court hearings and filings, reporting to law officials and for reporting victims of abuse.
- We may call you by name in the reception area when the doctor is ready for to see you.
- A postcard may be mailed to you at the address provided by you.
- When telephoning your home we may leave a message with whomever answers or on your answering machine.
- We may include a photo of you on our referral wall.

You have the right to request a copy of your records, ask to limit the information we share, amend your health information, request a list of whom we share your records with, advise our management if you believe your privacy rights have been violated.

Our Notice of Privacy Practices, which you can request to view at any time, describes in more detail how your health information may be used and disclosed, and how you can access your information.

By my signature below, I acknowledge that I have read, understand and agree to NOTICE OF PRIVACY PRACTICES.

____ ______________________

PATIENT SIGNATURE (or Parent/Guardian) DATE