SPINE & SPORTS
CHIROPRACTIC CARE OF CT, LLC

220 Farmington Ave., Farmington, CT 06032
Tel: 860-269-3225 • Fax: 860-269-3227
www.spinesportscare.com

PATIENT INFORMATION

Patient Name (Last, First, MI)		Date of Birth / /	Age
Mailing Address	City/State		Zip
Street Address (if different)	City/State		Zip
SS#	Marital Status ☐ S ☐ M ☐ D ☐ W	Name of Spouse	Language ☐ English ☐ Spanish Other; ☐ Specify
Race ☐ White ☐ American Indian/ Alaska Native ☐ Asian ☐ Native Hawaiian/ Other Pacific Islander ☐ Black/African American ☐ Decline to Answer Other; ☐ Specify			
Ethnicity ☐ Hispanic or Latino ☐ Not Hispanic or Latino ☐ Decline to Answer			
Home Telephone # ( )	Work # ( )	Cell # ( )	Email
Emergency Contact	Phone # ( )	Relationship	
Who referred you to this office? (e.g., Name of physician, family/friend, website, advertisement)			
Primary Care Physician	City/State	Phone	

EMPLOYMENT INFORMATION

Occupation	Employer's Name	Phone
Employer's Address	City/State	Zip

INSURANCE INFORMATION

Primary Insurance	ID#	Group #
Subscriber's Name	Date of Birth	Relationship
Subscriber's Employer	City/State	Zip
Secondary Insurance	ID#	Group #
Subscriber's Name	Date of Birth	Relationship
Subscriber's Employer	City/State	Zip

Complete below if this injury is due to a motor vehicle accident or work injury

☐ **Motor Vehicle Accident** ☐ **Work Injury**

Law Firm / Attorney Name		Phone #
Address	City / State	Zip
Insurance	ID#	Group #
Date of Injury	Claim Mailing Address	
Worker's Comp. Carrier	Adjuster	Phone #
Has this injury been reported to someone at work?		Is this visit approved?

PATIENT NAME: _____ **DATE:** _____

SOCIAL & FAMILY HISTORY

Live with: ☐ Family ☐ Spouse ☐ Significant Other ☐ Child/Children ☐ Friend ☐ Alone

Children: ☐ YES ☐ NO Ages:_____

Educational Level: ☐ Grade School ☐ High School ☐ College ☐ Graduate School ☐ Other

Smoking History: ☐ Never ☐ Former Smoker ☐ Current Smoker Years:_____ Amount:_____

Alcohol: ☐ YES ☐ NO Amount:_____ Substance Abuse: ☐ YES ☐ NO Type:_____

MEDICAL HISTORY

Recent Vitals: Height _____ Weight_____ Blood Pressure _____

Do you have a current or past history of: ***(Check all that apply)***

CARDIOVASCULAR	Current	Past
Angina/Chest pain/Irregular heart beat	[ ]	[ ]
Leg pain with walking/Leg swelling	[ ]	[ ]
Heart murmur	[ ]	[ ]
Rheumatic fever	[ ]	[ ]
Heart attack	[ ]	[ ]
Congestive heart failure	[ ]	[ ]
High Blood Pressure	[ ]	[ ]
Cardiac pacemaker	[ ]	[ ]
Any other heart problem	[ ]	[ ]

MUSCULOSKELETAL	Current	Past
Arthritis: Osteoarthritis, Rheumatoid, Psoriatic, Inflammatory	[ ]	[ ]
Gout	[ ]	[ ]
Osteoporosis / Osteopenia	[ ]	[ ]
Fractured Bones	[ ]	[ ]
Hernia	[ ]	[ ]

EYES	Current	Past
Glaucoma	[ ]	[ ]
Blurred/double vision	[ ]	[ ]

ALLERGIC	Current	Past
Allergies: Food / Environmental /Medication	[ ]	[ ]
Type:_____		

ENDOCRINE	Current	Past
Diabetes: Type I ____ or Type II_____	[ ]	[ ]
Thyroid disease/problems	[ ]	[ ]

GASTROINTESTINAL	Current	Past
Ulcers / Acid reflux	[ ]	[ ]
Gastrointestinal disorders	[ ]	[ ]
Liver disease/problems	[ ]	[ ]

URINARY / GENITOURINARY	Current	Past
Kidney disease/problems	[ ]	[ ]
Prostate disease/problems (Men)	[ ]	[ ]
Ovarian/Uterine disease/cysts/fibroids (Women)	[ ]	[ ]

RESPIRATORY	Current	Past
Emphysema	[ ]	[ ]
Shortness of breath	[ ]	[ ]
Chronic cough	[ ]	[ ]
Asthma	[ ]	[ ]

HEMATOLOGIC	Current	Past
Blood clots/phlebitis	[ ]	[ ]
Anemia	[ ]	[ ]
Any blood disorder	[ ]	[ ]

NEUROLOGICAL	Current	Past
Dizziness or Vertigo	[ ]	[ ]
Stroke or TIA (Transient Ischemic Attack)	[ ]	[ ]
Loss of consciousness (black out/fainting)	[ ]	[ ]
Seizures	[ ]	[ ]
Multiple sclerosis	[ ]	[ ]
Headache: Migraine, Cluster, Tension, Chronic	[ ]	[ ]
Other Neurological problems	[ ]	[ ]

PSYCHIATRIC / BEHAVIORAL	Current	Past
Drug Dependency	[ ]	[ ]
Alcohol Addiction	[ ]	[ ]
History of depression/anxiety	[ ]	[ ]

CONSTITUTIONAL	Current	Past
Recent unexplained weight change	[ ]	[ ]
Cancer: _____ Radiation therapy? Chemotherapy?	[ ]	[ ]
Lyme Disease	[ ]	[ ]
Tuberculosis	[ ]	[ ]
HIV/AIDS	[ ]	[ ]
Hepatitis	[ ]	[ ]
Surgery	**YES**	**NO**
Previous hospitalizations	**YES**	**NO**
Are you currently pregnant?	**YES**	**NO**
Other conditions or serious injuries?		

_____

_____

Please list any surgeries, date performed, and by whom

_____

_____

MEDICATION

Please list current prescriptions, vitamins, supplements, and herbals

_____

_____

▼▼▼ **For Office Use Only** ▼▼▼

_____

_____

_____

PATIENT NAME: _____ **DATE:** _____

PAIN QUESTIONNAIRE

When did your pain begin?_____

Is your pain related to an injury? ☐ **Yes** ☐ **No**

Please describe how it began: _____

_____

What do you hope to accomplish or gain from treatment?_____

Where is your pain?

☐ Head	☐ Forearm Rt / Lt / Both	☐ Low Back Rt / Lt / Both	☐ Groin Rt / Lt / Both
☐ Neck Rt / Lt / Both	☐ Hand Rt / Lt / Both	☐ Buttocks Rt / Lt / Both	☐ Knee Rt / Lt / Both
☐ Shoulder Rt / Lt / Both	☐ Upper Back Rt / Lt / Both	☐ Hips Rt / Lt / Both	☐ Calf Rt / Lt / Both
☐ Upper Arms Rt / Lt / Both	☐ Chest Rt / Lt / Both	☐ Leg Rt / Lt / Both	☐ Foot Rt / Lt / Both

Describe your pain and specify where?

☐ Sharp_____	☐ Stabbing_____	☐ Dull_____	☐ Achy_____
☐ Shooting_____	☐ Throbbing_____	☐ Burning_____	☐ Cramping_____
☐ Numbness_____	☐ Tingling_____	☐ Pressure-like_____	☐ Other_____

How often do you experience the pain?

☐ Constantly_____ ☐ Frequently_____ ☐ Intermittently_____ ☐ Occasionally_____

What aggravates your pain?

☐ Sitting Down	☐ Sitting for Long Periods	☐ Standing	☐ Standing for Long Periods
☐ Walking	☐ Walking for Long Periods	☐ Lying Down	☐ Flexing Forward
☐ Lifting	☐ Coughing	☐ Sneezing	☐ Straining
☐ Deep Breathing	☐ Sleeping	☐ Specific Movement(s)_____	

☐ Other_____

What relieves your pain?

☐ Sitting Down	☐ Standing	☐ Walking	☐ Lying Down	☐ Massage	☐ Therapy
☐ Moist Heat/Hot Shower	☐ Ice	☐ Sleeping	☐ Exercise	☐ Stretching	☐ Rest
☐ Medications	☐ Other_____				

What medications are you currently taking for your pain?_____

Since your pain began, is it: ☐ Better ☐ Worse ☐ About the same

Have you resumed your normal activities of daily living? ☐ Yes ☐ No

Are you disabled from your usual employment? ☐ Yes ☐ No Type of Work_____

If so, what is the date you were last able to work?_____

PREVIOUS TREATMENT

What type of treatment have you received so far?

☐ Physical Therapy_____
☐ Massage_____
☐ Chiropractic_____
☐ Acupuncture_____
☐ Epidural Steroid Injections / Trigger Point Injections or Nerve Blocks_____
☐ Surgery_____
☐ Other_____

DIAGNOSTIC TESTING

What diagnostic tests have you had completed so far and when?

☐ MRI Cervical Spine_____	☐ MRI Lumbar Spine_____	☐ MRI Other_____
☐ X-Rays Cervical Spine_____	☐ X-Rays Lumbar Spine_____	☐ X-Rays Other_____
☐ CAT Scan_____	☐ EMG/NCV_____	☐ Other Tests_____

▼▼▼ **For Office Use Only** ▼▼▼

_____

_____

_____

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AUTHORIZATION AND FINANCIAL RESPONSIBILITY

PATIENT NAME: _____

Thank you for choosing our practice. We are committed to providing you with quality and affordable health care. Part of our responsibility to you, our patient, is to keep you informed of our financial policies and your potential cost share. Please read the following, ask any questions, and sign. A copy can be provided upon request.

CHIROPRACTIC BENEFITS:
Spine & Sports Chiropractic Care will no longer be informing patients of their insurance benefits. It is your responsibility to know your insurance benefits and if our office participates in the plan. Please call your insurance carrier to verify your chiropractic benefits and whether Spine & Sports participates with your plan.

- Depending on your plan, there may be a deductible, a co-pay, or a co-insurance. You are responsible for any co-insurance, deductibles, or non-covered services as required by your insurance company. Insurance plans with which we contract require that all co-pays be paid prior to any services being rendered. The co-pay requirement cannot be waived by our practice as it is a requirement placed on you by your insurance carrier. Any remaining balance is due upon receipt of your first statement.
- There may also be a limit on the number of visits per year your insurance plan allows. If you do have a limited number of visits be sure to know if those visits apply to Calendar year or Plan year. We are not responsible to inform you ahead of time if there are any limits as to the number of visits your insurance allows.
- Some insurances require Spine & Sports Chiropractic Care to get authorization before they will apply the service towards the patient's benefits for payment. This means that the insurance will approve or deny your doctors' request based on whether they feel it is medically necessary. Authorization is done by a separate company which your insurance hires to run the authorizations. If you get authorized visits it means that the insurance feels that it is medically necessary for you to receive treatment on that day. The bill is then sent to your insurance and at that point they will see if the patient has the benefits for that claim to be paid.
- Insurance benefits quoted by your insurance company are NOT a guarantee of payment or coverage.

MEDICARE:
Medicare does not cover the fee for any exam, therapy, maintenance care, supports, or supplements. You are responsible for this fee and it is payable at the time of service. If your secondary insurance policy pays for these services, we will then refund your payment.

PATIENTS WITH NO INSURANCE:
Patients without insurance are required to pay in full at the time of service. If you are unable to pay your balance in full, your appointment may be rescheduled until proper arrangements have been made. We are happy to discuss payment options prior to service.

DELINQUENT ACCOUNTS:
In order for Spine & Sports Chiropractic Care to service your account or to collect amounts owed, Spine & Sports may contact you using the contact information provided with your account. Delinquent accounts may be assigned to a collection agency. Failure to pay a delinquent account could result in refusal to schedule appointments for you, your dependents, and/or possible termination from the practice.

CANCELLATION POLICY:
Please inform us at least 24 hours prior to your appointment if you need to cancel or reschedule your appointment. Failure to present at the time of your visit or give a 24-hour advance cancellation notice may result in a "No Show" charge of $25.

By signing below, I authorize the following:

- **I authorize this office to release any information concerning my diagnosis and medical records about any treatment or evaluation rendered to me or my dependent during the period of care to third party payers and/or health practitioners. I authorize and request my insurance company to pay the doctor directly for insurance benefits otherwise payable to me. I understand that my insurance carrier may pay less than the actual bill for service.**

By signing below, I understand the following:

- **I understand that I am responsible to know what my insurance benefits are for chiropractic.**
- **I understand I may have a deductible, co-pay, and co-insurance and if it is not collected at the time of service I will be billed.**
- **I understand that I am responsible for payment of all services rendered to me or my dependents.**
- **I understand that there may be a limit on the total number of visits my insurance will allow each year and if I go over that amount I will be responsible for the entire charge for that date of service.**
- **I understand that authorized visits are different than my total yearly benefits and the insurance may authorize visits that may not be paid because benefits have been exhausted.**

X_____ _____

Patient Signature (Parent/Guardian if patient is a minor) **Date**

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CONSENT TO EVALUATION AND TREATMENT

PATIENT NAME: _____

Thank you for choosing our practice. We are committed to providing you with quality health care. Part of our responsibility to you, our patient, is to keep you informed of the treatment and professional services. Please read the following, ask any questions, and sign. A copy can be provided upon request.

CONSENT TO EVALUATION AND TREATMENT

I hereby authorize Spine & Sports Chiropractic Care of CT, LLC and its licensed doctor(s), based on my complaints and the history I have provided, to undertake an evaluation and provide a treatment plan which may include spinal manipulation and other ancillary procedures considered therapeutically appropriate.

I hereby authorize and release the doctor(s) and whomever he/she may designate as his/her assistants to administer treatment including spinal manipulation and any other procedures as recommended by the doctor(s) as being therapeutically appropriate in my case.

POSSIBLE RISKS

I understand that, as with any health care procedure, there are certain risks and complications, which may arise. Although the incidence of complications associated with services are rare, anyone undergoing spinal manipulation/adjustment and therapeutic procedures during the course of their care should know of rare possible hazards and complications which may be encountered. Complications could include fractures of bone, muscular strain, ligamentous sprain, dislocations of joints, or injury to intervertebral discs, nerves, or spinal cord. In extremely rare circumstances, cerebrovascular injury or stroke could occur upon injury to arteries of the neck. A minority of patients may notice stiffness, or soreness after the first few days of treatment. In rare circumstances, the ancillary procedures could produce skin irritation, burns, or minor complications.

I do not expect the doctor(s) to be able to anticipate all risks and complications and I wish to rely on the doctor(s) to exercise judgment during the course of the procedure(s) which the doctor(s) feels at the time, based upon the facts then known, are in my best interest.

There are reasonable alternative treatments to these procedures, each with their own associated risks. These may include rest, home applications of therapy, prescription or over-the-counter medications, exercises, possible surgery, and non treatment.

I understand and accept that:

- **I have the right to withdraw from or discontinue treatment at any time and that the Spine & Sports Chiropractic Care doctor(s) will advise me of any material risks in this regard.**
- **That neither chiropractic, physical therapy, nor medicine is an exact science and that my care may involve the making of judgments based upon the facts known to the doctor(s) during the course of my care and I acknowledge that no guarantee has been made to me regarding the outcome of these procedures.**
- **That it is not reasonable to expect the doctor(s) to be able to anticipate or explain all risks and complications or an undesirable result does not necessarily indicate an error in judgment or treatment.**

I have read this Consent (or have had it read to me) and have also had an opportunity to ask questions about the Consent and understand to my satisfaction the evaluation and treatment I may receive. My signature below acknowledges my consent to the evaluation and proposed course of care and treatments by Spine & Sports Chiropractic Care of CT, LLC.

_____
Patient's Printed Name

X_____ _____
Patient Signature (Parent/Guardian if patient is a minor) **Date**

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NOTICE OF PRIVACY PRACTICES
Patient Acknowledgement Form

Name of Patient _____ Date of Birth_____

Address _____ City/State/Zip _____

I hereby acknowledge that I received a copy of this medical practice Notice of Privacy Practices. I further acknowledge that a copy of the current notice will be posted in the reception area and that I can request a copy of any amended Notice of Privacy Practices.

Signature _____ Date _____

If not signed by patient, indicate relationship to the patient _____

HIPAA CALLING INFORMATION

With whom do you allow us to share your personal medical information at your home or elsewhere?

Name _____ Relationship _____

Name _____ Relationship _____

Is there anyone you do NOT want us to share your medical information with at your home or elsewhere?

_____

_____

How may we contact you?

Home Phone # _____

Do NOT leave a message ☐

Leave a message but with little detail ☐

Cell Phone # _____

Do Not leave a message ☐

Leave a message but with little detail ☐

Work Phone # _____

Do NOT leave a message ☐

Leave a message but with little detail ☐