

**WILLISTON CENTER FOR CHIROPRACTIC  
&  
SPORTSMEDICINE  
802 Industrial Ave, P.O. Box 669  
Williston, VT 05495  
802-863-2272**

Thank you for choosing our practice for your chiropractic needs!  
Please arrive **15 minutes** before your scheduled appointment time.

<b>For Office Use Only:</b> Provider: _____ Appointment Date and Time: _____ Reason For Visit: _____ Referred by: _____
----------------------------------------------------------------------------------------------------------------------------------

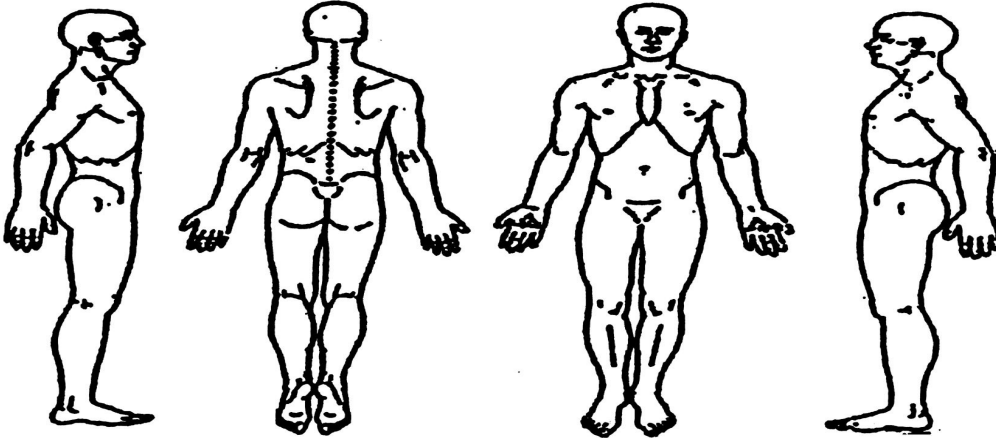
Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_  
Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_ Zip: \_\_\_\_\_  
Home Phone: \_\_\_\_\_ Social Security Number: \_\_\_\_ - \_\_\_\_ - \_\_\_\_  
Work Phone: \_\_\_\_\_ Is it okay for us to call you at work? Y N  
Cell Phone: \_\_\_\_\_ Email Address: \_\_\_\_\_  
Marital Status: ( S D W M ) Occupation: \_\_\_\_\_ Student: Y N  
Employer: \_\_\_\_\_ Address: \_\_\_\_\_  
City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_  
Emergency Contact: \_\_\_\_\_ Relationship: \_\_\_\_\_  
Emergency Phone Number: \_\_\_\_\_  
Name of person responsible for this account: \_\_\_\_\_  
Relationship to patient: \_\_\_\_\_ Phone: \_\_\_\_\_  
Address: \_\_\_\_\_  
Insurance Company Name: \_\_\_\_\_ Policyholder Name: \_\_\_\_\_  
ID/Patient Number: \_\_\_\_\_ Policy/Group/Account Number: \_\_\_\_\_  
Do you have a deductible? ( Y N ) If so, how much? \_\_\_\_\_  
Do you have a co-pay (list amount) \_\_\_\_\_ Maximum per year? \_\_\_\_\_  
Insurance Co. Phone: \_\_\_\_\_ Name of Primary Care Physician \_\_\_\_\_

**Williston Chiropractic and Sportsmedicine  
Health Questionnaire**

**1. Is your problem caused by?**

- Auto Accident    Workman's Compensation    Neither

**2. Indicate on the drawings below where you have pain/symptoms**



**3. How often do you experience your symptoms?**

- Constantly (76-100% of the time)    Occasionally (26-50% of the time)  
 Frequently (51-75% of the time)    Intermittently (1-25% of the time)

**4. How would you describe the type of pain?**

- |                                   |                                                    |
|-----------------------------------|----------------------------------------------------|
| <input type="checkbox"/> Sharp    | <input type="checkbox"/> Numb                      |
| <input type="checkbox"/> Dull     | <input type="checkbox"/> Tingly                    |
| <input type="checkbox"/> Diffuse  | <input type="checkbox"/> Sharp with motion         |
| <input type="checkbox"/> Achy     | <input type="checkbox"/> Shooting with motion      |
| <input type="checkbox"/> Burning  | <input type="checkbox"/> Stabbing with motion      |
| <input type="checkbox"/> Shooting | <input type="checkbox"/> Electric like with motion |
| <input type="checkbox"/> Stiff    | <input type="checkbox"/> Other: _____              |

**5. How are your symptoms changing with time?**

- Getting Worse    Staying the Same    Getting Better

**6. Using a scale from 0-10 (10 being the worst), how would you rate your pain/problem?**

0   1   2   3   4   5   6   7   8   9   10 (*Please circle*)

**7. How much has the problem interfered with your work?**

- Not at all    A little bit    Moderately    Quite a bit    Extremely

**8. How much has the problem interfered with your social/physical activities?**

- Not at all    A little bit    Moderately    Quite a bit    Extremely

**9. Who else have you seen for your problem?**

- Chiropractor (how many visits this year? \_\_\_\_\_)    Primary Care Physician  
 Physical Therapist (how many visits this year? \_\_\_\_\_)    Orthopedist  
 Massage Therapist    No one  
 Other \_\_\_\_\_

10. How long have you had this problem? \_\_\_\_\_

11. How do you think your problem began?

\_\_\_\_\_

\_\_\_\_\_

12. Do you consider this problem to be severe?

- Yes       Yes, at times       No

13. What aggravates your problem?

\_\_\_\_\_

\_\_\_\_\_

14. What alleviates your problem?

\_\_\_\_\_

\_\_\_\_\_

15. What concerns you the most about your problem; what does it prevent you from doing?

\_\_\_\_\_

\_\_\_\_\_

16. What is your: Height \_\_\_\_\_ Weight \_\_\_\_\_  
Date of Birth \_\_\_\_\_ Occupation \_\_\_\_\_

17. How would you rate your overall Health?

- Excellent       Very Good       Good       Fair       Poor

18. What type of exercise do you do?

- Strenuous       Moderate       Light       None

19. Indicate if you have any immediate family members with any of the following:

- Rheumatoid Arthritis \_\_\_\_\_  Diabetes \_\_\_\_\_  Osteoarthritis \_\_\_\_\_  
 Heart Problems \_\_\_\_\_  Cancer \_\_\_\_\_  Back pain \_\_\_\_\_

20. For each of the conditions listed below, please circle any you have had in the past or are currently experiencing.

- |                      |                             |                          |
|----------------------|-----------------------------|--------------------------|
| Headaches            | High Blood Pressure         | Diabetes                 |
| Neck Pain            | Heart Attack                | Excessive Thirst         |
| Back Pain            | Chest Pains                 | Frequent Urination       |
| Shoulder Pain        | Stroke                      | Smoking/Tobacco Use      |
| Arm Pain             | Kidney/Bladder Disorders    | Drug/Alcohol Dependence  |
| Hip Pain             | Loss of Bladder Control     | Allergies: _____         |
| Knee Pain            | Prostate Problems           | Depression               |
| Ankle/Foot Pain      | Abnormal Weight Gain/Loss   | Systemic Lupus           |
| Jaw Pain             | Loss of Appetite            | Epilepsy                 |
| Joint Pain/Stiffness | Abdominal Pain              | Dermatitis/Eczema/Rash   |
| Arthritis            | Hepatitis                   | HIV/AIDS                 |
| Cancer               | Liver/Gall Bladder Disorder |                          |
| Asthma               | General Fatigue             | <b>For Females Only:</b> |
| Dizziness            | Muscular Incoordination     | Birth Control Pills      |
| Visual Disturbances  | Other: _____                | Hormonal Replacement     |
|                      |                             | Pregnancy                |

**21. List all prescription medications you are currently taking:**

---

**22. List all the over-the-counter medications and/or vitamins you are currently taking:**

---

**23. List all surgical procedures you have had:**

---

**24. What activities do you do at work?**

- Sit:**    Most of the day                       Half the day                       A little of the day  
 **Stand:**    Most of the day                       Half the day                       A little of the day  
 **Computer work:**    Most of the day    Half the day                       A little of the day  
 **On the phone:**    Most of the day    Half of the day                       A little of the day

**25. Please circle the activities you do outside of work:**

- |                 |                |
|-----------------|----------------|
| Aerobics        | Skiing         |
| Basketball      | Snowboarding   |
| Baseball        | Soccer         |
| Bicycling       | Softball       |
| Football        | Swimming       |
| Golf            | Tennis         |
| Hiking          | Triathlon      |
| Hockey          | Volleyball     |
| In-Line Skating | Walking        |
| Jogging         | Weight Lifting |
| Martial Arts    | Working Out    |
| Rock Climbing   | Yoga           |
|                 | Other: _____   |

**26. Have you ever been hospitalized?**       No     Yes

If yes, why \_\_\_\_\_

**27. Have you had significant past trauma?**     No     Yes \_\_\_\_\_

**Have you had any X-rays, MRI scans, or CT scans on the painful area? (circle which). What facility were they taken at: FAHC, Vt. Radiologist, other \_\_\_\_\_**

**28. Anything else pertinent to your visit today?**

---

---

## Informed Consent/Consent to Treat

I have been informed of the nature, purpose and scope of care to be provided by the doctors of Williston Center for Chiropractic & Sportsmedicine, the possible limitations and consequences of that care, and the possibility that the care given by Drs. Bisaccia may not completely resolve my complaint, dysfunction or condition. I consent to care and recommendations made by the doctors for myself (or my children, if minors) including, but not limited to examinations, chiropractic adjustments/manipulations, adjunctive therapies and rehabilitation. I understand that my care will be individualized and therefore may not be comparable with standards or guidelines required by insurance companies, Medicare, professional associations and/or consensus groups. I understand that my treatment will comply with the standard of care defined by the laws in the State of Vermont. I recognize that all health care procedures, including those used in this clinic, have risks associated with them. Risks, although rare, associated with chiropractic procedures may include minor aggravation of symptoms, musculoskeletal sprain/strain, neurological deficits, fracture, vertebral artery syndrome, including cerebrovascular accident (stroke) or death through complicating factors. I hereby accept the risks associated with any care by the doctors and staff of Williston Center for Chiropractic & Sportsmedicine and release Drs. Bisaccia of any liability for any injury or loss directly related to care I have received at this clinic. In the event of emergency, I grant the doctors and staff permission to provide emergency care and any follow-up necessary, including referral to Emergency Medical Services.

I am signing this consent after having been fully informed to my satisfaction of the risks and benefits of proceeding with care and declining care. I have been informed and fully understand that there are not guarantees of treatment success. By my presence and continuation of appointments, I consent and elect to care provided by Williston Center for Chiropractic & Sportsmedicine.

---

*Patient Name (please print)*

---

Patient Signature

Date

I have reviewed the above terms of acceptance and consent with the patient named above and I am satisfied that he/she fully understands the nature and content of the agreement.

Drs. John & Marna Bisaccia

---

Date

Vitals: BP \_\_\_\_\_, Pulse \_\_\_\_\_

# **Williston Center for Chiropractic & Sportsmedicine Office Policies**

In order to provide the best care possible, it is necessary to maintain certain office policies.

## **Appointments**

If you need to cancel an appointment please notify the office at least three hours in advance. We understand that emergencies and/or conflicts do arise, but would appreciate notice as soon as possible. Please remember that another patient in need of care may be treated in the time slot allotted to you. Cancellations without three hours notice are considered a no-show.

\* WE REQUIRE 24-HOUR CANCELLATION NOTICE FOR MASSAGE \*

## **Lateness**

It is imperative that you are on time for your appointment. We will be tolerant of occasional lateness, however, if you are going to be late, we ask that you try to call us immediately. We will excuse two late appointments. After that you will need to reschedule and pay for your visit in full. There will be a charge for all future lateness.

## **No-Shows**

We reserve the right to charge your account for a missed appointment. We will excuse one no-show in the event that you forgot or had an emergency. However, any subsequent no-shows will be charged at the full office visit rate each time thereafter.

## **Payment**

We will be happy to bill your primary insurance for you. You are responsible for any co-payments or percentages due at the time of service. If your insurance denies your claim, you will be responsible for payment in full when notification is given to you of non-payment.

Cash/uninsured patients are expected to render payment at the time of service unless arrangements are made with our billing manager.

## **Supplements & Equipment**

Most insurance companies will not pay for supplements or equipment such as supports or pillows. You will be expected to pay for these at the time of service.

We appreciate your cooperation and understanding. Please feel free to ask any questions you may have. We feel very strongly about enforcing these policies but will always do what we can to help accommodate your needs. We look forward to working with you towards better health!

Sincerely,  
Dr. John Bisaccia

Dr. Marna Bisaccia

Patient Signature: \_\_\_\_\_

Date: \_\_\_\_\_

## Attention Patients:

As of May 1, 2009, the Federal Trade Commission has issued regulations stating that financial institutions and creditors (a medical practice that submits medical bills and then sends patient a bill for the remaining balance is considered a creditor) must develop and execute written “identity theft prevention programs”. This must provide for the identification, detection and response to patterns, practices or specific activities.

The FTC states that “... **for most physicians in a low risk environment, an appropriate program might consist of checking a photo identification at the time services are sought and having appropriate procedures in place in the event the office is notified- say by a consumer or law enforcement- that the consumer’s identity has been misused.**”

Our policy will be as follows:

1. On your first visit, you will need to provide us with your insurance card and a valid driver’s license or picture identification.
2. Any change of address will need to be proven with documentation such as a letter mailed to you at you new residence or a changed driver’s license.
3. Any change in name, a marriage or divorce, will need to provide valid documentation as stated above.
4. Any changes in insurance, identification number or switching insurance companies, will need to provide a new insurance card.
5. Any credit cards that have not been signed will have to prove with valid documentation, such as a signed driver’s license.

Any misuse of other people’s identities, credit cards or mail will result in the police being notified immediately.

Any type of theft that may occur in the office, such as computers or files being stolen, will result in the police being notified. The patients will then receive a phone call or a letter in the mail.

Thank you  
WCSM