WILLISTON 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.

For Office Use Only: 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 (present or past): _____

Employer: _____ Address: _____

City: _____ State:_____ Zip:_____ Student: Y N

Emergency Contact: _____ Relationship: _____

Emergency Phone Number: _____ Primary Care Physician_____

Name of person responsible for this account: _____

Relationship to patient: _____ Phone: _____

Address: _____

Insurance Company Name:_____ Policyholder Name:_____

ID/Patient Number: _____ Policy/Group/Account Number:_____

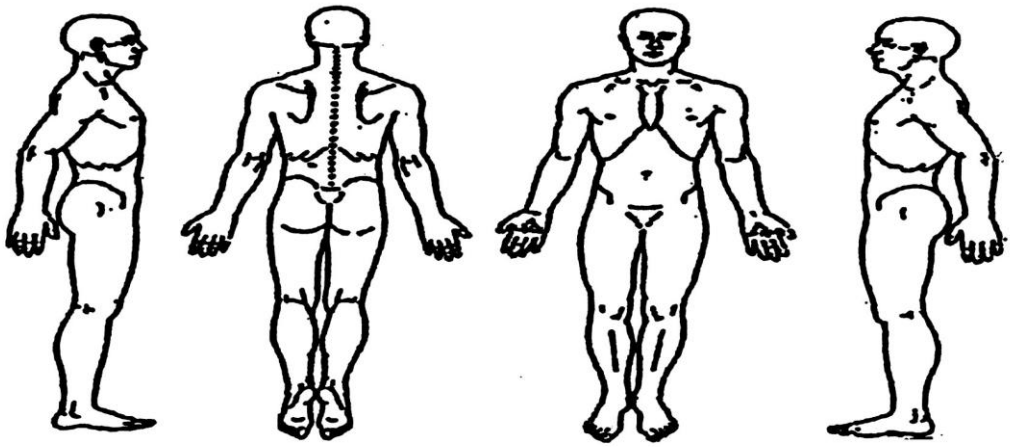
Do you have a deductible? (Y N) If so, how much? _____ Maximum per year? _____

Do you have a co-pay (list amount) _____ Insurance Co. Phone: _____

Williston Chiropractic and Sportsmedicine
Health Questionnaire

1. Is your problem caused by?
□ Auto Accident □ Workman's Compensation □ Neither

2. On the drawings below, indicate the <u>main</u> area of pain/symptoms to be addressed



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?

□ Sharp	□ Numb
□ Dull	□ Tingly
□ Diffuse	□ Sharp with motion
□ Achy	□ Shooting with motion
□ Burning	□ Stabbing with motion
□ Shooting	□ Electric like with motion
□ Stiff	□ 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 (Past and/or Present)_____

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	Other:_____
Asthma	General Fatigue	**For Females Only:**
Dizziness	Muscular Incoordination	Birth Control Pills
Visual Disturbances	Lyme Disease	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: UVMMC, VT Open MRI, NWMC, DHMC,
Other_____

28. Anything else pertinent to your visit today?

_____

Functional Assessment Tool: Pain Scales

Williston Chiropractic and Sportsmedicine

Patient Name: _____ DOB: _____ Date: _____

Instructions: Please circle the number that best describes the question being asked.
Note: If you have more than one complaint, please answer each question for each individual complaint and indicate the score for each complaint.

Example:

No pain 0-------1-------2-------3-------4-------5-------6-------7-------8-------9-------10 worst possible pain

Low Back Left Knee

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1) What is your pain **RIGHT NOW**?

No pain 0------1-------2-------3-------4-------5-------6-------7-------8-------9------10 worst possible pain

2) What is your **TYPICAL** or **AVERAGE** pain?

No pain 0------1-------2-------3-------4-------5-------6-------7-------8-------9-------10 worst possible pain

3) What is your pain level at its **BEST**? (How close to zero does your pain get?)

No pain 0------1-------2-------3-------4-------5-------6-------7-------8-------9-------10 worst possible pain

4) What is your pain level at its **WORST**? (How close to 10 does your pain get?)

No pain 0------1-------2-------3-------4-------5-------6-------7-------8-------9-------10 worst possible pain

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.

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.

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**.

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 a no show fee of $50.00 each time thereafter.

Lateness

It is important that you are on time for your appointment. We run on time most days and want to spend the time helping you. We will be tolerant of occasional lateness, however, if you are going to be late, we ask that you try to call us to let us know. We will excuse two late appointments. After that you will need to reschedule and pay for your visit. There will be a charge for future lateness.

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 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 and Dr. Marna Bisaccia

Patient Signature: _____ Date: _____

Dr. John Bisaccia
-CHIROPRACTIC PHYSICIAN
-CERTIFIED SPORTS
CHIROPRACTIC PHYSICIAN

Dr. Marna Bisaccia
-CHIROPRACTIC PHYSICIAN

Authorization to Release Information

Patient Name:_____

Date of Birth:_____

I hereby authorize you to release any and all information pertaining to my care including records, reports, and x-rays/MRIs/CTs (to include disc copies) to:

Williston Chiropractic and Sportsmedicine
Drs. John & Marna Bisaccia
802 Industrial Avenue
PO Box 669
Williston, VT 05495

Patient Signature:_____ Date:_____

Williston Chiropractic and Sportsmedicine

Privacy Notice Acknowledgement

We are very concerned with protecting your privacy, especially in matters that concern your personal health information. In accordance with the *Health Insurance Portability and Accountability act* of 1996 (HIPAA), we are required to supply you with a copy of our privacy policies and procedures. We encourage you to read this document carefully, for it outlines the use and limitations of the disclosure of your health information and your rights as a patient. If you ever have any questions or concerns regarding the use or dissemination of your personal health information, we would be happy to address them.

I acknowledge that I have received/offered a copy of Williston Chiropractic and Sportsmedicine's *Notice of Privacy Practices for Protected Health Information.*

_____ _____

Patient Name Printed Date

_____

Patient Signature