

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: _____
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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?

Cell Phone: _____ Email Address: _____

Marital Status: _____ Occupation (present or past): _____

Employer: _____ Address: _____

City: _____ State: _____ Zip: _____ Student?

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? _____ If so, how much? _____ Maximum per year? _____

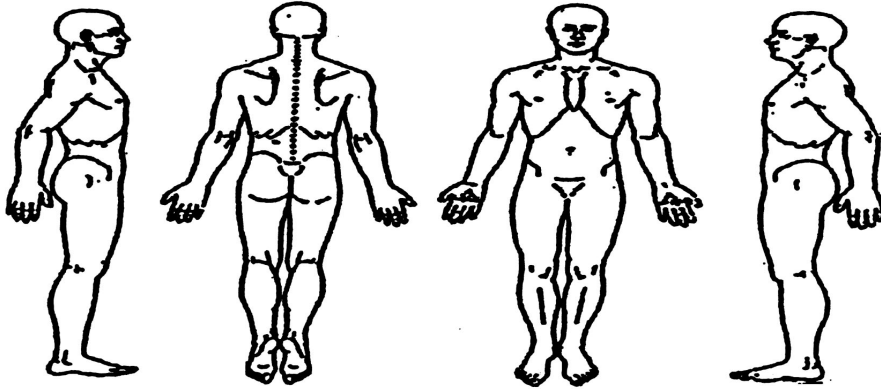
Do you have a co-pay (list amount) _____ Insurance Co. Phone: _____

**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 main area of pain/symptoms to be addressed
(You can fill this out in the office)**



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

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 check any you have had in the past or are currently experiencing:

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

- | | |
|--|---|
| <input type="checkbox"/> Aerobics | <input type="checkbox"/> Skiing |
| <input type="checkbox"/> Basketball | <input type="checkbox"/> Snowboarding |
| <input type="checkbox"/> Baseball | <input type="checkbox"/> Soccer |
| <input type="checkbox"/> Bicycling | <input type="checkbox"/> Softball |
| <input type="checkbox"/> Football | <input type="checkbox"/> Swimming |
| <input type="checkbox"/> Golf | <input type="checkbox"/> Tennis |
| <input type="checkbox"/> Hiking | <input type="checkbox"/> Triathlon |
| <input type="checkbox"/> Hockey | <input type="checkbox"/> Volleyball |
| <input type="checkbox"/> In-Line Skating | <input type="checkbox"/> Walking |
| <input type="checkbox"/> Jogging | <input type="checkbox"/> Weight Lifting |
| <input type="checkbox"/> Martial Arts | <input type="checkbox"/> Working Out |
| <input type="checkbox"/> Rock Climbing | <input type="checkbox"/> 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? What facility were they taken at: UVMMC, VT Open MRI, NWMC, DHMC, 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.

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