

Full Name _____ (Nick Name: _____) Age: _____

Marital Status: M S W D Children? (#, ages): _____

Occupation: _____ Are you: right handed left handed ambidextrous

How is most of your day spent? Standing Sitting Walking Lifting/Carrying

Ever been to a chiropractor? No Yes When & Why?: _____

Ever had a vehicle crash injury? No Yes When? _____

Ever had a work-related injury? No Yes When? _____

Current Complaints or Issues that Brought You Here:

Describe each complaint or issue. When did it begin? How long have you had it?

Have you had MRI, CT scan, X-Rays? No Yes : When/Where? _____

Is your condition: Improving? Getting Worse? The Same Does pain wake you from deep sleep? No Yes

Are symptoms interfering with: Work Sleep Activities/Sports Home Life

Who is your *Primary Care Physician*? _____

Have you seen any other healthcare providers (MD's, PT's, etc.) for this condition? No Yes

Please describe:

Describe Each Problem or Painful Body Region Separately (as best you can, e.g. "headaches," or "lower back," or "elbow").

Problem Area #1: _____

Are your symptoms?: Constant Comes & Goes; Grade your pain from 0 (no pain) to 10 (unbearable): 0 1 2 3 4 5 6 7 8 9 10

What provokes or alleviates your symptoms? _____

Problem Area #2: _____

Are your symptoms?: Constant Comes & Goes; Grade your pain from 0 (no pain) to 10 (unbearable): 0 1 2 3 4 5 6 7 8 9 10

What provokes or alleviates your symptoms? _____

Problem Area #3: _____

Are your symptoms?: Constant Comes & Goes; Grade your pain from 0 (no pain) to 10 (unbearable): 0 1 2 3 4 5 6 7 8 9 10

What provokes or alleviates your symptoms? _____

Today's Date: _____ Patient: _____ File: _____

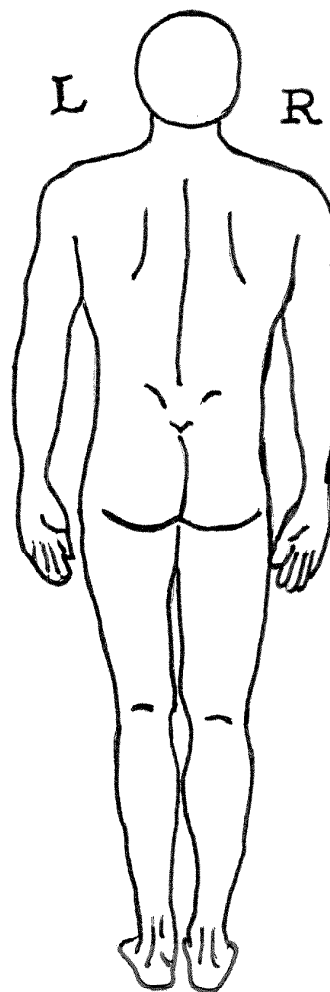
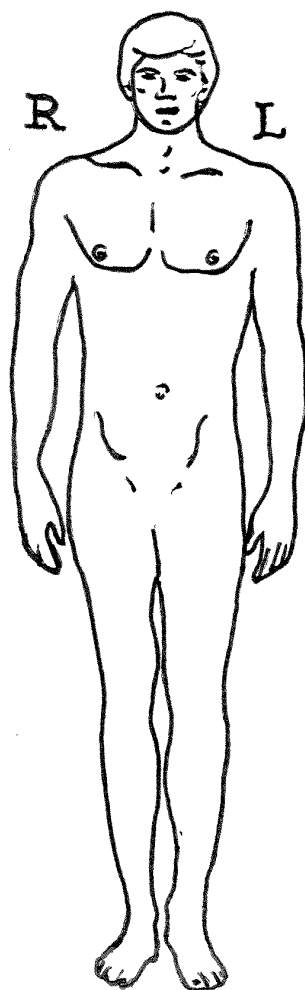
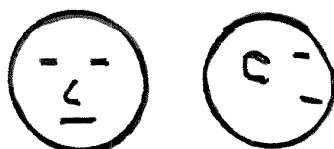
CIRCLE, MARK, COLOR-IN OR IDENTIFY AREAS OF YOUR BODY THAT HAVE A PROBLEM.

Feel free to use the symbols in the box below to describe the type(s) of pain or sensations you experience.

>>>	Aching Pain
XXX	Burning Pain
==	Numbness
OOO	Pins & Needles
////	Stabbing Pain

FOR FACE OR HEAD PAIN:

Rt Side Lt Side Both



Past Medical History:

If you've ever in the past been medically treated for, been diagnosed with, or had significant medical problems with any of the following conditions:

- | | | | | |
|--|--|---|---|---|
| <input type="checkbox"/> Back Pain | <input type="checkbox"/> Concussion | <input type="checkbox"/> Irritable Bowel | <input type="checkbox"/> HIV + | <input type="checkbox"/> Nervousness |
| <input type="checkbox"/> Neck Pain | <input type="checkbox"/> Struck Unconscious | <input type="checkbox"/> Digestion Problems | <input type="checkbox"/> Hepatitis | <input type="checkbox"/> Depression |
| <input type="checkbox"/> Numbness/Tingling | <input type="checkbox"/> Eye Injuries | <input type="checkbox"/> Heart Problem | <input type="checkbox"/> Mononucleosis | <input type="checkbox"/> Anxiety |
| <input type="checkbox"/> Sciatica | <input type="checkbox"/> Sinus Problems | <input type="checkbox"/> Kidney Problem | <input type="checkbox"/> Anemia | <input type="checkbox"/> Chemical Addiction |
| <input type="checkbox"/> Jaw Pain/TMJ | <input type="checkbox"/> Shortness of Breath | <input type="checkbox"/> Thyroid Problem | <input type="checkbox"/> Excessive Thirst | <input type="checkbox"/> Eating Disorder |
| <input type="checkbox"/> Headaches | <input type="checkbox"/> Dizziness | <input type="checkbox"/> Liver Problem | <input type="checkbox"/> Night Sweats | <input type="checkbox"/> Allergies |
| <input type="checkbox"/> Shoulder | <input type="checkbox"/> Chest Pains | <input type="checkbox"/> Gall Bladder Problem | <input type="checkbox"/> Weight Loss | <input type="checkbox"/> Difficulty Breathing |
| <input type="checkbox"/> Elbow/Arm | <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Lung Disease | <input type="checkbox"/> Frequent Urination | <input type="checkbox"/> Asthma |
| <input type="checkbox"/> Carpal Tunnel Syn. | <input type="checkbox"/> Arteriosclerosis | <input type="checkbox"/> Menstrual Irregularity | <input type="checkbox"/> Diabetes | <input type="checkbox"/> Chronic Cough |
| <input type="checkbox"/> Knee Problems | <input type="checkbox"/> Constipation | <input type="checkbox"/> Menstrual Cramps | <input type="checkbox"/> Limb Edema | <input type="checkbox"/> Cancer |
| <input type="checkbox"/> Foot or Ankle | <input type="checkbox"/> Sleep Disorder | <input type="checkbox"/> Prostate Problem | <input type="checkbox"/> Bruise Easily | <input type="checkbox"/> Lumps or Tumors |
| <input type="checkbox"/> Tendonitis/Bursitis | <input type="checkbox"/> Fractures | <input type="checkbox"/> Uterus/Ovary Prob's | <input type="checkbox"/> Chronic Fatigue | <input type="checkbox"/> Other: |
| <input type="checkbox"/> Sprained Ankle(s) | <input type="checkbox"/> Osteoporosis ('penia) | <input type="checkbox"/> Skin Diseases | <input type="checkbox"/> Lymes Disease | <input type="checkbox"/> Other: |

List **all** surgeries or major injuries or hospitalizations you had in the past. Do you have any residual issues?

List **all** medicines, herbs/vitamins you currently take (attach or email a list if you prefer);

Social History:

- Do you smoke? No Yes How much ? _____
- Consume alcohol? Daily Weekly Seldom Never
- Do you eat "fast" food? Daily Weekly Seldom Never
- Caffeine Beverages/Day 4-6/d 2-3/d 1-2/d Seldom/Never

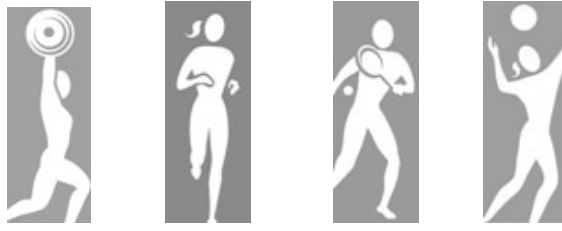
Family Medical History: e.g. Diabetes, Arthritis, Cancer...

- Mother:
- Father:
- Siblings:

Do you have a regular exercise program? No Yes If yes, what and how often?

Were you very active in any particular sports when you were younger (e.g. high school track, college football)?

Patient Signature: _____ **Date:** _____



PATIENT INFORMED CONSENT TO TREATMENT

The Nature Of Chiropractic Treatment: The doctor will use his hands or mechanical devices in order to move your joints and mobilize soft tissues (e.g. muscles, ligaments). A “crack” or “pop” sound is inherent in some of the joint manipulation procedures and is a natural effect of joint movement. Various other procedures, including, but not limited to, hot packs, electric stimulation, therapeutic ultrasound, exercises, massage or other soft tissue therapies may also be used. Physical examination is physical! It involves the doctor manually challenging your joints and testing your muscle strengths and it can sometimes lead to temporary soreness or worsening of your pain.

Possible Risks and Side Effects: As soon as ANY doctor intervenes with your healthcare there is risk of side effects and complications. The risk of serious complications from chiropractic treatment has been described as “extremely rare.” While less serious complications are possible from chiropractic treatment, most are highly unlikely, but could include fractures, sprains/strains, injury to intervertebral discs, nerves, spinal cord, a worsening of symptoms or development of new symptoms. Cerebrovascular accident such as a stroke is highly sensationalized by the news media, but real research data proves that it is very rare, with odds calculated as one in a million to one in forty million, about the same odds of a stroke from having your hair washed in a salon (“beauty parlor syndrome”), and significantly less than the odds of being struck by lightning. Usually, side effects of treatment include transient muscular stiffness or soreness. Some people report it as feeling like they exercised new muscles for the first time. Some procedures (e.g. hot packs or deep tissue massage) could produce skin irritation, burns or bruises.

Other Treatment Options That Could Be Considered (Just To Put Things In Perspective):

Over-the-counter analgesics, prescription medicines, surgical procedures, and hospitalization all carry significant risk of complications, far greater than those encountered in a chiropractic office.

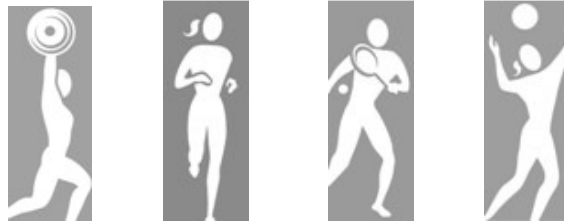
Risks Of Remaining Untreated: While it is possible that your symptoms can go away with no treatment at all, delay of treatment could reduce body mobility, induce chronic pain, and lessen chances of complete recovery.

I have read the explanation above regarding chiropractic treatment. I have had the opportunity to have questions answered to my satisfaction. I freely decided to undergo the recommended treatment, and hereby give full consent to treatment.

Patient or Parent/Guardian

Date

Witness



OFFICE POLICIES OF THE GILLMAN CHIROPRACTIC OFFICE

PERMISSION TO COMMUNICATE (HIPPA)

I authorize and give permission to Dr. Scott F. Gillman and his staff and/or associates to communicate with me by regular mail, email, phone calls to my home, work, wireless phone, or answering machine(s). I understand that communication will be in regards to appointments, clerical issues and clinical issues. I understand that due diligence will be employed in being discrete about any clinical issues conveyed via the above modes of communication. I understand that I have the right to refuse certain types of communication by notifying Dr. Scott F. Gillman or his staff in writing.

AUTHORIZATION TO RELEASE HEALTHCARE INFORMATION (HIPPA)

I hereby authorize Dr. Scott F. Gillman or his assigned staff members to release information contained in my medical record to any and all insurance carriers from whom I may be due benefits, to my primary care physician or other healthcare providers associated with my treatment, to the state chiropractic society in the event their assistance is needed on my behalf, and to my attorney of record (if an attorney is involved).

ASSIGNMENT OF PROCEEDS

Under Massachusetts Law, Chapter 106, Section 9-109(C)(8) and 9-315(C), I hereby instruct and direct that payments for my services be sent directly to Dr. Scott F. Gillman or the Gillman Chiropractic Office and not to me, my guardians, my estate, or my attorney, regardless of any assignment of benefits my attorney or others may present on my behalf, and regardless of the date such other assignment or instruction may be signed by me or presented by others.

- I hereby instruct and direct that payments for health care provided me by Dr. Scott F. Gillman, as reflected in bills for such service that he may present, as may be due me under terms of a contract of health insurance, or as a result of an action at court, settlement, structured settlement, judgment, verdict or arbitration award which I may receive or be due, be sent directly to Dr. Scott F. Gillman. This instruction shall be considered irrevocable, and shall survive me, and my period of care under Dr. Gillman forever and without exception.
- Regarding only payment for Dr. Gillman's services to me as reflected in bills he presents I hereby rescind any and all assignments of benefit presented by my attorney of any date prior to this date to any party receiving this notice.

Also, under all circumstances, I direct and instruct that any monies sent to any party as payment for the services at the Gillman Chiropractic Office, following receipt of office bills and or statements, BE MADE PAYABLE SOLELY TO DR. GILLMAN.

COLLECTION POLICY AGREEMENT

- I hereby acknowledge that I am ultimately fully responsible for the payment of all charges or fees for services provided me regardless of any contract of insurance, any action at court, any settlement, structured settlement, judgment, verdict or arbitration award which I may receive or be due, or the course or outcome of any dispute regarding same. I also understand that I may be charged a 1.5% monthly interest charge for any patient balances unpaid after 30 days.
- I agree to deliver to Dr. Gillman any check, draft or funds that I receive from any source intended as payment for services rendered me by Dr. Gillman within 10 calendar days of receipt by me and to be responsible for 1.5% month interest accrued for failure to deliver money after 30 days.
- I agree to reimburse Dr. Gillman for all reasonable collection costs he incurs that arise from collection actions he takes against me in the process of settling my account.

APPOINTMENT POLICY

We reserve the right to charge a \$30 fee for appointments that are blatantly missed or appointments that are cancelled without notice of at least four (4) hours. The \$30 fee is your bill, not your insurance company's bill.

I acknowledge that I received these HIPAA and office policies and have read, understood and agreed to them per my signature:

Signature: _____ Date: _____