Full Name____ (Nick Name:________________) Age:__________

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

Date of Injury: _______________ Who is your Primary Care Physician? __________________________

Occupation:____ Are you: ☐ right handed ☐ left handed ☐ ambidextrous

Describe (briefly) how you were hurt while at work:

____

____

____

____

Circle, Check, or In Any Way Describe Your Answers:

Any poor work-site conditions (e.g. wet floor, poor lighting)? No Yes: __________

Did you experience **any** pain or other symptoms immediately after the incident? No Yes Where:___________________

Did any pain occur later or next day? No Yes How so? ____

Where did you go after the accident: ☐ Home ☐ Back to Work ☐ Hospital (by ambulance, friend, co-worker, family)

Not including the hospital, have you seen any healthcare providers prior to your visit here? ☐ No ☐ Yes
Please list them, e,g, PT's, MD's, LMT's, etc:

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

Was pain medicine prescribed? No Yes If yes, by which doctor? ________________________

Any braces, supports, or canes issued? No Yes

Are pain(s)/symptom(s): Improving Getting Worse Changing in Character or Location The Same

Ever had similar pain/symptoms/problems in the involved areas before? No Yes Please Describe:

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

Any previous vehicle crashes? ☐ No ☐ Yes When?____

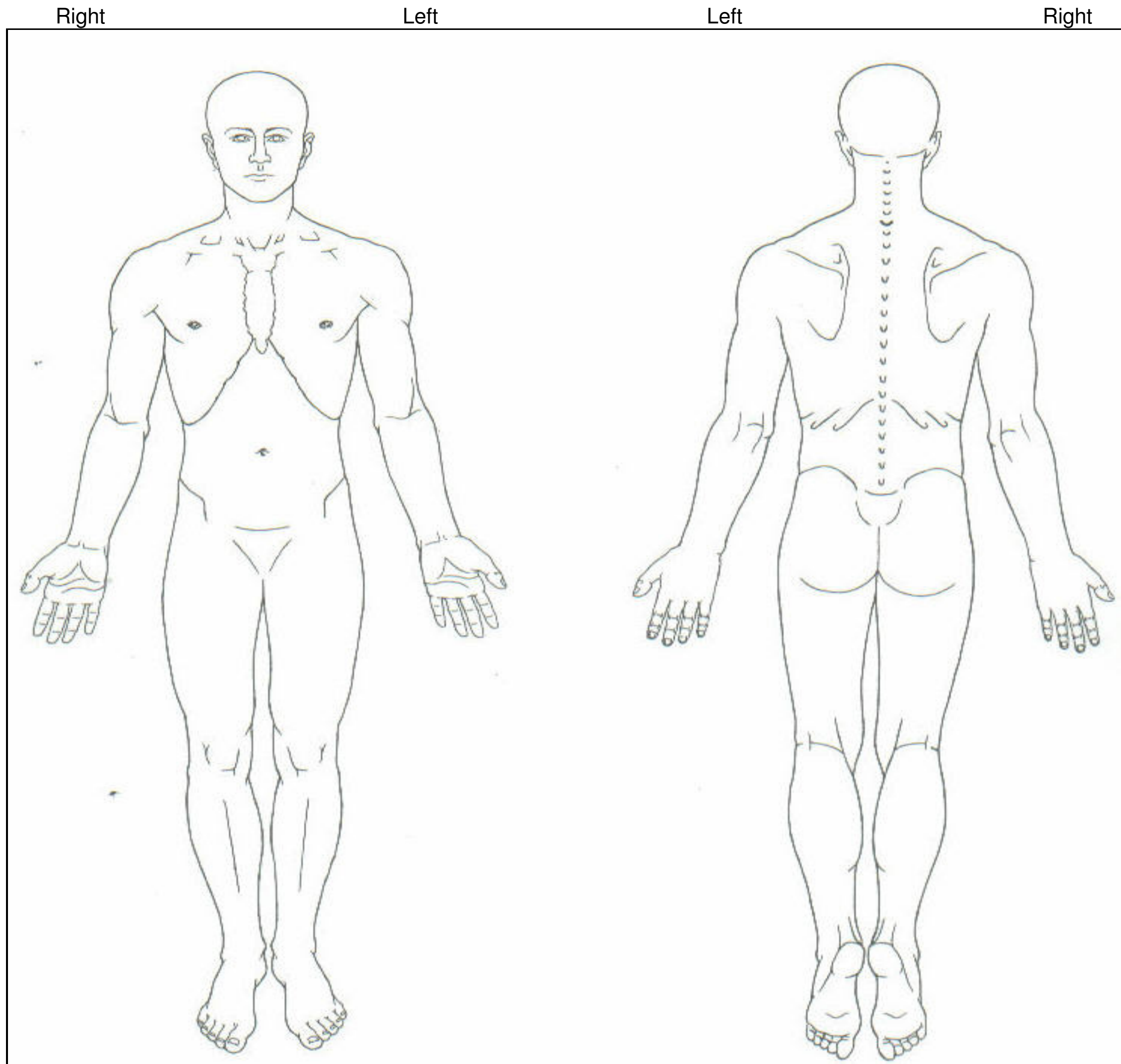
Any previous work-related injury? ☐ No ☐ Yes When?____

List all dates (times) you missed from work due to this injury: ________________________

Are you currently working limited hours? No Yes Working light or limited duty? No Yes

Did you have any work limitations or disabilities **prior** to the work-accident? No Yes

Using the diagram below, circle or mark the where you feel pain, aching, numbness/tingling, or any other symptom.



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

Pain or Problem Area #1:____

Are 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? ____

Pain or Problem Area #2: ____

Are 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? ____

Pain or Problem Area #3: ____

Are 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? ____

Past Medical History:

Check the box for any condition for which – **in the past** - you've been medically treated for, been diagnosed with, or had significant medical problems.

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

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

____

____

____

List **<u>all</u>** 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 ☐ 2-3 ☐ 1-2 ☐ Seldom/Never

Family Medical History:

Diabetes, Heart Ds., Arthritis, Cancer

Father:

Mother:

Siblings:

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

____

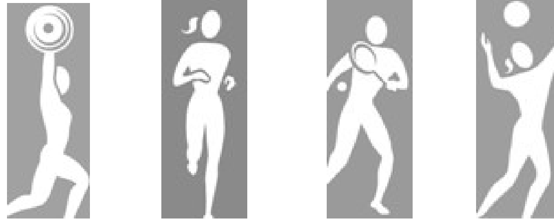
List any hobbies or sports you participate in:

____

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.

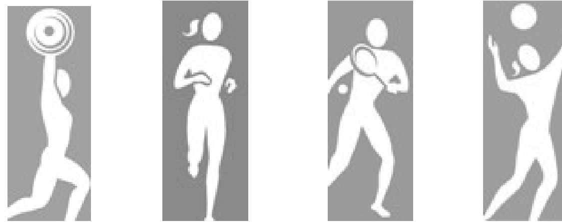
Other Treatment Options That Could Be Considered (Just To Put Things In Perspective):
Over-the-counter analgesics, prescription medicines, surgical procedures, and hospitalization all carry significant risk of complications, far greater than those encountered in a chiropractic office.

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: ____________

AGREEMENT TO PAY COSTS

IN THE EVENT OF WORKERS COMPENSATION CLAIM DENIAL

Claimant Name: ____________________________________

Address: ____

Employer: ____

Address: ____

Workers Comp. Ins. Carrier: __________________________

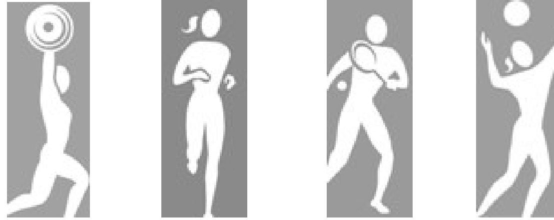
Date of Injury: ______________________________________

Claim Number: _____________________________________

If it is determined by the worker's compensation board that the above-named claim is not a result of a compensable workers compensation case, I ____________________ hereby agree to pay Dr. Scott F. Gillman of 251 West Central Street, Natick MA the usual and customary fees for services rendered.

_________________________________ ___________________________

Patient Signature Date



WORKERS COMPENSATION POLICY

If you have been involved in an on-the-job injury you are entitled to receive medical/chiropractic treatment. The injured party, in most instances, is allowed freedom of choice in selection of a doctor.

To activate you claim you must do the following:

1. Report you injury and complete an accident report and have it on record with your employer.

2. Furnish this office with all the pertinent information that relates to the accident. Specifically:

   a. Provide this office with the name, address, contact person and phone number or your employer.

   b. Provide this office with the name, address, contact person, phone number and claim number of your employer's worker's compensation insurance carrier.

   c. If you seek legal counsel, please provide this office with the name, address, contact person and phone number.

Failure to complete the above steps can result in your being personally responsible for the payment of services rendered by this office.

The worker's compensation carrier will be notified of your treatment plan with our office and will be billed directly. Payment for services rendered will be paid directly to this office. If the carrier denies your claim or refuses to pay your bill, it will become your responsibility to make payment. Charges for missed appointments will not be billed to the insurance carrier and are your responsibility with this office.

I have read and understand the above policy.

______________________________________ ________________________

Patient Signature Date