

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

Marital Status: M S W D Ages of Children: _____

Occupation: _____ Are you: right handed left handed ambidextrous

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

Have you ever been to a chiropractor? No Yes When & Why?: _____

Have you ever been in an auto accident? No Yes When? _____

Have you ever had a work related injury? No Yes When? _____

Current Complaints:

Describe your problem(s). When did it begin? How long have you had it?

Is it getting: Better Worse Same Does pain wake you up during 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 for this condition? No Yes:

Please describe:

Describe Each Problem Separately (It's okay to leave this section blank and discuss things with Dr. G).

Please list each problem area or painful body region separately.

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: _____

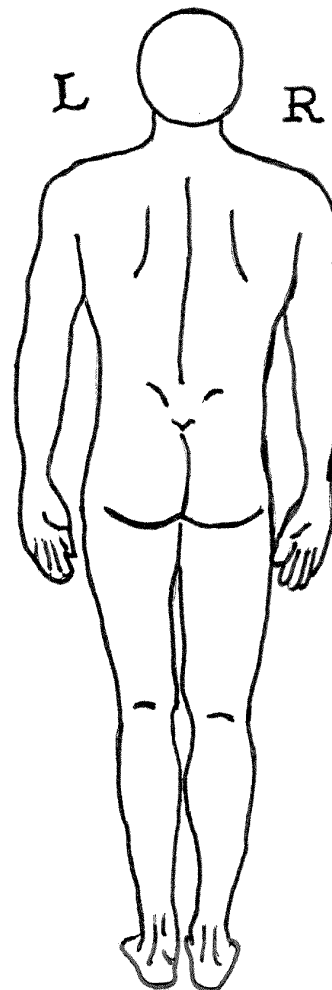
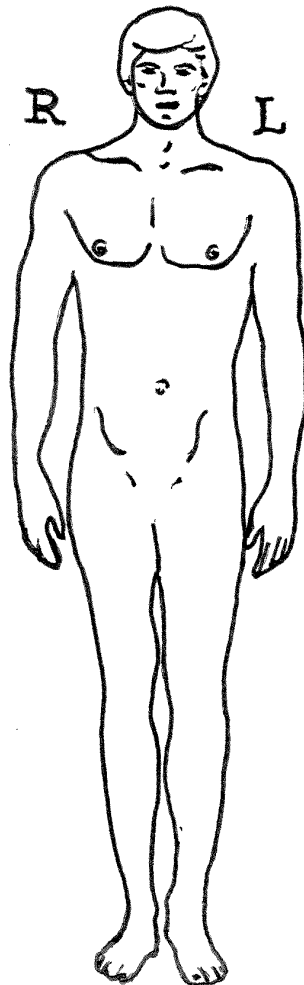
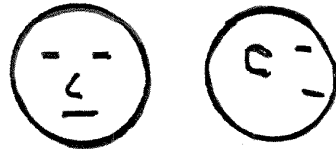
CIRCLE, MARK, COLOR-IN OR IDENTIFY AREAS OF YOUR BODY THAT HAVE A PROBLEM.

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:

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

- | | | | | |
|--|--|---|---|---|
| <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 Pain | <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 Pain | <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Lung Disease | <input type="checkbox"/> Frequent Urination | <input type="checkbox"/> Asthma |
| <input type="checkbox"/> Knee/Leg Pain | <input type="checkbox"/> Arteriosclerosis | <input type="checkbox"/> Menstrual Irregularity | <input type="checkbox"/> Diabetes | <input type="checkbox"/> Chronic Cough |
| <input type="checkbox"/> Foot or Ankle Pain | <input type="checkbox"/> Constipation | <input type="checkbox"/> Menstrual Cramps | <input type="checkbox"/> Limb Edema | <input type="checkbox"/> Cancer |
| <input type="checkbox"/> Sprained Ankles | <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:_____ |

Please list **any and all** hospitalizations, surgeries or major injuries you had in the past. Do you have any residual issues?

List **all** medicines you currently take:

Social History:

- Do you smoke? No Yes How much ? _____
- Do you consume alcohol? Daily Weekly Seldom Never
- Do you crave "sweets"? Daily Weekly Seldom Never
- Do you eat "fast" food? Daily Weekly Seldom Never
- Coffee/Caffeine per Day? _____ cups or cans (soda)

Family History:

Mother: _____

Father: _____

Siblings: _____

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

List any hobbies or sports you participate in:

Did you play any sports when you were younger? Which ones?

Patient Signature: _____ **Date:** _____

OFFICE POLICIES OF THE GILLMAN CHIROPRACTIC OFFICE

PERMISSION TO COMMUNICATE

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

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 BENEFITS

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 1) i received the HIPAA policies of this office and 2) I have read, understood and agreed to the above

Office Policies by My 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 hot packs, electric stimulation, therapeutic ultrasound, exercises, massage or other soft tissue therapies may also be used. Physical examination is physical! It involves mechanically challenging your joints and testing your muscle strengths and it can possibly lead 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 “rare,” and in one study was estimated at about 200,000 complications over a 5-year period. While complications are possible from chiropractic treatment, most are highly unlikely, but could include fractures, sprains, dislocations of joints, injury to intervertebral discs, nerves or spinal cord, or you can experience worse symptoms or new symptoms. Cerebrovascular accident such as a stroke is remotely possible and has been calculated between one in a million to one in forty million odds, about the same odds of a stroke from having your hair washed in a salon (“beauty parlor syndrome”) or 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 massage) could produce skin irritation, burns or bruises.

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

Over-the-counter analgesics, prescription medicines, surgical procedures, and hospitalization all have significant risk of side effects and serious complications which are far greater than that which is 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 reduce body mobility, induce chronic pain, and lesson 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

Authorization for Release of Medical Records To Dr. Scott F. Gillman

I hereby authorize _____ to use or disclose the following protected health
Name of Physician / hospital

information from the medical records of the patient listed below. I understand that information used or disclosed pursuant to this authorization could be subject to redisclosure by the recipient and, if so, may

not be subject to federal or state law protecting its confidentiality.

Patient Name: _____ Date of Birth: _____

Address: _____

City: _____ State: _____ Zip: _____

THIS AUTHORIZATION OR PHOTOCOPY HEREOF DIRECTS HEALTHCARE FACILITY/PROVIDERS TO RELEASE ANY OR ALL INFORMATION REQUESTED VIA PHONE OR MAIL.

Information to be disclosed to: Dr. Scott F. Gillman
251 West Central Street
Natick, MA 01760
(Phone) 508-650-1091, (Fax) 508-650-1563

Disclose the following information for treatment dates: _____ to _____

Complete Records Xray Reports Xray Films MRI Reports

Other Specified: _____

The above information is disclosed for the following purposes: **MEDICAL/ HEALTHCARE**

I understand that I may refuse to sign or may revoke (at any time) this authorization for any reason and that such a refusal or revocation will not affect the commencement, continuation or quality of my treatment at the offices of Dr. Scott F. Gillman; except, however, if my treatment at the offices of Dr. Scott F. Gillman is for the sole purpose of creating health or obtaining information for disclosure to Dr. Scott F. Gillman then he may refuse to treat me if I do not sign this authorization.

I understand that the Authorization will remain in effect until the term of this Authorization expires or until I provide a written notice of revocation to Dr. Scott F. Gillman at the address listed above. The revocation will be effective immediately upon Dr. Scott F. Gillman's receipt of my written notice, except that the revocation will not have any effect on any action taken by the offices of Dr. Scott F. Gillman in reliance on this Authorization before it received my written notice of revocation.

This authorization will be valid for 90 days from the signature date, or until _____.

I have read and understand the terms of this Authorization and I have has the opportunity to ask questions about the use and disclosure of my health information. By my signature below, I hereby, knowingly and voluntarily, authorize the above -mentioned physician/hospital to disclose my health information in the manner described above.

Patient Signature

Printed name of patient or patient's representative

Patient File Number