Chiropractic Registration and History

First Name_____MI_____Last name_____

Address_____City_____State_____Zip_____

Phone (h)_____(w)_____(c)_____

Date of Birth_____Marital Status_____

Emergency Contact_____Phone_____Relationship_____

Email_____

Occupation_____Employer_____

Employer Address_____Phone_____

Spouse_____Spouse's Date of Birth_____

Spouse's employer_____Phone_____

Whom may we thank for referring you?_____

Cancellation policy:

_____(initials) I understand that 24 hours notice must be given for all cancellations and I agree to pay a $40 missed appointment fee in the event that I cancel in less than 24 hours or do not show up for a scheduled appointment.

_____(initials) I acknowledge that I have read and been offered a copy of the Notice of Privacy Practices from Vermont Back and Body Care, LLC.

Current Condition

Is this condition related to an accident? Y N Type (auto, work, other)_____

Reason for visit_____Is condition getting worse? Y N Unknown

When did your symptoms appear?_____Severity of pain (1 to 10)_____

Type of pain: sharp dull aching burning numbness shooting stiffness swelling other_____

How often do you have this pain?_____Is it constant? Y N

Does it interfere with: work sleep daily routine recreation other_____

Which activities are painful to perform? sitting standing walking bending lying down

Have you seen another doctor for this condition? Y N Name_____

Date of last x-ray/MRI_____facility_____purpose_____

Name of Primary Care Physician_____Date of last physical_____

Health History

Please check the appropriate box if you have or have had any of the following.

C = currently have P = Past condition N = Never had

C	P	N	General	C	P	N	Gastro-Intestinal	C	P	N	Frequent urination
			Allergies				Constipation				Kidney stones/ disease
			Dizziness				Diarrhea				Prostate problems
			Fainting				Jaundice				***Respiratory***
			Fatigue				Liver Disease				Chest pain
			Headache				Nausea				Chronic cough
			Headache (migraine)				Vomiting				Difficulty Breathing

			Insomnia				***Eyes, Ears, Nose & Throat***	**Check the following conditions that you HAVE HAD**			
			Nervousness/Depression				Asthma				
			Numbness				Enlarged Glands		AIDS		Multiple Sclerosis
			Tremors				Sinus Infections		Alcoholism		Osteoporosis
			Muscle and Joint				***For Women Only***		Anemia		Parkinsons
			Arthritis				Breast lump		Appendicitis		Physical Abuse
			Bursitis				Cramps		Asthma		Pneumonia
			Foot Pain				Excessive menstrual flow		Bleeding disorder		Polio
			Hernia				Hot flashes		Cancer		Psychiatric care
			Low back pain				Irregular cycle		Diabetes		Rheumatoid(RA)
			Pain between shoulders				Menopausal symptoms		Eating disorder		STD
			Pain or Numbness in:				Miscarriage		Eczema		Stroke
			Neck/Upper back				***Cardio-vascular***		Emphysema		Substance abuse
			Shoulders				High blood pressure		Epilepsy		Suicide attempt
			Arms				Low blood pressure		Fracture		Thyroid Disease
			Elbows				High cholesterol		Goiter		Ulcers
			Hands				Pain over heart		Gout		
			Lower Back				Poor circulation		Heart Disease		
			Hips				Rapid heart rate		Hepatitis		
			Legs				Swelling in ankles/feet		Hernia		
			Knees				***Genito-urinary***		Herniated Disc		
			Feet				Blood in urine		Mononucleosis		

Are you pregnant? Y N Due date_____

Exercise level: None Little Moderate Heavy Days/week_____

Work Activity: Sitting Standing Light Labor Heavy Labor

Habits

Smoking Y N Packs/Day_____
Alcohol Y N Drinks/Week_____
Caffeine Y N Cups/Day_____
High Stress Y N Reason_____

Injuries/Surgeries

Please list incident and date it occurred
Falls_____
Head Injuries_____
Broken Bones_____

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Montpelier, VT 05602

Dislocations_____
Surgeries_____

List current medications and dosages:

_____
_____

Vitamins and Supplements:

_____
_____

Allergies:

_____

What are your goals for treatment?

1._____
2._____
3._____

Is there anything else you would like us to know about you and your health?

2017 Fee Schedule

Vermont Back and Body Care no longer accepts direct payment from insurance companies. Payment is due at the time services are rendered. We are happy to provide you with a detailed receipt which you may submit to your insurance company for any out-of-network benefits to which you may be entitled.

Adjustment only…….$40
- Prepay for 3 adjustments, save $20……...……$100

Ultrasound or Combo…….$10
Therapy (Graston, exercise, etc)…….$25
New patient visit……$150
Re-establishing care or new injury…….……$75
New patient prepay option (first 3 visits)…….…….$250
- The estimated cost of your first 3 visits is $290. This includes the examination and treatment on the first visit, treatment and exercise/stretch instructions on the 2nd visit and treatment on the third visit. If you prepay at your first visit you will receive a $40 discount on those services.

Parent/Child discount: Receive 50% off the adjustment for each child who gets adjusted on the same visit as a parent.
Special discounts are available for children, pregnant women and current CDL patients; please ask for more information at the front desk.

I agree to the above fee schedule and understand that I must pay at the time services are rendered. I also understand that I may request a detailed bill which I can submit to my own insurance company and they may or may not reimburse me directly for a portion of the services.

Patient Signature: _____

Date: _____

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INFORMED CONSENT FOR CHIROPRACTIC CARE

The Nature of Chiropractic Treatment: The doctor will use her hands or a mechanical device in order to manipulate/adjust your joints. You may or may not feel a "click" or "pop", such as the noise when a knuckle is "cracked". Some chiropractic techniques are not intended to produce an audible sound. Ancillary procedures, such as soft tissue stretching, treatment with stainless steel instruments, hot or cold packs, Electrical Muscle Stimulation, Therapeutic Ultrasound, Exercise Therapy or Energy work may also be used.

Possible Complications or Side Effects: As with any health care procedure, complications or side effects are possible following chiropractic care. The most common side effect seen is short term aggravation of symptoms or muscle soreness, much like the discomfort after starting a new exercise routine. While rare, some patients may experience rib fractures or muscle and ligament strains, sprains or bruising. There are rare reported cases of disc injuries following cervical and lumbar spinal adjustment although no scientific study has ever demonstrated such injuries are caused by spinal adjustments or chiropractic treatment.

Vertebrobasilar artery (VBA) stroke is the most serious and most controversial proposed complication from cervical (neck) adjustments. Present scientific evidence does not establish a cause and effect relationship between cervical spine adjustments and the occurrence of VBA stroke. A 2008 study published in the Journal *SPINE* found no evidence of excess risk of VBA stroke associated chiropractic care. Furthermore, the apparent association is noted very infrequently. A paper published in the 2002 *Canadian Medical Association Journal* reported a one in 5.85 million incidence of VBA stroke following a cervical spine adjustment. You are being warned of this association, however remote, because VBA stroke may cause serious neurological impairment, paralysis or death.

Other Treatment Options Which Could Be Considered:

- *Consultation with your family doctor, orthopedist or other health care provider.*
- *Over-the-counter analgesics.*
- *Receive no treatment at all.*

Risks of Remaining Untreated: It is estimated that 80% of back /neck pain cases may resolve within three months regardless of treatment. It is also estimated that 70% of cases will experience a recurrence of their problem within a year. Delay of treatment may allow the formation of adhesions, scar tissue and other degenerative changes. These changes can further reduce skeletal mobility, and induce chronic pain cycles. It is quite probable that delay of treatment will complicate the condition and make future rehabilitation more difficult.

I have read the above explanation of chiropractic treatment. I have had the opportunity to have any questions answered to my satisfaction. I have fully evaluated the risks and benefits of undergoing chiropractic treatment. I have freely decided to undergo the recommended treatment and hereby give my full consent.

_____	_____	_____
Printed Patient Name	**Signature / Signature of Legal Guardian**	**Date**

_____

Signature of Witness

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