ABOUT THE PATIENT — Leicester Spine and Wellness Center

Name _____ Today's Date_____ Birthdate _____ Age_____

Address _____ City _____ State _____ Zip _____

Home Phone _____ Cell Phone _____ Work Phone _____ Gender ❑ M ❑ F

Significant Other's Name _____ Kid's Names and Ages _____

Your Employer _____ Type of Work _____

e-Mail Address _____ Have you been to a chiropractor before? ❑ No ❑ Yes

Emergency Contact _____ ph # _____

Name of Medical Doctor(s)_____

I authorize the doctor or his staff to render care as deemed appropriate for me and / or my child.
I authorize Leicester Spine and Wellness Center to release and / or request records to/from other providers as may be necessary.
I understand I am responsible for all bills incurred in this office.
I authorize assignment of my insurance benefits (if applicable) directly to the provider.
Person responsible for this account if other than the patient?_____
I understand that after any initial promotional services all care is rendered at usual and customary fees.
For my balance my preferred payment method is: ❑ Cash ❑ Check ❑ Credit Card ❑ Car/Work Ins.

_____ _____

Patient / Parent Signature (This represents a long term authorization for all occasions of service) Date

REASON FOR SEEKING CARE

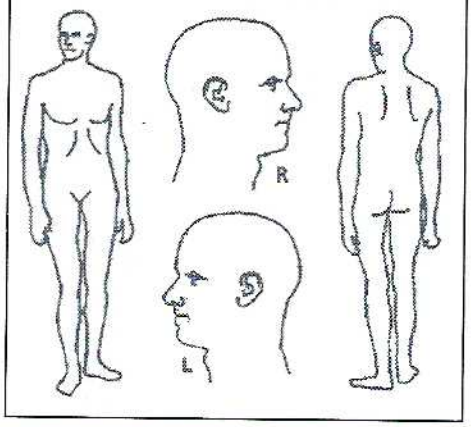
PRESENT COMPLAINTS

1. _____ How long has this been an issue? _____
   Is it: ❑ Dull ❑ Sharp ❑ Ache ❑ Numb / Tingle ❑ Stabbing ❑ Constant ❑ Occasional ❑ Staying the same ❑ Getting worse
   ❑ Mild ❑ Moderate ❑ Severe ❑ Worse in the morning ❑ Worse in evening ❑ Pain radiates to_____
2. _____ How long has this been an issue? _____
   Is it: ❑ Dull ❑ Sharp ❑ Ache ❑ Numb / Tingle ❑ Stabbing ❑ Constant ❑ Occasional ❑ Staying the same ❑ Getting worse
   ❑ Mild ❑ Moderate ❑ Severe ❑ Worse in the morning ❑ Worse in evening ❑ Pain radiates to_____
3. _____ How long has this been an issue? _____
   Is it: ❑ Dull ❑ Sharp ❑ Ache ❑ Numb / Tingle ❑ Stabbing ❑ Constant ❑ Occasional ❑ Staying the same ❑ Getting worse
   ❑ Mild ❑ Moderate ❑ Severe ❑ Worse in the morning ❑ Worse in evening ❑ Pain radiates to_____
4. _____ How long has this been an issue? _____
   Is it: ❑ Dull ❑ Sharp ❑ Ache ❑ Numb / Tingle ❑ Stabbing ❑ Constant ❑ Occasional ❑ Staying the same ❑ Getting worse
   ❑ Mild ❑ Moderate ❑ Severe ❑ Worse in the morning ❑ Worse in evening ❑ Pain radiates to_____

5. Does your condition affect: ❑ Sleep ❑ Work ❑ Daily Routine ❑ Sitting ❑ Driving
   _____
6. What makes it better?_____
7. What makes it worse? _____
8. What Doctor's have you seen for this?_____
   _____
9. Type of treatment:_____
10. Results: _____
NOTES: _____

Are you pregnant?
❑ Yes ❑ No

Please mark All areas of concern.



GENERAL HEALTH HISTORY Leicester Spine and Wellness Center

Patient Name_____ *Mark the conditions that apply to you.*

Past	Present		Past	Present	
❑	❑	Headaches	❑	❑	Urinary Problems
❑	❑	Migraines	❑	❑	Easy Bruising
❑	❑	Shortness of Breath	❑	❑	Tobacco Use
❑	❑	Allergies / Asthma	❑	❑	Dental Problems
❑	❑	Medication Side Effects	❑	❑	Fibromyalgia
❑	❑	Diabetes	❑	❑	Blood Thinner use
❑	❑	Hands or Feet cold	❑	❑	HIV Positive
❑	❑	Muscle aches	❑	❑	Cancer
❑	❑	Trouble Walking	❑	❑	Depression
❑	❑	Leg / Foot Numbness	❑	❑	Alcohol Use
❑	❑	Fainting	❑	❑	___High or ___Low Blood Pressure
❑	❑	Gall Bladder Trouble	❑	❑	Stroke History
❑	❑	Ringing in Ears	❑	❑	High Cholesterol
❑	❑	Ear Problems	❑	❑	TMJ
❑	❑	Sleeping Problems	❑	❑	Digestive Problems
❑	❑	Vision Problems	❑	❑	Pain all Over
❑	❑	Thyroid Problems	❑	❑	Tension / Irritability
❑	❑	Liver Disease	❑	❑	Chest Pains
❑	❑	Kidney Problems	❑	❑	Heart Pacemaker
❑	❑	Light Bothers Eyes	❑	❑	Heart Problems
❑	❑	Other _____			

1. List any medications are you taking:_____

2. Please list all doctors you are currently seeing: _____

3. Has any Doctor or other professional advised you to "Go to a Chiropractor ": ❑ No ❑ Yes, Name_____

PAST HISTORY

4. List any past auto collisions:_____ Was any care received?_____
5. List any past work injuries: _____ Was any care received?_____
6. List any past sport, recreational, or home injuries_____
7. Please describe any past conditions and treatment received: _____
8. Please list any past hospitalizations and surgeries: _____

FAMILY HISTORY

Father's side: ❑ Heart Disease ❑ Cancer ❑ Diabetes ❑ Heavy Medication use ❑ Arthritis ❑ Other_____

Mother's side: ❑ Heart Disease ❑ Cancer ❑ Diabetes ❑ Heavy Medication use ❑ Arthritis ❑ Other_____

Is there any other family history you want us to know?_____

LEICESTER SPINE AND WELLNESS CENTER
1103 MAIN ST. LEICESTER MA 01524
PH:(508) 892-8150 FAX:(508) 892-0372

NOTICE OF PRIVACY PRACTICES PATIENT ACKNOWLEDGEMENT & CONSENT FORM

I understand that under the Health Insurance Portability and Accountability Act of 1996 ("HIPPA"), I have certain rights to privacy regarding my protected health information. I understand that this information can and will be used to:

*Conduct , plan, and direct my treatment and follow-up among the multiple health care providers who may be involved in that treatment.
*Obtain payment from third party payers.
*conduct normal health care operations such as quality assessment and physician certifications.

I have received , read , and understand Leicester Spine & Wellness Center's Notice of Privacy Practices containing a more complete description of the use and disclosures of my health information. I understand that Leicester Spine & Wellness Center has the right to change its Notice of Privacy Practices, and that I may contact the office at any time to obtain a copy of the current Notice of Privacy Practices.

I understand that I may request in writing that Leicester Spine & Wellness Center restrict how my private information is used or disclosed to carry out treatment , payment, or health care operations. I also understand that Leicester Spine & Wellness Center is not required to agree with my requested restrictions, but if they do agree then the organization is bound to abide by such restrictions.
I understand that I may revoke this consent at any time, except to the extent that Leicester Spine & Wellness Center has already taken action on this consent.

PATIENT'S NAME:_____

SIGNATURE:_____

RELATIONSHIP TO PATEINT_____

DATE:_____

Leicester Spine & Wellness Center

**THE NATURE OF THE CHIROPRACTIC ADJUSMENT

I will use my hands or mechanical device upon your body in such a way as to move your joints. That may cause an audible "pop" or "click", much as you have experienced when you " crack" your knuckles. You may feel or sense movement.

**THE MATERIAL RISKS OF INHERENT IN CHIROPRACTIC ADUJUSTMENT

As with any health care procedure, there are certain complications which may arise during a chiropractic adjustment. Those complications include; fractures, disc injuries, dislocations, muscle strain, Horner's Syndrome, diaphragmatic paralysis, cervical myelopathy and costovertebral strains and seratations. Some types of cervical manipulation have been associated with injuries to the arteries in he neck leading to or contributing to serious complications including stroke. Some patients will feel some stiffness and soreness following the first few treatments.

**THE PROBABILITY OF THOSE RISKS OCCURING

Fractures are rare occurrences and generally result from some underlying weakness of the bone which we check for during the taking of your history and during examination. Stroke has been the subject of tremendous disagreement within and without the profession with one prominent authority, Scott Haldermen D.C.M.D saying that there is almost one in a million chance of such an outcome. Since even that risk should be avoided if possible, we employ tests in our examination which are designed to identify if you may be susceptible to that kind of injury. The other complications are also generally described as rare.

I HAVE READ OR HAD READ TO ME THE ABOVE EXPLANATION OF THE CHIROPRACTIC ADJUSTMENT AND RELATED TREATMENT. I HAVE DISCUSSD IT WITH DR.PETER ANTANAVICA AND HAVE HAD MY QUESTIONS ANSERED TO MY SATISFACTION . BY SIGNING BELOW I STATE THAT I HAVE WEIGHED MY RISKS INVOICED IN THE UNDERGOING AND DECIDED THAT IT IS IN MY BEST INTEREST TO UNDERGO THE TREATMENT RECOMMENDED. HAVING BEEN INFORMED OF THE RISKS, i HEREBY GIVE MY CONSENT TO THAT TREATMENT.

DATED:_____

PRINTED NAME:_____

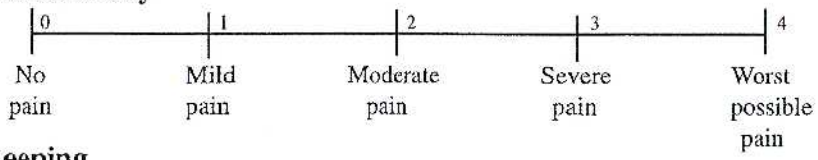
SIGNATURE:_____

Functional Rating Index

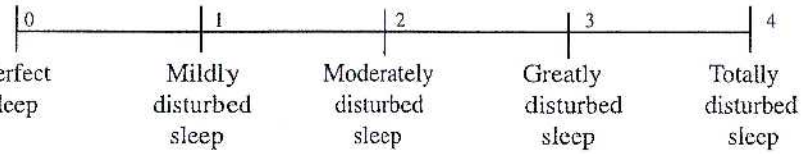
For use with **Neck and/or Back Problems** only.

In order to properly assess your condition, we must understand how much your **neck and/or back problems** have affected your ability to manage everyday activities.
For each item below, **please circle the number which most closely describes your condition right now.**

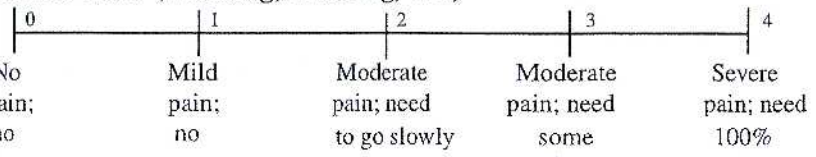
1. Pain Intensity



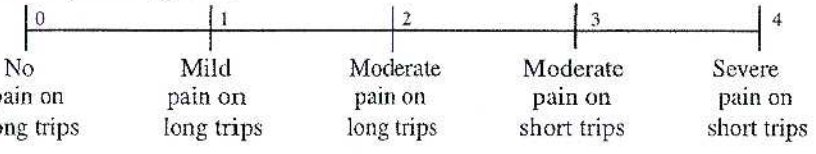
2. Sleeping



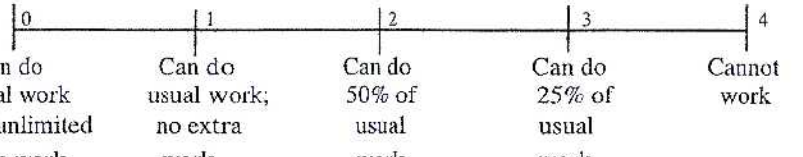
3. Personal Care (washing, dressing, etc.)



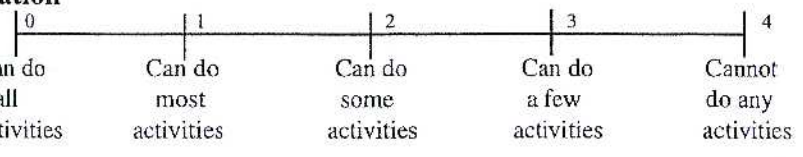
4. Travel (driving, etc.)



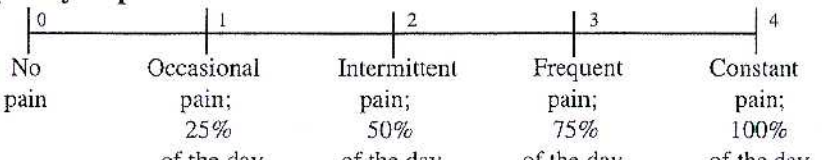
5. Work



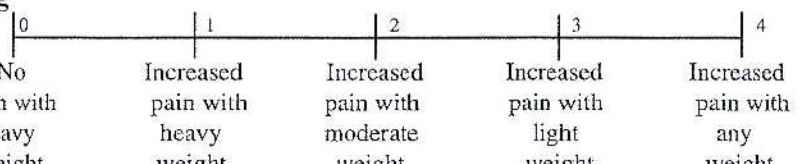
6. Recreation



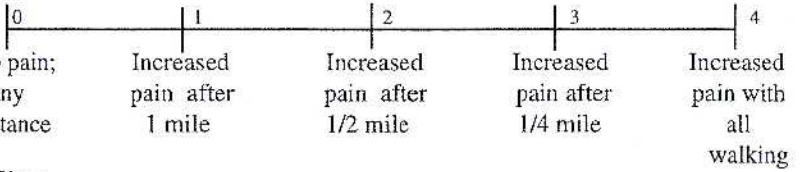
7. Frequency of pain



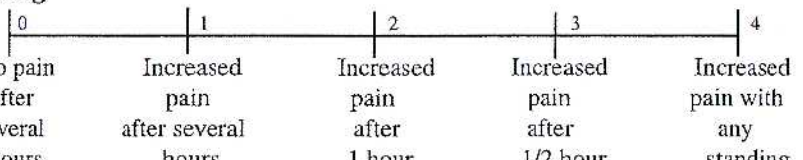
8. Lifting



9. Walking



10. Standing



Name _____ **ID#/SS#** _____ **Plan ID** _____ **Total Score** _____

PRINTED

_____

Signature

_____

Date