PATIENT INTRODUCTION FORM

Today's Date:_______________

Name:____ Birth date: _________________
(Last) (First) (MI)
Address:____ Age: _____ ( ) Male ( ) Female
City:________________________________ State:____________________ Zip: _____________
Home Phone:________________ Cell Phone:_______________ Text?( )Yes ( )No Best Hours:________
Email Address:____
( ) Married ( ) Single ( ) Divorced ( )Widowed # of Children _______
Referred to our office by: _______________________________ Relation:_________________________
Name of Emergency Contact:__________________________________ Phone: ____________________
Primary Care Physician: ______________________________________ Phone: ____________________
Employer:____Occupation:________________________
Address:___________________________________ City: _______________ State:______ Zip:________
Business Phone:___________________________ May we contact you at work?: ( ) Yes ( ) No

Is this visit a result of an accident? ( ) Yes ( ) No Work:_____ Auto:_____ Other:_____

Health Insurance Information: (If you are in the office, you can present your card and skip section below)

Primary Insurance Carrier:____________________________ ID#: ______________________________

Policy Holder's Name_________________________________ Group #: __________________________

Our office uses ELECTRONIC HEALTH RECORDS and you will be signing in with a tablet each visit to create your visits data.

Please select a 4 DIGIT pin code to sign in with. ___________ If no code is entered, we will use the last 4 digits of your phone if it's available.

Medical Release/Assignment of Benefits/Cancellation Policy
I authorize Connecticut Back and Wellness Chiropractic, LLC to release any information necessary to process my claims for health care benefits. I agree to assign the benefits of my insurance carrier to Connecticut Back and Wellness Chiropractic, LLC. I understand and that payments made directly to me from my insurance carrier for services rendered as an Out Of Network provider, are to be signed over to Connecticut Back & Wellness, LLC. upon my receipt. I understand that I am fully responsible for any unpaid portion of charges incurred at this office. Regardless of insurance status, charges for services rendered are ultimately the patient's responsibility.

To maintain our excellence in patient service, we require a 24 hour notice of cancellation for our professional massage and nutrition appointments. A $40 fee will be assessed for missed massage appointments.

Patient's Signature ____ Date:________________
(Parent or Guardian if Minor)

Patient Name:____ **Date of Birth:**______________

GENERAL HEALTH INFORMATION

Height _____ Weight _______ Left / Right Handed Do you have a pacemaker? ( )YES ( )NO

Have you ever received chiropractic care before? ( )YES ( )NO Dr's Name:______________________________

Have you undergone previous chiropractic or physical therapy in the past year? ( )YES ( )NO

List any diseases or health conditions you now have or have been treated for in the past. ______________________

____

____

List any known allergies: ____

List any other trauma or injuries:____

____

List any hospitalizations or surgeries: ____

____

Date of last physical: __________ Date of last Blood Test ___________ Dr with these results:_______________

XRAYS:_________ MRI'S:__________ Other tests:____

Exercise: Type and Frequency: ____

Family History -Check all that apply	Stroke	Heart Disease	Arthritis	Cancer	Diabetes	Other
Mother's Side	_______	_______	_______	_______	_______	_______
Father's Side	_______	_______	_______	_______	_______	_______

Current Symptoms

Reason for consulting Dr today: ____

____

When did this pain or condition begin?:____

Is your Pain: ______Sharp ________Dull ________Constant ________ Intermittent

Rate your pain on a scale from 0-10 (0=No Pain, 10=Severe Pain) Please circle: 0 1 2 3 4 5 6 7 8 9 10

Does your pain radiate or move? Please describe: ____

____

What aggravates your condition/pain?:____

____

What relieves you condition/pain?:____

Is the condition/pain worse at certain times of day? When?:_______________________________________

____

Activities that are limited due to your condition/pain?:____

____

Is the condition/pain getting progressively worse?:____

____

Previous Doctors or Treatments:____

____

Any Home Remedies used:____

____

Have you ever had the same or similar condition before? Please explain:______________________________

____

Patient Name: ________________________________ **Date of Birth:** ____________________

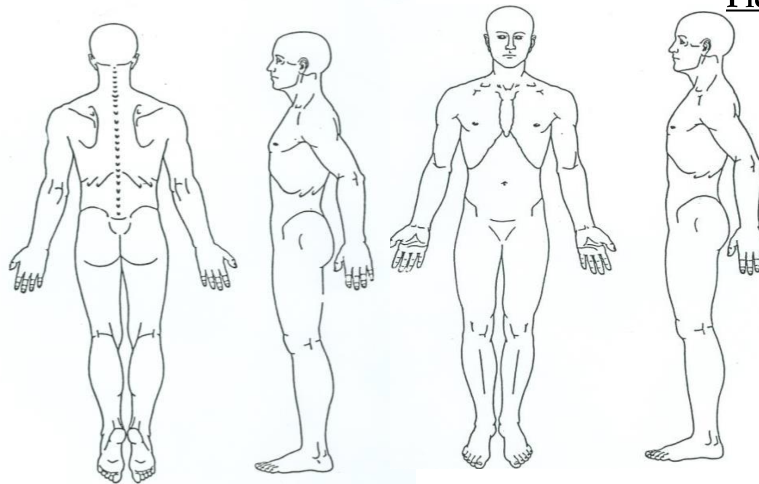
Check any of the following symptoms which you have now or have had in the past. N=NOW P=PAST

___ Headaches	___ Pins & Needles in Arms/Legs	___ Cold Hands/Feet
___ Neck Pain	___ Numbness in Fingers/Toes	___ Panic Attacks
___ Back Pain	___ Feeling of Anxiety	___ Stomach upset/Ulcers
___ Chest Pain	___ Irregular Heart Rate	___ Irritable Bowel/Colitis
___ Stiff Neck	___ Shortness of Breath/Asthma	___ Leg/Feet cramps at night
___Ears Ringing/Buzzing	___ Tension/Irritability	___ Unexplained Fever
___Sleeping Difficulties	___ High Blood Pressure	___ Eczema/Skin Rashes
___Clench/Grind Teeth	___ Cold Sores/Fever Blisters	___ Severe Menstrual Cramps
___ Dizziness/Vertigo	___Depression/S.A.D.	___ Chronic Fatigue
___ Alcoholism/Addictions	___ Eyes Sensitive to Light	___ Roving Muscle/Joint Pain
___ Recent Unexplained Weight Loss		___ Recent change in Bowel/ or bladder infection

Please list any medications you are prescribed and taking: ____

____

____



Please mark the diagrams with any of the following:

Numbness ----- Pins & Needles **00000**
Burning **XXXXX** Stabbing //////
Aching +++++ Other ******

Please list any significant traumas or injuries you have had:______________________________

____

____

____

____

DOCTOR USE ONLY

Ht:____Wt:_____ R/L Handed B.P.: _____	Neurological Evaluation	Orthopedic Evaluation	Range of Motion
Hypertonicity: Trigger Points: Joint Dysfunction: C1234567T123456789101112L12345 RS1 LS1 Posture: **Faulty Movement Patterns:** Neck Flexion Shoulder Abduction Hip Extension Trunk Flexion	**Deep Tendon Reflexes** Biceps L____ R____ Triceps L____ R____ Brachiorad L____ R____ Wrist Ext L____ R____ Patella L____ R____ Achilles L____ R____ **Dermatomes (Pinwheel):** **Muscle Strength:** **Plantar Response:** Vascular Screen George's Test: Pos/Neg	**Cervical Spine** For Spine L_____ R_____ Sh Dep L_____ R_____ Cerv Distr Pos/Neg Soto Hall Pos/Neg Bakody's Sign Pos/Neg **Thoracic Spine** Hyperextension__________ **Lumbar Spine** SLR L____ R____ Kemp's L____ R____ Yeoman's L____ R____ Hibb's L____ R____ Gaenslen's L____ R____ Fabere L____ R____ Minor's Sign Pos/Neg Valsalva Pos/Neg Flexion Bias Extension Bias Antalgia: Flexion RLF LLF Other:	Cervical Flex 60________ Ext 50________ RLF 40________ LLF 40________ RR 80________ LR 80________ Lumbar Flex 90________ Ext 30________ RLF 20________ LLF 20________ RR 30________ LR 30________ Other:

Patients Signature: ______________________________ **Today's Date:** ______________

Acknowledgement of Receipt of this Notice

Connecticut Back and Wellness Chiropractic, LLC is concerned about the privacy of our patient's health care information. Our intent is to make you aware of the possible uses and disclosures of your protected health information and your privacy rights. The delivery of your health care service will in no way be conditioned upon your signed acknowledgement, we will continue to provide your treatment, and will use and disclose your protected health information for treatment, payment, and health care operations when necessary.

You may request a copy of Connecticut Back and Wellness, LLC HIPPAA Notice of Privacy Practices.

I acknowledge that I have received the Notice of Privacy Practices for:

Connecticut Back and Wellness, LLC.

Name of Patient (Print) ________________________________

____ ____________________

Signature of Patient or Authorized Representative Date

Consent To Contact

By supplying my phone number, email address and any other personal contact information, I authorize my health care provider to employ a third-party automated outreach and messaging system (ChiroTouch) to use personal limited information for the purpose of notifying me of **pending appointment**, **a missed appointment, lab results or other communications.**

☐ **My signature indicates consent to be contacted by text message or email**

☐ **I choose to decline digital contact.**

____ ____________________

Signature of Patient or Authorized Representative Date

Connecticut Back & Wellness Chiropractic, LLC
Dr. Jean Bassani
755 Main St. Building #1 ~ Monroe, CT 06468
Phone: (203) 261-0064 ~ Fax: (203) 261-0065

INFORMED CONSENT TO TREAT

I hereby consent to the performance of chiropractic treatment, related modes of therapy and/or massage therapy, on me (or the patient named below, for whom I am legally responsible) by the doctors of chiropractic and/or licensed massage therapists employed by Connecticut Back and Wellness Chiropractic (Jean Bassani, D.C.). I understand that those doctors and massage therapists are providing services within their scope of practice as defined by the State of Connecticut.

I have had an opportunity to discuss with clinic personnel the nature and purpose of chiropractic procedures and/or massage therapy, and understand that results are not guaranteed.

I understand that, as in the practice of medicine, in the practice of chiropractic and/or massage therapy there are some risks to treatments, including but not limited to: fractures, disc injuries, dislocations and sprains. I do not expect the doctor/massage therapist to be able to anticipate and explain all risks and complications. I wish to rely on the doctor/massage therapist's judgment during the course of my treatment, based upon the facts then known, to provide therapies or procedures that he or she feels are in my best interests. As such, I understand that both my chiropractor and massage therapist must be made aware of any existing medical conditions, and that it is my responsibility to keep them updated on any changes to those conditions.

I have read the above noted consent and acknowledge that by signing this form, I confirm to consent to treatment and intend this consent to cover the treatment(s) discussed with me to deal with the physical condition for which I have sought treatment. I intend this consent form to cover the entire course of treatment for my present condition and for any future conditions for which I may seek treatment.

Patient Name: ______________________________________ **Date:**__________________

Patient Signature: ____________________________________ **Relationship:** ____________
(Or Patient Guardian/Representative)

FINANCIAL POLICY

If for any reason your account goes to our collection agency, all courtesy adjustments or discounts applied to your account will be removed. Attorney fees of 1/3 your total balance plus any processing fees that may be incurred will be added to your balance.

Patient Initials: ___________