Patient's Name	Sex	Date Of Birth	Marital Status	Social Security Number
	M F	___/___/___	S M W D	___-___-___

Occupation	Referred By	In case of Emergency Contact	Emergency Contact Phone Number

Patient's Address		Patient's Home Phone Number	Patient's Work Phone Number
Employer's Name & Address		State	Zip Code

Payments To Be Made By	Cash	Personal Check	Personal Insurance		Credit Card	Other
	Primary Insurance Carrier	Name	Policy Number	Secondary Insurance Carrier	Name	Policy Number

	Last	First	Middle	Home Phone
Responsible Party For This Account				
	Street	City	State	Zip Code

Primary Insurance: (HMO/PPO_____ Private_____ Work/Comp._____ Automobile_____) Policy #_____

Name of Insured_____ Relationship to Patient_____ Soc. Sec. # ___-___-___

Insurance Co. _____ Group # _____

Address _____ Phone # ( ) _____

Secondary Insurance (If Applicable) : (HMO/PPO_____ Private_____) Policy #_____

Name of Insured_____ Relationship to Patient_____ Soc. Sec. # ___-___-___

Insurance Co. _____ Group # _____

Address _____ Phone # ( ) _____

Additional Insurance Information (If Applicable): (HMO/PPO_____ Private_____) Policy #_____

Name of Insured_____ Relationship to Patient_____ Soc. Sec. # ___-___-___

Insurance Co. _____ Group # _____

Address _____ Phone # ( ) _____

Attorney Information (Please provide this information only if this is a personal injury or worker's compensation case.):

Attorney Name_____ Phone # ( )_____

Address_____

What Is The Purpose Of Your Appointment:_____ **Onset Date:**___/___/___

Is This Condition Due To An: Auto Accident _____ Work Injury _____ Other Accident _____ Unknown Cause _____ Illness _____

Are The Symptoms: Improving _____ Getting Worse _____ About The Same _____ Intermittent (Come and Go)_____

I understand and agree that health and accident insurance policies are an arrangement between an insurance carrier and myself. I authorize payment from my insurance carrier directly to this office with the understanding that all monies will be credited to my account upon receipt. However, I clearly understand and agree that all services rendered me are charged directly to me and that I am personally responsible for payment. I also understand that if I suspend or terminate my care and treatment, fees for professional services rendered me will be immediately due and payable. In the event of default I promise to pay legal interest on indebtedness together with such collection costs and reasonable attorney fees as may be required to effect collection.

Patient's Signature_____ **Date** ___/___/___

PATIENT INFORMATION SIDE (1)

PATIENT'S NAME

Name: Last	First	Middle	Date of Birth	Height	Weight	Sex	Date
			____/____/____			M F	____/____/____

Please check the appropriate box for any of the following symptoms which you now have or have had previously. We want all the facts about your health before we accept your case. THIS IS A CONFIDENTIAL HEALTH REPORT.

OCCASIONAL
FREQUENT

GENERAL
- ☐☐ Allergy (list below)*
- ☐☐ Convulsions
- ☐☐ Dizziness or Fainting
- ☐☐ Headache
- ☐☐ Neuralgia
- ☐☐ Numbness

MUSCLE AND JOINT
- ☐☐ Arthritis
- ☐☐ Bursitis
- ☐☐ Foot trouble
- ☐☐ Low Back Pain
- ☐☐ Neck Pain or Stiffness
- ☐☐ Pain Between Shoulders
- ☐☐ Sciatica
- ☐☐ Swollen Joints
- ☐☐ Pain, Numbness or Cramps
- ☐☐ Shoulders
- ☐☐ Arms
- ☐☐ Elbows
- ☐☐ Hands
- ☐☐ Hips
- ☐☐ Legs
- ☐☐ Knees
- ☐☐ Feet

OCCASIONAL
FREQUENT

GASTRO-INTESTINAL
- ☐☐ Colon Trouble
- ☐☐ Constipation
- ☐☐ Diarrhea
- ☐☐ Difficult Digestion
- ☐☐ Distension of Abdomen
- ☐☐ Gall Bladder Trouble
- ☐☐ Hemorrhoids
- ☐☐ Liver Trouble
- ☐☐ Pain Over Stomach

EYES, EARS, NOSE & THROAT
- ☐☐ Asthma
- ☐☐ Colds
- ☐☐ Deafness
- ☐☐ Earache
- ☐☐ Ear Discharge
- ☐☐ Ear Noises
- ☐☐ Eye Pain
- ☐☐ Nasal Obstruction
- ☐☐ Nosebleeds
- ☐☐ Sinus Infection

CARDIO-VASCULAR
- ☐☐ Hardening of Arteries
- ☐☐ High Blood Pressure
- ☐☐ Low Blood Pressure
- ☐☐ Pain Over Heart
- ☐☐ Poor Circulation
- ☐☐ Rapid Heart Beat
- ☐☐ Slow Heart Beat
- ☐☐ Swelling of Ankles

OCCASIONAL
FREQUENT

RESPIRATORY
- ☐☐ Chest Pain
- ☐☐ Chronic Cough
- ☐☐ Difficult Breathing
- ☐☐ Spitting up Blood
- ☐☐ Spitting up Phlegm
- ☐☐ Wheezing

SKIN
- ☐☐ Bruise Easily
- ☐☐ Dryness
- ☐☐ Skin Eruptions (Rash)
- ☐☐ Varicose Viens

GENITO-URINARY
- ☐☐ Bed-wetting
- ☐☐ Blood in Urine
- ☐☐ Frequent Urination
- ☐☐ Inability to Control Kidneys
- ☐☐ Kidney Infection or Stones
- ☐☐ Painful Urination
- ☐☐ Prostate Trouble
- ☐☐ Pus in Urine

FOR WOMEN ONLY
- ☐☐ Congested Breasts
- ☐☐ Cramps or Backache
- ☐☐ Excessive Menstral Flow
- ☐☐ Hot Flashes
- ☐☐ Irregular Cycle
- ☐☐ Lumps in Breast
- ☐☐ Menopausal Symptoms
- ☐☐ Painful Menstruation
- ☐☐ Vaginal Discharge
- ☐☐ Pregnant Yes No
- ☐☐ Date of Last Period_____
- ☐☐ Previous Miscarriages Yes No

DATE OF LAST : (Approx.)
- _____ Physical Exam
- _____ Blood Test
- _____ Chest X-Ray
- _____ Spine X-Ray
- _____ Dental X-Ray
- _____ Urine Test

HABITS
- ☐☐ Alcohol
- ☐☐ Coffee
- ☐☐ Tobacco
- ☐☐ Drugs
- ☐☐ _____

HAVE YOU EVER:
- ☐☐ Been Knocked Unconcious?
- ☐☐ Used Crutches, or Other Supports?
- ☐☐ Been Treated For Spine Problems
- ☐☐ Been Treated For Nerve Disorders?
- ☐☐ Had a Fractured Bone?
- ☐☐ Been Hospitalized For Other Than Surgery?
- ☐☐ Had Surgery? (list below)*

* Please list any Medications now taken, any Allergies, and any past Surgeries:_____

_____

_____

HAVE
HAD

Please Check the following conditions you have or have had in the past:
Circle items that are common to other family members

☐☐ Alcoholism	☐☐ Diabetes	☐☐ Gout	☐☐ Multiple Sclerosis	☐☐ Stroke
☐☐ Anemia	☐☐ Eczema	☐☐ Heart Disease	☐☐ Polio	☐☐ Tuberculosis
☐☐ Appendicitis	☐☐ Emphysema	☐☐ Miscarriage	☐☐ Rheumatic Fever	☐☐ Ulcer
☐☐ Cancer	☐☐ Goiter			☐☐ Foot Problem

After reading and filling out the Health Questionaire, your signature will verify that all the information you have given us is accurate and that you have read the case history question entirely.

Patient's Signature_____ **Date** ____/____/____

PATIENT INFORMATION Side (2)

COMMUNITY CHIROPRACTIC CENTER

SUSAN S. DENNY, D.C.

100 King Street, Suite 1
Northampton, MA 01060-3243
Telephone: (413) 586-8146
Fax: (413) 584-7911

Informed Consent to Chiropractic Treatment

The Nature of Chiropractic Treatment: The doctor will use his/her hands or a mechanical device in order to move your joints. You may feel a "click" or "pop", such as the noise when a knuckle is "cracked", and you may feel movement of the joint. Various ancillary procedures such as ice, heat, or traction may also be used.

Possible Risks: As with any health care procedure, complications are possible following a chiropractic procedure. Complications could include fractures of bone, muscular strain, ligamentous sprain, dislocations of the joint, or injuries to the intervertebral discs, nerves or spinal cord. Cerebrovascular incident could occur upon severe injury to the arteries of the neck. Some patients may notice stiffness or soreness after initial treatment. The ancillary procedures could produce skin irritation, burns, or minor complications.

Probability of Risks Occurring: The risks of complications due to chiropractic treatment have been described as "rare", about as often as complications are seen from the taking of a single aspirin tablet. The risk of cerebrovascular incident has been estimated at one in twenty million. Adverse reaction to ancillary procedures is also considered "rare".

Other Treatment Options: Other treatment options may include over-the-counter analgesics, prescription medications, injections, and surgery. These treatment options have their own potential risks and benefits.

Risks of Remaining Untreated: Delay of treatment allows 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 further rehabilitation more difficult.

No Warranty: I understand that my doctor cannot make any promises or guarantees regarding a cure or improvement in my condition. I understand that my doctor will share with me his/her opinion regarding potential results from chiropractic treatment for my condition and will discuss treatment options with me before I consent to treatment.

I have read the explanation above 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 treatment. I have freely decided to undergo the recommended treatment, and herby give my full consent to treatment.

_____ _____ __/__/__
Printed Name Signature Date

_____ __/__/__
Doctor's Signature Date

Consent to Treat Minor

I hereby authorize the doctor to administer chiropractic care, as deemed necessary, to my child.

_____ _____ __/__/__
Minor's Name Signature (Parent or Guardian) Date

COMMUNITY CHIROPRACTIC CENTER

SUSAN S. DENNY, D.C.

100 King Street, Suite 1
Northampton, MA 01060-3243
Telephone: (413) 586-8146
Fax: (413) 584-7911

Patient Policies

Please be on time for your appointments. You will be assigned a treatment room, please close the door so the doctor knows you are ready. **Please address all staff scheduling issues, and payment concerns after your treatment.**

Your doctor has set up a specific course of treatment for you and it is important that you follow the *prescribed treatment schedule to achieve the results desired. If you need to change an appointment, please plan* to make it up on the same day. If that is not possible, please make up the missed appointment in the same week. **This office requires a 24 hour notice for any changed appointments. A $20.00 fee will be charged for all missed appointments, and appointments changed with less than 24 hour notice.**

_____ ___/___/___
Patient (Guardian) Signature Date

Assignment of Benefits

I understand and agree that all fees for professional services rendered in my behalf are my personal liability and are due and payable at the time services are performed, and agree to pay for them within 30 days unless other arrangements are made.

_____ ___/___/___
Patient (Guardian) Signature Date

I hereby authorize and direct this office to release all medical information necessary to process this claim.

_____ ___/___/___
Patient (Guardian) Signature Date

I hereby authorize and direct my insurance carrier to pay all benefits which may be due by me according to my policy, directly to this office to be applied to my account.

_____ ___/___/___
Patient (Guardian) Signature Date