

**WILLISTON CENTER FOR CHIROPRACTIC
&
SPORTSMEDICINE
802 Industrial Ave, P.O. Box 669
Williston, VT 05495
802-863-2272**

Thank you for choosing our practice for your chiropractic needs!
Please arrive **15 minutes** before your scheduled appointment time.

For Office Use Only: Provider: _____ Appointment Date and Time: _____ Reason For Visit: _____ Referred by: _____

Name: _____ Date of Birth: _____

Address: _____ City: _____ State: _____ Zip: _____

Home Phone: _____ Social Security Number: _____ - _____ - _____

Work Phone: _____ Is it okay for us to call you at work? Y N

Cell Phone: _____ Email Address: _____

Marital Status: (S D W M) Occupation: _____ Student: Y N

Employer: _____ Address: _____

City: _____ State: _____ Zip: _____

Emergency Contact: _____ Relationship: _____

Emergency Phone Number: _____

Name of person responsible for this account: _____

Relationship to patient: _____ Phone: _____

Address: _____

Insurance Company Name: _____

Insurance Company Address: _____

Insurance Co. Phone Number: _____ Adjustor Name: _____

Claim Number: _____ Date of Injury: _____

Name of Primary Care Physician _____

**Williston Center for Chiropractic & Sportsmedicine
Office Policies**

In order to provide the best care possible, it is necessary to maintain certain office policies.

Appointments

If you need to cancel an appointment please notify the office at least three hours in advance. We understand that emergencies and/or conflicts do arise, but would appreciate notice as soon as possible. Please remember that another patient in need of care may be treated in the time slot allotted to you. Cancellations without three hours notice are considered a no-show.

* WE REQUIRE 24-HOUR CANCELLATION NOTICE FOR MASSAGE *

Lateness

It is imperative that you are on time for your appointment. We will be tolerant of occasional lateness, however, if you are going to be late, we ask that you try to call us immediately. We will excuse two late appointments. After that you will need to reschedule and pay for your visit in full. There will be a charge for all future lateness.

No-Shows

We reserve the right to charge your account for a missed appointment. We will excuse one no-show in the event that you forgot or had an emergency. However, any subsequent no-shows will be charged at the full office visit rate each time thereafter.

Payment

We will be happy to bill your primary insurance for you. You are responsible for any co-payments or percentages due at the time of service. If your insurance denies your claim, you will be responsible for payment in full when notification is given to you of non-payment.

Cash/uninsured patients are expected to render payment at the time of service unless arrangements are made with our billing manager.

Supplements & Equipment

Most insurance companies will not pay for supplements or equipment such as supports or pillows. You will be expected to pay for these at the time of service.

We appreciate your cooperation and understanding. Please feel free to ask any questions you may have. We feel very strongly about enforcing these policies but will always do what we can to help accommodate your needs. We look forward to working with you towards better health!

Sincerely,
Dr. John Bisaccia

Dr. Marna Bisaccia

Patient Signature: _____

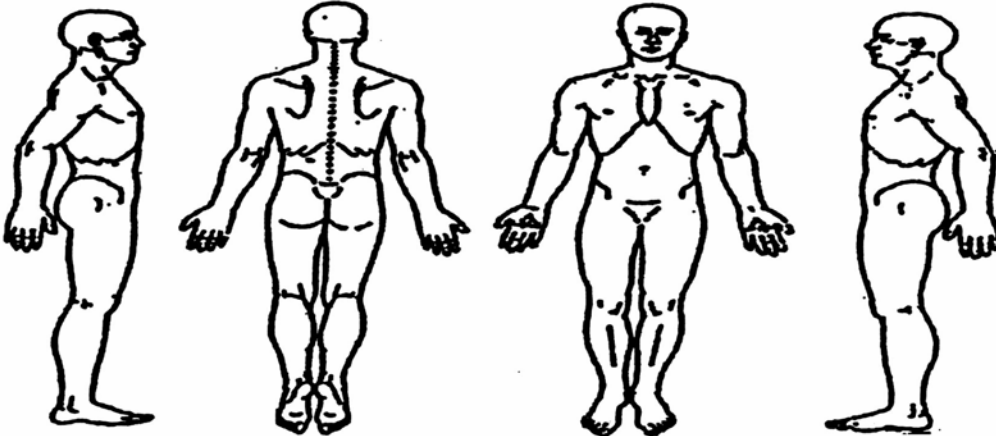
Date: _____

**Williston Chiropractic and Sportsmedicine
Health Questionnaire**

1. Is your problem caused by?

- Auto Accident Workman's Compensation Neither

2. Indicate on the drawings below where you have pain/symptoms



3. How often do you experience your symptoms?

- Constantly (76-100% of the time) Occasionally (26-50% of the time)
 Frequently (51-75% of the time) Intermittently (1-25% of the time)

4. How would you describe the type of pain?

- | | |
|-----------------------------------|--|
| <input type="checkbox"/> Sharp | <input type="checkbox"/> Numb |
| <input type="checkbox"/> Dull | <input type="checkbox"/> Tingly |
| <input type="checkbox"/> Diffuse | <input type="checkbox"/> Sharp with motion |
| <input type="checkbox"/> Achy | <input type="checkbox"/> Shooting with motion |
| <input type="checkbox"/> Burning | <input type="checkbox"/> Stabbing with motion |
| <input type="checkbox"/> Shooting | <input type="checkbox"/> Electric like with motion |
| <input type="checkbox"/> Stiff | <input type="checkbox"/> Other: _____ |

5. How are your symptoms changing with time?

- Getting Worse Staying the Same Getting Better

6. Using a scale from 0-10 (10 being the worst), how would you rate your pain/problem?

0 1 2 3 4 5 6 7 8 9 10 (*Please circle*)

7. How much has the problem interfered with your work?

- Not at all A little bit Moderately Quite a bit Extremely

8. How much has the problem interfered with your social activities?

- Not at all A little bit Moderately Quite a bit Extremely

9. Who else have you seen for your problem?

- Chiropractor (how many visits this year? _____) Primary Care Physician
 Physical Therapist (how many visits this year? _____) Orthopedist
 Massage Therapist Physical Therapist No one
 Other _____

10. What was the date of the injury? _____

11. What time did the injury occur? _____

12. What is the name of your employer? _____

13. What is the street address of your employer? _____

14. What is the City, State, and Zip of your employer? _____

15. What is the name of your attorney? _____

16. What is the street address of your employer? _____

17. What is the City, State, and Zip of your attorney? _____

18. Please describe your incident in a few sentences: _____

19. Did you report the incident to your supervisor? _____

20. What is your Supervisor's name? _____

21. Did your employer send you to a doctor? If yes, please provide the doctor's name

22. Did you go to a doctor on your own? If yes, please provide the doctor's name

23. Did you go to the hospital? If no, why. If yes, then answer 24-29

24. How did get to the hospital? _____

25. What was the name of the hospital? _____

26. Were you hospitalized over night? _____

27. Circle what you were prescribed at the hospital
- pain medication - muscle relaxors - neck brace -other _____

28. Did you receive any stitches for any cuts at the hospital? _____

29. Were x rays taken at the hospital? If yes, which area was taken? _____

30. Are there any other problems that affect your employment? _____

31. Does your job cause you to favor one side of your body? _____

32. Before the injury, were you capable of performing equal work with others your age? _____

33. Have you injured this area before? -yes _____ - no _____

34. Do you consider your problem to be severe? _____

35. What aggravates your problem? _____

36. What alleviates your problem? _____

37. What concerns you most about your problem? _____

38 What is your: Height _____ Weight _____
Date of Birth _____ Occupation _____

39 How would you rate your overall Health?

Excellent Very Good Good Fair Poor

40 What type of exercise do you do?

Strenuous Moderate Light None

41 Indicate if you have any immediate family members with any of the following:

Rheumatoid Arthritis _____ Diabetes _____ Osteoarthritis _____
 Heart Problems _____ Cancer _____ Back pain _____

42. For each of the conditions listed below, please circle any you have had in the past or are currently experiencing.

Headaches	High Blood Pressure	Diabetes
Neck Pain	Heart Attack	Excessive Thirst
Back Pain	Chest Pains	Frequent Urination
Shoulder Pain	Stroke	Smoking/Tobacco Use
Arm Pain	Kidney/Bladder Disorders	Drug/Alcohol Dependence
Hip Pain	Loss of Bladder Control	Allergies
Knee Pain	Prostate Problems	Depression
Ankle/Foot Pain	Abnormal Weight Gain/Loss	Systemic Lupus
Jaw Pain	Loss of Appetite	Epilepsy
Joint Pain/Stiffness	Abdominal Pain	Dermatitis/Eczema/Rash
Arthritis	Hepatitis	HIV/AIDS
Cancer	Liver/Gall Bladder Disorder	
Asthma	General Fatigue	For Females Only:
Dizziness	Muscular Incoordination	Birth Control Pills
Visual Disturbances	Other: _____	Hormonal Replacement
		Pregnancy

43. List all prescription medications you are currently taking:

44. List all the over-the-counter medications you are currently taking:

45. List all surgical procedures you have had:

46. What activities do you do at work?

- Sit:** Most of the day Half the day A little of the day
 Stand: Most of the day Half the day A little of the day
 Computer work: Most of the day Half the day A little of the day
 On the phone: Most of the day Half of the day A little of the day

47. Please circle the activities you do outside of work:

- | | |
|-----------------|----------------|
| Aerobics | Skiing |
| Basketball | Soccer |
| Baseball | Softball |
| Bicycling | Swimming |
| Football | Tennis |
| Golf | Triathlon |
| Hiking | Volleyball |
| Hockey | Walking |
| In-Line Skating | Weight Lifting |
| Jogging | Working Out |
| Martial Arts | Yoga |
| Rock Climbing | Other: _____ |

48. Have you ever been hospitalized for anything else? No Yes

If yes, why _____

49. Have you had any other significant past trauma? No Yes

If yes, what _____

50. Have you had any other X-rays, MRI scans, or CT scans? (circle which).

What facility were they taken at: FAHC, Vt. Radiologist,
other _____

51. Anything else pertinent to your visit today?

Informed Consent/Consent to Treat

I have been informed of the nature, purpose and scope of care to be provided by the doctors of Williston Center for Chiropractic & Sportsmedicine, the possible limitations and consequences of that care, and the possibility that the care given by Drs. Bisaccia may not completely resolve my complaint, dysfunction or condition. I consent to care and recommendations made by the doctors for myself (or my children, if minors) including, but not limited to examinations, chiropractic adjustments/manipulations, adjunctive therapies and rehabilitation. I understand that my care will be individualized and therefore may not be comparable with standards or guidelines required by insurance companies, Medicare, professional associations and/or consensus groups. I understand that my treatment will comply with the standard of care defined by the laws in the State of Vermont. I recognize that all health care procedures, including those used in this clinic, have risks associated with them. Risks, although rare, associated with chiropractic procedures may include minor aggravation of symptoms, musculoskeletal sprain/strain, neurological deficits, fracture, vertebral artery syndrome, including cerebrovascular accident (stroke) or death through complicating factors. I hereby accept the risks associated with any care by the doctors and staff of Williston Center for Chiropractic & Sportsmedicine and release Drs. Bisaccia of any liability for any injury or loss directly related to care I have received at this clinic. In the event of emergency, I grant the doctors and staff permission to provide emergency care and any follow-up necessary, including referral to Emergency Medical Services.

I am signing this consent after having been fully informed to my satisfaction of the risks and benefits of proceeding with care and declining care. I have been informed and fully understand that there are not guarantees of treatment success. By my presence and continuation of appointments, I consent and elect to care provided by Williston Center for Chiropractic & Sportsmedicine.

Patient Name (please print)

Patient Signature

Date

I have reviewed the above terms of acceptance and consent with the patient named above and I am satisfied that he/she fully understands the nature and content of the agreement.

Drs. John & Marna Bisaccia

Date

Vitals: BP _____, Pulse _____