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!

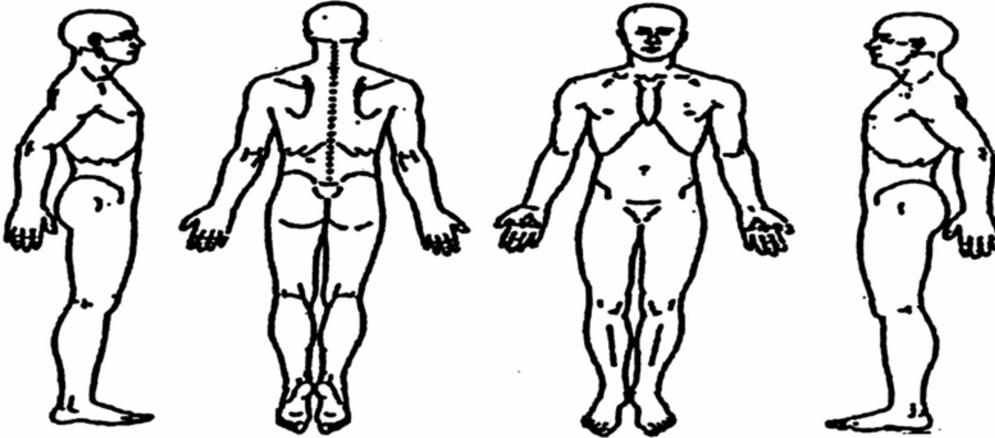
Sincerely,
Dr. John Bisaccia Dr. Marna Bisaccia

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?
□ Sharp
□ Dull
□ Diffuse
□ Achy
□ Burning
□ Shooting
□ Stiff
□ Numb
□ Tingly
□ Sharp with motion
□ Shooting with motion
□ Stabbing with motion
□ Electric like with motion
□ 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 accident?____

11. What time did the accident occur?____

12. How many vehicles were involved in the accident?________________________________

13. What was the estimated damage to the vehicle you were in? _______________________

14. What state did the accident occur in? ____

15. What city did the accident occur in? ____

16. What street or intersection were you on when the accident occurred?
____

17. What direction were you traveling in? ____

18. What type of impact was the auto accident? _______________________________________

19. Did your vehicle hit anything after the accident? if yes, please describe
____

20. Where were you sitting in the vehicle during the accident?
____

21. Did you know the accident was coming?____

22. What type of vehicle were you in? ____

23. What type of vehicle impacted yours? ____

24. At the time of the impact, how fast was your vehicle moving? ______________________

25. At the time of impact, how fast was the other vehicle moving? ______________________

26. During and after the crash what happened to your vehicle? (circle all that apply)

- kept going straight
- kept going straight hitting a car in front
- was hit by another vehicle
- spun around
- spun around and hit a stationary object
- hit a stationary object

27. Did you lose consciousness during the accident? -yes - no

28. How was your head positioned during the accident? _______________________________

29. How was your torso positioned during the accident? ______________________________

30. How were your hands positioned during the accident? _____________________________

31. Did your head hit anything during the accident?
-no - yes, please describe____________________________________

32. Did your face hit anything during the accident?

-no - yes, please describe______________________________________

33. Did your shoulders hit anything during the accident?

-no - yes, please describe______________________________________

34. Did your neck hit anything during the accident?

-no - yes, please describe______________________________________

35. Did your chest hit anything during the accident?

-no - yes, please describe______________________________________

36. Did your hips hit anything during the accident?

-no - yes, please describe______________________________________

37. Did your knees hit anything during the accident?

-no - yes, please describe_______________________________________

38. Did your feet hit anything during the accident?

-no - yes, please describe____

39. What kind of headrest was in your vehicle?

- movable fixed headrest
- non-movable fixed headrest
- no headrest

40. Where was the headrest positioned on your head? ___________________________________

41. Did you have your seatbelt on during the accident? - yes -no

42. Did you slide out of your seatbelt during the accident? ______________________________

43. What was damaged in your vehicle? (Circle all that apply)

- windshield	- rear bumper	- mirror
- steering wheel	- front bumper	- knee bolster
- dashboard	- trunk	- back right door
- seat frame	- front left door	- completely totaled
- side window	- front right door	
- rear window	- back left door	

44. Choose the items that dented inward

- floorboards - side door - dashboard

45. Choose the doors that would not open as a result of the accident

- front left - front right
- rear left - rear right

46. Did you go to the hospital? If no, why. If yes, then answer 47-52

____

47. How did you get to the hospital? _______________________________________

48. What was the name of the hospital? ____

49. Were you hospitalized over night? ___________________________________

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

51. Did you receive any stitches for any cuts at the hospital? _____________________

52. Were x rays taken at the hospital? If yes, which area was taken? _____________________

53. Do you consider the problem to be severe? ____

54. What aggravates your problem? ____

55. What alleviates your problem? ____

56. What concerns you most about your problem? _____________________________________
____

57. What is your: Height____________ **Weight** ______________
Date of Birth ____________ **Occupation**_____________________

58. How would you rate your overall Health?
□ Excellent □ Very Good □ Good □ Fair □ Poor

59. What type of exercise do you do?
□ Strenuous □ Moderate □ Light □ None

60. Indicate if you have any immediate family members with any of the following:
□ Rheumatoid Arthritis _________ □ Diabetes __________ □ Osteoarthritis __________
□ Heart Problems __________ □ Cancer ___________ □ Back pain ____________

61. 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

62. List all prescription medications you are currently taking:

____

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

____

64. List all surgical procedures you have had:

____

65. 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

66. 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: _________________

67. Have you ever been hospitalized for anything else? □ No □ Yes
If yes, why ____

68. Have you had any other significant past trauma? □ No □ Yes
If yes, what _____________________________

69. Have you had any other X-rays, MRI scans, or CT scans? (circle which).
What facility were they taken at: FAHC, Vt. Radiologist,
other____

70. 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__________