Onion River Chiropractic Registration and History

Patient Information

Date____________________
Name:____________________
Address____________________
City____________State______Zip______
SS/Patient ID#____________________
Birthdate____________________
Email____________________
Sex ☐ M ☐ F ______Height______Weight

____Married ____Widowed ____Single ____Minor
____Separated ____Divorced ____Partnered for ____years

Patient Employer____________________
Occupation____________________
Employer Phone (______)____________________
Spouse's Name____________________
*Whom may we thank for referring you?*____________________

Phone Numbers

Home Phone (___)__________Cell Phone(___)__________
IN CASE OF EMERGENCY, CONTACT
Name:________________Relationship__________
____
Cell Phone (____)__________Work Phone (___)__________

Accident Information

Is condition due to an accident? ☐ Yes ☐ No Date__________
Type of Accident ☐ Auto ☐ Work ☐ Home ☐ Other
To whom have you made a report of your accident?
☐ Auto Insurance ☐ Employer ☐ Worker Comp ☐ Other
Attorney Name (if applicable)____________________

Insurance Information

Who is responsible for this account?____________________
Relationship to patient: ____________________

Insurance Co. ____________________
ID#________________Group#__________
Is Patient covered by additional/secondary insurance? ☐ Yes ☐ No

Subscriber's Name____________________
Birthdate____________ SS#____________
Relationship to Patient ____________________
2nd Insur. Co.____________________
ID#________________Group#__________

ASSIGNMENT AND RELEASE

I certify that I, and/or my dependent(s), have insurance coverage with

____________________and assign directly to
(Name of Insurance Company(ies)

Dr. ____________________all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I authorize the use of my signature on all insurance submissions.

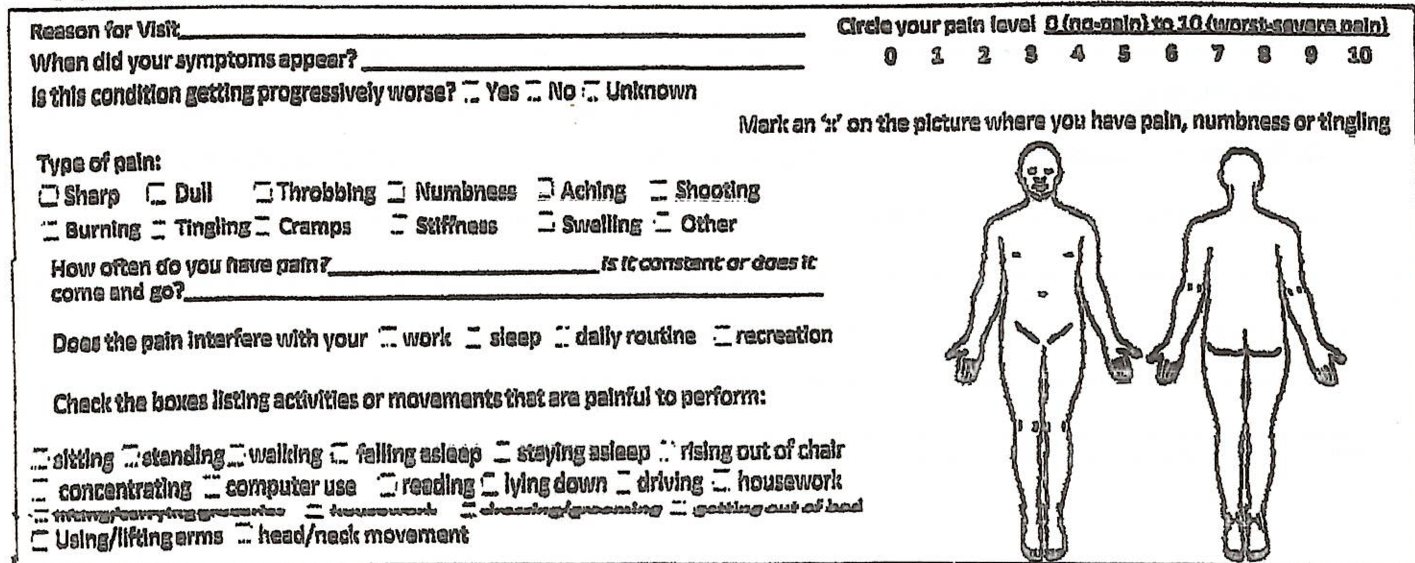
The above-named doctor may use my health care information and may disclose such information to the above-named Insurance Company and their agents for the purpose of obtaining payment for services and determining insurance benefits or the benefits payable for related services. This consent will end when my current treatment plan is completed or one year from the date signed below.

____
Signature of Patient, Parent, Guardian or Personal Representative

____
Please print name of Patient, Parent, Guardian or Personal Representative

__________ __________
Date Relationship to Patient

Patient Condition



Reason for Visit____________________
When did your symptoms appear? ____________________
Is this condition getting progressively worse? ☐ Yes ☐ No ☐ Unknown

Circle your pain level 0 (no-pain) to 10 (worst-severe pain)
0 1 2 3 4 5 6 7 8 9 10

Mark an 'x' on the picture where you have pain, numbness or tingling

Type of pain:
☐ Sharp ☐ Dull ☐ Throbbing ☐ Numbness ☐ Aching ☐ Shooting
☐ Burning ☐ Tingling ☐ Cramps ☐ Stiffness ☐ Swelling ☐ Other

How often do you have pain?____________*Is it constant or does it* come and go?____________________

Does the pain interfere with your ☐ work ☐ sleep ☐ daily routine ☐ recreation

Check the boxes listing activities or movements that are painful to perform:

☐ sitting ☐ standing ☐ walking ☐ falling asleep ☐ staying asleep ☐ rising out of chair
☐ concentrating ☐ computer use ☐ reading ☐ lying down ☐ driving ☐ housework
☐ ~~lifting/carrying groceries~~ ☐ ~~housework~~ ☐ ~~dressing/grooming~~ ☐ ~~getting out of bed~~
☐ Using/lifting arms ☐ head/neck movement

Health History

Have you ever seen a chiropractor before? ____ Yes ____ No Doctor: ____________________

What treatment have you already received for your condition? ☐ Medications ☐ Surgery ☐ Physical Therapy ☐ Other

Doctor name(s): ____________________

Imaging performed for this condition: ____X-ray _____CT _____MRI ____Other ____________________

Circle "yes" or "no" to indicate if you have had any of the following:

AIDS/HIV	Yes No	Diabetes	Yes No	Liver Disease	Yes No	Rheumatic	Yes No
Alcoholism	Yes No	Emphysema	Yes No	Measles	Yes No	Scarlet Fever	Yes No
Allergy Shots	Yes No	Epilepsy	Yes No	Migraines	Yes No	STD's	Yes No
Anemia	Yes No	Fractures	Yes No	Miscarriage	Yes No	Stroke	Yes No
Anorexia	Yes No	Glaucoma	Yes No	Mononucleosis	Yes No	Suicide Attempt	Yes No
Appendicitis	Yes No	Goiter	Yes No	Multiple Sclerosis	Yes No	Thyroid Problems	Yes No
Arthritis	Yes No	Gonorrhea	Yes No	Mumps	Yes No	Tonsillitis	Yes No
Asthma	Yes No	Gout	Yes No	Osteoporosis	Yes No	Tuberculosis	Yes No
Bleeding Disorders	Yes No	Heart Disease	Yes No	Pacemaker	Yes No	Tumors, Growths	Yes No
Breast Lump	Yes No	Hepatitis	Yes No	Parkinson's Disease	Yes No	Typhoid Fever	Yes No
Bronchitis	Yes No	Hernia	Yes No	Pinched Nerve	Yes No	Ulcers	Yes No
Bulimia	Yes No	Herniated Disk	Yes No	Pneumonia	Yes No	Vaginal Infections	Yes No
Cancer	Yes No	Herpes	Yes No	Polio	Yes No	Whooping Cough	Yes No
Cataracts	Yes No	High Blood Pressure	Yes No	Prostate Problem	Yes No	Other ________	
Chemical Dependency	Yes No	High Cholesterol	Yes No	Prosthesis	Yes No	________	
Chicken Pox	Yes No	*Kidney Disease*	Yes No	*Psychiatric Care*	Yes No	________	

Exercise	**Work Activity**	**Habits**
☐ None	☐ Sitting	Smoking: ____Current, every day ____Current, some days ____Former Smoker ____Never Smoked
☐ Moderate	☐ Standing	Alcohol: Drinks per week ________
☐ Daily	☐ Light Labor	Coffee/Caffeine Drinks: Cups per day ________
☐ Heavy	☐ Heavy Labor	High Stress Level: Reason ____________________

Preferred Language: ☐ English or other ____________________ Ethnicity: ☐ Hispanic ☐ Non-Hispanic

Race: ☐ Caucasian ☐ Black/African American ☐ Asian ☐ American Indian/Alaskan Native ☐ Native American or Pacific Islander ☐ More than one race ☐ Other

Are you pregnant? ☐ Yes ☐ No Due Date ____________________

Injuries/Surgeries you have had:	*Description*	*Date*
Falls/Head Injuries	____________________	________
Fractures/Dislocations	____________________	________
Surgeries	____________________	________
X-rays/CT/MRI taken	____________________	________

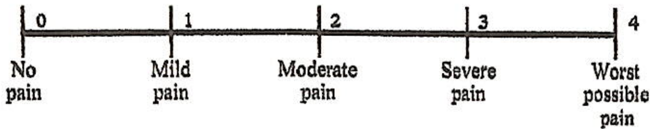
Medications Presently Taking	**Allergies to Medication**	**Vitamins/Herbs/Minerals**
________	________	________
________	________	________
________	________	________
________	________	________
________	________	________

Functional Rating Index

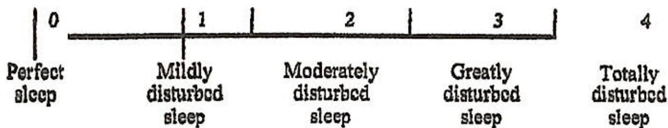
For use with **Neck and/or Back Problems** only.

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

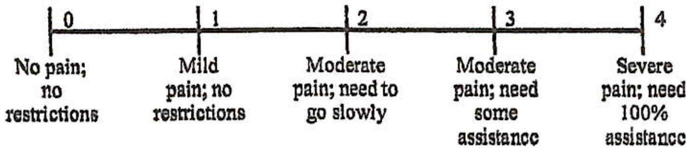
1. Pain Intensity



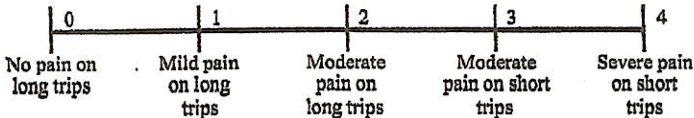
2. Sleeping



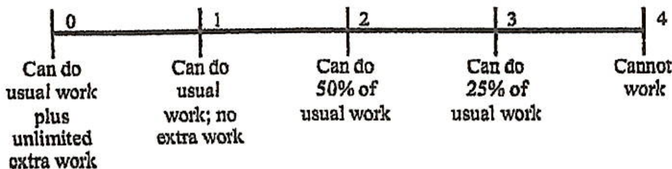
3. Personal Care (washing, dressing, etc.)



4. Travelling (driving, etc.)

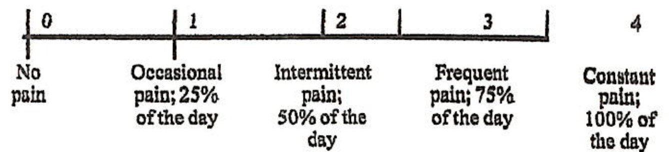


5. Work

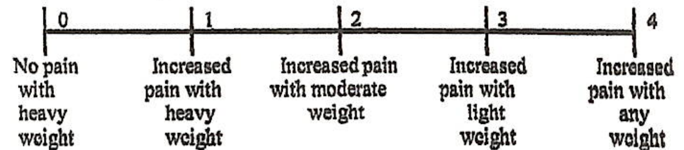


6. Recreation

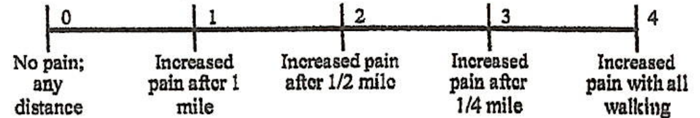
7. Frequency of Pain



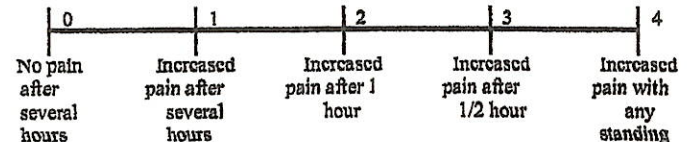
8. Lifting



9. Walking



10. Standing



______________________________ **Patient's Signature**

______________________________ **Date**

For Office Use Only:

Practitioner ID#: ______________________________

Total Score ______________/40

Clinical Diagnosis Codes:

Patient ID#: ______________________________

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As part of your treatment here, soft tissue massage may be recommended to treat your condition. However, due to issues with some insurance companies this may not be a billable service.

In instances when the massage is not billable, there will be a $20.00 charge in addition to your copay. If you do not wish to have this service performed, please let us know before treatment.

Signature:________________________________

Printed Name:______________________________

Date:___________

ONION RIVER CHIROPRACTIC

440 MAIN STREET • WINOOSKI, VERMONT 05404 • (802) 655-0354

ONION RIVER CHIROPRACTIC OFFICE POLICY

* PAYMENT FOR INITIAL EXAMINATION IS DUE AT TIME OF TREATMENT UNLESS OTHER ARRANGEMENTS ARE MADE.

* ONION RIVER CHIROPRACTIC WILL DIRECT BILL SOME INSURANCE CARRIERS. PLEASE ASK IF YOURS APPLIES.

* PAYMENT OF INSURANCE DEDUCTIBLES AND/OR CO-PAYMENTS ARE DUE AT TIME OF TREATMENT UNLESS OTHER ARRANGEMENTS ARE MADE.

* IN ORDER FOR CHIROPRACTIC TREATMENT TO BE EFFECTIVE A FREQUENCY OF VISITS HAS BEEN DETERMINED FOR EACH PATIENT. PATIENTS ARE EXPECTED TO MAINTAIN THEIR PERSONAL TREATMENT PLAN.

* IN CONSIDERATION OF OTHER PATIENTS, ALL PATIENTS ARE EXPECTED TO ARRIVE AT THIS OFFICE AT THEIR PRE-ARRANGED APPOINTMENT TIME. LATE PATIENTS OR WALK-INS WILL BE ATTENDED TO AS TIME PERMITS.

* 24 HOUR NOTICE MUST BE GIVEN TO CANCEL AN APPOINTMENT. IF NO NOTICE IS RECEIVED A $30.00 CHARGE WILL BE ASSESSED.

I have read and understand the above notice

Signature:______________________________________

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PRIVACY NOTICE ACKNOWLEDGEMENT

We are very concerned with protecting your privacy, especially in matters that concern your personal health information. In accordance with the *Health Insurance Portability and Accountability Act* of 1996 (HIPAA), we are required to supply you with a copy of our privacy policies and procedures. Copies of this policy are available in the blue folder on the table or on the bulletin board. If you'd like a copy for your records, please ask at the front desk. We encourage you to read this document carefully, for it outlines the use and limitations of the disclosure of your health information and your rights as a patient. If you ever have any questions or concerns regarding the use or dissemination of your personal health information we would be happy to address them.

I acknowledge that I have received a copy of
Notice of Privacy Practices for Protected Health Information.

____
Patient Name (please print)

____
Date

____
Patient Signature

____
Authorized Provider Rep.

____
Personal Representative (Please print)

____
Personal Rep. Signature

____
Description of Personal Rep.'s authority to act for the patient:

ONION RIVER CHIROPRACTIC: INFORMED CONSENT

As with all health care professions, Chiropractic is associated with very rare potential risks in the delivery of treatment. While Chiropractic is extremely safe, it is our policy that all patients read and understand fully those possible risks involved with the chiropractic treatment prior to initiating treatment. Please understand that we are highly trained in patient examination and evaluation, allowing us to avoid many of the risks herein.

Stroke is the most serious known complication of Chiropractic treatment. It occurs in very rare circumstances after cervical manipulation and is due to an injury to the vertebral artery. Cervical treatment posts a very small risk. The most recent studies indicate that the incidence of stroke is approximately one in every three million cervical adjustment. Practitioners can lower this occurrence even further with proper orthopedic testing and history taking during their examination. Soreness may occur as a side effect after the adjustment and can last for 24-48 hours. This is a normal and accepted response to chiropractic care. If you do feel any abnormal amount of pain or if you are uncomfortable for a prolonged period of time following treatment, please inform us. *Soft tissue injury may result from* chiropractic care. On occasion discs, joints, ligaments and tendons can become irritated from an adjustment. Rib injury or fracture is a rare side effect of thoracic spine manipulation. Treatment is provided carefully to avoid such circumstances. Physical therapy modalities may cause rare minor burns to the skin and should be reported to the doctor or staff member if they occur. Other rare side effects may occur as a result of Chiropractic care and should be immediately reported to the doctors or staff of Onion River Chiropractic.

While we make it a goal to provide the best possible treatment for every one of our patients, it is important that patients understand that we cannot promise a cure for every symptom, condition or disease as a result of treatment in our office. Every attempt will be made to treat your condition to the best of our abilities and if we do not achieve the results we hope for, we will refer you to another provider who we feel can better assist you with your condition. If you have any questions or concerns with the above mentioned material or at any point during your course of care please feel free to ask questions. When you have full understanding of the above mentioned material and consent to receiving chiropractic care in our office, please print your name, sign and date below.

PRINT NAME:_______________________________

SIGNATURE: _______________________________ DATE: _______________

WHAT TO EXPECT FOLLOWING SPINAL MANIPULATION OR AN ADUSTMENT

The purpose of spinal manipulation is to realign misaligned vertebrae, restore proper joint functioning and intersegmental motion and, of course, to reduce joint-related pain. Your doctor of chiropractic uses methods such as observation and static and motion palpation of the vertebrae or joint to identify these dysfunctional areas.

Generally, spinal manipulation is not uncomfortable or painful and usually is quite relieving in nature. Patients commonly experience the feeling of decreased pressure or decreased compression in the spinal segments or joints following a spinal adjustment. Occasionally, especially if the muscle tissue surrounding the joints is taut or spasmed or if the spinal/joint segments have been restricted or misaligned for a long period of time, the adjustment may be uncomfortable. Fortunately if this occurs, the discomfort is typically momentary following the adjustment.

Occasionally, one may be sore following the treatment but this is not typical and will frequently pass within 1-2 days. If you are sore for more than 1-2 days, please discuss this with the doctor at your next visit. Typically, icing the area for 15-20 minutes following a treatment shortens the period of soreness. Remember, this is not a common event and your spine may need time to adapt to a new, more correct position or alignment on the journey to healing.

WHAT TO EXPECT FOLLOWING SOFT TISSUE MASSAGE THERAPY

Our goal with therapeutic soft tissue massage is to help release muscular tightness, adhesions and "knots" in the muscles which are either specifically ***causing*** your condition or ***contributing*** to the chronic patterning of your condition (i.e., muscular tightness which is causing spinal vertebrae to remain out of alignment, restricted or subluxated).

When you are having therapeutic soft tissue massage performed, the treatment should not be painful. However, in order to be effective, the massage should be deep enough to help decrease the muscular tension and release the tight bands and trigger points. Remember, the goal in our office is ***not*** relaxation massage (as nice as that is). The day following the soft tissue work, you may experience some soreness (or maybe not at all). If you do experience this, it should pass within 2 days and then you will overall feel improved. If you experience soreness for more than 2 days, or you are very sore, you should inform the doctor at your next visit and we will adjust the intensity of the soft tissue work.

The treatment process often takes time to help improve or reduce the "knots" or adhesions. Sometimes a few visits suffice and other times it may be a maintenance process to help reduce the size and negative effects of the muscular tightness or trigger points. Prescribed stretching and exercises may be recommended by the doctor and will often augment and speed up the healing process. Patience with the treatment process is often necessary in advanced or very chronic cases. However, with time, patience, and adherence to the treatment plan, you should succeed in improving or resolving your condition.

Massage Therapy at Onion River Chiropractic

Massage is not just a luxury anymore. According to the National Institute of Health, regular massage may help control pain and ease the effects of depression, cancer, fibromyalgia, and AIDS. Research also shows that massage can improve athletic performance and speed recovery. These studies confirm what we have seen first-hand: massage is a vital part of overall wellness.

Along with improving overall health, massage therapy is the perfect complement to chiropractic treatment. Both are natural, hands-on, drug-free techniques. In addition, receiving a massage before or after a chiropractic adjustment aids in the adjustment itself. Massage relaxes tight muscles, decreases inflammation and spasm, and reduces overall body tension. Tight muscles can pull bones and joints out of alignment; a massage helps the adjustment last longer by releasing muscular tension and allowing the vertebrae to stay in place.

At Onion River Chiropractic, our massage therapists work in-house and are uniquely skilled to help treat a variety of health problems. And they work with Dr. Rybicki as part of a specific plan to treat your unique condition. Dr. Rybicki is one of the few chiropractors in the area who works with in-house *massage therapists.*

Half hour or 1 hour massages can be scheduled during regular business hours with or without accompanying chiropractic adjustment. To schedule a longer massage or to schedule outside regular business hours, please speak with a massage therapist for availability.

Rates and Times:
½ hour session: $45
1 hour session: $80

Therapists accept cash, checks, and most credit cards (HSA cards must be charged directly through ORC for an additional $3 fee, unless the payment is made with your chiropractic co-pay). Some insurance companies cover doctor-directed massage; Dr. Rybicki will advise you *if that is the case.*

NEW PATIENT SPECIAL OFFER!!

Experience the benefits of massage for yourself! **New patients who book a 1 hour massage within 30 days of their first chiropractic appointment will receive a $10 discount.** Book your massage appointment today at the front desk!