

# 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) \_\_\_\_\_

## 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

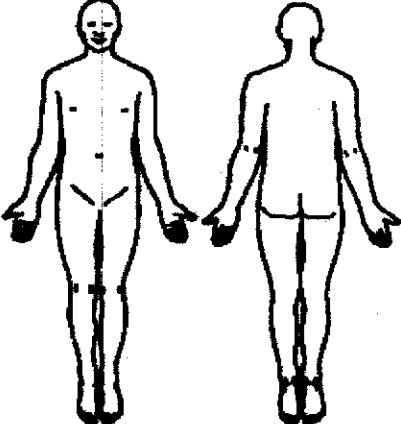
Type of pain:  
 Sharp  Dull  Throbbing  Numbness  Aching  Shooting  
 Burning  Tingling  Cramps  Stiffness  Swelling  Other \_\_\_\_\_

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



## 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 \_\_\_\_\_

# 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**

- None
- Moderate
- Daily
- Heavy

**Work Activity**

- Sitting
- Standing
- Light Labor
- Heavy Labor

**Habits**

Smoking:  Current, every day  Current, some days  Former Smoker  Never Smoked  
 Alcohol: Drinks per week \_\_\_\_\_  
 Coffee/Caffeine Drinks: Cups per day \_\_\_\_\_  
 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 _____		

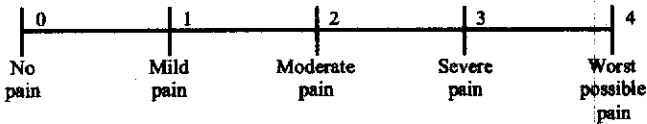
Medications Presently Taking	Allergies to Medication	Vitamins/Herbs/Minerals
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

# Functional Rating Index

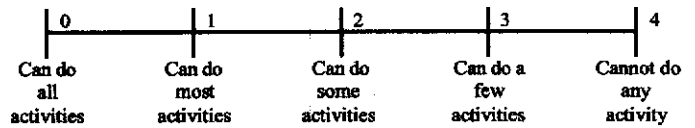
For use with Neck and/or Back Problems only.

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.**

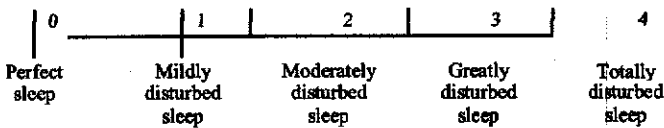
## 1. Pain Intensity



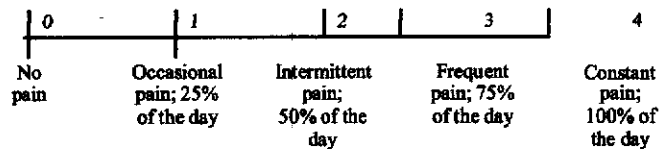
## 6. Recreation



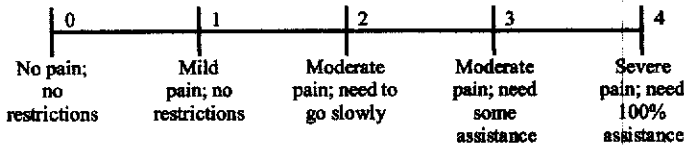
## 2. Sleeping



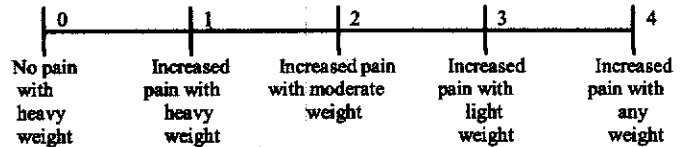
## 7. Frequency of Pain



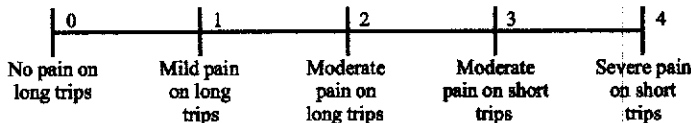
## 3. Personal Care (washing, dressing, etc.)



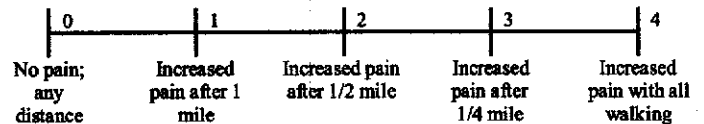
## 8. Lifting



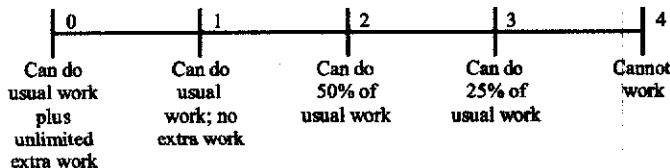
## 4. Travelling (driving, etc.)



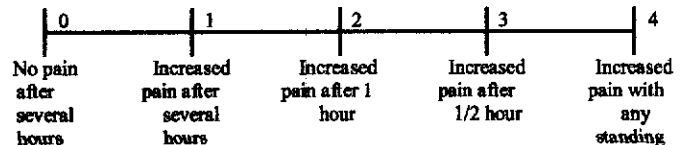
## 9. Walking



## 5. Work



## 10. Standing



\_\_\_\_\_  
Patient's Signature

\_\_\_\_\_  
Date

### For Office Use Only:

Practitioner ID#: \_\_\_\_\_

Total Score \_\_\_\_\_ / 40

Clinical Diagnosis Codes:

Patient ID#: \_\_\_\_\_



# ONION RIVER CHIROPRACTIC

440 MAIN STREET • WINOOSKI, VERMONT 05404 • (802) 655-8354

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## 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: \_\_\_\_\_



## **ONION RIVER CHIROPRACTIC**

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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 \$22 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

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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 ADJUSTMENT

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: \$50

1 hour session: \$90



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!