Southern Connecticut Chiropractic

Scott J Rocchio DC, LLC

Name_____ Age_____ DOB____/____/_____ Male □ Female □

Address_____ City_____ State_____ Zip_____

Home Phone_____ Cell_____ Email_____

Employer_____ Occupation_____

Name of Spouse_____ Spouse's Employer_____

Names & Ages of Children_____

Name and Number of Emergency Contact_____

Whom may we thank for referring you to this office?_____

CHIROPRACTIC CASE HISTORY

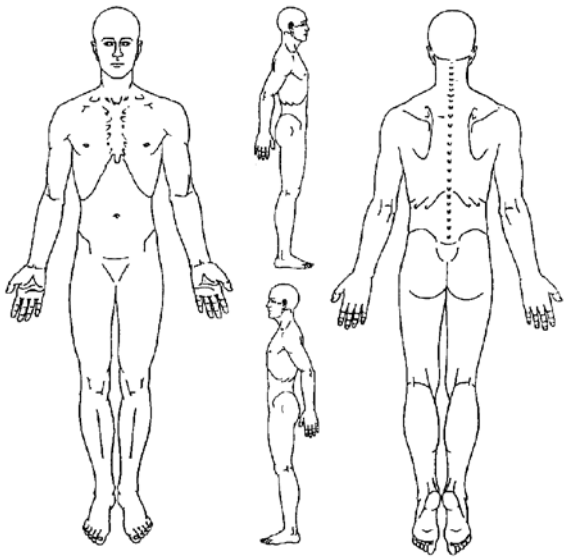
Please identify the condition(s) that brought you to this office:

Primary:_____ Second:_____

Third:_____ Fourth:_____

Rate the severity of the above complaint(s) on a scale of 0-10:

Primary:	0	1	2	3	4	5	6	7	8	9	10
Second:	0	1	2	3	4	5	6	7	8	9	10
Third:	0	1	2	3	4	5	6	7	8	9	10
Fourth:	0	1	2	3	4	5	6	7	8	9	10



*Fill in <u>all</u> areas of discomfort on the figure to the right by using the following letters: **A** – aching **B** – burning **D** – dull **N** – numbness **R** – radiating **S** – sharp **T** – tingling

When did this problem begin?_____ Has it ever occurred before? □ Yes □ No

The problem is worse in: □ AM □ PM □ At Night □ With Activity (bending, lifting, sitting, standing)

Frequency of complaint is: □ Constant □ On/off during day □ Comes and goes throughout the week

Is condition related to? □ Auto Accident □ Work Injury □ No Injury □ Other_____

Has this condition ever been treated by anyone in the past? □ No □ Yes, Dr._____ Date_____

How long were you under care?_____ What were the results?_____

Have you ever received chiropractic care? □ No □ Yes, Dr. Name_____ Date of last visit_____

What makes you feel better?_____ What makes you feel worse?_____

DAILY ACTIVITIES	What kind of effect does your condition have on the following? Check all that apply.			
Bathing	□ No Effect	□ Painful (can do)	□ Painful (limits)	□ Unable to Perform
Bending	□ No Effect	□ Painful (can do)	□ Painful (limits)	□ Unable to Perform
Carrying	□ No Effect	□ Painful (can do)	□ Painful (limits)	□ Unable to Perform
Climbing	□ No Effect	□ Painful (can do)	□ Painful (limits)	□ Unable to Perform
Computer Work	□ No Effect	□ Painful (can do)	□ Painful (limits)	□ Unable to Perform
Concentration	□ No Effect	□ Painful (can do)	□ Painful (limits)	□ Unable to Perform
Dancing	□ No Effect	□ Painful (can do)	□ Painful (limits)	□ Unable to Perform
Doing Chores	□ No Effect	□ Painful (can do)	□ Painful (limits)	□ Unable to Perform
Dressing	□ No Effect	□ Painful (can do)	□ Painful (limits)	□ Unable to Perform
Driving	□ No Effect	□ Painful (can do)	□ Painful (limits)	□ Unable to Perform
Exercising	□ No Effect	□ Painful (can do)	□ Painful (limits)	□ Unable to Perform
Gardening	□ No Effect	□ Painful (can do)	□ Painful (limits)	□ Unable to Perform
Lifting	□ No Effect	□ Painful (can do)	□ Painful (limits)	□ Unable to Perform
Playing Sports	□ No Effect	□ Painful (can do)	□ Painful (limits)	□ Unable to Perform
Pushing	□ No Effect	□ Painful (can do)	□ Painful (limits)	□ Unable to Perform
Reading	□ No Effect	□ Painful (can do)	□ Painful (limits)	□ Unable to Perform
Recreational Activities	□ No Effect	□ Painful (can do)	□ Painful (limits)	□ Unable to Perform
Rolling Over	□ No Effect	□ Painful (can do)	□ Painful (limits)	□ Unable to Perform
Running	□ No Effect	□ Painful (can do)	□ Painful (limits)	□ Unable to Perform
Sexual Activities	□ No Effect	□ Painful (can do)	□ Painful (limits)	□ Unable to Perform
Sitting / Standing	□ No Effect	□ Painful (can do)	□ Painful (limits)	□ Unable to Perform
Sleep	□ No Effect	□ Painful (can do)	□ Painful (limits)	□ Unable to Perform
Yard Work	□ No Effect	□ Painful (can do)	□ Painful (limits)	□ Unable to Perform
Walking	□ No Effect	□ Painful (can do)	□ Painful (limits)	□ Unable to Perform
Watching TV	□ No Effect	□ Painful (can do)	□ Painful (limits)	□ Unable to Perform
Working	□ No Effect	□ Painful (can do)	□ Painful (limits)	□ Unable to Perform

Please label the lines below by using the following letters: **C** – current **P** – past (over 6 months ago) **N** – never

__ADD/ADHD	__Allergies	__Anxiety	__Asthma	__Bed Wetting
__Blurred Vision	__Cancer	__Chest Pain	__Circulation	__Colon Trouble
__Convulsions	__Depression	__Digestion	__Dizziness	__Double Vision
__Ear / Hearing	__Eating Disorder	__Fainting	__Flu/frequent colds	__Gall Bladder
__Headache	__Heartburn	__Heart Problem	__Hepatitis (A, B, C)	__Hormone
__Impotence	__Irritability / Mood	__Jaw pain / TMJ	__Kidney Problem	__Liver Problem
__Loss of Balance	__Low Energy	__Lung Problem	__Muscle Spasm	__Nausea/Vomiting
__Nose Bleed	__Rash / Skin	__Scoliosis	__Sinus	__Sleep
__Swollen Joint	__Tremors	__Thyroid	__Ulcers	__Weight Gain/Loss

FEMALES ONLY:	__Irregular Period	__Painful Period	__No Period	__Hot Flashes
Are you pregnant?	__ Yes __ No	__ Not Sure		

List all medications currently used: Provide reason for use and length of time on medication:

Check surgeries or procedures that apply. □ I have never had any surgeries or procedures.

□ Appendix	□ C-Section	□ Chemotherapy	□ Gall Bladder	□ Heart
□ Hernia	□ Reproductive	□ Spine	□ Thyroid	□ Vaccinations

Other

List any conditions or diseases not previously mentioned

RESTRICTED ACTIVITIES	CURRENT ACTIVITY LEVEL	USUAL ACTIVITY LEVEL
1.		
2.		
3.		
4.		

Rate your stress level on a scale of 0-10: Cause of stress

Describe sleep patterns: List any hobbies

Alcohol drinks/day
Coffee cups/day
Smoking cigarettes/day
Water cups/day

EXERCISE
□ None
□ 3-4 times/week
□ Daily

FAMILY HISTORY	Spine	Cancer	Diabetes	Heart
Mother	□	□	□	□
Father	□	□	□	□
Siblings	□	□	□	□

On a scale of 1 to 10 with 10 being the highest, rate your commitment to getting rid of the problem:

Please specify any concerns that could interfere with your commitment (example: time, transportation, other)

Do you have Health Insurance? □ No (many of our patients do not) □ Yes (please complete the box below)

Insured's Name DOB / / SSN - -

Insurance Company Policy Number

I hereby authorize payment to be made directly to Southern Connecticut Chiropractic for all benefits which may be payable under a healthcare plan or from any other collateral sources. I authorize utilization of this application or copies thereof for the purpose of processing claims and effecting payments, and further acknowledge that this assignment of benefits does not in any way relieve me of payment liability and that I will remain financially responsible Southern Connecticut Chiropractic for any and all services I receive.

Patient Signature Date Completed

Doctor Signature Date Reviewed

Informed Consent

Regarding: Chiropractic Adjustments, Modalities, and Therapeutic Procedures

I have been advised that chiropractic care, like all forms of health care, holds certain risks. While the risk are most often very minimal, in rare cases, complications such as sprain/strain injuries, irritation of a disc condition, and although rare, minor fractures have been associated with chiropractic adjustments. Treatment objectives as well as the risks associated with chiropractic adjustments and, all other procedures provided at Southern Connecticut Chiropractic have been explained to me to my satisfaction and I have conveyed my understanding of both to the doctor. After consideration, I do hereby consent to treatment by any means, method, and or techniques, the doctor deems necessary to treat my condition at any time throughout the entire clinical course of my care.

PRINT NAME_____ SIGNATURE_____ DATE_____  *WITNESS INITIALS*

Regarding: X-Rays, Imaging Studies

By my signature below I am acknowledging that the doctor and/or a member of the staff has discussed with me the risks associated with exposure to x-rays. After consideration I therefore, do hereby consent to have the diagnostic x-ray examination the doctor has deemed necessary in my case.

PRINT NAME_____ SIGNATURE_____ DATE_____  *WITNESS INITIALS*

Notice of Privacy Practices (HIPAA)

This Notice of Privacy Practices describes how we may use and disclose your protected health information (PHI) to carry out treatment, payment or health care operations (TPO) and for other purposes that are permitted or required by law. It also describes your rights to access and control your protected health information. "Protected health information" is information about you, including demographic information, that may identify you and that relates to your past, present or future physical or mental health or condition and related health care services.

Uses and Disclosures of Protected Health Information
Your protected health information may be used and disclosed by your physician, our office staff and others outside of our office that are involved in your care and treatment for the purpose of providing health care services to you, to pay your health care bills, to support the operation of the physician's practice, and any other use required by law.

Treatment: We will use and disclose your protected health information to provide, coordinate, or manage your health care and any related services. This includes the coordination or management of your health care with a third party. For example, we would disclose your protected health information, as necessary, to a home health agency that provides care to you. For example, your protected health information may be provided to a physician to whom you have been referred to ensure that the physician has the necessary information to diagnose or treat you.

Payment: Your protected health information will be used, as needed, to obtain payment for your health care services. For example, obtaining approval for a hospital stay may require that your relevant protected health information be disclosed to the health plan to obtain approval for the hospital admission.

Healthcare Operations: We may use or disclose, as-needed, your protected health information in order to support the business activities of your physician's practice. These activities include, but are not limited to, quality assessment activities, employee review activities, training of medical students, licensing, and conducting or arranging for other business activities. For example, we may disclose your protected health information to medical school students that see patients at our office. In addition, we may use a sign-in sheet at the registration desk where you will be asked to sign your name and indicate your physician. We may also call you by name in the waiting room when your physician is ready to see you. We may use or disclose your protected health information, as necessary, to contact you to remind you of your appointment. We may use or disclose your protected health information in the following situations without your authorization. These situations include: as Required By Law, Public Health issues as required by law, Communicable Diseases: Health Oversight: Abuse or Neglect: Food and Drug Administration requirements: Legal Proceedings: Law Enforcement: Coroners, Funeral Directors, and Organ Donation: Research: Criminal Activity: Military Activity and National Security: Workers' Compensation: Inmates: Required Uses and Disclosures: Under the law, we must make disclosures to you and when required by the Secretary of the Department of Health and Human Services to investigate or determine our compliance with the requirements of Section 164.500.

Other Permitted and Required Uses and Disclosures Will Be Made Only With Your Consent, Authorization or Opportunity to Object unless required by law.

You may revoke this authorization, at any time, in writing, except to the extent that your physician or the physician's practice has taken an action in reliance on the use or disclosure indicated in the authorization.

Your Rights. Following is a statement of your rights with respect to your protected health information.

You have the right to inspect and copy your protected health information. Under federal law, however, you may not inspect or copy the following records; psychotherapy notes; information compiled in reasonable anticipation of, or use in, a civil, criminal, or administrative action or proceeding, and protected health information that is subject to law that prohibits access to protected health information.

You have the right to request a restriction of your protected health information. This means you may ask us not to use or disclose any part of your protected health information for the purposes of treatment, payment or healthcare operations. You may also request that any part of your protected health information not be disclosed to family members or friends who may be involved in your care or for notification purposes as described in this Notice of Privacy Practices. Your request must state the specific restriction requested and to whom you want the restriction to apply.

Your physician is not required to agree to a restriction that you may request. If physician believes it is in your best interest to permit use and disclosure of your protected health information, your protected health information will not be restricted. You then have the right to use another Healthcare Professional.

You have the right to request to receive confidential communications from us by alternative means or at an alternative location. You have the right to obtain a paper copy of this notice from us, upon request, even if you have agreed to accept this notice alternatively i.e. electronically.

You may have the right to have your physician amend your protected health information. If we deny your request for amendment, you have the right to file a statement of disagreement with us and we may prepare a rebuttal to your statement and will provide you with a copy of any such rebuttal.

You have the right to receive an accounting of certain disclosures we have made, if any, of your protected health information. We reserve the right to change the terms of this notice and will inform you by mail of any changes. You then have the right to object or withdraw as provided in this notice.

Complaints. You may complain to us or to the Secretary of Health and Human Services if you believe your privacy rights have been violated by us. You may file a complaint with us by notifying our privacy contact of your complaint. **We will not retaliate against you for filing a complaint.**

This notice was published and becomes effective on/or before **April 14, 2003.**

I authorize Southern Connecticut Chiropractic and it's agents to give information regarding my treatment at Southern Connecticut Chiropractic to family members, work associates or others over the telephone. I also authorized Southern Connecticut Chiropractic and it's agents to leave information regarding my treatment on my home, cellular, and office voicemail and other messaging systems that may be appropriate. This information may include, but not limited to, appointment reminders and incoming calls concerning your treatment and appointment times. We are required by law to maintain the privacy of, and provide individuals with, this notice of our legal duties and privacy practices with respect to protected health information. If you have any objections to this form, please ask to speak with our HIPAA Compliance Officer in person or by phone at our Main Phone Number.
Signature below is only acknowledgement that you have received this Notice of our Privacy Practices:

PRINT NAME_____ SIGNATURE_____ DATE_____  *WITNESS INITIALS*

I hereby acknowledge receiving a copy of a one page document titled ‘Southern Connecticut Chiropractic Office Policies’ (next page). I have read ‘Southern Connecticut Chiropractic Office Policies’ in its entirety and have retained it for my personal records. This page is recognized by me as the signature page and will be retained by Southern Connecticut Chiropractic as evidence of my receiving and understanding this notice. I further acknowledge that any concerns regarding these policies, as well as all of my questions, have been answered by a member of the staff to my complete satisfaction.

PRINT NAME_____ SIGNATURE_____ DATE_____  *WITNESS INITIALS*

SOUTHERN CONNECTICUT CHIROPRACTIC OFFICE POLICIES

Welcome to Southern Connecticut Chiropractic!

As a potential new patient, we feel it is important that you understand our office policies regarding how patients of this practice are cared for, and the various methods we offer to facilitate payment for that care. Please read each policy carefully so there is no misunderstanding as to what you can expect as a patient of this practice, and what we expect in return. Once you have read the "Office Policies", if you have any questions or any of these policies are unclear to you or you would like further explanation before submitting your "Application for Care", please let our front desk receptionist know and a member of our staff will be happy to discuss them with you further. We believe it is in everyone's best interests to provide potential new patients as much information as possible about how the doctors at this office practice chiropractic so that an informed decision can be made as to whether they wish to become a patient.

Over time, individuals who are accepted as patients at this office, gain a greater understanding as to the purpose of chiropractic. Since the majority of patient care occurs in an open bay area, patients have a unique opportunity to observe firsthand the positive results that are achieved and the benefits derived from being under chiropractic care. This knowledge and awareness creates a positive environment that promotes healing and encourages families to maintain good health. We want your experience with us to be an exceptional one, so help us to help you and together we can make positive changes in your life and the lives of those you care about.

□ **PATIENT PRIVACY** – Since the majority of patient care takes place in an open bay area it is important to understand that any conversations you have with the doctor can be overheard by other patients. In order to maintain patient privacy it is the policy of this practice to refrain from discussing any confidential matters with patients during office hours while patients are being adjusted. If you have a confidential matter you wish to discuss please let us know and we will schedule time for you to speak to the doctor in private. These consultations must be scheduled in advance!

□ **YOUR CARE** – When a patient seeks chiropractic health care and we agree to provide that care, it is essential for the patient and the doctor to be working toward the same objective. Chiropractic care at Southern Connecticut Chiropractic is rendered primarily to minimize and reduce subluxations that interfere with the expression of the body's innate ability to heal. The doctors use a myriad of techniques to accomplish this goal, including but not limited to Activator Methods, Diversified, Thompson, Toggle Recoil, and Upper Cervical techniques. It is important that you understand both the objective and the method(s) so there is no confusion or disappointment. Tremendous progress has been made in the rehabilitating and correction of spinal problems. Where in the past, chronic spinal structural problems could not be reversed or corrected, today they can. The doctor will outline a course of care that will take you beyond simple pain relief, through two distinct phases of care to make a structural correction to your spine that will enable your central nerve system to function optimally, thereby improving you overall health.

□ **FIRST THING FIRST** – Prior to receiving chiropractic care at this office, a health history and examination will be completed. Imaging studies as well as any other necessary diagnostics may also be ordered, to confirm the cause of your condition and exact location of any subluxations. The results of these procedures will aid in assessing your presenting problem, your overall health and, in particular, the condition of your spine. They will also assist the doctor in determining the type and amount of care you will need. All relevant findings will be reported to you along with care plan recommendations so that you can make the best possible decision regarding your health care needs. Our gold standard for care is to reduce and remove subluxations while teaching patients what they need to do in addition to being adjusted to experience amazing health for a lifetime.

□ **PATIENT'S REPORT OF FINDINGS** – To enhance your understanding of the chiropractic approach that will be used to manage your health, immediately following your first adjustment, you will be scheduled for a 'Patient's Report of Findings'. The information you receive at this appointment will be both informative and clinically relevant to your case, therefore attendance is required for individuals who wish to become new patients at Southern Connecticut Chiropractic. Because the results of your x-rays and all examinations as well as the doctors' recommendations for care will be discussed at that time, we strongly urge new patients to invite their spouse or significant other to attend. We know from experience that when a patient's family understands the goals and objectives of chiropractic care and how restoring and maintaining good health can affect their lives as well, they become infinitely supportive and helpful in making important decisions concerning care options.

~ PATIENT RETAINS THIS PAGE FOR PERSONAL RECORDS ~