

Date: ___/___/___
File #: _____

Steven M. Remillard, M.A., D.C.
Director



4079 Derry Street
Harrisburg, PA 17111

PH: (717) 558-9292
Fax: (717) 558-2006

Web: <http://www.capchiro.com>

Personal:

Name: _____ DOB ___/___/___ Age: ___ Date: ___-___-___ Sex: M F
Street: _____ Apt #: _____ City & State: _____ Zip: _____
Phone #: (___) ___-___ Social Security #: ___-___-___ Referred by: _____
Marital Status: S M D W Spouse: _____ Number of Children: _____

Work:

Employer: _____ Phone #: (___) ___-___ Address: _____
Position: _____ How Long: _____
Activities: Lifting Standing Computer Driving Phone Other: _____

Insurance:

Private Ins. Medicare Medicaid Worker's Comp. Personal Injury Cash
Insurance Company _____ Policy Holder's Name: _____ Policy holder's DOB: ___/___/___

Complaint:

Work Injury Car Accident Personal Injury General Care
What hurts most? _____
How long has it bothered you? _____ What is the cause? _____
Frequency: Constant Now and then
Type: Sharp Dull Burning Tingling Weakness Throbbing Cramp Other: _____

Do you Smoke? Yes No
How much? More than 1 pack/day
 Less than 1 pack/day
How Long? _____
Do you drink Alcohol/Coffee/Soda? (Please circle)
How Much? _____
How Often? _____

Are you on a diet? Yes No
Which Kind? _____
How Long: _____

Any family history of health problems?
 Heart High Blood Pressure Cancer
 Diabetes Stroke Overweight Back Pain
 Other _____

Are you suffering from the following stresses?

	None	A little	Moderate	A lot
Personal	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Work	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
School	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Family	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

How much sleep do you get? None 1-4 Hrs. 4-6 Hrs.
 6-8 Hrs. 8-10 Hrs. 10+ Hrs.

Do you Exercise? Yes No
How Often? 1-3t/week 3+t/week
What Kind? Wt. Lifting Aerobic Swimming
 Bicycling Running Stretching Other: _____

Do you have any bowel problems? Yes No
What Kind? Constipation Diarrhea Blood IBS

Do you have any eating disorders? Yes No
What Kind? _____ How Long? _____

Do you experience any of the following?
 Headaches Joint Problems Sinus Pain
 Menstrual Problems Allergies Dizziness
 Sexual Problems Ear Ache/Ringing Fatigue
 Repeated Infections Sleep Problems Snoring
 Weakness Breathing Problems Quick Temper
 Hyperactivity Depression Skin Problems
 Swallowing Problems

When is the last time you felt really good?

Recently Not for a While

(All information provided in this record is strictly confidential!) All information is true and accurate to the best of my knowledge.

Patient (Guardian) Signature _____

Date ___/___/___



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Red Flag Questionnaire

Name: _____ Age: _____ Date: _____

Please check the appropriate response. If "yes", please explain. If you are not sure, check the "?" box.
Thank You!

- | | | | |
|--------------------------|--------------------------|--------------------------|---|
| Yes | No | ? | |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Do you have a past history of cancer? |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Have you had unexplained weight loss? |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Does your pain improve with rest? |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Are you over 50 years old? |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Failure to respond to a course of consecutive care (4-6 weeks)? |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Have you had spinal pain greater than 4 weeks? |
| | | | |
| Yes | No | ? | |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Prolonged use of corticosteroids (such as organ transplant Rx)? |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Intravenous drug use? |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Current or recent urinary tract, respiratory tract or other infection? |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Immunosuppression medication &/or condition? |
| | | | |
| Yes | No | ? | |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | History of significant trauma? |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Minor trauma in person >50 years old? |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Do you have osteoporosis (weak bones)? |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Are you over 70 years old? |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Any history of prolonged use of corticosteroids? |
| | | | |
| Yes | No | ? | |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Acute onset urinary retention or overflow incontinence (wet underwear)? |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Loss of anal sphincter tone or fecal incontinence (bowel accidents)? |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Saddle anesthesia (numbness in groin region)? |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Global or progressive muscle weakness in the legs (legs give out)? |

Comments: _____



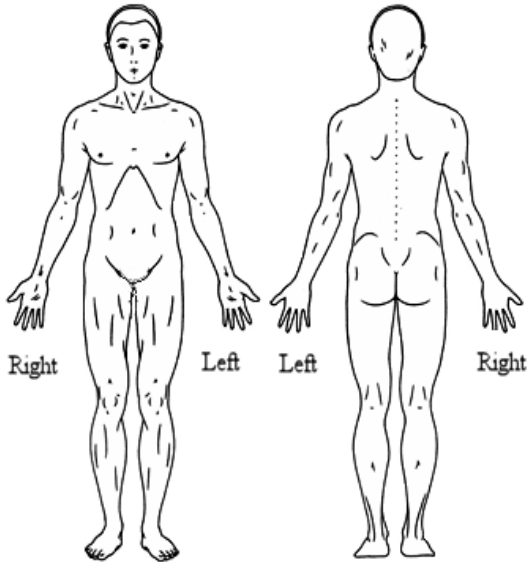
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Using the symbols below, mark on the pictures where you feel pain



Numbness

Dull Ache

Burning

Sharp/Stabbing

Pins, Needles

Other

Previous Injuries:

- Car: When ____ Injury: _____
- Falls: When ____ Injury: _____
- Sport: When ____ Injury: _____
- Work: When ____ Injury: _____
- Other: When ____ Injury: _____

Previous Hospitalizations:

- Surgery: When: _____ What: _____
 When: _____ What: _____
- Fracture: When: _____ What: _____
- Other: When: _____ What: _____

Medications:

- Heart/BP: _____
- Diabetes: _____
- Nerves: _____
- Pain: _____
- Allergy: _____
- Infection: _____
- Other: _____

Please circle where you are at: (No Complaint/Pain) 0 1 2 3 4 5 6 7 8 9 10 (Worst Possible Complaint/Pain)

Patient Signature:

Do not write below this line



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Informed Consent

The following examination is comprised of a series of tests designed to measure your strength and/or functional abilities that relate to performing daily activities. Some of the components of the exam will look specifically at your body's ability to provide muscle resistance and your ability to move extremities and spine. This information will assist in defining and determining the degree of impact your injury is having on your ability to perform daily tasks.

Your participation on this exam requests of you to exert maximal motion, force and effort in response to the activities offered to you to the best of your ability without changing your current level of being. Because you are going to be asked to engage in physical activity, you must be aware of the potential for injury or aggravation of your current status. Make sure that you understand all that is asked of you, that you understand fully the instructions and to stop or not engage in any offered activity in which you are not comfortable. If at any point in time you have increased pain, stop the activity that you are engaging in and report the increased pain. Do not perform any activity that you feel you are unable to perform. At no point in time will you be encouraged to participate in this exam beyond the levels with which you feel comfortable. If you do engage in a given activity, you can terminate your participation at any point in time. Remember, the goal of this exam is to determine your best ability without changing your current level of being. There is no goal that focuses on what you can do despite a worsening of your condition.

You may be placed in positions to isolate and test specific areas of your body. You may be asked to perform isometric tests, simulated lift tasks, cardiovascular tests, work activities, individual muscle tests, hand strength tests, and/or range of motion tests. You will be asked to give your best effort without causing yourself pain. You may be asked to repeat these procedures 2 to 4 times to determine your best effort. You will be allowed to rest at least thirty (30) seconds between each repetition.

You will be exposed to certain risks when performing the aforementioned tests, including temporary pain, a worsening of any existing injury, or a new injury. It is not possible to determine in advance whether or to what extent you will experience any of these complications as a result of doing these tests.

It is your responsibility to inform your evaluator if you have any physical limitations or restrictions prior to beginning the tests. You should gradually exert force or movement until you have reached maximum effort without experiencing pain. You should not jerk or use any form of ballistic movement. If you feel any pain, you must stop the test, and immediately report to the evaluator what has happened.

I understand the above procedures, risks, and instructions and agree to participate in the examination to the best of my ability.

Patient Signature: _____ **Date:** _____

Clinician/Examiner: _____ Date: _____



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Informed Consent to Chiropractic Care

(Please discuss any questions or concerns with the doctor before signing this consent)

I hereby request and consent to the performance of chiropractic adjustments and other chiropractic procedures, including various modes of physical therapy by the doctor of chiropractic named above.

I have had the opportunity to discuss with the doctor and/or with other office or clinic personnel the purpose and benefits of the chiropractic adjustments and other treatments outlined below. Alternatives to treatments have been reviewed:

Though chiropractic adjustments and treatments are usually beneficial and seldom cause any problem, I understand and am, informed that there are some risks to treatments. Risks include, but are not limited to: fractures, disc injuries, strokes, dislocations and sprains.

I understand that I will be receiving the following treatment:

I understand the chiropractic is not an exact science and that, therefore, reputable practitioners cannot fully guarantee results. I acknowledge that no guarantee or assurance has been made by anyone regarding chiropractic treatments that I have requested and authorized. I have had the opportunity to read this form and ask questions. My questions have been answered to my satisfaction. I consent to the proposed treatment.

Signature of Patient, Parent, Guardian or Personal Representative

Date

Printed Name of Patient, Parent, Guardian or Personal Representative

Relationship

Signature of Witness: _____

Date: _____

Signature of Doctor: _____

Date: _____



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OFFICE PAYMENT POLICY

DEDUCTIBLE:

This base amount must be paid each year before your insurance company begins their portion. It is your responsibility to pay this amount. All deductibles should be paid within 30 days of 1st visit.

CO-PAYMENTS:

This amount is patient's responsibility. It is the portion not paid by the insurance company. All co-payments are to be paid at the time of each visit or within 30 days of receipt of the bill.

CANCELLATION FEE:

We request 24 hour notice for cancellations of appointments. If a patient cancels an appointment with less than a one-hour notice, we will charge the patient \$25. Likewise, any appointments for which a patient does not show up, will incur the same \$25 charge. All unpaid balances will be subject to a 1.5% interest charge after 90 days unless prior arrangements are made.

Patient's Signature

Date

Staff's Signature



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Acknowledgement of Receipt of Notice of Privacy Practices

I acknowledge that I was provided a copy of the Notice of Privacy Practices and that I have read (or had the opportunity to read if I so choose) and understand the Notice.

Patient Name (Please Print)

Date

Patient Signature
(or signature of parent or authorized representative)