

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 \_\_\_\_\_

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? \_\_\_\_\_

Are you suffering from the following stresses?  
None A little Moderate A lot  
Personal      
Work      
School      
Family

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 then 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: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_



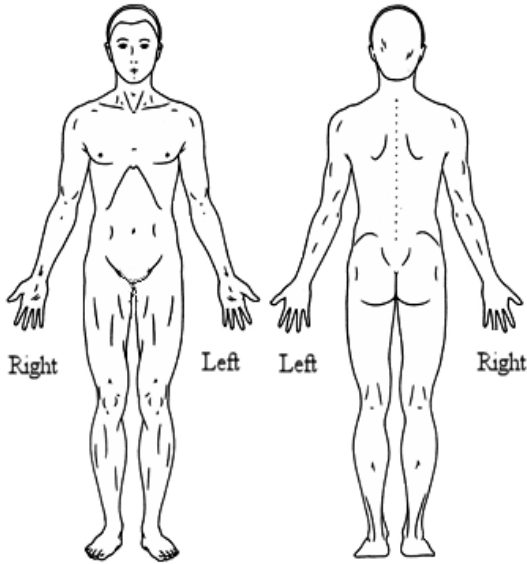
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Using the symbols below, mark on the pictures where you feel pain



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 1<sup>st</sup> 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)