Dr. Christopher Macadam, Dr. Gregory Brunelle & Dr. David Meder
12 Case St. Suite 312 Norwich, CT 06360
860-887-4325 ● Fax 860-823-1426

CONFIDENTIAL PATIENT CASE HISTORY

Please complete this questionnaire. Your answers will help us determine if chiropractic can help you. If we do not sincerely believe your condition will respond satisfactorily, we will not accept your case. THANK YOU.

NAME:_____

ADDRESS:_____CITY:_____ST:_____ZIP:_____

HOME PHONE:_____ BIRTHDATE:_____AGE:_____

WORK PHONE:_____EMPLOYER:_____JOB TITLE:_____

CELL PHONE:_____EMAIL _____

HEIGHT:_____WEIGHT:_____ REFERRED TO THIS OFFICE BY:_____

WHAT IS YOUR MAJOR COMPLAINT?_____

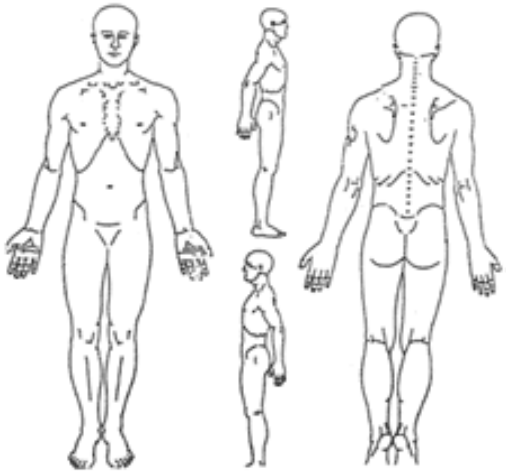
WHEN DID IT BEGIN?_____ HOW DID IT OCCUR?_____

PRIMARY PHYSICIAN:_____ MARITAL STATUS: M S D W

				(Please Explain)
1.	Have you ever been injured in a motor vehicle accident?	Yes	No	_____
2.	Have you ever been injured on the job before?	Yes	No	_____
3.	Have you ever had a similar condition or injury before?	Yes	No	_____
4.	Have you been treated by another doctor for this condition?	Yes	No	_____
5.	Does your condition get worse with activity?	Yes	No	_____
6.	Does your condition get worse with certain positions?	Yes	No	_____
7.	Has your condition gotten worse or better since it first began?	Yes	No	_____
8.	Are you able to perform your duties at work?	No	Yes	_____
9.	Are you able to do your chores at home?	No	Yes	_____
10.	Are you able to get proper sleep at night?	No	Yes	_____
11.	Are you taking any **medication for this condition?** (please list)	Yes	No	_____
12.	Are you taking any other medication for other purposes	Yes	No	_____
13.	Have you had any surgical operations?	Yes	No	_____
14.	Do you have any surgical implants (Metal plates, pace maker)	Yes	No	_____
15.	Have you been hospitalized within the last 5 years?	Yes	No	_____
18.	Are you experiencing more stress than normal lately?	Yes	No	_____
19.	Have you had a physical in the past 2 years?	Yes	No	_____
20.	Do you smoke?	Yes	No	_____
21.	Do you drink alcohol?	Yes	No	_____
22.	Do you participate in any sports or weekly activity?	Yes	No	_____
24.	Do you participate in any regular exercise program?	Yes	No	_____
25.	Have you ever suffered from:			
	1. Dizziness, headaches, sinus trouble	Yes	No	_____
	2. Asthma, heart trouble, diabetes, digestive problems	Yes	No	_____
	3. Arthritis, bursitis, tendonitis	Yes	No	_____
	4. Cancer or any other disease or serious illness	Yes	No	_____
26.	Do you have family history of diabetes, heart disorders, kidney disorders, back trouble or cancer?	Yes	No	_____

THAMES CHIROPRACTIC

PLEASE MARK YOUR AREAS OF PAIN (on the figure) **PLEASE CIRCLE ONE RESPONSE PER QUESTION**



1. Rate how severe your pain is right now **at this moment**.
(*No pain*) 0 1 2 3 4 5 6 7 8 9 10 (*Extreme Pain*)

2. Rate how severe your pain is **at its worst**.
(*No pain*) 0 1 2 3 4 5 6 7 8 9 10 (*Extreme Pain*)

3. Rate how severe your pain is **on the average**.
(*No pain*) 0 1 2 3 4 5 6 7 8 9 10 (*Extreme Pain*)

4. Rate how much your pain is **aggravated by activity.**
(*No pain*) 0 1 2 3 4 5 6 7 8 9 10 (*Extreme Pain*)

5. Rate how **frequently** you experience pain.
(*% of day)* 0 10 20 30 40 50 60 70 80 90 100 %

PLEASE CIRCLE ONE RESPONSE PER QUESTION

AUTHORIZATION AND ASSIGNMENT FORM

In consideration of your undertaking to care for me, I agree to the following:

1. You are authorized to release any information you deem appropriate concerning my physical condition to any insurance company, attorney or adjuster in order to process any claim for reimbursement of charges incurred.
2. I authorized the direct payment to you of any sum I now or hereafter owe you, by attorney, out of the proceeds of any settlement of my case, and/or by any insurance company obligated to make payment to me or you based in whole or in part upon the charges made for your services.
3. In the event any insurance company obligated by contractual agreement to make payment to me or to you for the charges made for your services refused to make such payment upon demand by you, I hereby assign and transfer to you the cause of action that exists in my favor against any such company (the name (s) of which is believed to be correctly set forth under pertinent data) and authorize you to prosecute said action in my name as you see fit and further authorize you to compromise, settle or otherwise resolve said claim as you see fit. However, it is understood that until a reasonable effort has been made to collect the sums due from the insurance company or companies contractually obligated, you will refrain from collecting the amounts owed, directly from me. I understand that whatever amounts you do not collect from insurance company's proceeds, whether it be all or part of what is due, I personally owe and agree to pay to you.
4. In addition to the above, I hereby waive the statute of limitations on collection and/or recovery in this State of Connecticut.
5. In the event of an unpaid account, if the account is transferred to a collection agency, I hereby agree to pay any and all collection fees and/or attorney fees.
6. I further agree that this authorization and assignment is irrevocable and ongoing until all monies owed are paid in full.
7. This authorization for assignment will be in continual effect until revoked by both parties.

_____ _____

Patients/Insured Signature Date

Thames Chiropractic and Acupuncture Center
Informed Consent

12 Case Street, Suite 312 • Norwich, CT 06360
860-887-4325 • 860-823-1426 (fax)

PATIENT NAME: _____

To the patient: Please read this entire document prior to signing it. It is important that you understand the information contained in this document. Please ask questions before you sign if there is anything that is unclear.

The nature of the chiropractic adjustment.

The primary treatment I use as a Doctor of Chiropractic is spinal manipulative therapy. I will use that procedure to treat you. I may use my hands or a mechanical instrument upon your body in such a way as to move your joints. That may cause an audible "pop" or "click," much as you may have experienced when you "crack" your knuckles. You may feel a sense of movement.

Analysis / Examination / Treatment

As part of the analysis, examination, and treatment, you are consenting to the all of the following procedures. If there is a procedure you do not consent to, prior to the history examination, please place a check mark next to that one.

☐ spinal manipulative therapy	☐ palpation	☐ vital signs
☐ range of motion testing	☐ orthopedic testing	☐ hot/cold therapy
☐ muscle strength testing	☐ postural analysis	☐ ultrasound
☐ electrical muscle stimulation	☐ basic neurological examination	
☐ nutritional counseling	☐ acupuncture	

The material risks inherent in chiropractic treatment.

As with any healthcare procedure, there are certain complications which may arise during chiropractic treatment. These complications include but are not limited to: fractures, disc injuries, dislocations, muscle strain, cervical myelopathy, costovertebral strains and separations, and burns. Some types of manipulation of the neck have been associated with injuries to the arteries in the neck leading to or contributing to serious complications including stroke. Some patients will feel some stiffness and soreness following the first few days of treatment. I will make every reasonable effort during the examination to screen for contraindications to care; however, if you have a condition that would otherwise not come to my attention, it is your responsibility to inform me.

The probability of those risks occurring.

Fractures are rare occurrences and generally result from some underlying weakness of the bone which I check for during the taking of your history and during examination and X-ray. Stroke has been the subject of tremendous disagreement. The incidences of stroke are exceedingly rare and are estimated to occur between one in one million and one in five million cervical adjustments. The other complications are also generally described as rare.

The availability and nature of other treatment options.

Other treatment options for your condition may include:

- Self-administered, over-the-counter analgesics and rest

- Medical care and prescription drugs such as anti-inflammatories, muscle relaxants and pain-killers.
- Hospitalization
- Surgery

If you chose to use one of the above noted "other treatment" options, you should be aware that there are risks and benefits of such options and you may wish to discuss these with your primary medical physician.

The risks and dangers attendant to remaining untreated.

Remaining untreated may allow the formation of adhesions and reduce mobility which may set up a pain reaction further reducing mobility. Over time this process may complicate treatment making it more difficult and less effective the longer it is postponed.

Appointment Reminders:

Thames Chiropractic & Acupuncture Center may need to contact you at the phone numbers you provided in regards to your appointments. There will not be any discussion of any medical conditions during these phone calls – the information will strictly pertain to your scheduled appointment. By checking the following box, you may opt not receive these phone calls.

□ I do not wish to have contact via the phone related to my appointment schedules.

DO NOT SIGN UNTIL YOU HAVE READ AND UNDERSTAND THE ABOVE.
PLEASE CHECK THE APPROPRIATE BLOCK AND SIGN BELOW.

I have read [ ] or have had read to me [ ] the above explanation of the chiropractic treatment. I have discussed it with my doctor and have had my questions answered to my satisfaction. By signing below I state that I have weighed the risks involved in undergoing treatment and have decided that it is in my best interest to undergo the treatment recommended. Having been informed of the risks, I hereby give my consent to the treatment.

Dated: _____ **Dated: _____**

_____ **_____**
Patient's Name **Doctor's Name**

_____ **_____**
Signature **Signature**

_____
Signature of Parent/Guardian
(if a minor)