South Windsor Neck & Back

Dr. Christopher A. Colby, DC

PATIENT INFORMATION

Patient Name: _____

Referred by: _____ Marital Status: Single ☐ Married ☐ Divorced ☐ Widowed ☐

Address: _____ City: _____ Zip Code: _____

Telephone: _____ Cell: _____ Work: _____

Social Security #: _____ Email address: _____

Date of Birth: _____ Age: _____ Sex: Male ☐ Female ☐

Employer/ School: _____ Position/ Grade: _____

Emergency Contact: _____ Telephone: _____

Primary Care Physician: _____ Telephone: _____

Physician`s Address: _____

PERSON RESPONSIBLE FOR PAYMENT

Responsible Party: _____ Telephone: _____

Self ☐ Mother ☐ Father ☐ Step Parent ☐ Spouse ☐ Other (Specify) ☐ _____

Address: _____ Zip Code: _____

Date of Birth: _____ Social Security #: _____

Employer: _____

PAYMENT IS DUE AT THE TIME OF SERVICE UNLESS PRIOR ARRANGEMENTS HAVE BEEN MADE

I understand that my insurance company may require a referral for care. If I do not have a valid referral, my insurance company could refuse to pay for my care. If my insurance company requires referrals and I fail to obtain a referral, I agree to assume responsibility for payment of my charges. I understand I am responsible financially if my insurance is not covering my visits. I hereby give South Windsor Neck & Back, LLC permission to release my records to my other doctors and to my health insurance company, including psychiatric, substance abuse and AIDS related information. Further, I acknowledge that I have access to and understand the HIPAA privacy agreement; I understand that I may contact the office manager if I have further questions or complaints and that I am entitled to receive a written copy of these policies at my request. I also understand that I am entitled to receive updates upon request if the Privacy Policy is amended or changed.

Signature: _____ Date: _____

1330 Sullivan Avenue ▪ South Windsor, CT 06074 ▪ Tel. (860) 644-2437 ▪ Fax (860) 644-8590

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South Windsor Neck & Back
Relief today ...function for life!

Patient Name: _____

Account# _____ D.O.B _____

CHIEF COMPLAINT(S): _____

Date of onset: _____

How did it happen? _____

Were you working at the time? □ Yes □ No

What makes it feel better? _____

What makes it feel worse? _____

How does it feel? (sharp, shooting, stiff, dull, aching etc.) _____

What time of day is it best? _____ Worst? _____ ☐ No timing

How severe is it? **(1-10)** with 0 being no pain and 10 being unbearable pain? _____

What other providers have you seen for this condition? ☐ MD ☐ DC ☐ PT ☐ Other: _____

Are you still seeing them? ☐ Yes ☐ No

Do you have a permanent disability rating? ☐ No ☐ Yes _____% Location: _____

What activities have been affected by this condition? _____

When was the last time you felt really good? _____

What are your goals with care? _____

If we were your "Health Genies", what would be your ONE wish? _____

General

	Not Applicable
	Anxiety/Depression
	Change in appetite
	Difficulty sleeping
	Excessive bleeding
	Excessive thirst
	Fatigue
	Fever
	Heat/cold intolerance
	Loss of appetite
	Nausea/vomiting
	Night sweats
	Sudden weight change
	Swollen glands

Illnesses

	Not Applicable
	AIDS
	Asthma
	Arthritis
	Cancer
	Diabetes
	Fibromyalgia
	Glaucoma
	Heart disease
	Hepatitis
	Hypertension
	High cholesterol
	Immune disorder
	Kidney stones
	Osteoporosis
	Prostate disease
	Shingles
	Skin condition
	Stroke
	Tuberculosis
	Thyroid disease
	Ulcer

Neurological

	Not Applicable
	Dizziness
	Fainting
	Headaches
	Head trauma
	Numbness/tingling
	Seizures
	Weakness

Chest

	Not Applicable
	Cough
	Heart palpitations
	Chest pain
	Shortness of breath

Orthopedic

	Not Applicable
	TMJ
	Neck pain
	Mid back pain
	Low back pain
	Shoulder pain
	Elbow pain
	Wrist pain
	Hand pain
	Pelvic/SI pain
	Hip pain
	Knee pain
	Ankle pain
	Foot pain

Eyes/Ears

	Not Applicable
	Blurred vision
	Double vision
	Eye pain
	Ear pain
	Loss of hearing
	Ringing in the ears

Nose/Throat

	Not Applicable
	Chronic discharge
	Hoarseness
	Nosebleeds
	Sinus problems
	Trouble swallowing

Abdomen

	Not Applicable
	Change in stool
	Constipation
	Diarrhea
	Food allergy
	Heartburn
	Pain

Urine

	Not Applicable
	Awaken to urinate
	Burning sensation
	Excessive urination
	Incontinence
	Urinary retention

Woman

	Not Applicable
	Breast masses
	Endometriosis
	Irregular menstruation
	Perimenopausal
	PMS

Habits

	Not Applicable
	Alcohol
	Balanced diet
	Coffee
	Regular exercise
	Stress
	Tobacco

Family History

	Not Applicable
	Arthritis
	Bladder/kidney disease
	Cancer
	Diabetes
	Heart disease
	High blood pressure
	Neurological/stroke
	Thyroid disease

Allergies (list)

Surgeries (list w/ dates)

Medications (list)

Vitamins (list)

Patient's Signature: _____ Date: _____

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Consent Form

PATIENT CONSENT: By answering the following questions, you will assist our team in identifying if you are a qualified to receive the application of today's treatment.

Are you pregnant?	Yes ☐	No ☐
Do you have cancer/tumor?	Yes ☐	No ☐
Do you have a skin infection?	Yes ☐	No ☐
Are 16-years of age or younger?	Yes ☐	No ☐
Do you have a tear in the tendon?	Yes ☐	No ☐
Do you have a cardiac pacemaker?	Yes ☐	No ☐
Do you have bleeding disorder/tendency to bleed?	Yes ☐	No ☐
Are you on NSAIDS, OPIOIDS or anti-coagulant treatment?	Yes ☐	No ☐
Have you received a cortisone injection within the last 30-days?	Yes ☐	No ☐

Please list which areas of concern you would like addressed and treated.

_____

_____

RISKS OF PROCEDURE: There may be temporary pain &/or soreness.
This typically resolves within hours or 1-2 days.

I, _____ , (circle one: Patient / Legal Guardian) do hereby consent to authorize the application of today's treatment for the above stated issues. I fully understand the nature of today's treatment/procedure. I have researched the treatment option &/or the treatment has been fully explained to me by the treating physician/staff. I confirm that upon entering the facility I have been provided the opportunity to have a discussion to clarify any concerns I may have. I authorize that guaranteed results/expectations have not been promised to me. I also understand I am forgoing the opportunity for alternative &/or medical treatments and opting to have today's treatment per my personal discretion.

Signature: _____ **Date:** _____